KEY POINTS

Private Equity and Provider Power: Implications for Global Health Insurers

Private equity (PE) investment in healthcare has grown rapidly, reaching approximately US$115 billion globally in 2024 and more than US$190 billion in 2025. A significant share is directed towards care delivery, including hospital groups, physician practices, outpatient services, behavioural health, diagnostics and healthcare IT. Provider and related services accounted for around US$62 billion of healthcare PE investment in 2025, highlighting growing investor interest in areas that directly influence care delivery.

Implications for global healthcare markets

PE ownership typically brings defined return targets, consolidation strategies and fixed investment horizons, increasing focus on financial performance alongside clinical outcomes.

The dominant PE model involves acquiring fragmented providers and combining them into larger platforms. Greater scale enables centralised pricing, contracting and operational control. Across OECD countries, including Australia, Germany and the UK, consolidation has been concentrated in higher-margin specialities, hospital groups and urban markets, often strengthening providers' influence over prices and access.

What the evidence says about impact

The key question is whether PE ownership improves efficiency and value. Overall, the evidence is mixed to negative, with limited indication of consistent benefit. A 2023 systematic review published in the BMJ, covering 55 studies across eight countries, found PE ownership was most consistently associated with higher costs for patients and payers, while quality impacts were mixed but often negative. The review found no consistent evidence of improved outcomes or efficiency.

Regulators have raised similar concerns. A 2025 report by the US Department of Health and Human Services (HHS), Department of Justice (DOJ) and Federal Trade Commission (FTC) warned that some PE transactions may reduce affordability, quality, workforce stability and market competition.

Evidence from hospitals supports these concerns. A large *JAMA* study covering more than 660,000 hospitalisations found PE acquisition was associated with a 25.4% increase in hospital-acquired conditions, including a 27.3% increase in patient falls and a 37.7% increase in central line-associated bloodstream infections.

In physician and specialist markets, PE-backed consolidation has also been linked to higher negotiated prices and greater market concentration, particularly where independent practices are rolled into larger provider groups. The strongest negative findings come from vulnerable care settings. A widely cited study of US nursing homes found PE ownership was associated with an 11% increase in short-term mortality, alongside lower staffing levels and reduced compliance with care standards.

There is also evidence of workforce impacts. A 2025 *Health Affairs* study found physician turnover increased following PE acquisition of practices,

suggesting reduced continuity of care and greater organisational disruption. While proponents argue PE can support investment in technology, operational improvement and service expansion, evidence has not consistently shown these benefits translate into lower costs, better outcomes or greater value.

The evidence is not entirely one-sided. Some studies found no significant changes in mortality, readmissions or inpatient prices following PE acquisition of hospitals. However, even in these cases, researchers reported lower patient satisfaction and reductions in administrative staffing and wages.

Overall, the evidence does not show that PE ownership consistently delivers better outcomes, lower costs or higher productivity, and frequently points to adverse effects on costs and selected quality measures.

Relevant Shifts in PMI Strategies

Insurers in several markets are adapting their purchasing and contracting strategies, not least in response to provider consolidation:

- **UnitedHealth/Optum (US):** pursuing vertical integration through acquisitions of physician groups, ambulatory surgery centres and outpatient providers to reduce reliance on large hospital systems and strengthen negotiating leverage.
- **Aetna, Cigna (US):** expanding Centres of Excellence programmes that direct members requiring high-cost procedures to providers meeting defined quality and cost criteria.
- **Bupa UK:** using preferred provider networks and referral pathways to steer members towards providers that meet agreed quality, governance and value standards.
- CZ, VGZ and **Menzis (Netherlands):** using selective contracting and value-based purchasing to reward quality and strengthen negotiating leverage.
- **Medibank, Bupa and HCF (Australia):** publicly resisting above-inflation reimbursement demands from large hospital operators such as Healthscope, highlighting the growing importance of contracting discipline.

Conclusion

Private equity is now a major force in healthcare provision, particularly across outpatient, specialist and community-based services. Although impacts vary by setting, the overall evidence raises questions about whether PE-driven investment and consolidation are improving care or primarily increasing costs.

For PMI, this reinforces the importance of understanding provider ownership structures, monitoring market concentration, strengthening contracting capabilities and developing reimbursement models that reward value rather than volume. These capabilities are likely to become increasingly important as provider consolidation continues across global healthcare markets.

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