

March 16, 2020

Janet Napolitano, President
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University of California Board of Regents
Office of the Secretary and Chief of Staff to the Regents
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Via email and U.S. Mail

Re: Affiliations that Impose Religious Restrictions on UC Health Care

Dear President Napolitano and Board of Regents:

As organizations working to ensure that all Californians, regardless of race, income, geography or other demographics, have equitable access to comprehensive and culturally relevant care, we are deeply concerned by Option 1 proposed in the Working Group on Comprehensive Access report, which would allow UC to place its providers and patients in hospitals where patient care is restricted by religious doctrine. Religious restrictions on health care have serious implications for patients of color, particularly Black, Latinx and low-income patients whose unequal access to care has been largely dictated by the legacy of structural racism and socioeconomic inequities deeply embedded throughout the health care system. UC Health leaders continue to assert that affiliations placing UC providers and patients in religiously restrictive hospitals are necessary to expand access to underserved communities, but Catholic religious directives prohibit many types of medical services that communities of color critically rely upon, particularly in the areas of reproductive and LGBTQ-inclusive health where some of the deepest racial health inequities exist. Therefore, we call on UC leadership to seek alternatives that would expand access to care for patients who need it most, instead of participating in systems that exacerbate the health inequities we strive to eliminate.

In the report, Option 1 suggests that underserved patients in religiously affiliated institutions would be better served by the presence of UC providers, who could “improve patient access to quality care by providing comprehensive advice and facilitating access to options for services elsewhere.” Yet in reality, under Option 1, UC providers would not be able facilitate patients’ access to comprehensive care, because the religious directives require that *all* personnel in Catholic facilities adhere to the directives and clearly forbid prescriptions and referrals for their “prohibited procedures” such as sterilization, a popular form of contraception used more often by patients of

color than by white patients.¹ Patients of color experience unintended pregnancy at higher rates than white patients, and sterilization refusals increase the risk of unintended pregnancy. Additionally, for transgender patients, the refusal of a gender-affirming sterilization may cause an unnecessary delay in care, as well as emotional and social harm resulting from the bias and stigmatizing treatment inherent in the denial.

In support of Option 1, UC Health leadership suggests that if it were to end affiliations that place UC providers and patients in Catholic health care settings this would jeopardize access to UC evidence-based care for vulnerable patients in underserved areas, asserting that there are no alternatives for regions like the Inland Empire. But Catholic hospitals actually have a variety of options for partnerships with other health care systems, and UC declining to place its providers in Catholic hospitals would not prevent these hospitals from securing quality care for their patients through another affiliation. Additionally, in the Inland Empire, faith-based providers make up less than a quarter of hospitals serving low-income and underserved patients. Thus, if UC wants to expand access to care for underserved patients in the region, it could instead partner with other Inland Empire hospitals that also provide significant care to Medi-Cal patients but are not subject to religious restrictions on care. UC Health also misleadingly overstates the impact of its affiliations with Catholic hospitals, as the number of patients currently served under these affiliations is quite small. For example, proponents of Option 1 report a seemingly high volume of 12,000 UCLA patients who were seen in Catholic-affiliated institutions in FY 2019; however that constitutes just 2% of the annual UCLA patient population of 600,000 patients per year.²

Citing capacity concerns, UC Health argues in favor of Option 1, stating that a prohibition on affiliations that place UC providers and patients in religiously restrictive hospitals would impact UC's ability to dedicate its tertiary and quaternary facilities to those patients who most need them. However, this argument would mean that UC would transfer patients for primary and secondary care to Catholic hospitals, where they could be denied basic care due to religious rules. We are deeply concerned with UC Health's apparent comfort in creating a two-tier system in which it would be facilitating denial of care to some patients in order to treat others. Additionally, research on expanding access to care for low-income patients, patients of color and other communities on the margins does not point to expanding hospital services as a key intervention. If UC is committed to expanding access to care to all patients, it should pursue evidence-based strategies that improve access to primary care, including the use of mobile and pop-up clinics and expanding community health centers.³

Finally, in endorsing Option 1, UC Health seeks to create a wedge between reproductive and LGBTQ-inclusive care and other care, proclaiming a larger purpose in serving all patients, including the underserved. However, this largely erases the complexities of patients as people, particularly low-income and patients of color, who live at the intersections of identities with a range of health care

¹ Michael G. Richardson, Sarah J. Hall, and Lisa C. Zuckerwise, *Postpartum Tubal Sterilization: Making the Case for Urgency*, 126 *Anesthesia & Analgesia* 1225-1231 (2018).

² Letter from Kum-Kum Bhavnani, Vanessa Jacoby, and Robert May to President Napolitano Re: Dissent and Concern Regarding the Working Group on Comprehensive Access Report 2 (Dec. 24, 2019).

³ Molly Miller and Tom Peterson. *10 Ways Hospitals Can Improve Healthcare Access*, <https://stakeholderhealth.org/healthcare-access/> (last visited Mar. 9, 2020).

needs. It also ignores that Catholic religious directives affect patient care across a wide spectrum of services, including cardiology, cancer care, and mental health. For instance, UC providers in Catholic facilities would be limited from providing evidence-based care for a pregnant patient with cancer or a transgender patient with mental health care needs. Patients of color, low-income patients and others who experiencing systemic barriers to health care access are most in need of quality, comprehensive care, including comprehensive reproductive health care and bias-free care for LGBTQ people.

As the fourth largest health care provider and leading public health care system in California, UC has demonstrated its commitment to public service and caring for the underserved, serving more than 60 percent of patients who are uninsured or covered by public insurance. In fulfilling such a vital role in the state's health care landscape, it is critical that UC continue to advance equitable access to robust, evidence-based and patient-centered care to patients, communities and areas of the state that are often left behind, rather than embed UC personnel in systems that erect barriers to complete care. We urge the Board of Regents to reject Option 1 and to seek alternatives to expanding access to care for underserved Californians that do not involve placing UC providers and patients in hospitals where patient care is restricted by religious doctrine.

Sincerely,

California Immigrant Policy Center
California Pan-Ethnic Health Network
Health Access California
Los Angeles Trust for Children's Health
San Francisco Community Health Center
Western Center on Law & Poverty