11
JUST ANOTHER BUSINESS
Private equity in health services

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Introduction

Private equity (PE) activity has become a generally well-known phenomenon since the late 1980s, with its roots in the corporate US. During these years, PE firms have widened their geographical as well as their sectoral scope. This has involved increased activity in Europe and more deals in services compared to manufacturing (Guo et al., 2011). Especially since the 2008 financial crisis, PE firms have increasingly acquired organizations providing services that are central to the daily lives of citizens (Ivory et al., 2016), such as health services. This chapter therefore focuses on the role of PE firms in health services. We develop a conceptual model to explain why health services organizations are perhaps not "just another business" for PE investment, and use this model to explore the impact of PE in health services.

The health care sector accounts for approximately 12% of PE deal activity worldwide, as measured by the number of deals. Investment has surged in the health provider and related services subsector, totaling over half of the global deal value in health care for the year 2015. PE investment in so-called "healthcare-heavy assets," a label the firms apply to assets with meaningful exposure to reimbursement risk, continues to grow, with investors becoming more comfortable with reimbursement risk (Bain & Company, 2016: 8–10). In 2010, the first industry-specific PE trade association was established in the health care sector: the Healthcare Private Equity Association (HCPEA). The increasing pervasiveness of PE in healthcare is motivated by two developments. First, PE firms – having funds available – look for "deals that will not sour even if the economy does" (Evans, 2011). Second, PE is expanding to fill the health care gap as many governments are retreating from health services provision, and encouraging increased private sector involvement to attract capital and to deliver health services.

The largest proportion of health services PE deals occur in the US, in particular in nursing homes. For example, 4 out of 10 largest for-profit nursing home chains in the US were purchased by PE firms in the period 2003–2008 (Harrington et al., 2012). PE investors, however, also target other types of health services organizations such as US emergency services (Ivory et al., 2016). Health services providers in Western Europe have also been acquired, for example the Finnish healthcare service provider Terveystalo was acquired by the Swedish PE firm EQT partners in 2013, the Swedish health services company Capio was acquired

by the PE firms Apax and Nordic Capital in 2006, and funding from several PE firms has backed small-scale nursing home facilities in the Netherlands.

The role of PE in such health services organizations raises a number of concerns. Their focus on financial performance can be at odds with the delivery of high quality health services. In the public as well as the academic debate, it is questioned whether PE interventions come at the expense of vulnerable patients (e.g., Duhigg, 2007; Pradhan et al., 2014: 4). For example, Ivory et al. (2016) report PE-owned health services organizations have implemented checklists named "Care to Cash," which may contradict key aims in health services such as providing "care to vulnerable patients." In line with this debate, this chapter develops a conceptual model to clarify how the nature of health services is fundamentally different from many other products or services, and suggests that health services are not "just another business" for PE firms. The specific nature of health services requires a multistakeholder and multidimensional performance approach to evaluate the impact of PE investment, which includes financial performance as well as employee, and client/patient well-being. Subsequently, we consider the empirical evidence of the impact of PE in health services. Since specific research on this topic is relatively scarce, we draw from other sources to formulate propositions: this involves systematically analyzing evidence over the last 10 years on what we know about (a) the impact of for-profit nursing home ownership in comparison to not-for-profit ownership, and (b) the cross-sectoral impact of PE. The combination of both reviews enables us to formulate propositions on the impact of PE in health services. Finally, we identify certain knowledge gaps that could be addressed in future research.

Conceptual framework

By specifying the nature of health services, our conceptual framework aims to distinguish health services from manufacturing and services companies invested in by PE. For a full understanding of the specific health services context it is necessary to evaluate the impact of PE in health services from a stakeholder approach. Our focus is particularly on nursing home services, as nursing homes have been an important target of PE in health services thus far, and subsequently most available evidence is on this subsector.

Not "just another business"

To distinguish health services from other services and products, we introduce the market frame and the public value frame. The market frame starts from the idea that health services are a commodity. By treating health services as such, PE can apply general interventions for improving efficiency and maximizing profits. However, we argue that health services are not "just another business." Health services do not fit into the commodification logic that is attached to the market frame. The market frame therefore needs to be complemented or even replaced by a public value frame. We here present four arguments that underscore the need for this public value frame, as an alternative framework for exploring PE in health services. These four arguments are based on:

(a) the starting point for managing health services;
(b) perceptions of organizational success;
(c) perceptions of well-organized labor;
(d) perceptions of the client/ patient.

First, the *starting point* for managing health services can differ. The way in which nursing homes operate can be seen as a touchstone for how societies care for their elderly and for societal values more broadly. Delivering health services is therefore not only creating value for money by delivering commodities, but also creating public value by being part of people's lives, and the broader society. It relates to what Sandel (2000) calls "the moral limits of markets": when health services are commodified, that makes them a regular market exchange. This commodification may change the character of the service itself, as it may crowd out values worth caring about, such as accessible quality care for the elderly poor, human dignity, and happiness. From a market frame, health services commodities can be at a lower cost, as long as the care delivery fits within legal requirements; from a public value frame, the possibilities for lowering costs are related to public values that often transcend legal requirements.

Second, the view of economic value as the main indicator for *organizational performance* is too narrow. The client and the healthcare professional become intertwined in the nursing home service delivery. The "commodity" thus cannot be separated easily between provider and client, as the quality of the service is heavily dependent upon – often intense – interactions and relationships between clients and professionals. Health services delivery is "emotion work" (Hochschild, 1983), as it occurs in face-to-face interactions with clients. It uses emotions to influence patients' emotions, attitudes, and behaviors; and the display of emotions by professionals has to follow certain rules (Zapf, 2002). A market frame might overlook crucial aspects of the value creation process: the social capital that is built in micro action and relationships between staff and patients on a daily basis. Interventions from a market frame, such as the search for more efficiency, thus needs to be weighed against forms of social capital that are not easily measured, such as the quality of the relationships between patients and staff. For example, redeploying staff to improve efficiency can damage employee-client relationships that are essential for care quality.

Third, health services are labor-intensive, which puts emphasis on the importance of good *labor management*. The labor-intensity leads to Baumol's cost disease: there are limits to the growth of productivity over time, since productivity gains come mostly from improved capital and technology (Baumol & Bowen, 1966). Research shows how Baumol's cost disease applies to the US health care sector (Bates & Santerre, 2013). Productivity gains in the primary process – an important starting point for many PE firms in reorganizing their portfolio organizations (e.g., Wilson et al., 2012) – are thus restricted. Moreover, it can even be argued that many health services need some staff slack because of unforeseen events for which extra staff are required immediately (for example, patient falls and acute episodes of distress), and the high risks of understaffing at those moments.

Fourth, the commodification of health services can blur the difference between "ordinary clients" and nursing home *patients*. One difference relates to the fact that it is much harder for most nursing home patients than the "ordinary client" of regular commercial day-to-day services to "vote with their feet" when they are dissatisfied with the services delivered. Relocation to another nursing home will disconnect patients abruptly from relationships with staff and other patients, and is especially distressing for physically frail patients or those with other complicated health needs. In addition, places in other nursing homes can be scarce and might not be available directly. Another difference refers to the fact that it is relatively difficult for patients to identify care quality and to compare alternative nursing homes or care providers. This is partly because the quality of care is difficult to measure and assess compared to standard commodities, information is not readily accessible, and the most vulnerable patients are often least equipped to make the comparison at the times of highest

Table 11.1 Summary of the ideal type market frame and public value frame for health services

	"Just another business" *Market frame: health services as a commodity*	*Not "just another business"* *Public value frame: health services as a service in its own right*
Starting point	Building a financially successful business within legal requirements	Building a financially successful business within a legal context and in addition also respecting public values
Organizational performance	Economic value is key to nursing home success	Economic value and social capital are both key to nursing home success
Organizing labor	Labor needs to be organized as efficiently as possible	The nature of the service implies some staff slack
Client/patient	Dealing with the empowered client, who is making rational choices	Dealing with the dependent patient who needs protection

need. There is a huge difference of knowledge between the care provider and the patient, and information asymmetry may result in sub-optimal client choices of services and facilities. These issues highlight the dependency of the patient on the nursing home, including high transaction costs directly related to building and maintaining client relationships. They call for a certain level of protection of the patients by the organization, service commissioners, or the regulators responsible, and the restriction of socially undesirable profit-maximization (e.g., Hirschman, 1980: 436).

These four characteristics of the nature of health services can also be applied to, for example, education or child daycare services. Table 11.1 provides a summary of the characteristics, which can be categorized from a market frame and a public value frame.

From a shareholder approach to a stakeholder approach

What follows is a multidimensional performance perspective on health services organizations, as the delivery of health services implies the creation of value that goes beyond financial performance. Health service delivery also includes elements of public value, social capital, staff slack, and patient protection. Good performance in health services balances financial performance, employee well-being, and client well-being, as owners, employees, and clients are all affected by PE ownership (e.g., Freeman et al., 2010). Research on the impact of PE in health services therefore needs to start from a stakeholder approach, as opposed to the "traditional" shareholder approach. We argue that a stakeholder approach in combination with a multidimensional performance model fits health services better than a shareholder approach.

In the shareholder approach, principals (owners) and agents (managers) are challenged to optimize financial interests to ensure long-term organizational competitiveness (Jensen & Meckling, 1976). This approach is widely used in the buyout and PE literature. It can be characterized by a focus on a limited number of stakeholders and a one-dimensional performance orientation (i.e., organizational and financial performance). In contrast, the stakeholder approach (e.g., Freeman, 1984) starts from a multidimensional view of performance,

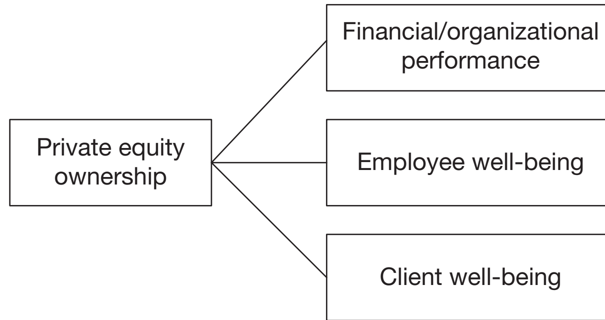

Figure 11.1 Multidimensional performance of PE in health services

Source: Authors.

with an emphasis on organizational outcomes, employee outcomes, and societal outcomes linked to the different stakeholders involved (see, for example, the Harvard model, Beer et al., 1984). In this chapter, we focus on three stakeholders in health services organizations: owners/employers, employees, and clients. While acknowledging that society as a whole has a stake in health service provisions and outcomes, society is not included in our review.

The stakeholder approach adds the possibility of dissimilar/conflicting outcomes for different stakeholders. Scholars identify a variety of potential outcomes from organizational decisions that range from conflicting outcomes to mutual gains outcomes (e.g., Van De Voorde et al., 2012). From the "conflicting outcomes perspective," the impact of PE ownership for different stakeholders is a zero-sum game: positive outcomes for one stakeholder come at the expense of another stakeholder. At the opposite end of the continuum, the "mutual gains perspective" assumes that decisions are possible that involve gains for all stakeholders. We will apply a multidimensional performance construct (see Figure 11.1), to explore which of these perspectives is most appropriate for describing the impact of PE ownership in health services. The goal of this chapter is to formulate propositions on the impact of PE in health services on organizational performance, employee well-being, and client well-being.

What we (do not) know about PE in health services

We argue that PE in health services needs specific attention in academic research. Lessons can also be learned for other public services sectors such as education and child daycare. Hitherto, research on PE has been mainly cross-sectoral, often using databases – such as the CMBOR database – that incorporate businesses in several sectors. Of the 62 papers included in our systematic review of the PE literature over 10 years, 79% presented cross-sectoral results (Bos et al., 2013). The few papers that focus on a specific sector are in nursing homes (8%) and retail (5%). We also found one paper for each of the following sectors: manufacturing, high technology engineering, telecoms, and the automobile industry.

Evidence on PE in nursing homes

The distinctive nature of health services calls for more sector-specific research on the impact of PE in health services. The first studies in this area have focused on nursing homes and the findings are inconsistent. Although Stevenson and Grabowski (2008) find lower staffing

levels in US nursing homes following acquisition by a PE firm, they report that staffing levels were already reducing pre-purchase. No harm to care quality is reported as a consequence. In contrast, Harrington et al. (2012) find no significant changes in staffing levels for PE-owned nursing homes, but report higher levels of deficiencies post-buyout. Deficiencies are issued by the inspection when a nursing home does not meet minimal standards. A study by Pradhan et al. (2014) also reports significantly more deficiencies after PE deals in nursing homes. This study also finds lower staffing intensity of Registered Nurses (the higher educated nurses working in US nursing homes). Moreover, the number of higher educated professionals is reduced in relation to lower qualified care workers. With regard to financial performance, Pradhan et al.'s (2013) study reports improved financial performance of PE-owned nursing homes, while Cadigan et al. (2015) found little impact of private investment firms on the financial health of nursing homes. These studies all highlight one particular aspect of multidimensional performance. Given research on the impact of PE in health services is relatively scarce and focused on one dimension at a time (i.e., organizational performance, employee well-being or client well-being), we draw from related literatures to formulate propositions on the impact of PE in healthcare.

Drawing from related literatures

We narrow our focus to PE's impact on nursing homes in the US for three reasons. First, US nursing homes have been acquired by PE since 2000, and therefore there is relatively much experience in this area. Second, the very first studies on PE in health services, as presented in the previous paragraph, have been in US. Third, although research on PE in nursing homes is relatively scarce, there is a huge body of literature on the profit status of US nursing homes, which is indirectly informative. In contrast to many other industries PE invests in, nursing home ownership can also be not-for-profit or public. Research on the impact of for-profit status therefore provides insight into the question of what it means to deal with nursing home care delivery in a commercial way: as "just another business."

Starting from the stakeholder approach, we applied a multidimensional performance perspective on the available empirical evidence. We conducted two separate systematic reviews of the literature (see Bos et al., 2013, 2017). In a broad search of empirical evidence over the last 10 years, we systematically categorized all the evidence on the impact of PE, and profit versus not-for-profit nursing homes on the basis of whether studies report on financial/organizational performance, employee well-being, and client well-being. By combining what we know about the impact of for-profit nursing home ownership (step 1) and the cross-sectoral impact of PE (step 2), we aim to draw propositions on PE's impact in health services and to show knowledge gaps that need to be addressed by PE scholars.

The reviews resulted in respectively 62 relevant studies on the impact of PE across sectors, beyond health services, and 50 studies on the impact of a profit status in US nursing homes. After in-depth review of full texts, studies were classified according to the categories "organizational performance," "employee well-being," and "client well-being." For "financial/organizational performance," the following variables emerged from our review: profit margins, efficiency, and innovation. For employee well-being, we included staffing levels/employment and other working conditions.[1] For client well-being, we analyzed studies on product or service quality. For more details on the methods in the two separate reviews, we refer to the separate reviews (Bos et al., 2013, 2017).[2] Figure 11.2 provides an overview of the two analyses.

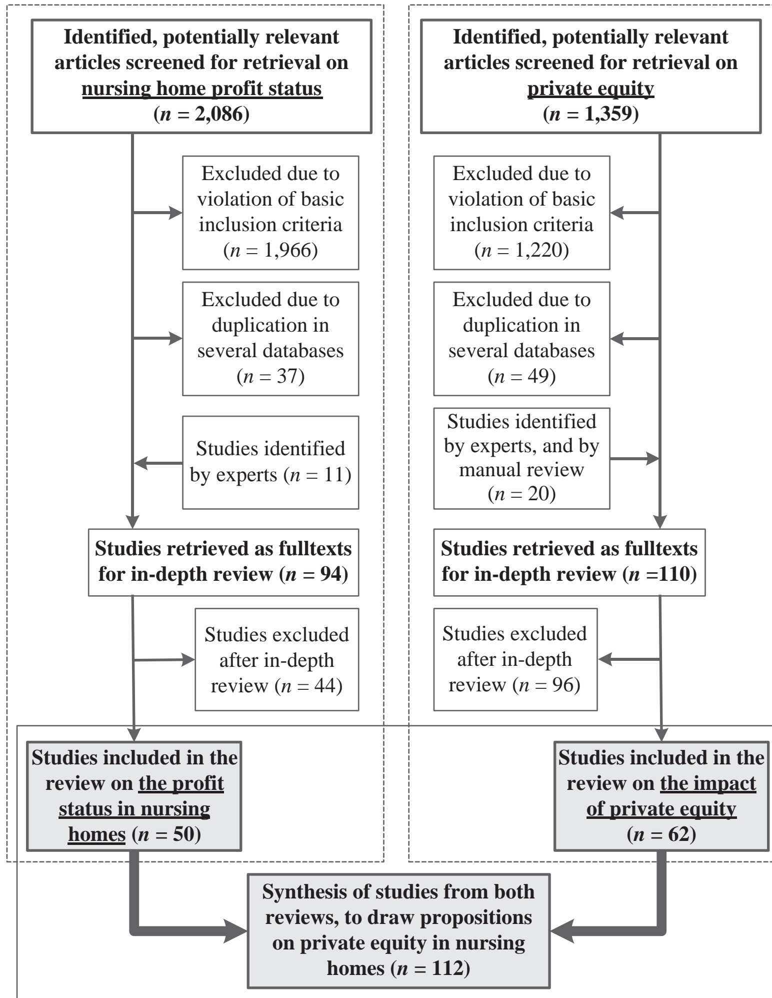

Figure 11.2 Overview of the steps taken in the systematic reviews that form the data for this chapter

Source: Authors.

Table 11.2 provides an overview of the findings from the review of the profit-status of nursing homes and the implications of PE ownership. The majority of research on the impact of PE focuses on variables of organizational/financial performance. More than one-third (profit status of nursing homes) and 4 in 10 (PE ownership) of the studies consider the implications for employee well-being. For the review of nursing homes, the majority of studies (over 6 in 10) concentrate on client well-being variables. This remarkable difference highlights the issues that PE firms are likely to be assessed against when acquiring health services. While the emphasis of PE scholars is on financial/organizational performance, health policy scholars accentuate care quality considerations. We now consider in turn the respective outcomes for organizational/financial performance, employee well-being, and client well-being.

Table 11.2 Overview of the results from the reviews[d]

	For-profit vs. not-for-profit nursing homes (n = *50*)	*PE vs. non-PE ownership across sectors* (n = *62*)
Organizational/financial performance	**12%**[a]	**74%**
Profit margins (profitability)	+[b]	+
Efficiency levels	+	+
Innovation (orientation)	0	0
Employee well-being	**36%**	**44%**
Employment/staffing levels	–	+/–
Other working conditions, including job satisfaction and benefits	–	+/–
Client well-being	**62%**	**7%**[c]
Quality	0/–	0/–

a The percentage of the studies included in the review that provide empirical data on organizational performance, employee well-being, or client well-being variables.
b – = decrease/worse, + = increase/better, 0 = no effect/difference
c Four papers, of which three are about PE in nursing homes
d The table only shows the variables that emerge in both reviews. The separate reviews contain more variables, such as bankruptcy rates, wages, industrial relations, turnover rates, hospitalization rates, and lawsuit/ complaint rates (see Bos et al., 2013, 2017).

By combining the outcomes from both reviews, we draw propositions on the impact of PE in nursing homes.

Organizational/financial performance

Based on the two reviews, we propose that PE in nursing homes will be largely beneficial for financial performance and does not seem to harm innovation. First, the review on the profit status of nursing homes shows that for-profit nursing homes tend to outperform not-for-profit nursing homes with regard to profit margins. The review on the impact of PE across sectors shows similar results: in general, PE-owned companies have higher margins than their industry counterparts which are not PE-owned. We therefore assume that PE increases the financial performance in PE-owned nursing homes. An initial study in this area (e.g., Pradhan et al., 2013) confirms this proposition, while a further study finds little impact of private investment firms on the financial health of nursing homes (Cadigan et al., 2015).

Second, efficiency is generally higher in for-profit nursing homes compared to not-for-profit nursing homes. Moreover, cross-sectoral research on PE shows that PE can generally be expected to increase efficiency. We therefore propose that PE ownership in nursing homes stimulates the efficiency of health services delivery.

Third, with regard to innovation PE investors are temporary owners with a potentially short-term time horizon that may reduce investment in new products and services. However, prior studies suggest PE ownership does not restrict innovation. Similarly, an initial study reports that the profit status of nursing home is not associated with changes in the orientation on innovation. We therefore propose that PE ownership will not hold back innovation

in nursing homes. For financial/organizational performance, we therefore formulated the following propositions:

P_1: PE increases the profitability of nursing homes.
P_2: PE increases the efficiency in nursing homes.
P_3: PE does not change innovation in nursing homes.

Employee well-being

We propose a negative impact of PE's interventions on employment, i.e., staffing levels, in nursing homes. Research on the impact of PE on employment across the sector shows mixed results. Outcomes seem to be dependent on the characteristics and context of the portfolio company at the time of the acquisition. At the same time, the review on nursing homes indicates that for-profit nursing homes are associated with lower staffing levels than not-for-profit nursing homes. Moreover, an initial study reports lower employment levels in PE-owned nursing homes compared to other for-profit nursing homes in Florida. This study also finds reduced employment post-buyout when compared to the pre-buyout period of the nursing homes (Pradhan et al., 2014).

With regard to employee well-being, research on the impact of PE on working conditions is limited and shows mixed outcomes. In comparison, two studies report worse job benefits in for-profit nursing homes when compared to not-for-profit nursing homes (Kash et al., 2007; Haley-Lock & Kruzich, 2008). We expect that the mixed findings for PE across sectors on working conditions will bend to the negative side when it comes to PE in the nursing home sector. For employee well-being, we therefore formulated the following propositions:

P_4: PE reduces staffing levels in nursing homes.
P_5: PE diminishes general working conditions in nursing homes.

Client well-being

We earlier described the labor-intensity of nursing home services and argued that many health services need some staff slack to deal with unforeseen events. Understaffing is therefore potentially damaging for client/patient well-being in nursing homes and staffing levels are closely tied to client well-being, i.e., care quality (e.g., Schnelle et al., 2004). Apart from research on PE in nursing homes in particular, research on the impact of PE on product or service quality is limited (such as the case study of Palcic & Reeves, 2013). In contrast, the vast majority of studies on the impact of for-profit nursing home ownership focuses on the implications for care quality. Care quality is measured in different ways, ranging from the level of deficiencies, the number of inappropriate medication prescriptions, the incidence of resident pain, the use of physical restraints, the prevalence of pressure ulcers, to the loss of ability on daily tasks. The impact of for-profit nursing home ownership is associated with either no or worse care quality outcomes. Studies that directly addressed the impact of PE on nursing home care quality tend to show similar findings. While two studies report no harm to quality (Stevenson & Grabowski 2008; Cadigan et al., 2015: 192), two other studies find reduced quality levels (Harrington et al., 2012; Pradhan et al., 2014). The study of Pradhan et al. (2014) also reported several quality indicators that were not

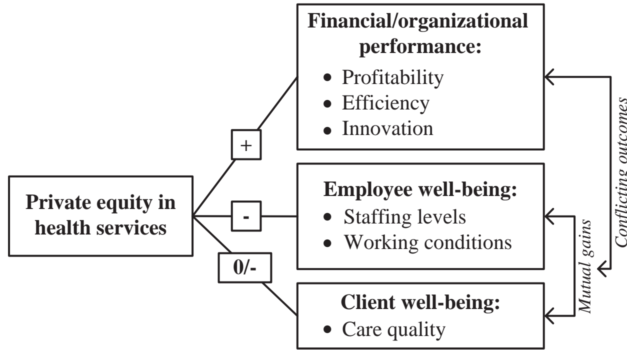

Figure 11.3 Propositions on PE in health services

Source: Authors.

influenced by PE. In line with these studies on care quality, as well as the intertwining of employee well-being and client well-being, we formulated the following proposition on client well-being:

P_6: PE has no impact or a slightly negative impact on care quality in nursing homes.

Summarizing our arguments, we predict that PE in nursing homes will be largely beneficial for financial performance and efficiency, and will not harm innovation. For employee well-being, we expect that PE ownership overall has a less positive impact. For client well-being, we predict that the impact of PE in nursing homes is either neutral or negative. By applying a multidimensional performance framework, we thus predict varied outcomes for different stakeholders. In terms of the conceptual framework, on conflicting outcomes and mutual gains, we therefore propose the following (see also Figure 11.3):

P_7: The conflicting outcomes perspective applies to the financial/organizational performance when related to employee well-being and client well-being.
P_8: The mutual gains perspective applies to employee well-being and client well-being.

Conclusions and future research opportunities

Conclusions

While we argued in our conceptual framework why health services are *not* just another business, PE investors nevertheless seem to treat health services as "just another business." Given the synthesis of the literature on both PE across sectors and for-profit nursing homes, we propose that PE owners are mainly successful from a market frame perspective. They are able to enhance financial/organizational performance in health services. Evidence also indicates that PE in health services can be associated with lower staffing levels, which is rather a signal of a labor process that is organized as efficiently as possible, than of a labor process that incorporates some staff slack with an eye on unforeseen events for which extra staff are required immediately. These outcomes go together with no or slightly negative consequences for patients/clients. The beneficial outcomes for employers/owners seems to be

associated with less fortunate outcomes for employees and clients, which fits in the conflicting outcomes perspective. We suggest that PE owners, especially in nursing homes, should focus on a more strategic balance between organizational/financial performance, employee well-being, and client well-being, because such a balanced approach can lead to long-term organizational success (see also Oliver, 1997; Deephouse, 1999).

Future research opportunities

In addition to the conclusions and drawing on two systematic reviews, we identify two priorities for future research on PE.

First, the review on nursing homes' profit status shows that health policy researchers mainly focus on the impact of ownership on measures of client well-being. In contrast, scholars that examine the impact of PE ownership mainly concentrate on organizational and financial performance. Furthermore, the few papers that focus on the impact of PE on client well-being are almost exclusively carried out by health policy scholars, and focused on care quality in nursing homes. We therefore observe a knowledge gap with regard to the impact of PE on product and service quality. Some critics argue that PE investors focus on financial engineering rather than operational improvements (e.g., Appelbaum & Batt, 2014), let alone increasing products and/or service quality for clients. More research is required on the impact of PE acquisitions on client outcomes to evaluate a broader range of economic and social implications.

Furthermore, the public value frame underscores this need for more attention to measures of client well-being in PE research. Public services, such as care for the elderly, should not only be judged by their economic returns but also by their quality, or more broadly, by their contribution to social goals such as the overall health and well-being of citizens. Because health services organizations are an important target for PE firms, this is another reason for increasingly incorporating client well-being variables in scholarly work on PE.

Second, we found that results for employee well-being – and to a lesser extent client well-being – are mixed. Literature has not been able to provide clear explanations for such diverse findings. We assume this is due to context-specific factors, such as the type of PE investor, the type of portfolio organization, and the type of sector, including government interference in that sector. To uncover the mechanisms that explain the implications of PE ownership for different stakeholders, more qualitative research is needed. Instead of *what* the impact of PE ownership is, the attention needs to shift to *how* PE owners influence portfolio organizations. In this way, explanations can be found and deepened for the diverse outcomes, preferably with "longitudinal studies that chart the development and impact of changes" (Wright et al., 2009: 510–511). The focus then changes to understanding the *mechanisms* at work in PE-owned portfolio firms, and to building new theory.

Notes

1 Includes several variables such as employee consultation, trust in implicit contracts with employees, organizational uncertainty, institutional trust, CEO turnover, skill mix in nursing homes (indicating that higher educated professionals are replaced by lower educated and lower paid health care professionals), managerial discretion, and high commitment management practices, i.e., long-term investments practices that enhance employee well-being.

2 A list of all the articles included in the reviews is available from the authors.

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