AMA Journal of Ethics®
May 2025, Volume 27, Number 5: E354-360

POLICY FORUM: PEER-REVIEWED ARTICLE

Private Equity Strategies in Nonprofit Health Care

Zachary J. Gallin and Emily L. Xu, MD

Abstract

Private equity firms exacerbate health inequity by driving hospital closures in historically underserved communities. Now nonprofit health systems seem to be adopting private equity practices to do the same. Drawing on a case study of one nonprofit hospital system that has adopted private equity business practices to acquire and close community hospitals, this article argues that nonprofit hospitals' adoption of private equity acquisition and closure practices sacrifices their missions, prioritizes profit, and works to the detriment of local communities. This article construes this set of practices as a breach of organizational ethics that must be addressed via policy changes, specifically by placing guardrails on closures and promoting responsible health care investments.

The American Medical Association designates this journal-based CME activity for a maximum of 1 AMA PRA Category 1 Credit™ *available through the* AMA Ed Hub™. *Physicians should claim only the credit commensurate with the extent of their participation in the activity.*

Overview of the Problem

Private equity firms invest in operating companies that are not listed on public stock exchanges. Investors acquire such a company using borrowed money and restructure the acquired company to increase its value before reselling.[1] Private equity firms have become increasingly involved in the health care sector and now own about 460 hospitals nationwide.[2]

Supporters of private equity in health care argue that private equity ownership of clinics and hospitals can increase health care quality and efficiency by prioritizing investments in rapidly growing sectors.[3] However, a growing body of research shows that private equity in health care has increased costs for patients and worsened health outcomes.[4] Furthermore, private equity ownership of health systems has exacerbated health inequities by decreasing access to care through hospital closures in historically underserved communities.[5] Academic discourse on private equity's negative impacts has not yet fully addressed how the business practices of nonprofit hospital systems—which engineer health system mergers and hospital closures to reap profits—parallel those of private equity.

Health system mergers and the growth of private equity in health care share causes and effects. First, both are driven by rising pressure on health systems to increase profit. Second, both are characterized by a power imbalance in which community hospitals and their patients are left at the mercy of wealthy investors. Finally, both often result in critical primary care shortages in historically underserved communities.

Here, we describe a case example of how a nonprofit health system adopted behaviors of private equity companies by acquiring a community hospital and then forcing its closure. We discuss how underregulated free-market economics drive acquisition and closure of community hospitals by incentivizing resource allocation based on profit over community needs. On the basis of our analysis, we call for increased government regulation that promotes responsible health care investments by mandating that nonprofit hospital systems gather feedback from local communities during hospital acquisitions and closures.

Private Equity Strategies Used by Heath Care Systems

America's first hospitals shared a mission to serve the destitute,[6] but in the 1920s, hospitals were forced to begin generating income due to increasing demand for services and professionalization that raised the cost of care.[7] Between 1980 and 2009, 18% of hospitals closed as expenditures rose and demand fell,[8] while others adapted by shifting services to a wealthier patient population.[9] At the same time, community hospitals merged with larger health systems to survive, resulting in major consolidations. For instance, about 85% of New York State's hospitals were consolidated into larger hospital networks between 2006 and 2019.[10]

Health system consolidation increases health care costs while decreasing care accessibility and quality.[11] As hospitals close, nearby communities suffer from loss of long-time doctors at the hospitals, increased travel distance to care, limitations in accessing emergency services, and fewer health care job opportunities. Furthermore, health care workers may find themselves pushed out of their workplaces and forced to adapt to a volatile health care system.[12] Hospital closures also overburden nearby community hospitals. For example, when a major public hospital temporarily closed after Hurricane Sandy, patients needing emergency care were redistributed to the nearby public hospital at rates unexplained by proximity alone.[13] Increased volume at nearby, already strained hospitals may lead to "spillover effects" that negatively impact the quality of patient care.[14]

Private equity firms have driven community hospital closures by buying health systems, restructuring them to generate short-term profits, and then leaving them with untenable debt.[15] For instance, a private equity company bought a hospital system (Hospital System A) in 2010, then made over $800 million by selling Hospital System A's buildings and land. The private equity company resold Hospital System A to its physicians 10 years later, leaving it bankrupt and forcing the planned closure of 2 of Hospital System A's hospitals.[16] A community coalition has responded to the hospital closures with a series of public rallies.[17] Likewise, community members have called for the state government to impose stricter regulations on the acquisition and closure of local hospitals.[18] The fate of the 2 hospitals is pending.[19]

Some hospital networks have adopted the rhetoric of private equity companies, endorsing the diversion of essential services from the indigent to the wealthy under the guise of "innovation" and "entrepreneurship." For instance, in one city where there are

no private equity-owned hospitals,[2] nonprofit health systems have undergone lucrative mergers in which community hospitals are viewed as assets that can be bought and restructured or closed to increase profits. Nonprofit health systems are fraught with ethical conflict in their mimicry of private equity, as they often present themselves as community benefactors to retain their tax-exempt status despite simultaneously prioritizing profits.[20]

One Case

These dynamics are exemplified in another case that included a nonprofit hospital system (Hospital System B) and a community hospital it acquired. In 2013, Hospital System B acquired several community hospitals through a merger with a smaller hospital system, thus growing its profit margins through increased negotiating power with insurers and access to new patients.[21] In 2023, Hospital System B announced its plan to close one of the community hospitals it had acquired.[22] It paired these closure plans with a diversion of resources toward more profitable medical services, establishing a concierge clinic in 2018 and a new cancer center in 2021.[23,24]

After announcing its plans to close one of its community hospitals, Hospital System B faced protests from the local community. Community activists formed a community coalition, which demonstrated through a health equity impact assessment that the community hospital's closure would have a devastating impact on many residents, limiting their access to care.[25] Additionally, community members challenged Hospital System B's claims that the hospital's planned closure was due to financial strain, arguing that Hospital System B had deliberately closed the community hospital's most profitable services to create a picture of financial struggle.[26] The local community filed multiple lawsuits against Hospital System B, accusing it of scheming to profit off the sale of the community hospital's real estate. The hospital closure was recently approved by the State Department of Health, but the community hospital remains open while the most recent lawsuit wends its way through the court system.[27]

Although Hospital System B's acquisition of a community hospital and ensuing attempts to close the hospital mirrors the private equity firm's behavior toward Hospital System A, there are key differences. The private equity firm resold Hospital System A's assets, leading to its bankruptcy, which in turn drove 2 planned local hospital closures, whereas Hospital System B is directly attempting to close the community hospital. Furthermore, at the time of merger, Hospital System A was a for-profit company in debt, while the community hospital was part of a financially stable nonprofit. For-profit and nonprofit health systems in the United States are regulated and taxed differently and thus have different obligations to serve the public interest.[28]

Despite these differences, there are uncanny parallels between the business practices of the private equity firm and Hospital System B. Both profited from purchasing a health system and then defunding it and closing services. Additionally, both cases involved pushback from local community members, with calls for increased government regulation of health system mergers and hospital closures.

Overall, the parallels between Hospital System B's management of the community hospital and the private equity company's behavior toward Hospital System A demonstrate how nonprofit health systems may emulate private equity as they undergo mergers and hospital closures.

Call to Action

Nonprofit health systems' imitation of private equity firms is unethical, as it prioritizes profits over patients and local communities. Envisioning the health care system of our near future, we call on nonprofit health systems to reject replacing their social mission with the values of private equity. To hold health systems accountable, we propose several policy actions at the institutional and government level.

Institutional implementation of community-based health care model. Policy reform can create a more equitable distribution of health care resources that improves health outcomes.[29] However, policy solutions must be envisioned in partnership between nonprofit health systems and the communities most impacted by the encroachment of private equity culture in health care. Working with communities requires building long-term relationships, breaking down hierarchies, and rejecting profit as the gold standard. To drive this shift from a private equity model to a community-based health care model, nonprofit health systems must be held accountable. A socially accountable health system is led by community members rather than outsiders with a vested interest in profits. Moreover, in this model, hospitals' success is measured not by the upper limits of their "excess revenue" but by the health of their surrounding communities.

Government regulation of hospital closures. While nonprofit health systems strive to implement a community-based health care model, policy makers must address impending hospital closures. For instance, New York State passed a law in 2021 that requires hospitals to submit a health equity impact assessment and certificate of need before closing services.[30] Additionally, New York State enacted Article 45-A in 2023, which requires health systems to notify the public before major mergers or acquisitions, thereby improving transparency.[31] Each of these pieces of legislation limit the power of nonprofit health systems and private equity alike to engage in the unethical business practices that resulted in the rapid planned closure of 2 of Hospital System A's hospitals and the planned closure of a community hospital (vis-a-vis Hospital System B) without substantial community input. Such strong moratoriums on hospital closures are needed to minimize retaliation by health systems and help build community power.

The perverse incentives that led to Hospital System A's planned hospital closures and Hospital System B's planned closure of the community hospital are present across the nation. Therefore, policy makers nationwide must set guardrails on profit-driven financial behavior by nonprofit hospital systems and increase transparency requirements regarding hospital closures in surrounding communities. For example, policy makers should require nonprofit hospital systems to conduct health equity impact assessments and gather community input before closing hospitals or services. Additionally, they should financially incentivize health systems to notify and solicit feedback from local communities during major mergers and acquisitions.

Health care workers can join the discussion of hospital closures by advocating for safety-net hospitals. Specialty-specific advocacy groups can help health care workers amplify their collective voices in conversations with policy makers.[32] As private equity practices pull nonprofit health systems from their social mission, policy change is needed within nonprofit hospital systems and state governments for community benefit. Furthermore, consideration of federal policy reform is warranted, as our case study delineates the consequences of adverse incentives that impact nonprofit hospital systems nationwide.

References

1. Offodile AC 2nd, Cerullo M, Bindal M, Rauh-Hain JA, Ho V. Private equity investments in health care: an overview of hospital and health system leveraged buyouts, 2003-17. *Health Aff (Millwood)*. 2021;40(5):719-726.
2. PESP Private Equity Hospital Tracker. Private Equity Stakeholder Project. Accessed August 3, 2024. https://pestakeholder.org/private-equity-hospital-tracker/
3. Frances C. Private equity investment in health care. *JAMA*. 2019;322(5):468.
4. Borsa A, Bejarano G, Ellen M, Bruch JD. Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: systematic review. *BMJ*. 2023;382:e075244.
5. D'Mello K. Hahnemann's closure as a lesson in private equity healthcare. *J Hosp Med*. 2020;15(5):318-320.
6. Wall BM. History of hospitals. Penn Nursing. Accessed June 24, 2024. https://www.nursing.upenn.edu/nhhc/nurses-institutions-caring/history-of-hospitals/
7. Moseley GB. The US health care non-system, 1908-2008. *Virtual Mentor*. 2008;10(5):324-331.
8. Fuchs VR. Major trends in the US health economy since 1950. *N Engl J Med*. 2012;366(11):973-977.
9. Kisacky J. An architectural history of US community hospitals. *AMA J Ethics*. 2019;21(3):E288-E296.
10. McGivney K. Impact of consolidation on healthcare in New York State. The Bonadio Group. July 15, 2019. Accessed June 24, 2024. https://www.bonadio.com/article/impact-of-consolidation-on-healthcare-in-new-york-state/
11. Levins H. Hospital consolidation continues to boost costs, narrow access, and impact care quality. Penn LDI. January 19, 2023. Accessed June 24, 2024. https://ldi.upenn.edu/our-work/research-updates/hospital-consolidation-continues-to-boost-costs-narrow-access-and-impact-care-quality/
12. Henry C. Hospital closures: the sociospatial restructuring of labor and health care. *Ann Assoc Am Geogr*. 2015;105(5):1094-1110.
13. Lee DC, Smith SW, Carr BG, Goldfrank LR, Polsky D. Redistribution of emergency department patients after disaster-related closures of a public versus private hospital in New York City. *Disaster Med Public Health Prep*. 2015;9(3):256-264.
14. Song LD, Saghafian S. The spillover effects of hospital closures on the efficiency and quality of other hospitals. Harvard University; 2020. Accessed August 8, 2024. https://scholar.harvard.edu/files/saghafian/files/hospital_closure_manuscript_20-01-13_nonblind.pdf
15. Vollers AC. When private equity comes to town, hospitals can see cutbacks, closures. *New Jersey Monitor*. January 18, 2024. Accessed June 24, 2024. https://newjerseymonitor.com/2024/01/18/shell-game-when-private-equity-comes-to-town-hospitals-can-see-cutbacks-closures/
16. Stern A. Who might buy hospitals from Massachusetts to Arizona? Steward Health Care looks for buyers. *The Enterprise*. May 15, 2024. Accessed June 24, 2024. https://www.enterprisenews.com/story/news/healthcare/2024/05/15/steward-health-care-bankruptcy-private-equity-firms-potential-buyers/73639526007/
17. Dwyer D. Coalition organizing rallies, forums in Steward Hospital communities. *Boston.com*. April 23, 2024. Accessed August 8, 2024.

https://www.boston.com/news/local-news/2024/04/23/coalition-organizing-rallies-forums-in-steward-hospital-communities/
18. Sager A. It may be Steward's decision to close hospitals, but it's Healey's too. *Boston Globe*. August 2, 2024. Accessed August 3, 2024. https://www.bostonglobe.com/2024/08/02/opinion/steward-hospital-closures-nashoba-carney/
19. Lambert B. Protestors fight to keep 2 Steward hospitals open amid hearing to expedite closures. *Boston 25 News*. July 31, 2024. Accessed August 4, 2024. https://www.boston25news.com/news/local/protestors-fight-keep-2-steward-hospitals-open-amid-hearing-expedite-closures/WNUSLLR2SZGXZBGDQ7R6X5XCEY/
20. Makary M. Hospitals that make profits should pay taxes. *STAT*. April 14, 2024. Accessed June 24, 2024. https://www.statnews.com/2024/04/14/nonprofit-hospitals-turn-profit-charity-care-tax-exempt-status/
21. Hartocollis A. 2 hospital networks agree to merge, raising specter of costlier care. *New York Times*. July 17, 2013. Accessed June 24, 2024. https://www.nytimes.com/2013/07/17/nyregion/2-hospital-networks-agree-to-merge-raising-specter-of-costlier-care.html
22. Kaufman M. Major NYC hospital warns of safety risks from delayed closure. *Politico*. July 18, 2024. Accessed October 1, 2024. https://www.politico.com/news/2024/07/17/mount-sinai-beth-israel-delayed-closure-00169116
23. Mount Sinai and Hudson Yards announce one-of-a-kind health care service portfolio at Hudson Yards. News Release. Mount Sinai Health System; March 12, 2018. Accessed June 24, 2024. https://www.mountsinai.org/about/newsroom/2018/mount-sinai-and-hudson-yards-announce-oneofakind-health-care-service-portfolio-at-hudson-yards
24. $60 million pledged to establish the Mount Sinai Tisch Cancer Center and to construct a state-of-the-art cancer hospital in Manhattan. Mount Sinai Health System. Accessed June 24, 2024. http://physicians.mountsinai.org/news/60-million-pledged-to-establish-the-mount-sinai-tisch-cancer-center-and-to-construct-a-state-of-the-art-cancer-hospital-in-manhattan
25. Community Coalition to Save Beth Israel and NYEEI. Lower Manhattan lifeline: what Beth Israel Medical Center means to local residents. Community Coalition to Save Beth Israel and NYEEI; 2024. Accessed June 24, 2024. https://assets.nationbuilder.com/stpcvta/pages/2479/attachments/original/1706820330/Beth_Israel_HEIA_report.pdf?1706820330
26. Goldstein J. A hospital's slow death: as Beth Israel shrinks, patient care suffers. *New York Times*. May 16, 2024. Accessed June 24, 2024. https://www.nytimes.com/2024/05/16/nyregion/beth-israel-hospital-closing.html
27. Khawaja N. Legal battle over Beth Israel hospital closure continues. *Spectrum News NY1*. August 14, 2024. Accessed October 1, 2024. https://ny1.com/nyc/manhattan/health/2024/08/14/legal-battle-over-beth-israel-hospital-closure-continues
28. Horty JF, Mulholland DM 3rd. Legal differences between investor-owned and nonprofit health care institutions. In: Gray BH, ed; Institute of Medicine. *The New Health Care for Profit: Doctors and Hospitals in a Competitive Environment*. National Academy Press; 1983:17-34.
29. Donabedian A. The quality of care: how can it be assessed? *JAMA*. 1988;260(12):1743-1748.

30. Health equity impact assessment. New York State Department of Health. Revised January 2024. Accessed June 24, 2024. https://www.health.ny.gov/community/health_equity/impact_assessment.htm
31. Required reporting of material transactions. New York State Department of Health. Revised June 2024. Accessed June 24, 2024. https://www.health.ny.gov/facilities/material_transactions/
32. Oestberg F. Getting involved in policy and politics. *Nurs Crit Care*. 2013;8(3):48.

Zachary J. Gallin is a fourth-year medical student at the Icahn School of Medicine at Mount Sinai in New York City, where he is involved with Physicians for a National Health Program, New York City Against Segregated Healthcare, and the student-run free clinic. His research interests include single-payer health care, hospital closures, and racial disparities in health care.

Emily L. Xu, MD is a neurology resident at Mass General Brigham in Boston, Massachusetts. She graduated from the Icahn School of Medicine at Mount Sinai, and, while there, she was a student activist with New York City Against Segregated Healthcare and the Mount Sinai Segregated Care Student Workgroup. Her organizing and research interests include single-payer health care, paid caregiving, and hospital closures.

Citation
AMA J Ethics. 2025;27(5):E354-360.

DOI
10.1001/amajethics.2025.354.

Conflict of Interest Disclosure
Authors disclosed no conflicts of interest.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

ISSN 2376-6980