INTRODUCTION

Catholic Hospitals in Illinois

Catholic hospitals are a large and growing part of the U.S. healthcare system. The country’s public and secular hospitals have recently declined in number, while from 2001 to 2016 the number of Catholic hospitals increased by 22%. Nationally, one in every six hospital beds are in Catholic owned or affiliated facilities, and in Illinois the Church controls nearly one in three hospital beds.1

Catholic hospitals are governed by the Ethical and Religious Directives for Catholic Healthcare Services (ERDs), written by the United States Conference of Catholic Bishops. These directives prohibit provision of common reproductive health services, including contraception, sterilization, and abortion.2 Every year, more than 44,000 births occur in Illinois Catholic hospitals, where obstetric/gynecologic (ob/gyn) care is restricted on the basis of religious doctrine. Unlike in secular hospitals and those affiliated with non-Catholic religious denominations, Illinois Catholic hospitals are unique in restricting contraceptive care: as one physician working at an Illinois Catholic hospital explained, “In no way at all are we allowed to provide [long acting reversible contraception]… on site, and sterilization [is] also completely not allowed on site.”3

Patients rarely seek out care in a hospital specifically because of its religion.4 In fact, nearly 40% of women who receive ob/gyn care in Catholic hospitals are not aware of the hospital’s religion,5 and the majority of women expect they will be able to receive the full scope of reproductive services regardless of a hospital’s religious or secular affiliation.6 For example, in a national survey only 17.5% of women were aware that a Catholic hospital would not provide a tubal ligation,6 while ob/gyns working in Catholic hospitals have described how even patients having a C-section are denied their requests to have a tubal ligation during the same procedure (to avoid an unnecessary second surgery) due to Catholic hospital policies prohibiting sterilization.7

DEFINITIONS:

Postpartum: Period of time following a birth, from a few months up to a year

Immediately Postpartum: The minutes, hours, or days following birth, usually while the patient is still in the hospital

Long-Acting Reversible Contraception (LARC): A method to prevent pregnancy that is not permanent but can be highly effective for multiple years; usually includes contraceptive implants and intrauterine devices (IUDs)

Sterilization: Permanent contraception, most commonly a tubal ligation or vasectomy

Comprehensive Contraceptive Care: Offering all available methods of pregnancy prevention, with accurate and patient-centered counseling about each method
Standards of Care for Postpartum Contraception

The American College of Obstetricians and Gynecologists (ACOG) recommends that clinicians counsel pregnant patients about all methods of postpartum contraception and offer immediate, in-hospital placement of long-acting reversible contraception (LARC) for patients who choose this approach. For pregnant patients who wish to undergo tubal ligation at the end of their pregnancy, ACOG advises that clinicians should offer the procedure immediately postpartum (during the birth hospitalization) and help patients access this care when hospitals or insurance plans raise barriers. These recommendations are motivated by research showing:

- Short interpregnancy intervals are a risk factor for maternal morbidity and preterm birth in subsequent pregnancies. This is especially true among low-income women, who already face higher risk for these adverse pregnancy outcomes.
- Providing patients with comprehensive contraceptive care in the postpartum period is the best way to help them achieve healthy interpregnancy intervals but many women face significant barriers to receiving desired postpartum contraception.

Comprehensive contraceptive care is important during all phases of a person’s reproductive life. In the postpartum period, the health of both the mother and her children can be negatively impacted if patients cannot access this care.

NEW RESEARCH FINDINGS

Study Aims and Methods

The objectives of this analysis were to:

1) Describe challenges patients face in obtaining the desired postpartum contraceptive method after delivering at an Illinois Catholic hospital.
2) Compare rates of short interpregnancy intervals between Medicaid-covered births in Catholic hospitals and non-Catholic hospitals in Illinois.

To accomplish these aims, we interviewed healthcare providers and patients and analyzed Medicaid Analytic Extract (MAX) data files. Interviews were completed in 2019 (n=19), with providers and patients sharing their experiences from 12 different Catholic hospitals geographically dispersed throughout Illinois. We recorded the interviews, and recordings were transcribed and verified for accuracy.
We reviewed MAX files under an approved Data User Agreement from the Centers for Medicare and Medicaid Services. Examining inpatient and outpatient claims from 2010-2012, we used International Classification of Diseases-9th revision (ICD9) diagnosis codes to construct a cohort of all births that took place in an Illinois hospital in from January 1 – September 30, 2010. These dates were selected to allow us to observe a full 27 months after the last birth in the cohort. For each woman with Medicaid insurance who had a birth in this initial cohort, we identified whether they had a subsequent pregnancy within our available dataset (i.e. by December 31, 2012). Subsequent pregnancies were identified using ICD9 codes for birth, prenatal care, and other pregnancy outcomes (Table 1). Dates of conception were estimated, based on a modified approach from previous research, to be 255 days before a full-term birth or 230 days before a premature birth. When the subsequent pregnancy did not end in birth, we estimated the date of conception to be 75 days prior to a miscarriage or ectopic pregnancy, or 45 days prior to the first prenatal visit. Calculating the inter-pregnancy interval as the difference between the date of birth in 2010 and the date of conception for the subsequent pregnancy, we used the Chi Square test to compare the percent of cohort births that were followed by short interval pregnancies (<18 months, <12 months, or <6 months) and multivariable logistic regression to control for individual demographic factors. The exposure was based on where the 2010 delivery occurred: at a Catholic vs. a non-Catholic Illinois hospital. Hospitals were identified using the billing provider identification number listed in the MAX file, which contained each hospital’s Employer Identified Number (EIN). We used publicly available search engines to identify each hospital by its EIN, and to classify the hospital as Catholic if it was listed in the Catholic Health Association’s directory.

**Table 1. Identification of Births and Subsequent Pregnancies from Medicaid Analytic Extract Files Using International Classification of Diseases-9th Revision (ICD9) Codes – Illinois, 2010**

<table>
<thead>
<tr>
<th>ICD9 Code</th>
<th>Diagnosis</th>
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</thead>
<tbody>
<tr>
<td>V27.xx</td>
<td>Outcome of delivery</td>
</tr>
<tr>
<td>650</td>
<td>Normal delivery</td>
</tr>
<tr>
<td>644.2, 644.4, 765.0, 765.1</td>
<td>Pre-term birth</td>
</tr>
<tr>
<td>V22.x, V23.x</td>
<td>Prenatal care</td>
</tr>
<tr>
<td>63x.xx</td>
<td>Ectopic or molar pregnancy, spontaneous or induced abortion</td>
</tr>
<tr>
<td>V27.xx</td>
<td>Outcome of delivery</td>
</tr>
<tr>
<td>650</td>
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</tr>
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**Results**

Interviews with healthcare providers revealed significant variation in how strictly Illinois Catholic hospitals apply the ERDs’ prohibition on providing contraception. One physician in a suburban Chicago-area hospital said that while they could not give contraception in the hospital, any contraceptives including LARC methods could be provided in the hospital’s outpatient clinic. On the other hand, a physician in an underserved area in central Illinois said that the Catholic hospital there would not even allow discussion of contraception with patients. The hospital’s particular sponsoring body did not, this provider explained, have “liberal views on how you manipulate the Ethical and Religious Directives, and so it just wouldn't fly
here.” This physician said that in their geographic setting, there are “families that still don’t have access to reliable forms of birth control.” Specifically, patients with Medicaid had very limited options: “They don't always get back in for their postpartum visit, because if it's- I think it's sometimes, on, their discharge papers, they'll say, ‘Call this number for an appointment.’ But then when they call, there's no appointment for the next four to six months, and then by then they may have stopped breastfeeding, they started ovulating and then you’re back in the short interpregnancy interval.”

Statewide Medicaid data confirmed this physician’s impression. Among 44,128 Medicaid-covered births from 1/1/2010 – 9/30/2010, those occurring in Catholic hospitals were significantly more likely to be followed by a short interval pregnancy <18 months (21.5% vs. 19.4% in non-Catholic hospitals, p<0.001).

This means that for every 47 women with Medicaid insurance who delivered in a Catholic hospital, one experienced a short-interval pregnancy that might have been prevented in a non-Catholic hospital. Very short interval pregnancies were also more common in Catholic hospitals: 14.6% vs. 13.0% in non-Catholic hospitals (<12 month interval, p<0.001), and 5.9% vs. 5.7% in non-Catholic hospitals (<6 month intervals, p non-significant). Controlling for the age, race/ethnicity, and residential zip code of women with Medicaid insurance, the odds of short interval pregnancies after giving birth at Catholic hospitals remained significantly higher than at non-Catholic hospitals (adjusted odds ratio 1.13, 95% confidence interval 1.07 – 1.20).

CONCLUSION

Catholic hospitals pose barriers to Illinois women with Medicaid insurance and their ability to access postpartum contraception. Since women with Medicaid insurance in Illinois are also less likely to receive preconception and adequate prenatal care compared to other women, the impact of missing postpartum contraceptive care may be even greater. Short interpregnancy intervals are more prevalent among women who deliver at Catholic hospitals than non-Catholic hospitals, which may cause worse downstream outcomes for women and children. Efforts to improve postpartum contraceptive care must address religious hospitals in the landscape of Illinois healthcare.

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References