



Is private equity in health care killing us?

"It's not just patients who didn't really need care that had to wait longer. It was actually patients who needed care and actually died. I mean, ... the hardest outcome you could have is death." Dr. Renee Hsia.

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Welcome to Code WACK!, where we shine a light on America's callous healthcare system, how it hurts us, and what we can do about it. I'm your host, Brenda Gazzar.

(music)

This time on **Code WACK!** What happens to staff and patients when private investors buy hospitals to make them more profitable? And why should this concern us all?

To break it down, we spoke to **Dr. Renee Hsia** (pronounced "Shaw") an attending physician at **San Francisco General Hospital and Trauma Center** and a Professor of Emergency Medicine and Health Policy at **the University of California, San Francisco**. She's also Vice Chair of Health Services Research in the Department of

Emergency Medicine, and a core faculty member of the Philip R. Lee Institute for Health Policy Studies. This is the first episode in a two-part series.

Welcome to Code WACK! Dr. Hsia.

Hsia: Thank you so much for having me, Brenda. I appreciate it.

Q: So tell us a bit about yourself. Who are you and how did you get involved in emergency medicine?

Hsia: So I'm an emergency medicine physician. I work at San Francisco General Hospital. I've been there for about 20 years. I became interested in emergency medicine because of my interest at looking at the healthcare system from a larger perspective. As someone who treats patients in the ED – in the emergency department – we are able to see patients from any walk of life regardless of their ability to pay or make an appointment or use the phone or go to the front desk. And so I really wanted to be in a setting where I could see patients with the fewest barriers of care. So that's how I got into the specialty and I've always been interested in the larger healthcare issues. So I also do research on population health and issues of access to timely care as well as practicing in the emergency department.

Q: Beautiful. So today we're going to talk about private equity in health care, which is when investment groups buy healthcare businesses like hospitals and clinics to try to make them more profitable and then sell them down the road. It's like house flipping, but instead of flipping homes, investors are doing it with clinics, nursing homes, and hospitals.

A new [Annals of Internal Medicine study](#) of private equity hospital buyouts revealed concerning trends in staffing, transfer rates, and death rates. Briefly, what did the study find and as an emergency medicine physician, which result worries you most?

Hsia: So this study was looking at what happens to certain outcomes after a private equity acquisition of hospitals. It found that after private equity acquisition, hospitals reduced their emergency department salary expenditures by about 18% and ICU salary expenditures by about 16%. They also looked at the

number of full-time employees and found that after [private equity] acquisition there were 12% fewer full-time employees and they also looked at salary expenditures relative to controls and found that there was a decrease of 17% after private equity acquisition.

When they actually looked at patient outcomes, they found that in the emergency departments for patients that were treat-and-release patients – those are patients that are discharged from the ED on the same day or in the same visit – there were about seven additional deaths per 10,000 visits after the acquisition, which is a 13% relative increase from the baseline, given that death is not that much of a likely outcome at usual. And so those were the main findings.

Q: Yeah. And which of those worries you the most? Or are they all equally concerning?

Hsia: I mean, I think it's actually nice to see this kind of both process and outcome measures because we're not just looking at one without the other. And I think the fact that the study was able to see all of these steps, it kind of allows you to see a mechanism or a pathway by which these outcomes are occurring. So for example, if there were just reduced salary expenditures, you might say, 'oh, they're just shaving off unnecessary, you know, employees' or there's kind of fluff that they're taking out. But when you match that, you know, not just reduced expenditures, but they actually have fewer employees. So it's not that they're just, you know, taking some benefits away or what have you, but they're actually having fewer employees and you tie that with the fact that they're having an actual increase in death. I think that's a really sobering outcome because we're not just looking at the fact that people are waiting longer in the emergency department.

You could imagine for example, if someone said, 'oh, well we're decreasing staffing because we don't need so many staff to treat all these sore throats or prescription refills in the emergency department that are coming. You know, we don't need to see them within, you know, an hour. They can wait, you know, a few more hours because they're not urgent.' And you know, that could be a plausible hypothesis. That might be something that could happen. But when they actually studied it, it's not just patients who didn't really need care that had to wait longer. It was actually patients who needed care and actually died. I mean, that's the

quote hardest outcome you could have is death. It's not just, you know, other measures that we typically use in research are things like time to antibiotics or time to first pain medication or time to [the] provider. But this is the most serious outcome you could have, which is death. And that's what we see. So that is very sobering and very concerning.

Q: <Affirmative> Hmmm-mmmm. Right. And the study noted about seven additional deaths per 10,000 treat and release ER visits. What are some examples of treat-and-release visits and which patients are most at risk?

Hsia: So treat-and-release visits are patients that come to the ED and they're not admitted to the hospital. You see them in the emergency department and then you're able to discharge them on that visit. So that might be, for example, patients come to the emergency department with chest pain. And our goal as emergency physicians is to rule out life or limb threatening diagnoses. So we want to make sure that you're not having a heart attack. We want to make sure that this aorta, which is the biggest vessel in your body, isn't bursting or rupturing. You know, we want to make sure that you're not having a big stroke. So for example, say you came in with chest pain and we were able to detect, you know, your EKG was okay that your blood tests show that you're not having a heart attack. You know, maybe it was just some acid reflux, which can be very painful.

You know, your body doesn't tell you what the diagnosis is, you just feel the pain. So that can be very painful. But say in the end we find that you don't have a heart attack or a stroke or aortic dissection, we're able to send you home. And that's called a treat-and-release visit. Obviously they still require careful evaluation and some of these treat and release visits. Just because they're treat and release doesn't mean that they didn't require evaluation. That's really important actually. There are some insurance companies, for example, that say this happened actually and still does happen, where they say, 'oh, if you were not admitted, then we're not gonna pay for that emergency department visit because it wasn't necessary.' But you only know that it wasn't necessary after you got the evaluation. You know, people don't come to the ED with a sticker on their forehead with a diagnosis.

You know, even I as a physician, I don't know if it's a life-threatening diagnosis until we keep you and do the necessary tests. So treat-and-release visits are, you know, that's an example of them. Other ones might be, you know, say you have pneumonia, but your oxygen level is still stable and you don't need to be hospitalized to get oxygen and we can send you out with outpatient oral antibiotics. You know, that's an example of that. Typical ones are injuries. Like you come in, you had a car accident, you have an ankle pain, we rule out that it's a fracture and it's just a sprain. So these are all types of treat-and-release visits and I think it's also very surprising actually, in fact, to find that they actually had increase of deaths for these treat-and-release visits because they tend to be patients that we aren't concerned about life or limb threatening diagnoses. These are patients that we did not admit to the hospital intentionally because we thought that they were okay. But the fact that there is an increase in death for this particular population does raise eyebrows.

Q: Yeah. What do you think that may indicate?

Hsia: Well, I think that the fact that we're discharging patients that we think might be okay could suggest a couple of things. So one might be that maybe you have to see more patients because there's fewer providers on shift or fewer ancillary staff to, you know, help you get what you need.

You know, I've worked in environments where I have to set up my own laceration tray, I have to irrigate, I have to get all the materials from, you know, the cleaning room because we don't have enough staff to do that. And that takes time, which means I don't have as much time to see the next patient and so things can be rushed. It is a reality that there are finite resources. That can be time, that can be people, that can be materials. And so all of those things are very real.

Q: So the researchers found ER and ICU salary spending dropped, as you mentioned, by roughly 16 to 18%. Hospitals cut salary spending. What usually changes at the bedside? Fewer staff, less experienced staff, or different staffing mixes. And why is this concerning?

Hsia: Sure. All of those things are possible. So at the bedside, when we think about salary cuts, it can translate into fewer staff per shift. So a lot of times

people are thinking about nurse to patient ratios. In certain states, these are mandated in hospitals, it might be hospital policy. So that may be difficult to necessarily change.

But there's also other people involved in health care. There's techs who do EKGs, there's phlebotomists who are drawing blood, there's unit clerks who are putting orders in and calling our specialists. All of these people are really important and critical. We have housekeeping, which is really important because without housekeeping we can't have clean rooms. You know, we have a patient who comes in with trauma and there's blood all over the floor. We can't see another patient until that room is clean and sterilized. So all of these staff are critical to our mission and a lot of times they're not thought of.

But you know, our porters, our housekeeping staff are essential. Other people that we need. Our experienced staff, you know, especially ones that are, for example, when we think about nurses or techs, everybody needs a level of experience so that they can perform their job well. And if what happens with salary cuts is that you're only able to recruit new graduates or people who haven't had experience before, that's okay. When you have senior people in their roles who can train them, but when they're all new, then that makes it very difficult. And there's more turnover because there's less job satisfaction. There's a lot of difficulty in performing your job if you don't have people helping you. So I think less experienced staffing, what you mentioned is true.

There's also a possibility that what could be happening is that there's a different staffing mix. So you might have more lower level trained assistants than higher level trained. So similar to what we're talking about, but you could actually change the mix permanently in such a way that you don't have the depth of coverage that you need. It could look like changing the staffing mix in terms of numbers at times of day in terms of how many people you have on per shift. You could have thinner coverage at certain times or actually throughout the entire day. So there's different ways that hospitals and management can change things so that their salary expenditures go down.

Q: Mmm=hmmm. <Affirmative>. Right. And in talking about the nurse to patient ratios, obviously if nurses or staff aren't getting paid adequately, it's much harder

to fill those positions. So let's talk for a minute about how we know that nurse to patient ratios are so critical.

I recall that studies during the COVID pandemic found that nursing homes with more nurses per resident — higher staffing levels — had lower death rates, while understaffed facilities experienced worse outcomes.

Why is this so critical to have an adequate number of staffing when dealing with any medical facility?

Hsia: As I mentioned before, there are finite resources and these can be pieces of equipment or they can be people. Essentially, it boils down to time and attention. So obviously the more people that you have putting eyes on a patient, then the more care they're able to provide. I will say that I think that literature on, you know, patient nursing staffing is a little bit mixed. I think that up to a certain point I mean that, that is a little bit of a different question, but there's also kind of consequences of always staffing at the highest level of where you would have your busiest patients and always keeping staffing decisions at that highest level when that's actually not when you can actually predict patient levels. And you know, people often say, 'oh, the ED is always unpredictable. You don't know which patients are coming.'

It's true, you don't know exactly which patients are coming, but it is actually quite predictable. <Laugh>, you know, not even just with AI, but even decades ago, you can actually measure when people come, the times of day, the weather, it's very predictable in the sense that you can predict staffing. So I don't necessarily think that the solution is to staff at max capacity 24 hours a day because to be honest, that's not feasible. It's inefficient and it's costly and it's not realistic. So that's not the goal. We want to be efficient in the emergency department. We also do not want to overstaff. We don't want staff sitting there twiddling their thumbs. So we want to staff in a way where we match the demand so that we're able to use limited resources, which includes the hospital budget efficiently.

Q: Mm-Hmm<Affirmative>. Great. So the study found a clear rise in ER deaths, but not in ICU deaths. Why might emergency departments be especially sensitive to staffing reductions?

Hsia: I think that's because when you actually work in a hospital, you'll understand more that the emergency department is truly the front door. And like I said, there's unpredictability in the sense that I don't know if a cardiac arrest is coming this minute or 15 minutes from now or the next hour, but I know that, you know, there's a certain pattern coming. These arrivals, even though you're able to quote, predict them in the sense that you're able to predict the number and flow, you're not able to prevent them from coming. But whereas the ICU, you can say we do not have enough beds. In the emergency department, you do also have a fixed number of beds. But we also expand to hallways. We often treat in waiting rooms. I mean, we have very unideal conditions where we're trying to take care of these patients.

And until they get through us, because we are a limited resource, they can't actually go to the ICU. So that's the sense that we're truly the front line. They actually have to hit the bottleneck, which might be us if the ED is so busy and crowded and then they can't, they can't go up to the ICU until they've actually been seen. So I think that's why we didn't necessarily see ICU deaths is because they don't get patients until they've been quote processed in a certain way.

<Laugh>

Q: Got it. After private equity acquisition, more patients were transferred out to other hospitals from both the emergency room and the ICU. What does a rise in transfers usually signal inside a hospital?

Hsia: Well we transfer patients outside of the hospital for several reasons. First, it might be because we're not able to provide that level of care. So in California we have different levels of emergency departments and also different types of hospitals can provide different types of coverage. So you may have a hospital that can do certain types of vascular surgery, which another hospital can't. So you have to transfer that patient out. So the first reason why we transfer out is because we aren't able to provide a higher level of care. So there are specialized services that another hospital can provide.

Now, in this case, if a private equity acquired hospital needs to transfer out more than they were before, the question is, is there a certain decrease in the type of

specialist services that were available at that hospital now compared to what there was before?

And so that might not just be, you know, something complicated like surgery. It might be something like say somebody has swallowed a button battery, that's something that actually requires gastrointestinal consultation to retrieve because those batteries can become very dangerous and become acidic in the stomach. That's one of the very few things we actually retrieve. Most other things come out the other end, but for example, say your hospital no longer decides to pay your gastroenterology group to be on call or there's fewer of them so that they actually can't stretch themselves so that they're on call. So if somebody comes in at 7:00 PM at night, you know, can they wait until 7:00 AM the next day? Maybe they can, but then you can imagine many types of emergencies where they can't wait for example, for the next day's coverage or maybe that hospital doesn't have that coverage at all. And so those are cases where those patients may need to be transferred. So I think that's the first reason.

The other reason why we transfer not just because of specialist services, but because of capacity strain in general. So it might not be that you don't have the specialist, but you just may not physically have the beds. So that may not just be physical beds. You may have physical beds that you can see that are empty, but maybe they're not staffed. And that's something that's actually difficult to get from hospital records sometimes, because most hospital records and state logs will tell you the number of licensed beds that a hospital's able to provide, but they don't tell you what the staffing is. So you might have an entire hospital wing that is full of empty beds because they're not staffed and that's where the patient ratios come in because if there's, you know, a strict patient ratio and you don't have enough nurses to fill it, then you can't open the bed.

And so anyway, again, that might be a little bit of a different conversation, but these all have interactions with each other, so capacity strain in terms of not having enough staffed beds is another reason. And then service gaps we talked about in terms of specialists.

And then there's another reason why we transfer patients out is you might feel like you're just not able to safely manage them with the coverage that you have.

And so that's not necessarily specialists, but you may be stretched so thin that you are the only hospitalist covering the ICU at night and you have one patient that's taking up the entire night that really could happen. And so you actually feel like it's unsafe to keep another very sick patient and so you have to transfer them out because it becomes very dangerous.

Thank you Dr. Renee Hsia. Stay tuned for next time when we dive into other ways patients and staff may be harmed when private investors acquire hospitals.

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