The Affect of Affiliation on Mission in Canadian Denominational Hospitals

by

Don McDermott

Submitted in partial fulfilment of the requirement for the degree of Masters of Arts
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ABSTRACT

Many religious hospitals throughout Canada are undergoing a dramatic change in role and structure. Where these denominational hospitals have functioned independently for many years, they are now, voluntarily and involuntarily, part of structures that have theoretically lessened their control over their religious mission for reasons of funding and efficiencies.

This study used a spectrum of affiliation definitions and asked CEOs and Mission Officers of hospital members of the Catholic Health Association and the Salvation Army of Canada, to provide their perception of changes in mission awareness by staff after affiliation. The spectrum of affiliation was derived from the literature and refined based on the types of regionalized structures created within Canada over the past three years.

Surprisingly, the CEOs and Mission Officers agreed in their perception that mission awareness after affiliation was as strong or stronger in staff, even when the type of affiliation they were involved in allowed little control over their service provision. Mission awareness appeared strongest in affiliation types that had the least threat to control of mission. A continuum of affiliation definitions was used to identify a perceived critical point in mission awareness. This was found, based on CEOs responses to values based questions.

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THE AFFECT OF AFFILIATION ON MISSION IN CANADIAN DENOMINATIONAL HOSPITALS

Throughout Canada and the United States there are many forms of affiliations taking place between denominational (religious) and non-denominational health institutions. Are these interdependencies allowing the continuation of the religious mission and roles of the denominational partners? No clear answer has been provided within the literature. It is clear, however that there is great concern within the membership of religious health care organisations in Canada.

Hospitals particularly are undergoing rapid structural changes. Mergers and involuntary regionalizations are occurring across the nation. Over the past three years the face of institutional health care has changed dramatically. This study is designed to begin the examination of the continued role of religious hospitals in Canada through the change from independence to interdependence with non-denominational hospitals. It is hoped that the conclusions found in this study will suggest ways to more thoroughly examine this subject and either allay concerns, or restructure future affiliation agreements to protect the religious based missions.

This study uses a range of affiliation definitions to see if there is a certain

point within this spectrum of agreements that appears to compromise the independence of mission and mission values in religious hospitals in Canada, as perceived by the Chief Executive Officers (CEOs) and Mission Officers.

Review Of The Literature

Governance and Mission

Governance is defined as the fulfilment of responsible ownership on behalf of the community (Chenoy & Carlow, 1993). For hospitals, this ownership usually means private or civic (community owned) corporations. Private owners of hospitals in Canada are often denominational, where a church owns and operates the organization, through government funding. Civic, or community owned means a hospital is incorporated as a public hospitals with its own boards, or is included within a municipal incorporation. It is usually operated independently from the municipality by a separate board.

Houle (1989) calls the board that carries out this governance role for an organization a group of people with the collective authority to control and foster an institution. The mission and values identification for an organization is described by Umbdenstock & Hageman (1990) and Houle (1989) as one of the main responsibilities of the governing board, followed by such duties as policy

determination, plan development, financial viability and control, quality assessment and improvement, legal and regulatory compliance and effective customer relations. Adding to this list, Chenoy & Carlow (1993) and Starkweather (1988) discuss choosing and evaluating the CEO and integrating the organization with the environment.

To accomplish good governance, Carver (1991) has stated that boards must be obsessed with the effects the organization has on people - that is, its mission. What good is to be done for what people at what cost? Defining its mission is the primary strategy of governance (Carver, 1991; Chenoy & Carlow, 1993; Shortell & Buehler, 1989; Umbdenstock & Hageman, 1990). Drucker (1989) has stated that the mission focuses the organization on action. Mission defines the specific strategies needed to attain the crucial goals. As a means of clarifying the organization's arena of action, the mission is a reflection of the organization's highest purpose, philosophies and values (Carlson, 1994). As such it is a source of power within highly successful organisations. Excellent organizations devote a great deal of time to mission and ensures the values of the mission are demonstrated throughout the organization at all levels. Carlson (1994) states the mission is reflective of where the organization is now or where it is going. He found that the employees of a highly successful organization have an emotional

attachment to the organization and believe in the mission.

Truly effective boards have a clear focus, with management, on the mission, goals and objectives of the organization (Shortell & Buehler, 1989; Umbdenstock & Hageman, 1990). The success of the board is dependent on linking the functions of governance and the priorities identified for the organization as a common game plan for management and board (Umbdenstock & Hageman, 1990). If the mission of an organization is not clear, is not relevant to the current circumstance or is not agreed to by the board and management together, the organization cannot be successful in carrying out its purpose.

Denominational mission

Within denominational institutions such as Catholic health facilities, the mission is defined around the teachings of the church and is seen as a ministry of the Church (Carlson, 1994; CHAC, 1991; CHA, 1991; Morrisey, 1987). The values of the mission are often expressed in phrases such as upholding the dignity of the individual, providing for the common good, stewardship of resources and care for the underprivileged (Schindler, 1995).

As an example of denominational institutions, Catholic institutions represent the largest denominational owners in Ontario, with 16.5% of all hospitals, greater than 8,100 beds in acute and chronic care hospitals and

approximately 1,800 extended and residential beds in homes for the aged and nursing homes (Marr & Faulkner, 1992).

Denominational agencies were treated somewhat differently from other owners in most provinces during the recent regionalization of health institutions in Canada (Catholic Health Association of Canada, 1995). Special role and mission considerations were negotiated or are currently being negotiated with religious institutions. New Brunswick however was a notable exception when, in 1994, this province passed a bill that divided the province into four regions, each with it's own incorporated health board (An Act to Establish Regional Health Boards, 1994). All assets of the hospitals within the province, including denominational institutions, were assumed by the regional health boards. Acts such as the Labour Standards Act, The Trade Union Act and the Expropriations Act were set aside and did not apply under this new act.

One author at least feels this New Brunswick legislation, in forcing the transfer of ownership from denominational hospitals without compensation, is open to constitutional challenge based on the Canadian Charter of Rights and Freedoms. Weisnagel (1995) argues that for Catholic hospitals at least, health care is rooted in the understanding that it is a ministry of healing within the Catholic Church. If a Catholic hospital ceases to be autonomous, it has lost an essential

component of free association identified within the religious section of the Canadian Charter of Rights and Freedoms and therefore may be challenged in a court of law.

The Alliance of Catholic Health Sponsors of Ontario (1995) has identified key components of corporate Catholic integrity, including the ability to:

1. Establish mission and philosophy within the framework of the Health Care Ethics Guide (CHAC, 1992).
2. Amend its corporate charter and bylaws
3. Appoint its board of trustees
4. Appoint or approve the appointment of the Chief Executive Officer.
5. Lease, sell or encumber corporate real estate.
6. Merge or dissolve the corporation.
7. Appoint the corporation's auditors.
8. Approve the long range plans for the corporation.

Mission integrity is paramount to the identification of denominational hospitals and must not be compromised through affiliation where autonomy to exercise the concepts of religious values are concerned. If a denominational hospital ceases to be autonomous, it has lost the healing mission philosophy that underlies its direction and management. As such, the individual patient will have

lost the right of access to the denominational hospital of his or her choice, which is akin to the right to attend the church of one's choice (Weisnagel, 1995).

A recent comparison of Catholic church law (canon law) and civil law by the Alliance of Catholic Health Sponsors of Ontario (1995) shows the great similarity between the two systems of law in dealing with organizations (Appendix A). The requirements of church law in maintaining mission and identity are essentially the same as those required to maintain corporate legality. What then is the limit of affiliation between a denominational hospital and a non-denominational organization? How much power can be removed from a denominational agency's board by legislation or affiliative agreement and still remain a representative of the church?

Collaboration and the Catholic Church

Chenoy & Carlow (1993) suggested that to better co-ordinate and unfragment the delivery of health care and provide for public accountability, hospitals must collaborate with each other and with other health and social agencies to plan and deliver services. They felt the focus must change from competitive to collaborative arrangements through strategic alliances with other providers. But organisations working together must have similar goals in some systems framework that clearly recognises and respects each member's mission.

Denominational institutions must be especially concerned with compatible missions within a working relationship.

A number of Catholic organisations have entered into collaborative agreements with non-Catholic partners and have found the results to be successful (Kramer, 1991; Marr & Faulkner, 1992). Of highest concern in these types of arrangements, and described as the primary consideration, is a compatible mission and vision (Cassidy, 1993; Hume, 1993; Kramer, 1991; Marr & Faulkner, 1992). Regardless of the motivation for collaboration, the compatibility of mission allows common commitment by all partners of the agreement to the denominational institution's ministry to serve the community in it's own religious way (Hume, 1993).

The evaluation of a potential affiliation to determine if the Catholic institutional partner can freely carry out its mission, will be its ability to operate under the medical and ethical directives of the Catholic Church. The conditions that would allow independence from the other partner in any activity not acceptable to these teachings, would be reviewed by the local church authority (Vowell, 1992). If autonomy is questionable within this collaborative venture, then the actual Catholicity of the institution is in question, as well as the public perception of the organization as Catholic.

Based on the 1983 Code of Canon Law of the Catholic church, clear criteria of Catholicity exist (CHAC, 1991; Morrisey, 1987; Vowell, 1992). These are:

- The institution is owned by the Catholic Church and is under the control of a competent ecclesiastical authority, or is acknowledged as Catholic.
- Principles of Catholic moral theology and medical ethics underlie all activity.
- The competent authority has authorized the organization to be Catholic.
- Pastoral care and practices are subject to the authority of the church.
- There is a right of visitation by the church authority.

From the above criteria, there is a strong relationship with church authority that provides for accountability; there is a legal establishment of the organization through the church; and there is a degree of control the church exercises over the institution.

Multi Institutional Arrangements (MIAs)

Affiliation, integration, collaboration and multi-hospital systems are terms that have been used interchangeably in the literature. *Integration*, according to Zalot & Jodoin (1992) implies authority over certain activities is given up and replaced by co-decision making with all other participants. An intermediate body

speaks on behalf of all and decisions are reached through negotiations and consensus. Integration refers to various degrees of joining, linking or fusing of similar or unlike programs or services, or of total organisations (Zalot and Jodoin, 1992).

Affiliation and *collaboration* both imply some form of agreement to work together for some purpose of mutual benefit. This is usually in response to some threat in the external environment that would allow the institutions to achieve greater organizational stability than would be possible separately (Fried & Gelmon, 1987). The type or model of affiliation chosen will depend on the objectives of the relationship and often include more than two institutions. These are often referred to as *multi-institutional arrangements* or MIAs (Brown, Donnelly & Warner, 1980; Dagnone, Goddard & Wilson, 1994; Freedman, Burke, & Gerring, 1989; Fried & Gelmon, 1987; Freund & Mitchell, 1985; Johnson, 1993; Zalot & Jodoin, 1992). This term refers to any form of collaboration of individual facilities under a formal or informal co-operative agreement ranging from shared services to a consolidated ownership structure (Freund & Mitchell, 1985; Fried & Gelmon, 1987).

Shared services are functions that are common to two or more institutions and are used jointly or co-operatively for some purpose, with all parties sharing the

risk of the venture (Freedman, Burke & Gerring, 1989).

The range of MIAs that have been described as practical is a continuum, from a loose coalition or alliance of individuals and groups (employees, providers, insurers), who are concerned with specific issues such as cost, quality or access to services (Johnson, 1993), to multi institutional systems where institutions are within a single corporate entity, as may be found in a merger (Brown, Donnelly & Warner, 1980; Dagnone, Goddard & Wilson, 1994).

Shared service arrangements are very common. Zalot & Jodoin (1992) found 84% of 117 Canadian hospitals surveyed in 1987 had a high degree of sharing of services. An American Hospital Association study (Hume, 1993) found a 3.5% increase annually in multi-institutional systems between 1975 and 1982. Further studies in 1990 found 302 multi-institutional systems in the USA. (Toomey & Toomey, 1993).

Increasingly, Canadian hospitals are entering into co-operative arrangements to meet demands imposed by change (Brown, Donnelly & Warner, 1980; Dagnone, Goddard & Wilson, 1994; Freedman, Burke & Gerring, 1989). These authors suggest multi-institutional systems are a vital way of positioning hospitals so they can respond effectively to demands from the external environment for greater quality and cost effectiveness.

Within Ontario, a recent review of activity by the Ontario Hospital Association (1995) described 59 restructuring studies either just completed or ongoing, involving 233 institutions. Of these, there were 16 mergers, 4 strategic alliances, 33 rationalisation agreements, 6 strategic plans, 2 comprehensive health organisations and two institutions closing.

In other parts of Canada there has been a movement to regionalize health institutions and other services under a common board. Individual hospital and agency boards have been dissolved and government appointed boards set up to replace them for governing, planning and service provision. British Columbia in February 1995, Alberta in December 1994, Saskatchewan in March of 1995 and Manitoba in September 1994 entered into legislated agreements with denominational providers to resolve governance and service provision powers after previously legislating regionalized governance.

The American Hospital Association (Anderson, 1992) reviewed the number of American mergers between 1980 and 1991 and found 195 mergers and consolidations took place involving 404 hospitals. A follow-up study identified 15 hospital mergers in 1992 (Burda, 1993b). Recently the American hospital literature has been reporting numerous mergers and affiliations as hospitals get ready to compete within the health reform environment. A new network was described as

including 22 hospitals, 3884 beds, 4400 physicians and 250,000 managed care enrollees (de Lafuente, 1994). A Health Maintenance Organization was recently created to serve 750,000 patients (Japsen, 1993). Another deal involved 48 hospitals and $1.6 billion in annual revenues (Burda, 1993a).

The anticipated benefits of the MIAs include economies of scale and greater efficiencies allowing cost savings, higher quality, expansion of scope of services and improved access (Freedman, Burke & Gerring, 1989; Freund & Mitchell, 1985; Fried & Gelmon, 1987).

Other hoped-for benefits of these arrangements include the ability to recruit and retain personnel, provide career mobility within the system, achieve organizational flexibility for political power and survival (Freund & Mitchell, 1985), and a common approach to service provision (Freedman, Burke & Gerring, 1989). Others (Fried & Gelmon, 1987) have suggested a sharpened role definition to correct imbalances in patient loads and activities among partners while eliminating competition and duplication. A strengthened financial position, new service acquisition, acquired technology and expertise, improved political clout and better physical facilities are other reasons to pursue MIAs.

In fact, the performance of MIAs has shown mixed economic benefits. The literature supports the theory that systems are better off than the independent

hospital in terms of economies of scale and improved access to services (Howard & Alidina, 1987; Zalot & Jodoin, 1992), but the savings sited as the primary reason to form an MIA may have costs associated with them that can take years to overcome and turn into savings (Brown, Donnelly & Warner, 1980; Doiron, 1985; Fried & Gelmon, 1987; Howard & Alidina, 1987; Johnson, 1993; Levitz & Brooke, 1985; Zalot & Jodoin, 1992).

Generally, larger systems, have higher costs per patient day with greater lengths of stay (Brown, Donnelly & Warner, 1980; Levitz & Brooke, 1985). It may be more realistic to expect cost containment than savings with MIAs (Fried & Gelmon, 1987) because economies of scale can be obtained regardless of size (Howard & Alidina, 1987).

Constraints, barriers and disadvantages to MIAs are sited by some authors and include, medical staff resistance, threats to institutional autonomy, lack of solid evidence for cost savings, lack of clarity of objectives, inequity of resource allocation and complexity and isolation resulting from the larger size of the organization's structure (Freund & Mitchell, 1985; Fried & Gelmon, 1987).

Successful MIAs have been identified as having strong leadership and support from top management, a common interest shared by all involved, a substantial budget, a history of collaboration among the players, mutual respect,

open and frequent communications, shared vision, and roles and responsibilities of each player clearly known and recognised by all (Anderson, 1992a; Johnson, 1993; Pavia & Berry, 1993). Others (Freedman, Burke & Gerring, 1989; Fried & Gelmon, 1987) have noted that the degrees of success are related to the type of MIA and the organisational types that are likely to enter into an MIA.

Governance issues such as the role of individual boards and their composition, as well as their involvement in choosing the model of affiliation, requires commitment to the principles of sharing and clear and open communication - a key consideration to successful collaboration noted by Freedman, Burke & Gerring (1989). Pavia & Berry (1993) have identified models of collaboration that are most successful. These indicate limited competition and concentration of the participants' activities on the needs of the community, as if there were only one real organization with one mission. To emphasise this point, Zalot & Jodoin (1992) found that service consolidation was more effective in larger systems under a single ownership than in less formal affiliative arrangements.

Model of Affiliation Continuum

A number of authors have described models of affiliation within a spectrum of formal agreements and interdependence (Dagnone, Goddard & Wilson, 1994; Freedman, Burke & Gerring, 1989; Fried & Gelmon, 1987; Morlock & Alexander,

1986; Pavia & Berry, 1993; Toomey & Toomey, 1993; Zalot & Jodoin, 1992). The continuum that best exemplifies the types of MIA's that can easily be defined and identified within a survey is described below and is based on DeVries (1978):

1. Voluntary consortia

Boards of two or more organizations agree to jointly plan services in order to avoid competition where possible. There is separate ownership and independent policy setting through separate boards.

2. Formal agreement e.g. Strategic Alliance

Boards of two or more organizations formally agree by contract to role differentiation. Each has a separate board and separate board policy setting ability.

3. Contract management

One organization provides a service to another under contract. Conditions of provision allow some control of policy by the organization providing service. There is no ownership of a specific service apart from the contract.

4. Joint venture

A shared service agreement is formalized whereby a separate corporation is set up with a separate board. Representatives from each participating organization are members. Policy control by any one member is limited to the membership ratio at the board.

5. Lease

Service is provided by a third party on space leased from the owner. Policy control is limited by the wording of the lease agreement. There is no ownership by the service provider.

6. Involuntary consortia

The role and services are imposed on the board by government. Ownership remains and there is moderate control over policy as to how services are provided.

7. Corporate ownership with separate boards

The organization is owned by another entity but the board remains with policy setting allowed, apart from some reserved powers by the owner, such as determining the services to be provided and/or board membership.

8. Corporate ownership without separate boards

The organization is owned by another corporation with a single corporate board for all units. There is no control over policy and no separate ownership. This is a true merger.

This study will attempt to ask CEOs and Mission Officers their opinion as to the integrity of their denominational mission after their affiliation with a non-denominational partner. By comparing the type of affiliation on the continuum above, the degree of affiliation that shows independence of mission will be seen.

Method

Subjects

The subjects were 95 Chief Executive Officers (CEOs) of hospital members of the Catholic Health Association of Canada (CHAO) and the Salvation Army in Canada. Mailings were also sent to the persons responsible for Mission in the same institutions. Names and mailing addresses were supplied by these organizations. Only hospital members were selected, although there are other institutional members of these organisations. No individual institution was identified within the study, but where numbers were limited, institutions were grouped for convenience, statistical analysis and confidentiality.

Instrument and Procedure

A survey tool was developed (see appendix B) based in part on a survey sent to all acute care facility members of the Catholic Health Association of the United States in February, 1995. The remainder of the questionnaire was developed to identify where on the model continuum of affiliations, mission related value statements could be identified by CEOs and Mission Officers as greater than, less than or the same as, the level prior to affiliation.

Questions involving value statements were constructed using the SSM *Health Care System Guide to 'Assessing Values Integration: Key Indicators'*; a

background statement on Social Justice, Spirituality and Ethical Reflection from the Catholic Health Association of Canada and valuable contributions from a number of reviewers. The questions were pre-tested in two hospitals prior to being finalized for distribution.

A covering letter was provided by the Catholic Health Association of Canada to encourage member participation. At least one follow-up telephone call was placed to each non-responder after the three week deadline was reached.

Results

62 responses were received from the 95 CEOs to whom the survey was mailed, giving a 65% response rate. Mission Officers responded in 35 cases. There was no identification of the numbers of institutions represented by these Mission Officers. One Mission Officer might be responsible for more than one institution. Similarly, some institutions may not have had a person designated as responsible for mission, so the percent response rate for Mission Officers could not be determined. The majority of responses examined were compiled from the CEO surveys. The Mission Officers survey was used to compare the mission/values questions and the type of affiliation to the responses of the CEOs.

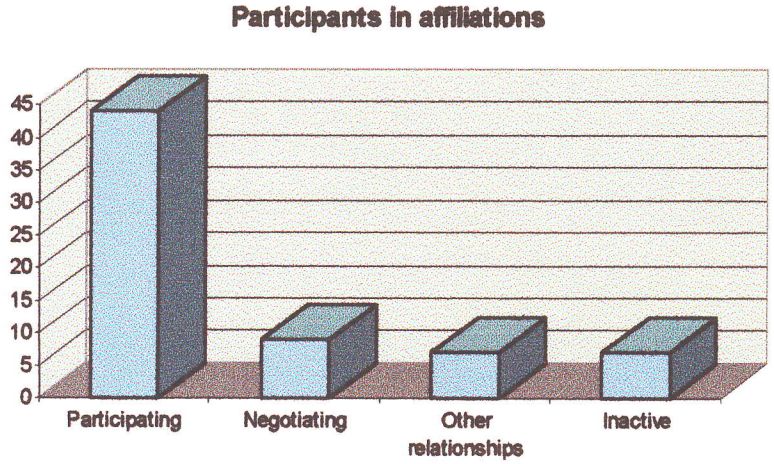
Because of the small number of membership and responses from Quebec,

this region was not used in the calculations.

Participation in an affiliation, or currently negotiating to be in an affiliation or another relationship, was seen in 55 of the responses or 89% (see Table 1). Some duplication was seen were responders were both involved in an affiliation and negotiating another agreement. This compares favourably to the 90% "participating or negotiating" rate seen in the Catholic Health Association of the United States survey of their membership in February of 1995.

Table 1
Involvement with networks
n=62

Affiliation	Number of Respondents	Percent
Participating	44	65.67%
Negotiating	9	13.43%
Other relationships	7	10.45%
Inactive	7	10.45%

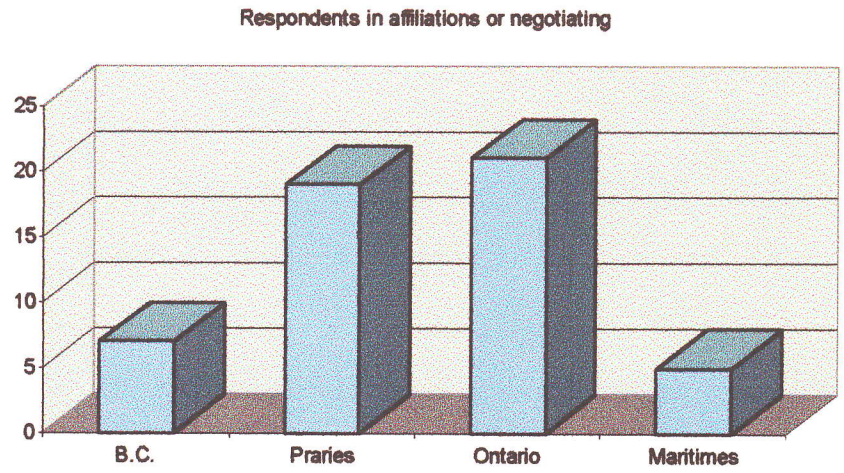


Responses in the present study were divided into geographic regions of Canada (see Table 2). These were, British Columbia; the Prairie provinces of Alberta, Saskatchewan and Manitoba; Ontario; the Maritime provinces including Nova Scotia, New Brunswick and Newfoundland. The response rate out of the total potential (mailings based on membership) for each region was 100% for B.C., 69% for the Prairie provinces, 76% for Ontario and 43% for the Maritime provinces. Participating or negotiating to participate in an affiliation or other

arrangement was found in 90% of responders in B.C., 88% of the Prairie responders, 88% of Ontario responders and 100% of Maritime responders.

Table 2
Affiliation by Region
n=52

Region	Number of Respondents in affiliations or negotiating	Percent
B.C.	7	13.46
Prairies	19	36.54
Ontario	21	40.38
Maritimes	5	9.62



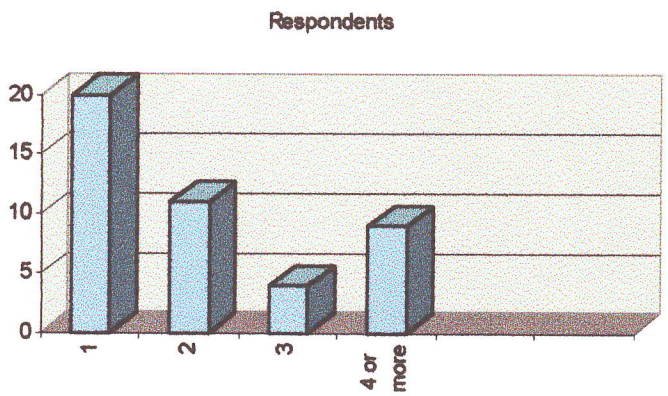
44 CEOs responded that their institution was currently involved in an affiliation within the definitions of the affiliation continuum provided in the questionnaire. Of the 44 responders involved in some affiliation, a total of 59 different affiliations were identified within this study (see Table 5).

Single partners were found in 20 of 44 institutions (45%), two partners in

11 (25%), three partners in 4 (9%), and 9 responded they had four or more partners (20%). In total, 45% had single non-denominational partners and 55% had multiple partners. (See Table 3 below).

Table 3
Number of Partners
n=44

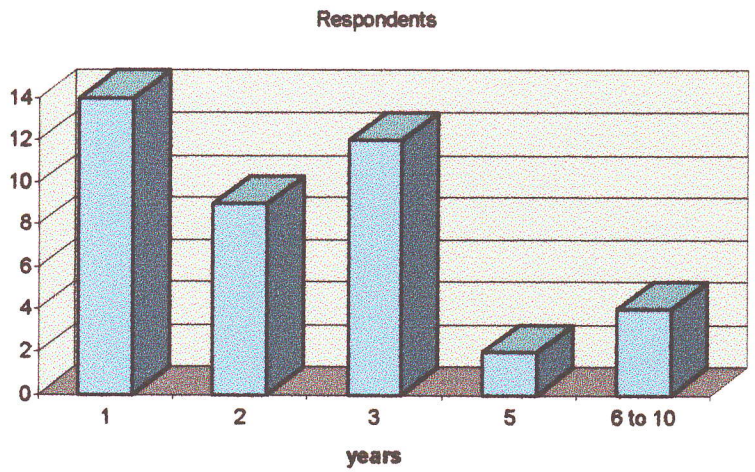
Affiliation partners	Number of Respondents	Percent
1	20	45.45
2	11	25.00
3	4	9.09
4 or more	9	20.45



The length of the current affiliation, answered by 41 responders is shown in Table 4. More than half (56%) had been in place for two years or less.

Table 4
Length of Affiliation
n=41

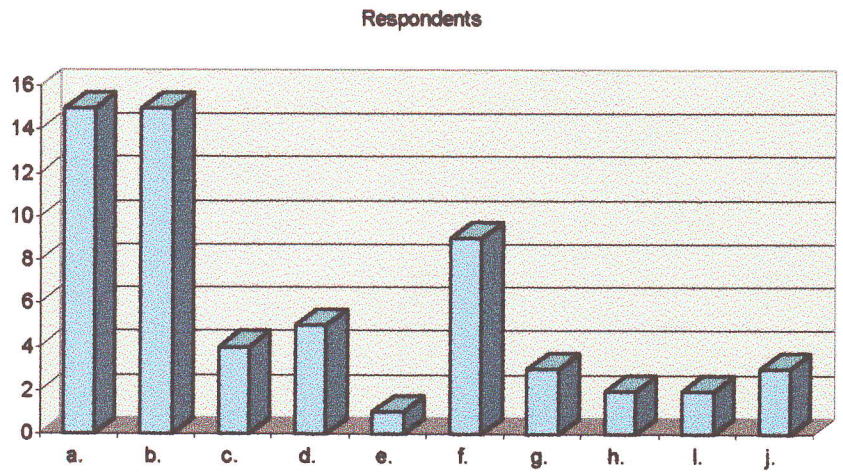
Years affiliation in place	Number of Respondents	Percent
1	14	34.15
2	9	21.95
3	12	29.27
5	2	4.88
6 to 10	4	9.76



The main type of affiliation within the continuum provided fell into the Voluntary consortium (a) and Formal agreement (b) such as Strategic Alliance categories. 51% responded that they were involved in categories (a) and (b). (See Table 5.) The other major category was Involuntary consortium with ability to set policy, (f). This type of affiliation accounted for 15% of the responses.

Table 5
Main Affiliation Type
n=59

Type of affiliation	Number of Respondents	Percent
a. Vol. Consortium	15	25.42
b. Formal Agreement	15	25.42
c. Contract Management	4	6.78
d. Joint Venture	5	8.47
e. Leased Space	1	1.69
f. Invol. Consort with Ability	9	15.25
g. Invol. Consortium without Ab	3	5.08
h. Corp. Owner, Sep Board	2	3.39
I. Corp. Owner, no Sep Board	2	3.39
j. Other	3	5.08

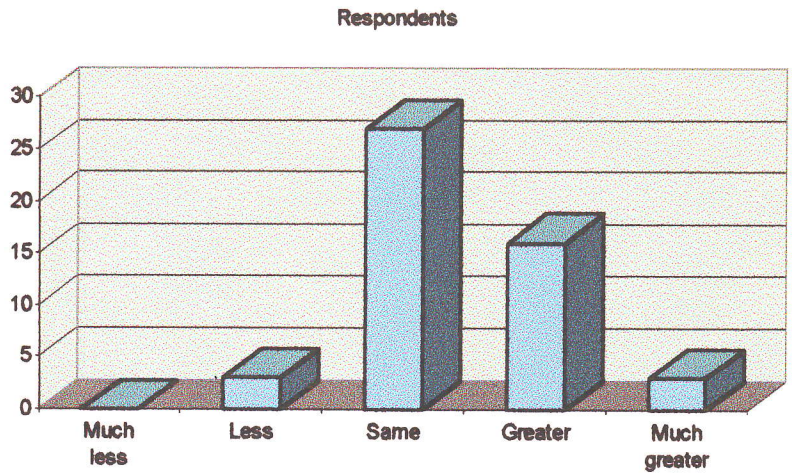


Within all categories of affiliations, Table 6 shows CEO respondents felt staff had greater or much greater awareness of mission than before the affiliation in

39% of the cases, and the same as before affiliation in 55%.

Table 6
Mission Awareness After Affiliation - CEOs
n=49

Staff awareness of mission	Number of Respondents	Percent
Much less	0	0.00
Less	3	6.12
Same	27	55.10
Greater	16	32.65
Much greater	3	6.12

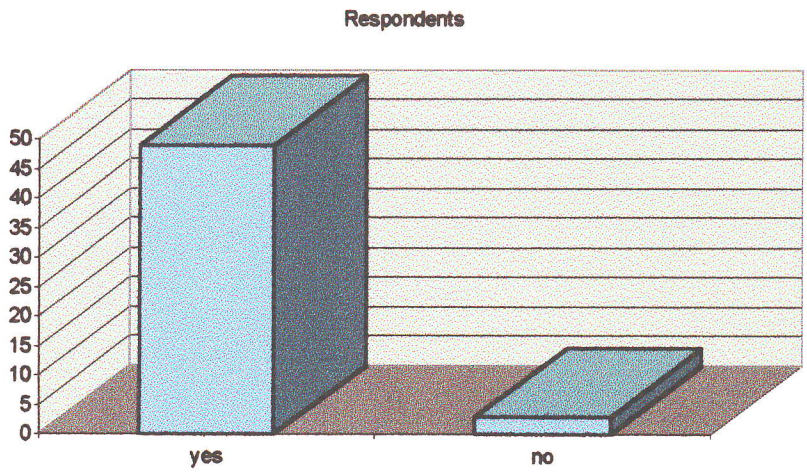


6% of the CEO responders felt staff were less aware of mission after affiliation, although only one responder had actually measured mission awareness both before and after affiliation.

Special considerations within the affiliation agreement were noted in 94% of responders. (See Table 7).

Table 7
Special Consideration for Denominational Hospital
n=52

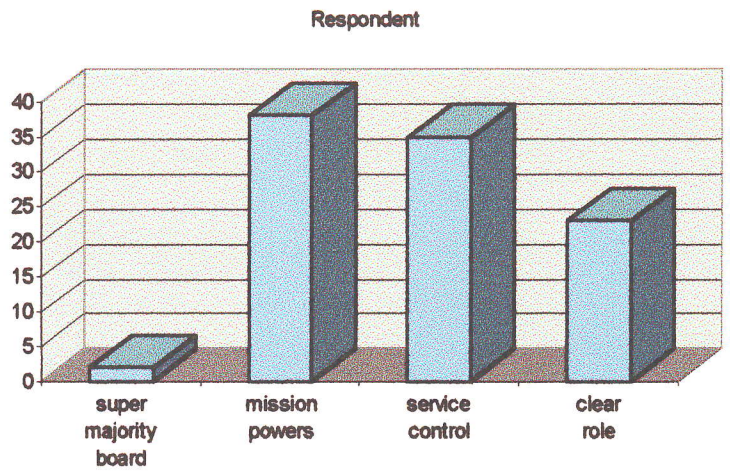
Special consideration given	Number of Respondents	Percent
yes	49	94.23
no	3	5.77



The majority of the special considerations given were identified as special powers for mission (39%), control over the services provided (36%) and clear role distinction (24%). (See Table 8).

Table 8
Type of Special Consideration
n=98

Consideration	Number of Respondents	Percent
super majority board	2	2.04
mission powers	38	38.78
service control	35	35.71
clear role	23	23.47

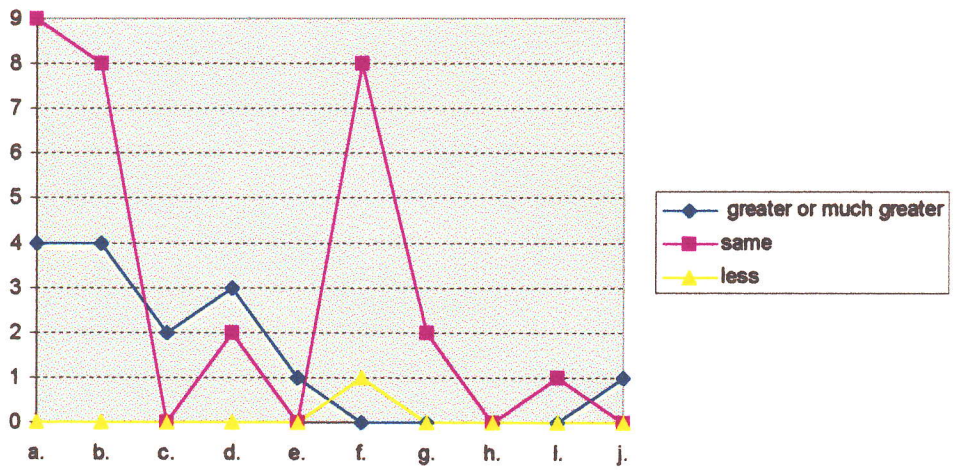


CEO respondents who considered their mission values to be functioning at a greater or much greater level were within the affiliation continuum of (a) through (e). From (f) through to (i) there was no increase in mission awareness demonstrated within their institutions and only a small increase noted in affiliation type (j). (See Table 9). The only affiliation type perceived as having less mission values after affiliation was (f) in one return.

Table 9
CEOs Perception of Mission Awareness by Type of Affiliation
n=46

Type of affiliation	Greater or Much Greater	same	less
a. Vol. Consortium	4	9	0
b. Formal Agreement	4	8	0
c. Contract Management	2	0	0
d. Joint Venture	3	2	0
e. Leased Space	1	0	0
f. Invol. Consortia with ability	0	8	1
g. Invol. Consortia without	0	2	0
h. Corp Owner, Separate board	0	0	0
I. Corporate ownership	0	1	0
j. Other	1	0	0

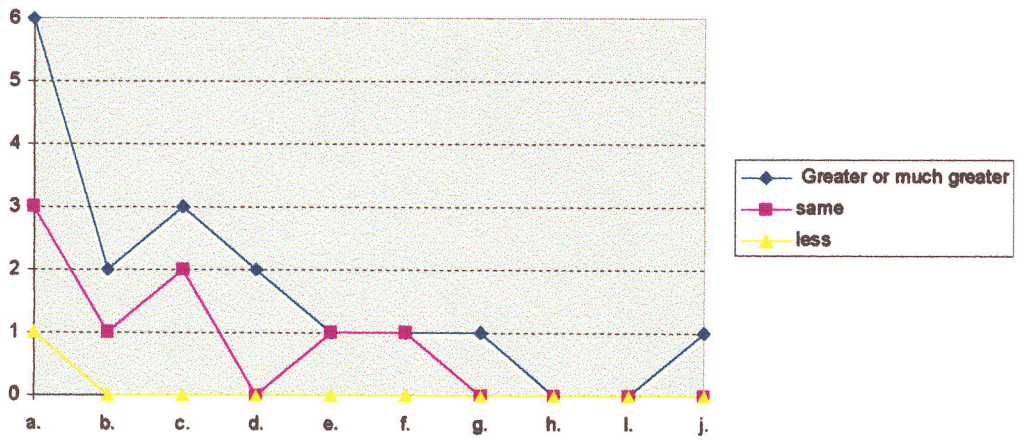
CEO perception of staff awareness of mission after affiliation



Mission Officers felt staff were generally more aware of mission after the agreement than before. (See Table 10).

Table 10
Mission Officers' Perception of Mission Awareness
n=35

Type of affiliation	Greater or much greater	same	less
a. Vol. Consortium	6	3	1
b. Formal Agreement	2	1	0
c. Contract Management	3	2	0
d. Joint Venture	2	0	0
e. Leased Space	1	1	0
f. Invol. Consort. With Ability	1	1	0
g. Invol. Consort. Without Ability	1	0	0
h. Corp. Owner, Sep. Board	0	0	0
I. Corporate Ownership	0	0	0
j. Other	1	0	0



Mission Officers perception of staff awareness of mission after affiliation

The affiliation type that is the least likely to interfere with denominational mission, is definition (a) through (d). These are the affiliation agreements where there is greatest autonomy over policy. Those responsible for mission, that is, the

CEOs and the Mission Officers, felt the staff in institutions where these types of agreements were in place, were more aware of the denominational mission after the affiliation, compared to before the agreement.

Chi square analysis was applied to the association between affiliation type and perceived association of mission awareness by the CEOs. The null hypothesis stated that there is no association between the type of affiliation and mission awareness. Grouping the types of affiliation as (a) through (d), where there is more autonomy of policy setting, and (e) through (j), where there is less autonomy, squares where constructed with respondents also grouped depending on the degree of perception of mission awareness, that is, either the same or less, and greater or much greater awareness. The following contingency tables were constructed:

Expected outcome:

	Same/less	greater/much greater
a-d	16	16
e-j	6	6

Observed outcome:

	Same/less	greater/much greater
a-d	19	13
e-j	11	2

At an alpha value of 0.05 and the degrees of freedom at 1, the 95% level of confidence critical value is 3.84. The calculated value is 4.73 so the null hypothesis is rejected. There is association between the types of affiliation and perception of mission awareness by the CEOs.

This is reasonable if the assumption that full autonomy of the boards to set policy is lost at around the (d-e) point in the continuum of affiliation types.

The Mission Officers' numbers were too few to apply the chi square analysis, but appeared to show greater or much greater perception of mission awareness in the a-d grouping of affiliation types, similar to the CEOs.

Discussion

Within any affiliation agreement between a denominational and a non-denominational hospital, loss of mission by the denominational partner is of the greatest concern at the board and senior management level.

Almost universally both the CEOs and the Mission Officers in this survey felt mission awareness by staff was the same or had even increased after any affiliation agreement. This perception had not been formally documented in any of the respondent's institutions through a mission awareness survey except in one instance.

Both the CEO and Mission Officer groups felt the awareness of mission values had increased or increased greatly in staff, when affiliations where of the type that did not interfere with policy setting ability. That is, that did not interfere with the denominational institution's ability to be autonomous.

Mission officers agreed with the CEOs and believed the mission values were known and demonstrated by staff to a greater or much greater extent than before the affiliation when these where similarly grouped into greater autonomy over policy, and lesser autonomy. (See Table 10).

The largest numbers of affiliations in those surveyed were found to be the types that gave the denominational institution greatest autonomy, where there

would theoretically be little or no loss of control over policy setting.

Universally, within each affiliation agreement, whether it provided autonomy over policy setting or not, there was structured some form of special consideration for the denominational hospital.

There is certainly room to question the perception by CEOs and Mission Officers. These are the two groups with the most credibility to lose if mission were to suffer in a voluntarily negotiated affiliation agreement. The CEO would no doubt be the main individual within the institution who would have negotiate the agreement. The Mission Officer would be responsible to ensure mission is carried out. Any admission of less than the same mission effectiveness as before the affiliation could be seen as failure on their part. However, a number of cases reported were involuntary (at least 12 responders, see Table 5) and could have suggested loss of mission awareness without loss of credibility, but didn't. As well, the study looked at the difference between the levels of mission awareness, (the same or less as one grouping, and greater and much greater as the other grouping,) rather than simply a greater or lesser amount. The result could be seen to compare degrees of awareness.

The majority of the affiliations have occurred within the past two years.

Conclusion

Both Mission Officers and CEOs surveyed felt mission awareness had not suffered within affiliation agreements created within their denominational hospitals and other non-denominational hospitals in Canada over the past few years. However is has been shown in this study that comparing the grouping of affiliation types that has the least potential for loss of policy setting capability to grouping of affiliation types that can result in loss of policy setting ability, both the CEOs and Mission Officers felt the greatest level of mission awareness occurred after the least severe type of affiliation.

In the future it will be important to monitor mission awareness and mission effectiveness after affiliation within all institutions who are mission oriented, especially denominational hospitals. The increasing response to budget cutbacks by affiliating with non-denominational institutions, will require denominational hospitals to know and understand the role of mission within their organizations.

Perhaps because affiliations are very new to religious hospitals, perhaps

because affiliation is seen as a threat to mission, and perhaps because of the almost universal "special considerations" provided to the denominational partner institutions within these affiliations, the mission values appear to be better understood by staff after the affiliations.

A clear differentiation of affiliation types was seen by the CEOs within the spectrum of definitions of affiliations. At the Joint Venture/Leased Space position of the continuum, the perception of staff awareness of mission was seen to change significantly. It is within this type of affiliation agreements that future research should focus in order to identify the potential for loss of mission effectiveness.

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APPENDIX A

Letter of introduction to the survey

ASSOCIATION CATHOLIQUE
CANADIENNE DE LA SANTÉ

CATHOLIC HEALTH
ASSOCIATION OF CANADA

memo

TO : **CHAC Hospital members and other denominational hospitals**

FROM : **Richard M. Haughian, President, CHAC**

DATE : **April 29, 1996**

SUBJECT : **Research project by Mr. Don McDermott, Executive Director, St. Joseph's Health Centre, Sarnia, Ontario**

The rapid and profound changes in healthcare across Canada are having an important impact on Catholic healthcare. Increased collaboration, partnerships and joint ventures, both voluntary and imposed, are creating a climate that offers both opportunities and risks for Catholic healthcare's ability to maintain and promote its religious mission and values.

In this period of change, there is a need for sharing of experiences, reflection and research so that the Catholic healthcare community might learn from the accumulated wisdom of its members. For this reason, the Catholic Health Association of Canada encourages you to participate in the enclosed survey, prepared as part of a Masters thesis by Mr. Don McDermott, Executive Director, St. Joseph's Health Centre, Sarnia, Ontario. It is our hope that the results of this survey will provide all of us with another resource in our efforts to promote the church's healing ministry in Canada.

Richard M. Haughian, D.Th.
President

RMH/lb

1247, PLACE KILBORN PLACE
OTTAWA ON CANADA K1H 6K9

TEL.: (613) 731-7148
FAX.: (613) 731-7797

APPENDIX B

Survey tool for CEOs

St Joseph's
HEALTH CENTRE OF SARNIA

89 Norman Street, Sarnia, Ontario N7T 6S3
Telephone (519) 336-6121

CONFIDENTIAL

Re: Affiliation Survey, May 1, 1996

Dear C.E.O. of a Denominational Health Care institution;

The degree of affiliation of denominational institutions with non-denominational partners has not been well studied. This issue has been of considerable interest throughout Canada with forced regionalization and voluntary joint ventures. Has this activity resulted in changes to mission and are there real benefits to the institution and community?

The enclosed questionnaire is intended to get some feedback from denominational institutions' C.E.Os. There is also a similar questionnaire enclosed for your Mission Officer/Director of Pastoral Care to complete and return. This will allow some review of the Mission Officer/Director of Pastoral Care's personal perspective on the issue. Would you please forward the enclosed envelope with the Mission Officer's questionnaire to the appropriate individual within your institution or within your ownership structure.

The C.E.O.'s questionnaire will take approximately 15 minutes to complete and should be forwarded in the stamped envelope provided, or faxed to (519) 336-8780) by May 15, 1996. **All responses will be kept confidential. Grouped results will be returned to you if you indicate on the questionnaire.** The study itself will use grouped responses so individual institutions will not be able to be identified. Completion of the questionnaire is voluntary and constitutes agreement to participate in the study and consent to use the responses for general statistical analysis only. The raw data will be retained by me under secure conditions for 5 years.

Thank you for helping investigate this very important question. Please contact me if you have any concerns or questions at (519) 339-1389.

Sincerely,

Don McDermott
C.E.O.
St. Joseph's Health Centre - Sarnia, Ontario
and
M.A. (Management) candidate
College of St. Scholastica
Duluth, Mn

CONFIDENTIAL

AFFILIATION SURVEY

FACILITY NAME
CITY/PROV
RESEARCH ID#

RESULTS REQUESTED YES-- NO ---

Thank you in advance for your prompt response. **Completion of this questionnaire acknowledges your consent to voluntarily participate in this study. All information is confidential; no individual questionnaires or identifying information will be available to institutions or owners.** Please return this completed questionnaire to Don McDermott in the enclosed envelope no later than **May 15/96** or **fax it** to (519) 336-8780.

Section 1 - general

An "affiliation" is defined here as any collaboration with another entity in which there is agreement to work together on some aspect of programs or services, to clearly differentiate programs and services and avoid duplication.

1. Is your organization, listed above, a member of an affiliation or regionalized service with non-denominational organizations or agencies, or are you in the process of developing such a relationship? Please check where applicable (✓)

Participant in an affiliation ---

Negotiating an affiliation ---

Presently not in an affiliation and not negotiating **(inactive)** ---

Participating/developing other relationships --- (please explain on separate page)

2. IF PRESENTLY INACTIVE, PLEASE FAX OR MAIL THIS PAGE ONLY. THANK YOU.

3. If your organization is a participant in either a regionalized service or affiliation with a non-denominational partner, please provide the names and locations of the partners.

Name ---------- Name ----------
City/Prov ---------- City/Prov ----------
---------- ----------
Name ---------- Name ----------
City/Prov ---------- City/Prov ----------
---------- ----------
Name ---------- Name ----------
City/Prov ---------- City/Prov ----------
---------- ----------

(add additional names on separate page if required)

Approximate length of time agreement has been in place: 1yr --- 2 yr --- 3 yr --- 5 yr --- 5-10 yr---

4. If your organization is in the process of forming an affiliation at this time with a non-denominational institution or agency, please list an approximate date the agreement is likely to take place. Month/Year ----------

Section 2. Type of Affiliation

If you have now, or are in the process of developing an affiliation agreement with a non-denominational partner, please complete this section. **If there is more than one non-denominational partner, please describe the partner with the most influence on your organization.**

5. **Please read definitions enclosed on separate sheet.** Check (-✓-) the one single type of affiliation that **most closely resembles the main** non-denominational affiliation in which you are involved.

a. Voluntary consortium (----)
b. Formal agreement such as a Strategic Alliance (----)
c. Contract management (----)
d. Joint venture (----)
e. Leased space (----)
f. Involuntary consortium *with* ability to set policy (----)
g. Involuntary consortium *without* ability to set policy (----)
h. Corporate ownership *with* separate board (----)
I. Corporate ownership *without* separate board (----)
j. Other (Please describe or attach additional information) (----)

DEFINITIONS: TYPES OF AFFILIATIONS

PLEASE USE THESE DEFINITIONS IN CONJUNCTION WITH QUESTION #5

a. **Voluntary consortium** ---

definition - your board and that of another organization agree to **jointly plan services** in order to avoid competition and duplication. Your organization retains a separate board with separate ownership and independent policy setting for services provided.

b. **Formal agreement such as a Strategic Alliance** ---

definition - your board and that of another organization formally agree by **contract** to **role differentiation.** Your organization retains a separate board with separate policy setting ability for the services offered.

c. **Contract management** ---

definition - Another organization provides a **service to you under contract**. Conditions of service provision allow some degree of policy control by your organization receiving the service. Each retains separate ownership and boards, but your policy setting for their service is limited to the terms of the contract.

d. **Joint venture** ---

definition - A shared service agreement sets up a **separate corporation** with a separate board to provide the specific service or services. Representatives from each participating organization are members. Your policy setting is limited to the degree of influence and control through your membership ratio at the board of the joint venture corporation.

e. **Leased space** ---

definition - A service is provided to you by a non-denominational entity **on space leased from you, the owner organization**. Control of services offered is limited by the wording of the lease agreement.

f. **Involuntary consortia <u>with ability</u> to set policy** ---

definition - Role and services imposed on your organization by government or others. Ownership remains, with the ability for you to control policy on how your services will be provided.

g. **Involuntary consortia <u>without ability</u> to set policy** ---

definition - Role and services imposed on your organization by government or others. Ownership remains but **without the ability for you to control policy** on how your services will be provided.

h. **Corporate ownership with separate board** ---

definition - Your organization is owned by a non-denominational entity, but **your board remains separate** with policy setting ability allowed within limitations set by the non-denominational owner.

I. **Corporate ownership without separate board** ---

definition - Your organization is owned by a non-denominational entity with **a single corporate board** or governing agency. You have little or no control over policy.

Note: **Policy setting ability** of a board includes such decisions as independently selecting the CEO, approving the budget for the fiscal year, board appointments, personnel policies, ability to sign a contract, deciding how a service will be provided and to whom.

Section 3. Perceived relationship

Please answer the following in terms of how you perceive this relationship. Circle the number that indicates the degree to which you agree or disagree with each statement.

1	**Much less**
2	**Less**
3	**The same**
4	**Greater**
5	**Much greater**

In the relationship(s) described above, my perception is that

6. mission awareness by staff within my organization is---------- 1 2 3 4 5
7. mission awareness has been measured in this organization before and after affiliation ---------- yes (----) no (----)

To what extent do you agree that since this affiliation, in my organization

8. employee orientation has emphasis on mission and values---------- 1 2 3 4 5
9. services are provided for those who previously had unmet needs-------- 1 2 3 4 5
10. lay-offs or downsizing is done with respect to the worker's dignity---- 1 2 3 4 5
11. all possible alternatives are explored before lay-offs or job reductions are considered ---------- 1 2 3 4 5
12. major policy decisions (strategic or financial) are made in light of the organization's mission and values---------- 1 2 3 4 5
13. major policy decisions are made after evaluating their possible impact on individuals and groups---------- 1 2 3 4 5
14. the organization has an ethics committee that reviews difficult clinical cases, with staff involved---------- 1 2 3 4 5
15. leaders encourage communication and dialogue with staff and physicians---------- 1 2 3 4 5
16. as a normal part of their health care, patients spiritual needs are provided for---------- 1 2 3 4 5
17. pastoral services are available for staff---------- 1 2 3 4 5
18. religious art and symbols are prominently and tastefully displayed---------- 1 2 3 4 5
19. religious services, reflection, rituals and celebrations are an integral part of the organization's practice. (e.g. prayer before meetings)- 1 2 3 4 5

Section 4. Special considerations

20. As part of the affiliation agreement, some special consideration has been given to my institution to ensure our denominational mission is not compromised---------- yes (----) no (----)

If you checked 'YES' in #20 above, check those special considerations that apply

21. a super-majority is required for policy decisions if separate board ---------- (----)
22. my organization's board has a reserved power for mission issues within our organization ---------- (----)
23. my institution has policy setting control over selected services related to mission ---------- (----)
24. there is clear role distinction and we have full autonomy within that role ---------- (----)
25. other --- (explain)

Section 5. Benefits of affiliation

USING THE SCALE ABOVE, to what extent do you agree that this affiliation (compared to before the affiliation)

26. provides financial benefits to my organization---------- 1 2 3 4 5
27. provides financial benefits to the community served---------- 1 2 3 4 5
28. provides efficiency of health care---------- 1 2 3 4 5
29. provides a range of health services---------- 1 2 3 4 5
30. provides quality services ---------- 1 2 3 4 5

Because of this affiliation, do you agree your organization has adequately dealt with

31. sponsorship changes ---------- 1 2 3 4 5
32. denominational identity ---------- 1 2 3 4 5
33. ethical issues ---------- 1 2 3 4 5
34. loss of control or shared control over policy---------- 1 2 3 4 5
35. other --- (briefly describe 31 - 35 if applicable. Use additional space if required)

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. PLEASE RETURN AS SOON AS POSSIBLE.

APPENDIX C

Survey tool for Mission Officers

St Joseph's
HEALTH CENTRE OF SARNIA

89 Norman Street, Sarnia, Ontario N7T 6S3
Telephone (519) 336-6121

CONFIDENTIAL

Re: Affiliation Survey, May 1, 1996

Dear Director of Pastoral Care/Mission Officer of a Denominational Health Care institution;

The degree of affiliation of denominational institutions with non-denominational partners has not been well studied. This issue has been of considerable concern throughout Canada with regionalization and voluntary joint ventures. Has this activity resulted in changes to mission effectiveness and has there been real benefits to the institution and the community?

The enclosed questionnaire is intended to get some personal feedback from denominational institutions' Directors of Pastoral Care/Mission Officers. A similar questionnaire has been provided to the institution's CEO to separately complete and return. This will allow some perspective from both the CEO and you, the institution's officer for mission. Would you please ensure the institutions you represent are listed at the top of the questionnaire and please complete one questionnaire **for each** denominational health care institution that has some form of affiliation with a non-denominational partner and for which you have responsibility.

Each questionnaire will take approximately 15 minutes to complete and should be forwarded in the stamped envelope provided, or faxed to (519) 336-8780) by May 15, 1996. **All responses will be kept confidential. Grouped results will be returned to you if you indicate on the questionnaire.** The study itself will use grouped responses so individual institutions will not be able to be identified. Completion of the questionnaire is voluntary and constitutes agreement to participate in the study and consent to use the responses for general statistical analysis only. The raw data will be retained by me under secure conditions for 5 years.

Thank you for helping investigate this very important question. Please contact me if you have any concerns or questions at (519) 339-1389.

Sincerely,

Don McDermott
C.E.O.
St. Joseph's Health Centre - Sarnia, Ontario
and
M.A. (Management) candidate
College of St. Scholastica
Duluth, Mn.

CONFIDENTIAL

AFFILIATION SURVEY

FACILITY NAME
CITY/PROV
RESEARCH ID#

RESULTS REQUESTED YES-- NO ---

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Negotiating an affiliation ---

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Participating/developing other relationships --- (please explain on separate page)

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---------- ----------
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---------- ----------
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City/Prov ---------- City/Prov ----------
---------- ----------

(add additional names on separate page if required)

Approximate length of time agreement has been in place: 1yr --- 2 yr --- 3 yr --- 5 yr --- 5-10 yr---

4. If your organization is in the process of forming an affiliation at this time with a non-denominational institution or agency, please list an approximate date the agreement is likely to take place. Month/Year ----------

Section 2. Type of Affiliation

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d. Joint venture (----)
e. Leased space (----)
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g. Involuntary consortium *without* ability to set policy (----)
h. Corporate ownership *with* separate board (----)
I. Corporate ownership *without* separate board (----)
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definition - Another organization provides a **service to you under contract**. Conditions of service provision allow some degree of policy control by your organization receiving the service. Each retains separate ownership and boards, but your policy setting for their service is limited to the terms of the contract.

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definition - Your organization is owned by a non-denominational entity with **a single corporate board** or governing agency. You have little or no control over policy.

Note: **Policy setting ability** of a board includes such decisions as independently selecting the CEO, approving the budget for the fiscal year, board appointments, personnel policies, ability to sign a contract, deciding how a service will be provided and to whom.

Section 3. Perceived relationship

Please answer the following in terms of how you perceive this relationship. Circle the number that indicates the degree to which you agree or disagree with each statement.

1	**Much less**
2	**Less**
3	**The same**
4	**Greater**
5	**Much greater**

In the relationship(s) described above, my perception is that

6. mission awareness by staff within my organization is---------- 1 2 3 4 5
7. mission awareness has been measured in this organization before and after affiliation ---------- yes (----) no (----)

To what extent do you agree that since this affiliation, in my organization

8. employee orientation has emphasis on mission and values---------- 1 2 3 4 5
9. services are provided for those who previously had unmet needs-------- 1 2 3 4 5
10. lay-offs or downsizing is done with respect to the worker's dignity---- 1 2 3 4 5
11. all possible alternatives are explored before lay-offs or job reductions are considered ---------- 1 2 3 4 5
12. major policy decisions (strategic or financial) are made in light of the organization's mission and values---------- 1 2 3 4 5
13. major policy decisions are made after evaluating their possible impact on individuals and groups---------- 1 2 3 4 5
14. the organization has an ethics committee that reviews difficult clinical cases, with staff involved---------- 1 2 3 4 5
15. leaders encourage communication and dialogue with staff and physicians---------- 1 2 3 4 5
16. as a normal part of their health care, patients spiritual needs are provided for---------- 1 2 3 4 5
17. pastoral services are available for staff---------- 1 2 3 4 5
18. religious art and symbols are prominently and tastefully displayed---------- 1 2 3 4 5
19. religious services, reflection, rituals and celebrations are an integral part of the organization's practice. (e.g. prayer before meetings)- 1 2 3 4 5

Section 4. Special considerations

20. As part of the affiliation agreement, some special consideration has been given to my institution to ensure our denominational mission is not compromised---------- yes (----) no (----)

If you checked 'YES' in #20 above, check those special considerations that apply

21. a super-majority is required for policy decisions if separate board ---------- (----)
22. my organization's board has a reserved power for
    mission issues within our organization ---------- (----)
23. my institution has policy setting control over
    selected services related to mission ---------- (----)
24. there is clear role distinction and we have
    full autonomy within that role ---------- (----)
25. other --- (explain)

Section 5. Benefits of affiliation

USING THE SCALE ABOVE, to what extent do you agree that this affiliation (compared to before the affiliation)

26. provides financial benefits to my organization---------- 1 2 3 4 5
27. provides financial benefits to the community served---------- 1 2 3 4 5
28. provides efficiency of health care---------- 1 2 3 4 5
29. provides a range of health services---------- 1 2 3 4 5
30. provides quality services ---------- 1 2 3 4 5

Because of this affiliation, do you agree your organization has adequately dealt with

31. sponsorship changes ---------- 1 2 3 4 5
32. denominational identity ---------- 1 2 3 4 5
33. ethical issues ---------- 1 2 3 4 5
34. loss of control or shared control over policy---------- 1 2 3 4 5
35. other --- (briefly describe 31 - 35 if applicable. Use additional space if required)

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. PLEASE RETURN AS SOON AS POSSIBLE.

APPENDIX D

Comparison of civil law to canon law

Corporate Responsibilities (Canon Law)	*Corporations Act (Ontario)* (Civil Law)
To establish the philosophy according to which the corporation operates	It is a membership function in a non-share capital corporation to determine the objects of a corporation, i.e. its philosophy and any amendment by way of supplementary letters patent. The Corporations Act (Ontario) Sections 120, 122, 132
To amend the corporate charter and bylaws	It is a membership function to confirm bylaws and amendments The Corporations Act (Ontario) Section 69 (2)
To appoint the board of trustees	It is a membership function to elect the Directors of the Corporation. The Corporations Act (Ontario) Section 317
To lease, sell or encumber corporate real estate	A borrowing bylaw requires approval of 2/3 of the votes cast at general meetings of members called for that purpose. The Corporations Act (Ontario) Section 60(3)
To appoint or approve the appointment of the corporation's Chief Executive Officer (CEO)	The bylaws may provide that the officers of the corporation may be elected or appointed at a general meeting of the members duly called for that purpose. The Corporations Act (Ontario) Section 319(3)
To merge or dissolve the corporation	It is a membership function to confirm the dissolution, surrender of charter or the amalgamation of a corporation. The Corporations Act (Ontario) Section 133 (Dissolution, Section 266 (Voluntary winding up), Section 349 (Surrender of Charter), Section 114 (Amalgamation).
To require a certified audit of corporate finances and to appoint the certified public accountant to perform the audit.	It is a membership function to appoint the auditors. The Corporations Act (Ontario) Section 95
To approve capital and operating budgets	Financial Statements • Statement of profit and loss • Statement of surplus • A balance sheet • Such further information respecting the financial position as the bylaws require The Corporations Act (Ontario) Section 98