The Hidden Cost of Private Equity Hospital Buyouts

“Right now we have a model that prioritizes short-term investor profit over patient care. And those incentives, because they're fundamentally not aligned, mean that they're gonna be in conflict with each other.”-- ***Dr. Renee Hsia***

911. What's your emergency?

America's healthcare system is broken, and people are dying.

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!** We’re taking a closer look at what happens when private equity buys hospitals. Our guest is **Dr. Renee Hsia** (pronounced “Shaw”). An emergency physician at **Zuckerberg San Francisco General Hospital,** she explains how patients can be harmed when Wall Street firms take over health care.

Dr. Hsia’s also a Professor of Emergency Medicine and Health Policy at the **University of California, San Francisco,** 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 part two of our two-part series.

Welcome back to Code WACK! Dr. Hsia!

Q: Last time, we spoke about a recent study in the Annals of Internal Medicine about private equity hospital buyouts, which revealed troubling trends in staffing, transfer rates, and death rates. If a local hospital is bought by private equity, what changes might patients notice first?"

Hsia: Yeah, it's hard to generalize because each situation may be different, but common ones that might be possible are that you might have longer waits to be roomed, to get medications, to get imaging or get your discharge paperwork. There's many steps of your ED visit not just being seen, but every single part of the process. So, you know, labs could take longer because maybe the nurse gets them off at the same time, but there's fewer lab techs or there's fewer machines. You know, those are all changes that are happening behind the scene, but are real parts that we need and so that could be happening. You could see that there might be more hallway care. It's not what we want. You know, we want to see patients in a bed, but when we have to treat patients and they're sick, we do it when, where we need.

So we may have to treat them in a hallway. And that's not ideal. You know, we don't wanna be suturing somebody's elbow in a hallway when people might be running across to go to a code. But if that's all the place that you have, they either wait for another six hours, at which time it would be not prudent to close their wound because they would be at a higher risk of an infection, or you do it in the hallway. And so those are all things that maybe because people don't go to the ED on a daily basis, they might not necessarily notice that that's a change, but that's something that we feel as providers. And then I mentioned that there's fewer staffed beds. So there are situations in hospitals all across the country where there are units that are physically closed. They close the whole unit because there's not enough staffing to open that unit.And so that's something that you may see and may feel.

And then also the issue about transfers, you know, we don't, again, don't want to transfer our patients, but in a situation where there's fewer staffing and fewer specialized services and consult services, that might mean that you have to go somewhere else.

Q: Have you ever worked at a hospital that was acquired by private equity?

Hsia: I have not. I've worked at our county hospital for almost my entire career.

Q: Would you have concerns about working at a hospital owned by private equity?

Hsia: It's hard to say because I don't have that much experience actually working in... I've received care in different hospitals or my family. But it's hard to compare if you're, you know, traveling and you don't know what it was before and after.

I do think in general, as a researcher and as a physician, I am aware, and I study this – I'm a physician, but I also do research in healthcare policy – because we have a very market oriented approach to health care in the United States. And because the emphasis, especially with private equity and venture capital, is to kind of turn over and, and to, you know, pay out to your investors. That incentive, unfortunately, is not aligned with actually providing high quality patient care. And you can see this deterioration over time, even as someone who, you know, I've been here 20 years, but that's not a long time to see a change. But I've been able to see that, unfortunately.

Q: When staffing is reduced, what do frontline clinicians like yourself feel first?

Hsia: There's fewer staff, less experienced staff. There's, you know, you're doing more on your own. Because of the staffing, there's fewer beds, you have more boarding and you have more crowding. And then in that sense, the emergency department becomes kind of a holding unit. And so we use this term called "boarding." And boarding means we've already decided that the patient obviously needs to be admitted to the hospital, but there's no room upstairs because there's no physical beds. So the [Emergency Department] becomes a holding unit where you are actually just holding patients that need to be in beds upstairs, but there's no beds upstairs. And so you actually don't have active beds to see patients that are coming in. And that's a terrible feeling and it's a bottleneck. But that's something

that is happening around the country and is not just happening in certain places, but it's everywhere.

Q; When the ER is full and patients keep arriving, what can staff tell them about their options?

Hsia: So yeah, hospital staff have to actually be very careful about this because there's a piece of legislation called EMTALA, which is the Emergency Medical Treatment and Labor Act that was passed in 1986. And the purpose of that act was to prevent dumping of patients. And when I say dumping of patients, that's what would happen is when you had a patient who might be uninsured and present to your emergency department and that ED might say, 'oh, you know we're not gonna see you so you can go down the street to the other hospital' because they didn't wanna see a patient that was uninsured. So what EMTALA requires is that you see all patients and medically stabilize them regardless of their ability to pay.

There's different ways that this has been interpreted, that if you provide people information about alternate sources of care, that could be seen as an EMTALA violation because you might be encouraging them to be seen elsewhere. And so hospitals have to walk a very fine line about giving people enough information, but you also do wanna tell people and set their expectations because one of the hardest jobs is working in triage and dealing with angry patients who don't understand. And if the expectations haven't been set that there is gonna be a 10 or 11 hour wait, and their thought was it was gonna be 30 minutes, then you are gonna have some very upset and maybe violent people in the waiting room, which we have unfortunately all experienced. And so it's difficult.

Q: Can hospitals tell patients how long the wait might be?

Hsia: It depends on each hospital. Each hospital's risk management has a different approach to it. So some people don't say at all because they don't wanna be in any risk. And some hospitals post a sign saying this is what their wait time is.

Q: Got it. Why do private equity acquisitions often involve hospitals serving low-income or Black communities?

Hsia: So just as a disclaimer, I'm not a researcher in private equity acquisition of hospitals, so I'll just speak on what my limited knowledge is, but there are a lot of hospitals that are at risk of closing down because of poor finances. And poor finances are usually, or in large part, due to decreased revenue because the insurance profile of the patients is such that they are reimbursing a lower amount. So specifically commercial insurance, Blue Cross, Blue Shield, Anthem, United generally pay more on the dollar than state funded programs or federal funded partnerships like Medicaid, for example. Or if you're uninsured, then you know you may not be able to reimburse or pay for your visit. So many community hospitals that are serving traditionally marginalized patients or high proportions of black patients or dual eligible [Medicare/Medical] which tend to be low income patients, are at more risk of closing. And so those hospitals are cheaper to acquire. They are sometimes in such a financially distressed situation that PE firms can acquire them at a low cost. And so there's more room for financial restructuring and those kind of desperate cases. And so that's why many targets of private equity tend to be community hospitals serving these types of patients.

Q: Got it. How can staffing cuts in ERs and ICUs worsen those disparities?

Hsia: Well, we know that if these areas are already underserved and that they don't have services that are adequate at the baseline, and then they become even more resource constrained, that that is only going to exacerbate and widen gaps in care that we had seen before.

Q: If policymakers want to protect patients without banning private equity, what should hospitals be required to do after an acquisition?

Hsia: Well, I think this is where it's hard to think of the quote solutions. Obviously we have a system that depends on the market to provide care. The majority of our hospital and health care in the United States is privately financed and delivered. I mean, that's just the way our system is structured. So unless we really try to do something about that, then we are dependent on this system. So we can't ban private equity, but there are ways that we may require hospitals to report and maintain certain measures so that it becomes more obvious what is happening instead of a black box of an acquisition – and then nobody knows. So examples might be maybe you need to report the ED and ICU staffing hours per day of, you

know, not just physicians, but also all of the staff, not just nursing, but also ancillary staff. Maybe we need to require reporting of turnover rates.

Maybe we need to require vacancy rate reporting. Although all of these numbers can be gamed in the sense that you can just change the denominator. You could just say, 'oh, well we have a low vacancy rate because we decrease the number of positions we're hosting.'

I think it's important. We talked about how there're many hospitals that have licensed beds, but they're not staffed, they're empty beds. And so staffed bed counts are actually, I think, would be very valuable to know because you would actually see how many, not just potential treatment spaces are open, but actual treatment spaces are available. And then, you know, I think that ED boarding metrics are important. I think it's important to know what is the, you know, we have traditionally CMS did a few years ago require hospitals to report left without being seen rates and boarding hours. And then that is no longer a required metric.But that would be important.

I think, transfer metrics and then not just transfer out rates, but also the reasons – time to acceptance, the outcomes after transfer. Of course, we don't wanna make it so burdensome for all hospitals to report these things because it's difficult, but now with our Electronic Medical Record, a lot of these pieces of data are already captured. And so I think making it available would be important.

And then the next step of course, is enforcement because say you show all these things, but nothing's happening, you know, it doesn't change anything. But the first step would be reporting it and making it available.

Q: So are there any policy efforts or bills addressing this right now?

Hsia: I'm not the expert in this area. Dr. [Zirui] Song at Harvard has been working in this field a lot. So he would know about the kind of current policy efforts. I think in general, states have struggled with trying to figure out how to provide essential services. So in California, for example, a few years ago we had a closure of a hospital in Santa Clara County, and it was a HCA hospital. It was one of the biggest corporations that had taken over this hospital, and they had cut services and cut

their cardiac care services and then also cut their trauma center services. The county actually took over the hospital when they closed and paid for it. I mean, that's very unique and it requires an infusion of millions, if not in the long term, billions of dollars. But I mean, that's not feasible for most counties, <laugh>. So I think that it's a difficult problem to solve. I don't know if there's a solution because this is the way our healthcare system is currently structured.

Q: …which leads us to our next question. Could payment reform – like a single-payer system – improve survival in emergency and critical care?

Hsia: I think it's actually really important to look at the fundamental restructuring of the way we finance and deliver care in the United States. I think without that, we are stuck with a system where we are only putting band-aids on the problems, but we're not able to fundamentally change the quality issues of quality and cost and access. I think that it takes a lot of effort and bravery to look at that. And our political environment has been such that health care is a sensitive topic and it's very easy for people to feel protective of the current situation because they don't know what could be different. There's a lot available – information that's been said about you know, government run healthcare that can be frightening for people. And I think people see stories of wait times in the UK or in Canada and say, *'oh, we would never want that.'*

I think there are ways that we can restructure our healthcare system that don't move us to those systems in such a way that we would not face those exact problems. You know when I think about ways that we think about our healthcare system, we don't necessarily need the government to run our healthcare system in the sense that, you know, I don't think that every physician in the United States would want to be a government employee. That is how it is run in some countries, but that's not what we're suggesting. You know, having a single payer system or actually a publicly financed system does not require, you know, everyone to be employed by the US government. And there are ways that we can privately deliver care, but publicly finance it that I think would really benefit our system and our patients and our families.

Q: Right. And single-payer Medicare for All would be a privately delivered, publicly financed type system.

Hsia: Yes, it would be. I think that, you know, the most important thing is that, you know, right now we have a model that prioritizes short term investor profit over patient care. And those incentives, because they're fundamentally not aligned, mean that they're gonna be in conflict with each other.

Q: So does this study suggest that profit incentives may be harming patient outcomes?

Hsia: Yes. I think that there is emerging literature, as I mentioned before, showing that it's not just this one study, but that in general when we have a system where you're prioritizing, you know, these kind of quick turnarounds and quick profits, because that's the way our system is structured, that unfortunately is to the detriment of patients.

Q: What's the key takeaway you want listeners to understand about this issue?

Hsia: I think this study and other studies that we have seen really point to the fact that having a market-based approach to health care in the United States isn't serving us when we have a high proportion of our dollars that's going to administrative and accounting costs because of very complicated, you know, insurance industry in general and now on top of this we have, you know, we've overlaid different investors who are trying to figure out how to leverage these hospitals and their assets in such a way that they can have a quick turnaround. That's not providing patient care, that's not helping patients at all. It is making healthcare more complicated. It's making health healthcare more wasteful. It is making healthcare more stressful for not just patients, but for providers. We're trying to actually provide care in a constantly changing environment where we're being pressured to see more patients and charge more because they want us to bill more. And that's not what we went into medicine for. And so I think that this environment, which we've seen a lot of providers leave health care is also unfortunately a testament to the kind of moral injury and the burnout that's happening because of the environment in which we're working.

Thank you Dr. Renee Hsia.

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