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In defense of private equity in health care, mostly

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Private equity's growing role in health care has drawn fierce criticism, yet the evidence of harm remains mixed and far from conclusive.

Private equity (PE) firms have [greatly expanded](#) their footprint in U.S. health care over the past 20 years. Once a minimal presence, they now own hundreds of hospitals, thousands of medical practices and a growing number of nursing homes nationwide. Their orientation toward profit has drawn fire from critics. From opinion pieces describing PE firms as “[vampires](#)” to scholarly articles labeling PE a “[scourge](#),”



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and from law review articles casting PE firms as “[barbarians](#)” to legislative proposals [seeking to regulate or ban](#) various types of PE activity, a popular narrative has taken root: that private equity is ruining health care.

This frenzy is at least premature, and possibly very misguided.

Judging private equity empirically

The empirical case against PE in health care is far from settled. One shortcoming in the way PE is commonly presented is the reliance on a handful of high-profile failures, such as the ordeal with Cerberus-backed Steward Health Care in Massachusetts or the closure of Paladin-backed Hahnemann University Hospital in Philadelphia. These failures are significant moments, to be sure. But these two examples represent a small sample of the many deals out there. Steward and Hahnemann were unusually large deals with complex ownership arrangements, and although some details about outcomes and key decisions have been reported, we do not have a full, transparent account of all internal deliberations and financial strategies in either case. These cases are interesting and possibly useful as cautionary tales, but they don’t tell us everything that would be good to know about PE.



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Another shortcoming in the coverage of PE is the prevalence of commentaries and perspective pieces. Opinion pieces outnumber original studies by a wide margin. In these opinion pieces, the same few studies are cited repeatedly, creating the impression that the evidence base is bigger than it really is.

A fairer assessment is that the evidence on PE in health care is mixed, occasionally contradictory and still emerging. Some studies have found negative or undesirable results associated

with PE ownership, such as lower nurse staffing hours per patient, higher clinician turnover and increased mortality in nursing homes. Other studies have found positive or beneficial results, such as a small decrease in acute myocardial infarction rates, better appointment availability and better quality indicator scores in nursing homes. Many studies have significant limitations, including small sample sizes, short observation windows and high risk of bias when assessed by academic tools such as the [ROBINS-I framework](#), created by the Cochrane library.

Judging private equity philosophically

If it's too early to pronounce a verdict on whether PE is "good" for health care in terms of outcomes and quality, does that mean we also cannot form a qualitative judgment about the practices and tactics that PE firms use in health care?

No. It is possible. However, it is once again critically important to proceed with eyes wide open. The conclusion that one reaches about PE practices and tactics depends on the philosophic lens through which one chooses to look.

Many commentators approach this issue holding the premise that profit-seeking is incompatible with the mission of health care, and/or that health care should not be treated like consumer goods and services (the anti-commodification view). This perspective looks upon the financial strategies used by PE firms very negatively. It regards leveraged buyouts, dividend recapitalizations and sale-leaseback arrangements as extractive maneuvers designed to enrich investors at the expense of long-term stability. Under this perspective, cost-cutting, workforce reductions and consolidation are all seen as tactics that hurt quality and access in pursuit of short-term profits.

This is the most common viewpoint, but it is not the only one.

There is a much different approach that might be called a classical liberal or rights-based approach, and it leads to a very different conclusion. Under this viewpoint, the primary moral test of an action is whether it involves the initiation of physical force, coercion or fraud — not whether it serves collective welfare. By this yardstick, almost all the practices and tactics used by PE in health care fall squarely within the bounds of legitimate, rights-respecting business practices.

Criticisms of PE land much differently against this viewpoint. Take, for example, the common charges that PE firms saddle hospitals with debt, cut staff or close unprofitable service lines. These managerial decisions may be unpopular, but in the classical liberal view they are not rights violations. To start with, every leveraged buyout is a [voluntary exchange](#). The sellers — physician owners, hospital boards or other private parties — are under no obligation to accept the terms offered by a PE firm. If they choose to proceed, they do so with the knowledge that the PE firm will make changes aimed at improving financial performance. These are rights of ownership.

After acquiring a physician practice or a hospital, PE firms might institute price increases, reduce staff autonomy, change the mix of services they offer or take a variety of other actions. Such changes tend to attract complaints. But the reason PE firms do these things is to improve the functioning of their health care business, not make it worse. It's true that PE firms view their health care properties as assets to improve and subsequently sell, but the goal of PE firms is to increase the value of those assets, not decrease the value. If they successfully increase the value, they ought to profit; if they

destroy value, they ought to suffer the loss. That is a foundational principle of the classical liberal view.

A potential loophole

From the classical liberal, rights-based perspective, most PE practices are permissible — but there is one practice to which even a PE-friendly classical liberal might object: when a PE firm seeks bankruptcy protection benefits for its acquired organization after it has intentionally extracted otherwise usable capital from that organization.

This critique is different from the ones that many critics make. Many critics object to how PE firms extract money from the health care organizations they acquire through management fees, land sale-leasebacks and dividend recapitalizations. From a procapitalist, classical liberal perspective, these practices are generally unproblematic because any decision to extract value today simply reduces the sale price by a corollary amount when the PE firm makes its exit later on.

But if the interplay of current bankruptcy law and the aforementioned extractive practices (management fees, land sale-leasebacks and dividend recapitalizations) creates a situation where it is possible for PE firms to privatize their gains while socializing their losses, then that is a scenario worth closer examination.

How does this work? Imagine that a PE firm buys a hospital. In one of its first moves, it sells the hospital's real estate to a third party (generating cash, which the PE firm uses to pay itself a dividend) and then directs the hospital to lease back the buildings and property, saddling the hospital with a new monthly rent payment. The hospital continues paying management fees to the PE firm that owns it, but with the new

debt to service, the hospital begins to struggle with other payments, missing payroll, defaulting on vendor contracts, walking away from pension obligations and racking up back taxes to the city. Limited liability allows the PE firm to remain untouched even if the hospital is driven to bankruptcy; the aforementioned extractive practices allow the PE firm to profit even if the hospital goes under.

Profiting when one's acquired business goes bankrupt is not just bad optics for PE firms; it's potentially unjust. If the management fees, land sale-leasebacks and dividend recapitalizations contributed to the bankruptcy, then it is not unreasonable to think of this as a form of fraudulent transfer.

Fraudulent transfer is when one moves assets out of reach of creditors so that the creditors have little or nothing to recover in the event of default. The textbook example is a debtor, knowing he is deeply in debt and likely to file for bankruptcy, "selling" his vacation home to a close relative for \$1 just weeks before filing for bankruptcy, so that the home cannot be seized and the value distributed to creditors.

Improving the policy debate

The evidence purporting to show that private equity is bad for health care is not as vast and robust as the most vocal critics present it to be. The newest study of PE in health care (a [JAMA study](#) on care quality at U.S. psychiatric hospitals) reports that "no evidence of lower quality among PE-owned facilities was found." But even in studies where researchers find some negative effect associated with PE ownership, the policy question to ask is not "What regulation could we pass to force-fix this?" but rather, "Is the basic mechanism of benefiting from one's own successes and bearing one's own costs still intact?"

We do not need to ban or heavily regulate PE in health care. But we do need to be on the lookout for loopholes that enable actors to privatize benefits and socialize their losses. (Such scenarios do not represent genuine capitalism; they typically are a product of firms cleverly gaming some government intervention, as happens in bailouts.)

We should ensure that we have a properly clarified legal boundary between acceptable financial engineering and fraudulent transfer, which, as the name rightly suggests, is a form of fraud and thus a violation of rights. Bankruptcy protection, which is a legitimate institution for a free society to have, is the special situation that creates this gray area. When a health care organization is solvent and operating normally, PE firms should be free to manage it as they see fit. But as an entity approaches insolvency and as financial transfers begin to look like asset-stripping rather than investment, current law seems less than fully clear on how to proceed. At this time, a targeted look into this narrow concern is a more appropriate response than the many sweeping calls to create a regulatory thicket around all of PE involvement in health care.

Jared Rhoads is the founder and director of the [Center for Modern Health](#), an independent policy institute dedicated to liberalizing American health care through research and education. He is also a senior lecturer in health policy at The Dartmouth Institute for Health Policy and Clinical Practice.

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