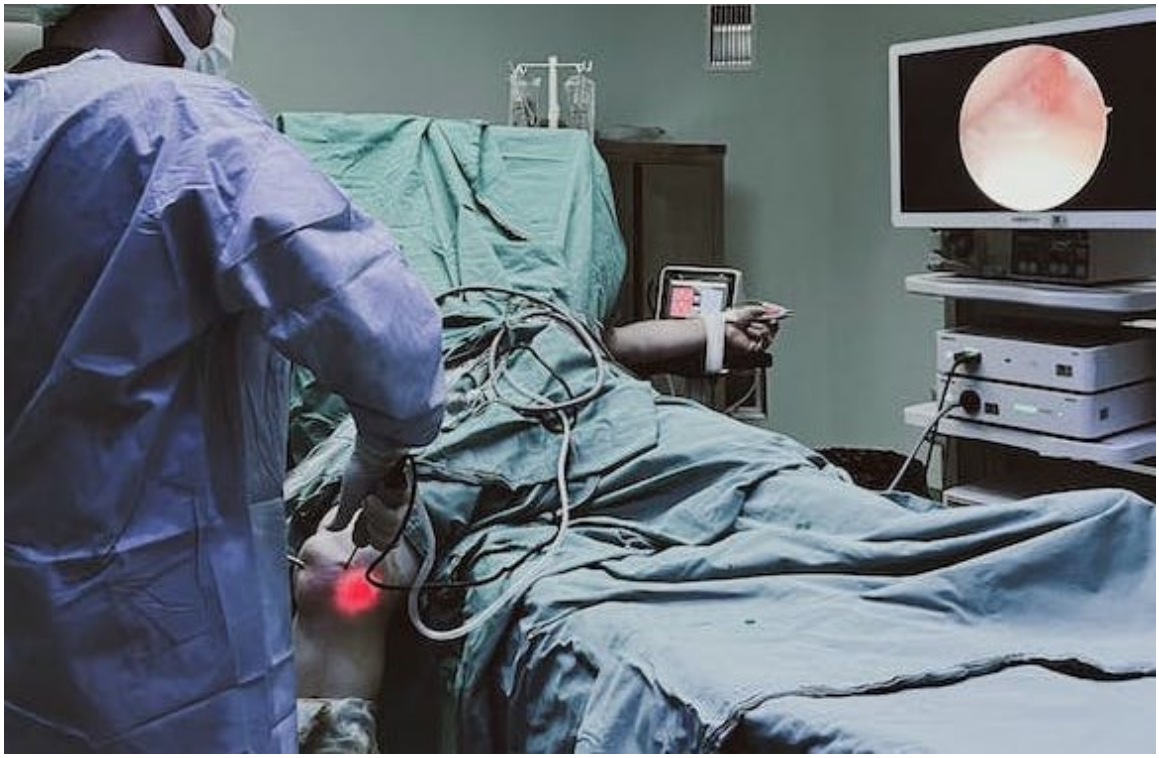

Unhealthy Profits

By **Christopher Mouré** and **Shai Gorsky**
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Surgery by Christopher Mouré and Shai Gorsky to explore what takes the not out of not-for-profit healthcare in the US.

At the end of November 2023, the New York Times published an editorial: *Why Are Nonprofit Hospitals Focused More on Dollars Than Patients?* It is certainly a valid question. Most people might assume that not-for-profit (NFP) organisations focus on providing a public benefit rather than profit. At most, common wisdom suggests that any income derived from providing a service should be reinvested into expanding or improving the service. There is no obvious reason why a NFP should accumulate large profits over years.

Yet in the NFP world of large US hospitals, profit, rather than public purpose, seems to have become the guiding light. The largest NFP hospital groups are not only larger by capacity but are now more profitable than their biggest for-profit counterparts (see figure 1). NFP hospital system Kaiser Permanente made $6.4bn in 2020, more than the largest for profit hospital behemoth, HCA. The outsized profits of large NFP hospitals are beginning to draw intense criticism, but analyses of the cause of this phenomenon are lacking. Why are large, ostensibly NPF, hospitals so profitable in the US?

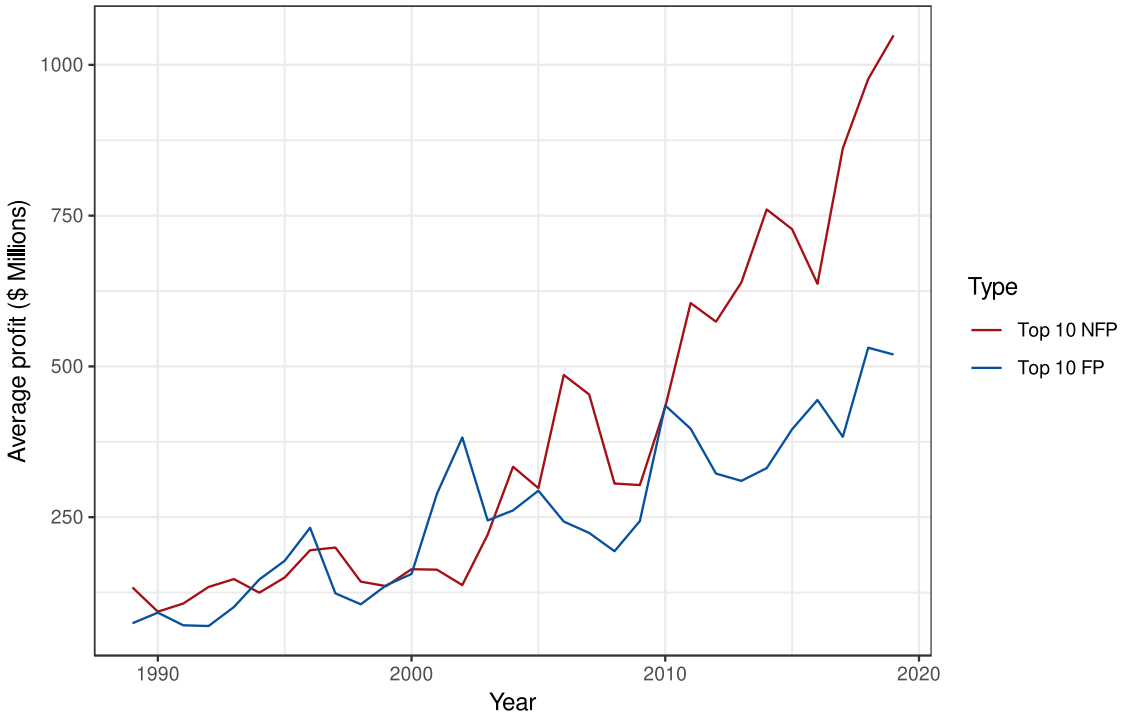


Figure 1: *comparison of average profits, top ten for-profit and not-for-profit hospitals Source: COMPUSTAT (FP) and IRS 990 forms via the NCCS data archive (NFP)*

What are these organisations doing with all this profit, as they can't give it out to shareholders, as FP companies do? There is some evidence that hospitals are simply keeping it in the bank. One 2023 study showed that between 2012 and 2019, cash reserves grew by 68% among NFP hospitals while care and bed capacity did not increase at all. The authors list three reasons why a hospital keeps cash reserves: weathering financial trouble and borrowing off the reserves to either build new capacity or buy other hospitals. Yet the largest hospitals consistently generate enormous profits over years and bed capacity has not increased. In part, this is because NFP hospitals are closing less profitable hospitals and expanding market share in wealthier areas. But this only raises further questions. For instance, why are NFP hospitals trying to expand market share at the expense of community benefits?

The capital-as-power political economic approach may help solve the riddle (see box Capital as Power Theory). This approach argues that for-profit firms pursue not absolute profits (maximisation) but the differential (that is, relative to other social groups) accumulation of organised power. Profit is seen as one of the main manifestations of that power. While most capital as power research has looked at how governments and FP firms accumulate power, this approach has not been applied yet to the NFP sector.

Capital as Power Theory

Capital as Power theory argues that "power over others" is the relevant unit of analysis for understanding capitalist social relations. Power is a relational concept, meaning it can only be meaningfully measured relative to the power of other groups. As such, the goal of accumulation is always differential. For example, if a firm's profit grows 10% in the same time that the average firm's profit grows 5% per year, that firm's differential profit is 5%. Conversely, if the average firm's profit had grown 15%, then the firm would have had a differential *loss* of 5%.

While profit is a central mechanism for expressing and measuring social power in the real world, theoretically, the logic of capital as power is universal. This means that any organisation can become oriented toward the differential accumulation of power, regardless of an institutional classification like "not-for-profit'. While profit is not equivalent to power, from a capital-as-power perspective, the dramatic increase in the profitability of large NFP hospitals appears as evidence that these organisations are oriented increasingly toward the accumulation of power.

So an answer to the mystery of nonprofit profits from the capital-as-power perspective would suggest that over time, the largest hospitals have become more focused on increasing their own relative power in society than on providing care *per se*.

To assess this hypothesis, we first need to examine what are the ways to raise profits. Hospitals can raise their income in all sorts of unethical ways: refusing treatment to patients who cannot pay; manipulating procedural billing codes to raise the price of care; and suppressing worker demands for higher pay and better working conditions. Each increases profits while harming the quality of and access to care. Strategies like these raise profit margins without growing the size of the organisation. Profits can also be raised when hospitals grow. Such growth can be achieved by increasing capacity: building more clinics, hiring more medical staff, reaching out to more patients, and ultimately selling more services. However, the relative size of a hospital could also grow without increasing capacity through mergers and acquisitions.

Regulation in the hospital business limits hospitals' ability to accumulate through cost-cutting and raising prices. The government sets an upper limit to (some) prices through Medicare and Medicaid while regulation forces hospitals to treat patients with a minimum standard of care, no matter whether they can pay or not. Cost-cutting measures are still endlessly pursued and implemented, especially by the large NFPs. Kaiser Permanente is among the worst offenders when it comes to unethical cost-cutting. However, given the regulatory limits, these practices can only be one part of the puzzle. Because these practices are also available to for-profit hospitals, it does not explain how the profits of large NFP hospitals have surpassed those of for-profit hospitals.

If hospitals are limited in their ability to cut costs and raise prices, the only remaining explanation for their increasing profits is that of differential growth. Is this growth achieved via increased capacity or through mergers and acquisitions? Figure 2 shows how spending on mergers and acquisitions has skyrocketed. By contrast, hospital capacity has been stagnating for decades. The evidence is clear: large NFP hospitals are not putting the same resources into expanding capacity as

they are into chasing leverage, as one financial analyst put it. The data also show that NFP hospitals have led the way in acquisition activity, exceeding the for-profit sector, especially since 2010. These tactics led to the fact that, in 2016, seven of the most profitable hospitals in the US were NFPs (measured as profit per patient).

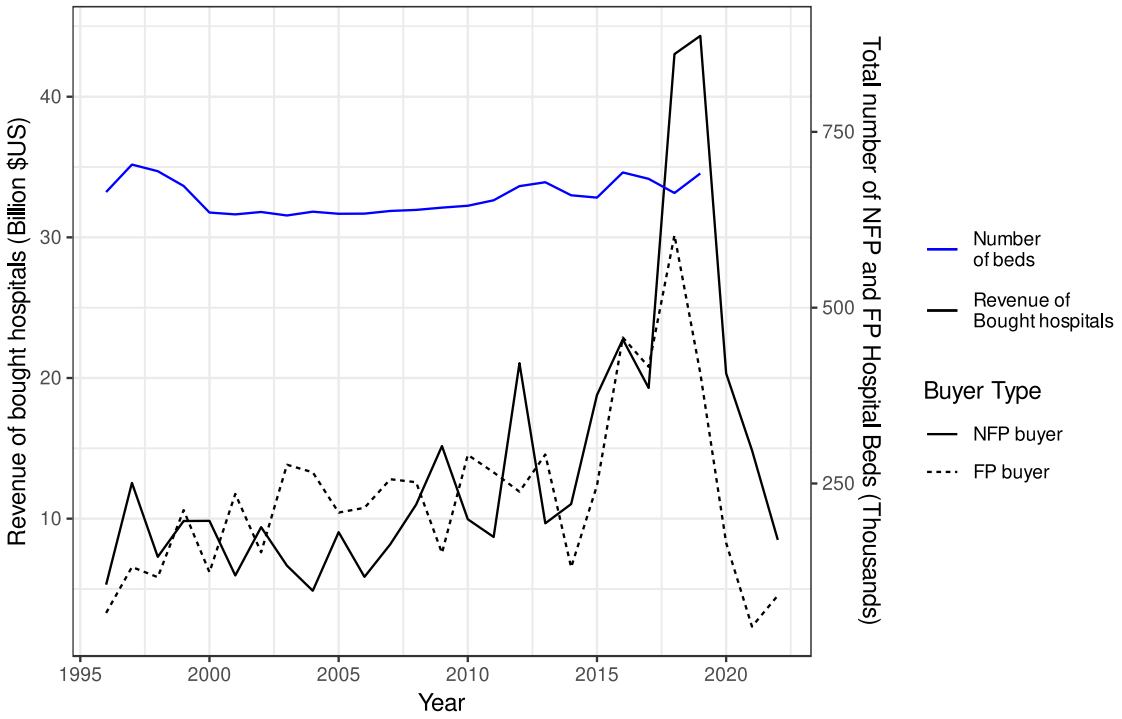


Figure 2: *revenue of hospitals bought in mergers and acquisitions (black) and total number of for-profit (FP) and not-for-profit (NFP) hospital beds (blue). Source: Centers for Medicare & Medicaid Services: Provider of Services File – Hospital & Non-Hospital Facilities; Cost Reports by Fiscal Year*

This past spring, Kaiser Permanente announced one of the biggest hospital mergers to date. It is buying Geisinger Health's 39-hospital system. As Kaiser spends billions acquiring other firms, its own workers have gone on strike. They claim that Kaiser is intentionally understaffing its hospitals to save costs. Our contention is that both these phenomena are evidence that large NFP hospitals are prioritising profit over care. Due to population increases and aging demographics, relative hospital capacity in the US has shrunk. Emergency room closures (a form of care disproportionately used by under-served communities) and staffing shortages are commonplace. All while large NFP hospitals spend billions chasing market share and profit. In the context of millions weathering the financial trouble of staggering medical debt, what future financial trouble could justify a NFP hospital making more profit than the largest for-profit hospital?

US historical context

US Government policy has played a significant structural and ideological role in shaping not for profit (NFP) hospitals' orientation toward differential accumulation. The 1960s were a watershed decade for private (for profit) FP and NFP hospitals. The passage of the Medicare and Medicaid Acts established a large source of public funds to pay private healthcare providers for providing services. The payment system, termed "cost-plus," paid hospitals for the cost of service plus a small markup. In addition, these public programs subsidised the capital costs of FP hospitals over NFP and public hospitals, leading to a wave of FP hospital growth, engineered largely through mergers and acquisitions.

Ironically enough, the Reagan administration ended the merger wave of the 1970s by eliminating preferential investment subsidisation for FP hospitals in the name of cost-cutting. In 1983, Medicare also replaced the "cost-plus" system with a fixed rate system. Policymakers hoped capping reimbursement would provide an incentive for hospitals to cut costs. Indeed, it did, and some of the more extreme cost cutting measures, like patient dumping, became so egregious that the government had to pass a bill (the 1986 Emergency Medical Treatment and Labor Act) restricting hospitals' ability to refuse treatment to unprofitable patients.

Throughout the 1980s, government agencies and hospital executives turned to commercial solutions to the problem of healthcare funding. Officials put policies in place that promoted financial solutions to hospital funding. For instance, in 1985, the U.S. Dept. of Health & Human Services encouraged public and private NFP hospitals to "approach capital investment decisions with the same analytical discipline and the same underlying principal [sic] of value maximisation that governs investment decisions in private industry."

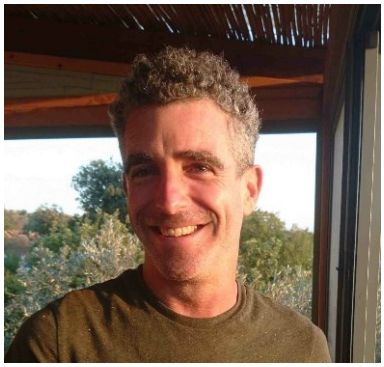
Policies up to the present moment are broadly continuous with the logic put in place in the 1980s. These policies brought increasing commercialisation and consolidation, successive merger waves, and higher costs. From the 1990s to the current year, the government has also actively encouraged merger and acquisition activity. The Department of Justice issued policy statements in 1993, 1996, and 2011 exempting hospitals from antitrust law. The Affordable Care Act (ACA), while reducing the number of uninsured patients, also encouraged further consolidation. The ACA benefited large FP and NFP hospitals and health insurers at the cost of rising levels of personal medical debt.

By choosing to spend precious funds on mergers that they could spend expanding the provision of care, hospitals choose profit over the public good. This, of course, does not happen in a vacuum. NFPs are heavily regulated by the government (see box US historical context). Their ability to engage in mergers and acquisitions can and should be limited by government policy. The increase in expenditure on acquisitions should therefore be a huge wake up call to society at large. Our analysis shows that NFPs do not adhere to their public purpose in the current political climate where policy and wider norms encourage power-oriented behavior, and even beat the FPs in their own game. Is this a reversible historical accident? Did NFPs ever have the choice to act differently? To answer these questions, we probably need to better understand what roles NFPs play within the

capitalist social order. At least looking at the current state of affairs, it seems that NFP hospitals are deeply implicated in the dismal state of US health care.

Chris Mouré

Chris Mouré is a graduate student at Carleton University in Ottawa. In the past, he has researched the political economy of big tech, the semiconductor business, and the covid-19 pandemic. Currently, he is investigating the political economy of not-for-profit hospitals in the US.



Shai Gorsky

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