A DIALYSIS DUOPOLY: HOW PUBLIC FUNDING ENTRENCHED PRIVATE POWER

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PUBLISHED 07.08.25

This post is part of a series on the corporate consolidation and financialization of health care. Read the rest of the posts here.

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For the half-million people in the U.S. with kidney failure, survival rests in the hands of two powerful corporations—DaVita and Fresenius. Together, these companies control over 70% of the outpatient dialysis market. But the history of dialysis isn't a simple narrative of corporate consolidation; it's a case study of how public funding can entrench private power in health care, and the detrimental effects this has on care quality and cost.

Chronic kidney disease (CKD) is one of the most common diseases in the U.S., affecting more than one in seven adults. The final stage of CKD, when the kidneys have lost nearly all their function, is called end-stage renal disease (ESRD). American ESRD patients are disproportionately poor, Black, Latino, and elderly, and ESRD is primarily caused by diabetes and high blood pressure, conditions that are themselves influenced by broader social determinants of health.

Only dialysis or a transplant can keep an ESRD patient alive. The gold standard of treatment is a transplant from a living donor, but transplants remain out of reach for most people. Even if a patient has family or friends willing to donate an organ, donors are regularly rejected for not meeting weight, health, or smoking requirements, reflecting the concentrated inequality of health among ESRD patients and their networks. The waitlist for a kidney from a deceased donor is nearly 90,000 patients long, with median wait times estimated to be around four years. This means that, for most patients, hooking up to a dialysis machine three times a week at an outpatient facility is their only option.

Today, Medicare guarantees dialysis coverage for nearly everyone who needs it, regardless of age or income (though notably, undocumented immigrants are not entitled to dialysis care at the federal level). Before this guarantee, because of limited resources, “God committees” or “death panels” composed of doctors and nurses decided which patients would live or die. Unsurprisingly, this sparked moral outrage and government action that led to a kidney disease-specific, Medicare-for-All. In 1972, when this entitlement was created, 24,000 people needed dialysis. Today, that number is over 500,000.

Critically, the entitlement guarantees universal *access* to treatment, but it leaves the actual provision of dialysis to the market. While the number of people on dialysis has grown twenty-fold since the entitlement’s creation, health care policymakers have been preoccupied with cost containment, privatization, and deregulation since the 1980s.

What happened next was predictable. From 1980 to 2011, Medicare’s reimbursement rate for each dialysis session remained nearly flat. Consequently, hospital-based dialysis centers and non-profit facilities were priced out, unable to absorb the rising costs of labor, supplies, tests, and equipment. As dialysis treatment shifted out of hospitals and into free-standing, for-profit clinics, the clinics themselves increasingly fell under the control of large chains.

Consolidation has accelerated in recent decades. Thirty years ago, 41% of all dialysis facilities were operated by seven large companies. Today, the picture looks alarmingly different. DaVita and Fresenius control over two-thirds of the 6,700 facilities that dot the country, and account for 90% of the industry's revenue. The $25 billion industry is among the most concentrated sectors of the economy—more concentrated than the markets for primary care, home health, and health insurance.

Several features of dialysis make it difficult to regulate. For example, patient choice is limited by geography: patients must travel to their clinic three times a week for the rest of their lives, or until they get a transplant. Once their doctor refers them to a clinic, patients are unlikely to switch to a new one. The Centers for Medicare & Medicare Services has tried to empower patients with informational initiatives like facility reports and five-star ratings, but in a duopoly, it's questionable whether additional information meaningfully empowers patients.

Antitrust enforcement has proven to be ill-equipped to handle the small-scale acquisitions in the industry. With an individual dialysis clinic valued at about $4 million, half of the clinic acquisitions in the past two decades have not been reportable to the FTC. Economist Thomas Wollman has dubbed these repeated transactions that fly under the FTC's radar "stealth consolidation."

Unsurprisingly, consolidation and corporatization have not led to higher quality care or greater innovation. In fact, the opposite has occurred. Chain acquisition is associated with increased hospitalizations, increased mortality, and fewer referrals to transplant. Compared with patients at non-profit dialysis centers, patients at for-profit facilities have higher hospitalization rates, are less satisfied with their experience, and are less likely to be placed on the transplant list. Furthermore, there have been no major breakthroughs in dialysis technology since its inception 50 years ago—patients must still travel to a facility and connect to a blood filtration machine for hours at a time.

With Medicare pumping billions into their coffers each year, the two dialysis giants have grown too big to regulate. DaVita has paid nearly $1 billion in civil penalties to settle whistleblower suits since 2012. The lawsuits included allegations that DaVita threw out good medicine, fraudulently billed Medicare, and paid illegal kickbacks to doctors for patient referrals. Fresenius has been involved in nearly identical fraud and kickback suits. With respective global revenues of $12 billion and $20 billion, settlements have become a routine cost of doing business for DaVita and Fresenius.

The two companies have also spent millions quashing legislation aimed at improving the quality of care. In California, where three-quarters of clinics are owned by DaVita or Fresenius, the duopoly broke spending records lobbying to defeat three bills that would have capped industry profits, required on-site clinicians, and mandated the regular reporting of infections. With control over the majority of the state's clinics, the companies held patients hostage by threatening to close if the bills passed.

A critical lesson from the kidney disease entitlement is that Medicare-for-All cannot be the end horizon. Pumping government money into health care will only lubricate the wheels of capital if the provision of care is left to the private market. Existing tools like antitrust enforcement and regulatory tinkering have proven inadequate and vulnerable to the whims of changing administrations. Unless the relationship of power between patients, health care staff, and corporations is altered, universal coverage will simply continue to funnel billions into the hands of companies eager to exploit our health for profit.

When the ashes left by the current administration clear, those who rebuild will have the opportunity to move beyond neoliberal health care policy. It will be tempting to settle for regulatory incrementalism like eliminating the premerger notification threshold for the dialysis industry or incentivizing transplant and home dialysis through payments. But such modular reforms face structural constraints; antitrust enforcement is a retroactive tool, and if DaVita and Fresenius control most of the clinics, incentive payments will merely offset penalties.

We can and should think expansively about what quality kidney care, and health care more broadly, can look like. The national system of deceased organ allocation is mired in bureaucratic chaos. Home dialysis, too, requires stable housing, space for large equipment, the ability to pay higher utility bills, and family support to manage complex medical routines. The Medicare entitlement should be responsive to these overlapping social needs. It should improve the overall health, housing conditions, and economic security of ESRD patients and their social networks as part of its scope of coverage.

While the death of *Chevron* and the ongoing evisceration of medical welfare programs put these proposals beyond our current reach, labor organizing remains a vital and important site of struggle. In California, the three defeated bills were spearheaded by the health care workers' union SEIU-UHW. Dialysis clinics in the state have seen a wave of unionization since 2022, and unionized workers in California are striking and negotiating contracts. This organizing will require

building solidarity between workers and patients as companies seek to drive a wedge between them. But if the fight is in service of both workers *and* patients, we could leverage our collective power in service of meaningful change in the political economy of dialysis.

For all its flaws, the sheer existence of the dialysis entitlement is proof that the state can take an expansive role in caring for its people. However, the entitlement is a cautionary tale of what happens when the government pours money into an unchecked private market without sufficient safeguards. While the current situation is grim, it is also a site of possibility. Incremental reforms won't deliver a health care system that prioritizes health over profits. Workers, patients, and policymakers must continue to fight for a more equitable public health infrastructure.

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