Issue No. 8 | November 2026

AcademyHealth

A Decisionmaker's Guide to Competing Health Evidence

Private Equity in Health Care: Higher Prices, Mixed Quality, Untested Reforms

Who owns a hospital, a nursing home, or a doctor's office can shape what it charges, how it's staffed, and whether it stays open. Over the past two decades a new kind of owner has moved in: private equity firms, which buy companies with investor and borrowed money and sell them within a few years. They now own some hospitals, nursing homes, and physician practices. Studies have linked buyouts in some settings to higher prices and worse care. But nearly all compare acquired providers with ones nobody bought, not with the same provider under a different owner, such as a health system or an insurer. Here is what the evidence shows, where it runs out, and what to watch.

AT A GLANCE

- **What it does:** A private equity fund buys a provider mostly with borrowed money, restructures it to raise revenue or cut costs, and sells within three to seven years.
- **How big it is:** Growing in **almost every setting studied**, though the size depends on the definition: **physician practice sites acquired by private equity in ten specialties rose from 816 to 5,779** between 2012 and 2021, and hospital counts run from **fewer than 4 percent** of general acute care hospitals under majority control to **488 hospitals**, about a quarter of for-profit hospitals, when psychiatric hospitals and partial stakes are counted.
- **What's at stake:** Whether patients pay more or get worse care when a provider changes hands, and whether laws aimed at one kind of owner protect them or just change who buys.
- **What the evidence shows:** Prices and spending rise after a buyout in some settings,, most clearly in physician practices; quality is worse in most nursing home studies and mixed in hospitals; and almost no study compares private equity with the buyer who would have come instead.

Who's Saying What

This map describes public positions of major stakeholders. It does not endorse or evaluate them.

Investors. The **American Investment Council**, the private equity industry's trade group, says private equity **improves care and expands access**, that its hospitals are more likely than other for-profits to serve rural and low-income communities, and that the critical studies are slanted. A **physician survey it commissioned** in October 2026 reports that physicians in backed practices credit the capital with shorter waits and better scheduling.

Watchdogs and labor. The **Private Equity Stakeholder Project** **tracks acquisitions, closures, and bankruptcies** and backs state deal review, limits on corporate control of medical practices, and bans on hospitals selling their buildings and renting them back. **National Nurses United**, **AFSCME**, and **Americans for Financial Reform** endorse the Health Over Wealth Act and argue disclosure alone won't fix a model built on debt.

Physicians. The **American Medical Association** adopted policy in June 2026 saying **medical practices should be majority-owned by practicing physicians** and opposing contract terms that let investors control clinical decisions.

Government. A **bipartisan Senate Budget Committee staff report** led by Senators Sheldon Whitehouse and Chuck Grassley concluded in January 2025 that two firms' strategies likely worsened staffing and services at the hospitals they owned. **FTC Chair Andrew Ferguson** has written that whether a firm is private equity is **irrelevant to antitrust enforcement**. **Senator Ed Markey and Representative Pramila Jayapal** sponsor the Health Over Wealth Act, which would license private equity ownership of providers; no federal bill has advanced.

Researchers. The critical studies come largely from **Zirui Song** at Harvard and **Joseph Bruch** at the University of Chicago, funded by NIH, AHRQ, and Arnold Ventures. Others, such as **Ryan McDevitt** at Washington University, whose **hospital ownership paper** discloses American Investment Council funding, and **Ambar La Forgia** at Berkeley, **argue the studies are being over-read** and that results differ by setting and by what's measured.

1. Why This Matters Right Now

Imagine the nursing home caring for your mother is sold to a private equity firm. The name on the building may not change. Whether the care does is what this guide is about.

Private equity is a way of buying a business: a fund collects money from pension plans, endowments, and wealthy investors, borrows more from banks, buys a company, works to make it more profitable, and sells it within three to seven years. The borrowed money usually becomes the company's debt, not the fund's. Over two decades these funds have bought hospitals, nursing homes, hospices, dental chains, and physician practices in specialties such as dermatology, eye care, and anesthesia. There are sellers because running a provider has gotten harder. Physicians who have sold their practices to larger organizations **most often say** they wanted more leverage with insurers, more resources, and help with regulatory and administrative work. Supporters say these firms supply money and expertise that small, independent providers can't find elsewhere. Without them, they argue, the choice is often a big hospital system, an insurer, or closing. Critics say a model that has to raise revenue and cut costs fast enough to pay off the debt is a bad fit for a business where cutting costs usually means cutting nurses. The question underneath is simple to state: when a fund buys a provider, what happens to prices, quality, and access, compared with what would have happened otherwise? That last clause is the hard part.

The question has moved from journals to statehouses. Selling a provider is legal by default. Federal antitrust review, which polices deals that reduce competition, covers only sales above a size threshold. **Most practice sales fall below it**, and until the last few years such sales **largely escaped state review** too. That's changing. A **bipartisan Senate Budget Committee staff report** in January 2025 concluded two firms' strategies likely made staffing and service problems worse at the hospitals they owned. Sixteen states now require notice of large health care deals, some can block them, and **Oregon**, **Connecticut**, and **Maine** have gone further. The FTC **formed a Healthcare Task Force** in March, and the **Health Over Wealth Act was reintroduced** in Congress in July. Unfortunately, nearly all of this rests on evidence about what happens after a buyout, and almost none on whether any of these tools changes it.

2. Why Do Smart People Disagree?

Start with what nobody disputes. Private equity's presence in health care has grown across almost all settings examined in a **2023 systematic review in the BMJ** of 55 studies. Negotiated prices usually rise after a fund buys a physician practice; the trade group argues that reflects investment, not that it's false. The deals are hard to see, and Steward Health Care, a hospital chain once owned by a private equity firm, collapsed in 2024 after the firm sold the hospitals' buildings and left them paying rent.

The fight is over which question you're asking, and three things make it worse than it needs to be. First, "private equity in health care" is at least four different things: hospitals, nursing homes, physician practices, and the staffing and billing companies between patients and providers. Prices rise in nearly every setting where they've been measured, but the evidence of worse care is strong in nursing homes, mixed in hospitals, and thin in physician practices. Second, almost every study compares an acquired facility with one nobody bought. That's the right comparison for asking whether a buyout changed anything. It's the wrong one for a regulator, who sees a deal only after an owner has decided to sell. Blocking the sale doesn't put things back. It leaves a seller who still wants out, and the next offer may come from a health system, an insurer, or another fund, or not come at all. The studies can't say which of those would have been better for patients. Third, "reform" is also several things. Some states require notice of a deal; some require permission; Oregon limits how investors control physician practices; Connecticut bans one kind of real estate deal; the FTC uses antitrust law against roll-ups, where one buyer acquires many small practices until it dominates a local market. They aim at different harms, and none has been evaluated.

THE QUESTIONS BEHIND THE DEBATE

The question being asked	What It Measures	Who Tends to Ask It
Do prices and spending rise after acquisition?	Negotiated prices, charges, and amounts paid per claim; visit volume and billing codes	Health economists, employers, insurers
Does quality of care fall?	Hospital complications, deaths, nurse staffing, inspection deficiencies	Physician researchers, patient safety groups, the Senate report
Is private equity worse than whoever else would have bought?	Outcomes at facilities bought by private equity versus those bought by health systems, insurers, or other for-profits	Investors, hospital finance analysts; a few studies, none following the same facility under both
Does it keep struggling facilities open or close them?	Closures, service cuts, bankruptcies, building sales, and how healthy the targets were before purchase	State regulators, rural health advocates, journalists
Is the problem private equity or for-profit ownership generally?	Private equity compared with publicly traded, chain, and independent for-profit owners	International researchers, legal scholars, trade groups
Do notice, approval, or control laws change anything?	Deal volume, prices, and quality in states with each kind of law versus states without	State legislatures; no published evaluation of any

The real disagreement isn't whether prices rise after private equity buys a physician practice. The do, as the do when hospital systems buy practices. It's whether the harms found in hospitals and nursing homes are caused by private equity or by debt and for-profit ownership generally, whether the next buyer in line would have done the same, and whether any of the laws now being written would change it. We've measured what happens after a buyout much better than what happens under a different buyer, and we haven't measured the reforms at all.

3. What Does the Evidence Show?

It depends on the setting and on what you measure. Prices rise most clearly in physician practices, harm is clearest in nursing homes, and hospitals are where the studies disagree. On whether private equity is worse than the owner who'd have bought instead, there's a little evidence. On whether any of the new laws change anything, there's none.

How a fund makes money from a provider

To pay off its debt and turn a profit within a few years, the new owner can raise prices, bill more per patient, cut staff, sell the buildings and rent them back, or borrow more to pay its investors. Other owners do most of these things too. What's different is the speed, and the fact that selling is the plan. Two-thirds of acquired hospitals change hands again within five years, so a study that follows a hospital for three years may be watching the owner's entire tenure.

Evidence on prices and spending

The strongest finding is in physician practices, and it's about negotiated prices, the amounts insurers actually pay. **Singh and colleagues** compared dermatology, gastroenterology, and eye care practices acquired between 2016 and 2020 with similar practices nobody bought: the amount paid per claim rose 11 percent, charges rose 20 percent, and visits were more often billed as long. A **study of 1.3 million colonoscopies** found prices at acquired gastroenterology practices rose 4.5 percent more than at independent ones, with no difference on six quality measures. One caveat: **a 2025 analysis of primary care** found hospital-owned and private-equity-owned physicians both negotiated higher prices than independent ones. Consolidation raises prices whoever does the consolidating; private equity does it faster and in specialties hospitals had mostly left alone.

In hospitals the picture is less tidy. **Bruch, Gondi, and Song** found 204 hospitals acquired between 2005 and 2017 raised charges by $407 per inpatient day and net income by $2.3 million a year relative to 532 controls. Charges are list prices, though, not what insurers pay. **Gao, Kim, and Sevilir**, using insurance claims, found no significant change in negotiated inpatient prices after acquisition. In nursing homes, **Braun and colleagues** found Medicare spending per long-stay resident rose 3.9 percent, but that's spending driven by more emergency visits and hospital stays, not a price.

Hospice is similar. A **2026 Health Affairs study** found stays 6.3 days longer and Medicare spending 5.9 percent higher per patient at hospices bought by private equity than at other for-profit hospices. The authors point to changes in which patients get enrolled; the figures don't show that care got worse.

Evidence on quality

Hospitals first, because that's where the fight is. **Kannan, Bruch, and Song** compared 51 hospitals acquired between 2010 and 2017 with 259 similar hospitals. Hospital-acquired conditions, the preventable complications Medicare tracks such as falls and bloodstream infections, rose 25 percent. In-hospital deaths fell slightly; deaths within 30 days didn't change. In 2025 the same group **reported in Annals of Internal Medicine** that emergency department deaths among Medicare patients rose 13 percent after acquisition, seven more per 10,000 visits, while salary spending fell 18 percent in emergency departments and 16 percent in intensive care units. A **2025 Health Affairs study** of common inpatient surgeries found 30-day deaths rose 2.7 percentage points, concentrated in emergency operations and driven by hospitals failing to rescue patients who developed complications.

The counterweight is real. **Cerullo and colleagues**, using the same design on 21 million Medicare admissions for five common conditions over 18 years, found no substantial change in deaths, readmissions, or spending. Gao, Kim, and Sevilir found no evidence of higher mortality or readmissions, though they note their patient data are limited, and found patient satisfaction fell about as much at hospitals bought by other for-profit owners. **Ryan McDevitt and Ambar La Forgia** dispute how Kannan and colleagues read their complication findings. The results depend on what's measured and where: complications rose, deaths across all admissions held steady or dipped, and deaths rose in emergency departments and after emergency surgery. Studies on both sides find staffing or salary spending fell on average after acquisition. The open question is what the cuts cost patients.

Nursing homes carry the strongest evidence of harm. **Gupta, Howell, Yannelis, and Gupta** used Medicare data on 18,000 facilities and a method that separates the effect of ownership from which homes funds chose to buy. Deaths among short-stay patients, mostly people recovering after a hospital stay, rose about 11 percent, alongside lower nurse staffing and more antipsychotic use. Braun and colleagues, comparing acquired homes with other for-profit homes, found 11 percent more avoidable emergency visits and 9 percent more avoidable hospitalizations among long-stay residents; that comparison group separates private equity from the for-profit effect decades of research had already found. The direction holds abroad: England's regulator **rates private-equity-backed care homes lower** than nonprofits, and a **Swedish study** under uniform public financing found homes owned by private equity and publicly traded companies did worst on staffing and satisfaction, so the finding isn't an artifact of American payment rules.

In physician practices the quality evidence is thin, and what exists is mostly null. The colonoscopy study found no quality difference, and a **2026 JAMA Health Forum study** of 24,000 Medicare patients whose primary care practices were bought by private equity found no meaningful short-term change in hospitalizations or avoidable hospitalizations.

Evidence on closures, assets, and the other buyer

On whether private equity rescues failing hospitals, **Kannan and Song** compared 242 hospitals with 870 similar hospitals in the year before acquisition. Earnings and margins were about the same, but the hospitals funds chose carried much less debt. On average, they weren't buying failing hospitals; they were buying hospitals that could carry debt. The Senate report's two case studies did involve struggling systems, so rescues happen; they just aren't the typical deal.

On closures themselves, the evidence is thin. The one study that tracked them, by **Gao, Kim, and Sevilir**, found hospitals acquired by private equity closed no more often than comparable hospitals. That's an average, and it sits beside well-known cases. When Steward went bankrupt in 2024, **two of its Massachusetts hospitals closed** for lack of a buyer, and Prospect Medical's bankruptcy **closed Crozer-Chester Medical Center** in Pennsylvania in 2025. Both chains had been owned by private equity firms, and both closures came about four years after those firms left: Cerberus **began its exit from Steward in 2020**, and Leonard Green **sold its Prospect stake in 2021**. That's why the cases settle less than either side says. No study has asked whether those hospitals would have survived under another owner.

What we know:

- Negotiated prices rise after private equity buys physician practices, and hospital charges and nursing home spending rise after acquisition; one hospital study using insurance claims found no change in the prices insurers pay.
- Staffing and salary spending fell on average in several hospital and nursing home studies, including studies that found no effect on deaths.
- One nursing home study linked acquisition to higher short-stay mortality and antipsychotic use; a separate study comparing acquired homes with other for-profit homes found more avoidable emergency visits and hospitalizations but no significant difference in antipsychotic use.
- On average, private equity buys hospitals with less debt than comparable hospitals, not more distressed ones, and the acquired hospitals close no more often.

What we don't know:

- Whether private equity is worse than the health system or insurer that would otherwise have bought the same facility.
- Whether more hospital complications translate into more deaths; some studies find higher mortality in specific settings and two large ones find none overall.
- What happens to a facility after the fund sells it, which is where most of them end up within five years.
- Whether any notice, approval, control, or real estate law has changed prices, quality, or access.

On whether funds sell off what hospitals own, **Schrier and colleagues** found the value of land, buildings, and equipment at 156 acquired hospitals fell 24 percent relative to similar hospitals within two years. (Two senior authors co-founded Physicians for a National Health Program, which supports single payer.) **Critics** say much of that is bookkeeping: a hospital that sells its building and rents it back still uses the building. The authors **reply** that the sale money went to investors and the rent stayed with the hospital. The building is still there; the money that would have maintained it isn't.

Then there's the other buyer. Two studies get close. Gao and colleagues compared hospitals bought by private equity with hospitals bought by other for-profit owners: patient satisfaction fell at both, but the private equity buyers cut more administrative staff, let clinical staffing recover over time, and kept hospitals open at the same rate. **Singh and colleagues** found in 2026 that neither hospital nor private equity acquisition of primary care practices significantly changed the amount of low-value care, meaning tests and treatments that do patients little good, in the short term. Neither study can say what would have happened to a particular hospital or practice under the other owner, which is the question a state review board faces.

The reform question

No evaluation exists of any of the tools now in use. Notice laws exist in sixteen states; approval laws, which let the state block a deal or attach conditions, in fewer; Oregon's limits on investor control of practices took effect this year; Connecticut's ban on selling and renting back hospital buildings in May; Maine's 180-day approval process starts January 1, 2027. Whether any of them changes who buys, what they pay, or what they do afterward is unknown.

4. Risks and Unknowns

These are tradeoffs, not predictions.

If states single out private equity, watch whether the problem moves to other owners. Consolidation raises prices whoever does it, and health systems have bought far more physician practices than funds have. The staffing cuts may be about debt as much as ownership, and some health systems and publicly traded chains borrow heavily too. If lawmakers write rules aimed only at private equity, the problem may just move to other owners. Several 2026 state bills have already **widened their reach** to real estate trusts, management companies, and insurers, and Vermont's **pending bill** targets debt and payouts to investors rather than the type of owner. Nobody has tested either design.

If review stops at the first sale, watch the second, and the rent. Two-thirds of acquired hospitals change hands again within five years, so a law that reviews the purchase and ignores the resale may be looking at the deal that matters less. Connecticut's ban on hospitals selling their buildings and renting them back stops new deals but does nothing about rent already owed on buildings sold years ago, which is what sank Steward. Monitoring after a deal closes, or rules on where sale money goes, would address these. Each costs more to run than a one-time approval, and none has been evaluated.

If private equity leaves a market, watch who's left. The typical target wasn't failing, and acquired hospitals closed no more often than others. But some private-equity-owned hospitals serve rural areas where the realistic alternative is a health system that doesn't want them or no buyer at all. Rules strict enough to keep funds out could produce a closure instead of a sale. Whether that's better or worse for patients who end up at a stronger hospital farther away is unknown; no study has followed them.

If the research keeps coming from a few groups, watch for replication. Much of the hospital research shares authors, funders, and a hand-built list of acquisitions, because no complete public registry of private equity ownership exists. The **hospital ownership data** released last month is a start, and studies built on it will show whether the headline findings hold up.

5. How to Read the Evidence Yourself

Claims about private equity arrive from every side, and most cite published studies. Five questions will sort most of them.

1. **Compared to what?** Nearly every study compares an acquired facility with one nobody bought. That tells you whether things changed after the buyout, not whether a health system would have done the same, and on price there's evidence it would have.
2. **Would the facility exist without the buyer?** Supporters say private equity keeps struggling hospitals open; the data say the typical target wasn't struggling. Critics count closures after a buyout; a hospital that closes three years later might have closed anyway. Treat both "we saved it" and "they killed it" as claims about a world nobody has measured.
3. **What's the outcome, and how common is it?** Complications are common and preventable; deaths are rare and have many causes. The same hospitals can show more complications, no change in deaths across all admissions, and more deaths in the emergency department. A study finding no change in deaths hasn't shown care is fine, and a study finding more infections hasn't shown people died.
4. **Which setting, and does the claim stay inside it?** Nursing home findings come from nursing homes, where most of the care is hands-on help from staff, so staffing cuts hit residents directly. Hospital findings come mostly from mid-sized hospitals bought between 2005 and 2017, and practice findings from a few specialties. The broader the claim and the narrower the study, the more skepticism it deserves.
5. **Who built the ownership list, and who paid for the study?** No complete registry of private equity ownership exists, so most studies rest on a hand-built list, and different lists produce different counts. Then ask who funded the work: the critical studies mostly NIH, AHRQ, and Arnold Ventures; the favorable ones often industry. That doesn't settle who's right. It tells you where to look harder.

6. The Bottom Line

Prices rise after private equity buys a physician practice. Spending rises in nursing homes and hospices, and nursing home residents do worse in the main studies. In hospitals, list prices and income rise, the prices insurers pay may not, complications rise in some studies, and the evidence on deaths is split, with harm concentrated in emergency departments and emergency surgery. Staffing or salary spending fell on average in most of these studies, including ones that found no effect on deaths. What the evidence doesn't settle is whether any of this is specific to private equity, or is what happens when any owner buys with borrowed money and plans to sell. Nobody can run the same facility under two owners, and the closest comparisons we have are few.

Unfortunately, the evidence about what happens after a buyout is much stronger than the evidence about what any law does about it. Sixteen states require notice of large deals, fewer can block them, and not one of those laws has been evaluated. The tradeoff no reform escapes is that providers need money and the people who supply it want it back. Rules can change the speed, the disclosure, and who holds the debt. They can't change that every owner has to be paid somehow, and which owner a struggling hospital should have is a judgment about communities, not a finding. Decisionmakers should be more skeptical of a confident claim that a particular reform will fix this than of the evidence that there's something to fix. Ask of every proposal the question these studies keep failing to answer: compared with which other owner, and what happened where that owner showed up instead?

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