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PERSPECTIVE

Investment or extraction? Reframing private equity in healthcare

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Abstract

Moral hazard is built into the structure of private equity investments, which incentivises debt-based extraction rather than value-adding investment. To craft effective regulation of private equity's participation in healthcare, and to cut through the industry's talking points, we must reframe and acknowledge private equity 'investment' as 'extraction'. In the U.S. healthcare system, this debt-based extraction has produced higher risks of bankruptcy and financial distress and associated facility closures, cost-cutting that affects patient safety and care, rising healthcare costs, inefficient use of taxpayer dollars, erosion of clinician autonomy, and increased consolidation. Policies that address extractive behaviours are the most targeted and efficient means of safeguarding patient care and may discourage the worst actors from acquiring healthcare providers. As private equity invests in health systems beyond the U.S. where regulatory regimes differ, the fundamentals of its extractive business model remain the same. Regulations must be calibrated to country specifics, but they should address the debt-based extraction built into the very structure of private equity investments. As policy debates continue, it is worth asking why we need private equity's extractive business model in healthcare in the first place.

Keywords: healthcare; health policy; private equity; financialisation; corporatisation

1. Introduction

In recent years, private equity has become a focal point for U.S. medical professionals, regulators, policymakers, and even the general public as evidence grows of its risks and harmful impacts in healthcare.[1] This evidence comes in the form of empirical research on its effects across various subsectors of the healthcare industry, as well as investigations and case study-based evidence from nonprofits, unions, journalists, and lawmakers. Collectively, this evidence has demonstrated how private equity investment strategies in healthcare have resulted in bankruptcies, facility closures, layoffs, higher costs, patient care issues, and the erosion of clinical autonomy, as just some examples. In response, federal[2] and state lawmakers[3] have introduced legislation to guard against

[1]This perspective piece will primarily focus on the U.S., although private equity healthcare investments are not limited to the U.S. and are creeping into healthcare systems around the world in both high-income and low-income countries alike.

[2]Examples of federal legislation include the Health Over Wealth Act, introduced by Senator Ed Markey and Representative Pramila Jayapal July 2024; the Corporate Crimes Against Health Care Act, introduced by Senators Elizabeth Warren and Ed Markey in 2024; and the Healthcare Ownership Transparency Act introduced by Representative Pramila Jayapal in March 2023. Federal legislators also introduced the Stop Wall Street Looting Act in 2021, legislation targeting the private equity industry's 'looting' tactics more broadly than just in healthcare. These bills all propose powerful and effective measures to address risks and harms associated with private equity investments, although none have become law or have gained serious traction among federal lawmakers.

[3]For an overview of state legislative proposals regarding private equity in healthcare in the U.S., the. Private Equity Stakeholder Project hosts a public-facing database, as well as released a 2025 State Healthcare Policy Review in November 2025.

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these risks and impacts, and 2025 saw an unprecedented number of state legislative proposals in response. However, federal legislative efforts have stalled, and with some notable exceptions,[4] much of what has passed at the state level has consisted of first steps and limited solutions, often watered down from ambitious first drafts (Fenne, 2025a; Bugbee, 2025c). Industry talking points implying that any new regulations would be overly burdensome and could chill investments in the relevant state's healthcare system, as well as aggressive lobbying tactics, seem to have been effective at spooking many legislators out of voting in favour of robust legislation.[5] Amidst industry pushback, a polarised political landscape, and growing scrutiny of private equity in healthcare, debate continues over the extent of its risks in healthcare, what shape regulations should (or should not) take, and whether we should permit private equity to invest in healthcare at all. To craft effective regulations around private equity's participation in healthcare, as well as cut through the industry's talking points, we must reframe and acknowledge private equity 'investment' as 'extraction'.

'Extraction' is a more specific term to describe the ways in which financialisation (see Bruch *et al*., 2024; Brown and Rooke Ley, 2026) and assetisation (see Nijboer *et al*., 2026) of healthcare are operating within the private equity business model. In particular, private equity business strategies serve to channel value out of portfolio companies to their investors, sometimes at the expense of patients, workers, and the long-term financial viability of the company. Conceptualising private equity's business model as extractive is certainly not a groundbreaking observation. However, I argue that using the term 'extraction' over less specific terms like financialisation or misleading terms like 'investment' more succinctly describes what private equity business strategies *do* and therefore carries greater rhetorical weight to cut through the industry's talking points. It can also help direct policymakers and regulators toward targeting the most harmful aspects of the private equity business model.

2. Private equity extraction

Under the typical private equity playbook, investment functions more like extraction. This is due to the very structure of the investment, which incentivises the use of high debt levels and limits liability for investors. In a typical investment setup, private equity firms raise money from institutional investors like pension funds, endowments and foundations; the firm puts up about 20 per cent of equity in the fund while the remainder is raised from the institutional investors (also referred to as limited partners). The fund is then used to acquire multiple companies in high-debt transactions called leveraged buyouts (LBOs). In an LBO, 60 to 90 per cent of the transaction is financed with debt that is saddled on to the acquired company, i.e. the portfolio company, and neither the private equity firm nor its limited partners will be on the hook for this debt (Kaplan and Strömberg 2008). Private equity funds might make healthcare-focused acquisitions, but many funds acquire companies across diverse sectors. Private equity firms will hold on to portfolio companies for approximately five to seven years before selling them, and sales are timed according to the private equity firm's need to provide returns to limited partners, not to the needs of the portfolio company. Despite contributing only about two per cent of the equity in an investment

[4]See Tsai *et al*. (2025) for an analysis of Massachusetts' HB 5159, which effectively banned sale-leasebacks of acute care hospitals among other policy interventions; Zhu and Rooke-Ley's (2025) analysis of Oregon's SB 951, which closed loopholes in the state's corporate practice of medicine (CPOM) doctrine; and Connecticut's SB No. 196, signed into law in May 2026, which adds restrictions and increases oversight of sale-leaseback transactions, bars private equity entities from holding a controlling interest in a hospital, and bars private equity entities from interfering in clinical decision-making at hospitals.

[5]See, for example, news coverage of a legislative proposal that passed in New Mexico after being watered down (Montaño, 2025). See also Senator Chris Murphy's August 2025 report, 'A Dangerous Prospect: How Private Equity Decimated Connecticut Hospitals,' (Murphy, 2025) to better understand how industry lobbying prevented Connecticut from passing legislation to address private equity's risks and harms in the state in 2025.

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fund, the private equity firm typically takes home 20 per cent of its returns, and this investment structure is consistent across industries (Appelbaum and Batt, 2014, 2017).

During the ownership period, private equity firms may direct companies to take on even more debt to finance add-on acquisitions or to pay dividends to investors – a practice referred to as a dividend recapitalisation. This type of transaction is fundamentally extractive because it adds no value to the company in question but leaves debt on its balance sheet. In the hospital and nursing home sectors, private equity-owned companies have also executed sale-leasebacks of real estate, in which the facility sells its real estate to a real estate investment trust (REIT) or other investment group, incurring long term lease liabilities on property it used to own. Meanwhile, the investors can siphon out the one-time revenue from the sale in the form of dividends (see Batt *et al.*, 2022). In another extractive practice, private equity firms often charge the companies they own management fees, sometimes to the tune of millions of dollars over the life of the investment (Appelbaum, 2016).

Because private equity firms are not responsible for the debt or lease obligations incurred by their portfolio companies, and because they invest so little of their own money while taking home a disproportionate share of returns, firms can generate outsize returns on an investment, sometimes even if their company becomes financially distressed or declares bankruptcy. In other words, both the limited liability structure of private equity investments and the asymmetry of fund financing and returns produce a moral hazard problem that incentivises firms to direct the companies they own to take on risky amounts of debt, all while being relatively shielded from the consequences of said risks (Appelbaum and Batt, 2017; Statchen and Grogan, 2025; Applebaum and Batt 2014). Appelbaum and Batt (2014, p. 51) characterise private equity investments as 'low risk, high rewards' for private equity firms. The risks that exist are externalised to limited partners and acquired companies and their employees. In the case of healthcare, patients and sometimes entire communities also bear the risks.

3. Risks and impacts arising from private equity extraction in healthcare

The extractive structure of private equity investments, amplified by the temporal mismatch between the five-to-seven-year investment horizon and the long-term investment needs of healthcare providers, generates unique risks for private equity-owned healthcare companies.

3.1. Financial distress and bankruptcy

Private equity's debt-based business strategies result in a disproportionately higher risk of financial distress and bankruptcy than seen in other types of corporate and investor-owned entities, especially in a high interest rate environment (Ayash and Rastad, 2021). Companies saddled with unwieldy amounts of debt are less nimble and competitive amidst changing market conditions and regulations, and failure to generate sufficient revenues to pay monthly interest payments on top of necessary operating costs can result in defaults and bankruptcy. In 2024, private equity-backed companies accounted for seven of the eight largest[6] healthcare-related bankruptcies in the U.S. (Dabos, 2025). Financial distress and bankruptcy can lead to hospital or facility closures and layoffs, which can have devastating impacts on patients, the healthcare workforce, and entire communities.

3.2. Facility closures

Currently, there is limited empirical research on private equity's impacts on healthcare access. Of the existing studies, access is measured by service utilisation, types of services offered,

[6]This refers to bankruptcies involving companies with greater than $500 million in liabilities. See Dabos (2025) *Private equity bankruptcy tracker*.

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appointment availability, number of physicians and advanced practice providers employed, and the number of patients seen (Singh *et al.*, 2026a; Unruh *et al.*, 2025).[7] In the United States, a growing number of private equity-related hospital closures in recent years invite further research into this issue, because when private equity-owned facilities close as a result of financial pressure or bankruptcy, reduced access to healthcare services may result. Since 2018, private equity-related financial distress and bankruptcies have contributed to the closures of at least 25 hospitals across the U.S.[8] Steward Health Care, for example, whose private equity investors siphoned out approximately $800 million from the system via dividend recapitalisations and sale-leasebacks (Weil, 2024), saw eleven hospital closures between 2018 and May 2025, resulting in the layoffs of at least 5,050 healthcare workers (Bugbee, 2025a). Hospital closures have ripple effects within their larger regions. Effects of closures can include increased emergency transport times, longer wait times for emergency care, and reduced access to surgical care (see Alexander and Richards, 2023; Arrey *et al.*, 2025; Cooper, 2025; LeMoult, 2025).

3.3. Cost-cutting and its potential impacts on patient care

The debt service obligations on the hefty multimillion dollar loans secured by private equity-owned companies can divert substantial resources from operating costs, such as paying and retaining healthcare workers, investing in patient care, or making capital improvements to facilities and medical equipment. Slashing costs to afford debt payments and increase revenues may look like reduced staffing, failure to properly maintain medical equipment and facilities, and overreliance on unlicensed staff. A limited but growing body of research has looked at the relationship between private equity ownership of health facilities and patient outcomes.

A 2025 scoping review that included an examination of impacts of private equity on healthcare quality and patient outcomes in the U.S.[9] found primarily harmful or mixed results, with just two out of 21 studies showing beneficial impacts (Unruh and Rice, 2025). The majority of such studies have looked at hospitals and nursing homes. For hospitals, research has shown a 25.4 per cent increase in hospital adverse events (i.e. central line bloodstream infections and patient falls) at hospitals acquired by private equity firms versus matched controls (Kannan *et al.*, 2023) and higher death rates in emergency rooms at private equity-acquired hospitals, potentially related to reduced staffing (Kannan *et al.*, 2025). Other research has found increased mortality among nursing home residents at private equity-owned facilities (Gupta *et al.*, 2021) and a higher

[7]Singh *et al.* (2026e) recently published a study in *Health Affairs* examining the impacts of private equity ownership on primary care providers. The study considered acquisitions of primary care practices during the time period 2016–2022 and found that the number of services billed, the number of patients seen, and the number of physicians and advanced practice providers employed at clinics increased post-acquisition. They conclude that these findings suggest that private equity investments have the potential to expand access to primary care. This study's timeframe does not capture the 2024 Chapter 11 bankruptcies of three private equity-backed value-based care primary care providers, two of which were large, publicly traded companies; at least two of these companies have closed clinics as a result (Bugbee, 2025b). Definitions of access should also take into account longer timeframes and the shifting provider landscape in specific geographic areas, in addition to changes at the individual clinic level.

[8]This tally is pulled from various reports and blog posts from nonprofit Private Equity Stakeholder Project: Steward Health Care – at least eleven related closures from 2018 to 2025, resulting in the layoffs of at least 5,050 healthcare workers (Sources: 'Steward Health Care's bankruptcy: one year later' and *The Pillaging of Steward Health Care*); Prospect Medical Holdings – at least five related closures from 2019 to 2025 (Sources: 'Prospect hospitals in Pennsylvania to close, lay off 2,651 workers' and *How Private Equity Raided Safety Net Hospitals and Left Communities Holding the Bag*); Pipeline Medical Holdings – at least three related closures from 2019 to 2025 (Sources: *How private equity raided safety net hospitals: Pipeline Health* and 'Another former Pipeline hospital closes'); ScionHealth – at least three related closures in 2025 (Source: 'Apollo-owned hospitals close amid declining financial condition'); Santa Cruz Valley Regional Hospital in 2022 (Source: 'Private Equity-Owned Rural Hospital Shutters After Collecting Millions of Dollars in Federal Aid'.); Johnstown Heights Behavioral Health in 2025 (Source: 'PE-owned behavioral health hospital closes'.).

[9]Borsa *et al.* (2023) published a systematic review of private equity ownership and impacts on health outcomes, costs, and quality; however, this study included studies spanning eight countries and found mixed to harmful impacts on quality.

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incidence of ambulatory care-sensitive emergency department visits and hospitalisations for long-stay nursing home residents at private equity-owned facilities (Braun *et al.*, 2021a). There is currently no research on the relationship between private equity ownership and patient outcomes in outpatient care.

3.4. Higher prices and increased health spending

The drive to generate outsize returns alongside debt-related pressures may also incentivise private equity-affiliated providers to increase prices. Recent research strongly supports this hypothesis (Unruh and Rice, 2025; Borsa *et al.*, 2023), with various studies finding higher prices at private equity-owned anaesthesia providers (La Forgia *et al.*, 2022), in outpatient specialties, such as gastroenterology ophthalmology, and dermatology (Braun *et al*, 2021b; Singh *et al.*, 2022, 2025e), in primary care practices (Singh *et al.*, 2025d), and at private equity-owned nursing homes (Braun *et al.*, 2021a).[10]

3.5. Inefficient use of taxpayer dollars

Private equity firms have benefitted from investing in segments of the healthcare industry that receive substantial financing from Medicaid and Medicare dollars, two types of public insurance programmes in the U.S. (McMahan *et al.*, 2025; O'Grady, 2021a).[11] These include behavioural health care, home health and hospice, value-based primary care, and long-term care in skilled nursing facilities. Even if government payment rates are often lower than private insurance rates, government insurance has historically provided a predictable and reliable stream of income, making sectors that rely on these dollars an attractive investment target.[12] For example, most hospice care in the U.S. is financed by Medicare, a public insurance for those 65 and older (Appelbaum *et al.*, 2023). Recent research has shown that private equity-owned hospices, versus other for-profit ownership types, recorded the highest profits and lowest spending on direct patient care (Soltoff *et al.*, 2025). Medicare's payment system for hospice care contains various legal loopholes that make it easy for profit-seeking investors to pocket as much of the Medicare reimbursement as possible while spending the bare minimums on patient care; this in turn has made hospice an attractive target for private equity (Appelbaum *et al.*, 2023).[13]

[10]Private equity-owned physician staffing companies have also been major drivers of the surprise billing problem in the U.S. that resulted in the federal bipartisan No Surprises Act, passed in 2020. However, recent research has shown that the arbitration provision in this law, which a dark money group that was financed by private equity-backed staffing companies fought to include in the final legislation (Sanger-Katz *et al.*, 2019; Leitner, 2025), has led to over $5 billion in additional costs since implementation began in 2022 (Hoadley and Watts, 2025). Private equity-backed providers have consistently dominated the list of highest-volume users of the No Surprises Act dispute resolution process and are disproportionately winning these disputes with payers (Watts and Hoadley, 2025). While patients are seeing less surprise medical bills, the arbitration process is producing ballooning costs that will likely show up in rising premiums (Hoadley and Watts, 2025).

[11]McMahan *et al.* (2025) describes how hospice has morphed from primarily a nonprofit and volunteer-based service to one increasingly dominated by for-profit interests following the 1982 Medicare Hospice Benefit.

[12]Starr (2013) notes how Medicare, in particular, generated widespread physician opposition during its policy debates, but after Medicare's implementation in 1966, '. . . the ideological as well as interest-group opposition disappeared, partly because the doctors discovered how much money they could make out of the programmes and no longer had any interest in rousing popular opposition to "socialized medicine (Starr, 2013, 49)"'.

[13]Private equity-owned healthcare companies also cashed in on the influx of taxpayer funded subsidies during the pandemic, including the emergency aid available to businesses across a wide range of economic sectors through the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Despite the deep pockets of their investors, private equity-backed healthcare companies had collected approximately $3.9 billion CARES Act funding by September 2021 (Valdes-Viara *et al.*, 2021), including Apollo Global Management's LifePoint Health, which collected $1.6 billion in COVID-related government relief (O'Grady, 2021b).

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3.6. Erosion of clinical autonomy

Private equity investments in physician staffing companies and practice management firms are often structured to skirt around state prohibitions of the corporate practice of medicine (CPOM). Many of these companies claim to handle the administrative side of medical practices, but business decisions such as staffing ratios and productivity targets can end up impacting physicians' clinical autonomy (Brown and Hall, 2024). There is no peer-reviewed research measuring private equity's impacts on clinician autonomy, although various professional associations and researchers claim or predict a reduction in clinical autonomy following private equity buyouts (see Dilip *et al.*, 2026; Bradley *et al.*, 2026). Recent research has found increased physician turnover following private equity acquisition of physician practices, which in turn invites further research into the mechanisms by which private equity acquisition results in higher turnover, and whether reduction in clinical autonomy is playing a part (Singh *et al.*, 2025a; Berquist *et al.*, 2025). In 2024 and 2025, some U.S. state legislatures explored ways to shore up their CPOM regulations in response to growing concerns about private equity and corporate influences in the practice of medicine; most notably, Oregon passed the strongest set of regulations to date to close CPOM loopholes and help restore clinician autonomy in medical decision-making (Zhu and Rooke-Ley, 2025; Fenne, 2025a).

3.7. Consolidation

Private equity firms frequently use platform companies to 'roll-up' smaller companies, a consolidation strategy intended to increase the value of the enterprise for its sale later on. Many of these acquisitions are financed by debt and are often below reporting thresholds to antitrust regulators (Brown and Hall, 2024). Consequently, this serial acquisition strategy has been referred to as 'stealth consolidation', and was a major focus of the Biden-Harris administration's Federal Trade Commission (Federal Trade Commission, 2024). Through roll-ups, private equity is contributing to consolidation across multiple health sectors, including in Ambulatory Surgical Centres (Fenne, 2025b), value-based care primary care providers (Bugbee, 2025b; Rooke-Ley, 2024a), opioid treatment (Singh *et al.*, 2025c), various outpatient specialties (Scheffler *et al.*, 2023; Singh *et al.*, 2024), hospice (Aldridge *et al.*, 2024; Appelbaum *et al.*, 2023) and home health care (Zhu *et al.*, 2025; Valdes-Viara *et al.*, 2025). Consolidation in the U.S. healthcare system, in turn, is contributing to overall rising costs (Hulver, 2024).

4. Critically examining industry talking points

The industry frames its contributions in healthcare as 'investments' in innovation and services and touts the $1.6 trillion it has 'invested' since 2008 (American Investment Council, 2024a). If we consider the typical fund structure of private equity investments and the practice of using LBOs to acquire companies, we can assume that much of this trillion-dollar figure is debt. The industry also claims that private equity is improving health care, arguing it 'plays a critical role supporting quality, affordable health care in the United States', and claiming it has funded life-saving innovations and helped lower healthcare costs (American Investment Council, 2024a). An eight-page report from the group published in February 2024 cites just two studies, one from 2021 and one from 2017, in the section captioned '[n]ew studies come out every year that demonstrate PE's ability to expand health care access, reduce costs, and improve the health care services system overall' (American Investment Council, 2024b, p. 3). Researchers Lietz and Song (2024, p. 14) have pointed out that the industry has failed to document its purported benefits in healthcare in a convincing way, and therefore, 'the lack of supporting evidence for PE's benefits does leave the evidence of patient and societal harms more concerning and unchallenged'.

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When up against potential regulations,[14] the industry has argued that these will deter investment and therefore reduce access to health services.[15] But there is scant evidence showing private equity has improved access to healthcare to begin with. By uncritically accepting industry talking points or allowing them to serve as justification for choosing not to regulate private equity in healthcare, we are ignoring the reality that the very structure of private equity investments incentivises extraction. If regulating the extractive practices deters 'investment', then what can that tell us about the raison d'être for private equity's participation in healthcare? Responsible private equity investors and their limited partners should welcome common-sense regulations that prohibit egregious business practices that threaten the reputation of the larger industry.

While it is important for researchers to continue compiling evidence on private equity's impacts in healthcare – both good and bad – the evidence as it stands is sufficiently robust for policymakers to see through industry talking points and recognise that private equity extraction in healthcare carries substantial risks for patients and can lead to higher healthcare costs for patients and payers alike. Even for those who choose to take seriously that private equity can play a role in providing much-needed capital in struggling health systems must also recognise that such a position does not foreclose the need to regulate private equity's associated risks and harms.

5. Policy recommendations

Private equity has become embedded in the privatised, for-profit U.S. healthcare system and to excise it through banning its participation altogether would not be politically feasible in the short nor medium term. That being said, there is definitive evidence that private equity's debt-based extraction in healthcare can produce unique risks, as well as amplify the general risks that arise with for-profit healthcare. These include a high risk of bankruptcy and financial distress and associated facility closures, cost-cutting that impacts patient safety and care, rising healthcare costs, inefficient use of taxpayer dollars, erosion of clinician autonomy, and increased consolidation. Continuing to allow private equity to play a role in healthcare means that policymakers have a responsibility to address its associated risks through updated laws and regulations, and with sufficient budgetary allocations for the agencies and offices tasked with enforcement.

Moral hazard is built into the structure of private equity investments, which incentivises debt-based extraction rather than value-adding investment. But with sufficient regulations, private equity's participation in healthcare can begin to look more like investment.[16] Some of the most egregious cases of private equity harms have involved large-scale sale-leaseback transactions with REITs and dividend recapitalisations, such as in the bankruptcies of Steward Health Care and Prospect Medical Holdings. Policies and regulations that address extractive behaviours like these head-on are the most targeted and efficient ways to safeguard patient care and may also discourage the worst actors in private equity from acquiring healthcare providers. Policymakers should

[14]When up against increased scrutiny, the American Investment Council was quick to boost a July 2024 analyst note from proprietary data provider, PitchBook (American Investment Council, 2024c), which argued, 'In general, the role of PE investment within the broader US healthcare ecosystem has been vastly overstated (Springer, 2024)'. Multiple healthcare industry news outlets reported on the analyst note without critically examining the data used to make this argument: the author of the analyst note had opted to exclude approximately two thirds (around 4,000) of private equity healthcare deals from the analysis for the time period in question (2018–2024) by leaving out add-on acquisitions (Bugbee *et al.*, 2024b).

[15]For example, when Assembly Bill 3129 was under debate in California, the American Investment Council opposed the bill on the grounds that 'it would result in less capital being available to fund health care services and research in California, diminished access to care for patients throughout the state, and additional failures in the health care system. More broadly, AIC believes the enactment of this bill would send the wrong message to private capital investors. California has long been the top destination for private capital investment and innovation. The state ranks first in the country for attracting private capital investment dollars, averaging around $100 billion per year'. See pp. 3–4 of Assembly Third Reading AB 3129 (California State Assembly, 2024).

[16]However, the fundamental structure of private equity investments produces misaligned incentives that no amount of regulation can change without entering into the realm of rewriting the rules of private equity, more generally.

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consider statutory limits on debt levels that can be used to acquire healthcare providers, including in smaller add-on acquisitions; limits or bans on the sale-leasebacks of healthcare facility real estate, as both the states of Connecticut and Massachusetts have done; and limits or bans on dividend recapitalisations involving healthcare companies. Policymakers should also create joint liability for private equity firms and their portfolio companies to disincentivise firms' use of excessive debt and other risky behaviours for which firms currently do not have to pay the price (Stewart and Baker, 2023). For policymakers concerned with regulating private equity with too broad a brush, they can consider regulating private equity's participation in specific subsectors of healthcare where there is evidence of heightened risks and harms to patients – such as inpatient care at long-term care facilities and hospitals.[17] In sectors where there is evidence of rising prices post-acquisition, such as outpatient specialty care, state policymakers should consider strengthening and enforcing antitrust regulations.[18]

Transparency measures and reporting requirements for private equity healthcare acquisitions have become a common angle taken up by state legislators looking to regulate private equity in healthcare. While these measures are an important first step, they fall short of actually preventing the harmful behaviours that private equity firms may engage in post-acquisition. For example, while Cerberus Capital's acquisition of Caritas Christi Health Care to create Steward Health Care was a highly scrutinised transaction that included a five-year monitoring period by the Massachusetts Attorney General, this transparency was insufficient to prevent Cerberus Capital's extractive practices that preceded Steward's historic bankruptcy and associated hospital closures.[19]

6. Looking beyond the United States

Researchers, policymakers, regulators and elected officials outside of the U.S. should take note of the evidence of private equity's risks and harms in the U.S. context, even if their countries have national health systems and/or strong public financing. The reality is that most countries' health systems are not insulated from the reach of private equity. A small but growing body of research has found steady increases in private equity healthcare investments among OECD countries in sectors such as primary care, outpatient specialty care, elder care, and hospitals (Singh *et al.*, 2025b, 2026b), including in European countries with relatively higher public investments in healthcare or universal health systems (Singh *et al.*, 2025b, 2026b). A recent exploratory analysis of private equity dealmaking in healthcare outside of the U.S. found that higher private equity deal volume was associated with higher healthcare expenditures, and the countries with the highest volume of deals were the United Kingdom, Germany, and France (Singh *et al.*, 2026b). Other countries have also seen substantial participation of private equity, such as in Sweden where one third of private primary care clinics are owned by international private equity firms (Singh *et al.*, 2026b; Winblad, 2023). Outpatient specialty care has been the most popular investment target while elder care and hospitals are also attractive targets in select markets, according to research by Singh *et al.*, (2026b). And in low-and middle-income countries, a damning report from Oxfam (Marriott, 2023) as well as recent investigative work from *Bloomberg* (Finch *et al.*, 2025; Taggart *et al.*, 2025) have demonstrated how development finance institutions are facilitating private equity's investments in private hospitals, sometimes with great financial and safety risks to patients and at the expense of providing affordable healthcare to those in most need.

[17]Connecticut recently passed a law barring private equity firms from holding a controlling interest in a hospital.

[18]It is beyond the scope of this article to offer comprehensive policy recommendations. For examples of policy options that have been proposed by researchers, see Cai and Song (2023), Brown *et al.* (2021), Brown and Hall (2024), and Bugbee *et al.* (2025a).

[19]See pp. 8–10 of Bugbee (2024), 'The Pillaging of Steward Health Care', for a description of the oversight mechanisms for Cerberus Capital Management's and Steward's acquisition of Caritas Christi Health Care.

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Some countries have taken the first steps in bringing regulatory scrutiny to private equity in healthcare; however, these policies and proposals remain limited in scope and have primarily focused on transparency and disclosure (Tracey *et al.*, 2025). More research is needed to investigate the extent of and the impacts of private equity's investments outside of the United States to help guide policymaking in these contexts, and greater transparency can help support these efforts. However, while the specificities and regulatory regimes of each country's health system vary, the fundamentals of private equity's extractive business model do not change as it travels across these differing contexts. Regulations will certainly need to be calibrated to country specifics, but all regulations will necessarily need to address the debt-based extractive business strategies that are built into the private equity investment structure. As we continue debating regulations – or even prohibitions – of private equity in healthcare, it is worth asking why we even 'need' private equity's extractive business model in the first place.

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