When public hospitals go private, low-income patients lose, says study

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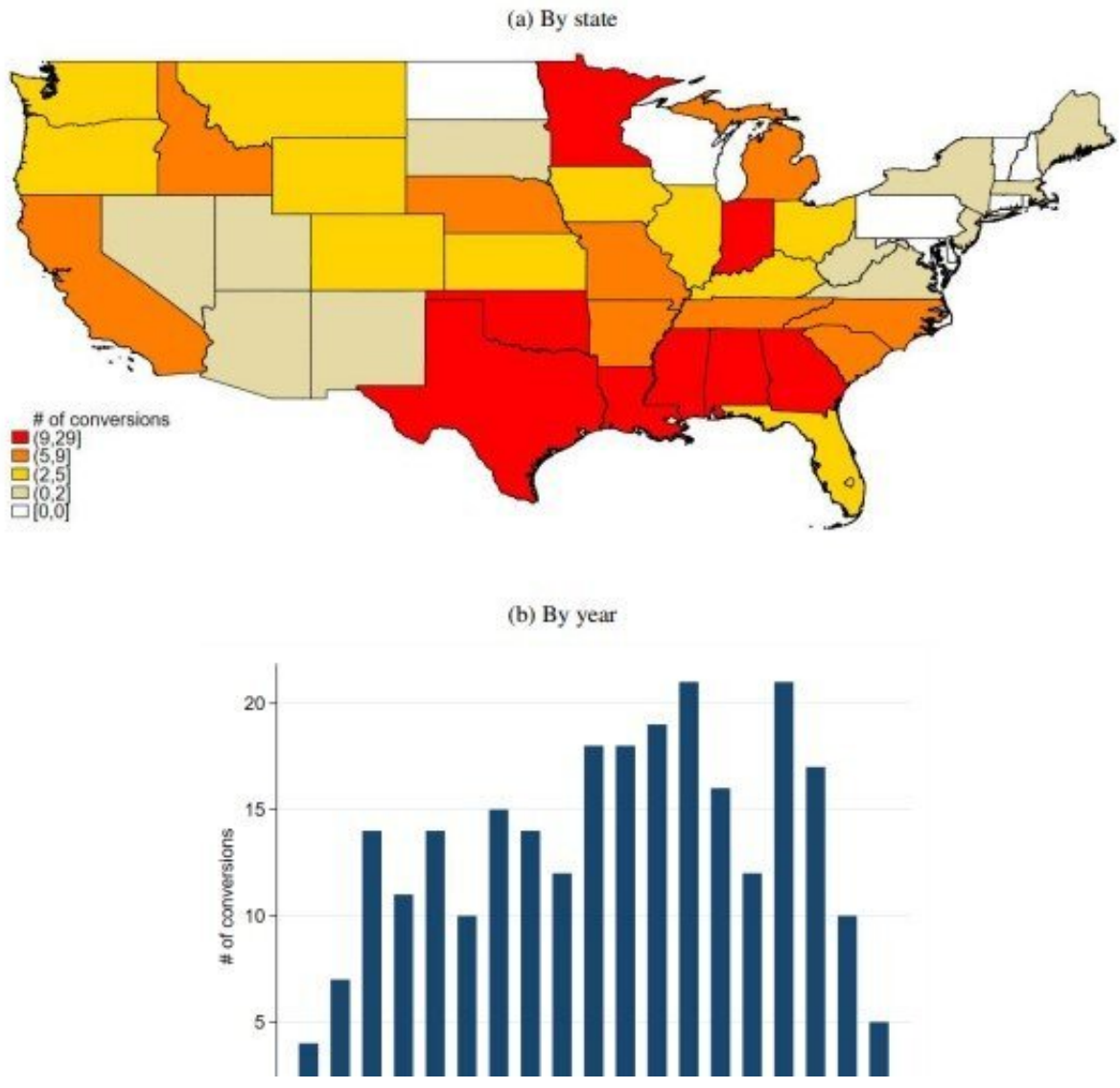

Note: The figure presents the distribution of non-federal, public-hospital privatizations during our sample period (2000–18). We restricted our sample to general-acute-care hospitals. Panels (a) and (b) present the distribution by state

and by year, respectively. Hawaii and Alaska are not pictured and include 4 and 1 conversions, respectively. We manually validated each conversion. Credit: Mark Duggan et al, The Impact of Privatization: Evidence from the Hospital Sector (2023). DOI: 10.3386/w30824

Government has been getting out of the hospital business in the United States, which begs a question: Are patients better off when private owners take over?

If they are poor and should be admitted to a hospital, the answer is likely to be "no."

That's according to a newly released Stanford study that delves into the rise of U.S. hospital privatization and its effects on patients. The researchers find that access to hospital beds significantly declines under private ownership—affecting all patients. But patients covered by Medicaid, the nation's public insurance program for low-income residents, are hit the hardest by the cutbacks in available beds and other levels of care.

The study, co-authored by Mark Duggan, the Trione Director of the Stanford Institute for Economic Policy Research (SIEPR) and the Wayne and Jodi Cooperman Professor of Economics at the School of Humanities and Sciences, analyzes nearly two decades of U.S. hospital privatizations. The researchers find that a formerly government-run hospital admitted on average 15% fewer Medicaid patients in the years immediately following privatization. By comparison, admissions of patients covered by Medicare, the federal insurance program for the elderly, didn't meaningfully change.

The reason why Medicaid patients are worse off when hospitals go

private is clear, says Duggan, whose research focuses on health economics. "Medicaid reimbursement rates are so low that treating patients covered by the program is often unprofitable," he says, adding that Medicare pays hospitals significantly more for care. "Many hospitals do not want to treat Medicaid patients given this financial hit."

The implications are significant given that one in four Americans are now covered by Medicaid, Duggan says. Twenty-five years ago, only one in nine Americans got their health insurance through Medicaid.

"The increase in Medicaid coverage since then has been gigantic," Duggan says. The Affordable Care Act of 2010 alone added nearly 16 million low-income patients to the program, according to government data. "Our study underscores how changes that are occurring in the health care system, including the widespread privatization of public hospitals, can have unintended consequences for the most vulnerable patients."

According to American Hospital Association data cited in the study, public control of hospitals declined by 42% from 1983 to 2019 as hospitals either closed or were taken over by private interests. As of 2020, roughly 80% of the approximately 4,500 general acute care hospitals in the United States are controlled by private non-profit or for-profit organizations. And as the share of public hospital beds dropped, Duggan and his collaborators find that the total number of patients admitted to newly privatized hospitals—including those on Medicaid—fell by 8.5%.

Job losses were also notable as private owners pared costs. Duggan and his co-authors estimate that full-time hospital staff declined by 8% on average, with many of the cuts hitting managers, medical technicians and back-office workers. They calculate, on average, a 30% decrease in the number of employed physicians. Privatization did not affect nursing

staffs.

Duggan says the study findings are especially important given that health care represents the largest sector of the U.S. economy at 19% of GDP and that hospitals employ as many workers as the entire U.S. construction industry.

"The profit motive is embedded throughout the health care system, which can be both good and bad," Duggan says. "Good in the sense that maybe things get done more efficiently, but bad in that it can end up having adverse effects for the least profitable patients who are typically poor."

Duggan's co-authors are Atul Gupta, an assistant professor at The Wharton School at the University of Pennsylvania; Emilie Jackson, an assistant professor at Michigan State University; and, Zachary Templeton, a doctoral student at Wharton. Gupta, Ph.D. '17, and Jackson, Ph.D. '20, are both former SIEPR graduate student fellowship recipients.

Why go private

The researchers look at nearly 260 privatizations of hospitals run by state and local governments between 2000 and 2018. While they find that admissions overall decline at newly private hospitals, neighboring hospitals absorbed most of the displaced patients.

But that wasn't the case for low-income patients. Not only did newly private hospitals admit fewer Medicaid patients, but so did nearby hospitals—with the steepest declines in access occurring in markets with the highest levels of poverty and concentrations of hospitals.

Duggan says Medicaid patients lose out because hospitals in high-

poverty areas already are financially strapped and that introducing a new competitor in the form of a newly privatized hospital makes it that much harder for all of them to stay afloat.

"At that point, all bets are off," says Duggan, who first analyzed hospital ownership and the role of government spending on health outcomes for low-income patients in *The Quarterly Journal of Economics* in 2000.

Hospitals, including neighboring ones, shed unprofitable Medicaid patients more out of necessity than avarice, Duggan says. There are multiple ways that hospitals trim their volume of Medicaid patients. For example, they might not contract with states to serve patients covered by the program or they might cut back on care that low-income patients tend to seek more than others.

Red vs. blue states: A counterintuitive finding

A better understanding of the effects of hospital privatizations on patient care is critical for policymakers, whose views on the right amount of government control appear to vary widely.

According to the study, some of the country's most conservative states have the largest share of government-owned hospital beds, while more liberal states have among the lowest. State or local governments control 44% of hospital beds in Alabama, for example. In Pennsylvania, they control just 4%.

Those stark differences defy conventional wisdom, Duggan notes. Blue (more liberal) states tend to support a bigger role for government in providing services, while red states advocate for minimal public involvement.

"You might think that government's role in hospital care would be larger

in blue states, but it turns out to be much bigger in red states," Duggan says. "Knowing that there's tremendous variation across states further highlights the importance of understanding the consequences of hospital privatization and figuring out what is the appropriate amount of public control."

There's a lot more to investigate, the researchers say.

The effects on wages for hospital staff and a close examination of types of care—like psychiatry or obstetrics—are ripe for future research, Duggan says. "If you're a nurse in a privatized hospital, do your wages go up less than if the hospital had remained under public control?" says Duggan, who plans next to start answering some of these questions by looking closely at specific state experiences with hospital privatizations.

More information: Mark Duggan et al, The Impact of Privatization: Evidence from the Hospital Sector (2023). DOI: 10.3386/w30824

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