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THE CORPORATIZATION OF U.S. HEALTH CARE

The Corporatization Deal — Health Care, Investors, and the Profit Priority

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The health care industry is exceptional in the United States: it relies on private businesses operating in markets to fulfill a fundamental human need. Because of health care's essential nature, many observers have viewed the growing influence of large companies in the industry, known as "corporatization," as odious, akin to privatization of fire and police departments. The corporatization of health care often evokes images of rapacious companies that prioritize profits over patients, since corporations operate according to the logic of business, emphasizing efficiency and financial returns, whereas medical institutions have traditionally operated as professional or charitable enterprises.

Although some critics yearn for a return to a purely professional ethos in health care, such a reversal is impractical and potentially irresponsible. Corporatization tends to arise in circumstances in which patients demand cheaper or higher-quality care and large organizations can support those aims by taking advantage of economies of scale (in which the cost of each additional unit — such as a hospitalization or dose of medicine — is lower than the cost of the previous one). Evaluating corporatization requires understanding why it occurs, when it can succeed, and why it can go wrong.

Corporatization represents a deal between organizations and investors. New technologies, upgraded facilities, research and development, and competitive salaries are expensive but are necessary to meet the expectations of patients, who value improvements in health more than improvements in other goods. Investors supply the capital needed to support these enhancements and, in exchange, expect a financial return on their investment. Investors include various entities, such as venture capitalists, private equity firms, banks, corporations, wealthy families, mutual funds, and pension funds. Some investors represent the interests of other entities, such as hospitals and universities (which invest their endowments) or individual people (who invest their personal savings). Although the terms of such investments vary, the goal is clear: the organization

receiving the investment must make a profit. If it doesn't, the investment can be deployed elsewhere. Corporatization unlocks capital in return for growth that prioritizes profits, and investors may take an ownership stake in an organization or adjust management incentives to generate the necessary profits.

But is this deal a good one? Consider the example of a small physician practice. Although guided by professional norms — providing high-quality care, practicing in accordance with medical standards, maintaining a good reputation in the community — it needs money to achieve these goals. A capital infusion could help the practice improve care by hiring more staff, moving into a nicer office, or purchasing new equipment. A moderate amount of capital could come from the physician's own savings or from a bank loan. Such an infusion would be unlikely to compromise professional norms.

But what if the practice needs more money — for instance, to purchase an expensive electronic medical records system? Or what if it cannot coordinate care effectively without becoming part of a larger provider network? The practice's owner may consider selling it to a physician group, a hospital, or an insurer — which could lead to an infusion of more capital, improved processes, and better care coordination. In return, the practice may need to change its operations in ways that challenge professional norms and prioritize profits. New investors may implement management incentives that encourage the organization to reduce charitable services, shorten appointments, "upcode" billing records, and raise prices.

Such agreements are voluntary and therefore presumably benefit the investors and medical organizations involved. But the key question for society and for policymakers is whether corporatization benefits groups that are not party to such deals: patients and payers.

In standard markets — such as those for cars, computers, movies, or travel services — high-quality products are more popular and can be sold at higher prices than low-quality products. Profits and value are aligned because consumers make purchases directly, and access for consumers who can't afford these goods has not been a societal concern. But for several reasons, health care is exceptional among U.S. markets in that profits and value often don't align.

First, patients may not be able to accurately assess the quality of medical care, so firms can make money by cutting corners, with little fear of affecting demand. Second, firms may engage in corporatization simply to build market power, which drives up prices. Third, many medical products and services are fundamentally unprofitable because people who could benefit from them cannot afford them. Society may value lifesaving HIV medicines, neonatal intensive care, transformative gene and cell therapies, or psychiatric services, but patients may have little ability to pay market prices for them. When quality is hard to assess, market power is sizable, and patients are vulnerable, corporatization carries the risk of increasing prices or reducing quality.

Three examples help illustrate these principles. In vitro fertilization (IVF) is a sector in which evidence suggests that corporate ownership has positive effects.[1] IVF is a capital-intensive business for which scale is valuable: setting up a clinic requires substantial investment, but serving additional patients involves smaller marginal costs. Large IVF firms can analyze internal data to enhance the complex processes of ovarian stimulation, egg retrieval, fertilization, genetic testing, and embryo culturing and implantation. Moreover, the key outcome for IVF, pregnancy, is easily measurable, and because patients typically pay out of pocket for these services and are willing to spend large amounts for the chance to have children, clinics compete directly on price and success rates. IVF illustrates the ways in which profits and value for patients can align, yielding lessons that may be applicable to other health care markets, such as elective eye surgery, dentistry, dermatology, and cosmetic surgery.

In contrast, corporatization's effects on nursing home care appear to be largely negative. After being acquired by a private equity firm, nursing homes tend to avoid sicker residents, deliver lower-quality care, and have higher resident mortality.[2] Many nursing homes with private equity backing engage in questionable financial practices, such as "profit tunneling," which involves paying inflated prices to suppliers that are owned by the same firm to shield profits from regulators and reduce potential liability in malpractice litigation.[3] Regulation is weak, and unlike in the IVF industry, people using nursing home care tend to be vulnerable and quality is hard to measure, which creates incentives for profit-driven managers to reduce quality in order to boost profits.

The biopharmaceutical industry is an example of a sector that probably couldn't exist without investors, since enormous amounts of funding are needed to conduct expensive clinical trials with high failure rates. Research suggests that the industry spends more than $275 billion on research and development globally each year, which is outside the reach of any individual person or organization.[4] Quality is informed by clinical trials and assessed by physicians, payers, and the Food and Drug Administration, whose approval is required before medicines can be marketed in the United States. Even if patients cannot always assess a medicine's quality independently, their agents — physicians and insurers — can help them do so. At the same time, investors' profit imperative may distort the direction of innovation (e.g., toward developing medicines for cancer and away from less profitable markets, such as malaria treatment) and tempt manufacturers to make decisions that don't benefit patients (e.g., abusing intellectual property protections to boost profits).

Corporatization isn't the only tool medical firms can use to raise capital. One alternative is government funding, including subsidized loans or tax credits. But relying on public financing has downsides. Governments struggle to identify what patients want, owing to bureaucratic hurdles, a lack of incentives, and budgetary constraints. They are also subject to shifting political climates, making them unreliable funders for large or long-term investments that require steady outlays.

An audio interview with Amitabh Chandra is available at NEJM.org

Another alternative is the nonprofit model, in which funding comes from donations and the financial benefits associated with tax exemptions. In theory, nonprofits can combine corporate scale with a professional and charitable mission (involving teaching, research, and care for low-income patients). Nonprofits play a large role in health care in the United States, and their presence in a market can pressure profit-driven firms to improve quality or reduce prices. But nonprofit financing can't fully substitute for private capital, especially in areas in which innovation is expensive, such as biopharmaceutical development. Moreover, nonprofit organizations' commitment to a professional or charitable mission isn't automatic and may be diluted when they face financial shortfalls or undergo leadership changes.

Given this mixed record, what steps can be taken to unlock the benefits of corporatization while limiting its harms? The guiding objective should be better aligning profits (which drive corporate decision making) with value for patients. One approach involves improving quality measurement and reporting to steer patient demand toward medical organizations that provide high-quality services. This strategy works well when measuring quality is straightforward, as it is for IVF services. But a mixed record for nursing home quality reporting suggests a need for caution. Simple measures often fail to create true alignment between profits and value and can lead to unintended consequences, such as incentives to avoid sicker patients or to upcode to boost profits.

A second approach involves empowering regulators to enforce antitrust rules aimed at limiting market power that wasn't sanctioned — or regulating prices when those efforts fail. But regulators already have these goals and struggle to achieve them because of tight budgets and bureaucratic limits.

Ultimately, the exceptional nature of health care means that any market incentives will be imperfect.[5] Corporatization will always involve trade-offs because there is no simple or universal "fix" to align profits with value for patients. In each area of medicine, regulators will need to decide whether the deal inherent to corporatization is a worthwhile one — and whether the alternatives are any better.

The series editors are Atheendar S. Venkataramani, M.D., Ph.D., Lisa Rosenbaum, M.D., Debra Malina, Ph.D., Genevra Pittman, M.P.H., and Stephen Morrissey, Ph.D.

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