Discussion of “Merchants of death: The effect of credit supply shocks on hospital outcomes”

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Stress tests had credit tightening impact

- What is the backdrop?
- Banks were under-capitalized before/during-GFC relative to their risks
- Gains from intermediation and real economy were “privatized” but costs were “socialized” when banks failed
- Stress tests have been part of the post-GFC attempt to address this “regulatory failure” (in addressing a market failure!)
- A benign view of stress tests thus would be that they made real economy’s cost of capital in line with its cost NET OF EXTERNALITIES BANKING INTERMEDIATION CREATES (e.g., systemic risk, bailout costs)

This paper…

- Credit tightening “tightened up” borrower’s financial efficiency
- However, financial efficiency led to operational inefficiency
- Sector at hand: Healthcare, in particular, hospitals
- Their borrowing costs sharply increased if matched to a stress-tested bank, and they improved revenues in response

  BUT…
- This was accompanied by substantial deterioration in the provision of healthcare services
- We should care about this as healthcare quality matters

Under the benign view of stress tests…

- There is nothing necessarily “wrong” about the tightened credit standards facing hospitals post the stress tests
- The post-stress-test cost of credit may in fact be the right one taking account of the net cost to the taxpayer of intermediating that credit
- So what is the issue?
- There are potentially two:

1. Private financing of public good provision should factor in not just the social costs of such financing but also the social benefits
2. Why are hospitals so leveraged that their default risk is so high?

- Healthcare comes second after housing(!) in defaults on municipal bonds issued by “competitive”(!) enterprises; 20% of all defaults (housing: 40%)

Under the malignant view of stress tests…

- As the quality of service provision declines when the cost of bank credit rises…

  Is the socially efficient cost of lending to healthcare then zero?
- This clearly can't be a social optimum.
- Imagine a world in which healthcare is entirely socially financed.
- Healthcare would then compete with other public projects.
- Provision of fiscal expenditures would neither be unbounded nor free of any cost of capital considerations.
- It really begs the question: <u>Why are hospitals so credit risky?</u>

Leverage and operational inefficiency – I

- Leverage -> Corporates need to avoid default risk
- Default risk in the short run can arise from liquidity risk
- Leverage -> Financial efficiency -> More Near-term Cashflow
- Operational efficiency -> Upfront investments in quality of products (spare capacity, inventory, supply chain diversification, excess staff…)
- Operational efficiency -> Less Near-term Cash flow
- "**Efficiency or resiliency? Corporate choice between financial and operational hedging**" (with Heitor Almeida, Yakov Amihud and Ping Liu)
  - Tradeoff should be at work for financially constrained firms w/ short-term leverage

- Is Financial Leverage the Merchant of Death in Healthcare?
  - Is such a tradeoff at work? Sort hospitals by financial constraints / short-term debt?

Leverage and operational inefficiency - II

- Private equity deals -> Leveraged buyouts
- Leverage -> High-powered stakes for private equity managers/CEOs
- Leverage -> (Ruthless) financial efficiency, exploiting govt subsidies
- Leverage -> Operational inefficiency
- Growing evidence in academic research, e.g., by my NYU-Stern colleagues Arpit Gupta and Sabrina Howell
- Private equity in nursing homes; private equity in media; private equity in higher education, …

- Is PE-linked Financial Leverage the Merchant of Death in Healthcare too?
  - Did the affected hospitals get more private equity as a bank finance substitute?

Reconciling the two views…

- Stress tests created a “transition risk” for highly leveraged or credit risky borrowers
- At high leverage, if cost of rollover rises suddenly, then owners are reluctant to recapitalize swiftly (key lesson from the GFC!)
- If we want hospitals to provide high quality healthcare for social reasons, is there a case to regulate their financial leverage?
- Should they be required to maintain capital buffers so that when transition risk of leverage rises, they remain well-capitalized and operate efficiently?

- How did the affected hospitals alter their leverage? Did they? Swiftly?

Additional suggestions

1. Repeated credit market shocks since the global financial crisis:

- Bank failures, Municipal bond shock, SCAP (2009), …

- Requires longer parallel trend analysis, ideally pre-GFC onwards

Additional suggestions

2. Provide another sector as a strawman:

- Are effects specific to the hospital sector or more widespread?

- Did operational efficiency suffer in stress-test-affected leveraged firms in other sectors also?

Additional suggestions

3. Focus is skewed to 2012, 4-5 geographies: Magnitudes large, but…

- Did the effects persist? For how long? More for constrained hospitals?

- Did more-leveraged/constrained hospitals “specialize” to increase clinical volumes from lucrative procedures like cardiology or ambulatory surgeries?

- Did less-leveraged/constrained hospitals gain eventually?

Additional suggestions

4. Address potential bias/econometric issues with staggered difference-in-differences methodology?

- Baker, Larcker and Wang critique of existing methods (treatment effect heterogeneity)

Thought-provoking paper!

I commend the authors – and this line of research – that goes beyond financial metrics and examines the operational efficiency of goods and services supplied by firms to the real economy

Connecting this issue to bank stress tests is clever…

Lesson might be that the merchant of death is leverage and policies subsidizing it, rather than stress tests seeking to correctly price the subsidy