The Evolution of Sponsorship Models: A Progress Report

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Despite significant progress in our understanding, we are still asking some of the same questions about identity, authority and competence related to sponsorship — the structured relationships through which the sponsor, in the name of the Church, directs and influences the Catholic health care ministry.[1] I would like to sketch the history of sponsorship in recent decades and pose some questions for the ministry to consider regarding these relationships moving forward.

The first significant change in sponsorship occurred in 1980, when eight groups of sisters agreed to create the Catholic Health Corporation, a civil entity based in Omaha that combined their separately sponsored hospitals into one Catholic system.[2] Eventually, the system became Catholic Health Initiatives, which is now part of CommonSpirit Health.

In 1985, the sisters went a step further and petitioned for establishment of a new juridic person, a type of church corporation that would replace the sisters' collaborative arrangement with a single sponsor. Because this had never been done before, there were a lot of questions. For instance, it was not clear which canonically competent church authority was the most appropriate to establish such an entity.

The system went first to the Congregation for Institutes of Consecrated Life and Societies of Apostolic Life (now a dicastery) in 1985; CICLSAL referred them back to the NCCB (the National Conference of Catholic Bishops, precursor of the USCCB) since a national bishops' conference may establish a PJP. When the NCCB failed to act on the petition, the group considered establishing a PJP in each diocese where they had a ministry. That seemed too complicated, so they settled on a single PJP that would be established in the Archdiocese of Omaha. After further consultation between the Archbishop of Omaha and CICLSAL, CHC was referred back to CICLSAL, which in June of 1991 established Catholic Health Care Federation as the new sponsoring entity for CHC.[3]

The term "sponsorship" is relatively new and does not appear in canon law. The late Fr. John J. McGrath appears to be the first to use the term in 1968.[4] Sr. Melanie DiPietro, SC, JCD, JD, said that she, Father (later Cardinal) Adam Maida and Nicholas Cafardi used the term around 1975 as they were completing a book and needed a title. They wanted to be clear that sponsorship describes a relationship distinct from ownership. At the last minute, they inserted "sponsorship" into the original title and published *Ownership, Control and Sponsorship of Catholic Institutions*.[5]

The late Sr. Mary Concilia Moran, RSM, probably knew about the early use of the term, but

she was the first to examine it systematically and bring it into common usage. In 1978, she said sponsorship "consists of the support of, influence on and responsibility for a project, program or institution which furthers the goals of the sponsoring group." She also provided a detailed list of criteria for sponsorship.[6]

Today, we often define sponsorship as a "link" or a relationship between a good work in health care, education or social services and the Church; this link makes it Catholic. Until the 1980s, sponsorship was highly visible because of the sisters and brothers who literally embodied it, but we didn't talk about it much. Today, sponsorship is invisible to most Catholics, but there is a great deal of theological ferment about what it is, what it means and whether it is effective.[7] (See sidebar on pages 40 and 41 for descriptions.)

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SPONSOR CHALLENGES

Each model of sponsorship faces certain challenges. Let me articulate a few of them.

What is the unique role of the sponsor?

One of the most frequent questions about Catholic health care sponsorship is "What does the sponsor do that is distinct from board governance?" or "Is there anything that is unique to the sponsor's role?"

The sponsor must influence the organization, but it has no operational or managerial role. Its influence is limited to a short but important list of things that are described as *reserved powers* in its statutes and bylaws. These powers differ from one system to another, but they may include appointing or confirming board members and the CEO; changing the mission; presenting regular reports to the Holy See, and maintaining a good relationship with the local church. Maintaining Catholic identity and a functional relationship with the local and universal Church and initiating and ensuring spiritual formation at all levels seem to be the most important.

Systems that have mirror boards, where the sponsor and board are the same group of people, may find it difficult to clarify the unique responsibilities of each. There is a danger that the role of one will just collapse into the other.

Systems that have a separate board and sponsor, on the other hand, need to ensure that the sponsor understands its distinct role to avoid disempowering or interfering with the board. Likewise, the board needs a clear understanding of sponsorship, or it may view input as interference.

The fact that the sponsor's distinct role defined by its reserved powers means its members must have different competencies.[8] Boards have to be diverse and representative of the ministry's service area. They must have financial, legal, medical and other kinds of specialized expertise. Religious and cultural diversity is also important.

The sponsor, on the other hand, may have some of these competencies, but they *must have theological competence* and *ecclesial prudence* so that they can mandate and assess formation for the ministry and navigate the sometimes murky waters of ecclesial relationships.[9] In systems where the board and the sponsor are the same group, we must ask whether it is possible or reasonable to expect board members who are not Catholic or even Christian to exercise sponsor authority in the name of the Church.

Geography and Mission

The Church is divided up into dioceses, which are geographical areas governed by a bishop. The bishop is responsible for the life of the church in his geographical area. Religious communities do a particular specialized work (such as education or health care) and they usually serve in many different dioceses. Our founders responded to bishops' invitations and went where they were called. There was no strategic plan.

Managing such an organization requires a *market* strategy, which is primarily the board's responsibility. But it also requires a *ministry* strategy that is focused on the following question: "What is the most effective way to preach the Gospel through

the ministry of health care?" Board and sponsor must work together to assure that they address both areas.

Diversity and Identity: Can we have it both ways?

Our health care and educational institutions were shaped by generations of European immigrants and the sisters who accompanied them. They planted Catholicism in the United States, and started schools and hospitals to serve others, even though as immigrants and as Catholics they faced discrimination and, in some cases, exclusion.

Today we are serving even more diverse racial and ethnic populations and LGBTQ persons. We intentionally cultivate diversity in our leadership, providers and staff. We are keenly aware of cultural, racial and economic differences that lead to disparities in access and quality of care. CHA's "We Are Called" initiative is just one example of many efforts we are proud of, designed to identify and eliminate socio-economic disparities.

Paradoxically, as we are cultivating diversity, we are also trying to be more Catholic (or more explicitly Catholic). CHA and all of its members have formation programs geared toward deepening identity and mission, but this can sometimes

REVIEW OF PUBLIC MODELS OF SPONSORSHIP

There are two broad categories of juridic persons in canon law: *private* (in which tangible assets are privately owned but at the service of the Church) and *public* in which assets are church property or stable patrimony. We will focus on those that are public.[1] Described in the following are four and a half major kinds of public juridic persons, starting first with "traditional." (You may be wondering how there can be a half of a sponsorship model. I'll get to that shortly.)

1. Traditional Sponsorship: There are two kinds of traditional sponsors, namely, *religious institutes* (mostly women's communities, but some men's communities, like the Alexian Brothers and the Camillians) and *dioceses*, where the bishop is the official sponsor. Both have existed for centuries, but today there are only a few of each of these sponsor models.

Religious sponsorship relies on the presence of a religious institute, usually the founding community. CHRISTUS Health (founded by the Sisters of Charity of the Incarnate Word and joined by the Sisters of the Holy Family of Nazareth in 2016 as co-sponsors) and Franciscan Sisters of Christian Charity Sponsored Ministries in Manitowoc, Wisconsin, are examples. In each case, the sisters themselves are a juridic person, so they are the link between the ministry and the rest of the Church.

Diocesan sponsorship includes systems that were founded or acquired by a diocese. Catholic Health in Buffalo, New York (Diocese of Buffalo and the Franciscan Sisters of St. Joseph), and St. Elizabeth Healthcare (Diocese of Covington, Kentucky) are examples of diocesan-sponsored health care. There are also some diocesan senior care systems, such as ArchCare in the Archdiocese of New York. Institutions under diocesan sponsorship do not need a further link because they are part of the local church.

The next three models do not rely on a traditional religious sponsor but on a new canonical entity — a church corporation called a public juridic person. Dioceses, religious orders, parishes and lay groups like Sant'Egidio are all types of juridic persons. The particular kind we are talking about in health care is often referred to as a "ministerial juridic person" (MJP) to distinguish it from religious orders and other groups that were founded primarily to nurture personal spirituality and prayer rather than to sponsor institutional ministries.

2. Distinct or separate sponsorship exists where a new MJP has been established to succeed the traditional religious sponsor (or sponsors in the case of a merger or collaborative partnership). It meets separately from the board but collaborates with it through regular communication. It may meet jointly with the board for relationship building and common understanding of issues of importance to the ministry, but does not vote on governance matters. Ascension, Bon Secours Mercy and Hospital Sisters Health System are examples of a distinct or separate sponsorship arrangement. SCL Health is a somewhat different case. It recently merged with Intermountain Healthcare but retains its Catholic identity under the sponsorship of Leaven Ministries.

3. Hybrid models are so called because the sponsor is a distinct group of people, but they are all also voting members of the board. In this model, all sponsors are board

appear to be in tension with our efforts to foster diversity. We are accused of discriminating against women, people of color and sexual minorities. Some say we mislead patients about services we provide.[10] Can we counter this negative perception and also promote our Catholic identity? I think we can.

To accomplish this, our formation programs must be inclusive but focused. Our institutions act in the name of the Church, and we are concerned with passing on a particular theological and spiritual heritage through our ministries. We are not out to convert anyone to Catholicism, but we must make a special effort to *explain* Catholicism: what our fundamental theological convictions are, why we do what we do, and how we view the world, political life, economics and the human person. Our view of the person as essentially communal, for example, is not popular in a culture obsessed with individual rights and freedom and which tends to see the culmination of Christian faith in an individual commitment to choose Jesus Christ as a personal savior. Our commitment to the common good is suspect at best in American society, and the notion of sacramentality — that God's grace is mediated through human actions, rituals

members, but not all board members are sponsors. The sponsor members are always present when the board meets, but they also meet separately. Calais Ministries (sponsor of Franciscan Missionaries of Our Lady Health in Louisiana) and SSM Health Ministries (sponsor of SSM Health in Missouri) are hybrid sponsorship structures.

4. A "mirror" board is a third model. Many of Catholic health care's biggest systems, including CommonSpirit Health, Mercy and Trinity Health have what we call mirror boards. In a mirror arrangement, the MJP and the board are the same group of people and function as both the civil board and the canonical sponsor. This group usually includes representatives of some of the founding communities. In some cases, a certain number or percentage of sister members of founding communities are required; in others, it is not.[2]

4 1/2. "Catholic by contract." I call this half of a sponsorship model because it is not sponsorship in the sense that there is an official canonical link to the Church. Instead, these are situations in which an outside, other-than-Catholic entity buys a hospital or other facility from a Catholic system. The buyer may be another faith-based entity, a nonprofit secular entity, a university-based medical center or an investor-owned entity.

In an attempt to maintain Catholic values, these arrangements use a Catholic identity agreement or covenant in which the buyer agrees to preserve some aspects of Catholic identity as a condition of the sale. These conditions vary from one agreement to another, but usually include adherence to the *Ethical and Religious Directives for Catholic Health Care Services*, leadership formation, a priest chaplain, hiring of a senior mission leader, one or more seats on the governance board, maintenance of Catholic symbols, chapel and sacramental services and ways of honoring the founding community. These arrangements lack permanence and in some cases may only be an attempt to lessen the pain of the need to sell.[3]

Examples of this model are Mercy Hospital in Miami, owned by HCA Healthcare; Saint Vincent Hospital in Worcester, Massachusetts, owned by Tenet Healthcare in partnership with the Diocese of Worcester; and Mercy Hospital of Pittsburgh, which merged with the University of Pittsburgh Medical Center as UPMC Mercy.

NOTES

1. Fr. Frank Morrisey, "Canon Law–Ownership Defined Differently in Civil, Canon Law," *Health Progress* 90, no. 1 (January/February 2009): 14-15. PeaceHealth is the only private juridic person in the United States. This means that while it is a Catholic work, the material goods are held by a civil corporation and are not considered church goods.
2. Some charters require that the sponsor have a certain number of religious; some require a majority of Catholics, while some do not stipulate that religious are required, but allow the original sponsors to appoint and remove members of the PJP.
3. Sr. Sharon Holland, "Sponsorship and the Vatican," *Health Progress* 82, no. 4 (July/August 2001): 35; Kathleen Boozang, ed., "Is a For-Profit Structure a Viable Alternative for Catholic Health Care Ministry?" Proceedings of a Symposium, Seton Hall Law School in Collaboration with the University of St. Thomas (Seton Hall University, 2012).

and relationships — was largely rejected by many of the Reformers in favor of unmediated grace and reliance on Scripture alone.[11]

How do pontifical Ministerial Juridic Persons (MJPs) relate to the local Church?

The sponsor has a canonical obligation to the universal Church. It is the Holy See that grants approval to new pontifical MJPs, and these MJPs must report regularly to Rome.[12] Accountability on a local level is more complicated because most Catholic health systems in the U.S. are large and may operate in five, 10 or even 20 different dioceses. This is not so much of an issue in traditional sponsor models because religious orders have years or even centuries of experience working with local bishops. Bishops and religious superiors understood each other's roles and knew how to make it all work.

It is a bigger concern for new MJPs whose lay members do not have that history and who may be operating from an "obedience" model rather than a kind of collaborative one that is necessary for a sponsor and a bishop who both report to the Holy See. Most lay people know nothing about MJPs, and there are even some bishops who do not fully understand the reality of new MJPs and how to relate to them. The ministry's formation programs for sponsors must help lay members acquire the *ecclesial prudence* that enables them to fulfill their mission and do so in particular diocesan churches.

Who is competent to establish and oversee new ministerial juridic persons?

I already noted the early confusion that began in 1985 about who would establish the Catholic Health Care Federation. This remains an issue today.[13] DICLSAL continues to consider petitions for new MJPs, but it has made it clear that new MJPs will be approved only if the petitioner can assure that there will be religious who serve as members of the MJP into the foreseeable future. Today, however, we can see that many founding communities are diminished and some will complete their mission and cease to exist. There will be cases in which a sponsor body has no religious members at all yet the dicastery says its competence does not extend to such entities. It has rejected at least one petition from a group that could not guarantee the presence of sisters for the long term.

What happens if the founding community has no more sisters who can serve on the sponsor body? Do they just find any religious who happens to be available? If we do that, how do we preserve the charism of the founding community?

Can a MJP consisting entirely of lay people be created? If so, who would be the competent authority to approve it? DICLSAL with a modified charter? Another existing dicastery? An entirely new dicastery? These questions echo those that arose in the creation of the Catholic Health Care Federation.

We are keenly aware of cultural, racial and economic differences that lead to disparities in access and quality of care. CHA's "We Are Called" initiative is just one example of many efforts we are proud of designed to identify and eliminate socio-economic disparities.

The creation of an entirely lay MJP would be the most important development in the role of the laity since Vatican II.[14] Lay people always "helped the sisters" with their ministries, but soon they may be fully in charge and directly accountable to the Holy See. Do we have confidence that we can now identify and form lay members of MJPs to lead their institutions as *ministries* of the Church? Are we prepared to provide the kind of adult ecclesial formation they need? Are these lay persons able to grasp, preserve and transmit the charism they have inherited and keep our institutions as vital and effective in the Church and for the world as they were in the past?[15] If we are unable to do so, Catholic health care (and education) will cease to exist as ministries of the Church in any meaningful way.

CONCLUSION

There is no assurance that Catholic health care as we know it today will survive into the future.

I believe that Catholicism's institutional presence in the world is essential. Our institutions provide essential services, and they are a counterbalance to secular institutions that do not serve the common good or promote human flourishing in the same way.

However, the fact that we have retained our identity and values — despite continued mergers and acquisitions and partnerships, political intrigue, concerns over government funding and pressure to conform to secular expectations — is very encouraging. I believe that Catholicism's institutional presence in the world is essential. Our institutions provide essential services, and they are a counterbalance to secular institutions that do not serve the common good or promote human flourishing in the same way. They are also a sacramental presence to the world. They exist in time and space but reveal the transcendent.

With continued development of sponsorship by Catholic laity and formation of leaders and associates, the Catholic health care ministry can remain an important Gospel presence in the American context.

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NOTES

1. Anne Asselin, "The Ministry of Sponsorship and Its Duty of Accountability," *Studia Canonica* 55, no. 1-2 (2021): 75-102; Sr. Doris Gottemoeller, "Challenges for Sponsorship Today," *Health Progress* 103, no. 3 (Summer 2022): 12-16.
2. This effort was preceded by the Sisters of Mercy, who in 1976 brought their hospitals in the Midwest into the Sisters of Mercy Health Corporation which is now part of Trinity Health. See historical note at https://www.mercyone.org/about-us/history.
3. The history of this process is described in detail by Fr. Jordan Hite and Jane E. Poe, "An Innovative Way to Continue the Ministry" *Health Progress* 73, no. 7 (September 1992): 56-58.
4. John Joseph McGrath, *Catholic Institutions in the United States: Canonical and Civil Law Status* (Washington, DC: Catholic University of America Press, 1968). This was early in the debate about whether hospital properties remained church goods when they were owned by a civil corporation.
5. Fr. Adam Maida and Nicholas P. Cafardi, Pennsylvania Catholic Conference (Harrisburg, Pennsylvania, 1975). See Sr. Melanie DiPietro, SC, "An Examination of the *Universitas Rerum* and the *Universitas Personarum* of New Public Juridic Persons Succeeding to the Healthcare Apostolates of Religious Institutes in the United States" (JCD diss., Pontifical University of St. Thomas Aquinas, 2004), 37-39, note #47. The term sponsorship suggested "under the auspices of," and was meant to highlight influence rather than title to property and to allow some flexibility for the future. It did not have all the technical nuance it has today.
6. Sr. Mary Concilia Moran, RSM, "Sponsorship: The Uneasy Question," *Hospital Progress* 59, no. 10 (October 1978): 52.
7. Karen Sue Smith, *Overview of Sponsorship* (St. Louis: Catholic Health Association, 2014), https://www.chausa.org/docs/default-source/sponsorship/overviewofsponsorship-karensuesmith.pdf?sfvrsn=0. CHA uses this definition of sponsorship: "Sponsorship of a health care ministry is a formal relationship between an authorized Catholic organization and a legally formed system, hospital, clinic, nursing home (or other institution) entered into for the sake of promoting and sustaining Christ's healing ministry to people in need." Patrick Shea provides several definitions of sponsorship, in "Transitioning Sponsorship with Regard to Religious Institutes," *Proceedings of the Catholic Theological Society of America Annual Meeting* 77 (2015): 328-351.
8. *Guide for Sponsors in Catholic Health Care: An Explanation of Purpose, Qualifications, Structures and Competencies* (St. Louis and Washington, DC: Catholic Health Association, 2021).
9. Anne Asselin makes a similar point: "Members who sit on sponsorship boards, although fulfilling the usual responsibilities of other corporate boards, must realize that far more is required of them." ("The Ministry of Sponsorship," 90.)
10. Katherine Stewart, "Why Was a Catholic

Hospital Willing to Gamble with My Life?," *The New York Times*, February 25, 2022, https://www.nytimes.com/2022/02/25/opinion/sunday/roe-dobbs-miscarriage-abortion.html; Frances Stead Sellers and Meena Venkataramanan, "Spread of Catholic Hospitals Limits Reproductive Care Across the U.S.," *The Washington Post*, October 10, 2022, https://www.washingtonpost.com/health/2022/10/10/abortion-catholic-hospitals-birth-control/. Groups like MergerWatch monitor expansions by Catholic hospitals with the assumption that such agreements limit women's care.

11. Clarke E. Cochran, "Renewing the Sacramental," *Health Progress* 84, no. 6 (November/December 2003): 12-15.

12. Today there are about 35 pontifical ministerial juridic persons. There are 18 in the United States, 13 in Australia and three in Canada. Those in Australia belong to an umbrella membership organization called the Association of Ministerial PJPs Juridic Persons.

13. Sr. Sharon Holland, IHM, JCD, discusses the basis for CICLSAL'S competency on page 34 in "Sponsorship and the Vatican," *Health Progress* 82, no. 4 (July/August 2001). In a later article she notes that national bishops' conferences have the competency to establish juridic persons and suggests that the Pontifical Council for the Laity and the Pontifical Council for the Pastoral Care of Catholic Health Care Workers as entities that could possibly erect new PJPs. "Vatican Expert Unpacks Canonical PJP Process," *Health Progress* 92, no. 5 (September/October 2011): 54.

14. A 2014 article written at the request of a number of CEOs described the development of these new canonical entities. Catholic Health Association, "Ministerial Juridic Persons: The Growing Role for Laity in Canonical Sponsorship of Catholic Health Care," *Health Progress* 95, no. 5 (September/October 2014): 60-63.

15. Sr. Sharon Holland raises the question of formation twice. In 2001 she asks, "Is there adequate formation for a 'Catholic culture' led by laypersons, especially for those more accustomed to working in the public sector?" in "Sponsorship and the Vatican," 37; in 2011 she asks whether the laity are prepared: "From the beginning … there was a sense that the PJP might be a provisional, or even an immediate, step toward total lay responsibility for the apostolates long in the hands of religious. Congregations neither affirmed nor denied the possibility of an eventual lay responsibility for the ministry. However, most intended to retain qualified religious in the governing group for the immediate future. The goal was to preserve the future of the apostolic works in the church, and to do so while the religious still had choices about how to proceed and while there were still active and expert members who could mentor a new beginning." ("Vatican Expert," 59.)

This article was updated in 2023 to clarify the sponsors of Catholic Health in Buffalo, New York, and CHRISTUS Health in Irving, Texas.

QUESTIONS FOR DISCUSSION

In this article on sponsorship, CHA's Senior Director of Theology and Sponsorship, Fr. Charles Bouchard, OP, STD, explains the complexities of forming early public juridic persons before highlighting the evolution of different sponsorship models and posing some key questions to consider about sponsorship's future.

1. Who do you think needs to understand what a sponsor is and their role in your Catholic health care ministry? Is it church leadership, executive leadership, frontline care providers or the public? Why?

2. Does your system or facility effectively explain sponsors and their roles? Why is this important to advance the healing ministry of Jesus?

3. If you are on a sponsor board, what are your thoughts about the best ways to prepare for the future? How do you communicate the values of your organization to others? If a tension arises between secular and Catholic understandings on an issue, how do you proceed to maintain the integrity of the ministry?

4. Leadership roles in Catholic health care require a variety of intellectual abilities and skills related to theology, ethics, health care, medicine and business, among others. What does your system do to support these needs? Is more education or formation needed? Or possibly a greater ability to build teams where people's diverse skills can be joined together?