Mass General Brigham

Investing in America's Health: Intrusion of Private Equity in American Healthcare

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Background

The healthcare sector is the fastest growing segment of the US economy[1] and has become the second largest recipient of Private Equity (PE) investment funds in the last 10 years. As consumer demands for health care services remain stable regardless of economic conditions, health care organizations have been seen as a "safe" investment. While PE investment have shifted over time from hospitals to independent physician practices and groups, it shows no signs of stopping.[2] The potential disastrous impact of PE investment was brought to light during the very public and abrupt closure of the 500-bed teaching and safety net hospital, Hahnemann University Hospital in 2019.[3] Although Hahnemann's closure was a result of larger historical forces in American healthcare, dating back to the failure to pass a comprehensive national healthcare program, the 1970s recession, neoliberal economic reforms, and Reagan era healthcare spending cuts, the final death knell dealt to Hahnemann in form of PE investment makes both the hospital a case study and the trend of PE a worthy topic of discussion.

We conducted our literature review with the aim of evaluating the overall scope of PE presence in healthcare, perception of PE and impact on physicians and the practice of medicine, and to assess the current solutions posed.

The death of Hahnemann University Hospital

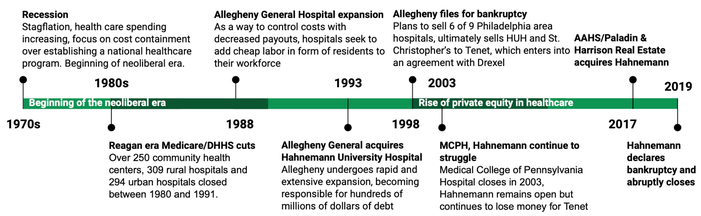


Fig 1. Timeline of Hahnemann University Hospital acquisitions and major trends affecting healthcare financing

Model of PE in Healthcare

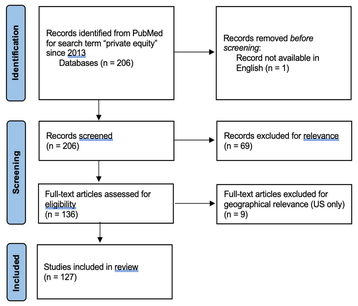
Major common characteristics emerged from specialties which have been targeted for PE investment: predominantly outpatient services; preponderance of small, fragmented independent practices; relatively high percentage of out-of-pocket services; and concentration in larger metropolitan areas for outpatient practices, and rural areas for hospitals.[4]

Dermatology, anesthesiology/pain medicine, gastroenterology,[5] ophthalmology,[6] orthopedics,[7] oral maxillofacial surgery/dentistry,[8] reproductive endocrinology and fertility[9] are among the most highly represented specialties though it has also been growing in plastic surgery[10] and ENT.[11] PE acquisitions of physician practices have been concentrated in the Northeast, Florida, and Arizona, with many PE-acquired hospitals being in similar regions, showing joint PE penetration into the same market.[12]

PE Modus Operandi PE firms start by acquiring a large platform practice ("target company") within a region, before acquiring other smaller practices in the region. Significant amount of debt is often used to finance these further acquisitions and loaded onto newly acquired practices.[13] This level of debt necessitates a healthy cashflow for the acquired practice or facility to remain functional.[14] Profit is generated by consolidating multiple practices acquired within a region, streamlining overhead and administrative costs, cutting costs (reducing staff, or hiring less costly advanced practice providers over physicians). Proponents of PE note these potential cost savings as a boon for patients and insurers. Unfortunately, evidence shows that these savings are not passed onto patients. Instead, PE revenues may be increased with increased prices, increased billing, increased patient volume.[15] With their market dominance, PE-affiliated practices face reduced competition and able to negotiate higher reimbursement rates with insurers.[16, 17] Once sufficient revenue has been generated to warrant a significantly higher selling price, the practice is sold at great benefit to the PE firm.[18] While PE-firms look to invest for an average of 3 – 5 years,[13] it may be as long as 10 years, and some far shorter (one dermatology practice was owned by 4 different groups within an 18 month period[19]). Occasionally, PE firms may target facilities in dire financial straits (if the facility-owned real estate is independently valuable enough) and separate the real estate holdings from the hospital for sale, as in the case of Hahnemann Hospital.[20]

Generational Dynamics. In the acquisition of the practice or physician group, the physician partners or owners receive a sizable upfront payment for the practice, as much as $1-2 million.[21] Junior partners or other younger physicians become employees with salaries lower than income from a physician-owned practice,[22] without option for partnership.[23] This introduces a specific generational dynamic to PE acquisitions.[24] Senior physicians often receive a larger up-front pay out and the potential of a reduced salary does not impact a senior physician close to retirement nearly as much as an early- or mid-career physician, whose lifetime earnings may be significantly reduced by PE acquisition. While junior physicians may be offered stock options (to align physician interest with that of the PE firm,[25] the future sale which would generate the return on the stocks often lead to an uncertain future for the physician.[23] If the practice is bought again by a new PE firm at the second sale, the practice enters another cycle of cost cutting and profit maximization anew.[26] For physicians who had sought out private practice to avoid becoming an employee of a hospital or a health system may find that the ultimate buyer of the PE practice is the same employer they had hoped to avoid.[25] In either case, with subsequent sales, physician autonomy is likely to continually decrease,[27] and physician ownership of the practice is increasingly unlikely.[26] If secondary buyers fail to materialize, or if PE firms fail to generate sufficient returns to finance their high levels of debt, there may be a repeat of the mass bankruptcies of Physician Practice Management organizations of the 1980s and 1990s.[28] When hospitals and clinics close, especially abruptly, patients can lose medical records and left abandoned without continuity of care.[19]

Methods



As we were focused on the experience of American physicians and healthcare organizations, we limited our search to PubMed. After filtering for relevance and US, we included 127 articles for review. We noted increase in articles published in private equity over time, mirroring the growth of PE. The number of publications by specialty seemed to reflect the "invasiveness" of PE investment in the specialty.

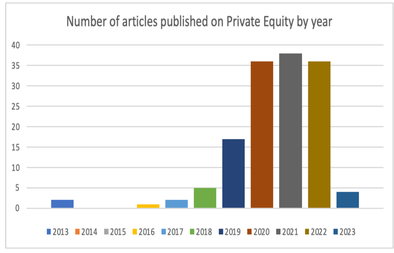


Fig 2. Number of articles on private equity by year from 2013 - 2023

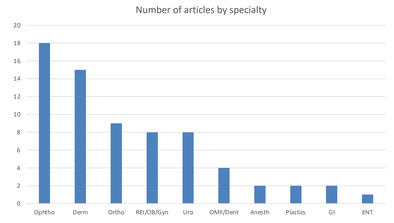


Fig 3. Number of articles on private equity by medical specialty

Key Findings of PE vs non-PE owned facilities

Fertility: PE-affiliated clinics comprised 14.7% of all fertility clinics in the US but responsible for 29.3% of all ART cycles in 2018 and had increased use of preimplantation genetic testing.[9]
Anesthesiology: Hospitals contracting with Physician Management Companies (PMCs) had increases in anesthesia service prices, and greatest price increases were associated with PE-backed PMCs.[17]
Nursing homes: Residents of PE-owned nursing homes were 11% more likely to experience an ED visit, 8.7% more likely to experience a hospitalization, and had 3.9% higher total Medicare costs.[41]
COVID related impacts: There was no difference in COVID deaths between PE-owned nursing homes and non-profit or government owned nursing homes; however, PE-owned nursing homes were significantly less likely to have 1 week supply of N95 masks compared to both non-profit and government-owned nursing homes, but less likely to have staff shortages.[41]
Ambulatory Surgical Centers: the percentage of unplanned hospital visits, total costs, and total number of encounters at ASCs did not differ between the ASCs acquired by PE entities or non-PE entities.[33]
Ophthalmology: The number of patient encounters per provider did not change with PE acquisition, but there was an increase in billing for diagnostic testing and procedures.[35] Ophthalmology practices after PE acquisition had increased charges per claim, increased amount per claim, and increased numbers of unique patients, and increased percentage of office visits for established patients billed as longer than 30 minutes.[15]
Hospitals: PE-acquisition was associated with increase in hospital charges, charge-to-cost ratios, lower all-staffing ratios.[42]
Focus on pay-for-performance and quality improvement: For patients with an acute myocardial infarction (AMI), PE-owned hospitals had a greater decrease in in-hospital mortality and greater decrease in 30 day mortality but not for patients to pneumonia, COPD, congestive heart failure, or stroke. Improving outcomes for AMI patients may be well-suited for PE-owned hospitals, given that there are clear guidelines, a strong "association between guideline adherence and improved outcomes," and highly billable diagnostic and treatment pathway.[43]
Shifts in payer base: PE-owned hospitals had a decrease in Medicare patients relative to non-PE owned hospitals.[44]
Shifts in work force composition: PE-owned dermatology practices employed a greater number of advanced practice providers (APPs) and have a higher ratio of APPS to physicians. Dermatology practices had an increase in patient volume, increase in prices after PE acquisition.[45]
Urology: After PE-acquisition, PE-affiliated urologists maintained a greater Medicare patient volume and maintained a consistent inflated-adjusted payment per patient, whereas non-PE affiliated urologists had a decline during the study period.[37]

Fig 4. Summary of PE acquisitions

Study	Specialty	Total	Notes
Billig et al 2021[29]	Surgical practices (ASCs, surgical services/physician groups)	193 acquisitions and investments from 2000 - 2020	52% operative facilities 48% surgical services 46% in the south
Boddapati et al 2022[7]	Orthopedic surgery practices and surgeon groups	41 acquisitions and investments from 2004 - 2019	Increasing each year 51.2% in the south 70.7% in metropolitan areas
Braun et al 2021[30]	Nursing homes	79 acquisitions from 2013-2017	Increasing each year
Braun et al 2021[31]	Hospice Agencies	87 acquisitions from 2011-2019	58% involving purchase of a non-profit
Brown et al 2020[32]	Behavioral Health treatment centers	11 acquisitions in 2013 24 large acquisitions in 2016	Focus on addiction, eating disorders, autism
Bruch et al 2022[33]	Ambulatory Surgical Centers	91 acquisitions from 2009-2014	PE-acquired ASCs were primarily urban
Bruch et al 2020[34]	Women's Health Centers (Ob/Gyn practices, hospitalists groups, fertility services)	24 acquisitions from 2010-2019	Primarily urban Average median household income 24% higher than national average
Chen et al 2020[6] Del Piero et al 2022[35]	Ophthalmology and optometry Same specialty and time period	228 acquisitions from 2012-2019	75% of acquisitions occurred in metropolitan areas Average adjusted gross income in PE practices $18954 higher than national average
Mikhail et al 2021[36]	Orthopedics	5 acquisitions from 2010 - 2019	59 total unique buyers and 68 acquired practices, of which 5 were PE firms
Nie et al 2022[37]	Urology	10 acquisitions from 2013 - 2018	
Khetpal et al 2021[10]	Plastic surgery and related fields	31 deals (investments, acquisitions) from 2011-2019	$85 million in investments on plastic surgery groups and practices
Seiger et al 2021[38]	Dermatology	109 clinic acquisitions from 2018-2019	52 organic clinics or non-disclosed acquisitions
Tan et al 2019[39]	Dermatology	184 acquisitions from 2012 - 2018	One third of acquisitions in Florida and Texas
Zhu et al 2020[40]	All specialties – Physician medical groups	355 acquisitions (355 practices, 1426 sites, 5714 physicians) from 2013 - 2016	43.9% in the South 33.1% anesthesiologists

Discussion and Solutions

The papers we reviewed show physicians succumbing to the dominant economic powers within the Medical-Industrial Complex. Trends in the healthcare labor market reveal that physicians are changing from *owners* of a medical practice billing for services to *employees* of an institution, creating value for shareholders.[1, 46] While we do not wish to return to "the good old days" of individualized profit-based private practice, the direction that physicians are heading today is far worse than even the most uncharitable interpretations of petit bourgeois notions of 'physician autonomy.' While Organized Medicine has been busy negating the threat of socialized "Big Government" medicine,[47] it has now been captured within the tendrils of Capital instead. Though we are tempted to call this a 'new development,' it is a story as old as capitalism itself, and private equity, merely the most recent accelerant of Capital's expansion into healthcare, continues to use land acquisition & proletarianization as weapons of choice.

Rather than perceiving the workplace as a medium where employers and workers come together free from coercion to produce good outcomes for patients (the *doxa* of capitalist social relations), we should understand that under a capitalist paradigm, workers are merely a part of the outlay a capitalist must invest in to increase the value of the commodities they will sell on the market. Like any other enterprise, the PE healthcare capitalist will attempt to lower their costs & raise their revenues however possible: price-gouging,[15, 17, 42, 45] short-staffing,[48, 49] and anti-competitive practices like buyouts, mergers, acquisitions,[38] and integrations.[50, 51] The real goal for the owners of healthcare capital – PE or otherwise – isn't the production of health - it's the *realization of profit, reinvestment in the enterprise, and infinite growth.* Greed, though ubiquitous and destabilizing, is a moral claim, a secondary and individualized phenomenon that runs *above* a systemic capitalist axiomatic that prioritizes profit over all else. Once we understand the capitalist workplace as a site of value-extraction from workers, administered by the power structures inherent to the organization of capitalist production itself and the laws governing the ownership schemas of private property - rather than as a neutral partnership between two parties acting on their own volition - we understand PE's place in this puzzle: another vulturous enterprise attempting to secure pieces of the healthcare pie. PE does not wish to "partner" with medicine: it wishes to be its new exploiter.

Many of the authors in our review implore us to further research the phenomenon of PE in healthcare,[52, 53, 54] curb the worst excesses of PE with legislation,[53, 55] make deals easier to find in public databases,[56] teach physicians professionalism,[57] ethics, and business law[58, 59]; however, the hundreds of studies and piecemeal legislations thus far have had all the ballistic impact of a banana cream pie on growth of PE. It is exceedingly clear to us at this point which way the wind is blowing. Healthcare capitalists in the hospital sector, insurance, pharmaceuticals, have been carving up healthcare for the past century, and PE is merely the latest iteration of value capture. Despite the putative benefits of "business managing business" while physicians manage patients, this has not seemed to consistently bear the fruit that was promised by PE. PE has managed to accomplish, however, destabilization of vulnerable communities through hospital/land acquisitions and the facilitation of the medical profession's proletarianization. In the overall trends of PE-affiliated practices and the study of American healthcare, it seems clear to us that we cannot work with private interests; we must struggle to *overcome them*. PE's parasitic functions have no place in medicine, and - for completeness - *neither do the private interests of physicians themselves*. We propose three potential solutions by which healthcare workers may begin to reclaim & rebuild medicine for the social interest.

Physician unionization: Although unions as an entity presuppose the continued capitalist organization of production, there remains a profound necessity for worker organizing. As physicians are increasingly falling into the "Professional-Managerial Class" - salaried mental workers who do not own the means of production - it is becoming increasingly urgent that physicians understand their new relationship to the production of health. Physicians should consider organizing into unions with their co-workers to achieve near-term goals like improved workplace conditions and appropriate staffing ratios that improve patient safety.

National Health Service: An NHS model also faces presuppositions of its own, the most obvious being the State-led organization of production with physicians as government employees. Public sector services, similarly to the private sector, are functional and well-received when funded appropriately; this is evidenced by the VA system and especially Medicare's high patient satisfaction ratings. Governments, while still susceptible to hijacking from private interests at least present the *possibility of accountability to the public*.

Physician Group "Collective Practice" Under Worker Self-Directed Enterprise & Consumer Cooperative Models: The groundwork has already been laid for the proliferation of physicians cooperating in Worker Self-Directed Enterprise (WSDE), an organization of production where physicians simultaneously retain ownership of the means of production, the value of their labor, & the enterprise itself. Physicians have been shifting from solo to group practice over the last few decades. While many of these single-specialty group practices do offer ownership rather than merely employment, one of the problems is that many of these group practices are *not cooperative*, and reproduce the same hierarchical structures (senior vs. junior partners, management vs. workers) and exploitative conditions (vast differences in pay, production speed-ups that compromise safety, reduced autonomy, etc.) seen in capitalist production. Therefore, physicians could reorganize & build group practices into true WSDE one-person-one-vote structures that simultaneously center a *multispeciality, multidisciplinary approach* to patient care and overcome the profit-investment-growth compulsion. Hired administrators & managers with actual patient care experience can work *with* physicians and health workers to improve patient outcomes - rather than the perversion commonly seen today wherein non-medical MBAs are directly and indirectly making medical decisions. Using these methods, we can invert who the production of health actually benefits - health workers, patients, and the larger community of which we are a part.

What limits us - in addition to the free movement of Capital accumulation - are the dominant meta-narratives & value systems that have only offered resignation to capitalism: *this is just the way it is*. What limits us are outdated political and economic institutions that have been captured by the private interests of Capital. Once freed from our status quo, what further horizons might exist? We are not crusading to "banish evil" from healthcare - whether institutions or entities are "evil" is another moral claim, and entirely beside the points made here. What we are interested in is identifying & facilitating the removal of parasitic relations from social reality that will meaningfully improve the lives of people living within that reality. We seek to create an ethics, the conditions of possibility for people's self-determination, not dependency. We only accept authority that can actually justify its own existence. We wish to imagine an organization of medicine that serves not private practitioners, not hospitals, not insurers, not drug and device industries, not private equity - let us create a system that serves *people.*

References

Full list of publications : https://www.ncbi.nlm.nih.gov/sites/myncbi/heather.kim.1/collections/62572293/public/

Selected 59 references for this poster attached as notes