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# *Can For-profit Catholic Health Care Get the Mission Right?*

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BY KELLY A. CARROLL, J.D.

**A**scension Health, both the largest Catholic and the largest nonprofit health system, announced in early 2011 its intention to create a new kind of joint venture — “an acquisitive, equity-based, for-profit Catholic health care system” — with Oak Hill Capital Partners, a private equity firm.<sup>1</sup> The new entity, Ascension Health Care Network (AHCN), will grow through acquisition of struggling nonprofit Catholic health care facilities and networks, offering them much-needed capital and the ability to retain their Catholic identity and sponsorship while converting them to for-profit entities.<sup>2</sup>

The new health care network's creation comes at precisely the same moment Catholic health care struggles to formulate what constitutes "Catholic identity" and while the political, regulatory and fiscal viability of nonprofit organizations appear to be in great peril.

Various Catholic theologians have argued that Catholic hospitals should and must retain their nonprofit status, on theological and anthropological grounds.<sup>3</sup> However, these arguments were offered primarily in response to the growing threat of secular, for-profit mergers and acquisitions of nonprofit Catholic health care organizations. The advent of a Catholic-owned, for-profit venture, coupled with the current tumult in Catholic identity and nonprofit health care, calls for an examination of the theological basis for preferring nonprofit health care — specifically, teasing apart Catholic identity from nonprofit status.

### **Although seemingly contradictory, for-profit Catholic-owned health care organizations may prove coherent with the Catholic health care mission.**

If, indeed, there is a great deal of overlap between the theological principles supporting Catholic sponsorship and those supporting nonprofit ownership, then perhaps a for-profit, Catholic-owned entity would adequately perform Jesus' healing ministry. On the other hand, perhaps some critical aspects of Catholic health ministry rest on the legal/structural ownership model, regardless of Catholic sponsorship and management. This article attempts to differentiate the qualities of a hospital's Catholic identity from its nonprofit status, concluding that although seemingly contradictory, *for-profit* Catholic-owned health care organizations may prove coherent with the Catholic health care mission.

#### **NONPROFIT HEALTH CARE**

Legally and structurally speaking, nonprofit corporate status is conferred by state laws and may offer benefits such as exemption from state property, income or sales taxes.<sup>4</sup> Yet, "organizing as a non-profit organization at the state level does not automatically grant the organization exemption from federal income tax"; rather, the federal Inter-

nal Revenue Code (pursuant to 501(c)(3)) confers on qualifying charitable organizations both federal income tax-exempt status and the ability to receive tax-deductible contributions.<sup>5</sup> Under current Internal Revenue Code exemption requirements, "health care itself [is] considered a sufficient charitable purpose for exemption."<sup>6</sup>

For simplicity, discussions about "nonprofit" health care organizations in this article refer to nonprofit, tax-exempt charitable organizations, as the vast majority of nonprofit Catholic hospitals meet both state and federal law requirements. It should be noted, however, that these technically distinct terms confer different benefits and rights, and turmoil continues to build over changing requirements for receiving tax exemption at both the state and federal levels.

The nonprofit corporate form presents a unique type of private property ownership in which the assets are neither owned by a private person (corporate or individual), nor by the government or the community. Instead, "nonprofit assets are held in a manner akin to a trust, dedicated to serving a particular purpose that the state has deemed charitable."<sup>7</sup> A charitable trust is "a fiduciary relationship with respect to property arising as a result of a manifestation of an intention to create it, and subjecting the person by whom the property is held to equitable duties to deal with the property for a charitable purpose."<sup>8</sup>

In addition to operating for a charitable purpose, the earnings of a nonprofit cannot be distributed to private persons (e.g., shareholders or investors). The trustees of the nonprofit do not owe a duty to any person or company, they "owe a duty to the community at large with respect to the property held under such trust."<sup>9</sup> The tax exemptions afforded to a nonprofit consequently places a higher tax burden on other community members paying that tax; thus, the subsidizing taxpayers expect that the nonprofit will serve their espoused charitable purpose. A nonprofit can receive tax-deductible donations; and, in the case of nonprofit *hospitals*, government funding, patient fees and private payer reimbursements.<sup>10</sup>

Finally, conversion of a nonprofit organization to a for-profit entity is governed by state law and strictly scrutinized by a state's attorney general. When for-profit health systems purchase nonprofit hospitals, no private party can benefit from the sale (the proceeds are to be used for the public's benefit, and often a separate charitable foundation is formed when the sale occurs). As one health lawyer noted, the state attorney general will determine whether:

... the terms are fair and reasonable to the nonprofit, the sale price is fair market value and has not been manipulated by interested parties, the transaction will not result in private inurement, the sale proceeds will be used in a manner consistent with the organization's charitable purposes, the board has not breached its fiduciary duty of trust, and the transaction is in the public interest and does not adversely affect the availability or accessibility of health care in the community.<sup>11</sup>

#### **BEHAVIORAL DIFFERENCES AMONG OWNERSHIP TYPES**

Although the legal realm clearly differentiates between for-profit and nonprofit organizational structures, University of Michigan law professor Jill Horwitz details the skepticism surrounding the uniqueness of the nonprofit corporate form: "Many scholars claim, however, that diversity of corporate form is essentially a fiction ... While the particular arguments vary, the message is simple. The not-for-profit form does not matter for the public good or, in many cases, matter at all."<sup>12</sup>

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These claims speak more to the function and behavior of the various organizational forms, rather than to the legal form itself. Thus, beginning in the 1990s, researchers sought to measure the differences between health care ownership types (including Catholic) through empirical studies.<sup>13</sup> These studies have produced mixed results and conclusions, and these mixed results have led some researchers and members of Congress to argue that little difference exists between for-profits and nonprofits in the context of health care.<sup>14</sup>

The studies, however, measure different types of community benefits, clinical outcomes, patient demographics and a host of other outcomes difficult to compare. In addition to utilizing empirical inconsistency to support a theory that nonprofits and for-profits have become indistinguishable,<sup>15</sup> some policymakers and scholars have focused

on a measure where there exists some statistical agreement — the provision of uncompensated care — which also represents the narrow measure of "community benefit" currently required on federal tax forms.

In one study examining nonprofit hospitals acquired by for-profit corporations over a 12-year period, researchers found no statistical difference between "the amount of uncompensated care (charity care and bad debt) provided before and after acquisition."<sup>16</sup> Similar reports by the American Hospital Association and the federal adviser Prospective Payment Assessment Commission detail no discernible difference between nonprofits and for-profits in the aggregate amounts of either charity or uncompensated care they provide.<sup>17</sup>

The debate surrounding the definition of "community benefit" has reached a fever pitch, based on rumblings in the federal and state governments about setting a benchmark standard for "community benefit" that nonprofit hospitals wishing to retain tax-exempt status must meet. Opining that nonprofit health care organizations do not

provide community benefits equivalent to the tax exemptions they receive, U.S. Senator Charles Grassley (R-Iowa) stated, "tax-exempt status is a privilege. Unfortunately, some charities abuse that privilege."<sup>18</sup> At the state level, the Illinois Department of Revenue recently denied property

tax exemptions for several nonprofit hospitals whose levels of charity care were deemed to have fallen short, although the state has yet to issue clear guidelines or benchmarks regarding charity care.<sup>19</sup>

Although most scholars seem to concur that little empirical difference exists between for-profits and nonprofits in the provision of uncompensated care, a more expansive view of other types of community benefits demonstrates significant difference between the two corporate forms.<sup>20</sup> After conducting a comprehensive literature review of 275 empirical studies on behavioral differences in nonprofit and for-profit health care, authors Mark Schlesinger and Bradford Gray found that ownership differences do correlate with differences in behavior, in specific contexts and outcomes.<sup>21</sup> For instance, for-profit hospitals exhibit higher mortality rates and higher price markup over costs

than their nonprofit counterparts.<sup>22</sup> Evidence suggests that nonprofit health care organizations “are more likely to provide health promotion services, support safety-net providers, collaborate

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to meet community needs, conduct community health assessments, and work with local health departments.”<sup>23</sup>

In an odd dichotomy, nonprofits have proven slower to react to changes in the market,<sup>24</sup> yet they foster innovation more frequently: “nonprofits are typically the incubators of innovation (for example, health maintenance organizations, or HMOs, during the 1930s or hospice three decades ago), using philanthropy and cross-subsidies to finance the development of services for which there is not yet a market.”<sup>25</sup> As an intangible community benefit, nonprofits provide health care services in a more trustworthy fashion,<sup>26</sup> “being less likely to make misleading claims, to have complaints lodged against them by patients, and to treat vulnerable patients differently from other clientele.”<sup>27</sup>

Finally, Kaiser Permanente CEO David Lawrence argues that nonprofits will be more likely to sustain community benefit activities over the long haul than their for-profit counterparts: “We do not believe that the profit margins in health care [for investor-owned corporations] will be sufficient to sustain investment in direct community benefit and still meet shareholders’ expectations.”<sup>28</sup>

**MORE THAN A COMMODITY**

The late Cardinal Joseph Bernardin, the former Archbishop of Chicago, gave a speech shortly before his death entitled, “Making the Case for Not-for-Profit Healthcare,” often cited by theologians and other scholars who call for the protection of the nonprofit ownership model in health care to prevent the commercialization of health care delivery.<sup>29</sup> In this speech to the Harvard Business School Club of Chicago, Bernardin articulated two main arguments: “first, that health care is more than a commodity — it is a service essen-

tial to human dignity and to the quality of community life; and second, that the not-for-profit structure is best aligned with this understanding of health care’s primary mission.”<sup>30</sup>

Speaking during the height of the managed care and capitation movement in health care, Bernardin sought to counter the growing swell of support for treating health care like other market goods, where economic competition could save health care by increasing efficiency. He argues that health care delivery should not be compared to other market commodities, that it falls into a category of non-economic goods that remain essential to human

dignity. Bernardin describes the American treatment of these types of goods:

In the belief that the non-economic ends of the family, social services and education are essential to the advancement of human dignity and to the quality of our social and economic life, we have treated them quite differently from most other goods and services. Specifically, we have not made their allocation dependent solely on a person’s ability to afford them.<sup>31</sup>

The provision of health care strikes at the heart of an individual’s human dignity — his or her body, mind and spirit — and also the ability of individuals to participate fully in the community. It also supports the community’s character and flourishing, as “[w]e endeavor to take care of the poor and the sick as much for our benefit as for theirs...[w]e all benefit from a healthy community; and we all suffer from a lack of health, especially with respect to communicable disease.”<sup>32</sup>

In perhaps the most compelling argument for economists, Bernardin points out that health care does not behave like other market goods, as it frequently succumbs to “market failure.”<sup>33</sup> Health care consumers (patients) do not purchase health care in a predictable fashion; urgency, geography, and the lack of transparency and accountability afforded by the third-party insurance payer renders comparison shopping for health care practically impossible.

Based on the special nature of health care as more than a mere commodity, Bernardin concludes that, in accordance with one of the ethical hallmarks of medicine “the primary end or essential purpose of medical care delivery should be a cured patient, a comforted patient, and a healthier

community, not to earn a profit or a return on capital for shareholders.”<sup>34</sup>

Similarly, Sr. Jean deBlois, CSJ, Ph.D., in response to the proposed sale of Saint Louis University Hospital to Tenet Healthcare Corporation, a for-profit group based in Santa Barbara, Calif., unequivocally argues that publicly traded, investor-owned companies should never deliver health care services because health care is not a commodity but “a social good rendered in response to basic human need.”<sup>35</sup> Moral theologian Fr. Kevin O’Rourke, OP, J.C.D., concurs in the incompatibility of health care designed to make money and the values of Catholic health care, and theologian Fr. Kenneth Himes, OFM, Ph.D., cautions against the idolatry of “a market ideology which stipulates that everything human is most adequately understood in terms of market value.”<sup>36</sup>

#### **STRUCTURAL ALIGNMENT OF NONPROFIT WITH PROVISION OF HEALTH CARE**

Bernardin contends that four characteristics of health care make the nonprofit ownership model more appropriate structurally, namely access, patient-centered ethic, focus on community-wide needs and volunteerism.<sup>37</sup> Importantly, Bernardin argues for the necessity of nonprofit health care even if the U.S. were to move to a system of universal insurance:

With primary accountability to shareholders, investor-owned organizations have a powerful incentive to avoid not only the uninsured and underinsured, but also vulnerable and hard-to-serve populations, high-cost populations, undesirable geographic areas, and many low-density rural areas. To be sure, not-for-profits also face pressure to avoid these groups, but not with the added requirement of generating a return of equity.<sup>38</sup>

Ethicists Fr. Benedict M. Ashley, OP, Ph.D., Sr. deBlois and Fr. O’Rourke highlight the significance of following a patient-centered ethic: “if the person-centered paradigm becomes predominant, then we can retain the best qualities from the past, develop a health care system that fulfills our personal and social needs, and hopefully extends access to health care to all in need of it.”<sup>39</sup>

Nonprofits remain more deeply rooted in the community, and thus are more likely to provide unprofitable but necessary services such as neonatal intensive care units, burn centers and teaching and research. This community orientation

also renders nonprofits less likely to abandon a community in need when profits dissipate or an economic downturn occurs.<sup>40</sup> A for-profit system concerned with return on investment would give lesser priority to these important characteristics of health care. As Ashley et al. note, “[w]hen profit becomes the principal goal of any enterprise, all other partial goals, no matter how noble, are sooner or later sacrificed.”<sup>41</sup>

In addition, nonprofit health care serves an integral mediation function between the state and private sector.

Private sector failure to provide adequately for essential human services such as healthcare invites government intervention. While government has an obligation to ensure the availability of and access to essential services, it generally does a poor job of delivering them. Wherever possible we prefer that government work through and with institutions that are closer and more responsive to the people and communities being served. This role is best played by not-for-profit hospitals. Neither public nor private, they are the heart of the voluntary sector in healthcare.<sup>42</sup>

Indeed, Bernardin argues, the very structural purpose of a nonprofit distinguishes it from the goals of the business and governmental sectors; and, the nonprofit purpose best serves special human goods such as health and well-being. Quoting the noted management expert Peter Drucker, Bernardin notes,

The ‘non-profit’ institution neither supplies goods or services nor controls (through regulation). Its ‘product’ is neither a pair of shoes nor an effective regulation. Its product is a changed human being. The non-profit institutions are human change agents. Their ‘product’ is a cured patient, a child that learns, a young man or woman grown into a self-respecting adult; a changed human life altogether.<sup>43</sup>

The differing purposes and measurements of performance driving nonprofits and for-profits leads to differences in decision-making processes. They employ “different rationales for decisions about investment, employment policies, product delivery and customer service.”<sup>44</sup> While for-profit institutions focus on the bottom line of profitability, nonprofits must look at both the impact

on the specific organizational mission and the organization's finances.<sup>45</sup> Nonprofits "must measure performance in terms of service to people, of meeting human needs."<sup>46</sup> Nonprofits also place greater importance on the value of employee participation in decision-making, a value supported by the Catholic social teaching that "participation in decisions that affect one's life is a basic human right."<sup>47</sup> Respect for human dignity encourages

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nonprofit leaders to seek input from wider groups of employees, and, by following these principles, nonprofits should see that "mutuality and co-responsibility in community will be promoted as values in themselves."<sup>48</sup>

#### **CATHOLIC ORGANIZATIONAL IDENTITY**

Catholic hospitals represent the largest single private-sector provider of health care services in the United States, with almost 16 percent of all hospital admissions nationwide and more than 20 percent of admissions in 22 states.<sup>49</sup> With approximately 60 health systems and more than 600 hospitals nationwide,<sup>50</sup> the Catholic health ministry experienced a period of consolidation and mergers over the last few decades.<sup>51</sup> These ownership changes, along with the rapid evolution of American medicine, has led to a great deal of debate and reflection within the Catholic health ministry on elucidating health organizations' Catholic identity.

The Catholic Church has a long history of caring for the ill in institutions, serving a prominent role during the early times of American medicine when hospitals, many Catholic, provided care exclusively for the indigent (almshouses). Congregations of women religious predominantly created and owned the first Catholic hospitals, serving these facilities at all levels, from CEO to health care practitioner.<sup>52</sup> The women religious had a noticeable physical presence in the hospi-

tals, both in number and appearance. Catholics would seek out these Catholic hospitals for health care, as hospitals represented an integral part of Catholic subculture.<sup>53</sup>

In the middle of the last century, in order to "enhance their ability to receive public funding, and to protect the religious congregation from legal and financial liabilities stemming from the activities of the hospital," the sponsoring religious congregations created separate legal corporations for their health care institutions.<sup>54</sup>

In addition to the potentially financially devastating consequences of malpractice liability, another influential factor was "state certificate-of-need laws which required proposed health care organizations to provide extensive financial disclosure, since many sponsoring organizations did not want to provide full access to their institution's financial records."<sup>55</sup> Notably, although "a hospital separately incorporated from its sponsoring religious institute may be the civil-law owner of the hospital land and buildings, Church law would consider the hospital property and improvements to be part of the religious institute's public juridic person and hence properties of the institute."<sup>56</sup>

Later, independent, freestanding Catholic hospitals began disappearing at an alarming rate, while Catholic health systems appeared. To maintain Catholic identity in their hospitals acquired by networks or other organizations, the religious congregations created sponsorship arrangements:

The concept of sponsorship has its legal roots in what the civil law might term a blend of trusteeship and ownership. Canon law charges the sponsoring religious institute to be a good steward. Canon 1279 requires the Superior to 'administer' ecclesiastical goods. While canon law does not define 'administration,' this canon is generally thought to require that the sponsoring congregation retain certain key authorities over its health care institutions.<sup>57</sup>

These "reserved powers" retained by the religious congregation afford great legal and organizational control over the health care institution;

they are “powers not given to the governing board but maintained and exercised by so-called corporate members.”<sup>58</sup> Reserved powers include control over corporate bylaws, corporate mission, board and executive appointments, ownership and structural corporate decisions, budget approval and ethical and mission-related decisions.<sup>59</sup>

### CATHOLIC IDENTITY

In discussing the future and identity of Catholic health care, leaders repeatedly cite certain principles of Catholic social teaching, including, “human freedom and dignity, commitment to justice and serving the poor, the common good, stewardship of resources given by God, health care ministry as both curative and exemplary of care for the suffering.”<sup>60</sup> In 2005, the Catholic Health Association (CHA) and its members produced a statement of shared identity, stating that the ministry of Catholic health care is to “promote and defend human dignity, attend to the whole person, promote the common good, act on behalf of justice, care for poor and vulnerable persons, steward resources and act in communion with the church.”<sup>61</sup> Fr. O’Rourke proposes 12 elements that constitute Catholic identity:

- Carrying on the ministry of Christ
- Expressing Gospel values
- Respecting human dignity
- Supporting the sanctity of life
- Fostering a holistic vision of health care
- Ensuring high-quality health care
- Demonstrating a preferential option for the poor
- Forming a community dedicated to social justice
- Fostering the common good
- Observing Catholic ethical and religious directives
- Being a not-for-profit institution
- Being approved by the Church hierarchy<sup>62</sup>

CHA ethicist Ron Hamel, Ph.D., affirms O’Rourke’s call for high-quality health care, and adds some other characteristics that point toward the survival of Catholic health institutions in the current health care delivery environment: the highest professional standards, ability to adapt to changes of secular health organizations, compliance with relevant legal and operational requirements and continued financial solvency.<sup>63</sup>

In a recent empirical study, researchers examined Catholic mission statements to determine services common to Catholic hospitals; they

found access services (emergency and obstetric services), socially stigmatized services (for conditions such as HIV, substance abuse and mental illness) and compassionate care services (focusing on the continuum of care across the span of life) to be common themes throughout the mission statements.<sup>64</sup> White et al. then utilized large national databases to compare the provision of these services among Catholic, other nonprofit, investor-owned and public hospitals.<sup>65</sup> Based on the raw data, the researchers indeed found that Catholic hospitals provide more access services, socially stigmatized services and compassionate care services than the other organizational types.<sup>66</sup> These services are rooted in Catholic social teachings related to ministry to the suffering, respect for human dignity and the common good, and a commitment to justice, and care of the poor and marginalized, discussed below.

### HEALING AS MINISTRY TO THE SUFFERING

The church supports and actively pursues the ministry of healing because it manifests the ministry of Jesus. *The Ethical and Religious Directives for Catholic Health Care Services (ERDs)* state that a “Catholic institutional health care service is a community that provides health care to those in need of it. This service must be animated by the Gospel of Jesus Christ and guided by the moral tradition of the Church.”<sup>67</sup> As revealed in Scripture, “Jesus does not simply *heal* the sick; he *identifies himself* with the sick ... [o]n the cross Jesus takes on the whole weight of physical and moral evil, especially suffering and death.”<sup>68</sup> Thus, Catholics are called to heal as Jesus did, at an individual and institutional level: “Catholic hospitals testify to the Catholic commitment to fight illness and injury ... Catholic nursing homes can be a model of care for the elderly and loving attention to the dying.”<sup>69</sup> Cardinal Bernardin contends that the distinctive nature of Catholic health care “is its vocation to comfort people who are experiencing the chaos of illness, even the prospect of death, by giving them a reason to hope.”<sup>70</sup>

### HUMAN DIGNITY AND THE PRINCIPLE OF THE COMMON GOOD

Respect for human dignity (not a distinctly Catholic concept) remains the key principle in ethical health care delivery. Catholic health care ministry is committed to promoting human dignity, based on the sacredness of and right to human life and adequate health care.<sup>71</sup> Perhaps more important in a discussion of the identity of Catholic health care institutions, respect for human

dignity informs and guides employee relations:

A Catholic health care institution must treat its employees respectfully and justly. This responsibility includes: equal employment opportunities for anyone qualified for the task, irrespective of a person's race, sex, age, national origin or disability; a workplace that promotes employee participation; a work environment that ensures employee safety and well-being; just compensation and benefits; and recognition of the rights of employees to organize and bargain collectively without prejudice to the common good.<sup>72</sup>

The respect for dignity of employees and their work "will ideally promote mutuality, cooperation, and equality, in contrast to the competitive status seeking fostered in a for-profit atmosphere."<sup>73</sup>

Respect for human dignity requires respect for the "conviction that the human person is defined relationally — by the relationships he or she has with God, other persons, and other creatures ... the good of each person is bound up with the good of other persons."<sup>74</sup> This notion that human flourishing comes through relational solidarity describes the idea of the "common good" in Catholic social teaching.<sup>75</sup>

While magisterial documents show an evolution of the meaning of the "common good" over time, magisterial teaching consistently uses the term as a way of combating individualism, instead emphasizing "the social dimension of the human condition [and] human dependence and interdependence."<sup>76</sup> The *ERDs* note that "the common good is realized when economic, political and social conditions ensure protection for the fundamental rights of all individuals and enable all to fulfill their common purpose and reach their common goals."<sup>77</sup> Recently, Pope Benedict XVI rooted the common good in love and charity:

To love someone is to desire that person's good and to take effective steps to secure it. Besides the good of the individual, there is a good that is linked to living in society: the common good. It is the good of "all of us," made up of individuals, families and intermediate groups who together constitute society. It is a good that is sought not for its own sake, but for the people who belong to the social community and who can only really and effectively pursue their good within it. To desire the *common good*

and strive towards it is a requirement of justice and charity."<sup>78</sup>

With its focus on society and institutions, the principle of the common good directly impacts the organizational structure and mission of Catholic health ministry.

#### COMMITMENT TO JUSTICE AND SERVICE OF THE POOR AND MARGINALIZED

The competitive health care marketplace challenges all health care organizations to reduce costs and increase revenues, and with tight profit margins in a regulated market, Catholic organizations distinguish themselves by serving the poor and marginalized.<sup>79</sup> Serving the poor and vulnerable represents an imitation of Jesus' ministry and compassion as described in Scripture and reiterated by Pope John Paul II.<sup>80</sup> The *ERDs* call on Catholic health care to

distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: the poor; the uninsured and the underinsured; children and the unborn; single parents; the elderly; those with incurable diseases and chemical dependencies; racial minorities; immigrants and refugees. In particular, the person with mental or physical disabilities, regardless of the cause or severity, must be treated as a unique person of incomparable worth, with the same right to life and to adequate health care as all other persons.<sup>81</sup>

Although respect for human dignity provides a basis for caring for the most vulnerable, the preferential option for the poor is separately rooted in the Gospel.<sup>82</sup> Separating the provision of health care from one's ability to pay enables Catholic organizations to renew their distinctive fight against the commodification of health care.

#### DISCUSSION AND CONCLUSIONS

The *ERDs* state that "an increased collaboration among Catholic-sponsored health care institutions is essential and should be sought before other forms of partnerships."<sup>83</sup> The Ascension Health Care Network (AHCN) fulfills this recommendation of the U.S. bishops, by allowing struggling nonprofit Catholic health care entities "to maintain in perpetuity the Catholic identity, sponsorship, and mission" of the properties sold to AHCN.<sup>84</sup>



While moral theologians like Fr. O'Rourke and Sr. deBlois find nonprofit ownership essential to Catholic identity, in theory most of the community benefits conferred by the nonprofit ownership model find similar support and significance in Catholic social teachings and the *ERDs*, integral parts of Catholic identity in health care ministry. By retaining the Catholic identity of these hospitals, many benefits of nonprofits will be maintained: respect for human dignity, respect for the unique nature of health care as a social good and not a commodity, service to the poor and marginalized, patient-centered health care, respect for employees, respect for the common good and respect for humans as relational beings.

Nonprofit hospitals have a duty to the community to operate in accordance with their espoused charitable purpose, in part because the community has assumed a greater tax burden in granting those hospitals tax exemptions. Catholic health care organizations' commitment to benefiting their communities is arguably even stronger, rooted in a scriptural commitment to service of the poor and marginalized and respect for the common good.

Finally, experiences of pastoral care directors of Catholic hospitals purchased by the secular, for-profit Tenet Healthcare Corporation support the conclusion that hospitals can retain their Catholic identity and mission within a for-profit company.<sup>85</sup>

Yet, some distinctive aspects of nonprofit ownership may be endangered, even if Catholic identity is retained. The ability of Ascension Health Care Network institutions to serve the mediating purpose in society described by Bernardin, or the ability of the Catholic identity to mediate the decision-making processes and rationales of these new for-profits, remains to be seen.

Private equity firms, by their very nature, provide a temporary investment of capital, and so the partnership of Ascension Health with Oak Hill Partners makes the nonprofit ideal of long-term commitment to communities more difficult to meet. As Seton Hall University health law professor Kathleen Boozang cautioned on the creation of the new Ascension Health Care Network, "the empirical evidence suggests that for-profit companies are very nimble at getting out of communities that are stressed, and they eliminate services that are unprofitable."<sup>86</sup>

Regardless of corporate form, hospitals aim to turn a profit. However, Catholic for-profits will face a more significant challenge balancing the obligations to turn a profit and support the Catholic health care mission when they are in conflict, because earnings will be distributed to investors (return on investment, or ROI). The obligation to provide a return on investment to investors might

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make breaking even or operating at a loss intolerable for any length of time, especially at the beginning stages of this venture (once a larger group of hospitals has been acquired, losses by a few might be more tolerable).

Again, turning a profit and embracing Catholic identity are not mutually exclusive propositions. Many Catholic health care organizations currently do both. These motivations come into conflict most significantly when cuts to valuable services or institutions are contemplated for financial reasons. It appears that the Ascension Health Care Network will seek to avoid such conflicts with its initial acquisitions, as AHCN President and CEO Leo Brideau said that the network is looking to invest in "Catholic hospitals or systems with enough market share and size to succeed ... or the joint venture will enter markets where executives can consolidate Catholic and non-religious hospitals for sufficient scale."<sup>87</sup> Focusing on acquisitions with high potential for sustained success in the local marketplace should enable the AHCN to make a long-term commitment to the community, avoiding some of the gravest conflicts (such as closing a single distressed community hospital).

In the papal encyclical *Caritas in veritate*, Pope Benedict XVI calls on the faithful to create new types of business ownership, seemingly describing the organizational purpose of the AHCN:

... there must be room for commercial entities based on mutualist principles and pursuing social ends to take root and express themselves. It is from their reciprocal encounter in the marketplace that one may expect hybrid forms of commercial behaviour to emerge, and hence an attentiveness to ways of *civilizing the economy*. Charity in truth, in this case, requires that shape and structure be given to those types of economic initiative which, without rejecting profit, aim at a higher goal than the mere logic of the exchange of equivalents, of profit as an end in itself.<sup>88</sup>

While supporting the market and creative business models, Pope Benedict XVI cautions against just the sort of short-term commitment to the community more likely with a for-profit investor: “a speculative *use of financial resources* that yields to the temptation of seeking only short-term profit, without regard for the long-term sustainability of the enterprise.”<sup>89</sup>

In addition, Pope Benedict addresses the concern that the Catholic identity does not necessarily fully replicate the decision-making process of a nonprofit: “there is nevertheless a growing conviction that *business management cannot concern itself only with the interests of the proprietors, but must also assume responsibility for all the other stakeholders who contribute to the life of the business: the workers, the clients, the suppliers of various elements of production, the community of reference.*”<sup>90</sup>

With the important cautions of Pope Benedict XVI in mind, a for-profit, Catholic-owned health care entity that mindfully embraces the distinctive Catholic identity will retain most of the nonprofit characteristics closely aligned with, and perhaps integral to, the meaningful provision of the good of health care.

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#### NOTES

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