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Commentary

Corporate Takeover Has Not Been Good for Healthcare

By Ken Terry
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Four decades ago, Paul Starr noted in his landmark history of U.S. healthcare, "The Social Transformation of American Medicine," that the industry had taken a decisive turn toward corporate ownership. "Medical care in America now appears to be in the early stages of a major transformation in its institutional structure," he wrote. "Corporations have begun to integrate a hitherto decentralized hospital system, enter a variety of other health care businesses, and consolidate ownership and control in what may eventually become an industry dominated by huge healthcare conglomerates."

Forty years later, Starr's prediction has come true. The vast majority of hospitals (other than critical access facilities) are now part of health systems, and some of those belong to giant for-profit or not-for-profit corporations. Nearly 80% of physicians are now employed by hospitals or private companies, including health insurers like United Healthcare. Most community pharmacies have been displaced by enormous chains like CVS, Walgreens and Walmart. Nursing home chains have taken over two-thirds of skilled nursing facilities. A handful of huge firms dominate health insurance, and a dozen drug manufacturers produce and set the prices of the most common prescription medicines.

Private equity (PE) investors focus like a laser beam on generating profits. There can be an amoral quality to PE investing, seeking returns whether or not they create value for customers in the marketplace.

Steward Healthcare, a large hospital chain initially created with PE investment has become, whether fair or not, a poster child for what can go wrong with private investment in healthcare. Steward went bankrupt after aggressively expanding into new markets beyond Massachusetts with funding generated from sales-leaseback arrangements with Real Estate Investment Trusts (REITs).

But many of the PE firms that now own over 200 acute care hospitals take a similar approach. According to a recent study of PE-owned hospitals, two years after they were purchased, 61% of them had reduced capital assets, compared to 15.5% of control hospitals. Assets decreased by a mean of 15% for acquired hospitals and increased by 9.2% for controls during that period.

CORPORATE GOALS VS. VALUE-BASED CARE

The consolidation of the industry by large corporate entities has received a fair amount of media attention. What has been less noticed is the incompatibility between corporate goals and value-based care. One reason for this is that many big healthcare systems pretend to be interested in population health management. For example, they may operate accountable care organizations (ACOs) that seek to improve the quality of care and reduce costs through better prevention and care coordination. They may also try to reduce readmissions, which helps them avoid Medicare penalties.

Don't be fooled. There are exceptions — including the few integrated systems like Kaiser and Geisinger that take financial responsibility for care — but most healthcare systems have no intention of turning their business model upside down by using population health management to decrease admissions and empty their beds. When for-profit chains deliver reports to stock analysts, or not-for-profits seek to sell bonds, the metric they most often use to show their financial health is their occupancy rate, not their success in value-based care.

Meanwhile, the healthcare behemoths are continuing to grow larger. While the Department of Justice has ramped up its antitrust activity under the Biden Administration and has discouraged some mergers, this has had relatively little impact on healthcare consolidation. Academic medical centers are acquiring more community hospitals as referral sources, and some large systems like Risant Health, a nonprofit entity created by Kaiser Permanente, are doing interstate deals that help them escape the oversight of state laws.

Physicians have been largely a football in the matches between giant healthcare systems and equally massive insurers. Many independent practices have been forced to sell out to hospitals because Medicare pays hospital outpatient departments more than independent practices for the same services. (That this remains the case nearly 10 years after Congress passed its first "site-neutral" payment law is a testament to the power of regulatory capture.) While there are some sizable independent groups and physician-led ACOs, it is difficult for doctors to determine their own destinies today. And, because of how their corporate overlords affect the practice of medicine, many employed physicians are unhappy with their working conditions and its impact on patients. We're even starting to see the beginnings of unionization in some systems.

SAVING PRIMARY CARE

A variety of reforms have been tried to shore up primary care, the cornerstone of value-based care. For example, some primary-care-driven ACOs with value-based contracts generate significant savings that they have shared with their doctors. But the percentage of all payments made in these kinds of arrangements is still fairly small. The risk-taking portion of the healthcare business will not grow substantially as long as hospitals and specialists continue to make good money doing the same old fee-for-service thing.

Insurers have also taken the lead in some efforts to fortify primary care. United, which employs about 10% of the nation's physicians, has been training them to practice evidence-based medicine and reduce waste. Elevance Health recently struck a deal with PE firm Clayton, Dubilier & Rice to create a new primary care model in Elevance's Millenium Physician Group and Carelon Health. This "whole-person health" model will emphasize the patient-doctor relationship, along with care coordination, referral management and health coaching within "value-based care" financial arrangements.

This is all to the good. But health insurers don't make their profits by encouraging primary care doctors to take better care

of patients. They use provider networks, prior authorization, high deductibles and other tools to limit access and the cost of services. In Medicare Advantage, carriers like United and Humana have used diagnostic coding to inflate their Medicare payments by an estimated $88 billion just this year. Efforts to infuse value-based care into healthcare delivery have not been a major priority for insurance companies.

DRUG COMPANY PROFITS

Whole books have been written about how the pharmaceutical industry has ripped off the American consumer. Following notorious, out-of-whack price increases over the years for drugs like insulin, Humira and Truvada, in 2022 net prices jumped 6.2% for Darzalex, 6% for Prolia, 7.2% for Xgeva, 6% for Perjeta, and 8.9% for Adcetris, among others. These price hikes, which were unsupported by new clinical evidence of the drugs' effectiveness, netted from $63 million to $248 million in additional revenue for their manufacturers. Drug companies can get away with it because nothing in U.S. law prevents them from raising prices for patented medications by however much they want to. How they price their drugs can also have a strong impact on health costs as a whole, especially when a lot of people take a particular medication. Current examples include Wegovy, Ozempic and the other high-priced GLP-1 weight-loss drugs, which eventually could cost the health system as much as $1 trillion a year — five times as much as could be saved in lower costs for other conditions — if prescribed to all obese Americans.

The kicker is that we spend nearly three times as much per person on prescription medicines as other leading countries do, because their governments bargain with pharmaceutical companies and ours doesn't. Yet the drug makers complain that any limitations on their U.S. profits will make it impossible for them to develop more lifesaving medicines.

Overall, it's clear that the corporatization of our healthcare system is not good for our health. In Portugal, for example, health spending per capita is one-fifth that of the U.S., yet life expectancy there is six years longer, on average, than in our country. The difference is largely rooted in the fact that Portugal has a national health service that guarantees access to healthcare, regardless of ability to pay. In other words, health takes precedence over profits in Portugal.

If we really want good healthcare at an affordable cost — the definition of value-based care — we have to move away from our profit-driven, corporatized healthcare model. As long as corporations are allowed to profit from healthcare, they will maximize those profits, regardless of the impact on consumers. It doesn't matter how much we talk about value-based care or reforms that merely nip at corporate profits. Until Americans demand the same kind of healthcare that every Portuguese has, and insist that our government rein in the corporate owners of healthcare entities, we will get poorer healthcare and die sooner than citizens of other advanced countries.

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