

**DIRECTORATE FOR EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS
HEALTH COMMITTEE**

Trends in the financialisation of outpatient care

Fast-Track for December 2024

36th Session of the Health Committee to be held on 2-3 December 2024 in Paris 16th

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Note from the Secretariat

1. In recent years, countries across the OECD have seen an increase in interest, investment and involvement in outpatient care practices from financial firms, including private equity firms and for-profit chains. The entry of such actors into outpatient and primary care has been previously reported in the United States and across Europe. The increase in financialisation has spurred a debate about potential benefits and pitfalls of the trend. While the participation of for-profit actors in health systems is common across OECD countries, the implications of the recent entry of private equity and for-profit commercial chains into primary and outpatient care, including both the potential risks and benefits from this trend, are still not well understood.

2. In November 2023, the Health Committee selected “*Financialisation of primary health care*” as the fast-track report for December 2024. While the original proposal focused its scope on primary care, preliminary research and consultations suggested that most of the financialization in outpatient care was also taking place in more specialized outpatient services, and that broadening the scope of health care services considered in this project would provide a more relevant picture of current trends and challenges for health systems.

3. This paper summarises the findings of research into the financialisation of outpatient care across OECD countries. It finds that outpatient specialised services have become a recent target of financial institutions active in the healthcare sector, notably across dentistry, ophthalmology, radiology, biology and primary care. While financialisation was reported to be a concern by a majority of responding countries, how financialisation is taking place also varies depending on how health systems are structured. Moreover, despite a growing evidence base around the potential – often negative – impacts of investments by some financial actors, notably private equity firms, countries lack a cohesive picture of the extent to which financial firms have scaled-up investments into their health systems. The paper further presents a set of policy considerations to address financialisation in outpatient care.

4. Delegates are invited to:

- **COMMENT** on the key findings and messages of the fast track report;
- **SUBMIT** any written comments, suggestions or additional information to the Secretariat by 24 January 2025;
- For countries that have not yet done so, **RESPOND** to the 2024 OECD Policy Questionnaire on Financialisation in the Health Sector by 24 January 2025.

* The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

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Key findings

5. Financialisation of the healthcare sector refers to the growing influence of financial actors and non-financial entities whose main business lies outside healthcare, in owning and operating healthcare delivery organisations. This paper focuses its attention on the outpatient sector, an area that has received less attention in research compared to hospitals and long-term care facilities.

6. According to a survey conducted by the Secretariat, the financialisation of outpatient services appears to be increasing in OECD countries, with half of 20 responding countries reporting that financialisation is a high or moderate trend. The most attractive sectors in outpatient care are dentistry, ophthalmology, radiology, and laboratories. As an example, the share of practices run by dental service organisations in dental markets across North America and Europe has grown substantially in recent years, doubling in the three years between 2015 and 2018 in Denmark, Norway, Spain and the United Kingdom.

7. Financialisation also leads to significant consolidation taking place in some regions and specialties. Consolidation refers to the practice of acquiring and merging multiple healthcare providers to increase market shares and negotiation power. In France, for example, the laboratories experienced a high trend of consolidation in recent years. Between 2010 and 2022, the share of outpatient laboratories directly owned by financial investors increased from 16% to 78% of the total.

8. Key factors driving financialisation of the healthcare sector in OECD countries include growing, publicly financed healthcare demand from aging populations, which provide stable revenue streams to investors; important opportunities for profitable investments in outpatient care, especially in sectors with high capital costs such as radiology; potential for consolidation and economies of scale in certain specialties; evolving provider demographics and preferences, with older physicians looking to sell practices and younger doctors more interested in salaried positions; and strong regulations on ownership of medical practices which can limit competition.

9. Evidence from the literature on the impact of financialisation in outpatient care on health policy goals such as quality of care, cost, and equity and access remains scarce and mostly based on data from the United States. To date, most countries surveyed reported that no evaluations were taking place, with just three reporting that national or regional authorities had published reports on financialisation in the health sector. On access, while some studies suggest slightly improved appointment success rates in private equity owned-clinics in the United States, others highlight concerns about private equity acquisitions predominantly targeting metropolitan areas with high percentages of privately insured individuals.

10. Quality of care assessments are particularly scarce in the outpatient sector, with some studies noting improvements in operational scale and clinical outcomes in United States fertility clinics, while others raise concerns about potential "upcoding" practices prioritising profitability over patient care. However, these concerns may not be prevalent across all outpatient sectors. A study on ambulatory surgical centres found no significant changes in unplanned hospital visits between private equity-acquired, independent, and non-private centres. In some cases, financialisation has facilitated the adoption of higher care standards, such as an improvement

in the accreditation standards for laboratory practices in France. Regarding costs, several studies have documented volume and price increases in specialist practices following private equity acquisition, although the extent and underlying causes vary by speciality and market conditions.

11. While financialisation is taking place across many countries, data reporting and monitoring remain insufficient. In many cases, policymakers are flying blind when it comes to understanding the potential impacts of financialisation in their health systems. Across 20 surveyed countries, only two reported that data on healthcare practice ownership is collected and can be aggregated nationally.

12. Given continuing trends, it is critical that policymakers gain a better understanding of the extent to which financialisation is taking place, and its potential impacts on access, quality of care and costs. Health systems should consider policy options that improve transparency and ensure that key standards of quality and access are ensured. These could include more systematically collecting and aggregating information related to the ownership of outpatient services, strengthening co-operation and exchange between competition authorities and Ministries of Health, implementing standards and measures to maintain quality of care, and ensuring that price and ownership regulations ensure access (to physicians and services), to avoid inappropriate shifts in activity, and discourage increases in costs to patients or payers.

1 Financialisation of healthcare is a growing phenomenon in some OECD countries

Financialisation: key concepts and scope of the analysis

13. In recent years, financial investors have become increasingly involved in the health services sector. Many countries have seen an expansion in the types of actors a stake in their health systems. In many of these cases, these new actors have purchased small-scale, often physician-owned clinics and transformed them into consolidated businesses that are meant to harness economies of scale to overcome low margins and high capital investments that are deterrents to market entry. This trend is driven by several factors, including the sector's relative stability through economic fluctuations, opportunities for consolidation in a fragmented market, and the potential for increased efficiency in care delivery (Appelbaum and Batt, 2020^[1]). Health systems dynamics and changing demographics – among the population and the healthcare workforce – may also play a role.

14. In the health sector, financialisation typically involves the entry of for-profit financial firms and non-financial entities whose main business lies outside healthcare into the healthcare system through the purchase of practices and other healthcare services. This includes private equity firms, pension funds, and health insurers, as well as large commercial chains expanding from other sectors like food supply. This report does not consider the consolidation or integration of healthcare institutions into larger businesses or entities as financialisation, unless there is a financial investor behind the market consolidation. For example, a private hospital acquiring an outpatient practice or two hospitals merging into one are not included in this definition¹. At the same time, a hospital owned by a private equity firm that purchases outpatient practices would be considered to be financialisation. This definition aims to focus specifically on the **entry of external financial actors into the healthcare sector**, and more particularly **private equity**, distinguishing it from broader trends of healthcare market consolidation².

15. Financialisation within the health sector has taken place in the context of a broader expansion of financial sector activities in the economy. Broadly defined, financialisation refers to the growing role that financial markets, financial actors and their attendant systems have played across the economy (Aalbers, 2019^[2]). As Epstein (2005^[3]) notes, financialisation entails "the

¹ Some non-profit healthcare entities, particularly in the United States, have adopted practices similar to for-profit organisations. These include generating large revenues through consolidation and potentially reducing market competition. However, such practices are not included in this analysis which focuses on the entry of financial actors into the capital of healthcare providers.

² Consolidation refers to the practice of acquiring and merging multiple healthcare providers to increase market shares and negotiation power

increasing role of financial motives, financial markets, financial actors and financial institutions in the operation of the domestic and international economies". It can reshape how non-financial firms operate, with greater emphasis on financial activities and metrics. This often leads to changes in corporate governance and investment patterns across various industries. Financialisation can also influence government policies and public sector operations. Chiapello (2017^[4]) refers to this as "the penetration of financialised logics and forms of evaluation in the formulation and implementation of [public] policies, even when these do not involve the financial sector".

16. Financial actors in the healthcare sector typically focus on four main investment domains: pharmaceuticals, health services, health data, and medical devices. Each of these areas attracts different types of investors and employs various financial mechanisms. This report concentrates specifically on health services, with a particular emphasis on outpatient care. While the original proposal focused its scope on primary care, preliminary research and consultations suggested that most of the financialization in outpatient care was also taking place in more specialized outpatient services, and that broadening the scope of health care services considered in this project would provide a more relevant picture of current trends and challenges for health systems.

17. Importantly, financialisation does not refer to "privatisation". Nearly all OECD countries have at least some private provision of health services. In 2023, for example, 14 of the 25 respondents to the OECD Health Systems Characteristics Survey reported that outpatient specialist services were provided predominantly by private solo or group practices (OECD, 2023^[5]). Many countries have a long history of private-sector participation in the health system, including both as government-contracted service providers within the public system and as providers of services outside of or in addition to publicly provided care.

18. This report includes 4 sections. The first describes trends in the financialisation of outpatient healthcare services in OECD countries; the second focuses on determinants of this trend; the third section reviews the impact of financialisation on healthcare systems and the last sections looks at policy options to limit the negative impacts of financialisation in healthcare. Methods used to elaborate this report are described in Box 1.1.

Box 1.1. Methods

The findings in this report were developed based on information gathered through a variety of channels. In addition to desk research and a literature review on the prevalence and impact of financialisation, further information was gathered via policy surveys and expert interviews.

Policy surveys

Two policy questionnaires were developed and circulated. The **OECD Policy Survey on Financialisation in the Health Sector** was circulated to countries in the summer of 2024. The questionnaire aimed to collect information on the extent of financialisation of outpatient services in the country (4-level scale from “not at all” to “high”), the types of firms involved, the most affected sectors, the availability of statistical information on prevalence and trends, the existence of impact assessment and any policy measures related to financialisation of health care services. The questionnaire sent to countries is presented in Annex A. Countries were invited to provide links to relevant documents and provide contact names. Twenty countries (Australia, Austria, Belgium, Costa Rica, Denmark, France, Germany, Greece, Iceland, Israel, Korea, Latvia, Luxembourg, the Netherlands, Norway, Slovak Republic, Slovenia, Switzerland, the United Kingdom, and the United States) responded to the survey.

Interviews of researchers and stakeholders

Expert interviews were conducted with country experts from health ministries, competition authorities and political bodies, as well as academics, representatives of the medical profession, and financial and legal firms. Countries were invited to submit the names of experts to interview via the Policy Survey; other experts were identified via desk research and a snowball approach. Findings based on the expert interviews have been included in the report but are not identified to a specific interviewee, for privacy purposes.

Financialisation is well underway in outpatient care

Half of 20 OECD countries report that financialisation in outpatient care is a high or moderate trend in their countries

19. Even in countries with long-established private markets and private sector participation in healthcare, there appear to be new trends in the types of actors entering the health sector and the business models they have adopted. Half of countries who participated in the *OECD Policy Survey on Financialisation in the Health Sector* consider financialisation to be a moderate or high-frequency trend in the outpatient sector in their country (OECD, 2024^[6]).

20. In the decade between 2012 and 2021, for example, the acquisition of physician-owned practices by financial entities in the United States increased more than six-fold, to 484 purchases in 2021, compared to 75 in 2012 (Fuse Brown and Hall, 2024^[7]). In Norway, financialisation has increased over the last four to five years, though data is more limited (OECD, 2024^[6]). In a number of countries, the financialisation of outpatient care was preceded by prior entry into the hospital and long-term care sector by a financial entity, including the purchase of nursing homes.

21. Data from corporate analyses of financial investments in the healthcare sector point to the rapid growth of financialisation over recent years. Globally, the total disclosed deal value of private equity transactions in all sectors of healthcare grew from 112 billion USD in the five years between 2010-2014 to 446 billion USD in the five years between 2018-2022 globally (Bain & Company, 2024^[8]). Moreover, the share of transactions taking place outside of the United States appears to

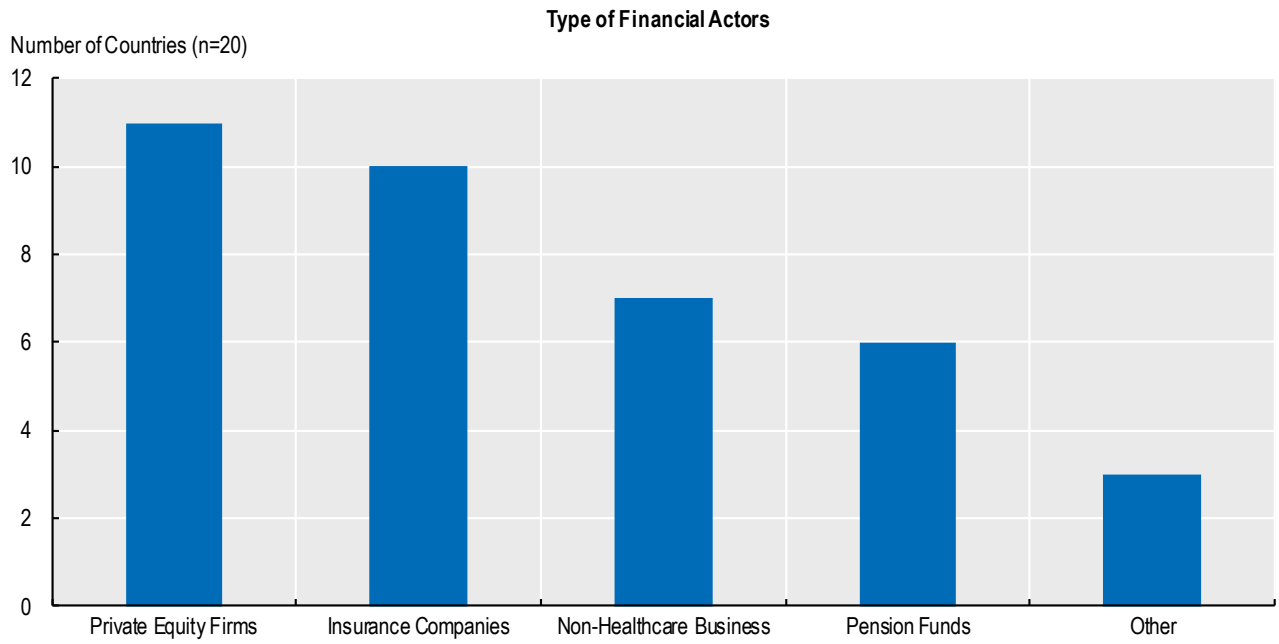
be growing, with buyout deals growing in Europe and the Asia Pacific over the period (Bain & Company, 2024^[8]).

Private equity is the most common actor involved in financialisation of the outpatient sector

22. More than half of responding countries reported that private equity actors are involved in financialisation activities in the outpatient sector in their country, more than any other type of financial firm or non-health business (see Figure 2.1). Given how recent private equity appears to have scaled-up acquisitions in outpatient care, this is particularly notable (see Box 1.2 for more information on private equity). Insurance companies and other non-healthcare businesses made up the next two most frequently reported financial firms involved in outpatient care.

23. For example, private equity funds have increased their investments in ambulatory health care centres in Germany (known as Medizinische Versorgungszentren or MVZs) in recent years, particularly following a 2015 law aimed at encouraging the development of ambulatory care practices. This law, which strengthened outpatient care and removed rules limiting MVZ growth, made these centres more attractive for business, leading to a significant increase in new MVZs. By 2021, private equity owned about 21% of the 4,179 MVZs in Germany, with many being dental practices, though investments also extended to eye care, radiology services and orthopaedics (Deloitte, 2023^[9]). Private equity funds often establish these centres with a hospital partner, attracted by stable demand and growth potential due to an ageing population and a fragmented healthcare market. Most private equity funds employ a "buy-and-build" strategy, acquiring MVZs and expanding the network (Deloitte, 2023^[9]).

24. In Sweden, a reform to primary care in 2010 has created a market for private providers in what was previously a largely publicly-provided system. As of 2020, some 40% of primary care centres were privately owned (Winblad, 2023^[10]). A 2018 analysis of contracts identified that one-third of privately owned primary care centres were owned by international private equity firms, suggesting that as many as one in eight primary care clinics in Sweden may be owned by private equity firms (Winblad, 2023^[10]).

Figure 1.1. Types of financial actors involved in the outpatient health sector

Source: OECD Policy Questionnaire on Financialisation in the Health Sector (OECD, 2024^[6]).

Box 1.2. Defining private equity

What is Private Equity?

Private equity (private equity) refers to investments normally made in private companies or assets that are not publicly traded on stock exchanges. It represents an important source of financing for businesses at various stages of development, from early-stage startups to mature companies.

Private equity firms raise capital from institutional investors and high net worth individuals to invest directly in private companies or conduct leveraged buyouts of public companies, delisting the companies from public markets and operating them as privately held entities. The goal is to improve the performance and value of these companies over a period of typically 3-7 years before exiting the investment through a sale or public offering.

Unlike public equity markets where investors can easily buy and sell shares, private equity investments cannot be readily converted into cash and have long holding periods. This allows private equity firms to take a hands-on approach in managing their portfolio companies to drive operational improvements and growth.

How does private equity work?

The private equity model typically involves the following key steps:

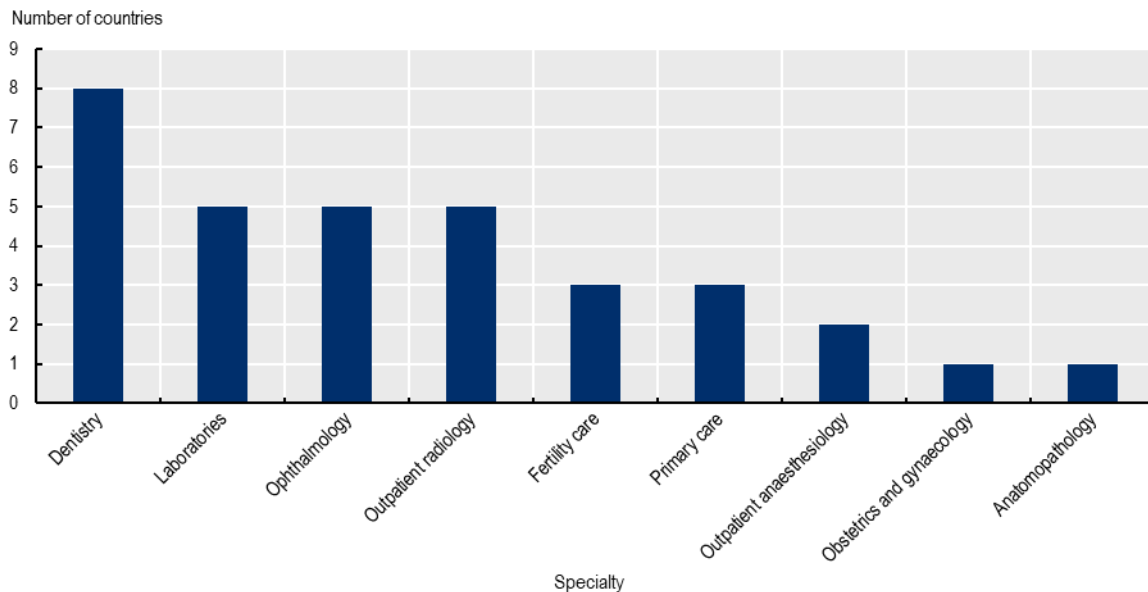
- **Fundraising:** Private equity firms raise capital by establishing investment funds, usually structured as limited partnerships. Institutional investors like pension funds and endowments commit capital as limited partners.
- **Deal sourcing and due diligence:** Firms identify potential investment opportunities and conduct extensive due diligence to assess the target company's financials, operations, management, and growth potential.
- **Investment:** The private equity firm acquires a majority stake in the target company, often using a combination of investor capital and debt financing in the case of leveraged buyouts.
- **Value creation:** The firm works closely with company management to improve operations, drive growth, and increase profitability over a 3-7 year holding period. This may involve strategic shifts, cost cutting, acquisitions, or management changes.
- **Exit:** The firm sells its stake in the company through a trade sale, secondary buyout, or initial public offering to realize returns for its investors.

Source: (Demaria, 2020^[11])

Dentistry, ophthalmology, radiology and laboratories report high financialisation

25. Certain outpatient specialities and services are more often reported to have been impacted by financialisation. Dentistry, ophthalmology, outpatient radiology, and laboratories were most frequently reported by countries to be the top three outpatient services impacted by financialisation (See Figure 1.2). Available data suggest that many of these specialities have undergone rapid consolidation and financialisation in recent years.

Figure 1.2. Number of countries reporting specialties among the top 3 impacted by financialisation



Note: N=14

Source: OECD Policy Questionnaire on the Financialisation in the Health Sector ((OECD, 2024^[6])).

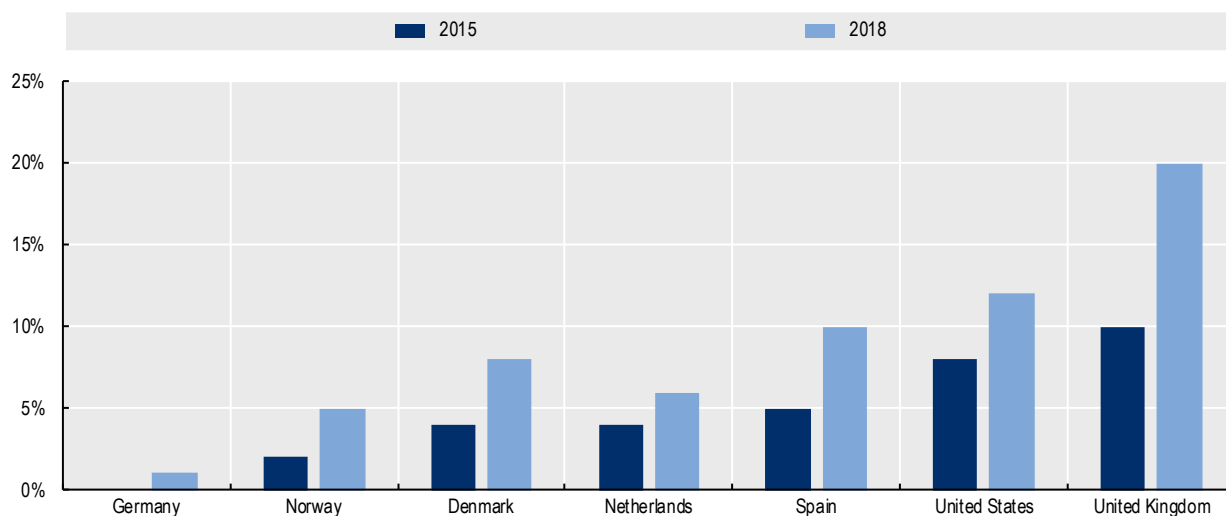
The financialisation of dental care is expanding rapidly in some countries

26. Dental services are particularly attractive for financial investors. The share of practices run by dental service organisations (DSOs)³ in dental markets across North America and Europe has grown dramatically in recent years, at least doubling in the three years between 2015 and 2018 in Denmark, Norway, Spain and the United Kingdom (See Figure 1.3) (van der Schrier and Visscher, 2020^[12]).

27. DSOs market shares in terms of revenues are generally higher than in terms of practices. In Norway, DSOs are estimated to capture 7% of the dental market share in terms of revenue, compared to 5% by practice size. In the Netherlands, 10-15% of the dental market by revenue is estimated to go to DSOs, compared to a market share of 6%. Similar trends have been found in Spain (10% of practices, 17% of revenue) and the United States (12% of practices, 16% of revenue) (van der Schrier and Visscher, 2020^[12]).

³ Dental Services Organizations (DSOs) handle the business side of dental practices, such as administrative, marketing, bookkeeping, and financial services.

Figure 1.3. Market share (by number of practices) of dental service organisations



Source: *The dental chain opportunity II: Value creation beyond a consolidation strategy* (van der Schrier and Visscher, 2020^[12]).

28. More than 80% (96 of 116) of the largest DSO deals conducted in Europe between 2017 and 2019 were found to be backed by private equity firms, who have previously been found to own 90% of the 30 largest dental service organisations (van der Schrier and Visscher, 2020^[12]). Among the 25 largest mergers and acquisition transactions for DSOs between 2005 and 2019, the value of transactions conducted by private equity or investment groups represented more than four-fifths (82%) of the value of all deals, amounting to 7.2 billion USD of 8.8 billion USD in M&A transactions over the period across six countries (Finland, Italy, the Netherlands, Spain, the United Kingdom and the United States) (van der Schrier and Visscher, 2020^[12]).

High investments in radiology and radiotherapy in some countries

29. Australia has seen significant growth in its private oncology services in recent years. Of 104 radiation oncology facilities in Australia, 42 are public and 62 are private (OECD, 2024^[6]). Moreover, at least 94% of private oncology clinics in Australia are run by one of two private equity-backed oncology chains (Australian Competition & Consumer Commission, 2024^[13]). This would suggest that more than half of all oncology clinics in Australia may be financialised. The largest oncology chain in Australia, backed by private equity and investment funds, filed for bankruptcy in 2023 after taking on \$2 billion AUD in debt following an unsuccessful attempt to expand into the US market (LaFrenz and Whyte, 2024^[14]).

30. In France, an estimated 15% of medical imaging services are owned by private equity (URPS Médecins Libéraux Auvergne-Rhône-Alpes, 2024^[15]). Recent analysis suggests private equity penetration at the physician level grew from near zero in 2012 to approximately 5% by 2021 in the United States (Abdelhadi et al., 2024^[16]). Several factors make radiology an appealing target for private equity investment. The radiology sector has historically been composed of many independent practices, offering opportunities for consolidation and economies of scale. It is also a technology-intensive field, requiring significant capital investments that private equity firms can provide, which as a result creates barrier to entry, even more so when the authorities control the number of authorised machines. Radiology practices often offer profitable ancillary services, enhancing revenue potential.

Financialisation of ophthalmology

31. The ophthalmology sector has experienced a significant surge in private equity investment over the past decade. Between 2012 and 2019, private equity firms acquired 228 ophthalmology and optometry practices in the United States, associated with 1,466 clinical locations and 2,146 ophthalmologists or optometrists (Chen et al., 2020^[17]). The pace of acquisitions accelerated markedly from 2017 onwards. While only 42 practices were acquired between 2012 and 2016, 186 practices were acquired from 2017 through 2019 (Chen et al., 2020^[17]). By 2022, an estimated 1,400 ophthalmologists were practising under private equity ownership in the United States (Groothoff and Browning, 2024^[18]). While the majority of reported private equity activity in ophthalmology has been concentrated in the United States, the trend is not limited to this market, even if equally comprehensive data remains missing for the European market. In France, “Point Vision” has become the leading national network of ophthalmological centers. The company was created in 2011, had 27 centers in 2018, and now has 562 (Imbert, Jomier and Henno, 2024^[19]). The rush of investors on ophthalmology practices in the United States has been impressive in financial terms. As of 2019, the large ophthalmology platform practices, generally worth more than \$2 million of earnings before interest, taxes, depreciation and amortisation (EBITDA), were paid eight or more times the adjusted EBITDA, while smaller practices received five to eight times the adjusted EBITDA (Brill et al., 2022^[20]).

32. Several factors make ophthalmology an attractive target for private equity investment. These include high procedural volume, the outpatient nature of services, additional revenue from ancillary services such as ambulatory surgery centres and optical shops, and an ageing population increasing demand for eye care services (Patel, Groth and Sternberg, 2019^[21]).

Financialisation of laboratories and pathology services

33. The pathology sector has experienced consolidation at different periods and under different forms in OECD countries (Satta and Edmonstone, 2018^[22]). While it started in the 1980s in the United States with mergers and acquisitions of private pathology practices, the consolidation in the United Kingdom occurred mainly between public (hospital) institutions in the 2010s. This means that consolidation does not always involve financialisation. The outpatient laboratory sector is also highly concentrated in Australia, where 3 companies accounted for 95% of all payments made to all private pathology practices in 2018 (Centre for International Economics, 2019^[23]).

34. In France, the laboratory sector has experienced a high trend of concentration and financialisation since 2010. Between 2010 and 2022, the share of sites directly owned by financial investors increased from 16% to 78%, while the number of companies shrunk from more than 3400 to 400. While public authorities had encouraged consolidation and industrialisation of the sector in the 1990, they are now trying to slow down this trend (see Box 1.3) (Leymarie, 2022^[24]).

Box 1.3. The financialisation of laboratories in France

In France, about 85% of all lab tests were performed by the private sector in 2022. Between the mid-1970s and 1990s, regulations mandated ownership and management of laboratory practices by health professionals exercising in the practice and prohibited their participation in other practices. Despite a very fragmented supply dominated by small enterprises, the sector was the most profitable of all health sectors, due to a favourable (negotiated) fee schedule.

In reaction, policymakers decided to encourage the consolidation of the sector. To that aim, a 1990 law created a new type of society, allowing participation of non-professionals to the capital up to 25% and easing the acquisition of practices. The trend towards consolidation remained modest. Another law in 2000, allowing laboratory biologists to own shares in several practices, accelerated consolidation. Although participation of non-professional (e.g., non-biologists) remained in principle limited to 25%, commercial actors from other EU countries have been able to purchase shares that exceed this limit, by leveraging differences in ownership requirements between countries. Because not all EU countries have similar ownership rules, non-professional individuals have been able to establish laboratory companies in other countries, and invest in the French laboratory sector – via their laboratory companies abroad – without their investments counting towards the non-professional threshold of 25%. Backed by financial or industrial actors, these companies launched the financialisation of the sector. Finally, a 2010 law imposing high standards of accreditation, to increase the quality of routine tests and analyses, made the system costly for small companies, further encouraged consolidation.

In 2013, policymakers attempted to slow down this trend. Since then, regional health agencies can oppose to opening, acquisition or merger of laboratory practices if this leads to a group earning more than 25% of the revenues or control more than 33% of supply in a given territory, or if the total supply is expected to exceed 25% of what was planned for this territory. In addition, the 2013 law removed the possibility for non-professional investors to create new groups. However, this law left unchanged rules applicable to existing financialised groups, still allowed to acquire new practices, the consolidation of the sector continued. Biology groups earned significantly during the covid-19 crisis and continue to have high levels of profitability. In 2021, the profit rate was 32 %. According to CNAM, high earning during Covid-19 enabled early exit of investors and secondary and tertiary LBOs, with high valuations disconnected from the real values of assets (CNAM, 2023^[25]).

Source: (Leymarie, 2022^[24])

Financialisation in primary care

35. While primary care does not appear to be the centre of financialisation activity as some other specialities, 9 of 14 responding countries reported some financialisation in the primary care sector.

36. In Sweden, a reform of 2010 aimed to increase competition between public and private providers of primary care services. Since then, two-fifths of primary care centres are estimated to be privately owned, with one-third of private centres owned by international private equity firms – corresponding to ownership of more than one in eight primary care centres overall (Winblad, Isaksson and Blomqvist, 2020^[26]; Rechel et al., 2023^[27]).

37. Finland has seen a high concentration of primary care since the 2000s thanks to a roll-up strategy of private investors. In 2022, three groups supplied 70% of primary care services in 2022 (CNAM, 2023^[25]). In France, where payments for primary care health centers do not make them

very attractive, investors may benefit from new experimental payment methods to design a profitable model of care (Imbert, Jomier and Henno, 2024^[19]). In Australia, nearly one-fifth (18%) of GPs are estimated to work in corporate group practices (Royal Australian College of General Practitioners, 2023^[28]).

38. In 2023, NIVEL looked at the different forms of commercialization of primary care services in the Netherlands (Groenewegen and Timans, 2023^[29]). They describe four types: vertical integration of GP practices by health insurers (prohibited since 2014), the constitution of for-profit General Practice Chain Organisations, the development of online services for general practices and apps for communication for patients. Focusing on the two first categories, the authors note that the number of commercialized practices is uncertain but ranges between 45 and 230 general practices, out of 4874 practices registered in 2022 (Groenewegen and Timans, 2023^[29]).

39. In the United States, Cutler and Song (2024) observed a recent increase in private investments in new primary care models, aiming to improve access to primary care to reduce further health needs (Cutler and Song, 2024^[30]). These models are based on intensive patient outreach for sicker populations or are more high-tech and based on virtual and home-base care as the first option. Authors also observed a high increase in the financial valuation of these models despite the scarcity of evaluations.

40. In Australia, private equity acquisitions of health delivery services has risen in the last 15 years, with a recent study finding the number of acquisitions increased from 3 in 2008 to 18 in 2022 (Berquist, 2024^[31]). Of the 39 acquisitions that occurred between 2020 and 2022, more than half (22 of 39) represented acquisitions of clinics or chains of clinics (Berquist, 2024^[31]). The majority of these clinics (256 of 446) were in primary care (general practice) (Berquist, 2024^[31]). Since 2017, close to 3% (2.6%) of general practice clinics were estimated to have been acquired by private equity firms, or sold between private equity firms (Berquist, 2024^[31]).

Within countries, financialisation can be particularly prevalent in certain regions

41. Financialisation has not been distributed evenly across countries, with certain regions or even metropolitan areas more impacted than others. In the United States, for example, while 7.2% of private practice urologists were estimated to be working for practices affiliated with one of five large private equity firms across the country, more than one in four urologists in New Jersey and Maryland were working for practices owned by these firms (Nie et al., 2022^[32]).

42. Consolidation represents an important lever to benefiting from economies of scale. In some cases, firms employ “roll-up” strategies to increase their market share in an area, making multiple purchases under the thresholds required for notification or authorisation to competition authorities, until they control a sizeable part of the local market. Researchers have identified near total capture of specific markets in the United States: In Idaho Falls, Idaho, for example, 91% of radiology physician groups were controlled by private equity firms, while 80% of anaesthesiology physician groups were owned by private equity funds in Wilmington, North Carolina (OECD, 2023^[33]).

43. Similarly variable distribution of financialisation has been observed in Germany, where the share of ambulatory care centres operating under the structure of *Medizinisches Versorgungszentrum* (MVZ) has grown in recent years⁴. This arrangement has grown very popular, with approximately 27% of all MVZ estimated to be investor-owned (Deutscher Bundestag, 2023^[34]). Across all dental planning areas in Germany, investor-owned MVZs are

⁴ While investors are not allowed to invest directly in MVZ, they can do so via purchasing hospitals that can in turn own MVZ clinics.

estimated to be present in less than one-fifth (18.6%) of planning areas, with very low activity in the majority of areas. However, investor-owned MVZs have been estimated to represent 10-19% of dentists within six planning areas, indicating high variability in the concentration of investor-owned services across the country (Deutscher Bundestag, 2023^[34]).

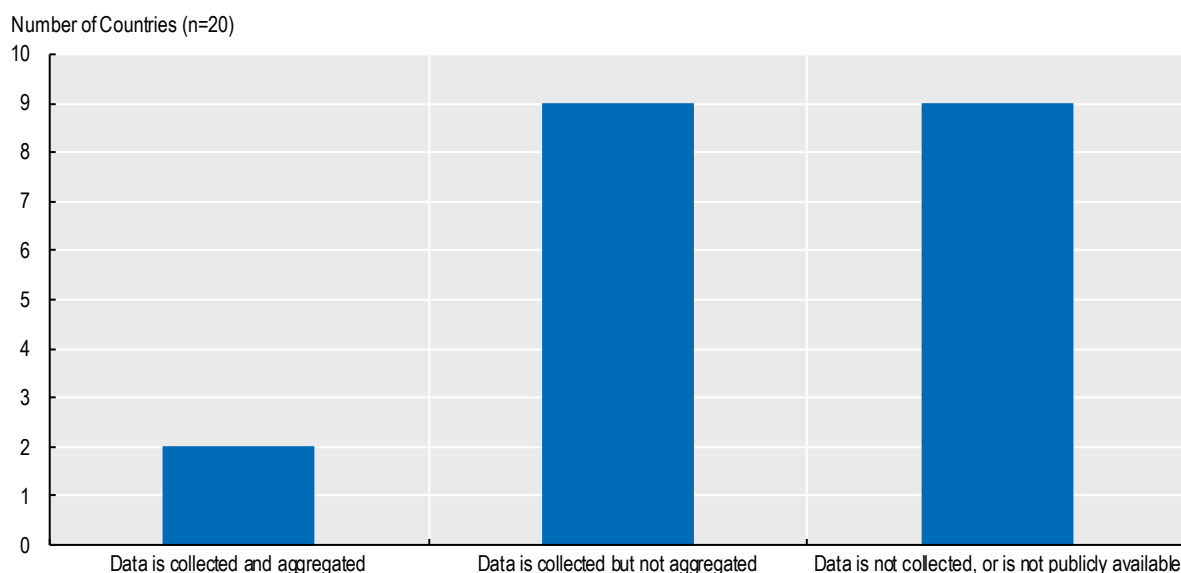
Countries do not have a good picture of the extent of financialisation in their health system

44. The first condition to monitor trends and impact of financialisation of outpatient services is to collect and analyse information on the ownership of healthcare practices. Better information related to ownership is also critical to monitoring the impact of any subsequent policies adopted to mitigate potential risks. Considering the detailed data collected by health systems on activity, outcomes and system characteristics, the lack of easily accessible data on practice ownership is noteworthy, particularly given the growing evidence around the potential impacts of different types of ownership on outcomes of interest, including healthcare cost, quality and access.

45. Across the 20 countries OECD countries responding to the OECD Survey on financialisation, only two – Costa Rica and Iceland – reported that data on healthcare practice ownership is collected and can be aggregated (see Figure 1.4). The vast majority report that information on the ownership of healthcare practices is either not collected or publicly available (9 countries) or is collected but not aggregated in a way that would enable this information to be analysed (9 countries).

Figure 1.4. Most countries do not have a good picture of the scope of financialisation

Country responses to the question, “Does your country collect and monitor information on the ownership of healthcare practices?”



Source: OECD Policy Questionnaire on Financialisation in the Health Sector (OECD, 2024^[6]).

46. Where data is not aggregated, this creates significant challenges to better understanding how financialisation – or ownership changes more broadly – might impact healthcare outcomes,

costs, access and quality. Without aggregating data on ownership into a national or regional-level database, the only way to collect this information in countries where this data is publicly available at some level is to go into the filing information of each individual practice to identify ownership information directly.

47. In the absence of national data on practice ownership, several researchers have constructed their own datasets using data from research firms specialising in mergers and acquisitions, private equity and venture capital, such as PitchBook. However, relying on these data sources poses challenges. Data provided through private research firms is not exhaustive and needs to be complemented with data with exhaustive newspaper searchers and other approaches to identify further publicly-reported acquisitions (OECD, 2024^[35]). Moreover, acquisitions below a certain monetary threshold may not be included – an issue that becomes particularly problematic if acquisitions are undertaken as part of a ‘roll-up’ strategy of purchasing and merging multiple small practices or businesses into a larger company. Lastly, the purchase of private research firm data is expensive, creating a further barrier for researchers and policymakers to access it.

48. In some cases, data exist that were not previously put to use. In the **United States**, for example, the Department of Health and Human Services and the Centers for Medicare and Medicaid published a new rule requiring more information from nursing homes on ownership, to better allow for research into the impact of certain types of ownership – notably private equity – on outcomes (Leonard and Homchick, 2023^[36]). The Centers for Medicare and Medicaid published ownership information on hospitals for the first time in December 2022, in an effort to improve transparency (Welch et al., 2023^[37]). Such requirements, however, do not appear to have been applied to outpatient practices.

2 What drives the financialisation of healthcare?

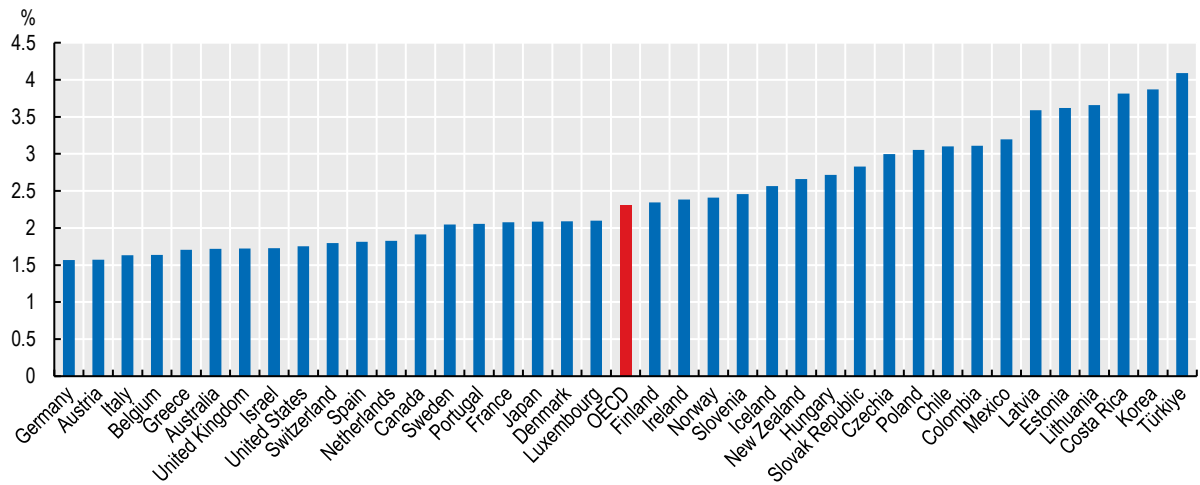
49. The financialisation of the outpatient healthcare sector is driven by a complex interplay of factors, related on one side to growing demand for care and to opportunities to make profitable investments on the supply side.

Ageing and increasing demand for health services, largely publicly financed, guarantee flows of revenues for providers

50. As populations across OECD countries age, demand for health services has grown and is projected to continue to do so in the decades ahead. Population ageing and its attendant demands for healthcare, coupled with substantial government involvement and financial support in health systems in all OECD countries, may have helped attract many investors to the sector. Investments in healthcare may be seen as relatively stable investment opportunities that can help to offset riskier investments in other sectors.

51. According to projections by the OECD, health spending from public sources across the OECD is projected to grow at an average annual rate of 2.6% in real prices for 2019-40 for the base scenario (Figure 2.1). This results from several factors, with ageing and increases in income representing the largest contributors.

Figure 2.1. Projected increase of health spending for 2019-40 in real terms (Average annual growth, base scenario)



Source: OECD (2024), Fiscal Sustainability of Health Systems: How to Finance More Resilient Health Systems When Money Is Tight?, OECD Publishing.

Opportunities for profitable investments in outpatient health care services

52. Increasing demand, coupled with good coverage of health care services or with individuals' ability and willingness-to-pay for non-covered services, are essential determinants for investors and they are observed in almost all segments of health care. However, all countries and sectors are not equally attractive. In some countries – mainly those with National Health Services – certain categories of healthcare services are only provided by the public sector. Openness to private sector provision of care, such as the possibility for private institutions to supply health care services, as well as openness to ownership of medical practices by non-professionals, may help contribute to the phenomenon of financialisation in the outpatient sector.

53. The structure of health systems can also impact the potential attractiveness of the outpatient sector for investors, by delineating the types and roles of private practices. Broadly, four different types can be identified:

- Systems with a long-standing tradition of private practices providing publicly funded services (e.g. health systems based on social insurance, like Germany, France, Austria, the Netherlands, etc.).
- Systems with more recent changes that have established the private provision of publicly-funded healthcare services; e.g., national health systems which organised purchaser-provider splits from the 1980's (e.g. some autonomous communities in Spain) or who authorise private provision of care when underfunded public providers are not in the position to provide timely care (Portugal, Denmark).
- Systems where private practices provide health care services that are mainly financed through out-of-pocket payments or private voluntary health insurance (e.g. dentistry in many countries).
- Systems where private providers deliver services that can be covered by the public system, but are delivered at the expense of patients or their voluntary (duplicate) private insurance, largely targeting wealthier individuals.

Many OECD Countries rely on private provision of outpatient specialised services

54. The first condition for a country to attract financial investors is to have private providers of outpatient healthcare services or to be open to the entry of private actors in this sector. In OECD countries, the provision of publicly funded out-patient specialist services is organised in different ways. In at least 14 OECD countries, these services are provided by private physicians in solo or group practice, providing potential targets for investors (Table 2.1). The entry of financial investors in private practice, however, is limited in some countries which regulate the ownership of private healthcare facilities (Box 3.1).

Table 2.1. Predominant modes of provision of outpatient primary care and specialist services in OECD countries

	Countries
Primary care services	
Solo private practice	Austria, Canada, Czechia, Korea, Slovak Republic, Switzerland,
Group private practice (own patients)	Estonia, Hungary, Luxembourg, Norway,
Group practice (shared patients)	Private: Australia, Belgium, Finland, Iceland, Ireland, Latvia, Lithuania, Netherlands, Poland, Slovenia, Sweden, United Kingdom Public: Portugal, Spain
Multispecialty group practice	Greece
Other	Costa Rica, Germany, Israel, Japan, United States
Outpatient specialised services	
Outpatient departments of public hospitals	Estonia, Finland, Ireland, Norway, Portugal, Slovenia, Sweden, United Kingdom
Public multi-specialty clinic	Costa Rica, Hungary, Israel, Latvia, Lithuania, Poland
Private solo practice	Austria, Belgium, Canada, Czechia, Germany, Greece, Korea, Luxembourg, Slovak Republic, Switzerland
Private group practice	Australia, France, Iceland, Netherland,
Outpatient departments of private hospitals	Spain

Source: OECD 2023 Health Systems Characteristics Survey and authors. Missing countries did not respond to the survey or to this specific question.

Box 2.11. Ownership of healthcare practices

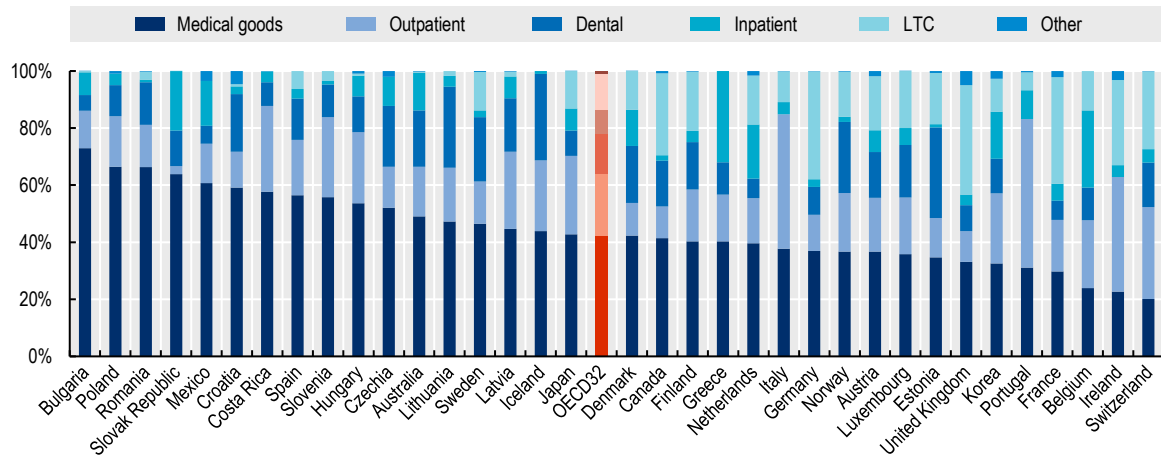
Professional autonomy has traditionally been presented by the medical profession as a driver of quality and ethics of healthcare provision. Although preserving professional autonomy is not a final objective, it is often perceived by policy makers as a means to protect quality of care, even though physicians also respond to financial incentives. This is why some countries regulate the ownership of private facilities in healthcare. Such regulation mandates that facilities are owned and managed - at least in majority- by health professionals with the aim to promote professional values and ethics over conflicting goals such as profit seeking or cost-cutting. Systematic international comparisons of ownership regulations in health care are not publicly available.

- In the United States, there is no federal regulation of ownership of healthcare practices. In most US States, however, private equity firms are prohibited from directly owning physician practices. To circumvent these regulations, firms typically link a private-equity owned physician management company with a well-established and large physician-owned medical group. Then, firms recruit additional physicians by acquiring smaller practices. Similarly, in most US states, dentists are legally required to own their practice. To circumvent this, investors create separate entities that provide related practice management and business services. Dental Services Organizations (DSOs) handle the business side of dental practices, such as administrative, marketing, bookkeeping, and financial services.
- In the European Union, national authorities have some flexibility to regulate ownership of healthcare practices and restrict EU-wide “freedom of establishment”, in order to protect public health. In France, for example, ownership of physician practices is regulated. Non-professional stakeholders cannot own more than 25% of a medical practice (Sénat, 2024). This regulation, however, has been circumvented in some cases, enabling financial firms to take majority controls of practices.
- In France, a new law, adopted in 2023, also seeks to better control the financialisation of outpatient activities, in reactions of scandals of malpractices. This new regulation imposes prior agreement from regional health authorities for new dental, ophthalmologist and orthoptic centers, as well as a monitoring of their practices and a reinforcement of sanctions in case of non-compliance (Sénat, 2024).

55. The private sector may also play a role in countries with predominant public provision of outpatient services, especially in two circumstances: first, to provide services that are not or only marginally publicly funded (typically, adult dental care); second, to provide private services to patients who cannot be treated in a timely fashion by the public sector due to waiting times, or who prefer to be treated in the private sector with higher copayments or full out-of-pocket payments because of increased choice of provider and timing of care.

56. For example, adult dental care is not or only poorly covered by social insurance or national health systems in many countries. Across 32 OECD countries, out-of-pocket payments for dental services made up 14% of all out of pocket spending on average, and comprised at least one-fifth of out-of-pocket expenditures in eight countries (Figure 2.2). This leaves room to private provision of dental care, especially for people with sufficient income and willingness to pay.

Figure 2.2. Composition of out-of-pocket spending on health, by type of service, 2022 (or nearest year)



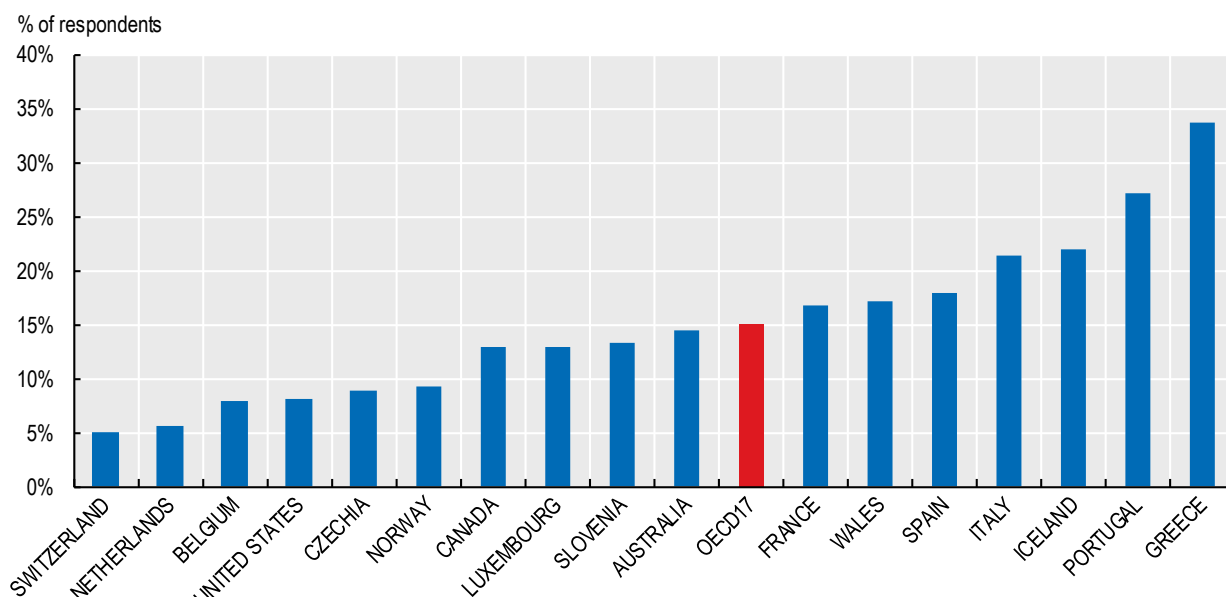
Note: 2021 or nearest year. The “Medical goods” category includes pharmaceuticals and therapeutic appliances. LTC refers to long-term care. The “Other” category includes preventive care, administrative services and services unknown. For countries that do not report spending on dental, this is typically reported under outpatient care which can affect the coverage rate.
Source: OECD Health Statistics 2024.

57. Waiting times for healthcare – both for services like general practitioner (GP) and specialist appointments, as well as for more complex care such as elective surgeries – are an important factor in patient experience and satisfaction with health services, and can impact both healthcare access and experience of care. Across OECD countries, waiting times were reported to be an issue for elective treatments (21 countries) and specialist care (20 countries) in more than four-fifths of the 24 countries responding to the 2019 OECD Waiting Times Policy Questionnaire, while half of countries reported that waiting times were also an issue in primary care (OECD, 2020^[38]). The COVID-19 pandemic also resulted in backlogs for care, including cancellations in elective procedures, which have resulted in increases in waiting times that in some cases have persisted even as medical activities rebounded (OECD, 2023^[39]).

58. Recent evidence from the OECD Patient-Reported Indicators Survey (PaRIS) underscores the impact of delays in seeing a health professional on patient experience and outcomes of care. Preliminary analysis suggests that 30% of responding patients across 17 OECD countries who waited for a week or more for an appointment reported finding these waiting times to be problematic, compared with just 11% among those who were able to get an appointment within a week, and 4% who reported getting an appointment on the same or next day. Overall, on average across 17 OECD countries, 15% of patients reported that the amount of time they waited to see a GP or specialist was a problem for them (Figure 2.3).

Figure 2.3. Waiting times are a concern for an important proportion of patients

% of respondents who found the amount of time they waited to be a problem



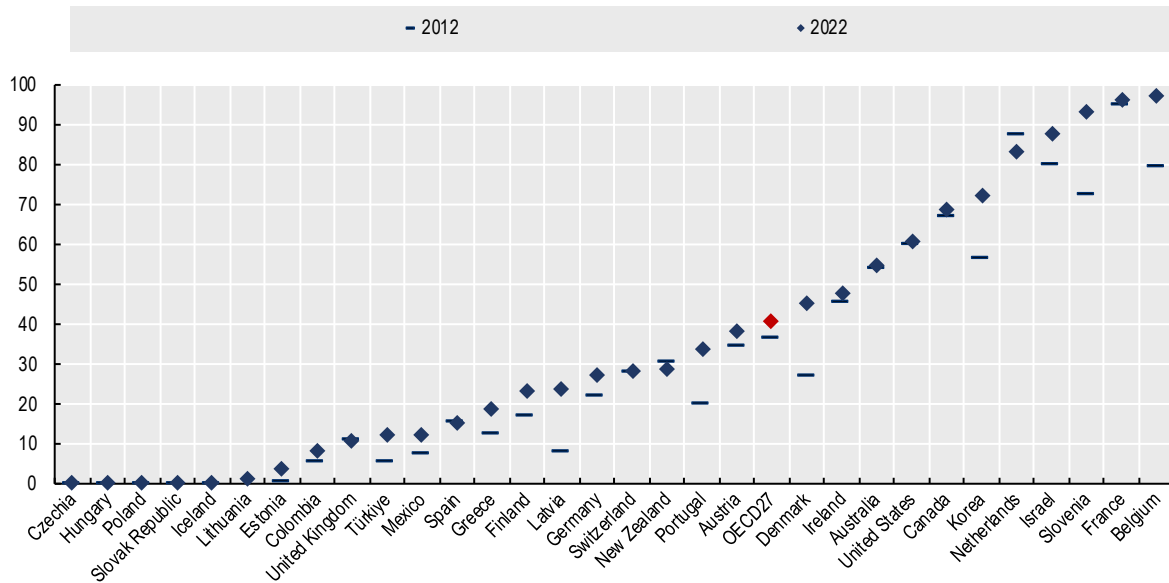
Note: Preliminary analysis based on OECD PaRIS survey data

Source: OECD Patient-Reported Indicators Survey 2024 (OECD, 2024^[40]).

59. In some countries, long waiting times have led patients to seek alternatives to the public system. In Denmark and Portugal, patients have a right to seek treatment in the private system when waiting times exceed a certain threshold. Patients in Denmark may go to a private hospital when their guaranteed waiting time between a GP or specialist referral and treatment exceeds 30 days, while patients in Portugal may use a voucher to seek care through any provider, including those working in the private sector, if they have waited for at least 75% of the maximum allowed waiting time for treatment (OECD, 2020^[38]).

60. Seeking faster access to services in private hospitals has also been cited as one reason why more people in Poland have purchased private health insurance in recent years (OECD, 2020^[38]). The share of the population covered by voluntary health insurance has grown over the past decade in nearly all OECD countries with private health insurance markets (Figure 2.4). Across 27 OECD countries where some proportion of the population has voluntary health insurance, the proportion covered by private voluntary health insurance increased in all but three countries between 2012 and 2022. The proportion of the population covered by voluntary health insurance rose by 12% - to more than 40% - between 2012 and 2022 on average across 27 OECD countries. VHI plays very different roles in health systems (OECD, 2022^[41]). It can provide supplementary coverage for services not included in the public benefit package (in Israel or Canada, for example); complementary coverage covering co-payments needed to use services included in the public benefit package (e.g. France, Slovenia); or duplicate coverage, for services delivered by providers not included in the public benefit package, to obtain faster access or increase the choice of providers (e.g. Australia, Ireland). All types of VHI can potentially contribute to the development of financialised services. The contribution of VHI to expenditures for outpatient services is relatively high in the Netherlands, Canada, France and Switzerland for example.

Figure 2.4. Proportion of the population with voluntary health coverage



Source: OECD Health Statistics 2024

61. The lack of availability of usual primary care networks to respond to urgent responses, particularly out-of-office-hours, has also encouraged the development of private groups providing 7/24 services on site or by telemedicine. This has been reported for example in France (OECD, 2024^[35]).

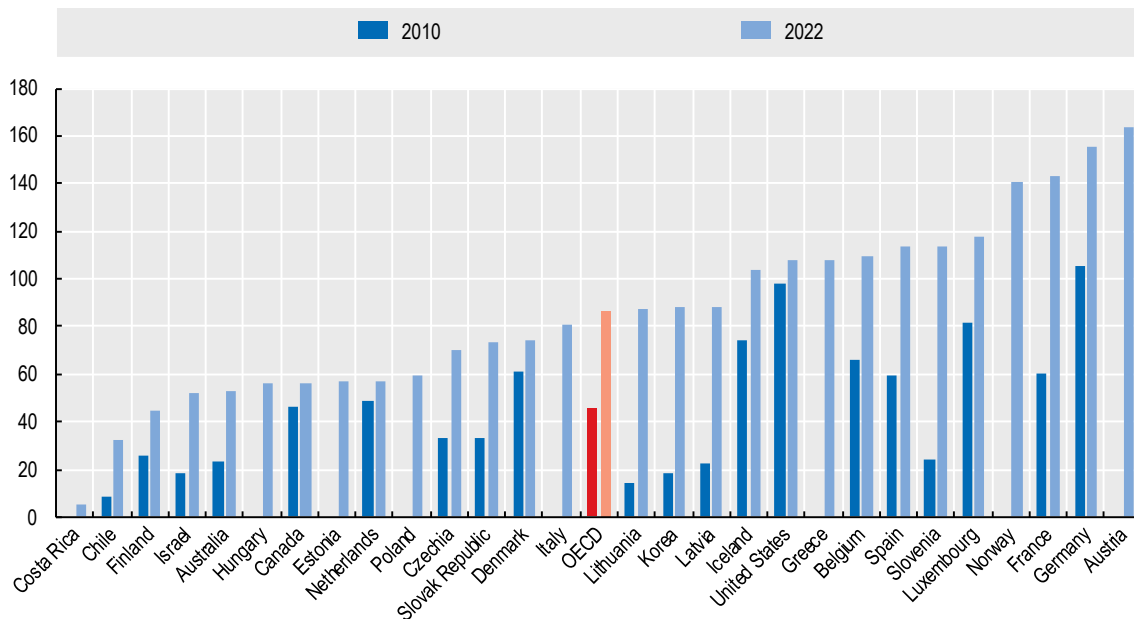
Outpatient services requiring high capital investments and with potential for market consolidation and scale economies are attractive to investors

62. Some sectors of care, such as imaging, radiotherapy, dentistry, biology, or ophthalmology, require high capital investments⁵, increasing with technological progress. Such investments are very expensive for health professionals, making seeking opportunities to partner with financial investors attractive. *De facto*, outpatient sectors reported to be most impacted by financialisation often have high upfront investment costs, with expensive equipment purchases required to set up and run a practice and high capital costs to upgrade and maintain equipment and facilities. In theory, easier access to capital and the ability to spread these costs across a larger number of physicians, practices and patients – as in the case of consolidated networks – make these sectors more attractive to capital-rich financial investors.

⁵ In many health systems, private providers of healthcare services generally invest in the equipment they need to provide care and are compensated for these investments through their remuneration, although some public support to finance investment may also be available to specific private providers in some countries. For outpatient healthcare services, existing data suggests that governments' direct investments in capital or transfers to private providers for investments in capital only account for a small proportion of governments capital expenditure in health care. In the Euro Area, for example, only 1 in 10 Euros of all government spending on Gross Fixed Capital Formation in the health sector was for outpatient services (ESTAT, 2024^[113]). For capital transfers such as investment grants, this share was even smaller."

63. Moreover, trends in health service utilisation suggest rising demand for services within these sectors. For example, on average, across OECD countries, magnetic resonance imaging (MRI) exams have risen substantially over the last decade, with diagnostic exams increasing by 89% per patient between 2010 and 2022 (Figure 2.5). Similar trends can be seen in the utilisation of other imaging technologies, including computerised tomography (CT) scans. In addition to an increase in the utilisation of diagnostic scans, the number of diagnostic machines has also increased markedly in recent years in many countries.

Figure 2.5. Trends in MRI exams, 2010-2022



Note: 2020 data for Iceland, 2021 data for United States.

Source: OECD Health Statistics 204.

64. Private investments are attractive to financial actors, and especially private equity, if there is a potential to realise profits. Consolidation of fragmented healthcare provision into a smaller number of larger providers offers opportunities to realise efficiency gains. Economies of scale can be obtained through shared administrative resources and pooled purchasing practices, while enhanced management can help cutting costs and better allocating resources.

65. Medical technology development is also expected to facilitate efficiency gains in healthcare delivery. For example, advancements in diagnostic technologies, such as liquid biopsy and point-of-care testing, have expanded the role of diagnostic laboratories in chronic condition management. In radiology and pathology, digital workflows and artificial intelligence-enabled decision-support tools are deemed to offer significant efficiency gains. Private investments can facilitate the acquisition of advanced diagnostic equipment and the implementation of these technologies, potentially improving diagnostic accuracy and patient care and reducing costs.

66. Entry barriers, such as regulation over the installation of expensive equipment or certain activities, shapes the market structure by deterring the entry of competitors. This is for instance the case for medical imaging in Austria, France, and certain US States, where the number of high-cost equipment is limited by the authorities in order control supply relative to population health needs and moderate healthcare cost increases (Rakotoniaina and Butler, 2020^[42]; Dreger,

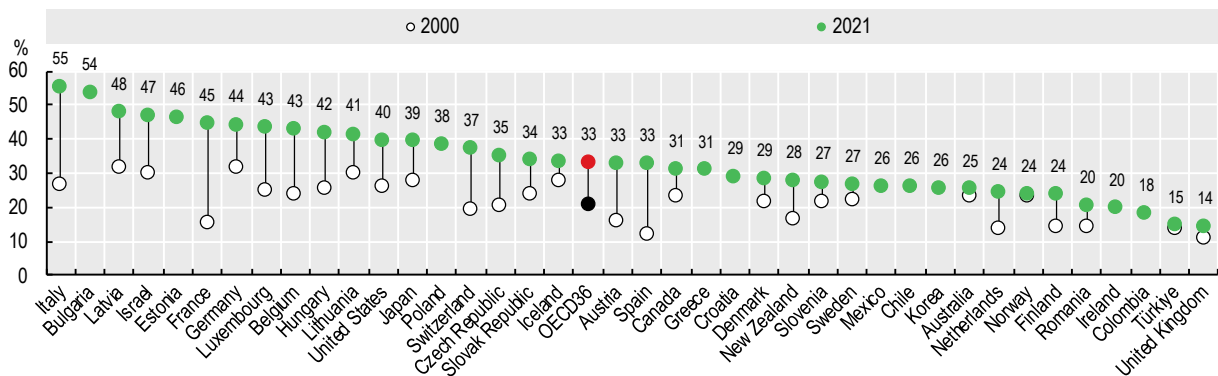
Langhoff and Henschke, 2021^[43]; Or et al., 2023^[44]). Investments in such sectors are of particular interest for financial stakeholders because they can help secure the medium-term profitability of their investments.

67. In the short term, efficiency gains are captured by investors. Public payers often regulate and adapt the prices of private healthcare services based on resource use, but fee schedules are not always adjusted in real time to take into account efficiency gains or scale economies. One exception might be US Medicare payments for physician services, which are annually updated, taking into account the “relative values” of physicians’ activities (Barber, Lorenzoni and Ong, 2019^[45]). The Centers for Medicare & Medicaid Services (CMS) does not revise every single fee based on new costing information but focuses on new, revised, and some potentially mis-valued services (Barber, Lorenzoni and Ong, 2019^[45]).

Evolving provider demographics and practice models make external investment attractive to clinicians

68. Literature and interviews insist on the impact of ageing professionals nearing retirement, struggling to find younger professionals willing and able to purchase their practice. Across OECD countries, the clinical workforce is ageing rapidly. Between 2000 and 2021, the share of the workforce aged 55 and over across OECD countries increased by 56% (Figure 2.6). By 2023, one-third of physicians, including more than half in Italy and more than 40% in a further 10 OECD countries, were at least 55 years old (OECD, 2023^[46]).

Figure 2.6. Share of doctors age 55 and older, 2000 and 2021



Source: OECD Health Statistics 2023 (OECD, 2023^[47]).

69. Several countries also report shortages of health professionals (OECD, 2016^[48]). This situation leads to increased demand for contract workers and outsourced staffing solutions but also brings growth opportunities for clinical staffing organisations and enterprises offering workforce management solutions. Investors have found potential in businesses that assist healthcare providers in managing utilisation variability and in reducing administrative burdens associated with human resources functions.

Changing aspirations and preference among healthcare workers

70. In some countries, younger doctors in particular appear to be moving away from the model of private practice ownership. Surveys of clinicians suggest that a growing number of doctors report

shifting preferences in their work life, moving away from the financial and administrative responsibilities of owning a practice towards greater perceived stability through salaried employment.

71. Between 2012 and 2022, practice ownership among younger doctors (those under 45 years) fell by 12 percentage points in the United States, dropping from just under half (44%) to less than one-third (32%) (Smith, 2023^[49]). In Germany, the proportion of doctors and psychotherapists working as salaried employees within the statutory health insurance (SHI) system has nearly doubled over the last decade, rising from 15% in 2014 to 28% in 2023 (Kassenärztliche Bundesvereinigung (KBV), 2024^[50]). In Australia, the share of general practitioners (GPs) who owned their practice fell from 35% in 2008 to 25% in 2020 (Moel-Mandel and Sundararajan, 2021^[51]). These trends reflect the expressed wishes of younger doctors, with medical school students reporting in surveys an increasing preference to work as a salaried employee, rather than owning their own practice. In France, 68% of new physicians in 2018 started their career as salaried workers, and this was also the case for 50% of new dentists in 2022 (Imbert, Jomier and Henno, 2024^[19]).

72. Shifting professional and demographic preferences among physicians also appear to be driving a growing number of doctors to reducing their hours and working part time. These changes in preferences may reduce the appeal of practice ownership, which is accompanied by significant time and administrative investments that may not reflect changing priorities among the health workforce. The proportion of doctors working part-time has grown substantially in recent years across OECD countries. In Germany, the share of doctors and psychotherapists working part-time more than doubled between 2014 and 2023, from 15% in 2014 to 35% in 2023 (Kassenärztliche Bundesvereinigung (KBV), 2024^[52]). In the United Kingdom, just over one-fifth (21%) of medical practitioners worked part time in 2023 (Office for National Statistics, 2024^[53]). In both countries, the share of women working part-time vastly dwarfed that of men, with female three times more likely than men to report working part-time. As more women enter the workforce, the overall share of physicians shifting to part-time work may continue to rise.

73. Shifting preferences in practice ownership, coupled with an increasingly ageing workforce, can compromise doctors' ability to sell their practices to young practitioners. The situation is particularly complex for physicians living in rural areas, where trends towards urbanisation have already further reduced the population of physicians interested in practicing, leading to 'medical deserts' where local populations struggle to find general practitioners available. Sectors with high capital investments are also more attractive for financial institutions than for young physicians, in part due to the high cost barriers of investing in expensive technologies (OECD, 2024^[35]).

74. These changing workforce dynamics have meant that in many cases, there is a lack of demand from the healthcare workforce to purchase existing clinics, or to establish new practices. In the absence of interested physicians, financial firms offer a lucrative opportunity for physicians who would otherwise be unable to sell their practices to retire or leave their clinics. Given the increasing age of the workforce, these trends is likely to continue to amplify in the years to come.

75. At the same time, evidence suggests that where financial firms purchase practices from physician owners, they sometimes do so at above market rates, as high as two to three times the estimated market value (OECD, 2024^[35]). Given the lack of competing demand for clinics, these inflated prices suggest one of two possibilities: physicians may be reluctant to sell to a non-independent physician practitioner at lower prices, and/or firms see significant potential room for growth in the profitability of these practices.

3 What is the impact of financialisation on health systems ?

Financialisation of healthcare services: risks and opportunities

76. The growing presence of financial investors in the health sector presents both risks and opportunities for policymakers, patients, and healthcare providers. Indeed, while offering opportunities for boosting investment, helping to keep practices on the market, and realising scale economies and other efficiencies, the financialisation of healthcare has raised concerns about potential conflicts between profit-seeking behaviour and the ethical imperatives of medical care.

77. Proponents argue that financial actors' involvement brings benefits such as an infusion of capital for investment in new technologies and facilities, operational efficiency through management expertise, and benefits from market consolidation of fragmented activities. By creating larger healthcare entities, private equity stimulates economies of scale and improves negotiating power with insurers and suppliers. However, critics point to several drawbacks, including a short-term focus that prioritises financial gains over long-term patient care quality, increased costs due to leveraged buyouts debts for instance, quality concerns from cost-cutting measures taken to increase profits, access issues where private equity-owned facilities cherry-pick profitable patients or services, and reduction of healthcare providers' professional independence (Kirsh and Kapoor, 2021^[54]).

78. Moreover, a main argument for the entry of financial actors into the health sector is that they have the capacity to bring capital investments, to improve supply in quantity and quality, and to realise efficiency gains through consolidation and management practices. Yet to date, there is extremely limited data on the impact of financialisation on capital investments. Evaluating the impact of financialisation on these outcomes requires further research.

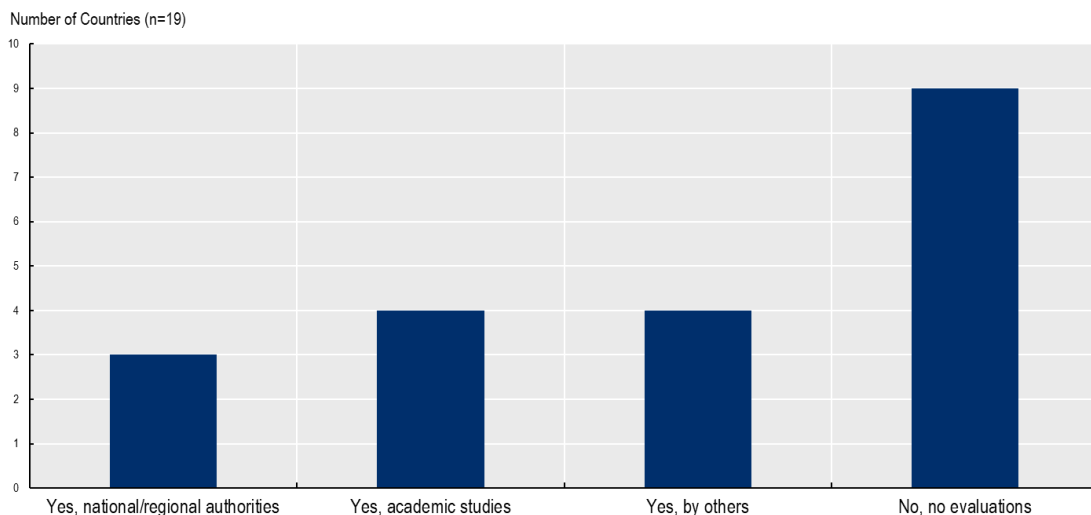
79. While the scope of this review focuses on evidence from outpatient care, it should be noted that the effect on acute and long-term care facilities is well documented in the literature. In these settings, private equity ownership is frequently associated with negative outcomes. According to recent systematic literature reviews (Borsa et al., 2023^[55]; Karamardian et al., 2024^[56]), private equity-ownership of facilities –mainly nursing homes and acute hospital care – is most often associated with negative impacts on outcomes for patients, such as mortality, major and other adverse health outcomes, and complications such as hospital acquired infections, with only one study finding better outcomes for patients (Borsa et al., 2023^[55]). The impact on costs for patients and payers is also overwhelmingly negative, due to higher volumes, higher prices and shifts in practices. Impact on access is negative for some categories of patients, with reduced percentages of Medicare, Medicaid, or Dual-Eligible patients. The evidence on impact on costs for operator is mixed, with studies finding increase and others observing a decrease in these costs. This is the same for impact on process quality, showing mixed results, though no study found a positive impact on patient experience (Borsa et al., 2023^[55]). Annex 1: Impact of financialization in long-term care and hospital settings presents further findings for nursing homes and hospitals.

80. The most important element to highlight about the impact of financialisation of outpatient services is that evidence is scarce, and mostly based on US studies. The unique features of the US health system may not make them generalisable. A recent scoping review of the impact of private equity on healthcare in New Zealand and Australia, for example, was unable to identify literature that evaluated the impacts of private equity investments in healthcare, even while noting a trend towards growing private equity ownership of clinics (McInerney et al., 2023^[57]). The paragraphs below summarise available evidence from the literature focusing on outpatient services⁶ and, in some cases, report anecdotal evidence drawn from interviews or media coverage. The first part of this section looks at impact on access and quality of care, then at impact on costs. The last part of this section presents the views of competition authorities in some countries, as well as physicians' perception of the financialisation.

Most countries have not evaluated the impact of financialisation on health system policy objectives

81. The vast majority of countries responding to the 2024 OECD Policy Questionnaire on Financialisation in the Health Sector reported that, to date, no reports or other information have been published that look at either trends in or the impacts of financialisation on healthcare (Figure 3.1). Nearly half of countries (9 of 19) reported that no evaluations were taking place, while just three – France, Israel and Norway – reported that national or regional authorities had published reports on financialisation in the health sector.

Figure 3.1. Nearly half of countries report no evaluations on the financialisation in healthcare have been published



Source: OECD Policy Questionnaire on Financialisation in the Health Sector, 2024 (OECD, 2024^[6])

⁶ The literature review identified largely PE-backed practices.

Access to Care

82. A few studies have identified beneficial impacts of private equity ownership on access to outpatient services. In the United States, Creadore et al. (2021) explored insurance acceptance, appointment waiting times, and access to dermatologists, finding that private equity-owned clinics had slightly higher appointment success rates for Blue Cross Blue Shield (BCBS) and Medicare patients (Creadore et al., 2021^[58]). However, Medicaid patients still faced significantly lower success rates and longer waiting times. private equity-owned clinics were more likely to offer new patient appointments with non-physician clinicians and had greater next-day appointment availability. This study highlights that, despite some improvements in access and service availability, significant disparities for Medicaid patients persist, underscoring the complex and often mixed effects of financializations on healthcare access.

83. Another trend identified in several studies is that private equity firms tend to buy practices in urban areas (Chen et al., 2020^[17]). One review found that private equity acquisitions in ophthalmology were predominantly located in metropolitan areas with a high percentage of privately insured individuals (Del Piero, Parikh and Weng, 2022^[59]). Similar patterns have been observed in orthopedic practices and surgical groups (Boddapati et al., 2022^[60]). Furthermore, Borsa and Bruch found that private equity-owned fertility clinics were concentrated in regions with higher median incomes. Another study on ambulatory surgical centres indicated that the majority of private equity acquisitions between 2011 and 2014 occurred in urban settings (Borsa and Bruch, 2022^[61]). In France, the consolidation of the laboratory sector has dramatically transformed supply in recent years, without changes observed in geographical access to laboratory services, but a reduction in the hours of availability (OECD, 2024^[6]).

84. While these findings do not directly indicate whether access to care is reduced or enhanced, they offer valuable insights into the geographic and socioeconomic factors that private equity firms consider prior to investment. However, research examining the effects of these investments across different countries is still lacking, highlighting a critical gap in understanding how private equity ownership influences healthcare access.

Quality of care

85. Evidence on the impact of financialisation on quality of care is also very scarce, possibly because the measurement of quality of care in the outpatient sector is traditionally less frequent than in hospitals.

86. La Forgia and Bodner (2023) analysed the effects of corporate ownership, including private equity investment, on US fertility clinics, finding significant improvements in both operational scale and clinical outcomes (La Forgia and Bodner, 2023^[62]). After being acquired by corporate entities, clinics experienced a 28.2% increase in IVF cycles and a 13.6% rise in live birth rates, with full corporate acquisitions showing the strongest gains. Clinics backed by private equity investment, which accounted for 15% of all clinics by 2018, saw a more modest 2 percentage point (pp) increase in live birth rates but a similarly large expansion in IVF cycles (28.2%). private equity-backed clinics also employed aggressive marketing strategies, such as money-back guarantees, and expanded market share without reducing the volume of independent clinics. These findings contrast with other healthcare sectors where private equity ownership has been criticised for cutting costs at the expense of patient care. In the fertility industry, the transparency of IVF success rates aligned corporate and patient interests, incentivising both corporate and private equity owners to invest in quality and growth, though private equity firms focused more on scaling operations than immediate clinical improvements.

87. However, while private equity investments can lead to increased service volume and utilisation, they do not necessarily guarantee superior clinical success rates across all metrics. Borsa and Bruch (2023) found that private equity-affiliated fertility practices in the US accounted for 29.3% of assisted reproductive technology (ART) cycles reported to the CDC (Borsa and Bruch, 2022^[61]). These practices were predominantly located in wealthier areas, with an average median household income of \$83,610 in their zip codes, compared to \$72,161 for non-private equity-affiliated practices. Service utilization patterns also differed significantly, with private equity-affiliated practices showing a 10.6% higher use of pre-implantation genetic testing (PGT) (46.4% vs. 30.9%), a trend further confirmed in sensitivity analyses. Despite these differences, there were no statistically significant variations in key success rates, such as the percentage of intended retrievals, completed retrievals, or transfers resulting in live births between private equity and non-private equity-affiliated practices, indicating that while private equity-affiliated practices may offer more extensive services, they do not necessarily achieve higher success rates.

88. Beyond fertility care, the influence of private equity ownership extends to other outpatient sectors as well. Braun et al. (2021) investigated dermatology practices in the United States and found that while private equity-owned clinics experienced a higher volume of cosmetic procedures and elective surgeries, these increases were not necessarily accompanied by improved patient outcomes (Braun et al., 2021^[63]). The study raised concerns about potential “upcoding” practices, where procedures are billed at higher rates without corresponding improvements in clinical effectiveness or patient satisfaction. This highlights the potential risk of financialisation prioritising profitability over patient care. However, these concerns may not be prevalent across all outpatient sectors, as a study on ambulatory surgical centers did not find statistically significant changes in unplanned hospital visits when comparing private equity-acquired centers with independent and non-private centers (Bruch et al., 2022^[64]).

89. In some cases, financialisation facilitates the adoption of higher standards of care. For instance, in France, the law imposing the accreditation of laboratory practices to improve the quality of tests is being seen as the real accelerator of the consolidation of the sector since the costs and burden of accreditation could hardly be borne by smaller enterprises (Leymarie, 2022^[24]) (See Box 1.3).

Impact on costs

90. Several studies have documented volume and price increases in specialist practices following private equity acquisition. However, the extent of these increases and their underlying causes vary by speciality and market conditions. Practices related to price regulation across different health systems is likely to affect the impact of financialisation on cost.

91. Researchers in the United States found that in eight of the ten specialties studied, private equity was associated with statistically significant increases in prices of physician services. The price increases were as follows: gastroenterology (14%), dermatology (4%), orthopaedics (7.1%), oncology (16.4%), and primary care (4.1%). This impact was more pronounced in markets where a single firm controlled over 30% of the market, leading to further elevated prices in specialties like gastroenterology (18%), obstetrics and gynaecology (16%) and dermatology (13%). The authors believe that small sample sizes explain why two specialties were not associated with statistically significant price increase (urology and cardiology). The same study found that per-patient expenditure also increased for six of the ten specialties, ranging from 4.1% in dermatology to 16.4% in gastroenterology. These price increases may ultimately lead to higher insurance premiums, negatively impacting consumers (Scheffler et al., 2023^[65]).

- Ophthalmology, Gastroenterology, and Dermatology: An analysis of 578 practices found that private equity acquisitions were linked with a 20% increase in charges per claim alongside a 38%

increase in new patient visits, and a 16% higher volume of encounters compared with non-private equity-owned practices. These trends indicate that private equity acquisition may drive higher healthcare costs through increased service utilization and possibly more intensive coding and billing practices. (Singh et al., 2022^[66]).

- **Dermatology:** A focused study on dermatology practices found that prices for routine visits were 3–5% higher 1.5 years after private equity acquisition compared to non-private equity-owned practices. This was accompanied by a 4.7% to 17% increase in the volume of patients per private equity dermatologist compared to non-private equity dermatologists. Overall, this suggests that private equity firms may seek to utilise their dominance in a market to increase prices paid by health insurers, whilst also increasing patient volume to maximise revenue (Braun et al., 2021^[63]). This is further supported by another study which found that dermatology practices owned by private equity firms and large corporations were linked to increased spending in Medicare (Konda et al., 2019^[67]).
- **Urology:** Research in the United States found that before acquisition, urologists who later joined private equity groups had higher average Medicare payments and patient volumes compared to those who did not. After acquisition, private equity-affiliated urologists saw an 11.0% increase in Medicare payments and a 12.5% rise in patient volume, while non-private equity-affiliated urologists experienced a 6% decline in payments and a modest 2.7% increase in patient volume. These results suggest that private equity firms target practices with already higher payments and volumes, and the gap between private equity and non-private equity practices may widen post-acquisition (Nie et al., 2022^[68]).
- **Ambulatory Surgical Centres (ASCs):** One study found no statistically significant differences in total costs or total encounters for Medicare beneficiaries following acquisition compared to independent ambulatory surgical centres or those acquired by non-private entities. However, the authors note that further research and increased transparency on such acquisitions is necessary to monitor long-term effects on quality as well as financial sustainability (Bruch et al., 2022^[64]).
- **Anaesthesia Practitioners:** Another study found that outpatient practices in the United States contracting with physician management companies (PMC) saw increases in allowed amounts and unit prices paid to anaesthesia practitioners of 16.5% and 18.7%, respectively, compared to facilities that did not partner with physician management companies. Furthermore, this impact was even more significant for companies with private equity investment, which experienced a 26% increase in allowed amounts and 25.6% increase in unit prices. This indicates that PMCs, especially those supported by private equity, may be able to negotiate higher rates for anaesthesia services, perhaps due to their enhanced market leverage and negotiating skills. The price increase may lead to higher insurance premiums and patient cost-sharing (La Forgia et al., 2022^[69]).

92. A recent study of the Finnish Competition and Consumer Authority (FCCA) on private healthcare and dental markets shows significant price increases in acquired clinics, compared to non-acquired clinics: around 20% for auxiliary services (such as medical imaging and laboratory tests), and over 10% in the dental market. These trends may partly be explained by differences between independent and chain clinics in digital service availability and objective functions (Buri, Heinonen and Pietola, 2024^[70]).

93. It is important to note, however, that price increases may not be possible in all health systems and all sectors of care, as many countries regulate the fees payable for healthcare services covered by the government or compulsory health insurance. Nonetheless, even in countries with stricter regulations on price, some concerns have been raised on the ability of payers to negotiate prices when consolidation has reduced the number of service providers in the market.

94. When practices backed by financial firms generate more volumes and higher costs than competitors, it is important to understand whether these result from greater access and response to unmet medical needs, attraction of patients from other providers, or overbilling and over-

provision of services. Fuse Brown and Hall (2024) presents numerous cases of fraud and overbilling in private equity-backed facilities (Fuse Brown and Hall, 2024^[71]).

Competition authorities are increasingly concerned about consolidation in the healthcare sector, often linked to financialisation

95. Competition authorities, who are responsible for ensuring market competition and regulating anti-competitive behaviour in countries, can play an important role in monitoring acquisitions and mergers that can impact who owns healthcare practices. Increasingly, competition authorities have expressed concern at rising trends towards financialisation and consolidation of healthcare activities in the health sector, and have taken steps to better understand and influence the issue.

- In the United States, the Federal Trade Commission (FTC) has worked with other federal agencies, including the Department of Justice and the Department of Health and Human Services, to look into the growing corporatisation of healthcare in the United States. A public FTC workshop on private equity in healthcare was organised in March 2024. The FTC has also sued a number of healthcare companies for anticompetitive behaviour. Given the size of the US healthcare market, the FTC cannot monitor all mergers and acquisitions taking place, and instead responds in an ad-hoc manner to potential cases that are brought to its attention, including by members of the public.
- In Australia, the Australian Competition & Consumer Commission (ACCC) recently published concerns about lease acquisitions undertaken by one of the country's largest private providers of oncology services, which is owned by an international private equity firm. The ACCC reported concerns that further acquisitions of leases in the area would further strengthen its position in the market and reduce competition, allowing it to reduce service quality or increase prices (Australian Competition & Consumer Commission, 2024^[72]).
- In Finland, the Finnish Competition Authorities have drawn attention to “stealth” consolidation that has taken place in the health sector, finding that a very small proportion of all mergers in the health sector were notified to Competition Authorities, but that the resulting “roll-ups” in the sector have led to increases in prices at clinics that were acquired (Buri, Heinonen and Pietola, 2024^[70]).

96. Expert interviews with market authorities working on competition and consolidation concerns in the health sector suggested that co-ordination between market authorities and health systems policymakers is fragmented, with poor information exchange occurring between the two actors. Improving information exchange between health policymaking and market regulators would help to ensure that policies within the health sector do not have unintended consequences for competition that could impact health systems performance – including cost, quality and access – in the longer term.

Physician Perspectives on healthcare financialisation

97. The financialisation of healthcare has raised concerns among physicians about the impact on professional autonomy and patient care. In the United States, a survey of 602 early-career radiologists found that 85% were aware of this trend, with 86% believing it negatively impacts radiology. Most of them preferred independent practices, citing fears that corporate ownership prioritised profit over patient care, potentially harming their earnings and work-life balance. Additionally, concerns about the lack of transparency in practice acquisitions were prevalent (Ortiz, Muroff and Vijayarathi, 2020^[73]).

98. Within radiology, several physicians have written about the negative impacts of increased corporatisation and consolidation. Many find that the potential benefits of private equity, such as economies of scale, are simply not enough to outweigh the negative impact firms can have on physician autonomy as well as overall physician well-being. Davis and D'Souza (2024) advocate for greater "physician ownership and physician control" (Davis and D'Souza, 2024^[74]). They urge radiologists and physician groups to come together to make informed decisions about the future of radiology. A Health Policy Expert Panel of the Journal of American College of Radiology reiterated some of these arguments, along with potential ways of mitigating the risks of private equity involvement. One of the proposed ways of achieving this includes holding private equity firms accountable for their commitment to positive health outcomes, care quality, and technological innovation (Lee et al., 2023^[75]).

99. Many of these concerns were echoed by another study focused on private equity acquisitions in ophthalmology (O'Donnell et al., 2020^[76]). Researchers conducted 35 semi-structured interviews with stakeholders such as physicians, consultants, attorneys, and private equity leaders to understand the motivations and concerns surrounding these deals. Many physicians, particularly those approaching retirement, were drawn to private equity because of high sale prices and relief from administrative burdens. Ophthalmology practices are especially attractive to private equity firms due to the specialty's fragmented structure, high demand for services, and diverse revenue streams. However, concerns emerged regarding the potential impact of private equity ownership on clinical care, with some physicians worried about increased pressure to maximise revenue through higher procedure volumes or costlier treatments. While private equity acquisitions may introduce efficiencies and capital for growth, physicians also feared a loss of professional autonomy and a shift toward more profit-driven clinical decisions. However, these considerations vary between early, mid, and late career physicians (Khan, 2022^[77]).

100. Shah and Wolfe (2022) argue that successful partnerships between private equity firms and physicians requires alignment in values and objectives (Shah and Wolfe, 2022^[78]). They mentioned the case of a company) which consolidated many refractive surgery practices in the United States. The private equity entity required physicians to treat a greater volume of patients, resulting in 20% of the chain's physicians to leave, and a number to sue the company for putting profits over patient care.

101. In a 2020 study conducted in the United States, Novice et al. surveyed 137 dermatology residents about their perceptions of private equity ownership of medical practices (Novice, Portney and Eshaq, 2020^[79]). Most respondents expressed negative views, with 65% indicating an unwillingness to work for practices backed by private equity, and 70% believing that private equity involvement has had a negative impact on dermatology. Furthermore, 77.3% felt that private equity ownership would adversely influence their future career choices. There was a statistically significant association between residents' willingness to work for private equity-backed practice and their views on private equity's impact on physician autonomy, quality of care, and long-term earnings. These concerns are echoed in numerous editorials and opinion pieces authored by physicians (Konda et al., 2019^[67]; Resneck, 2018^[80]; Sharfstein and Slocum, 2019^[81]). Furthermore, many dermatologists have expressed concerns regarding the utilization of less qualified dermatology personnel, such as physician extenders in private equity-backed practices. According to Konda et al. (2019), physician extenders can generate higher profits due to reduced salaries compared to dermatologists, and the level of supervision may vary significantly across practices (Konda et al., 2019^[67]). Additionally, some practices may categorize physician extenders as physicians on their websites, which could create misunderstandings for patients.

102. A study in Germany similarly highlighted physicians' fears about losing professional autonomy and decline in care quality under private equity ownership (Nolte, Miedaner and Sülz,

2022^[82]). Many physicians believed that private equity firms prioritise profits over patient care, which contrasts sharply with the core values of the medical profession. While some younger physicians noted potential benefits such as improved work-life balance and managerial expertise, apprehensions persisted about the sustainability of private equity-owned practices. Interviewees stated that private equity firms often lack the medical expertise needed to foster effective partnerships. Another significant concern was the short-term nature of private equity involvement, typically three to seven years. Furthermore, many interviewees criticised the practice of private equity firms removing profits from the German healthcare system, including the potential for profits to be moved offshore. Importantly, this study, along with others, highlighted a lack of adequate empirical support for many critical arguments surrounding private equity involvement (Nolte, Miedaner and Sülz, 2022^[82]). This represents a limitation in the existing literature, indicating a need for more robust research.

4 Policy considerations going forward

103. Trends toward financialisation in the health sector, and particularly the entry of private equity firms, have been found to be associated with largely – although not exclusively – negative outcomes for health systems and patients. At the same time, much of the evidence thus far has been published based on findings from one unique health system (the United States), calling into question the generalisability of current findings for other health systems.

104. Existing evidence from other sectors, nursing homes and hospitals in particular, and evidence from other non-health sectors that have experienced financialisation in recent years, provide a strong rationale for policymakers to consider policy action to minimise the risks for health policy objectives from the financialisation in the health sector, particularly the entry of private equity firms, and to more actively monitor trends in, and the impact of, financialisation on outpatient services (see Table 4.1). This highlights the need to build an information system that enables improved monitoring, and for improved policies on how to draw benefits from financialisation while protecting patients and healthcare payers from harmful impacts.

Table 4.1. Policy options for reducing the risks of financialisation

Policy	Policy target	Policymaker concerned
Transparency (of ownership)	Evidence-based policymaking, accountability	Ministries of Health
Quality standards and reporting requirements	Quality of care	Ministries of Health
Ownership regulations (practices and equipment)	Access (to physicians/practices and services)	Ministries of Health
Price regulation, Update of fee schedules	Capture a share of efficiency gains Avoid inappropriate shifts in activity due to distortions in fee schedules	Ministries of Health
Competition reviews	Consolidation, access (to physicians/practices), price increases	Competition authorities

Source: OECD analysis, informed by Fuse Brown and Hall, 2024 (Fuse Brown and Hall, 2024^[71]).

105. Requirements related to collecting and aggregating information on the ownership of healthcare services should be enhanced to improve monitoring and facilitate the collection of quality metrics to understand more reliably the impacts of ownership structures on quality of care. In order to safeguard quality of care, policymakers could also consider establishing mandatory minimum requirements such as staffing levels, as research showed that private equity acquisition is frequently associated with staff reductions that can lead to adverse patient outcomes. Policy makers could implement requirements that protect against "asset stripping" such as the sale of critical assets post-acquisition which can undermine care quality.

106. Research shows that private equity acquisitions frequently lead to higher prices, particularly through consolidation. To address this, regulators could consider strengthening antitrust oversight, including lowering the threshold for merger review to capture smaller acquisitions that collectively can create significant market concentration and are frequently not visible to authorities. Additionally, policymakers could be empowered to review and potentially block acquisitions that would lead to anticompetitive pricing power. Regulatory oversight could also include requirements that private equity firms demonstrate how their acquisitions would maintain or improve access to care, particularly for underserved areas or populations. Given that these facilities often serve as essential community providers, maintaining equitable access to care should be a critical policy consideration when reviewing acquisitions by financial entities.

107. Some of these policy options are outside of the scope of Ministries of Health. As described above, action by competition authorities represents an important policy tool for regulating financialisation. Stronger co-ordination between Ministries of Health, Ministry of Trade and Finance, and competition authorities could also help Ministries of Health address the harmful consequences of financialisation.

108. Overall, this report suggests that while financialisation can bring capital to healthcare organisations, without proper safeguards it risks prioritising short-term financial gains over quality of care. As healthcare systems face mounting pressures from aging populations and increasing costs, policymakers must strike a careful balance between leveraging private investment and protecting public health objectives. This requires developing robust regulatory frameworks that ensure transparency, maintain quality standards, and preserve affordable access while allowing for beneficial private sector participation. Moving forward, policy makers should strengthen their capacity to monitor and evaluate the impact of financial ownership in healthcare, share best practices in regulatory oversight, and develop evidence-based policies that safeguard policy objectives of quality, and affordable healthcare for all.

References

- Aalbers, M. (2019), *Financialization*, Oxford Wiley. [2]
- Abdelhadi, O. et al. (2024), “Private Equity–Acquired Physician Practices And Market Penetration Increased Substantially, 2012–21”, *Health Affairs*, Vol. 43/3, pp. 354-362, <https://doi.org/10.1377/hlthaff.2023.00152>. [16]
- Appelbaum, E. and R. Batt (2020), “Private Equity Buyouts in Healthcare: Who Wins, Who Loses?”, *Institute for New Economic Thinking Working Paper Series*, pp. 1-115, <https://doi.org/10.36687/inetwp118>. [1]
- Australian Competition & Consumer Commission (2024), *Icon Group’s proposed lease acquisitions raise concerns*, <https://www.accc.gov.au/media-release/icon-groups-proposed-lease-acquisitions-raise-concerns>. [72]
- Australian Competition & Consumer Commission (2024), *Statement of Issues: Icon - proposed acquisitions in the radiation oncology sector*, <https://www.accc.gov.au/system/files/public-registers/documents/Icon%20Group%27s%20proposed%20acquisitions%20-%20Statement%20of%20Issues.pdf>. [13]
- Bain & Company (2024), *Global Healthcare Private Equity Report 2024*, https://www.bain.com/globalassets/noindex/2024/bain_report_global_healthcare_private_equity_2024.pdf. [8]
- Barber, S., L. Lorenzoni and P. Ong (2019), *Price setting and price regulation in health care: Lessons for advancing Universal Health Coverage*, <https://iris.who.int/bitstream/handle/10665/325547/9789241515924-eng.pdf?sequence=1&isAllowed=y>. [45]
- Beaulieu, N. et al. (2020), “Changes in Quality of Care after Hospital Mergers and Acquisitions”, *New England Journal of Medicine*, Vol. 382/1, pp. 51-59, <https://doi.org/10.1056/nejmsa1901383>. [91]
- Berquist, V. (2024), “Private equity investment in health care delivery, Australia, 2008–2022”, *Medical Journal of Australia*, Vol. 220/7, pp. 368-371, <https://doi.org/10.5694/mja2.52270>. [31]
- Boddapati, V. et al. (2022), “Recent Trends in Private Equity Acquisition of Orthopaedic Practices in the United States”, *Journal of the American Academy of Orthopaedic Surgeons*, <https://doi.org/10.5435/jaaos-d-21-00783>. [60]
- Borsa, A. et al. (2023), “Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: systematic review”, *BMJ*, Vol. 382:e075244, <https://doi.org/10.1136/bmj-2023-075244>. [83]
- Borsa, A. et al. (2023), “Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: systematic review”, *BMJ*, p. e075244, <https://doi.org/10.1136/bmj-2023-075244>. [55]

- Borsa, A. and J. Bruch (2022), "Prevalence and performance of private equity-affiliated fertility practices in the United States", *Fertility and Sterility*, Vol. 117/1, pp. 124-130, <https://doi.org/10.1016/j.fertnstert.2021.08.035>. [61]
- Bos, A. and C. Harrington (2017), "What Happens to a Nursing Home Chain When Private Equity Takes Over? A Longitudinal Case Study", *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, Vol. 54, <https://doi.org/10.1177/0046958017742761>. [101]
- Braun, R. et al. (2021), "Private Equity In Dermatology: Effect On Price, Utilization, And Spending", *Health Affairs*, Vol. 40/5, pp. 727-735, <https://doi.org/10.1377/hlthaff.2020.02062>. [63]
- Braun, R. et al. (2021), "Association of Private Equity Investment in US Nursing Homes With the Quality and Cost of Care for Long-Stay Residents", *JAMA Health Forum*, Vol. 2/11, p. e213817, <https://doi.org/10.1001/jamahealthforum.2021.3817>. [85]
- Braun, R. et al. (2020), "Comparative Performance of Private Equity–Owned US Nursing Homes During the COVID-19 Pandemic", *JAMA Network Open*, Vol. 3/10, p. e2026702, <https://doi.org/10.1001/jamanetworkopen.2020.26702>. [88]
- Brill, D. et al. (2022), "Private equity in ophthalmology: lessons from other specialties", *Current Opinion in Ophthalmology*, Vol. 33/5, pp. 352-361, <https://doi.org/10.1097/icu.0000000000000876>. [20]
- Broms, R., C. Dahlström and M. Nistotskaya (2023), "Provider Ownership and Indicators of Service Quality: Evidence from Swedish Residential Care Homes", *Journal of Public Administration Research and Theory*, Vol. 34/1, pp. 150-163, <https://doi.org/10.1093/jopart/muad002>. [98]
- Bruch, J., S. Gondi and Z. Song (2021), "COVID-19 and Private Equity Investment in Health Care Delivery", *JAMA Health Forum*, Vol. 2/3, p. e210182, <https://doi.org/10.1001/jamahealthforum.2021.0182>. [106]
- Bruch, J., S. Gondi and Z. Song (2020), "Changes in Hospital Income, Use, and Quality Associated With Private Equity Acquisition", *JAMA Internal Medicine*, Vol. 180/11, p. 1428, <https://doi.org/10.1001/jamainternmed.2020.3552>. [105]
- Bruch, J. et al. (2022), "Private Equity Acquisitions Of Ambulatory Surgical Centers Were Not Associated With Quality, Cost, Or Volume Changes", *Health Affairs*, Vol. 41/9, pp. 1291-1298, <https://doi.org/10.1377/hlthaff.2021.01904>. [64]
- Buri, R., M. Heinonen and M. Pietola (2024), *The ones that got away? Stealth consolidation in the Finnish private healthcare market*. [111]
- Buri, R., M. Heinonen and M. Pietola (2024), *The ones that got away? Stealth consolidation in the Finnish private healthcare market*, <https://www.kkv.fi/tutkimus-ja-vaikuttaminen/julkaisut/working-papers/the-ones-that-got-away-stealth-consolidation-in-the-finnish-private-healthcare-market/>. [70]
- Centre for International Economics (2019), *The economic value of pathology: achieving better health, and a better use of health resources*, https://www.publicpathology.org.au/wp-content/uploads/2019/07/Economic-value-of-pathology_June-2019-APPROVED.pdf. [23]

- Cerullo, M. et al. (2022), "Association Between Hospital Private Equity Acquisition and Outcomes of Acute Medical Conditions Among Medicare Beneficiaries", *JAMA Network Open*, Vol. 5/4, p. e229581, <https://doi.org/10.1001/jamanetworkopen.2022.9581>. [100]
- Chen, E. et al. (2020), "Private Equity in Ophthalmology and Optometry", *Ophthalmology*, Vol. 127/4, pp. 445-455, <https://doi.org/10.1016/j.ophtha.2020.01.007>. [17]
- Chiapello, E. (2017), "La financiarisation des politiques publiques", *Mondes en développement*, Vol. 178/2. [4]
- Cho, S. et al. (2019), "Nurse staffing, nurses prioritization, missed care, quality of nursing care, and nurse outcomes", *International Journal of Nursing Practice*, Vol. 26/1, <https://doi.org/10.1111/ijn.12803>. [97]
- CNAM (2023), *Améliorer la qualité du système de santé et maîtriser les dépenses: Propositions de l'Assurance Maladie pour 2024*, https://www.assurance-maladie.ameli.fr/sites/default/files/2023-07_rapport-propositions-pour-2024_assurance-maladie.pdf. [25]
- Creadore, A. et al. (2021), "Insurance Acceptance, Appointment Wait Time, and Dermatologist Access Across Practice Types in the US", *JAMA Dermatology*, Vol. 157/2, p. 181, <https://doi.org/10.1001/jamadermatol.2020.5173>. [58]
- Cutler, D. and Z. Song (2024), "The New Role of Private Investment in Health Care Delivery", *JAMA Health Forum*, Vol. 5/2, p. e240164, <https://doi.org/10.1001/jamahealthforum.2024.0164>. [30]
- Davis, L. and S. D'Souza (2024), "Private equity in radiology – Why aren't we more concerned?", *Current Problems in Diagnostic Radiology*, Vol. 53/4, pp. 449-451, <https://doi.org/10.1067/j.cpradiol.2024.04.001>. [74]
- Del Piero, J., R. Parikh and C. Weng (2022), "Driving forces and current trends in private equity acquisitions within ophthalmology", *Current Opinion in Ophthalmology*, Vol. 33/5, pp. 347-351, <https://doi.org/10.1097/icu.0000000000000880>. [59]
- Deloitte (2023), *The Future of Private-Equity-led Medical Care Centers in Germany*, <https://www.deloitte.com/de/de/services/financial-advisory/analysis/future-of-private-equity-led-medical-care-centers.html>. [9]
- Demaria, C. (2020), *Introduction to private equity, debt and real assets: From venture capital to LBO, senior to distressed debt, immaterial to fixed assets.*, John Wiley & Sons. [11]
- Deutscher Bundestag (2023), *Antwort der Bundesregierung auf die Kleine Anfrage der Fraktion der CDU/CSU - Drucksache 20/4778 - Auswirkungen investorengetragener Medizinischer Versorgungszentren auf das Gesundheitssystem in Deutschland*, <https://dserver.bundestag.de/btd/20/051/2005166.pdf>. [34]
- Dreger, M., H. Langhoff and C. Henschke (2021), "Adoption of large-scale medical equipment: the impact of competition in the German inpatient sector", *The European Journal of Health Economics*, Vol. 23/5, pp. 791-805, <https://doi.org/10.1007/s10198-021-01395-w>. [43]
- Epstein, G. (2005), *Financialization and the world economy*, Edward Elagr. [3]

- ESTAT (2024), *Eurostat database 2024 - General government expenditure by function (COFOG)*, [113]
https://ec.europa.eu/eurostat/databrowser/view/gov_10a_exp_custom_13599532/default/table.
- Evers, J. and M. Geraedts (2023), “Potential determinants of the quantity and duration of COVID-19 outbreaks in geriatric long-term care facilities”, *BMC Geriatrics*, Vol. 23/1, [86]
<https://doi.org/10.1186/s12877-023-04446-4>.
- Fuse Brown, E. and M. Hall (2024), “Private equity and the corporatization of health care”, [71]
Stanford Law Review, Vol. 76, pp. 527-596,
https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4373557.
- Fuse Brown, E. and M. Hall (2024), “Private Equity and the Corporatization of Health Care”, [7]
Stanford Law Review, Vol. 76, pp. 527-596.
- Gandhi, A., Y. Song and P. Upadrashta (2020), “Have Private Equity Owned Nursing Homes Fared Worse Under COVID-19?”, *SSRN Electronic Journal*, [89]
<https://doi.org/10.2139/ssrn.3682892>.
- Gao, J., M. Sevilir and Y. Kim (2021), “Private Equity in the Hospital Industry”, *SSRN Electronic Journal*, [90]
<https://doi.org/10.2139/ssrn.3924517>.
- Grabowski, D. et al. (2016), “Low-Quality Nursing Homes Were More Likely Than Other Nursing Homes To Be Bought Or Sold By Chains In 1993–2010”, *Health Affairs*, Vol. 35/5, pp. 907-914, [102]
<https://doi.org/10.1377/hlthaff.2015.1042>.
- Groenewegen, P. and R. Timans (2023), *Commercial chains in general practice*, [29]
https://www.nivel.nl/sites/default/files/bestanden/1004398_0.pdf.
- Groothoff, J. and D. Browning (2024), “Assessing Private Equity Involvement in Ophthalmology: Parallels with the Past, Concerns for the Future”, *American Journal of Ophthalmology*, [18]
<https://doi.org/10.1016/j.ajo.2024.09.026>.
- Gupta, A. et al. (2021), *Owner Incentives and Performance in Healthcare: Private Equity Investment in Nursing Homes*, National Bureau of Economic Research, Cambridge, MA, [84]
<https://doi.org/10.3386/w28474>.
- Harrington, C. et al. (2017), “Marketization in Long-Term Care: A Cross-Country Comparison of Large For-Profit Nursing Home Chains”, *Health Services Insights*, Vol. 10, [108]
<https://doi.org/10.1177/1178632917710533>.
- Hyer, K. et al. (2011), “The Influence of Nurse Staffing Levels on Quality of Care in Nursing Homes”, *The Gerontologist*, Vol. 51/5, pp. 610-616, [96]
<https://doi.org/10.1093/geront/gnr050>.
- Imbert, C., B. Jomier and O. Henno (2024), *Rapport d'information fait au nom de la commission des affaires sociales (1) sur la financiarisation de l'offre de soins*, [19]
<https://www.senat.fr/rap/r23-776/r23-7761.pdf>.
- Kane, C. (2023), “Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022”, *American Medical Association*. [110]

- Kannan, S., J. Bruch and Z. Song (2023), “Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition”, *JAMA*, Vol. 330/24, p. 2365, <https://doi.org/10.1001/jama.2023.23147>. [92]
- Karamardian, M. et al. (2024), “An Update on Impacts of Private Equity Ownership in Health Care: Extending a Systematic Review”, *Health Management, Policy & Innovation*, Vol. 9/2, <https://hmpi.org/category/new-research-private-equity-investments-impacts/?pdf=4765>. [56]
- Kassenärztliche Bundesvereinigung (KBV) (2024), *Gesundheitsdaten: Immer mehr Ärztinnen und Ärzte, Psychotherapeutinnen und Psychotherapeuten arbeiten Teilzeit*, <https://gesundheitsdaten.kbv.de/cms/html/16400.php>. [52]
- Kassenärztliche Bundesvereinigung (KBV) (2024), *Gesundheitsdaten: Trend zur Anstellung in der vertragsärztlichen Versorgung hält an*, <https://gesundheitsdaten.kbv.de/cms/html/16399.php>. [50]
- Katz, B. et al. (2023), *Baby HSRs: States Are Modeling Laws After Federal Act to Investigate More Transactions*, <https://www.hklaw.com/en/insights/publications/2023/10/baby-hsrs-states-are-modeling-laws-after-federal-act>. [112]
- Khan, M. (2022), “Private equity acquisitions: physician considerations at different stages of career”, *Current Opinion in Ophthalmology*, Vol. 33/5, pp. 381-384, <https://doi.org/10.1097/icu.0000000000000872>. [77]
- Kirsh, G. and D. Kapoor (2021), “Private Equity and Urology”, *Urologic Clinics of North America*, Vol. 48/2, pp. 233-244, <https://doi.org/10.1016/j.ucl.2020.12.004>. [54]
- Konda, S. et al. (2019), “Future considerations for clinical dermatology in the setting of 21st century American policy reform: Corporatization and the rise of private equity in dermatology”, *Journal of the American Academy of Dermatology*, Vol. 81/1, pp. 287-296.e8, <https://doi.org/10.1016/j.jaad.2018.09.052>. [67]
- Konetzka, R., S. Stearns and J. Park (2007), “The Staffing–Outcomes Relationship in Nursing Homes”, *Health Services Research*, Vol. 43/3, pp. 1025-1042, <https://doi.org/10.1111/j.1475-6773.2007.00803.x>. [95]
- Kumar, W. (2024), “Steward Health Care: A Cautionary Tale”, *Health Management, Policy & Innovation*, Vol. 9/2, https://hmpi.org/hmpi_issue/private-equity-investments-in-healthcare-june-2024-special-issue-volume-9-issue-2/feed/?pdf=4811. [109]
- La Forgia, A. and J. Bodner (2023), “Corporate Ownership and Firm Performance: Evidence from Fertility Clinics”, *Academy of Management Proceedings*, Vol. 2023/1, <https://doi.org/10.5465/amproc.2023.11712abstract>. [62]
- La Forgia, A. et al. (2022), “Association of Physician Management Companies and Private Equity Investment With Commercial Health Care Prices Paid to Anesthesia Practitioners”, *JAMA Internal Medicine*, Vol. 182/4, p. 396, <https://doi.org/10.1001/jamainternmed.2022.0004>. [69]
- LaFrenz, C. and J. Whyte (2024), *GenesisCare emerges from bankruptcy, cuts deal with government*, <https://www.afr.com/companies/healthcare-and-fitness/genescare-emerges-from-bankruptcy-cuts-deal-with-government-20240218-p5f5t5>. [14]

- Lee, C. et al. (2023), "JACR Health Policy Expert Panel: Private Equity Investment in Radiology", *Journal of the American College of Radiology*, Vol. 20/9, pp. 940-942, <https://doi.org/10.1016/j.jacr.2023.01.014>. [75]
- Leonard, M. and R. Homchick (2023), *Ownership Transparency: The New Normal in Healthcare?*, <https://www.dwt.com/insights/2023/12/new-rule-for-medicare-medicaid-nursing-facilities>. [36]
- Leymarie, A. (2022), "L'échec de la lutte contre la financiarisation des laboratoires de biologie médicale", *Tribunes*, Vol. 73, pp. 75-85, https://www.jle.com/fr/revues/tsa/e-docs/lehec_de_la_lutte_contre_la_financiarisation_des_laboratoires_de_biologie_medicale_350036/article.phtml?tab=citer. [24]
- McInerney, M. et al. (2023), "Private Equity Investment in Private For-Profit Healthcare in Australia and New Zealand: A scoping review", *Asia Pacific Journal of Health Management*, <https://doi.org/10.24083/apjhm.v18i2.2347>. [57]
- Moel-Mandel, C. and V. Sundararajan (2021), "The impact of practice size and ownership on general practice care in Australia", *Medical Journal of Australia*, Vol. 214/9, p. 408, <https://doi.org/10.5694/mja2.51038>. [51]
- Morris, P., L. Phalippou and B. Wu (2022), "How Deadly Is Financial Leverage? Evidence from Care Homes during the COVID-19 Crisis", *SSRN Electronic Journal*, <https://doi.org/10.2139/ssrn.4017507>. [87]
- Nie, J. et al. (2022), "Urology Practice Acquisitions by Private Equity Firms from 2011e2021", *Urology Practice*, Vol. 9/1, <https://doi.org/10.1097/UPJ.000000000000269>. [32]
- Nie, J. et al. (2022), "Association Between Private Equity Acquisition of Urology Practices and Physician Medicare Payments", *Urology*, Vol. 167, pp. 121-127, <https://doi.org/10.1016/j.urology.2022.03.045>. [68]
- Nolte, T., F. Miedaner and S. Sülz (2022), "Physicians' Perspectives Regarding Private Equity Transactions in Outpatient Health Care—A Scoping Review and Qualitative Analysis", *International Journal of Environmental Research and Public Health*, Vol. 19/23, p. 15480, <https://doi.org/10.3390/ijerph192315480>. [82]
- Novice, T., D. Portney and M. Eshaq (2020), "Dermatology resident perspectives on practice ownership structures and private equity-backed group practices", *Clinics in Dermatology*, Vol. 38/3, pp. 296-302, <https://doi.org/10.1016/j.clindermatol.2020.02.008>. [79]
- O'Donnell, E. et al. (2020), "The Growth Of Private Equity Investment In Health Care: Perspectives From Ophthalmology", *Health Affairs*, Vol. 39/6, pp. 1026-1031, <https://doi.org/10.1377/hlthaff.2019.01419>. [76]
- OECD (2024), *OECD Expert Interviews on Financialisation in the Health Sector*. [35]
- OECD (2024), *OECD Policy Questionnaire on Financialisation in the Health Sector*. [6]
- OECD (2024), "Preliminary analysis based on OECD PaRIS survey data". [40]
- OECD (2023), *Health at a Glance 2023*. [46]
- OECD (2023), *Health Systems Characteristics Survey*. [5]

- OECD (2023), *OECD Health Statistics*. [47]
- OECD (2023), *Ready for the Next Crisis? Investing in Health System Resilience*, OECD Health Policy Studies, OECD Publishing, Paris, <https://doi.org/10.1787/1e53cf80-en>. [39]
- OECD (2023), *Serial Acquisitions and Industry Roll-ups*, [https://one.oecd.org/document/DAF/COMP\(2023\)13/en/pdf](https://one.oecd.org/document/DAF/COMP(2023)13/en/pdf). [33]
- OECD (2022), *Focus on: Private health insurance spending*, https://www.oecd.org/en/publications/private-health-insurance-spending_4985356e-en.html. [41]
- OECD (2020), *Waiting Times for Health Services: Next in Line*, OECD Health Policy Studies, OECD Publishing, Paris, <https://doi.org/10.1787/242e3c8c-en>. [38]
- OECD (2016), *Health Workforce Policies in OECD Countries: Right Jobs, Right Skills, Right Places*, OECD Health Policy Studies, OECD Publishing, Paris, <https://doi.org/10.1787/9789264239517-en>. [48]
- Office for National Statistics (2024), “Occupation (SOC2020) by sex, employment status and full/part time”, *nomis: official census and labour market statistics*, <https://www.nomisweb.co.uk/> (accessed on 2024). [53]
- Ortiz, D., L. Muroff and A. Vijayasarithi (2020), “Early-Career Radiologists’ Perceptions of National Corporations in Radiology”, *Journal of the American College of Radiology*, Vol. 17/3, pp. 349-354, <https://doi.org/10.1016/j.jacr.2019.12.013>. [73]
- Or, Z. et al. (2023), *France: Health system review*. [44]
- Patel, S., S. Groth and P. Sternberg (2019), “The Emergence of Private Equity in Ophthalmology”, *JAMA Ophthalmology*, Vol. 137/6, p. 601, <https://doi.org/10.1001/jamaophthalmol.2019.0964>. [21]
- Patwardhan, S., M. Sutton and M. Morciano (2022), “Effects of chain ownership and private equity financing on quality in the English care home sector: retrospective observational study”, *Age and Ageing*, Vol. 51/12, <https://doi.org/10.1093/ageing/afac222>. [104]
- Pradhan, R. et al. (2013), “Private equity ownership and nursing home financial performance”, *Health Care Management Review*, Vol. 38/3, pp. 224-233, <https://doi.org/10.1097/hmr.0b013e31825729ab>. [94]
- Rakotoniaina, A. and J. Butler (2020), *50-State Scan of State Certificate-of-Need Programs*, <https://nashp.org/state-tracker/50-state-scan-of-state-certificate-of-need-programs/>. [42]
- Rechel, B. et al. (2023), “Private equity investment in Europe’s primary care sector—a call for research and policy action”, *European Journal of Public Health*, Vol. 33/3, pp. 354-355, <https://doi.org/10.1093/eurpub/ckad061>. [27]
- Resneck, J. (2018), “Dermatology Practice Consolidation Fueled by Private Equity Investment”, *JAMA Dermatology*, Vol. 154/1, p. 13, <https://doi.org/10.1001/jamadermatol.2017.5558>. [80]
- Royal Australian College of General Practitioners (2023), *General Practice Health of the Nation 2023: An annual insight into the state of Australian general practice*, <https://www.racgp.org.au/getmedia/122d4119-a779-41c0-bc67-a8914be52561/Health-of-the-Nation-2023.pdf.aspx>. [28]

- Satta, G. and J. Edmonstone (2018), “Consolidation of pathology services in England: have savings been achieved?”, *BMC Health Services Research*, Vol. 18/1, <https://doi.org/10.1186/s12913-018-3683-8>. [22]
- Scheffler, R. et al. (2023), *Monetizing medicine: Private equity and competition in physician practice markets*, https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf. [65]
- Shah, C. and J. Wolfe (2022), “How private equity achieves return on investment in ophthalmology”, *Current Opinion in Ophthalmology*, <https://doi.org/10.1097/icu.0000000000000879>. [78]
- Sharfstein, J. and J. Slocum (2019), “Private Equity and Dermatology—First, Do No Harm”, *JAMA Dermatology*, Vol. 155/9, p. 1007, <https://doi.org/10.1001/jamadermatol.2019.1322>. [81]
- Singh, Y. et al. (2022), “Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization”, *JAMA Health Forum*, Vol. 3/9, p. e222886, <https://doi.org/10.1001/jamahealthforum.2022.2886>. [66]
- Smith, T. (2023), *Generational trends underlie doctors’ move from private practice*, <https://www.ama-assn.org/practice-management/private-practices/generational-trends-underlie-doctors-move-private-practice#:~:text=physicians%20forgo%20ownership-Younger%20physicians%20forgo%20ownership,were%20independent%20contractors%20in%202022>. [49]
- Stevenson, D. and D. Grabowski (2008), “Private Equity Investment And Nursing Home Care: Is It A Big Deal?”, *Health Affairs*, Vol. 27/5, pp. 1399-1408, <https://doi.org/10.1377/hlthaff.27.5.1399>. [93]
- Stevenson, D. et al. (2023), *Trends in Ownership Structures of U.S. Nursing Homes and the Relationship with Facility Traits and Quality of Care (Research Brief)*, <https://aspe.hhs.gov/sites/default/files/documents/29b280bc8ec7632e5742ab466f5429d2/ownership-structures-nh-facility-traits.pdf>. [103]
- URPS Médecins Libéraux Auvergne-Rhône-Alpes (2024), *Financiarisation: en radiologie, CORAIL fait la différence*, <https://urps-med-aura.fr/financiarisation-en-radiologie-corail-fait-la-difference/>. [15]
- van der Schrier, B. and N. Visscher (2020), *The dental chain opportunity II: Value creation beyond a consolidation strategy*, <https://assets.kpmg.com/content/dam/kpmg/xx/pdf/2020/06/the-dental-chain-opportunity-part-2-2020.pdf>. [12]
- Welch, W. et al. (2023), *Ownership of Hospitals: An Analysis of Newly-Released Federal Data & A Method for Assessing Common Owners*, <https://aspe.hhs.gov/reports/hospital-ownership>. [37]
- Winblad, U. (2023), “Private equity investment in Sweden’s primary care sector and regulatory responses to avoid risk selection”, *European Journal of Public Health*, Vol. 33/Supplement_2, <https://doi.org/10.1093/eurpub/ckad160.408>. [10]
- Winblad, U., P. Blomqvist and A. Karlsson (2017), “Do public nursing home care providers deliver higher quality than private providers? Evidence from Sweden”, *BMC Health Services Research*, Vol. 17/1, <https://doi.org/10.1186/s12913-017-2403-0>. [99]

Winblad, U., D. Isaksson and P. Blomqvist (2020), "Preserving social equity in marketized primary care: strategies in Sweden", *Health Economics, Policy and Law*, Vol. 16/2, pp. 216-231, <https://doi.org/10.1017/s1744133120000092>. [26]

Yu, J. et al. (2023), "Physician Management Companies and Neonatology Prices, Utilization, and Clinical Outcomes", *Pediatrics*, Vol. 151/4, <https://doi.org/10.1542/peds.2022-057931>. [107]

Annex 1: Impact of financialization in long-term care and hospital settings

109. The financialization of LTCFs and hospitals, primarily through private equity (private equity) firms and other investment-driven ownership models, has been extensively researched over the last decade, particularly in the United States. This limits the generalizability of findings to other countries; however, the documented effects provide valuable insights into the impacts on patients and residents in a variety of settings.

110. According to a recent systematic literature review (Borsa et al., 2023^[83]) (Karamardian et al., 2024^[56]), private equity-ownership of facilities -mainly nursing homes and acute hospital care-, is most often associated with negative impacts on outcomes for patients, such as mortality, major and other adverse health outcomes, and complications such as hospital acquired infections, with only one study finding better outcomes for patients. The impact on costs for patients and payers is also overwhelmingly negative, due to higher volumes, higher prices and shifts in practices. Impact on access is negative for some categories of patients, with reduced percentages of Medicare, Medicaid, or Dual-Eligible patients. The evidence on impact on costs for operator is mixed, with studies finding increase and others observing a decrease in these costs. This is the same for impact on process quality, showing mixed results, though no study found a positive impact on patient experience. The paragraphs below presents in more details some findings for nursing homes and hospitals.

Health Outcomes

111. The ownership of LTCFs by financial entities has been linked to worse health outcomes for residents. In the United States, research by the National Bureau of Economic Research found that private equity acquisition of nursing homes was associated with an 11% increase in mortality both during a resident's stay and in the 90-day period following discharge (Gupta et al., 2021^[84]). Similarly, another US study found higher incidences of ambulatory-care-sensitive (ACS) emergency department visits (11.1%) and hospitalizations (8.7%) in private equity-owned nursing homes compared to non-private equity-owned facilities (Braun et al., 2021^[85]).

112. During the COVID-19 pandemic, the negative impact of private equity ownership was further highlighted. In Germany, higher mortality rates were found in private equity-owned facilities compared to non-private equity-owned facilities (Evers and Geraedts, 2023^[86]). In the United Kingdom, research found that highly leveraged (indebted) care home groups had significantly higher death rates than care homes that were not highly leveraged (Morris, Phalippou and Wu, 2022^[87]). Additionally, another US study reported that private equity-owned nursing homes were less likely to have one-week supplies of medical gowns and N95 masks (Braun et al., 2020^[88]). However, some conflicting evidence exists: a study found fewer resident and staff cases in private equity-owned facilities (Gandhi, Song and Upadrashta, 2020^[89]), while not all studies found there were statistically significant differences in COVID-19 cases or mortality based on nursing home

ownership (Braun et al., 2020^[88]). These discrepancies may be due to differences in study design, regional healthcare policies, or specific operational models used by individual private equity firms.

113. In acute care settings, the effects of private equity ownership on patient outcomes have been mixed. Some studies have shown minimal impacts on clinical outcomes, such as mortality and readmission rates. For instance, one study found that private equity-acquired hospitals in the United States did not experience significant changes in these metrics compared to non-acquired hospitals (Gao, Sevilir and Kim, 2021^[90]). Another found no significant changes in mortality or readmission rates post-acquisition, although there was a slight decline in patient experience scores (Beaulieu et al., 2020^[91]). In contrast, other research linked private equity acquisition to a 25.4% increase in hospital-acquired infections, even though private equity-owned hospitals tended to serve younger and lower-risk Medicare beneficiaries. This suggests that lower standards of care in private equity-owned hospitals may be driving worse outcomes for patients (Kannan, Bruch and Song, 2023^[92]).

Workforce Stability

114. Financialization has significantly affected workforce stability in both LTCFs and acute care settings. In LTCFs, private equity acquisition has been associated with reductions in staffing ratios, particularly among registered nurses, which can adversely affect patient care (Stevenson and Grabowski, 2008^[93]). Private equity-owned nursing homes have been found to have fewer registered nurse (RN) hours per patient day compared to other for-profit types (Pradhan et al., 2013^[94]). Instead, these facilities often relied on less-qualified staff, such as licensed practical nurse (LPN) and certified nurse assistants (CNA). This staffing structure is associated with reduced care quality, as higher RN-to-patient ratios are consistently linked with better patient outcomes (Konetzka, Stearns and Park, 2007^[95]; Hyer et al., 2011^[96]; Cho et al., 2019^[97]).

115. Workforce reductions due to financialization extend beyond the US context. In Sweden, nonprofit-run residential homes generally had higher staff density and better-trained employees compared to for-profit facilities, including those owned by private equity firms. Residents in nonprofit homes reported higher satisfaction levels, and for-profit facilities underperformed on input-related quality indicators such as staff-to-resident ratios (Broms, Dahlström and Nistotskaya, 2023^[98]). Private equity-owned nursing homes had fewer staff compared to non-profit and other private ownership types, with only two or three staff per resident. These findings were further corroborated by Winblad and colleagues (Winblad, Blomqvist and Karlsson, 2017^[99]).

116. In acute care settings, staffing changes following private equity acquisition are similarly concerning. One study found that private equity firms typically maintain or stabilize the number of core clinical workers, such as doctors and nurses, but often cut administrative and support staff to reduce costs (Gao, Sevilir and Kim, 2021^[90]). This can lead to initial periods of high turnover and disrupt hospital operations. Additionally, reduced staffing in non-clinical roles may indirectly affect care quality and efficiency by increasing the burden on remaining staff and potentially impacting coordination and patient services. Private equity-owned hospitals have been found to have experienced reductions in nurse staffing and total staffing despite increased inpatient utilization. This may have contributed to improved financial performance, but potentially at a cost to care quality (Cerullo et al., 2022^[100]).

Quality of Care

117. Private equity-owned nursing homes have been reported to receive more citations and deficiencies compared to other ownership types (Bos and Harrington, 2017^[101]; Grabowski et al., 2016^[102]). Pradhan (2013) determined that although private equity-owned nursing homes received more citations, they were less likely to be cited for actual harm compared to other for-profit ownership types (Pradhan et al., 2013^[94]). Furthermore, Stevenson and colleagues (2023) found that private equity-owned nursing homes received poorer inspection scores (2.49/5) compared to non-profit ownership (Stevenson et al., 2023^[103]).

118. In England, private equity-backed care homes were more likely to receive ratings of "requires improvement" or "inadequate" compared to not-for-profit care homes (Patwardhan, Sutton and Morciano, 2022^[104]). While private equity chains performed better in governance and operational engineering ("well-led" domain), they were rated lower in safety, effectiveness, and responsiveness outcome measures. These deficiencies are often attributed to cost-cutting practices, such as reducing resident-to-staff ratios.

119. The impact of financialization on quality of care within inpatient settings has shown varied effects, perhaps due to the smaller number of studies. One study found that private equity-acquired hospitals demonstrated improved performance in specific clinical areas compared to non-acquired hospitals (Bruch, Gondi and Song, 2020^[105]). Specifically, the aggregate score for acute myocardial infarction care increased by 3.3 percentage points, while the score for pneumonia care rose by 2.9 percentage points (Bruch, Gondi and Song, 2020^[105]). Both findings were statistically significant. However, another study reported lower patient satisfaction scores in private equity-owned hospitals compared to similar non-private equity-owned hospitals (Bruch, Gondi and Song, 2021^[106]). Furthermore, another study found that physician management company (PMC) affiliation of NICUs led to increases in price and physician spending (Yu et al., 2023^[107]). However, there were no significant changes in utilization, readmissions, or clinical outcomes. The study notes that this may be due to limitations of the study design, and future research on process indicators and mortality are necessary (Yu et al., 2023^[107]).

Impact on costs

120. In long-term care facilities, private equity ownership can lead to higher costs for both payers and residents. Gupta et al. (2021) found that Medicare billing for residents' stays as well as for post-discharge care during the 90 days following their stay, was higher in private equity-owned nursing homes (Gupta et al., 2021^[84]). Likewise, Braun et al. (2021) identified a 3.9% quarterly increase (\$1080 per resident annually) in Medicare costs per resident after private equity acquisition, further highlighting the cost implications of private equity involvement in the sector (Braun et al., 2021^[85]).

121. Moreover, Liu (2022) determined that after private equity buyouts, healthcare spending increased by 11%, driven primarily by higher prices at both private equity-owned hospitals and non-private equity hospitals, due to market spillover effects. However, this increase in spending did not correlate with greater service utilization. Counterfactual simulations in the study indicate that reduced private equity involvement could lead to lower prices without compromising the quality or quantity of services offered. Not all studies have observed significant cost differences; another study found that no significant changes in total healthcare payments per thirty-day care episode were found between private equity-acquired and non-private equity-acquired hospitals (Cerullo et al., 2022^[100]).

122. Higher profits have been a consistent finding in private equity-owned healthcare facilities. Pradhan et al. (2013) observed that private equity-owned nursing homes reported higher profit margins compared to facilities owned by other investor types (Pradhan et al., 2013^[94]). In the United States, private equity ownership has been found to be associated with increases in net income, including higher charges per inpatient day and increases in the charge to cost ratio for emergency room visits (Bruch, Gondi and Song, 2020^[105]). A cross-national analysis of for-profit nursing home chains in the US, UK, Sweden, and Canada found that private equity-owned homes had higher revenues and profit margins (Harrington et al., 2017^[108]). Similarly, Gao et al. (2021) documented an increase in profitability post-acquisition in private equity-owned hospitals (Gao, Sevilir and Kim, 2021^[90]).

123. Despite the short-term financial gains, concerns have been raised regarding the long-term financial sustainability of private equity-backed healthcare systems, with an increased risk of bankruptcy. In May 2024, the largest physician-owned hospital system in the US, backed by private equity, filed for bankruptcy. This case has sparked scrutiny, with lawmakers and the media attributing the bankruptcy to factors such as high debt financing, sale-leaseback agreements, and greed (Kumar, 2024^[109]).