

Hospital Consolidation in Washington State

Summer 2025



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Abstract

This study examines the impact of hospital consolidations in Washington State using a qualitative research approach. Seven in-depth interviews were conducted with medical professionals who have firsthand experience with or insights into hospital mergers. Common themes emerged across these interviews, highlighting significant concerns related to the loss of patient-centered care, increased prioritization of investor profits, cultural shifts within institutions, staff reductions, unchecked expansion, and the erosion of physician and community governance. Based on the insights gathered, the study concludes with policy recommendations aimed at mitigating these impacts, including strengthening merger oversight, mandating financial and pricing transparency, reinforcing clinical autonomy, and preventing harmful vertical integration.

Chapter 1 – Introduction

One of the fundamental challenges within the U.S. healthcare system is the significant influence of profit-driven incentives. As noted in the Journal of Moral Theology, when financial gain becomes a main motivator, the focus of healthcare delivery shifts away from patient-centered outcomes. This can manifest as a prioritization of revenue generation through increased patient volume or cost-efficiency metrics, potentially at the expense of long-term health outcomes and the overall well-being of individuals.

The debate surrounding this issue often centers on the ethical consideration of healthcare as a right, rather than merely a commodity to be bought and sold. For-profit healthcare organizations, driven by the need to return value to shareholders, may exhibit both advantages and disadvantages. They often have easier access to funding and may prioritize financial sustainability, leading to efficiency and innovation. However, concerns arise regarding the potential for profit motives to take precedence over patient care, potentially leading to higher costs and pricing structures. This inherent tension between financial objectives and the ethical obligations of healthcare provision creates significant challenges within the current system.

The U.S. health care system is heavily affected by consolidation, with highly concentrated hospital, pharmacy, and physician markets. For example, three firms control two-thirds of pharmacy benefit management, and five firms dominate over half of the pharmacy market. In 9 out of 10 metro areas, hospital markets are considered highly concentrated under federal antitrust standards. Consolidation has accelerated in recent

years, including both horizontal mergers (e.g., hospital-to-hospital) and vertical integration across different health care services. (Gee & Gurwitz, 2018,1)

In Washington state, consolidation has led to approximately 40% of hospitals being affiliated with five major hospital systems, such as Providence-Swedish Health Alliance, MultiCare, Virginia Mason Franciscan Health, UW Medicine, and PeaceHealth. This shift from 10% in 1986 to 40% in 2022 reflects a broader trend of horizontal consolidation and vertical integration across healthcare providers and insurers. As of 2022, eight systems employ 65% of physicians and physician assistants in the state. This consolidation has been linked to increased healthcare costs and reduced access to care for patients, according to the Washington Insurance Commissioner's report.

The purpose of this capstone is to identify how hospital consolidations have impacted on our healthcare system in Washington State and what are the solutions to this issue. It addresses the research questions: What are the current impacts of industry consolidation on the cost, equity, and effectiveness of our healthcare delivery in WA.

The importance of this research is to identify the effects on healthcare. Finding solutions is the key motivator. Washington State is a unique state because we have a liberal view of caring about people. We believe in humanity.

Chapter 2 - Literature Review

Over the past decade, private equity (PE) acquisitions of U.S. hospitals have increased, raising concerns among lawmakers, health leaders, and the public about potential negative effects on patient care due to PE's focus on rapid financial returns. While previous research links PE hospital takeovers to reduced staffing and higher profits, evidence on quality outcomes is mixed. To address this gap, a national study used a difference-in-differences design to compare changes in patient care experience between hospitals acquired by PE firms and similar non-acquired hospitals from 2008 to 2019. The study specifically examined overall care experience and patient-reported aspects like communication, clinical processes, and hospital environment, and the key indicators for evaluating the patient-centered impact of PE ownership. “In this difference-in-differences analysis of 73 private equity–acquired hospitals and 293 matched control hospitals, global measures of patient care experience worsened after private equity acquisition of hospitals, as did patient-reported staff responsiveness. The difference in these measures of patient care experience at private equity–acquired hospitals compared with matched control hospitals increased with each subsequent year after acquisition.” (Bhatla et al, 2025).

Health care in America such as “hospitals, physician groups, insurers, retail pharmacies, technology companies, and others have sought to solidify their position or gain a competitive advantage” (Panicola, 2019,1) By reaching this goal, the traditional stakeholders in the mergers and acquisitions (M&A) have combined the industry deliberately in favor of local or regional health care. From 1998 through 2017, there were over 1,600 hospital and health system mergers.

According to Wall Steet Journal June 2024, in the past two decades, there have been over 1,000 hospital mergers nationwide out of approximately 5,000 hospitals. Despite this activity, the FTC only challenged 13 mergers, even though more than 200 qualified as potentially anti-competitive. Vertical and horizontal integrations have given hospital systems increased bargaining power, which has led to higher healthcare costs for patients and insurers who without meaningful improvements in patient care. In the Guardian article June 2024, between 2012 and 2022, the percentage of physician practices owned by hospitals rose from 29% to 41%. When a doctor's practice is acquired, prices for procedures increase by an average of 14.1%. "Facility fees"—additional charges for visits to hospital-owned outpatient clinics that are estimated to be about 50% higher than for similar services provided in independent settings.

This article Hospital Mergers and Economic Efficiency critically analyzes recent healthcare merger antitrust cases, focusing on the landmark *St. Luke's Health System* case in the Ninth Circuit. It highlights the growing trend of hospital and physician group consolidations, partly driven by the Affordable Care Act (ACA), and examines the legal and economic implications of these mergers. In the *St. Luke's* case, the merger was blocked due to antitrust concerns as it would have given the combined entity control over 80% of adult primary care in the Nampa, Idaho area. Although the merger claimed to improve efficiency and care integration, the courts prioritized concerns about reduced competition.

The article argues that the Ninth Circuit missed a key opportunity to modernize merger analysis by failing to apply a more rigorous economic framework, particularly regarding efficiencies and competitive effects. It critiques the court's shallow economic reasoning and lack of clarity in distinguishing between vertical and horizontal integration in healthcare mergers. The

authors emphasize the importance of careful antitrust scrutiny, as poorly judged mergers can result in substantial price increases (up to 40–50%) without improving care quality. They advocate for more sophisticated, economically informed judicial analysis to guide future healthcare merger cases and propose policy recommendations to align legal approaches more closely with the realities of healthcare markets. (Blair et al, 2016, 5)

Although many of these were small-scale transactions, large systems have become increasingly active, with eleven transactions involving sellers with net revenues of \$1 billion or more in 2017. This activity has become forceful and powerful. In the past decades, this issue has led to a tremendous increase in mergers and acquisitions, especially hospitals, physicians, insurers, pharmaceutical manufactures and retail pharmacies. Because of these mergers, Americans started experiencing a higher cost of health care.

According to Health Affairs New Data from the AHRQ Compendium in 2021, there is a vertical grouping of healthcare systems which means there was an increase in the variation of consolidation of hospitals from 2018 to 2021. American healthcare experienced continued consolidation, with relatively stable system counts but growing affiliation among hospitals and physicians. This period includes the COVID-19 pandemic. The turn was caused by mergers and acquisitions, and the increase in physician affiliation with health systems. In 2021, 76% of acute care hospitals and 52% of physicians were affiliated with a health system—up slightly from 2018. Of the 637 systems in 2018, only 572 were still designated as systems in 2021, and over 10% were lost, mostly due to mergers and acquisitions. There were 49 systems (75% of those lost) acquired or merged with others. This has created a huge disparity between systems from the top to bottom in size distribution which means a few big ones on the top and the new smaller ones

are on the bottom. Though the median system size remained stable, extremes in size distribution expanded. The Large systems became larger (such as Common Spirit, and Bon Secours Mercy). Small new systems also emerged and there were many with fewer than 70 physicians or 100 beds, and 71% of new systems in 2021 had less than 70 physicians.

Healthcare consolidation has reshaped the U.S. medical system, especially in Washington State, with mixed outcomes. Large faith-based nonprofit systems, such as Common Spirit Health formed in 2019 through the merger of Dignity Health and Catholic Health Initiatives have become dominant, operating hundreds of hospitals and clinics across the country. While this consolidation has sometimes led to improved access to specialty care and greater electronic medical record integration, it has also introduced major challenges.

Consolidation has caused many issues both good and bad for the healthcare system, such as faith-based non-profit health care system. Now, we have one of the largest faith-based systems called Common Spirit which is formed in 2019. There were two systems that merged: Dignity Health which is based in San Francisco and Catholic Health which is based in Colorado. These two systems combined into a new \$29 billion health system. “The new nonprofit system’s national office is in Chicago. It operates 142 hospitals and more than 700 care sites” according to the MedCityNews article 2019. In Washington State, it had St. Joseph, St. Francis, and St. Elizabeth in 2009, and they have joined Common Spirit now. This merger hasn’t brought much in the way of good benefits for the communities, but it has created profits for the new unified entity.

This level of M&A activity among hospitals and health systems may benefit a lot of constituents (financial advisors, health care executives, bondholders and investors). In

addition, there are some sponsors, such as boards, and management within the Catholic Health care system who own about 20% of the U.S. health care system and the corporations.

In M&A in Review 2022 article reports that there were 53 announced hospital merger and acquisition transactions, up slightly from 49 in 2021 but still below pre-pandemic levels. The smaller parties in these deals remained financially strong: over 15% had annual revenues above \$1 billion and more than 15% held credit ratings of A- or higher. The average revenue size of the smaller party reached a historic high of \$852 million, reflecting a 10-year CAGR near 12%. Despite fewer deals overall, the total transacted revenue topped \$45 billion, surpassing the previous record set in 2017. Only 15% of sellers were financially distressed, slightly lower than in prior years. Notably, not-for-profit hospitals and systems dominated activity, representing 91% of all transactions in 2022, up from 81% in 2020. (Singh,2023)

The consolidation of hospitals has brought increased costs to patients because of a lack of competition. According to the New York Times, the average cost of hospital beds increased up to 54% after the merger. There are 12% higher prices without competition according to Kaiser Family Foundation's reports. "Between 2010 and 2017, there were 778 hospital mergers in the U.S. By 2017, 66% of all hospitals were part of a consolidated system" KFF reports, "The consolidations have shown "monopolistic practices".

There are a few journal articles and a thorough analysis to approve that the merge has caused prices to rise. According to New York Times and the Bureau of Economics:

Data from California illustrates how hospitals have exploited this situation. From 2002 to 2016, total billed charges by hospitals rose by a staggering \$263 billion, to \$386 billion, even though the number of patients admitted did not increase. Billed charges to health plans grew from \$6,900 per day to over \$19,500 per day. This astronomical run-up in billed charges gave California hospitals leverage to demand and receive much higher prices for in-network patients, too. The average price paid by health plans to hospitals for all care grew almost 200 percent — to \$7,200 per day from \$2,500.

In effect, they [the hospitals] could threaten: Pay us \$7,200 per day to sign a contract or \$19,500 per day for emergency admissions without a contract. (Glenn Melnick, 2018)

There is also other evidence from other states showing the increase of prices after the merge from the Bureau of Economics. (Wilson & Garmon 2009, 1). This study analyzed the price effects of two hospital mergers in Chicago's north shore in the early 2000s: ENH's acquisition of Highland Park Hospital and the merger of St. Therese Medical Center with Victory Memorial Hospital. Using difference-in-differences methods and multiple data sources, including actual insurance transaction prices, the researchers found a significant price increase following the ENH/HPH merger. In contrast, the STMC/VMH merger showed no evidence of a price increase. These findings were consistent across various datasets and analytical approaches.

Economists have proposed five reasons why hospital mergers might lead to price increases across markets: common customers, tying, change in control, quality improvements, and multimarket contact (Arnold et al, 2025). Arnold et al (2025) adds to the emerging research on cross-market hospital mergers by showing that such acquisitions are associated with significant price increases, averaging 12.9% in six years after the merger, compared to control hospitals. The delay in price effects may result from existing insurer contracts or strategic pricing choices. Price increases were more pronounced when the acquiring hospital had less market share than the target, suggesting a strategic gain in market power. Both in-state and out-of-state mergers led to higher prices, with in-state effects appearing earlier. Importantly, hospitals that engaged in four or more cross-market acquisitions had 16.3% higher prices than controls, whereas systems with fewer acquisitions showed smaller, temporary price changes. Despite these price increases, the study found no improvement in quality across six measures, indicating that higher prices are not driven by better care. This is the first study of using claims data to directly link cross-market hospital acquisitions with long-term price effects while highlighting which merger patterns are most impactful.

Arnold et al (2025) finds that cross-market hospital mergers have no meaningful impact on the quality of care at acquiring hospitals. Using event study analyses, researchers examined mortality and readmission rates for heart failure, heart attacks, and pneumonia. For heart failure and pneumonia, both mortality and readmission rates showed no significant changes after the mergers, with all post-merger effects statistically indistinguishable from zero. Similarly, heart attack mortality remained unaffected. While

there was a slight increase in heart attack readmission rates after mergers, this result is ambiguous due to a pre-existing upward trend before the merger. Overall, the findings suggest that cross-market hospital mergers do not improve or worsen clinical quality outcomes.

According to Schwandt et al (2018), over the past 15 years, Catholic hospitals in the U.S. have increased by 22%, now accounting for one in six hospital beds and 10 of the top 25 health systems. In Washington State, a region traditionally supportive of abortion rights, Catholic influence is especially pronounced, with 34% of hospitals and 40% of hospital beds affiliated with Catholic institutions, exceeding the national average. This trend is expected to grow. Of 98 hospitals listed on Washington's Department of Health site, 90% had posted reproductive health policies. Among them, 30% were religiously affiliated which 96% Catholic, and 81% of Catholic hospitals were part of large conglomerates, highlighting increasing consolidation under religious healthcare systems. (Schwandt et al, 2018, 3)

Hospital consolidation has increased antitrust issues and transparency is required. For example, in this Vista Health Acquisition of Provena St. Therese Medical Center, File No. 011 0225 had shown a concern for antitrust issue for their consolidation of these two hospitals, Evanston Northwestern Healthcare and Highland Hospital in the suburbs of Chicago in 2000. However, this case was closed because there was not enough of evidence.

In early 2000, two hospital mergers took place in Chicago's northern suburbs: Evanston Northwestern Healthcare (ENH) acquired Highland Park Hospital (HPH), and Provena St. Therese merged with Victory Memorial to form Vista Health. The FTC investigated both mergers in 2002. While the Vista Health merger was closed due to limited evidence of anti-competitive effects, the ENH-HPH merger led to an FTC complaint. In 2005, an administrative law judge ruled the ENH acquisition violated antitrust laws, and a decision upheld in 2007. ENH ultimately accepted the FTC's remedy in 2008, requiring separate contracting and binding arbitration.

Another case has also shown a lawsuit on anti-competitive issues. Saint Francis Hospital filed a complaint against Hartford HealthCare and its subsidiaries, accusing them of using exclusion, acquisition, and intimidation to harm healthcare competition in the Hartford area. The complaint claims Hartford HealthCare, particularly Hartford Hospital that offers lower-quality care at prices more than 15% higher than nearby competitors, including Saint Francis, despite receiving lower federal quality ratings. Due to its dominant market position and alleged anti-competitive practices, Hartford HealthCare faces little pressure to improve cost or quality, allowing it to charge more for inferior care. No. 3:22-cv-00050 (D. Conn. Jan. 11, 2022).

In summary, healthcare consolidation can offer benefits such as better resource access and coordinated care, especially in underserved regions. However, it often comes at the cost of staff morale, ethical medical practice, service availability, and community identity. Without stronger policy protections for independent providers and ethical safeguards, continued consolidation may lead to a healthcare system more focused on

financial efficiency than on patients' well-being, especially in smaller or vulnerable communities.

Chapter 3 - Methodology

I used qualitative research methods for this project. I interviewed 7 healthcare professionals and executives and one executive from Washington State Alliance. These professionals have worked or used to work for several large healthcare systems, see the details below. These interviewees are all English speaking professionals. The age group is from mid-40s-late 60s. I interviewed them through zoom and in person. I used Audio recordings for the interviews, transferred the auto-generated transcript by email, cleaned up the transcript, and analyzed the data to find themes.

I have operated a fundraising business with hospitals in WA for over 15 years. I have met lots of medical professionals and recruited the seven interviewees in a purposive sample. The reason I chose these medical professionals to learn what kind of impact that consolidation of hospitals has had on our healthcare system. How has the merge impact of the hospital consolidation on patient-care, quality-care, cost, and equity. The other reason I chose them is because they have worked for the hospitals for at least 15 years plus. They have experienced the change through the years when they work in the healthcare system. A few of them are nurses who are intimately involved with patients on the floor. They are not only experienced at patient-care but also seeing what the impact that the leaderships have created. There are a few executive/doctor level professionals who understand deeper why and what happened to our healthcare system. There are also a couple of executive and administrative professionals who have lots of experience with a network of healthcare

system in our area. One executive professional has lots of experience on political side with a membership-based organization.

The limitation of my research data is that I selected 7 interviewees who are in variety of healthcare system which are the major players in Washington State and nationally as well, especially after the vertical consolidation occurred in the past decades. My sample size may be too small and may not represent the broader population because I chose the interviewees who work for the urban hospitals and the findings may not apply to rural areas. It may reduce the diversity of perspectives and may skew results. The focus groups may be influenced by personal beliefs, experiences, and emotions.

My interviews might have a limited scope with only 7 participants, it's difficult to capture the full range of experiences across different roles, specialties, or systems. It may be impacted the Important viewpoints, and it may be missed. The study may not capture the full range of viewpoints, particularly those from underrepresented specialties, non-physician staff, or institutions with different operational models. The findings may be heavily influenced by the local or institutional context of the participants, limiting their applicability to other healthcare systems or geographic areas. In short, because I used a non-random sample, the interviews are not generalizable to all health care providers' experiences of hospital consolidation.

Even though my data size is small, overall, they all have similar experience on the impact of healthcare system after the consolidations. Despite these limitations, I believe my qualitative methods are excellent for this research because my interviewees provided a

deep understanding of attitudes, beliefs, or processes. The limitations are clearly acknowledged and contextualized in this study.

Chapter 4 - Interview Themes

Healthcare consolidation is fundamentally reshaping the U.S. healthcare system that is undermining local culture, frontline care, staff stability, and patient access while concentrating power in large corporate entities that prioritize efficiency and expansion over community needs and clinical values. My interviews stress how consolidation dissolves long-standing hospital cultures rooted in community trust, clinical autonomy, and patient-centered values. Whether it's small-town hospitals or legacy institutions like Virginia Mason, mergers often result in the loss of identity, traditions, and frontline decision-making that replaced by corporate or faith-based priorities with limited connection to local needs.

Theme 1: Losing Patient-Centered Care

It is a big concern as the interviewees expressed below. As business interests increasingly drive medicine, the culture at previously independent hospitals has shifted toward corporate priorities like revenue and metrics. Staff at Virginia Mason reported that after merging with a larger system, their long-standing patient-first values were replaced by a generic, profit-driven approach, leading to high turnover and loss of identity. At Franciscan, funds meant to support care were diverted to expand the hospital network, resulting in chronic understaffing and poor working conditions. Patients suffered from inadequate care, outdated facilities, and occasional denial of services due to staffing shortages. Clinicians argue that consolidation has failed to improve outcomes for patients

or staff and instead has concentrated power while driving up costs and eroding the quality of care.

Swedish/Providence Medical Center executive explained that business has involved in health care:

Over the last 10 years or so, there's been more and more excursions of business into medicine. To the point now, where 70%, probably more of physicians in the United States, are now employees. And that was not the case when I was in practice. I was not an employee. In fact, I've never been an employee.

A doctor at Virginia Mason/Common Spirit states that after consolidating with a larger health system, staff from Virginia Mason observed a significant cultural shift. While clinical staff remained committed to patient care, the broader organization emphasized business priorities which focusing on income, output, and metrics rather than patient-centered values. The new culture felt generic and corporate, lacking the distinct identity Virginia Mason once had. For many original staff, the merger was a loss, even traumatic, leading to high turnover and the erosion of the organization's previous patient-focused culture.

At the end, in all of the hospital consolidations, there's the bigger person and the littler person. The bigger system and the littler system, and the littler system gets eaten up day and day out, their culture evaporates. And our culture was always one of focusing on the patient. We used to have this thing called a pyramid and it was how we approached every meeting, everything had to always start with a pyramid had the foundational portions of that were the pillars of it, and always at the top of

the pyramid was the patient, meaning the patient was driving all of the work below it, all of the people, all of the structure below it. Everything you did have to go up through that chain and say, hey, what is how this affecting the patient at the very end? Even if it wasn't direct patient care, it was like, well, here's this IT change that we want to do. Why are we doing it?

A nurse practitioner/doctor at Franciscan Health System explained how the financial changes after hospital consolidation affected patient care:

Since these are nonprofit hospitals, the revenue is supposed to be recycled back into departments and facilities to sustain what we already have. But instead, the money was often redirected toward acquiring new hospitals.

As a result, those of us working on the ground, as clinicians, providers, and staff serving the community were left operating on a skeleton crew. We were consistently short-staffed, which widened the gap between patient needs and the number of available nurses and support staff. This imbalance led to high turnover. People left because the working conditions were so difficult. We were always short-handed, treating very sick patients with limited resources and not enough CNAs.

We still operate out of old buildings that can't accommodate modern care needs. Because we can't turn patients away due to their financial situation, we end up combining surgeries with med-surg units. That means patients suffer, and they don't receive the specific care they need to heal and return to their lives...We've seen tragic outcomes, mistakes, and ongoing staffing shortages. Sometimes patients are

even turned away because there are no nurses available overnight. That's unacceptable.

Nurse practitioner/doctor at Franciscan Health System argued that healthcare is a human right and that everyone deserves equal treatment:

Healthcare is a human right. Everyone should have access to it with dignity whether they're healthy or sick. I don't see advantages in consolidation from the perspective of patients or frontline staff.

There's a tremendous concentration of power in the hands of these few healthcare systems. The positive impact would be much greater if these entities used that power to negotiate better deals for consumers, for example, cheaper medications, better access to transitional care, home health aids, and expanded services that people are paying for. But that's not happening. Instead, costs keep rising at every step.

Theme 2: Healthcare Has Turned Into Profit Earning Machines For Investors

Executives and clinicians from Swedish/Providence, Virginia Mason/CommonSpirit, and MultiCare/Overlake report that private equity and corporate consolidation have shifted priorities from patient care to financial return. As medicine becomes more attractive to venture capital, over 70% of physicians are now employees with limited autonomy. Hospitals prioritize high-revenue elective surgeries over routine or essential care like

treating pneumonia, which generates less income. Departments that don't turn a profit are downsized or eliminated, even vital services like labor and delivery, leaving growing communities underserved. Private equity firms often cut or sell off unprofitable units, regardless of their importance to public health, particularly harming low-income areas. The overarching concern is that healthcare is now driven by business strategies and investor gains, rather than the well-being of patients.

The Executive at Swedish/Providence explained that medicine has become a money making for investors:

Medicine has become an area where venture capitalists like to put their money, because they can get a return on investment. Now, over time, over the last 10 years or so, there's been more and more excursions of business into medicine. To the point now, where 70%, probably more of physicians in the United States, are now employees." And what does that mean? They don't have that kind of freedom to practice their medicine.

The doctor described the effects of this profit orientation on hospital services:

Hospitals, for the most part, make their money on surgery. On the procedures. They don't make money on it. Somebody's comes in with pneumonia. They are not going to make money on that patient. A patient comes in, they take up a bed, they are dripping soft water and giving them antibiotics. And, meanwhile, they are paying three shifts of nurses every day to take care of the patients, who really is just kind of sitting in bed. They don't make money from them on that. They make money on

procedures, especially elective procedures. When people come in and their back has been given a bad time for all these year, and now they need a big orthopedic procedure of where they need maybe cages and wires and screws and in their back with all of which cost a lot of money, and the insurance companies are willing to pay a lot of money for them. So that is when they make their money. Not just on surgery, but on elective surgery, for he most part that they can schedule at the appropriate time. You in act of surgery, that means, the procedure not complicated. No, it means it is not an emergency. It is not an emergency.

A doctor at Virginia Mason/Common Spirit argued that after their merge with Common Spirit, it has changed into business focused rather than patient care:

Usually, the primary goal of private equity firms is to generate profit for their investors. What they do is analyze all the ins and outs of a healthcare system. If a department isn't turning into a profit, they cut it. For departments that are net positive, they try to boost volume and revenue, but sometimes through questionable practices. If you research "private equity in healthcare," you'll see that while these firms often make more money, they can also weaken or dismantle hospital systems. They sell off parts of the organization that don't align with their profit goals, even if those parts are essential to community health. Unfortunately, this kind of behavior often affects underserved communities. Hospitals in those areas may end up closing altogether. In some cases, they're turned into critical access hospitals, which come with more government protections and tax breaks, another way for the firms to maximize profits.

At the end of the day, these are business people. That's their job. But the question is: Do we really want business people running our healthcare systems? Their focus is on profit, not on caring for people. And that's fundamentally misaligned with the mission of healthcare.

A nurse practitioner at MultiCare/Overlake Hospital shared a similar story, noting that healthcare has increasingly become a corporately operated system. In such systems, the focus is often on profit rather than the quality of patient care, which has led to the closure of certain units:

After the acquisition by MultiCare, it became much more corporate. Merging with the large system has also caused the closure of some units because they couldn't earn profits. They did have to close the maternity unit there, which was a big loss, especially in a community with so many growing families. Maple Valley, Covington, Kent, those are all rapidly expanding areas. Losing labor and delivery services left a significant gap, but I understand it was a cost-saving decision.

Theme 3: Culture Changing And Losing Staff

Consolidation has brought culture change and loss within the system. It leads to a clash of workplace culture whether in values, practices, or communication styles. Mergers often create friction between different work cultures, leading to disengaged staff, lower morale, and diminished care quality. Examples include the mergers involving Stevens Hospital, Swedish Medical Center, and Evergreen Health, where staff felt unsupported and disconnected after joining larger systems. Administrators may focus on cost efficiencies,

such as bulk purchasing while neglecting essential human factors such as workplace identity and communication norms.

An executive at Evergreen Health explained that the merger of the Steven's Hospital in Redmond and Swedish Medical Center in Seattle changed culture and because the staff was unhappy, unsupported and disconnected, and they couldn't perform well. It impacts patient care. The staff are the "backbone" of the healthcare system. During the process of the consolidation, the administrators monitor on cost savings, supply chain efficiencies, purchasing power, such as bulk ordering like at Costco, etc. They neglect intangible but crucial elements like morale, communication norms, and workplace identity. Efficiency isn't everything. There's acknowledgment that larger systems can operate more efficiently, such as larger purchasing power. However, the impact on staff, especially from culture clashes, is ignored when trying to make things more efficient.

Staff across merged systems face growing workloads, leadership churn, changing benefits, and cultural confusion. This contributes to demoralization, burnout, and high turnover among nurses, physicians, and frontline staff. The interviews highlight how lack of continuity and respect for hospital culture alienates clinicians and erodes team cohesion, and threatening care quality and safety.

A doctor at Virginia Mason/Common Spirit explained what happened when their hospital merged with a larger health system:

Much of the leadership, especially middle management and above was either removed, replaced, or let go. With them, our culture essentially disappeared.

The doctor saw this happening in other places as well:

The Polyclinic that used to be downtown Seattle, and the Everett Clinic, were both purchased by Optum. After that, they went through a lot of consolidation and internal restructuring. Many of their doctors left because they didn't want to work for a company primarily focused on the business side of healthcare.

A nurse practitioner at St. Franciscan explained the effects of consolidation on hospital personnel that staff got burned out, with limited resources, many have left, and laid off. The result was not only exhaustion for staff but compromised care for patients:

Those of us working on the ground, as clinicians, providers, and staff serving the community were left operating on a skeleton crew. We were consistently short-staffed, which widened the gap between patient needs and the number of available nurses and support staff. This imbalance led to high turnover. People left because the working conditions were so difficult. We were always short-handed, treating very sick patients with limited resources and not enough CNAs.

Theme 4: Increased Access For Patients

Interviewees also described some positive outcomes from consolidating our healthcare system. A major advantage is improved access to specialists within the same system that referrals to providers like rheumatologists or endocrinologists are processed much faster. A smaller group of doctors who are independent or the rural hospitals cannot afford to buy large X-ray, CT, MRI, etc. equipment. The benefit of the consolidation is that after joining the smaller system with the larger system, the smaller hospital patients can go

to the large hospital system Another benefit is the consolidated charting system, which allows for quicker, more efficient access to patient records, particularly valuable in urgent care or emergency settings. It is more convenient for patients.

The Swedish/Providence Medical Center executive says:

So that's why this consolidation, so that they could control the full-service line, everything that they're offering the patient. That's a good reason for it.

The nurse practitioner from Franciscan Health made this point clearly explains that a major benefit of hospital consolidation is improved local access to emergency and hospital care, allowing faster response times and the establishment of standalone emergency departments in previously underserved communities.:

One of the most significant benefits is increased accessibility. Patients now have access to hospitals and emergency care within their immediate communities. For example, I'll speak from my own experience if you live in a place like Lakewood, you have access to St. Clare Hospital nearby. You don't have to travel to another city or town to receive care.

If someone calls 911, the response time is faster, and the transport to care is quicker because facilities are embedded within the community. That proximity can be lifesaving. The fact that care is localized makes a real difference in urgent situations.

Also, because of consolidation, we're seeing the development of standalone emergency departments (EDs) in areas that previously didn't have any hospitals.

These EDs may not be full hospitals, but they provide critical, immediate care in communities that were once medically underserved. That's possible because of the pulled resources and financial capacity that come with consolidation.

A doctor at Virginia Mason/Common Spirit agreed that while hospital consolidation has drawbacks, it has improved access to specialists and streamlined medical records, allowing for faster referrals and more efficient patient care:

Personally, I think there are more negatives overall, but there are some definite positives. One of the biggest benefits is access to specialists. Referrals to MultiCare specialists like rheumatologists or endocrinologists are much smoother now. For example, if I refer a patient within MultiCare, it's often processed within a day or two. But if I'm referring to the system, it could take weeks or even months.

Another positive is the consolidated charting system. As a provider, it's essential to have immediate access to a patient's medications and medical history, especially if I'm working in urgent care or the ER. Consolidation makes this easier and more efficient.

The Executive at Swedish/Providence says that one key reason for consolidation is to create a seamless, full-service healthcare system that can provide comprehensive care which is from basic exams to advanced treatments, and it is under one network, improving coordination and access for patients:

One of the reasons for consolidation is that if you have a larger system with more revenue, you're able to afford to offer services that people can't become part of a

larger hospital system so they can send the patients to Seattle to get those kinds of things. They're not piecing it together. They're part of a seamless system where they can get everything that the patient needs. from a physical exam to chemotherapy and surgery, all within the same system. So that's why this consolidation, so that they can control the full-service line, everything that they're offering the patient. That's a good reason for it.

Theme 5: Expansion Without Reinforcement

A key critique is that systems expand too rapidly which is acquiring new facilities or launching projects while neglecting to stabilize or invest in existing hospitals. Essential services get stretched thin, operating rooms become outdated, and patient care suffers, particularly in underserved or rural regions. Expansion, interviewees argue, is often driven by market strategy, not health equity.

The Nurse Practitioner/Doctor at Franciscan Health Shared her 15+ years of experience working for Common Spirit/Franciscan Health, witnessing the consolidation of hospitals firsthand that although marketed as an effort to expand access, the consolidation redirected critical resources away from existing hospitals, leading to staff shortages, outdated facilities, burnout, and compromised patient care, ultimately prioritizing growth over the quality and sustainability of services:

While the organization framed the expansion to improve community access and reach, the reality was different internally. Resources were diverted from existing hospitals to fund acquisitions, leading to under-resourced facilities, staff shortages,

and burnout. As a nonprofit, the organization was expected to reinvest in care services, but instead prioritized growth, resulting in a decline in quality of care and high staff turnover.

I saw the process firsthand over 15 years. The justification used was that we were expanding to serve more communities, increase our reach, and be present in more areas. Originally, we were just St. James, St. Francis, and St. Elizabeth.

While that mission sounds positive on the surface, what I experienced on the inside was that resources were pulled away from existing hospitals. Being a nonprofit organization, we should have reinvested our funds into our departments and services. However, instead of sustaining and improving our existing facilities, funds were often diverted to buy more hospitals.

That left those of us providing care, clinicians, nurses, and support staff, working with minimal resources. We were frequently short-staffed. The patient-to-staff ratio became overwhelming. This created burnout and high turnover. Many colleagues left because we were constantly dealing with critical shortages with limited staff, insufficient equipment, not enough CNAs. We simply didn't have what we needed to provide quality care." She also argues that while expansion made the organization appear larger and more influential, it came at a cost. In practice, support for healthcare staff and patients declined. Space and resource limitations became so severe that procedures like stress tests were performed in the emergency department that highlighted how the expansion overextended the system and

compromised care quality. Quality depends on the people who make rules and design the system. We must ensure care is provided regardless of income, race, or language ability. Laws like EMTALA require stabilization of all patients.

Expanding is fine when current needs are fully met. But when we're still lacking essential services, like surgical facilities, maternity care, or cardiology, that we shouldn't be diverting funds elsewhere.

In our case, the buildings were outdated and unable to accommodate expanding care needs. Yet, capital projects were placed on hold for years in favor of acquiring new properties. Patients who needed specific care, C-sections, surgeries, cardiology that often had to be treated in makeshift spaces or shared units. That's not only inefficient, it puts patients at risk. We were forced to consolidate units. For example, surgical patients were placed in med-surg units. Patients suffered as a result, and staff struggled to provide the level of care we all aspired to. Even now, some hospitals have had to turn patients away overnight due to lack of nursing coverage. That's a serious issue. We're not just providing primary care which we're emergency facilities. We're the frontline for major medical issues.

Theme 6: Loss Of Physician and Community Governance

The shift toward large, centralized systems also brings a loss of independence and community connection. Many hospitals once founded and run by local physicians are now controlled by administrators with limited clinical experience, creating tension between profit-driven decisions and patient-centered care. Faith-based institutions, such as

Providence, have gained influence, sometimes imposing restrictions on reproductive services.

Interviewees expressed a clear concern about the shift from physician-led models to top-down corporate structures. Interviewees describe how governance models changed dramatically after mergers—moving from community-elected boards to opaque executive decision-making. This shift sidelines clinicians’ voices in shaping care and policy

The Executive at Swedish/Providence recalls that over the past 40 years, physicians shifted from independent practitioners with hospital privileges to employees within integrated medical groups, where clinical autonomy has diminished under growing administrative oversight and consolidation into large health systems like Providence and Swedish:

In the past 40 years ago, doctors were independent, and they were separated from hospitals. Doctors were not employed by the hospital. They had privileges to practice there but operated independently. This allowed them to make clinical decisions based on patient needs without pressure from hospital administrators. In the 80s, “Managed Care” sounded like it worked well because it allowed “the hospitals and physicians worked close to keep the cost under control.” However, when physicians started forming groups to take advantage of managed care contracts. That's the first group that Providence was involved in was called Medallia. Now that has evolved into the Swedish Medical crew. So, the medical system, Providence, and now Swedish, it's all together not part of the same system. They

have medical groups. It's Providence Medical Group, and there's a Swedish medical group. They're not really independent entities, but still, the medical group is supposed to be responsible for the quality of care that physicians deliver, and they're supposed to be responsible, that the physicians actually are well trained and competent to do what they're doing. So that's how it works.

Chapter 5 - Conclusion and Recommendations

Hospital consolidation has undeniably shifted the U.S. healthcare landscape toward a model dominated by a few powerful entities, often at the expense of patient-centered care, provider autonomy, and community-based services. While proponents argue that mergers bring financial stability, operational efficiency, and streamlined services, the real-world outcomes paint a more concerning picture: loss of local control, diminished workplace culture, restricted services that particularly around women's health, and inflated healthcare costs.

Our health care system has become fewer and bigger players in society, and soon it will be left with giant monopolies. It will leave fewer alternatives for patients, less negotiation power for insurance companies, providers and even governments. These massive entities will control the majority of the access, limit choice, and reduce competition. In this kind of market, if the smaller player doesn't want to play, it will get pushed out. It will also create a difficult barrier for smaller innovative healthcare providers. It suppresses competition, innovation, and community-driven models. Having this large monopolistic health care system will drive prices high and reduce quality services. Visiting an ER is overpriced. Patients have no alternatives. Hospitals prioritize revenue over patient care and need. On the other hand, nonprofit systems are supposed to invest and return their financial profit back to their system, and the consolidation seems like it will improve care. However, while the new unified entity holds more power, it still fails to reinvent its core public service and suppresses competition.

Our interviews revealed that hospital consolidations often result in smaller systems being absorbed by larger ones, causing the loss of patient-centered cultures.

Their other concern is about large Catholic health systems dominating the landscape, particularly regarding women's reproductive rights. Smaller hospitals are vital to communities, especially rural ones, where traveling for care isn't always feasible. These hospitals depend heavily on community support and provide localized, accessible care.

The deeply rooted organizational cultures that once prioritized ethical, patient-first care have been diluted or eliminated, replaced by profit-driven motives and cost-cutting measures. Staff morale, retention, and effectiveness have suffered, directly impacting the quality of care.

Vertical integration, as seen in entities like Optum, further blurs the line between insurer and provider, introducing financial incentives that often contradict patient needs. Even well-intentioned nonprofit systems now face criticism for failing to reinvest adequately in care improvements, while leveraging their nonprofit status for business gain. Legal frameworks designed to protect clinical independence, like California's corporate practice of medicine laws, have proven inadequate in preventing business influence from shaping care delivery.

Ultimately, while consolidation may solve certain financial and logistical challenges, it risks eroding the foundational values of healthcare. Without deliberate, policy-driven protections for small hospitals, frontline workers, and ethical medical practices, the trend toward massive health systems may continue to prioritize profits over

patients that leaving communities underserved and providers disillusioned in a corporatized medical landscape.

Consolidations are not the solution to save our health care trouble that we are facing in our current state. Listening to these health care professionals has helped me understand the complexity of the system. Making a profit is the major motivation for the consolidation of the hospitals. Venture capital and monopolization have helped shift healthcare from a community-centered, service-oriented model into a profit-driven, market-dominated industry. Venture capital and monopolization have pushed healthcare into a state where business interests often outweigh public health priorities. This model erodes trust, increases costs, limits access, and creates an environment where the most vulnerable suffer most.

Policy Recommendations

1. Strengthen Merger Oversight

Give federal (e.g., FTC) and state regulators more authority and tools to block or closely monitor hospital and insurance company mergers. Many hospital consolidations reduce competition, drive up costs, and limit patient choice. By requiring hospitals to prove that a merger won't harm affordability, access, or equity before it's approved, we can prevent monopolies from forming. Revise merger guidelines that specifically address hospital and physician group mergers and include clear criteria for evaluating efficiencies, quality improvements, and cost reductions, alongside potential anti-competitive effects.

2. Mandate Financial and Price Transparency

Make nonprofit hospitals share their actual costs, revenues, pricing practices, and how they invest in the community. Many nonprofit hospitals benefit from tax breaks but don't reinvest enough into public service. Patients can see what they're being charged for and hold hospitals accountable for using funds to improve care rather than maximizing revenue.

Require merger parties to publicly disclose anticipated efficiencies and follow up with post-merger evaluations to assess whether promised benefits (cost, access, quality) were achieved.

3. Reinforce Clinical Autonomy

Pass state-level legislation that explicitly protects doctors, nurses, NPs, and PAs from administrative or financial pressure in medical decision-making. Similar to "corporate practice of medicine" restrictions, these laws can prohibit non-clinical executives from directing care decisions. Require boards of hospitals to include physician representation and limit CEO veto power over clinical protocols.

Strengthening whistleblower protections and requiring transparency in clinician compensation structures can deter unethical practices, while shifting reimbursements toward value-based care reduces incentives for unnecessary procedures. Additionally, mandating community health impact assessments before hospital mergers ensure consolidation does not erode care quality.

4. Prevent Vertical Integration

Prevent insurers (like UnitedHealth's Optum) from buying up hospitals and clinics.

When insurers own the providers, they control both access and payment which leads to conflicts of interest. Keep financial decisions separate from medical decisions and prevent monopolistic control of care delivery.

Summary

Hospital consolidation has been left unchecked which poses a serious threat to the equity, affordability, and integrity of healthcare in the United States. While scale can bring efficiency, it must be balanced by accountability, clinical ethics, and patient-centered values. Policy interventions must focus on regulating monopolistic behavior, protecting local and rural care, and promoting alternative care models that center health over profit.

Acknowledgments

To Dr. Nitta: My deepest gratitude to my professor and advisor, Dr. Keith Nitta for his invaluable guidance, support, and encouragement throughout this research project and at the beginning this program. His ethics, knowledge, expertise, patience, and well-balanced teaching method were instrumental in shaping the direction and quality of my work. I am sincerely thankful for the time and dedication he invested in helping me succeed.

To Dr. Walsh: My deepest gratitude to Dr. Camille Walsh, whose expertise in law, economics, and public policy has been invaluable to my academic growth. Her thoughtfully designed course and the many exceptional books she assigned challenged and inspired me to think critically about the intersection of healthcare and policy. Dr. Walsh's dedication to teaching and her support throughout this research process have made a lasting impact, and I am truly grateful for her guidance.

To Dr. Jung: Thank you to Dr. Jin-Kyu Jung for his support and encouragement during my academic journey. His kind willingness to write a recommendation letter played a key role in helping me gain admission to this master's program. I am truly grateful for his belief in my potential and for helping open the door to this opportunity.

To Dr. Collins: Thank you to Dr. Charlie Collins for teaching us statistics and providing the analytical tools necessary to understand and interpret data effectively. His clear instruction and support played a crucial role in strengthening my research skills.

To Dr. Ferrare: Thank you to Dr. Joseph J. Ferrare for his guidance in research design. His course was instrumental in helping me understand how to structure and develop a strong research paper, and his clear teaching provided a solid foundation for this project.

To Dr. Raissa: My heartfelt thanks to Dr. Raissa DeSmet, whose early encouragement and support were instrumental in my decision to pursue this master's program. Her teaching, particularly in history, has been both inspiring and thought-provoking. As a forward-thinking professor, she consistently challenged us to see the broader context and deeper implications of our studies, and I am grateful for her guidance at the start of this journey.

To Nhi: Thank you to my academic advisor, Nhi Tran, for her thoughtful guidance throughout my studies. Her advice on course selection helped me build a well-rounded and meaningful academic experience. I deeply appreciate her support and commitment to my success in the program.

To Crystal: I would also like to extend my gratitude to Crystal Galvan, our master's program advisor, whose guidance and support helped us successfully navigate the program. Her steady presence and helpful advice made a meaningful difference throughout this journey.

To Chelsea: I am also grateful to Chelsea Nesvig, our librarian, who provided tremendous assistance in locating and accessing research articles essential for this project.

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Appendix

Data:

Table 2. Changes in Patient Care Experience Measures After Private Equity Acquisition of US Hospitals (After vs Before Acquisitions Periods)

Table 2. Changes in Patient Care Experience Measures After Private Equity Acquisition of US Hospitals (After vs Before Acquisitions Periods) ^a								
	Measure description, patient response	Private equity-acquired hospitals, % (n = 73)			Matched control hospitals, % (n = 293) ^b			Difference-in-differences, percentage points (95% CI) ^c
		Before acquisition	After acquisition	Change	Before acquisition	After acquisition	Change	
Global measures (primary outcomes)^d								
Overall rating of hospital	9 or 10 on a scale of 0-10	65.0	65.2	0.2	66.2	69.2	3.0	-2.38 (-3.88 to -0.89)
Willingness to recommend hospital	Would "definitely recommend"	66.9	65.5	-1.4	68.2	69.3	1.1	-2.14 (-3.59 to -0.68)
Secondary outcomes								
Clinical process measures								
Responsiveness of hospital staff	"Always" received help as soon as they wanted it	62.1	63.5	1.4	63.2	65.4	2.2	-1.31 (-2.43 to -0.18)
Discharge information	"Yes" they were given information about what to do during their recovery at home	80.7	83.6	2.9	82.3	85.1	2.8	0.06 (-0.88 to 1.00)
Communication measures								
Doctor	"Always" communicated well	79.3	78.7	-0.6	80.1	80.3	0.2	-0.54 (-1.70 to 0.62)
Nurse	"Always" communicated well	74.6	75.6	1.0	75.4	77.7	2.3	-0.83 (-2.00 to 0.34)
Medication communication	Staff "always" explained medications before giving it to them	59.3	61.3	2.0	60.3	63.0	2.7	-0.64 (-1.88 to 0.59)
Hospital environment measures								
Cleanliness	Room and bathroom were "always" clean	69.5	70.8	1.3	69.7	71.4	1.7	-0.81 (-2.49 to 0.88)
Quietness	Area around their room was "always" quiet at night	58.3	60.4	2.1	59.2	60.6	1.4	-0.42 (-1.70 to 0.86)

^a The Centers for Medicare & Medicaid Services (CMS) defines a "top-box response" as the most positive category response to Hospital Consumer Assessment of Healthcare Providers and Systems survey items. The exception to this is for the overall hospital rating measure, for which CMS designates a rating of 9 or 10 out of 10 as a top-box response.

^b Private equity-acquired hospitals were matched to control hospitals based on year, ownership, geographic region, bed size, teaching hospital status, metropolitan vs nonmetropolitan location, and safety-net status.

^c The difference-in-differences estimate represents the mean (percentage point) differential change between private equity-acquired and matched control hospitals during the postacquisition period compared with the preacquisition period.

^d Primary outcomes for the analysis: overall rating of hospital, willingness to recommend hospital.

(Bhatla, Bartlett, Liu, Zheng, & Wadhera, 2025), <https://doi.org/10.1001/jama.2024.23450>

Top 10 nonprofit health systems in the U.S.

Ran k	Health system	HQ city	HQ stat e	Numb er of beds	Number of discharg es	Net patient revenue	Hospital ownership	Explor e datase t
1	Department of Veterans Affairs	Washingt on	DC	25,260	N/A	N/A	Government al - Federal	Explor e
2	CommonSpi rit Health	Chicago	IL	19,009	855,070	\$29,489,596,0 79	Voluntary Nonprofit - Church	Explor e
3	Kaiser Permanente	Oakland	CA	13,098	602,773	\$29,084,677,6 29	Voluntary Nonprofit - Other	Explor e
4	Ascension Health	Saint Louis	MO	11,975	489,319	\$16,957,357,4 09	Voluntary Nonprofit - Church	Explor e

Rank	Health system	HQ city	HQ state	Number of beds	Number of discharges	Net patient revenue	Hospital ownership	Explore dataset
5	Advocate Health	Charlotte	NC	11,854	530,402	\$22,534,193,686	Voluntary Nonprofit - Other	Explore
6	Trinity Health	Livonia	MI	10,903	534,925	\$18,620,462,127	Voluntary Nonprofit - Church	Explore
7	Providence St Joseph Health	Renton	WA	10,282	439,182	\$19,049,927,394	Voluntary Nonprofit - Church	Explore
8	AdventHealth	Altamonte Springs	FL	9,564	466,828	\$15,867,773,374	Voluntary Nonprofit - Church	Explore
9	Dignity Health	San Francisco	CA	7,681	402,314	\$15,986,477,693	Voluntary Nonprofit - Church	Explore

Rank	Health system	HQ city	HQ state	Number of beds	Number of discharges	Net patient revenue	Hospital ownership	Explore dataset
10	University of Pittsburgh Medical Center	Pittsburgh	PA	7,171	252,425	\$11,512,271,034	Voluntary Nonprofit - Other	Explore

Fig. 1. Data is from the Definitive Healthcare [HospitalView](#) product, according to the most recent 12-month interval tracked in our database. Accessed May 2025.

Top 10 largest health systems by number of hospitals

Rank	Health system	City	State	Definitive ID	# of hospitals
1	HCA Healthcare (FKA Hospital Corporation of America)	Nashville	TN	4710	222
2	Universal Health Services	King Of Prussia	PA	7055	187
3	Encompass Health Corporation (FKA HealthSouth)	Birmingham	AL	7277	172

4	Department of Veterans Affairs (AKA Veterans Health Administration)	Washington	DC	7265	161
5	CommonSpirit Health	Chicago	IL	981465	156
6	Select Medical Corporation	Mechanicsburg PA		7013	119
7	Ascension Health	Saint Louis	MO	4695	100
8	LifePoint Health (FKA LifePoint Hospitals)	Brentwood	TN	7004	95
9	ScionHealth	Louisville	KY	1043246	92
10	Trinity Health (FKA CHE Trinity Health) Livonia		MI	4712	90

Fig. 1 Data is from the Definitive Healthcare's [HospitalView](#) product. Health system data is sourced from proprietary research and updated on a continuous basis. Data is accurate as of February 2025.

Top 10 largest health systems by net patient revenue

Rank	Health system	City	State	Definitive ID	Net patient revenue
1	HCA Healthcare (FKA Hospital Corporation of America)	Nashville	TN	4710	\$ 55,715,901,452
2	CommonSpirit Health	Chicago	IL	981465	\$29,482,623,643

3	Kaiser Permanente	Oakland	CA	4713	\$28,719,693,565
4	Advocate Health	Charlotte	NC	1057655	\$22,488,598,233
5	University of California Health (AKA UC Health-CA)	Oakland	CA	560423	\$21,278,349,013
6	Providence St Joseph Health (AKA Providence)	Renton	WA	4716	\$19,049,927,394
7	Trinity Health (FKA CHE Trinity Health)	Livonia	MI	4712	\$18,451,706,903
8	Ascension Health	Saint Louis	MO	4695	\$16,505,003,192
9	Dignity Health	San Francisco	CA	4698	\$15,986,477,693
10	AdventHealth (FKA Adventist Health System)	Altamonte Springs	FL	4694	\$15,729,621,918

Fig. 2 Data is from the Definitive Healthcare [HospitalView](#) product and aggregated from the most recent 12-month interval tracked in our database. Data is sourced from the [Medicare Cost Report](#). Accessed February 2025.

Top 10 largest health systems by bed count

Rank	Health system	City	State	Definitive ID	# of staffed beds
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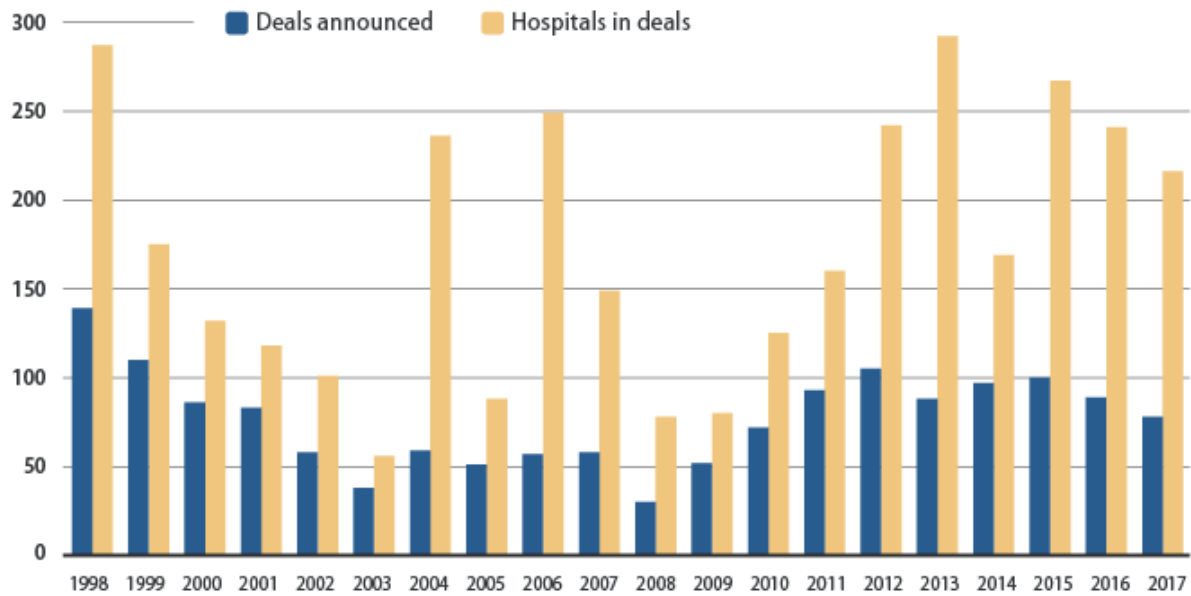
1	HCA Healthcare (FKA Hospital Corporation of America)	Nashville	TN	4710	41,194
2	Department of Veterans Affairs (AKA Veterans Health Administration)	Washington	DC	7265	25,260
3	Universal Health Services	King Of Prussia	PA	7055	21,394
4	CommonSpirit Health	Chicago	IL	981465	19,009
5	Kaiser Permanente	Oakland	CA	4713	13,098
6	Ascension Health	Saint Louis	MO	4695	12,037
7	Advocate Health	Charlotte	NC	1057655	11,854
8	Tenet Healthcare	Dallas	TX	4685	11,600
9	Trinity Health (FKA CHE Trinity Health)	Livonia	MI	4712	10,926
10	Providence St Joseph Health (AKA Providence)	Renton	WA	4716	10,282

Fig. 3 Data is from the Definitive Healthcare's [HospitalView](#) product. Health system data is sourced from proprietary research and updated on a continuous basis. Data is accurate as of January 2024.

FIGURE 3

Hospital consolidation shows no signs of slowing

Number of announced hospital mergers and acquisitions, 1998–2017



Source: American Hospital Association, "Trendwatch Chartbook 2016" (2016), available at <https://www.aha.org/system/files/2018-01/2016-chart-book.pdf>; idem; American Hospital Association, "Trendwatch Chartbook 2018" (2018), Chart 2.9: Announced Hospital Mergers and Acquisitions, 2005–2017, available at <https://www.aha.org/system/files/2018-05/2018-chartbook-chart-2-9.pdf>



Gee, E., & Gurwitz, E. (2018, December 5)