The Growing Presence of Faith-Based Hospitals in California Restricts Access to Sexual and Reproductive Healthcare

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Abstract

Sexual and reproductive healthcare restrictions imposed by faith-based hospitals prevent women, sexual minorities, and gender minorities from accessing the full range of comprehensive healthcare. The share of faith-based hospitals in California has increased rapidly in recent years, but no analysis has been completed to understand their distribution and rate of growth. In this paper, we calculate the percentage of religiously affiliated acute, short-term hospital beds per California county. We find that faith-based hospitals have a majority market share in 17 out of 58 California counties. Furthermore, while the percentage of faith-based hospitals in these counties has remained relatively stable from 2000-2010, this proportion has increased tenfold in the past decade. Our data suggest that the expansion of faith-based healthcare systems in California presents a significant barrier to sexual and reproductive healthcare access.

Introduction

Faith-based hospitals refer to hospitals that are affiliated with a certain religion. In the United States (US), the dominant faith-based hospital systems are Christian, specifically Catholic: 10 out of the 35 largest health systems in the U.S. are affiliated with the Catholic church, and 1 out of 6 hospital beds in 2016 were under the purview of the Catholic Church (Solomon et al. 2020). In general, Christian hospital systems decline to provide a variety of medical sexual and reproductive health (SRH) services, but the types of restrictions enforced vary depending on the hospital's religious affiliation (Table 1).

Faith-based hospitals, like those owned or affiliated with the Catholic Church or Seventh-Day Adventist Church, operate on religious doctrine that can prevent women, sexual minorities, and gender minorities from receiving evidence-based and doctor-informed care (Guiahi et al. 2020; Hill, Slusky, and Ginther 2019; Kaye et al. 2016; Stulberg et al. 2010, 2012, 2014). Catholic

hospital systems impose the most severe faith-based restrictions on SRH because they operate under the Ethical and Religious Directives (ERDs) written by the U.S. Conference of Catholic Bishops (United States Conference of Catholic Bishops 2018). Reproductive healthcare services prohibited by the ERDs include assisted reproductive technology (e.g., *in vitro* fertilization), contraception (e.g., intrauterine device implantation), and sterilization (e.g., tubal ligation or vasectomies). The ERDs also restrict the circumstances under which physicians can terminate a pregnancy, including when it would be the safest and most effective medical treatment. All elective abortions are prohibited, including for pregnancies resulting from sexual violence or incest.

Recent legislation has also dramatically limited access to SRH for many patients across the United States. A record number of abortion restrictions passed across 21 states in 2021(Guttmacher Institute 2021); in 2020-2021 alone, half of US states enacted or proposed restrictions on gender-affirming care for transgender youth (Movement Enhancement Project 2021). California legislators have been focused on responding to legislation that seeks to restrict access to abortion and gender-affirming care nationwide. To date, California has the greatest number of laws in place to protect access to reproductive healthcare (Guttmacher Institute 2018) and officials have rallied behind an effort to make California a "sanctuary state" for SRH: examples include eliminating out-of-pocket abortion cost for certain insurance providers (*S.B. 245* 2022) and expanding the eligibility of licensed nurse practitioners to perform elective first-trimester abortions (S.B. 1375 2022). The Legislature has also introduced bills that would protect the privacy of out-of-state patients seeking abortion in California (A.B. 2091 2022) and block out-of-state subpoenas of families of transgender youth who have received gender-affirming care (Farrell 2022; S.B. 107 2022).

While California takes legislative steps to preserve access to SRH, the influence of faith-based hospitals has been growing largely unchecked in the state. This growth has been enabled by a general lack of awareness of these hospitals' existence and policies, as well as their prevalence and impact on healthcare access. Here, we survey SRH restrictions imposed by California's faith-based hospital systems, review the medical impacts of these restrictions, and discuss legislative precedents for building accountability of these systems. In the first study of its kind, we present data on the prevalence of faith-based hospitals across California counties, analyzing the distribution and rate of growth of these faith-based systems. Overall, our study suggests that current regulations on publicly funded faith-based hospitals in the state insufficiently protect the interests and rights of California patients.

Background: Consequences of sexual and reproductive healthcare restrictions

I. Maternal health

Restrictions on comprehensive and evidence-based SRH services have far-reaching and often life-threatening implications. Terminating a pregnancy is often the safest and most effective medical treatment in the cases of ectopic pregnancy (A. M. Foster, Dennis, and Smith 2011), miscarriage, pregnancy with a lethal anomaly, or when the mother has underlying conditions such as severe preeclampsia, intrauterine infection, or certain cancers (UC WGCA 2020). For these patients, abortion may be necessary to prevent life-threatening complications such as

hemorrhage and sepsis (Bryant et al. 2011). However, the ERDs only permit terminating pregnancies once the complication has occurred and the pregnant person's life is in immediate danger (Freedman, Landy, and Steinauer 2008; Freedman and Stulberg 2013; Hamel and Louis 2014; United States Conference of Catholic Bishops 2018).

SRH restrictions thus force physicians to determine an acceptable threat of death before terminating a pregnancy, leading to prolonged expectant management of pregnancy complications (also known as 'deferred therapy') as doctors hesitate to intervene (Belluck 2022; Freedman, Landy, and Steinauer 2008; Raghavan 2007). A recent study in Texas shows nearly a twofold increase in serious maternal morbidity in hospitals compelled by statewide legislation to provide expectant management instead of immediate intervention (Nambiar et al. 2022). Furthermore, when physicians do decide that an imminent lethal threat to a patient necessitates an abortion, that patient can be endangered by a lack of resources, medications, and trained professionals in hospitals that do not routinely perform the procedure (Guiahi et al. 2020; Kaye et al. 2016) and substandard care from the chilling effect on physician practice (Arey et al. 2022; A. M. Foster, Dennis, and Smith 2011). Indeed, 1 in 10 of U.S. accredited obstetrics and gynecology residency programs occur at faith-based hospitals and lead to deficiencies and delayed competency in training (Guiahi et al. 2020). Catholic training hospitals in particular reported poor abortion training, graduate training requirements not being met for crucial miscarriage care, and citations for poor family planning training (Guiahi, Hoover, et al. 2017).

Aside from medical risks, studies suggest there may also be emotional and economic risks to SRH restrictions on abortion. A 2015 investigation of depression and anxiety trajectories experienced by women in the Turnaway Study– a longitudinal study of women who either received or were denied an abortion– predicts greater initial anxiety levels among women denied an abortion (although the increased anxiety was not shown to persist long-term) (D. G. Foster et al. 2015). Furthermore, linking credit report data with the Turnaway Study indicates that those who were denied an abortion experience a large increase in financial distress that is sustained for several years, including a 78% increase in the amount of debt at least 30 days past due and an 81% increase in negative public reports, like bankruptcies or evictions (D. G. Foster et al. 2018; Miller, Wherry, and Greene Foster 2020). This study suggests that denying abortion has economic penalties beyond the birth of a child to a woman of similar socioeconomic status (Miller, Wherry, and Greene Foster 2020). Even if women are able to obtain an abortion by visiting a different clinic, patients in counties with a high prevalence of faith-based healthcare facilities may need to travel long distances for their procedure. Traveling to circumvent abortion restrictions has been shown to lead to delays in care, negative mental health outcomes, and even consideration of self-induction (Jerman et al. 2017). Taken together, these studies indicate that the outright denial of abortion access– or even increasing logistical barriers to abortion access– is associated with increased emotional and financial stress for women.

II. Family planning

Advances in family planning, which refers to the ability of individuals to determine their family size and the timing of their children, have led to substantial decreases in maternal mortality and improvements in maternal health and socioeconomic conditions (Butler and Clayton 2009). However, components of such medical advancements—including contraception, assisted

reproductive technology, and elective sterilization—can be restricted at faith-based hospitals and are expressly prohibited by the ERDs, at times causing increased medical risks to patients. Many faith-based hospitals refuse to provide contraceptive care (Liu et al. 2019), including long-acting reversible contraception such as intrauterine devices (IUDs) that have led to fewer unintended pregnancies (Guiahi 2020). Since the ERDs also prohibit many fertility treatments, including *in vitro* fertilization, the ability of individuals to benefit from safe medical advancements in family planning can be denied (United States Conference of Catholic Bishops 2018).

Patients seeking sterilization may face increased medical risks when denied service at faith-based medical centers. The American College of Obstetricians and Gynecologists suggests performing desired sterilization procedures (tubal ligation or salpingectomy) 'opportunistically' during a cesarean section or immediately after vaginal delivery (Committee on Health Care for Underserved Women 2021). Doing so allows doctors to use the anesthetic administered and incisions made to perform the procedure with minimal added risk or recovery time for the patient (Chan and Westhoff 2010). Because the ERDs prohibit sterilization, patients delivering their children at faith-based hospitals are unable to request this additional postpartum procedure (Menegay et al. 2022; Stulberg et al. 2014). Indeed, mergers resulting in hospitals' switch to Catholic ownership were found to reduce rates of tubal ligation by 30% (Hill, Slusky, and Ginther 2019). This restriction particularly disadvantages women who have a family history of ovarian cancer, for whom opportunistic salpingectomies are the recommended cancer prevention strategy by the American College of Obstetricians and Gynecologists (Committee on Gynecologic Practice 2019) and the Society of Gynecologic Oncology (Society of Gynecologic Oncology 2013). Whether for birth control or cancer prevention, patients delivering via cesarean section and seeking sterilization would have to schedule separate 'interval' tubal ligations or salpingectomies at a secular facility, requiring another round of incisions under general anesthesia (Kaye et al. 2016). Although these procedures are generally considered safe, previous abdominal or pelvic surgery (like a cesarean section) is an independent risk factor for one or more complications from interval laparoscopic tubal ligation (Committee on Health Care for Underserved Women 2021; Jamieson et al. 2000).

III. Healthcare for sexual and gender minorities

SRH restrictions additionally affect sexual and gender minorities. For example, in order to conceive, same-sex couples rely primarily on *in vitro* fertilization (Weigel et al. 2020), which the ERDs prohibit. Additionally, the vast majority of Catholic hospitals will not provide hormone therapy or gender-affirming care for transgender patients (UC WGCA 2020), despite an overwhelming consensus among physicians that gender-affirming care is a critical component of comprehensive healthcare (Medical Association Statements Supporting Trans Youth Healthcare and Against Discriminatory Bills 2021). A statement by the U.S. Conference of Bishops to the U.S. Department of Health and Human Services states that "we object to the proposed mandatory coverage of health services related to gender transition… medical and surgical interventions that attempt to alter one's sex are, in fact, detrimental to patients. Such interventions are not properly viewed as health care because they do not cure or prevent disease or illness. Rather they reject a person's nature at birth as male or female" (United States Conference of Catholic Bishops 2018). This dismissal of the essential nature of gender-affirming care for transgender patients illustrates

how non-scientific standards can override evidence-based medicine to dictate physicians' decisions in faith-based hospitals.

Table 1: Restrictions on sexual and reproductive healthcare vary across faith-based hospital systems. The table below lists reported availabilities of various sexual and reproductive healthcare services across three major categories of faith-based hospitals in California. Catholic facilities in California that follow the Ethical and Religious Directives include hospitals managed by Dignity Health, Providence St. Joseph, Ascension Health, and Trinity Health.

Procedure or Service	Catholic Facilities (ERDs)	Dignity Health Other-than-Catholic Facilities (Statement of Common Values)	Adventist Health
Contraception	No	Varies[2]	Yes
Assisted reproductive technology	No	No	Yes
Elective sterilization	No	Varies[2]	Yes
Elective abortion	No	No	No
Abortion to treat miscarriage	Varies[1]	Unclear[2]	Varies[4]
Abortion in instances of incest or rape	No	Unclear[2]	Varies[5]
Referral to abortion service	No	Unclear[2]	Varies[6]
Gender-affirming hormone therapy	No	Varies[2]	Varies[7]
Gender-affirming Surgery	No	Varies[3]	No

[1]The ERDs only permit abortion as a miscarriage treatment when the pregnant person's life is in immediate danger
[2]Individual other-than-Catholic facilities vary in their policies on emergency abortions, elective sterilization, gender-affirming care, and IUD placement. Patients must ask or examine Dignity Health & CHI merger impact reports to determine if their medical center of choice will provide treatment.
[3]Only Bakersfield Memorial, St. Francis Memorial, and Sequoia Hospital perform gender-affirming surgeries.
[4]When a patient experiencing a miscarriage is not in immediate danger of dying, abortions are referred to the hospital's ethics committee.
[5]Contingent on sexual assault victims presenting at the hospital for a medical forensic exam.
[6]Referral services are provided at an individual physician's discretion.
[7]Statement of transgender care (Adventist Health Policy Association 2020) is belied by a statement from the Church (Seventh-day Adventists Executive Committee 2017).

Statement of Issue

I. Faith-based healthcare policies lack informed consumer consent

In California, three categories of faith-based hospital systems restrict SRH procedures: Adventist-affiliated hospitals, Catholic-affiliated hospitals, and Dignity Health non-Catholic hospitals (Table 1). Dignity Health is a Catholic hospital system but manages non-Catholic hospitals that follow the Dignity Health Statement of Common Values instead of the ERDs (Dignity Health n.d.). This Statement prohibits physicians at these hospitals from providing abortion and *in vitro* fertilization. Adventist Health lacks an equivalent of the ERDs and does not consistently disclose healthcare restrictions on their hospital websites. Statements from the organization suggest that elective abortions are banned while abortions to address life-threatening pregnancy complications or underlying medical conditions are permitted at the discretion of the attending physician and, in some instances, the hospital's ethics committee (Littlefield 2020; Seventh-day Adventists Executive Committee 2019; Xavier Becerra Attorney General 2019).

Patients must have adequate information about the availability of SRH services in order to fully and ethically participate in shared decision-making with their doctors (Murray 2012). Nationwide, poor transparency across faith-based hospitals makes it difficult to understand whether a hospital is religiously affiliated, in turn limiting the patient's ability to engage in informed and ethical decision-making. Less than 25% of Catholic hospital websites across the U.S. cite their adherence to the ERDs, and only 15% provide a direct link to the ERDs (Takahashi et al. 2019). Thus, although 80.7% of American women state that it is important to be informed of religious restrictions on obstetric/gynecological care (Freedman et al. 2018), many patients remain unaware of faith-based healthcare policies – one national survey estimates that 37% of women whose primary hospitals are Catholic are unaware of the affiliation (Wascher et al. 2018). Even if patients are aware of religious affiliation, many do not materially understand how this affects their healthcare options: a 2013 survey found that patients' expectations for receiving an IUD were similar at Catholic and secular clinics (Guiahi, Sheeder, and Teal 2014), and a mystery-caller study of found that only 32% of the 95% of Catholic gynecology clinics that agreed to book a birth control appointment disclosed –with prompting– that copper IUDs would not be offered to the patient (Guiahi, Teal, et al. 2017).

II. The regulation and oversight of faith-based hospitals in California are underdeveloped

While existing regulations provide some guidance and control over mergers and acquisitions of healthcare entities (Chang et al. 2020), there is no standardized regulation of hospital acquisitions by faith-based systems in California. The sale or transfer of acute-care hospitals that receive public funding is reviewed by the state Department of Justice (Nonprofit Health Facility Transaction Notices 2012). These reviews have prevented the expansion of faith-based hospital systems in the past: then California Attorney General (AG) Xavier Becerra blocked St. Joseph Health from acquiring Adventist Health System/West facilities. This proposed merger was predicted to have restricted SRH care in six rural California counties. While both hospital systems are faith-based, St. Joseph Health is a Catholic system that follows the ERDs and imposes more severe SRH limitations on patients than the Adventist Health system (Table 1) (Meyer 2019, 20).

Although the AG review process has blocked some proposed mergers, merger oversight largely focuses on healthcare prices, not reproductive rights. Consequently, the approval of the 2018 merger of Dignity Health & Catholic Healthcare Initiatives requires the acquired non-Catholic Dignity Health facilities to adopt the Statement of Common Values by 2024 (California DOJ greenlights CHI-Dignity merger, with conditions 2018; Office of the Attorney General's Dignity Health Decision 2018; Solomon et al. 2020), which prohibits certain SRH procedures. It is also important to note that since the AG review process is the primary avenue of oversight, regulatory decisions can vary across administrations.

Data and Methods

To determine which sexual and reproductive health services are offered across three primary faith-based or religiously affiliated hospital systems described in Table 1 above, we employed a two-pronged approach. First, we searched the relevant websites and documentation for each category (Catholic Facilities, Dignity Health Other-than-Catholic Facilities, and Adventist

Health) for SRH-related keywords. Next, we used an email approach to assess what SRH services are available to patients and the ease of obtaining such information from a patient perspective. Since most emails did not receive a response, the data presented in Table 1 is largely based on pre-existing public information. All accessed webpages and documents, searched keywords, and contact information are listed in the Methodological Appendix.

To calculate the presence of faith-based short-term acute-care hospitals in California, we first identified hospital facilities and staffed beds available in all 58 counties. To do so, we used a combination of the Hospital Annual Utilization Report accessible from the California Health and Human Services Open Data Portal and the American Hospital Directory (AHD). Both are open-source, publicly accessible databases that contain a list of California hospitals and the number of staffed hospital beds within each facility with updated data from the last year. The Hospital Annual Utilization Report contains data reported directly from facilities to the California Department of Health Care Access and Information as required by the Health Data and Advisory Council Consolidation Act (California Health and Safety Code §127285). These reports include information on patient services provided by bed classification. The AHD database similarly provides operational data and hospital bed utilization statistics for acute-care hospitals. Its database is built from both public and private sources, including Medicare claims data (MedPAR and OPPS), hospital cost reports, and other files obtained from the federal Centers for Medicare and Medicaid Services (CMS). Our method allows us to verify that we accessed the most updated information for each hospital.

Next, to determine which short-term acute-care hospitals and the number of staffed beds are faith-based, we manually cross-referenced each hospital to each faith's website to determine which hospitals are faith-based. We also largely used this method to calculate the rate of change in faith-based hospitals across California counties by determining what year the hospital was founded or acquired by a faith-based hospital system. Additional detailed methodological information is available in our methodological appendix.

Results

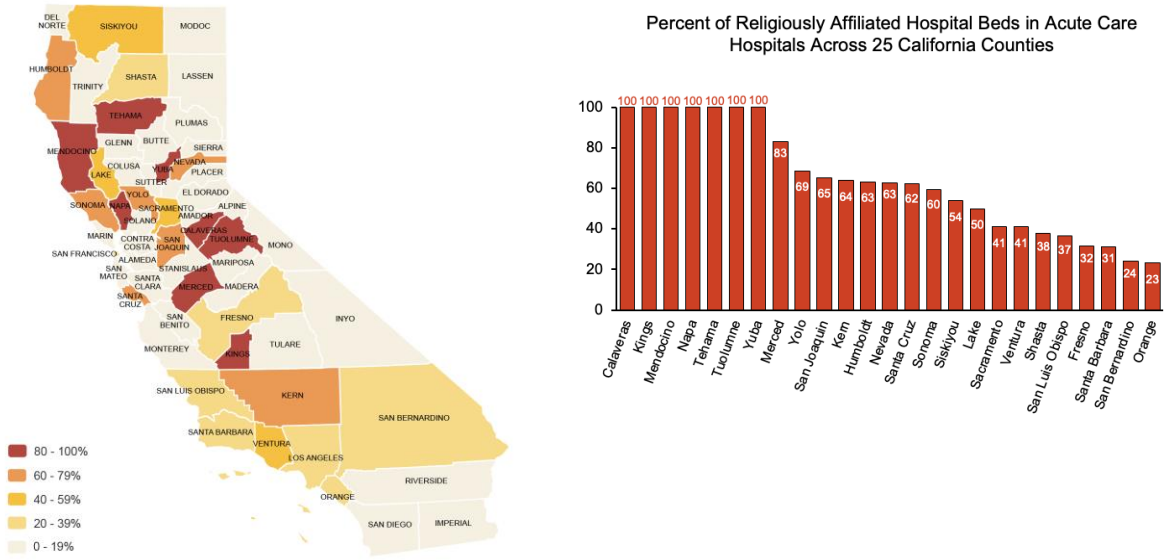
I. Several California counties are dominated by faith-based hospital systems

To better understand the presence of faith-based hospitals in California, we calculated the percentage of religiously affiliated acute, short-term care hospital beds (market share) by county (Figure 1). We find that seven counties have exclusively faith-based acute, short-term care hospitals (Figure 1) and that faith-based hospitals have a majority market share in 17 out of 58 counties (Supplementary Table 1). A similar analysis conducted in 2020 determined that an average of 16% of California's hospital beds were affiliated with Catholic hospitals (Solomon et al. 2020). In comparison, our analysis reveals that an average of 29% of California's hospital beds are religiously-affiliated. There are 25 counties where greater than one-fifth of their hospital beds are religiously-affiliated. Of these top 25 counties, the average market share of religiously affiliated hospitals rises to 64%, ranging from 23-100% (Figure 1B, Supplementary Table 2). Our numbers demonstrate that this previous report insufficiently conveys the prevalence and impact of faith-based hospitals in the state for two main reasons: First, faith-based hospitals that restrict access to sexual and reproductive healthcare include non-Catholic Christian hospital

systems that were not included in the 2020 study. Second, we find that the prevalence of faith-based hospitals Inconsistent verb tense varies dramatically across California counties. This variation in market share aligns with a previous national county-by-county analysis of Catholic hospitals (Drake et al. 2020).

Figure 1: The prevalence of faith-based hospitals varies across California. A) A heatmap depicts the percentage of short-term care hospital beds that are religiously affiliated by county. Source Data in Supplementary Table 1. B) A bar graph depicts the percentage of short-term care hospital beds that are religiously affiliated by county for twenty-five counties. This percentage ranges from 23-100%. Source data in Supplementary Table 2.

A **B**



To further characterize geographic disparities in SRH access, we examined the counties with a majority market share of faith-based hospital beds. While nearly one-third of California counties met this criterion, none of the ten most populous counties appear on this list (U.S. Census Bureau 2020). This implies that California's rural, less densely populated counties bear a disproportionate share of faith-based SRH restrictions. Thus, the consequences of limited SRH access are unevenly distributed across the state. We provide a web interface for browsing these data (https://www.scipolucla.com/data-viz).

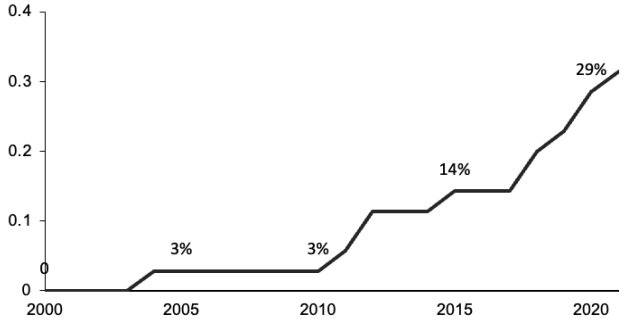
These data suggest that many California patients are limited by geography when seeking SRH services. Insurance also constrains consumer choice: the Catholic hospital system Dignity Health is the top Medi-Cal provider in the state (Solomon et al. 2020). Low-income rural patients are therefore likely to be disproportionately affected by this constraint when choosing an SRH provider. A 2017 study reported that 28 counties in California do not have a facility to provide Medi-Cal-covered abortions, and that 51% of Medi-Cal insured women had to travel 50+ miles to visit an abortion provider (Johns, Foster, and Upadhyay 2017). Additionally, low-income rural patients may lack additional resources to access a hospital that offers the full range of comprehensive care. Such resources include paid time off, transportation, and childcare, since 60% of abortion patients in the U.S. are mothers (Kortsmit 2021). While non-emergency medical transportation for Medi-Cal patients was established via A.B. 2394 (Garcia) in 2016 (A.B. 2394 2016), this measure excludes elective abortion due to the Hyde Amendment (Consolidated

Appropriations Act 2022). Moreover, counties with a shortage of SRH outpatient specialists refer patients to hospitals for reproductive or obstetric care (Ranji et al. 2019), but the strong presence of faith-based hospitals further exacerbates unequal access to SRH services.

II. The accelerating growth of faith-based hospitals in California

The number of faith-based hospitals in the top 25 counties has grown tenfold from 2011-2021 when compared to the previous decade, rising from 3% to 28% of the hospitals in these counties (Figure 2, Supplementary Tables 3 and 4). This increased presence is due to mergers and acquisitions by faith-based hospital systems that operate via a positive-feedback loop: expanding hospital systems increase their buying power through these acquisitions, which facilitates future acquisitions (Barry-Jester and Thomson-DeVeaux 2018; Uttley and Khaikin 2016). For example, the Catholic hospital system Dignity Health recently merged with Catholic Healthcare Initiatives to create CommonSpirit Health, the largest non-profit hospital network in the country (Bannow and Meyer 2018).

Figure 2: The prevalence of faith-based hospitals is growing at an increasing rate. The cumulative percent increase in the number of faith-based hospitals from 2000-2020 in the top twenty-five counties analyzed in Figure 1B. Source data in Supplementary Table 3.



The immense buying power of religious hospital systems allows them to acquire financially struggling hospitals, particularly in sparsely populated or low-income areas, providing the financial stability and administrative infrastructure for failing hospitals to remain open (Solomon et al. 2020). For example, Mendocino Coast District Hospital (now Adventist Health Mendocino Coast) was acquired by Adventist Health in 2019 following a $1.2 million net loss the prior year, thereby permitting the hospital to continue its operations to meet the community's healthcare needs (JD Healthcare, Inc. prepared for the Office of the California Attorney General 2019). These mergers and acquisitions have led to a rise in the number of Catholic hospitals designated as “sole community providers” in a 2020 report (Solomon et al. 2020).

An increased presence of faith-based hospital systems in underserved communities can improve healthcare access in these areas (excluding the full range of end-of-life options and various SRH services) (Alliance of Catholic Health Care 2021). However, faith-based health systems’ domination of healthcare markets leaves struggling hospitals with increasingly fewer options when seeking new ownership. This can force hospitals to adopt SRH limitations in order to continue operating.

Discussion

While faith-based hospitals can provide important community services and may reflect the values of a portion of Californians (Alliance of Catholic Health Care 2021), patients should be able to make informed decisions about which hospitals they visit. This lack of consumer consent is especially concerning when essential healthcare is withheld for non-scientific reasons. Indeed, according to one survey, 71.4% of patients believe that their healthcare choices should take precedence over a healthcare facility's religious affiliation (Guiahi et al. 2019). In addition to the general public, it is important that California's policymakers and health professionals understand the prevalence and scope of medical restrictions imposed by faith-based hospitals. The lack of public information on the impact of faith-based hospital facilities endangers patients and impedes accountability of these systems.

Washington is currently the only state that has passed legislation to increase the transparency of healthcare restrictions in faith-based hospitals. In 2014, Washington state mandated that hospitals disclose religious affiliations "where it is readily accessible to the public, without requiring a login or other restriction" (Washington State Legislature, WAC 246-320-141, amended in 2014). Of all Catholic hospitals in the U.S., fewer than 3% list which services they do not offer, and all of those that do list restrictions are in Washington as a result of its state mandate (Hafner 2018). Washington state went further in 2019, passing legislation to address ambiguous healthcare policy language that insufficiently outlines SRH care options (Schwandt, Sparkle, and Post-Kinney 2018). The bill (S.B. 5602 2019) established a database of SRH hospital policies based on survey results collected and published by the Washington Department of Health (Hospital Policies Washington State Department of Health n.d.). Since physicians in some faith-based hospitals can be prevented from providing referrals for SRH services (Stulberg, Jackson, and Freedman 2016), a public database can help patients navigate ambiguous healthcare policies.

Adopting Washington's two-pronged approach to increase the transparency of healthcare restrictions in faith-based hospitals may be an enforceable and relatively low-cost way to protect informed consumer consent. A similar database of SRH service availability across California hospitals may help patients choose their healthcare provider without disrupting the operations of faith-based facilities. However, if the creation of this database is not marketed to the general public, its primary benefit may be to keep the Attorney General (who oversees healthcare system mergers), policymakers, researchers, and healthcare providers informed of the SRH hospital policy landscape rather than helping patients make informed decisions.

Washington's mandates are also limited because they do not account for the visibility, contextualization, and dissemination of hospital policy information. For example, the Washington state legislation that requires faith-based hospitals to disclose religious affiliations online does not specify where and how this information should be published. As a result, 70% of Washington's compliant Catholic hospitals placed this information on obscure pages of their website (Schwandt, Sparkle, and Post-Kinney 2018). California legislation could correct for this by specifying that religious affiliations be stated on the hospital website homepage. To effectively notify patients of healthcare restrictions, disclosure of religious affiliation must be

accompanied by a clear list of impacted medical services as well. In fact, Dignity Health's webpage explicitly states that the organization does not participate in California's End of Life Option Act due to their religious affiliation (End of Life Option Act n.d.). It is demonstrably feasible to require hospitals to provide similar disclosures for other restrictions, including those on SRH.

In addition to ensuring that disclosures of religious affiliations are accessible and include patient impact, robust dissemination of this information is critical to increasing public awareness of healthcare restrictions. Confining transparency mandates to hospital websites may not be the most effective way to inform patients of restrictions since not all patients may seek out such information online. A more direct way to notify patients of religious affiliations and affected services may be to require verbal disclosures from hospital personnel that schedule and provide care (e.g., receptionists, physicians, and nurses). Disclosures are especially pertinent for pregnant patients who may be unaware of the impact of SRH restrictions on their care. For instance, patients should understand the availability of treatments if they experience complications or seek further care post-delivery (e.g., opportunistic tubal ligation) (Guiahi, Teal, et al. 2017; Hafner 2018). Alternatively, faith-based hospitals could be required to include their religious affiliation in the names of their institutions. The Adventist Health System does this already, yet the Catholic hospitals which constitute a much larger share of California's faith-based hospitals do not. Again, there is precedent for such a measure, as Dignity Health was named Catholic Healthcare West until 2012. CEO Lloyd H. Dean stated that this switch was made to "enhance the organization's ability to work across the spectrum of healthcare and expand partnerships" (Griffin 2012), and introduced non-Catholic hospitals into the system. However, these non-Catholic hospitals in the Dignity Health system are still prohibited from offering certain medical services (Table 1). Even as Dignity Health claimed to shift to a more secular identity, the next decade marked a period of rapid proliferation (Fig. 2, Supplementary Table 3) that has reshaped healthcare access in California and across the country.

California legislators have failed to ensure public awareness of the existence, prominence, and influence of faith-based hospitals. The 2022 midterm elections found Californians codifying access to abortion in the state by overwhelmingly approving Proposition 1, the Constitutional Right to Reproductive Freedom. Interestingly, 76% (13 out of 17) of the counties that are dominated by faith-based hospital systems (>50% market share) approved Proposition 1 (CALMATTERS 2022). These results suggest that unregulated expansion of healthcare systems with SRH restrictions, including elective abortions, likely contradicts the expressed preferences of voters. We urge policymakers to consider strengthening regulations on California's publicly funded faith-based hospitals to better reflect the state's commitment to accessible healthcare and patient protection.

Resources

Online portal to facilitate data access and browsing:
https://www.scipolucla.com/data-viz

Methodological Appendix

I. Reporting which sexual and reproductive health services are offered across three primary faith-based or religiously affiliated hospital systems

To determine the ethical guidelines for Dignity Health's Catholic and other-than-Catholic facilities(Table 1), the Catholic Church's Ethical and Religious Directives (https://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf) and Dignity Health's Statement of Common Values (https://www.dignityhealth.org/content/dam/dignity-health/pdfs/northstate/statement-of-common-values.pdf) were searched for the following keywords: "STD," "HIV," "Contraceptive," "Fertilization," "IVF," "Tubal ligation," "Hysterectomy," "Sterilization," "Abortion," "Termination," "Transgender," "LGBT," and "Gender." Some services are not specifically discussed in the ERDs and/or Statement of Common Values.

In order to determine if gender-affirming care, contraceptive services, elective sterilization, or emergency contraception or abortions were offered at specific institutions, we searched Dignity Health and Catholic Health Initiatives Merger Impact Reports (Google search: "[Name of Hospital] + CHI + Impact Report + pdf") for the following key words: "Sterilization," "Tubal ligation," "IUD," "Gender," "Terminate," "Emergency contraception," and "Abortion." Additionally, the websites of the Dignity Health (https://www.dignityhealth.org/) and Adventist Health systems (https://www.adventisthealth.org/) were also searched for the following keywords to determine what services are offered and advertised to patients: following keywords: "STD," "HIV," "Contraceptive," "Fertilization," "IVF," "Tubal ligation," "Hysterectomy," "Sterilization," "Abortion," "Termination," "Transgender," "LGBT," and "Gender."

Lastly, emails were sent to Dignity Health and Adventist Health to confirm their provision or denial of the services listed in Table 1. Emails were sent to the following contacts: Dignity Health LGBTQ Advocate (lgbtqadvocate@commonspirit.org), CommonSpirit General Inquiry (contact@commonspirit.org), Adventist Health (CorpComm@ah.org), Adventist Health Lodi Media Contact (nelsonlr@ah.org) and Adventist Health Sonora Media Contact (luggj@ah.org). Most emails did not receive a response, but a Dignity Health patient advocate confirmed that no IVF procedures nor elective abortions were performed at Dignity Health facilities.

II. Calculating the presence of faith-based hospitals in California

We pulled a list of California incorporated cities organized by county from the California State Association of Counties website (https://www.counties.org/cities-within-each-county). We listed hospitals by city, accessing the Hospital Annual Utilization Report by California's Department of Health Care Access and Information. This database of California hospitals is accessible from the California Health and Human Services Open Data Portal

(https://data.chhs.ca.gov/dataset/hospital-annual-utilization-report). The data contained in this Final Annual Utilization Report of Hospitals - 2021 were extracted from the System for Integrated Electronic Reporting and Auditing (SIERA) application on September 16, 2022. Hospitals that were in other census-designated places (CDP) or unincorporated communities were included in this list. We excluded any hospitals that are permanently closed or are not short-term acute care hospitals (e.g. excluded psychiatric facilities or specialized medical centers unrelated to SRH). To identify only General Acute Care Hospitals providing General Medical/Surgical services, the database was sorted by 'License Category Type' (LIC_CAT), then 'Principal Service Type' (PRIN_SERVICE_TYPE). Any facility with a suspended or closed license (LICENSE_STATUS) was removed. Given that the number of licensed beds listed on this database was occasionally not necessarily the number of available beds (e.g. Providence Redwood has 35 licensed beds, but only 25 available (St. Joseph and Redwood Memorial Hospital Community Benefit Committee, 2021)), we also cross-referenced this list of hospitals and number of staffed beds with a database from the American Hospital Directory (https://www.ahd.com/states/hospital_CA.html).

To determine which hospitals are faith-based, we first looked at the parent company of each hospital facility available on the Department of Health Care Access and Information database. However, given that there are some incomplete reports, we additionally cross-referenced each hospital with the Alliance of Catholic Healthcare website (https://thealliance.net/member-locations) and the Adventist Health website (https://www.adventisthealth.org/find-a-location/). We then calculated the percent of religiously-affiliated beds per county by dividing the number of staffed beds in faith-based hospitals by the total number in that county. This data are available in our Supplementary Table 1 (all counties).

We then used Adobe Illustrator with a county-level map of California from the U.S. Census Bureau to create a heatmap depicting the geographic distribution of faith-based hospital beds (Figure 1A). We used Microsoft Excel to create a bar-chart depicting the same percentage for the top 25 counties that had the greatest presence of religiously affiliated hospital beds (Figure 1B).

III. Calculating the rate of change in faith-based hospitals across twenty California counties

To report the year that each hospital within the top 25 California counties we are analyzing (listed in Figure 1B) was acquired by or created by a faith-based hospital system, we first checked the American Hospital Directory (https://www.ahd.com/states/hospital_CA.html). However, due to the merger between Dignity Health and Catholic Health Initiatives, Dignity Health Hospitals were all listed as being acquired in 2019, though they were religiously affiliated before. We therefore visited the official website for each hospital system: Dignity Health (https://www.dignityhealth.org/), Adventist Health (https://www.adventisthealth.org/), and Providence St. Joseph (https://www.providence.org/). For the vast majority of the faith-based hospitals we were analyzing, the individual websites included a “history” that reported what year the hospital was founded or acquired by a faith-based hospital system. This data are available in our Supplementary Table 2. For the four hospitals that this method did not yield the necessary information, we searched the internet for alternative sources. The alternative sources are linked in Supplementary Table 2 in the column titled “source”.

We categorized all hospitals founded/acquired before 2000 as "<2000") and used this total as our baseline (35 hospitals) when calculating the rate of change in faith-based hospitals. We then listed each year between 2000~2021 and counted the number of acute, short-term care faith-based hospitals that were present each year. We then calculated the cumulative increase for each year, as well as the percent change that occurred from baseline. These data were represented in a line-plot via Microsoft Excel (Figure 2). This data can be found in our Supplementary Table 3.

For a per-decade increase between 2000-2010 vs. 2011-2021, we calculated this per-decade percent increase in the number of faith-based hospitals in top 25 counties from each decade's baseline. These data can be found in our Supplementary Table 4.

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