Financialization and the crisis of US healthcare

Harvard study exposes deadly toll of private equity hospitals

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Research led by Dr. Zirui Song of Harvard Medical School published in the *Annals of Internal Medicine*, September 2025, has delivered one of the clearest warnings yet about the dangers of private equity in American hospitals. The study demonstrates in no uncertain terms that when hospitals fall under the control of private equity firms, the pursuit of profit takes precedence over patient care, leading to deadly consequences in the most critical areas of medicine—the emergency departments and intensive care units of US hospitals.

Private equity's incursion into healthcare follows a well-worn, perfidious and predatory playbook employed by financial wizards. Firms will usually opportunistically acquire providers through debt-laden leveraged buyouts promising easy cash flow. But in these schemes, hospitals rather than investors are left with the burden of repayment on massive loans.

Then, within a short investment horizon typically of three to seven years, the owners strip out cash through staffing cuts, sale-leasebacks of hospital real estate, and dividend recapitalizations that funnel borrowed money directly into investor pockets. The result is a healthcare system financially hollowed out and left vulnerable to collapse.

The bankruptcy of Steward Health Care in May 2024, which filed for Chapter 11 with more than $9 billion in liabilities after its private equity sponsor, Cerberus Capital Management, reportedly extracted $800 million in profit, stands as a chilling example of this model in practice. The former CEO of Steward, Ralph de la Torre, received $250 million over four years before the company's collapse.

Private equity's move into healthcare is not accidental but is rooted in the sector's unique financial appeal. Healthcare represents $4.5 to $5 trillion in annual spending in the United States, or nearly 18 percent of GDP, and is characterized by relatively stable demand, since people require care regardless of the economic cycle.

For Wall Street, this stability and sheer size have made healthcare one of the most attractive frontiers for financial extraction. The term financialization describes the transformation of systems built for providing important social services into those driven by purely financial motives, where the immediate extraction of profit dominates decision-making. More and more, hospitals are being transformed into vehicles for generating returns rather than serving communities.

The consequences are stark. Studies consistently show that private equity ownership raises costs for patients and payers, undermines quality, and contributes to bankruptcies. In 2023 alone, more than one-fifth of all healthcare bankruptcies were at PE-owned companies, including seven of the eight largest failures. Communities lose hospitals, workers lose jobs, and patients lose access to care while investors emerge enriched.

Higher mortality in emergency departments and intensive care units

In this regard, it bears reviewing the findings of Dr. Song and colleagues at Harvard Medical School in collaboration with the University of Chicago and the University of Pittsburgh. Their research examined mortality rates in emergency departments (ED) and intensive care units (ICU) of hospitals held by private equity compared to matched hospitals that serve as controls for their analysis. These two settings were used because survival is acutely dependent on staffing and resources in these critical areas of the hospital. What the researchers asked was, "Does private equity's model of cost-cutting and financial engineering increase patient deaths?"

The investigators conducted an exhaustive nationwide matched difference-in-differences analysis, using 100 percent Medicare claims and hospital cost reports between 2009 and 2019. They compared 49 private equity-acquired hospitals with 293 control hospitals, covering more than one million ED visits and over 121,000 ICU admissions in the private equity group, alongside more than six million ED visits and 760,000 ICU admissions in the control group. The design allowed them to isolate changes that occurred after acquisition, filtering out both pre-existing hospital differences and broader time trends.

The findings were sobering indeed. After acquisition, Medicare patients arriving in the emergency departments of hospitals owned by private equity faced a 13 percent relative increase in mortality, or seven additional deaths per 10,000 visits, compared to similar non-private-equity hospitals. These outcomes coincided with deep cuts to frontline staffing and pay.

ED salary expenditures fell by more than 18 percent, ICU salaries by nearly 16 percent, while overall full-time employment dropped by 12 percent and total hospital salaries by almost 17 percent. Patients, often the sickest among them, were also more likely to be transferred to other acute-care facilities, underscoring how reductions in capacity directly translated into patient risk. The average ICU stay shortened, suggesting pressure to move patients out more quickly, an efficiency for administrators but a hazard for the critically ill.

This study capped a series of investigations by Dr. Song's team tracing the trajectory from financial strategy to patient harm. A 2020 *JAMA Internal Medicine* study had shown that private equity-owned hospitals boosted net income by 27 percent, largely by raising charges and shifting their patient mix toward more profitable, commercially insured patients.

That study revealed the motive but stopped short of documenting harm. In 2023, a related *JAMA* study led by Song's colleague Dr. Sneha Kannan found that private equity ownership was associated with a 25 percent increase in hospital-acquired conditions such as infections and falls, hinting at a decline in care quality but leaving the mechanism unclear.

Another analysis that year found a paradoxical decline in in-hospital mortality at private equity hospitals, an effect the researchers attributed to selection bias (a statistical sleight of hand), as healthier patients were admitted while sicker ones were transferred elsewhere.

The recent 2025 ED/ICU study provided the missing link. By focusing on the emergency department, where hospitals have no control over who walks through the door, the researchers stripped away the masking effect of patient selection. What they found confirmed their suspicions. When high-acuity patients arrive at hospitals stripped of staff and resources, mortality rises. In this sense, the study stands as a definitive indictment of the private equity model in healthcare, demonstrating that financial engineering does not just destabilize institutions, it kills.

The financialization of US healthcare

The rise of private equity in healthcare is not accidental, but the product of a decades-long political and economic shift that has transformed companies (and health systems) and clinics into targets for financial extraction. Its roots lie in the deregulatory policies enacted in the 1980s, which saw the popularization of borrowing capital to acquire hospitals, with the necessary changes in the tax codes to reward debt-driven takeovers.

This was the birth of the "shareholder value" model, which allowed corporations to prioritize short-term profits over long-term stability. For years, healthcare appeared insulated by its predominantly nonprofit character and public mission. But once Medicare and Medicaid reimbursements were opened to for-profit providers and antitrust enforcement was made toothless, the sector became fair game. By the 1990s, for-profit chains had already absorbed parts of the buyout model, paving the way for private equity firms to expand their reach.

The financial crisis of 2007-2008 became the accelerant for such operations. With interest rates slashed and cheap debt flooding the system, private equity firms gained easy access to the lifeblood of their model, leverage. At the same time, investors searching for higher yields turned toward "recession-proof" industries like healthcare, with its steady demand and government-backed revenue streams. Hospitals and nursing homes already reeling from the downturn became easy prey. They were sold off at discount prices and restructured for maximum profitability at the expense of patients and healthcare workers.

The consequences have been devastating. Philadelphia's Hahnemann University Hospital closed in 2019 less than two years after its purchase. The land was carved off as a lucrative real estate play while the surrounding low-income community lost its only safety net provider.

HCR ManorCare, one of the nation's largest nursing home chains, collapsed into bankruptcy in 2018 after its PE owner siphoned off dividends. Later studies tied PE ownership in nursing homes to a measurable rise in patient mortality.

Genesis HealthCare, another massive nursing home chain, filed for bankruptcy in 2025 after years of sale-leasebacks and debt loads engineered by its investors. Envision Healthcare made fortunes by exploiting surprise billing loopholes, only to declare bankruptcy in 2023 once regulators curtailed the practice. Steward Health Care, once the largest private-equity hospital operator in the US, filed for bankruptcy in 2024.

These examples lay bare the logic of financializing health systems. Private equity can profit handsomely even as the institutions it acquires are quickly liquidated. The tactics are straightforward. Dividend recapitalizations force hospitals to borrow money, not to improve care, but to pay out cash to their owners. Sale-leasebacks strip hospitals of their real estate, providing an immediate windfall for investors but saddling providers with punishing rent obligations.

Prospect Medical Holdings' private equity owner extracted more than $650 million in fees and dividends while leaving the company with over a billion dollars in liabilities. Steward's 2016 sale-leaseback deal with Medical Properties Trust alone financed nearly half a billion in dividends for Cerberus but planted the seeds of Steward's collapse.

What makes this cycle possible is a regulatory regime built to protect financiers rather than the public. Because the debt in a leveraged buyout sits on the hospital's balance sheet, investors face little risk. Limited liability ensures they can walk away with profits intact, while patients, workers, and communities are left to pick through the wreckage. Bankruptcy law, designed to shield "entrepreneurial risk-taking," has become a shield for predatory finance. Profits are privatized while the social costs that include job losses, care deserts, and preventable deaths are externalized.

A crisis in healthcare and a social catastrophe

Six years into the COVID-19 pandemic, the US healthcare system is buckling under converging pressures: rising costs, chronic staffing shortages, deep political uncertainty concerning the future of the Affordable Care Act. The spread of private equity ownership has magnified the crisis.

Studies show that mortality rates in PE-owned nursing homes are measurably higher than in non-PE facilities, while emergency departments across the country report record wait times as understaffed hospitals struggle to meet demand. For patients, this means longer delays for critical care. For communities, it means living with the constant threat of their local hospital being shuttered or stripped of essential services. All of this is unfolding as healthcare costs climb to nearly $5 trillion annually and federal debt negotiations threaten to undermine the already fragile safety net.

These consequences are not isolated failures but the expression of a larger political transformation—the financialization of life itself. Healthcare, once recognized as a public good, has been reframed as a commodity to be bought, leveraged, and flipped. In this framework, hospitals are not places of healing, but vehicles for extracting wealth, their real estate and revenue streams carved up by distant financiers. The avoidable deaths, higher morbidity, care deserts and broader inequities, and the erosion of social trust, are simply collateral damage of the profits reported at board meetings.

Ultimately, the rise of private equity in healthcare must be understood as part of a broader assault on social and democratic rights that drives capitalist barbarism. Firms thrive on opacity, exploiting loopholes in antitrust law and bankruptcy rules to extract wealth while insulating themselves from responsibility. Even during the COVID-19 pandemic, PE-backed companies received billions in public aid through the CARES Act, only to continue the very practices that destabilize care.

Dr. Song's study stands as an objective affirmation of a truth that can no longer be ignored by the working class. Capitalism, in its most financialized form, is transforming health systems not into arenas of healing but into factories of death. The private equity model, with its debt, asset-stripping, and profiteering, is not an accidental distortion of the market, but the purest expression of a system that values returns over lives. Each closed hospital, each preventable death in a PE-owned emergency department or nursing home is not merely a failure of policy, but evidence of a social order in terminal decline.

What is at stake is not simply the future of healthcare policy, but the

future of society itself. The advanced financialization of healthcare is a *sine qua non* of the barbaric transformation that has long been underway. The social contract is being torn apart, and the necessities of life are being commodified for speculation. Far from being insulated, the entire working class is being dragged into this descent through higher costs, declining life expectancy, and the destruction of the very institutions meant to preserve health and dignity.

Despite the Democratic Party's posturing (and the endless promises of its pseudo-left and "progressive" satellites), its calls for reform and re-regulation cannot hold water. For decades, the Democrats have stood at the very center of the healthcare crisis, enabling the predatory practices of Wall Street while posing as champions of the working class. Their statements are lies meant to confuse and pacify, while they care not one iota for the lives being lost. To imagine that this party, bound hand and foot to finance capital, could deliver genuine relief is to indulge in dangerous illusions.

What private equity has done to healthcare is not an aberration, but the culmination of capitalism in decay. A system organized around the distribution of profit to Wall Street will always sacrifice human need to financial return. The working class must see private equity in healthcare for what it is: part of a broader assault on democratic rights, social protections, and life itself.

The answer is not accommodation, but revolt, a collective struggle to reclaim healthcare as a basic premise of social life. The banner under which this fight must be waged is socialism, the reorganization of society according to human need, where all people are equal and possess inalienable democratic and social rights. The choice before the working class could not be starker: society organized for profit, or society organized for human need.