A Closer Look at the Critiques of Private Equity in Healthcare

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Abstract

Private equity (PE) firms have become heavily involved in healthcare in recent years, to the dismay of many critics. This paper critically examines the dominant critiques of PE involvement in healthcare and evaluates whether such critiques justify regulatory intervention. Using a classical liberal conception of individual rights, we analyze eight common complaints—ranging from financial instability and price increases to declining quality and lack of transparency. While some concerns may reflect real challenges to system performance, we find that none of the standard critiques constitute a rights violation. However, we identify one specific scenario—where financial extraction contributes to bankruptcy—that may meet the threshold of a rights violation if understood as a form of fraudulent transfer. We argue that this limited case could justify targeted reform without undermining the broader legitimacy of PE in healthcare. The paper concludes with practical guidance for both private equity firms and potential acquisition targets.

Keywords

private equity, leveraged buyout, rights-based analysis, financial regulation, fraudulent transfer

Introduction

Private equity (PE) investment in healthcare has grown rapidly in the past two decades, with annual investments increasing from $5 billion in 2000 to over $100 billion in 2018 (JEC, 2024), and reaching an estimated $505 billion as of 2023 (Schrier, 2024). PE firms now own approximately 8% of U.S. hospitals and have acquired thousands of physician practices (PESP, 2025). The trend has been driven by many factors, including the availability of low-cost capital (used for leverage buyouts), the existence of a perception that healthcare is recession-resistant, and a growing popularity of the strategy of using consolidation to achieve advantages in negotiations with payers.

PE involvement in healthcare is not without controversy. High-profile bankruptcies and failures have roused activists and political figures to assert in the popular media that PE involvement in healthcare endangers patient welfare. Critics in the mainstream media call PE firms vampires and accuse them of "looting" healthcare entities. The peer-reviewed literature, too, is largely critical of PE, with academics claiming that PE ownership is associated with increased cost, reduced quality, and financial distress for stakeholders (Borsa et al., 2023). Many policy interventions have been proposed, though few have been enacted thus far.

In this paper we examine the main complaints and assess whether they justify intervention. We use an evaluation framework grounded in classical liberal values, emphasizing individual rights, voluntary exchange, and limited government intervention. This perspective differs from other philosophical approaches such as Rawlsianism, which prioritizes distributive justice and the welfare of the least advantaged, and Utilitarianism, which focuses on maximizing overall societal well-being. By contrast, our analysis is primarily concerned with whether private equity practices in healthcare violate individual rights—rather than whether they produce equal outcomes or maximize aggregate utility.

Our bottom line up front is that while some mainstream concerns about PE in healthcare may have merit in terms of outcomes or system performance, none of the typical critiques amounts to a violation of individual rights. That said, we do identify one particular scenario that—if conceptualized in a specific way—*could* potentially qualify as a rights violation and warrant policy intervention. We recommend further research and expert consultation to explore this scenario in greater depth.

Private Equity Involvement in Healthcare

Private equity is an investment strategy in which investors buy an existing business with the intention of increasing its value and reselling it for a profit (Lee, 2024). In healthcare, common acquisition targets are hospitals, medical practices, and nursing homes. PE firms acquire their target organizations through leveraged buyouts (LBOs), using a combination of investor capital and debt financing. The level of debt used in these deals is relatively high; often as much as 60%-80% of the purchase price is borrowed.

Once a PE firm acquires a healthcare business, it aims to improve financial performance, whether by increasing revenue, reducing costs, consolidating operations, or a combination of these, before selling the organization for a profit, usually within three to seven years (Lee, 2024). The PE firm may hire a new leadership team to execute these changes, or it may use its own team to manage the acquired business directly. When the PE firm is ready to make its exit, the healthcare business is typically sold to either a strategic corporate buyer seeking to expand its market share, or to a larger private equity firm that is getting underway with a new fund.

Controversial Practices

PE firms claim that their involvement in healthcare introduces efficiencies, imposes financial discipline, and brings strategic management expertise to the businesses that they acquire. Critics argue that PE firms' focus on short-term financial gains comes at the cost of patient care and quality, among other things, and that instead of helping hospitals and medical practices and nursing homes to succeed in the long term, PE firms through various tactics actually hurt the long-term financial viability of the businesses they acquire, while enriching themselves (Offodile, 2021).

At the heart of the debate over PE involvement in healthcare are two inquiries that need to be disentangled and evaluated independently. The first inquiry is whether PE involvement is associated with various negative or undesirable performance outcomes. This is worth studying for a number of

reasons, including helping patients decide where to seek care, and helping physicians and clinical employees decide whether the ownership structures of the places where they work matter to them. The second inquiry is whether any of the practices that PE firms routinely engage in constitute any sort of rights violation that should be addressed through policy.

Eight Common Complaints, None of Which Constitutes a Rights Violation

1. Increased Financial Instability and Risk

PE-backed leveraged buyouts are carefully structured to be on advantageous terms to the PE firm. In these leveraged buyouts, the debt goes onto the books of the acquired entity (e.g., the hospital, medical practice, or nursing home), not the PE firm. The acquired business receives the full purchase amount as a cash infusion, but typically a large portion of that purchase amount must be paid back. This arrangement makes funds available in the short term for the acquired business, but in so doing, saddles that business with long-term debt while limiting liability for the PE firm. The PE firm is not obligated to repay the loan in the event that the acquired entity becomes unable to pay its bills.

This financial arrangement is counterintuitive, and in some cases, it may be unwise for acquirees to accept, but it is an entirely voluntary transaction. Unless fraudulently concealed in the details of the purchase, which would be a violation of ordinary contract law, this arrangement involves no force. All of these details are known and agreed upon by both parties in advance of the decision to go ahead with the acquisition.

2. Short-Term Financial Focus

PE firms seek to improve the short-term financial position of their acquired businesses in order to make an exit within three to seven years at an attractive sale price. Critics argue that this makes certain unwise actions such as land sale-leaseback deals especially attractive. In a land sale-leaseback, a hospital (for instance) sells the land and buildings that it owns, and then enters into a lease with the new property owner, often a real estate investment company. The hospital obtains capital in the short term, but going forward must pay rent to occupy the land and buildings that it previously owned.

Organizational management involves countless rent-versus-buy decisions. Land sale-leasebacks allow businesses to unlock capital tied up in real estate while maintaining use of the property. They are neither good nor bad. Even if used for no other reason than to liquidate holdings and extract short-term value for the PE firm, this tactic reduces the resale value of the business at exit time by a corresponding amount, which ought to reassure critics that there is no free lunch to this tactic. Land sale-leasebacks may be strategically unwise under certain terms (e.g., high rents), but no rights are violated by PE firms managing their acquired business in this way.

3. Price Increases

Studies suggest that PE-acquired organizations tend to raise prices, particularly in outpatient specialty services. For example, one study of ambulatory surgery centers (ASCs) found price increases of up to

50% on certain surgeries within four to five years of PE acquisition (Lin, 2023). Another study of dermatology, gastroenterology, and ophthalmology medical practices found prices increased by about 11% post-acquisition (Singh, 2022). In their systematic review, Borsa and colleagues wrote that "[o]f all the impacts measured, costs to patients or payers showed the most consistent pattern across a total of 12 studies." Nine of the twelve studies that reviewed prices found price increases, three found no change, and zero found price reductions.

A tendency toward price increases is consistent with PE firms' own stated intentions of improving top line performance, and should surprise no one. However, while price increases make care more expensive for patients and contribute to overall healthcare expenditures, they do not violate individual rights and thus do not warrant regulatory intervention. There was a time prior to 2022 when PE firms bought stakes in ambulance companies and arguably engaged in illegitimate surprise billing practices (violating well-accepted legal norms of offer, acceptance, and mutual assent), but the No Surprises Act has largely put a stop to such activity. Recently, new concerns have been raised about PE firms manipulating the arbitration process by flooding the federal Independent Dispute Resolution (IDR) portal with frivolous claims. This is a price-related issue that might warrant a policy fix, but it has yet been fully substantiated.

4. Increased Utilization of Services

Some critics argue that PE-backed organizations drive increased service utilization. There is some evidence to support this claim. For instance, one study found a 16% rise in patient encounters following PE acquisition (Singh, 2022). There are also claims that staff at PE-acquired organizations report feeling pressure to sell additional medical products to patients, and pressure to refer patients to affiliated specialists (Gondi, 2019). Additionally, there are anecdotal reports of PE firms pressuring physicians to perform unnecessary procedures (Woolhandler, 2024).

Even if we discover that there is a strong association between PE ownership and increased utilization, however, whether any practices meet a threshold of intentional fraud is a separate question. Unless it can be shown that PE-owned firms systematically deceive patients or coerce them into unnecessary treatments, tests, or procedures, a mere increase in utilization does not meet the test of a rights violation, and therefore does not justify government intervention. Critics can point out that financial incentives influence clinical decision-making, but financial incentives exist in all healthcare systems—whether public or private. Physicians employed by hospitals, for example, may also face pressure to increase admissions or procedures, yet this is rarely framed as a justification for regulatory intervention.

In a genuinely market-driven system, overutilization would be held in check by competitive forces and consumer choice, not just professional norms. If we are concerned about PE-backed providers consistently delivering unnecessary or low-value care, we should adopt more market-oriented reforms so that insurers, employers, and patients will have the normal incentives to take their business to the place that treats them best. Regulation that attempts to curb overutilization without clear evidence of systematic fraud risks overstepping by restricting access to care that some patients may genuinely need.

5. Declining Quality of Care

Several studies associate PE ownership with negative patient outcomes. A commonly cited pair of numbers comes from a JAMA study that reported a 27% increase in patient falls and a 37% increase in central line-associated bloodstream infections at PE-owned hospitals (Kannan, 2023). Another study found that nursing home mortality rates rose by 10% following PE acquisition (NBER, 2021). Also in nursing homes, a study found that PE ownership was associated with a decrease in RN staffing hours per resident day and an increase in nurse aide staffing hours per resident day (Stevenson and Grabowski, 2008).

The mechanism that would cause a deterioration in care quality is logically plausible—e.g., cutting staffing costs could result in patients at risk for falls being less closely supervised–and there is some supporting evidence—e.g., the studies above. As with many critiques of PE in healthcare, however, the evidence base is small and insufficient for making sweeping generalizations about all healthcare settings and services. Moreover, even where deteriorations in quality are observed, PE-owned facilities still appear to be within industry-accepted ranges.

6. Negative Effects on Workforce

Studies of physicians and staff in organizations post PE acquisition have found lower job satisfaction, reduced autonomy, and a decreased desire to stay with the organization (Gross, 2024). Physicians report worsening burnout and loss of practice autonomy (Rickert, 2024). Administrative staff wages declined by 11% in PE-owned hospitals (Gao, 2021). Although very limited and not necessarily representative, these findings suggest that PE acquisition could be associated with workplace dissatisfaction.

It is plausible that workers could experience PE acquisition as deleterious. In pursuit of better financial metrics, PE firms might, for instance, pressure clinicians to see more patients in less time and adopt new standardized protocols. Clinicians might experience this as undermining their professional autonomy. Being asked to shift from a patient-centered decision-making paradigm to a more revenue-driven management style can be demoralizing. Once again, however, even if true, ordinary changes to business policies and procedures do not violate workers' rights. Owners, by virtue of their ownership, have the right to set the policies and procedures that must be followed in their workplace—it would be bizarre if ownership did not allow for that. Employees are not without some protection. For example, existing employment contracts generally remain in effect unless legally modified as part of the acquisition. Union contracts typically must be honored until renegotiated. Employees may experience acquisition-related changes as negative effects, but owners have the right to make these changes, even if they are unwise decisions that cause employees to leave.

7. Service Line Reductions

Another common critique of PE involvement in healthcare is that PE-backed firms often eliminate or scale back service lines that generate limited financial returns. These may include labor and delivery units, mental health services, or emergency departments in rural or underserved areas. Critics argue that

such closures reduce access to care, increase travel times for patients, and place additional strain on neighboring facilities. There is at least some evidence for this claim. For instance, compared to controls, PE-owned hospitals have been found to discontinue labor and delivery (-7%), outpatient psychiatric care (-4%), and adult day care (-16%) (Cerullo, 2021). The notorious case of Steward Health Care provides more examples. For example, in Massachusetts, Steward closed one hospital within a year of acquisition despite promising the community that it would keep the facility open for at least a decade. In Ohio, Steward closed a hospital eliminating several hundred jobs and reducing local healthcare access (Bugbee, 2024).

To those who believe healthcare is a "public good," these closures are experienced as a betrayal. However, the act of closing a service line does not constitute a violation of rights, provided the closure does not breach existing contractual or legal obligations. The mere fact that a business chooses not to provide an unprofitable service does not by itself justify legal prohibition or government intervention into ownership models. This critique is further weakened by potentially offsetting evidence that available of some services increases with PE involvement. Services lines that have exhibited increases in a post-acquisition context include robotic surgery, digital mammography, freestanding or satellite emergency departments, adult cardiac surgery, and adult interventional cardiac catheterization (Borsa, 2023).

8. Lack of Transparency in Ownership Status

A final theme of concern about PE-involvement in healthcare is ownership transparency, since these transactions are typically structured in ways that obscure ownership relationships, and PE firms rarely advertise their involvement. As a result, patients might not even be aware that the medical practice or hospital that they go to, or the nursing home they have a loved one in, have been acquired by PE. This limited transparency undermines informed choice: if patients knew that a facility was PE-owned—and therefore potentially subject to cost-cutting measures, staffing reductions, or changes in clinical priorities—they might choose to seek care elsewhere. Health services researchers also complain about the lack of transparency, as it makes it more difficult to assemble data sets and only in some cases can they get the information they need from SEC filings and M&A data to determine ownership (Kannan, 2023).

It is true that hospitals, medical practices, and nursing homes are not required to post PE ownership on their websites or on a sign at the front desk. However, there are methods by which information about ownership can be discovered. For example, under the Corporate Transparency Act, some private equity firms are required to provide information about their beneficial owners. In some states, hospital ownership changes require public reporting. Additionally, it is always possible for a patient, vendor, or journalist to inquire directly about ownership by asking, "Is this hospital owned by a private equity firm?" While hospitals are not affirmatively required to publicly disclose private equity ownership, they also cannot engage in deception. If a hospital representative knowingly and falsely replied "No," that could constitute fraudulent misrepresentation.

Our analysis of the eight common critiques described in this section is summarized in Table 1.

Table 1. Summary of Common Critiques

Complaint	True/Plausible/False	Does it Violate Rights?
Increased Financial Instability and Risk	Plausible	No
Short-Term Financial Focus	Plausible	No
Price Increases	Plausible	No
Increased Utilization of Services	Plausible	No
Declining Quality of Care	Plausible	No
Negative Effects on Workforce	Plausible	No
Service Line Reductions	Plausible	No
Lack of Transparency in Ownership Status	True	No

Calls for Intervention That Miss the Mark

From this exploration of conventional critiques, we can see that when held to a strict standard of whether any rights-violating activity has occurred, the case for intervention is not particularly strong. However, that has not stopped scholars, advocates, and political figures from proposing myriad interventions and policy changes (see Table 2).

Table 2. Commonly Proposed Interventions and Policy Changes

No.	Proposed Intervention or Policy Change	Example
1	Transparency rules to require disclosure about the identity of investors in PE arrangements	(CMWF, 2023)
2	Mandatory quality reporting of patient experiences, price changes, or outcomes measures such as 90-day mortality post-merger	(Cai, 2023)
3	Prohibit PE firms from "draining resources" e.g., land leasebacks, either completely or for a certain period post-acquisition, e.g., two years	(Goozner, 2023)
4	Prohibit PE firms from having any involvement in medical decision-making, including hiring	(CA SB.351)
5	Eliminate the carried interest tax loophole that allows management fees to be taxed as capital gains rather than as corporate income	(Crosson, 2023)
6	FTC and states could have stricter review of deals before they happen (e.g., CA >$25m)	(Garber, 2024)
7	Tie executive income for healthcare orgs to outcomes and limit in the case of bankruptcy	(Cai, 2023)
8	Requiring a reduced leverage (LTV) ratio; Moody's rating >Baa	(Leitz, 2024)
9	Imposing an outright ban on PE ownership of doctors' practices	(Woolhandler, 2023)
10	Prohibit PE firms from including non-compete and non-disparagement clauses in deals	(CA SB.351)
11	Joint and several liability for the PE firm for all liabilities of the target company; require escrow	(US S.5333, 2024)
12	Monitor PE-owned healthcare organizations to prevent allied practitioners from billing without proper supervision viz False Claims Act	(Gondi, 2019)
13	Start monitoring potential anti-competitive effects of private equity acquisitions	(Lee, 2024)
14	Stringently enforce CPOM laws, including no longer allowing Friendly Private Corporations	(Lee, 2024)
15	CMS should mandate transparency in hospital and medical practice ownership	(Rickert, 2024)
16	Banning dividend recapitalizations altogether	(Bugbee, 2024)
17	Up to 6yrs imprisonment for PE executives "unjustly enriched" resulting in a patient death	(US S.4503)
18	Require PE firms hold 10yrs before profiting	(Cai, 2024)

In the scholarly literature, private equity is losing the rhetorical battle. The good that private equity in healthcare accomplishes is invisible and unmeasured, which leaves impressions to be shaped primarily by high-profile failures and negative anecdotal reports. Policy entrepreneurs have taken notice of the opportunity. Private equity practices—especially those that go against the moral intuition of ordinary voters—soon could be curtailed.

Policy Considerations—One Scenario That Might Justify Action

From a classical liberal perspective that first and foremost concerns itself with individual rights, the aforementioned critiques of private equity in healthcare that are conventionally offered may have empirical merit as critiques about health system performance, but they do not justify government intervention. However, we do believe a new critique is possible that *might* justify action. It is that *extraction of funds specifically in cases that lead to bankruptcy could constitute a rights violation, akin to fraudulent transfer*.

Current law allows private equity firms to extract wealth through mechanisms such as land leasebacks and dividend redistributions. There is nothing wrong with these maneuvers as long as the acquired business stays operational. Whatever value is extracted from the acquired firm is offset by a lower expected sale price upon exit. The PE firm is simply exercising choice about time preference, internalizing the tradeoffs. In short, under normal business circumstances, PE firms cannot extract value with impunity.

The situation becomes complicated, however, when the acquired firm is on a path to bankruptcy. Bankruptcy is a special feature of the law that allows a business to walk away from obligations when the business becomes unsustainable. Key to it working as intended is the assumption that individuals and businesses want to avoid bankruptcy. However, unlike individuals and traditional business owners, PE firms structure their ownership relationship with the acquired firm in ways that limit their liability. In some cases—the kinds of cases that are often brought up in critiques of PE involvement in healthcare—it is possible for firms to extract value from the acquired business as the acquired drifts toward bankruptcy, leaving unpaid rent, unpaid taxes, unpaid vendors, and unfunded pension obligations.

A key component is when and how financial extractions occur. Dividend recapitalizations, land sale-leaseback arrangements, and the imposition of management fees can accelerate financial distress. If these actions occur while an organization remains solvent, they represent aggressive but legal financial strategies. However, if they are conducted when an organization is approaching bankruptcy, they may constitute fraudulent transfers, akin to asset-stripping before insolvency.

Fraudulent transfer laws exist to prevent individuals from shielding assets before defaulting on obligations. Under the status quo, we have a system that makes it possible for PE firms to, in essence, privatize the benefits when their acquisitions go well, and socialize the costs when their acquisitions fail. Conceptualizing these practices as fraudulent transfer when done in the context of bankruptcy is a targeted reform that aligns with classical liberal principles, leaving the vast majority of PE involvement in healthcare free to continue, while preserving capitalism as *a system of profit and loss*.

Advice for Acquirers and Acquirees

Most critiques of PE in healthcare do not justify regulation or intervention, but action is nevertheless likely because the critics of PE in healthcare are numerous and vocal, and there are few who will offer a defense of PE in healthcare.

Advice for Private Equity Firms

Our advice for PE firms is to be aware that there is an appetite for increased scrutiny and regulation of business practices. We encourage firms that have turnaround successes to tout them and to communicate the value that your involvement brings. PE firms should consider some voluntarily reforms:

- Concede on ownership transparency disclosure, as this information ultimately is discoverable anyway.
- Consider adopting or offering a voluntary two-year moratorium on land sale-leaseback agreements, as this is one of the practices that makes people most nervous.
- Offer some backing or guarantee on the debt that gets assigned to the target organization upon purchase and/or through dividend redistributions.

Advice for Healthcare Organizations (i.e., Candidates for Acquisition)

Our advice for medical practice, hospitals, and nursing homes who might be approached by private equity firms is to conduct your due diligence and enter into an agreement only if you are confident that it is right for you and your organization.

- If you are approached by a PE firm and you do not trust them to run your organization or practice competently, don't accept their offer. PE acquisitions are not hostile takeovers.
- Understand the terms. For instance, realize that the real buyout amount is the sale amount minus the assigned debt.
- Use your position to negotiate. You have a role and a responsibility to shape how the deal will play out. As a condition of acquisition, you could require that the PE firm guarantee the loan, or a large portion of it.
- Ask the other practices and facilities you work with about their PE status, and if you are concerned about undue influence, don't refer your patients out to them.

Conclusion

The literature on PE in healthcare is overwhelmingly negative, but much of it reflects ideological opposition rather than empirical evidence of rights violations.

The academic literature is very negative toward private equity in healthcare. Critics are slowly accumulating what they consider to be damning evidence, but there are still many more Perspective-, Viewpoint-, and Commentary-type articles than studies with original data points. High-profile failures will motivate researchers to keep building a case against PE in healthcare. Case studies with especially

unseemly details—such as the Steward Health System CEO who bought himself a $40 million yacht after exiting a PE deal that left a hospital in ruin—will continue to win converts for the pro-regulation side, regardless of whether the facts are real or cherry-picked. Much of the animus against PE involvement comes from a general ideological discontent with the presence (or admission) of any profit motive in healthcare. However, as we have seen, even when viewed from a pro-capitalist, classical liberal perspective, it is possible to find at least one tactic— the extraction of financial resources from healthcare organizations on the verge of bankruptcy—as a policy failure in need of remedy.

Critics will construct a regulatory thicket around PE involvement in healthcare, individually addressing each alleged ill if PE firms do not become more proactive. It may be prudent for PE firms to explore preemptive voluntary reform while political conditions for self-directed action are still favorable.

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References

Appelbaum and Batt. Private Equity at Work. 2014.

Blumenthal, D. Private Equity's Role in Health Care, Commonwealth Fund, November 17, 2023

Borsa, E Brunch, JD, Evaluating Trends in Private Equity Ownership and Impacts on Health Outcomes, Costs, and Quality: Systematic Review, BMJ July 19, 2023

Brown, Erin C. Fuse, & Hall, M. A. (2024). Private equity and the corporatization of health care. Stanford Law Review, 76(3), 527-596.

Bugbee, M. How Private Equity Has Looted Our Hospitals and What We Can Do to Stop it. AFT Healthcare. 2024

Cai and Song, Protecting Patients and Society in an Era of Private Equity Provider Ownership: Challenges and Opportunities for Policy, NIH National Library of Medicine, May 2024

Crosson FJ, Ostrer IR, Gross CP. Private equity in US health care—now cradle to grave? JAMA Intern Med. 2023;183(6):511-512.

Dmitri, C. Spillover effects from private equity acquisition in the health care sector. Harvard School of Public Health. 2023

Field et al., "Private Equity in Health Care: Barbarians at the Gate?" (2023) 15:4 Drexel L Rev 821.

Gao, Sevilir, Kim, Private Equity In the Hospital Industry Working Paper, Electronic Clinical Quality Improvement Resource Center, April 2023

Goozner, M. “Private equity takeovers are harming patients” BMJ 2023

Gupta A, Howell S, Yannelis C, Gupta A. Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes. Feb 2021

Joint Economic Committee. “Predatory Private Equity Practices Threaten Americans’ Health and the Economy. July, 2024

Kannan MD, Bruch Ph.D., and Song, MD, PhD, Changes in Hospital Adverse Events and Patient Outcomes Associated with Private Equity Acquisition, P. 2366, JAMA, December 2023

Lietz and Song, Does Private Equity Have Any Business Being in the Health Care Business? Harvard Business School. Working Paper 25-012. 2024

Leshin, B. Private Equity: The Good. Dermatol Clin. (2023)

Lee, S. Private Equity n Health Care: A State-Based Policy Perspective. Health Affairs. 2024

Luh, J. Private Equity and Health Care Delivery. JAMA. 2021

Ma, L. Healthcare Private Equity: A Review of Key Case Studies. HMPI at Stanford. 2024

Private Equity Stakeholder Project, 2025

Powers, et al. Private equity and health care delivery: value-based payment as a guardrail? JAMA. 2021

Rickert, J. On Patient Safety: The Danger of Private Equity Involvement in Healthcare. Clin Ortho. April 2024

S.4503, “Corporate Crimes Against Health Care Act” 118th Congress (2023-2024).

Salik, I. A call to arms: private equity and the US healthcare system. British Journal of Anaesthesia, 132 (6). 2024

Scheffler, Alexander, Fulton, Arnold and Abdelhadi, Monetizing Medicine: Private Equity and Competition in Physician Practices. American Antitrust Institute. 2023

Saran, et al. “Healthcare Private Equity Transactions Under Scrutiny: Midyear Review” Holland & Knight. August 1, 2024.

Woolhandler, D Himmelstein, E Schrier, H Schwartz, “Private equity: health care's vampire” STAT, August 29, 2024