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Définition et problématique

Dans le cadre français, la financiarisation du système de santé a été définie comme le processus par lequel des acteurs privés, non directement professionnels de santé, capables d'investir de façon significative, entrent dans le secteur des soins avec, comme finalité première, rémunérer le capital investi. Depuis plusieurs années, l'Assurance maladie produit des analyses sur des secteurs de soins conventionnés (biologie, transports sanitaires et soins primaires) qui ont documenté l'évolution des dépenses et la rentabilité[1] des secteurs de soins et permis d'appréhender le phénomène croissant de financiarisation.
L'expansion rapide du capital-investissement dans le secteur de la santé suscite un débat important sur ses implications juridiques, éthiques et réglementaires. Alors que ses partisans dans le secteur de la santé, affirment qu'il améliore l'efficacité et réduit les coûts, ses détracteurs soutiennent souvent que sa tendance à employer des stratégies axées sur le profit menace la sécurité des patients, la qualité des soins et l'autonomie des prestataires.
Néanmoins, la plupart des pays de l'Ocde ne connaissent pas l'ampleur exacte de ce phénomène.
Cette bibliographie, non exhaustive, rassemble des éléments de réflexion sur ces problématiques dans la littérature scientifique.

Les principales bases de données interrogées sont les suivantes : base interne de l'Irdes, Pubmed, openalex, web of science

Le cadre conceptuel et les dynamiques en place

EN FRANCE

Andre, C., Batifoulier, P. et Jansen-ferreira, M. (2016). "Privatisation de la santé en Europe. Un outil de classification des réformes". Villetaneuse, C.E.P.N.
https://hal-univ-paris13.archives-ouvertes.fr/hal-01256505

> Les systèmes de santé européens ont été soumis à de nombreuses réformes depuis une trentaine d'années. La privatisation en constitue une tendance majeure que l'on retrouve dans tous les pays. Mais le concept de privatisation revêt plusieurs dimensions qu'il convient de préciser pour effectuer une comparaison internationale. On propose dans une première partie de caractériser la privatisation selon deux critères : le champ d'application (financement et délivrance du soin) et le caractère « externe » ou « interne » de la privatisation. Dans une seconde partie est menée une analyse empirique systématique des privatisations dans les systèmes de santé de quatorze pays européens depuis 1980. Une cartographie des processus de privatisation est enfin proposée qui fait ressortir les différences dans la hiérarchisation des formes de privatisation selon les pays.

Batifoulier, P., Chiapello, E., Da Silva, N., et al. (2025). "Health capitalism and financialization of healthcare. Introduction." Review of Evolutionary Political Economy **6**(2): 249-272.
https://doi.org/10.1007/s43253-025-00157-1

> This introductory article explores the intersection of healthcare and capitalism in order to introduce the concept of health capitalism in this special issue. It examines the structural changes within the healthcare sector, where welfare states—historically a barrier to

[1] Rapports charges et produits de la Cnam

commercialization have nevertheless facilitated capitalist expansion. It explores financialization, privatization, and commodification as key processes transforming healthcare. The article emphasizes the role of mainstream economics in legitimizing market-driven healthcare, promoting a financial logic that permeates healthcare decisions. The special issue contributes to the understanding of health capitalism by analyzing its multifaceted impact across various healthcare sectors.

Batifoulier, P., Da Silva, N. et Domin, J. p. (2018). "Économie de la santé". Paris Armand Colin

Cet ouvrage présente, dans un langage simple et accessible, les débats économiques sur les questions de santé pour les ouvrir aux débats citoyens. Pour ce faire, il propose un ensemble pluraliste de réflexions relatives à la santé en considérant que l'organisation actuelle du système de santé ne peut se comprendre sans avoir recours à ses trajectoires historiques. Ce manuel s'organise autour d'une logique thématique qui permet de présenter les grands objets de santé : l'hôpital, la médecine de ville, l'industrie pharmaceutique, les assurances privées mais aussi l'émergence des systèmes de santé, la quantification de l'activité de soin, les inégalités, la marchandisation du soin et les rapports entre santé et capitalisme.

Batifoulier, P., Da silva, N. et Math, A. (2017). "Crise et réformes au prisme de la santé." Revue de l'ires (la)(91-92): 245p.
http://www.ires-fr.org/publications-de-l-ires/itemlist/category/287-n-91-92

La santé est un besoin fondamental et universel dont la satisfaction conditionne de façon cruciale le bien-être des populations. Elle occupe de ce fait une place centrale dans l'étude des problèmes économiques et sociaux et constitue un étalon majeur d'évaluation des transformations de la société. Les contributions rassemblées dans ce numéro spécial s'inscrivent dans cette démarche en analysant certaines de ces transformations à l'aune de leurs effets sur la santé des populations. Dans un contexte marqué par diverses formes de « privatisation » du secteur de la santé, ces contributions mettent en lumière les conséquences souvent négatives des politiques publiques, à la fois sur l'état de santé des populations mais aussi sur les conditions de travail du personnel soignant.

Bourgueil, Y. (2023). "La financiarisation dans le secteur de la santé : tendances, enjeux et perspectives". Paris, Presses de Sciences Po
https://www.sciencespo.fr/chaire-sante/sites/sciencespo.fr.chaire-sante/files/La%20financiarisation%20dans%20le%20secteur%20de%20la%20sant%C3%A9%2008.01.pdf

Cette note porte sur les expressions d'un mouvement de "financiarisation" au sein du système de santé. Elle s'efforce, avec une visée exploratoire, d'identifier et d'illustrer un certain nombre de tendances récentes et d'enjeux transversaux, sans prétendre les analyser de manière exhaustive ni entièrement reposer sur des données précises à ce stade. Elle se fonde sur des échanges et réflexions conduits au sein de la Chaire Santé de Sciences Po, en relation avec la DSES de la CNAM. Une vidéo des auteurs complète cette note. Les débats actuels sur la financiarisation s'inscrivent dans une histoire longue, et dans une tradition pluraliste, à la fois publique et privée, du système de santé français, qu'elle interroge à nouveaux frais. D'un côté, l'intervention renouvelée d'acteurs privés donne à voir un déplacement vers des formes de propriété, d'organisation et d'activités susceptibles d'être animées et justifiées par des logiques financières, à but lucratif. La thématique de la financiarisation interroge la question du pluralisme du système de santé français, de ses composantes, à la fois anciennes et en évolution constante, ainsi que des capacités et formes

spécifiques de régulation de ces espaces composites, ne se réduisant pas aux seules formes traditionnelles de l'action publique ou d'acteurs privés historiques. La financiarisation questionne aussi en creux la thématique de l'investissement nécessaire dans le secteur de la santé dans un moment de transformation de l'organisation des soins et de bascule démographique, avec un vieillissement de la population et le départ à la retraite des médecins du baby-boom. Si les acteurs privés investissent aujourd'hui dans la santé, notamment dans le secteur ambulatoire traditionnellement libéral ou privé, n'est-ce pas parce que ce secteur est caractérisé par un sous-investissement chronique caractérisé par des accélérations brutales et des ralentissements prolongés et par une orientation à dominante hospitalière ? Le contexte macroéconomique, caractérisé par une disponibilité de capitaux, n'est-il pas de surcroît déterminant dans le développement de la "financiarisation" de santé, indépendamment de ses dynamiques et caractéristiques propres ?

Domin, J.-P. (2022). "Le développement du capitalisme sanitaire et l'émergence du complexe médico-industriel." Économie et Institutions.
https://doi.org/10.4000/ei.7169

Ce travail s'intéresse aux évolutions récentes du marché de la santé et notamment au développement du capitalisme sanitaire. Si l'accès à la santé s'est généralisé à la fin du XIXe siècle comme un outil d'amélioration de la qualité de la force de travail, il tend aujourd'hui à évoluer. Le système de santé s'émancipe ainsi de sa mission initiale pour devenir un élément à part entière du capitalisme. Les évolutions récentes du système de santé (développement de l'assurance maladie complémentaire, de la télémédecine, des cliniques privées, …) sont devenues des activités génératrices de profit et semblent aller à l'encontre de ses objectifs premiers. L'article montre que le développement du capitalisme sanitaire va à l'encontre de l'objectif principal du système de soins, l'entretien de la force de travail.

Lavenir, F., Pilloux, A. et Mariani, L. (2025). "Causes et effets de la financiarisation du système de santé". Paris, I.G.A.S.
https://igas.gouv.fr/causes-et-effets-de-la-financiarisation-du-systeme-de-sante

Dans un contexte marqué par des évolutions profondes de l'offre de soins en France, des craintes se sont exprimées sur la « financiarisation de la santé » et sur ses conséquences. Pour faire le point sur ce que recouvre cette notion et sur ses enjeux, l'Igas et l'IGF ont analysé ses causes, ses mécanismes et ses conséquences. Soigner n'est pas une activité comme une autre : l'investissement privé ne doit pouvoir s'y déployer qu'en contribuant à l'amélioration durable de la qualité et de l'accessibilité des soins, dans le respect de l'indépendance d'exercice des professionnels. C'est pour le régulateur un défi nouveau, qui suppose une évolution du système réglementaire et tarifaire, notamment vers plus de transparence, de réactivité et de prévisibilité.

Vezinat, N. (2024). "Le Service Public Empêché". Paris, Presses Universitaires de France
https://www.puf.com/le-service-public-empeche

Fragilisé mais loin d'avoir disparu, le service public est aujourd'hui « empêché ». Plusieurs mécanismes l'entravent, le gênent, font obstacle à sa conduite et produisent confusion et insatisfaction chez les usagers, perte du sens de leur mission et souffrance au travail pour les agents, sentiment d'abandon et fatalisme chez les citoyens. D'une entreprise ou d'une administration à l'autre (au sein de La Poste, de la SNCF, d'EDF, d'hôpitaux et d'autres services publics), les mêmes processus sont à l'œuvre : la libéralisation européenne favorise la concurrence, la marchandisation et la financiarisation fixent des objectifs de rentabilité, les

privatisations bouleversent le statut des organisations qui produisent l'intérêt général. Cet ouvrage se penche sur les effets de ces processus sur les usagers comme sur les travailleurs. Mais même si le principal effet de ces politiques est d'entraîner une désingularisation du service public, il n'empêche qu'il continue, malgré tout, de fonctionner. Un ouvrage qui fait dialoguer plusieurs disciplines : sociologie, histoire et droit, par une spécialiste reconnue de la sociologie de l'action publique et du travail.

ETUDES ETRANGERES ET ETUDES COMPAREES

Assa, J. et Calderon, C. (2020). "Privatization and Pandemic: A Cross-Country Analysis of COVID-19 Rates and Health-Care Financing Structures". New York, New School for Social Research The New School for Social Research Working Paper 08/2020

The outbreak of coronavirus and the infectious disease it causes (COVID-19) have taken different paths around the world, with countries experiencing different rates of infection, case prevalence and mortality. This simultaneous yet heterogenous process presents a natural experiment for understanding some of the reasons for such different experiences of the same shock. This paper looks at the privatization of healthcare as one key determinant of this pattern. We use a cross-section dataset covering 147 countries with the latest available data. Controlling for per capita income, health inequality and several other control variables, we find that a 10% increase in private health expenditure relates to a 4.3% increase in COVID-19 cases and a 4.9% increase in COVID-19 related mortality. Globalization also has a small positive effect on COVID-19 prevalence, while higher hospital capacity (in beds per 1,000 people) is significant in lowering COVID-19 mortality. The findings suggest caution regarding policies which privatize healthcare systems in order to boost efficiency or growth in the short-run, as these reduce countries' long-term preparedness for dealing with pandemics.

Bifulco, L. et Neri, S. (2022). "The Italian National Health Service: Universalism, Marketization and the Fading of Territorialization." Forum for Social Economics **51**(2): 192-206.

At the time of its inception, in 1978, prevention and primary care were set as fundamental pillars of the Italian National Health Service (NHS), emphasizing the collective and social dimension of health. These principles were progressively neglected over the following four decades. Marketization, managed competition and managerialization privileged the individualized, highly specialized healthcare services mainly provided in hospitals, to the detriment of local outpatient and primary care services. After 2008-09, austerity policies exacerbated this situation determining under-financing as well as structural and staff shortages, while increasing tensions arose between the central government and Regions in the decentralized NHS. In 2020-21, the pandemic highlighted these critical issues. The need to develop a universal and strong outpatient, primary and community care system became evident in order to ensure the appropriateness and quality of foundational health services. This requires the State to play a more prominent role in the NHS governance.

Brissaud, C. (2025). "Accounting for healthcare capitalism: the OECD numbers and the international field of health system reform (1972–2001)." Review of Evolutionary Political Economy **6**(2): 353-372.

This article examines the genesis and features of OECD health accounts to understand the development of healthcare capitalism. Created in the early 1970s, those accounts primarily evaluate health systems according to their economic dimensions, while other indicators developed at the World Health Organization since the 1950s focused on health systems'

institutional characteristics or concentrated on health outcomes. Therefore, OECD health accounts gave their statistical argument to assessments of health systems focusing on their economic viability. Epitomizing this trend, the main metric used at OECD to evaluate health systems is the ratio of public health expenditure on GDP—the "Poullier line," as it is called from the name of Jean-Pierre Poullier, the creator of OECD health accounts. The article shows that the prominence of OECD health accounts stems not from their inherent accuracy but from the interplay of dynamics within the field of international organizations and the political arenas of influential member states, including the USA. In 2000, the delegitimization of WHO led major countries to redirect their funds to OECD, hence contributing to making the budgetary considerations on health systems dominant in the international field of health policy reform. The alignment of WHO, the most specific international organization in the field, on an economic assessment of health systems tends to silence alternative voices and fuels the development of healthcare capitalism.

Bruch, J. D. et Thurston, C. (2026). "Financial epidemiology: Linking financialization to population health." Social Science & Medicine **392**: 118930.

Financialization represents a pivotal transformation in modern capitalism. We argue that public health scholars and practitioners must attend to financialization – recognizing that financial institutions, markets, and motives have amassed significant power over large swaths of social and economic life and have the potential to transform population health. We begin by providing an overview of the financial industry and financialization. We then describe the channels through which financialization may impact health outcomes. We conclude by calling for a new disciplinary approach focused on critically examining the role of finance in shaping population health, which we refer to as financial epidemiology. We assert that financial epidemiology invites a new and uncharted line of inquiry addressing some of the most pressing issues in this era of financialization.

Cordilha, A., Carolina (2023). "Public Health Systems in the Age of Financialization
Lessons from the Center and the Periphery. Leiden / Boston Bril
https://hal.science/hal-04579776

In Public Health Systems in the Age of Financialization, Ana Carolina Cordilha unpacks policy shifts that have transformed public health systems into vehicles for financial speculation and capital accumulation. While it is commonly thought that these systems are being cut back in the period of financialization, the author shows that current changes in public health financing go far beyond budget cuts and privatization measures. She examines how public health systems are adopting financial instruments and participating in financial accumulation strategies, with harmful impacts on transparency, democratic accountability, and health service provision. With an in-depth study of both the French and Brazilian systems, Cordilha explores the different ways in which this process unfolds in central and peripheral countries.

Cordilha, A. (2022). "Financialisation and Public Health Systems: a new concept to examine ongoing reforms." Économie et Institutions(30-31).
https://doi.org/10.4000/ei.7418

Friel, S., Schram, A., Frank, N., et al. (2024). "Financialisation: a 21st century commercial determinant of health equity." The Lancet Public Health **9**(9): e705-e708.

Gouzoulis, G. et Galanis, G. (2021). "The impact of financialisation on public health in times of COVID-19 and beyond." Sociology of Health & Illness **43**(6): 1328-1334.

The substantial literature in political economy and sociology has shown that the increasing importance of financial activities (financialisation) exhibits significant effects on many socioeconomic conditions. While these conditions are relevant to public health, the dominant focus of the literature has been centred on the impact of financial markets on health services and health-care systems. This paper analyses how the financialisation of non-financial corporations, real estate and pensions can worsen public health through the transformation of workplace and living conditions as well as financially dependent social groups' perception of health risk. Our analysis raises several questions which aim to provide the basis of a future research agenda on the effects of financialisation on public and global health.

Hunter, B., McCoy, D., Cordilha, A., et al. (2025). "Private Financial Actors and Financialisation in Global Health". Kuala Lumpur : United Nations University International Institute for Global Health https://doi.org/10.37941/rr/2025/1

This briefing paper responds to the expansion of private finance in global health, demystifying the process of financialisation and offering a vital counter-perspective to an increasingly pervasive but questionable narrative that positions private finance as necessary to the future of global health. The paper charts the expansion of private finance across global health, pointing to how actors once marginal to this sector are becoming central to its financing and governance. Drawing on several case studies and a growing body of evidence, the briefing paper highlights three overlapping concerns associated with the financialisation of global health: the high cost of private investment; the undermining of public health principles and values; and the weakening of democratic governance and regulatory capture by powerful private financial actors.

Hunter, B. M. et Murray, S. F. (2019). "Deconstructing the Financialization of Healthcare." Development and Change **50**(5): 1263-1287.

Financialization is promoted by alliances of multilateral 'development' organizations, national governments and owners and institutions of private capital. In the healthcare sector, the leveraging of private sources of finance is widely argued as necessary to achieve the Sustainable Development Goal 3 target of universal health coverage. Employing social science perspectives on financialization, the authors of this article contend that this is a new phase of capital formation. The article traces the antecedents, institutions, instruments and ideas that facilitated the penetration of private capital in this sector, and the emergence of new asset classes that distinguish it. The authors argue that this deepening of financialization represents a fundamental shift in the organizing principles for healthcare systems, with negative implications for health and equality.

Kehr, J. (2023). "The moral economy of universal public healthcare. On healthcare activism in austerity Spain." Social Science & Medicine **319**.

Spain has a national health service, universal in access and free at the point of use. The global economic crisis of 2008, with its subsequent austerity policies, has put the universality of public healthcare at risk. This has led to an increase in healthcare activism, whose aim is to fight healthcare cuts and privatization to safeguard the national health service for all. This article addresses such healthcare activism. Drawing on long-term fieldwork with a heterogeneous set of actors ranging from individual activists and unions to ad hoc activist collectives, I will analyze the moral economy of healthcare activists in Madrid, to understand

why and in which terms they defend universal healthcare as a common good and challenge its marketization. In Spain, since the democratic transition, struggles around what constitutes a common weal have been highly politicized and affect-laden. The national health system stands as one example here, as it is closely linked to the emergence of the democratic welfare state in the late 1970s, following decades of Franco's dictatorship. This makes Spain a particularly interesting case, as the widely acknowledged understanding of public healthcare as a public and social good is intimately linked to democratization and welfare. Therefore, struggles over the nature of health systems are also struggles over the political, moral and economic organization of society, over (il)legitimate forms of power and over ways of caring for each other. In such struggles, visions of the public, the state and the political economy come to the fore. In Spain, there is ambivalence about the state's role as both protector and provider of the public good, but also as facilitator of capitalism, which this article will address.

Krachler, N., Greer, I. et Umney, C. (2022). "Can Public Healthcare Afford Marketization? Market Principles, Mechanisms, and Effects in Five Health Systems." Public Administration Review **82**(5): 876-886.

Policymakers now have four decades' experience using marketization to address cost and quality problems in public-sector health services. While much is known about the challenges, it is difficult to draw lessons because there remains no agreed-upon definition of marketization. This article contributes a definition that focuses on the transaction, particularly the effects of funding arrangements on the intensity of competition among providers. Based on prior literature and 106 interviews with practitioners and researchers in five countries, the authors contribute a systematization of 12 concrete market mechanisms enacting three market principles. Furthermore, the authors analyze respondents' perceptions of healthcare marketization's effects on costs and quality. While marketization is a multi-faceted, sometimes ambiguous phenomenon requiring further research before definite conclusions can be reached, most statements from our respondents about cost and quality effects were negative.

Mason, K. et Araujo, L. (2021). "Implementing Marketization in Public Healthcare Systems: Performing Reform in the English National Health Service." British Journal of Management **32**(2): 473-493.

To implement marketization in public healthcare systems, policymakers need to situate abstract models of prescriptive practice in complex user settings. Using a performativity lens, we show how policy processes attempt to bring about the changes they presume. Investigating the implementation of the Health and Social Care Act 2012, and the development of policy instruments and 'Clinical Commissioning Groups', we explicate the performance of a marketization programme. Our longitudinal study of the interactions amongst the multiple constituencies the Act attempted to enrol, and the existing socio-technical arrangements the Act aimed to change, generates three contributions: (1) we characterize the performativity of policy instruments as a process of bricolage that incorporates the principled attitude of making do on both sides - those who design the policy and those who are charged to implement it; (2) we identify the mechanisms through which the performativity of an envisioned model of marketization operates at multiple scales within a complex and highly distributed system of provision; and (3) we document and explicate why specific performances result in misfires and unintended outcomes. In short, we conceptualize policy performativity as a non-linear, dynamic process where theories and

their effects are constantly being assessed, reconfigured and fed back into policymaking and implementation.

Propper, C. et Le grand, J. (1997). "Central government and quasi-markets : the case of health care". Londres, L.S.E. (London School of Economics) LSE Health Discussion Paper n° 6.

Quasi-markets have now become an integral part of the British public sector. Devices for introducing competition into public service delivery while avoiding some of perils of full privatisation, they determine the delivery of health care; education, social care, housing and most local government services. Introduced by the Conservative Government of Mrs Thatcher, they may be one of that Government's most significant legacies. The paper begins with an outline of the functions for central government in a quasi-market. This is followed by two sections, one on the promotion of competition, the second on planning. The final section draws together the conclusions.

Salignac, F., Barkemeyer, R., Franklin-Johnson, E., et al. (2024). "Understanding the evolution of competing institutional logics in the marketization of care: A stage model analysis of Australia's National Disability Insurance Scheme." Health Policy **149**.

This study explores the marketization of healthcare through a stage model analysis, focusing on Australia's National Disability Insurance Scheme (NDIS). By employing mixed methods, including sentiment and frequency analysis as well as qualitative content analysis of policy documents and media coverage, we trace the NDIS's evolution and the interplay of competing social welfare and market logics over time. Our findings underline that the evolution and interplay between competing institutional logics follow a stage model of institutional change, detailing pre-emergence, orientation, contestation, consolidation, and normalization phases. Additionally, we observe a shift in dominant institutional logics across different stages, demonstrating the critical role of media and public sentiment in shaping discourse about the marketization of care, which intertwines with policy decision-making. Our findings emphasize the importance of adaptive engagement and communication strategies by policymakers to avoid marginalizing vulnerable groups as institutional logics evolve, especially in the latter stages of the process when a dominant logic has emerged. The study highlights the complex dynamics of institutional change and offers insights for both researchers and practitioners in the healthcare sector, shedding light on the coevolution of competing logics in the policy development and implementation process.

Seddon, J. et Currie, W. L. (2017). "Healthcare financialisation and the digital divide in the European Union: Narrative and numbers." Information & Management **54**(8): 1084-1096.

Financialization in health care considers the exchange of goods and services as financial instruments. This paper uses multivariate statistical methods to provide comparative cross-country health analysis in two dimensions: ICT infrastructure (availability and access) and Health data (usage and sharing). Based on the quantitative indicators/metrics used in our study, our results reveal three distinct country grouping emerge: Frontrunners, Followers and Laggards. These groupings highlight vastly different socio-political and economic conditions facing national health systems, where health inequalities will only partially be alleviated by building capacity in ICT infrastructure and eHealth. (C) 2017 Elsevier B.V. All rights reserved.

Sénat (2024). "Note sur la financiarisation du système de santé". Paris, Sénat https://www.senat.fr/notice-rapport/2024/lc339-notice.html

À la demande de la commission des affaires sociales, la division de la Législation comparée a réalisé une étude sur la financiarisation du système de santé et son encadrement juridique en Allemagne et en Suède. Le phénomène de financiarisation dans le secteur de la santé peut être défini comme « un processus par lequel des acteurs privés, non directement professionnels de santé, capables d'investir de façon significative, entrent dans le secteur des soins avec comme finalité première de rémunérer le capital investi ». La financiarisation doit être distinguée de la privatisation en ce qu'elle traduit, au sein du secteur privé, un transfert de propriété entre des acteurs professionnels et des acteurs financiers non professionnels.

Singh, Y., Reddy, M., Papanicolas, I., et al. (2026). "Private equity investments in health care in OECD countries: an exploratory analysis." Health Economics Policy and Law: 1-28.

Private equity (PE) firms are increasingly investing in healthcare, seeking short-term returns through market consolidation, price increases, asset sales, and financial engineering. Although PE is transforming the healthcare sector, many countries lack systematic data to determine whether a regulatory response is warranted. Using data from PitchBook, we document substantial and growing PE investment in health care across 25 of 38 Organization of Economic Cooperation and Development (OECD) countries, totalling over 8,400 reported deals and $1.4 trillion in capital between 2013 and 2023. Outpatient clinics represent the dominant target of investment, while hospital and elder care sectors have attracted investments in select countries. Exploratory regression analyses suggest that PE firms are less likely to invest in countries with a social health insurance system and that PE deal volume is positively associated with health expenditures. Country-specific deviations from model predictions underscore the importance of unmeasured country-specific factors such as regulation, payment policy, and market competition. Eight case studies illustrate the operational, financial, and social implications of PE investments, as well as diverse regulatory contexts. Given the lack of disclosure requirements, a key policy priority for governments is to enhance transparency to enable effective monitoring of the financialisation of health care delivery.

Szymborska, H. et Szymborski, J. (2025). "Public health outcomes and the neoliberal health system in Poland." Review of Evolutionary Political Economy **6**(2): 405-424.

The paper discusses the relationship between the dysfunction of the market health system implemented since the beginning of the twenty-first century in Poland and the scale of the country’s health crisis. Life expectancy and mortality of population in Poland deteriorated more during the COVID-19 pandemic than in most European Union countries. We argue that rather than being attributable solely to the pandemic, the health crisis is a consequence of nearly two decades of public health marginalisation, shortcomings in health promotion, disease prevention and healthcare, especially alcohol-related and infections-related diseases. We show that while in the first decade of the political transformation (1990–2000), the increase in average life expectancy in Poland was one of the fastest in Europe, it stalled and subsequently froze against a series of neoliberal reforms since 2002. We present a historical analysis of the neoliberal turn in the Polish health system, arguing that it has led to a vicious cycle, whereby low public investment in public health, driven by the forces of neoliberal market mechanisms, contribute to higher morbidity and mortality from preventable diseases, increasing the population’s need for restorative treatments and widening health inequalities in society, which in turn put an upward pressure on the cost of treatment and medical staff workloads, thus raising the budgetary requirements in the health sector that divert away resources from long-term care, prevention and public health initiatives.

Unruh, L. et Rice, T. (2025). "Private equity expansion and impacts in united states healthcare." Health Policy **155**: 105266.

> Over the past two decades, private equity (PE) firms-private investors that use large pools of money to buy into and restructure companies-have become increasingly involved in U.S. healthcare ownership and management. PE's goal of acquiring quick financial gains is typically accomplished by assigning debt to the facilities and practices it buys, cutting labor costs, changing services to the most lucrative, upcoding diagnostic codes to raise prices, and merging, shutting down, or selling practices. This study shows that private equity has expanded into nearly every corner of U.S. healthcare, and in some sectors, such as hospitals, nursing homes and physician specialties, quite significantly. The PE business model is theorized to be incompatible with high quality, efficient, accessible healthcare. Empirical research supports this framework to some extent. Few studies find evidence for better healthcare quality/patient outcomes or lower expenditures. A few studies find better access in profitable areas for PE, and three find lower operating costs and/or higher operating margins, which may have negative impacts in other healthcare system outcomes. A few studies show no difference in various healthcare system outcomes. Otherwise, the preponderance of studies indicates worse or mixed (mostly worse) outcomes with PE ownership. PE involvement in healthcare is greater in the U.S. than Europe, but there is potential for it to reach similar levels in Europe. Federal and state policy initiatives to regulate PE in U.S. healthcare are in the incipient stage and would benefit greatly by more research on PE's impacts.

Vural, I. E. (2017). "Financialisation in health care: An analysis of private equity fund investments in Turkey." Social Science & Medicine **187**: 276-286.

> The 2007-2008 global financial crisis revived interest in the impacts of financial markets and actors on our social and economic life. Nevertheless, research on health care financialisation remains scant. This article presents findings from research on one modality of financial investments in health care: global private equity funds' investments in private hospitals. Adopting a political economy approach, it analyses the drivers and impacts of the upsurge of global private equity investments in the Turkish private hospital sector amid the global financial crisis. The analysis derives from review of research and archival literature, as well as six in-depth interviews held with owners/executive board directors/general managers of the largest private hospital chains in Turkey and the general partners of their PE investors. The interviewing process took place between January and November 2016. All interviews were conducted by the author in Istanbul. The findings point to a mutually reinforcing relationship between neoliberal policies and financialisation processes in health care. The article shows that neoliberal healthcare reforms, introduced under consecutive Justice and Development Party (JDP) governments in Turkey, have been important precursors of private equity investments in healthcare services. These private equity investments, in turn, intensified and broadened the process of marketisation in health care services. Four impacts are identified, through which private equity investments hasten the marketisation of health care services. These relate to the impacts of private equity investments on a) advancing the process of chain formation by large hospital groups, b) spreading financial imperatives into the operations of private hospitals c) fostering internationalisation of capital, and d) augmenting inequities in access to health care services and standards. (C) 2017 Elsevier Ltd. All rights reserved.

Yuan, M., Wen, W. et Bardhan, I. (2025). "Does Private Equity Hurt or Improve Healthcare Value? New Evidence and Mechanisms". New York, arXiv
https://econpapers.repec.org/paper/arxpapers/2507.14717.htm

> What is the impact of private equity (PE) investment on healthcare value? Does PE investment hurt or improve healthcare value, and if so, can its effect be mitigated through the use of health information technologies (IT)? Given the significant investments by PE firms in the healthcare sector in recent years, these are important research questions. Stakeholders, including policy makers, care providers, and patients, need to understand their likely impact and whether PE ownership is aligned with their interests. Using a staggered difference-in-differences approach and data from US hospitals from 2008-2020, we observe that the overall value of healthcare delivered by hospitals declines after PE investment. However, our empirical evidence reveals that IT-enabled, health information sharing plays an important moderating role. Hospitals with stronger information-sharing capabilities exhibit greater cost efficiencies and improvements in care quality, leading to higher healthcare value after PE investment. Furthermore, we find that the type of health information sharing matters. Specifically, we observe that improvements in care quality are primarily driven by information sharing between hospitals and ambulatory care providers, instead of simply hospital-to-hospital sharing of patient health data. Our research also identifies the underlying mechanisms through which health information sharing improves care value by reducing hospital-acquired infections and readmission rates, thereby improving care quality, and enhancing labor productivity by reducing operating costs. Our results highlight the critical role of policies and common data standards needed to promote IT-enabled information sharing between healthcare providers, which, in turn, can align incentives of PE firms with the goals of value-based care.

Tous les secteurs sont concernés

FOCUS SUR LE CAS DES MAISONS DE RETRAITE

La DREES a produit une étude sur la concentration des groupes d'Ehpad à partir de données administratives. Ses conclusions montrent la place des grands groupes dans le secteur lucratif : plus de la moitié des EHPAD privés lucratifs appartiennent à cinq grands groupes (définis par ≥100 EHPAD sous contrôle), représentant une part notable des lits et des résidents, avec distribution géographique plutôt urbaine[2]
Une autre étude de l'Irdes[3]*, a montré que les tarifs des établissements privés lucratifs sont d'autant plus élevés que la part du secteur non lucratif est plus faible ; ce pouvoir de marché plus important du secteur lucratif s'accompagne aussi d'une fréquence plus élevée des hospitalisations des résidents dans ces établissements (réadmissions à 30 jours, hospitalisations potentiellement évitables, hospitalisations non programmées), ce qui interroge la qualité des soins fournis.*

[2] Louvel, A., Monirijavid, S. (2025). Ehpad : un résident sur dix est accueilli dans un établissement géré par l'un des cinq grands groupes d'Ehpad. Études et résultats Drees (1346)

[3] Penneau, A., Or, Z. (2024). Les Ehpad les plus chers ne sont pas les meilleurs. Questions d'économie de la santé

En 2022, une étude comparant la situation de trois pays de l'OCDE (France, Royaume-Uni et le Japon)[4] sur les facteurs de développement des investissements immobiliers dans le secteur de la santé explique qu'en France, les prestataires à but lucratif ne détiennent qu'une part relativement faible du marché (23 % des lits médicalisés, contre 80 % au Royaume-Uni et 50 % au Japon), mais que la dynamique de consolidation a également conduit à la formation de groupes commerciaux de taille moyenne et grande. 40 % des établissements EHPAD gérés par des prestataires à but lucratif sont agréés pour les soins sociaux financés par l'État. Ces conditions offrent aux investisseurs financiers un potentiel évident pour des opérations de cession-bail, d'autant plus que de nombreux établissements sont situés dans les zones côtières et les banlieues des grandes villes.
Enfin, au Canada En 2020, les sociétés financiarisées possédaient environ 33 % des logements pour personnes âgées du pays, dont 42 % des places dans les maisons de retraite et 22 % des lits de soins de longue durée. L'influence des sociétés financiarisées s'étend au-delà de leurs propres propriétés, avec certaines qui offrent des services de gestion et de conseil à des maisons d'autres types de propriété.[5]

Aveline-Dubach, N. (2022). "Financializing nursing homes? The uneven development of Health Care REITs in France, the United Kingdom and Japan." Environment and Planning A: Economy and Space **54**(5): 984-1004.

> Population aging has led to the establishment of Healthcare Real Estate Investment Trusts (HC-REITs) to boost the supply of nursing homes, but these initiatives have met with contrasting success in different countries. This paper bridges two strands of research on financialization, social welfare and the built environment, to explain the uneven geography of HC-REIT development in France, the UK and Japan. It argues that nation-specific processes of nursing home securitization are shaped by the interrelationships between three crucial factors: (i) the regime of retirement income, (ii) public policies dedicated to long-term institutional care and (iii) the power relations between the REITs and care providers themselves. Drawing on discussions with experts in these sectors, the paper demonstrates that liberal welfare states such as the UK have an especially attractive profile for Healthcare REIT investors due to the advanced state of financialized pension reforms, significant state disengagement in the provision of long-term care and REIT-friendly regulations that facilitate investment operations and leases. On the one hand, these tendencies are driving financial investors to satisfy a growing demand for retirement savings in niche markets such as Healthcare REITs. On the other hand, value extraction is being increasingly sought through the capture of care-dependent residents' home equity. By linking social benefit provisioning to later life housing accommodation, this article casts important light on current debates on the political economy of real estate financialization, while also emphasizing the need for continued state support for long-term institutional care.

Blomqvist, P. et Winblad, U. (2022). "Contracting out welfare services: how are private contractors held accountable?" Public Management Review **24**(2): 233-254.

[4] Aveline-Dubach, N. (2022). "Financializing nursing homes? The uneven development of Health Care REITs in France, the United Kingdom and Japan." Environment and Planning A: Economy and Space **54**(5): 984-1004.

[5] Brown, J. (2022). "La financiarisation du logement des personnes âgées au Canada: un rapport pour le Bureau du défenseur fédéral du logement" Commission canadienne des droits de la personne

A challenge for governments contracting out public services is holding accountable contractors who fail to meet agreed-upon standards. In social services, contract monitoring is complicated by the fact that contracts tend to be incomplete and performance hard to assess. In this study, we examine how local governments in Sweden hold private contractors accountable in nursing home care. The main finding is that a mixture of accountability mechanisms was used, but that social accountability was seen as most effective. Market accountability measures like contract termination and financial sanctions could not be applied as local governments lacked the capacity to enforce them

Bonne, B. et Meunier, M. (2022). "Le contrôle des Ehpad : Rapport sénatorial"Sénat https://www.senat.fr/rap/r21-771/r21-7711.pdf

Suite à la publication de l'ouvrage de Victor Castanet sur le scandale Orpea, groupe privé gestionnaire d'Ehpad, la commission des affaires sociales du Sénat a mis en place une mission d'information dotée de pouvoirs d'une commission d'enquête consacrée à la question du contrôle et, plus largement, à l'exercice du pilotage stratégique du secteur des Ehpad par l'État et les autorités de tarification. Ces travaux font apparaître des lacunes dans le contrôle des établissements. Les limites de ces contrôles viennent de la réglementation mais aussi des moyens insuffisants qui y sont consacrés, alors que la présence de groupes privés lucratifs gestionnaires de plusieurs établissements n'a pas été prise en compte. La commission des affaires sociales du Sénat propose une vision globale de la place des groupes privés à but lucratif dans le secteur, de l'évolution de leurs relations avec l'État et les autorités de tarification et de contrôle. Elle propose de renforcer l'environnement réglementaire dans lesquels ces groupes développent leur activité afin d'améliorer la qualité de la prise en charge des résidents. Cette démarche doit être complétée par une meilleure articulation de l'activité des autorités chargées des contrôles tant au niveau national que départemental et le développement d'un dialogue de gestion entre ces groupes et la CNSA. En complément de ses travaux récents invitant au virage domiciliaire, elle souhaite réinsérer les établissements dans une politique globale en adéquation avec les besoins que va nourrir l'évolution démographique des années à venir. Des mutations profondes du secteur devront enfin être envisagées ; une loi consacrée au grand âge et à l'autonomie est donc indispensable afin de répondre aux besoins de la population.

Borsa, A. et Bejarano, G. (2023). "Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: systematic review." **382**: e075244.

OBJECTIVE: To review the evidence on trends and impacts of private equity (PE) ownership of healthcare operators. DESIGN: Systematic review. DATA SOURCES: PubMed, Web of Science, Embase, Scopus, and SSRN. ELIGIBILITY CRITERIA FOR STUDY SELECTION: Empirical research studies of any design that evaluated PE owned healthcare operators. MAIN OUTCOME MEASURES: The main outcome measures were impact of PE ownership on health outcomes, costs to patients or payers, costs to operators, and quality. The secondary outcome measures were trends and prevalence of PE ownership of healthcare operators. DATA SYNTHESIS: Studies were classified as finding either beneficial, harmful, mixed, or neutral impacts of PE ownership on main outcome measures. Results across studies were narratively synthesized and reported. Risk of bias was evaluated using ROBINS-I (Risk Of Bias In Non-randomised Studies of Interventions). RESULTS: The electronic search identified 1778 studies, with 55 meeting the inclusion criteria. Studies spanned eight countries, with most (n=47) analyzing PE ownership of healthcare operators in the US. Nursing homes were the most commonly studied healthcare setting (n=17), followed by hospitals and dermatology settings (n=9 each);

ophthalmology (n=7); multiple specialties or general physician groups (n=5); urology (n=4); gastroenterology and orthopedics (n=3 each); surgical centers, fertility, and obstetrics and gynecology (n=2 each); and anesthesia, hospice care, oral or maxillofacial surgery, otolaryngology, and plastics (n=1 each). Across the outcome measures, PE ownership was most consistently associated with increases in costs to patients or payers. Additionally, PE ownership was associated with mixed to harmful impacts on quality. These outcomes held in sensitivity analyses in which only studies with moderate risk of bias were included. Health outcomes showed both beneficial and harmful results, as did costs to operators, but the volume of studies for these outcomes was too low for conclusive interpretation. In some instances, PE ownership was associated with reduced nurse staffing levels or a shift towards lower nursing skill mix. No consistently beneficial impacts of PE ownership were identified. CONCLUSIONS: Trends in PE ownership rapidly increased across almost all healthcare settings studied. Such ownership is often associated with harmful impacts on costs to patients or payers and mixed to harmful impacts on quality. Owing to risk of bias and frequent geographic focus on the US, conclusions might not be generalizable internationally. SYSTEMATIC REVIEW REGISTRATION: PROSPERO CRD42022329857.

Broms, R., et al. (2020). "Competition and service quality: Evidence from Swedish residential care homes." Governance-an International Journal of Policy Administration and Institutions **33**(3): 525-543.
10.1111/gove.12436

Against a backdrop of increased levels of marketization of welfare services in OECD countries, this article aims to shed light on the separate effects of private ownership and competition for the market on service quality. Using residential elder care homes in Sweden as our case, we leverage unique panel data of ownership and competition against a set of indicators, pertaining to the structure, process, and outcome dimensions of care quality. The main finding of our analyses is that competition for the market does surprisingly little for quality: private entrepreneurs perform neither better nor worse under stiff competition and the quality of care is approximately the same in those nursing homes that are exposed to the market as in those that are not.

Chatterji, P., et al. (2025). "Mergers and Quality Provision in Healthcare: Evidence from Nursing Homes". NBER Working Paper 33967. N.B.E.R.
https://www.nber.org/papers/w33967

This paper tests whether mergers between nursing home chains and independent facilities affect quality of care using facility-level data from 1999-2019. Staggered difference-in-differences estimates suggest that acquired facilities experience a 5% reduction in health deficiency citations 2 years post-merger. This improvement relies on the continuous supply of efficiency from chains; persists for four years; and is specific to mergers between chains and independent homes. Quality effects are driven by mergers involving smaller, higher-quality and non-private-equity-owned chains. A structural model suggests that the quality effect is generated by enhanced cost efficiency achieved by facilities serving larger numbers of residents after mergers.

Delouette, I. et Nirello, L. (2016). "Le processus de privatisation du secteur des établissements d'hébergement pour personnes âgées dépendantes." Journal de gestion et d'économie médicales **34**(7): 387-408

[BDSP. Notice produite par ORSRA sHR0xB8k. Diffusion soumise à autorisation]. L'objet de cet article est de décortiquer le processus de privatisation du secteur des EHPAD. L'analyse

s'appuie sur une série d'entretiens réalisée auprès d'acteurs clés du domaine et sur l'étude d'un corpus de rapports d'institutions publiques et privées. Nous montrons que la privatisation du secteur est encouragée par les pouvoirs publics au travers de plusieurs dispositifs. D'abord, dès 1997, les régulateurs du champ construisent un rapport de concurrence entre les différents types d'établissements du secteur (public, économie sociale, privé lucratif) en abrogeant la relation privilégiée qu'ils entretenaient avec les acteurs traditionnels non lucratifs, et en ouvrant les financements publics aux établissements privés lucratifs. Les autorités de tarification imposent aussi, au travers des instruments de financement, une médicalisation des établissements menant à une standardisation de leurs activités. Ces normes favorisent le développement des groupes lucratifs tout en affaiblissant les acteurs traditionnels de l'économie sociale et du public, moins armés face aux nouvelles réglementations et ainsi affaiblis financièrement. Nous observons aussi une concentration économique des groupes d'EHPAD résultant d'incitations publiques et de leur mise en concurrence face à un faible nombre de nouvelles places autorisées. La concentration ouvre enfin la voie à une financiarisation progressive des établissements qu'ils soient privés lucratifs ou de l'économie sociale. La privatisation du secteur s'opère donc par le biais de la croissance du privé lucratif face à un tarissement de l'économie sociale et du public, par l'incorporation des normes du privé par les gestionnaires du champ et, par la privatisation des financements des établissements.

Bosch, G. et Evans-Borchers, M. (2026). "Revaluation of Essential Work: The Example of Elderly Care in Germany." Industrial Relations Journal **57**(1): 47-58.

This article is about how labour in a sector can be upgraded through new labour market institutions by mobilizing political support across political camps, even if collective bargaining power through strong trade unions and employers' associations is insufficient. The article summarizes the results of several empirical research projects by the two authors on elderly care, in which the key players in the sector were interviewed. Institutional erosion in labour relations, with its particularly dynamic 'force field', is a key topic of recent institutional theories. In contrast, the analysis of the revitalization of successful institutional innovations for the upgrading of work plays a subordinate role. The field of elderly care in Germany is an example of the successful upgrading of key workers in this market-oriented sector through a deliberate institutional change in the German industrial relations system.

Burau, V., Zechner, M., Dahl, H. M., et al. (2017). "The Political Construction of Elder Care Markets: Comparing Denmark, Finland and Italy." Social Policy & Administration **51**(7): 1023-1041.

In Europe over the last two decades, marketization has become an important policy option in elder care. Comparative studies predominantly adopt an institutional perspective and analyze the politics and policies of marketization. This analysis takes a step back and examines the fundamental ideas underpinning the policies of marketization, using the What's the problem?' approach by Carol Bacchi. The central question is how the market was discursively framed as the solution to the perceived problems of three different systems of elder care, and how such processes are similar or different across the three countries. The analysis includes two extreme types of elder care systems, the Nordic public systems in Denmark and Finland, and the Southern European family-based model in Italy. Empirically, the analysis offers interesting insights into processes of constructing and legitimating markets at the level of discourse; this occurs by defining specific problem representations, underlying assumptions and silences. In all three countries, marketization is presented as a solution which builds on rather than challenges dominant ideas of care. Conceptually, in addition to its institutions, it is crucial to understand the ideas behind the marketization of

elder care. Ideas emerge as a key leverage for making policies and practices of marketization acceptable and which decision makers and other influential political/societal actors use in policy and public debates. The importance of ideas is further underlined by the fact that they do not necessarily relate to the institutions of elder care systems in a linear way.

Deseyne, C., et al. (2024). "Rapport d'information sur la situation des EHPAD" Paris Sénat https://www.senat.fr/notice-rapport/2023/r23-778-notice.html

La situation financière des Ehpad s'est fortement dégradée depuis trois ans : non seulement la proportion d'Ehpad déficitaires a augmenté mais l'ampleur des déficits s'est aggravée, exposant de nombreux établissements à des difficultés de trésorerie à court terme. Une combinaison de causes conjoncturelles et structurelles explique cette situation, que des aides ponctuelles ne suffiront pas à surmonter.

Feltenius, D. et Wide, J. (2024). "Approaching the private model? The public provider in the marketized Swedish elderly care." Nordic Social Work Research. 1–14. https://doi.org/10.1080/2156857X.2024.2393823

This article investigates the public provider of home-care services in Swedish municipalities with user choice. Since the introduction of the Act on Systems of Choice (LOV) in 2009, older citizens have been able to choose their providers for home-care services. Accordingly, in many municipalities, a mix of public and private home-care providers has emerged. We analyse the public provider's course of action in this competition. We assume that it may be categorized as either 'convergence' or 'divergence' in relation to the idea of a private firm. 'Convergence' means that the public provider attempts to imitate the private firm, while 'divergence' refers to efforts to distinguish itself from the private firm. We conducted an empirical study of the public provider of home-care services in six Swedish municipalities considering the following aspects of its operations: organization, designation and graphic design, profiling of services, and marketing. The main materials used consist of in-depth interviews with municipal politicians and officers as well as unit managers for the public provider. The results provide support primarily for the scenario of 'divergence' since there is limited evidence of the public provider imitating the idea of the private firm. Hence, the dominant picture leans towards 'divergence', but to some extent, a course of action in terms of 'convergence' is also apparent. Based on the result we discuss how public providers react to the context of marketization and the challenge to key values in public administration.

Eurofound (2017). "Care homes for older Europeans: Public, for-profit and non-profit providers". Luxembourg, Office des publications de l'Union européenne http://www.eurofound.europa.eu/docs/ewco/tn1212025s/tn1212025s.pdf

With people living longer, the need for affordable care of high quality to support Europe's population increases. Over the last ten years there has been an expansion of the private sector in terms of the number of care homes and the places they provide. This increase takes place in a context of decrease or very slow growth in the services provided in public care homes. This report examines services in the public and private sectors, how they differ in the services they provide in terms of the quality, accessibility and efficiency of services. As private provision increases, costs to users are likely to become a more significant barrier issue unless there is an increase in public benefits to subsidise use. There are also some differences in the location of different types of care homes, with private care homes more

likely to be found in affluent urban areas. Differences in the types of residents are influenced by the profitability of the services they require.

Gandhi, A. et Olenski, A. (2024). "Tunneling and Hidden Profits in Health Care". NBER Working Paper 32258. N.B.E.R.
https://www.nber.org/papers/w32258

This study examines “tunneling” practices through which health care providers covertly extract profit by making inflated payments for goods and services to commonly-owned related parties. While incentives to tunnel exist across sectors, health care providers may find it uniquely advantageous to do so. Masking profits as costs, thereby obscuring true profitability, may dissuade regulators from imposing stricter quality standards and encourage public payers to increase reimbursement rates. Likewise, tunneling effectively “shields” assets from malpractice liability risk, by moving them off the firm’s balance sheet. Using uniquely detailed financial data on the nursing home industry, we apply a difference-in-differences approach to study how firms’ stated costs change when they start transacting with a related party, allowing us to infer by how much these payments are inflated. We find evidence of widespread tunneling through inflated rents and management fees paid to related parties. Extrapolating these markups to all firms’ related party transactions, our estimates suggest that in 2019, 63% of nursing home profits were hidden and tunneled to related parties through inflated transfer prices.

Gupta, A., et al. (2021). "Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes". NBER Working Paper 28474. N.B.E.R.
https://www.nber.org/papers/w28474

The past two decades have seen a rapid increase in Private Equity (PE) investment in healthcare, a sector in which intensive government subsidy and market frictions could lead high-powered for-profit incentives to be misaligned with the social goal of affordable, quality care. This paper studies the effects of PE ownership on patient welfare at nursing homes. With administrative patient-level data, we use a within-facility differences-in-differences design to address non-random targeting of facilities. We use an instrumental variables strategy to control for the selection of patients into nursing homes. Our estimates show that PE ownership increases the short-term mortality of Medicare patients by 10%, implying 20,150 lives lost due to PE ownership over our twelve-year sample period. This is accompanied by declines in other measures of patient well-being, such as lower mobility, while taxpayer spending per patient episode increases by 11%. We observe operational changes that help to explain these effects, including declines in nursing staff and compliance with standards. Finally, we document a systematic shift in operating costs post-acquisition toward non-patient care items such as monitoring fees, interest, and lease payments.

Hoppania, H. K., Karsio, O., Näre, L., et al. (2024). "Financialization of Eldercare in a Nordic Welfare State." Journal of Social Policy **53**(1): 26-44.

The increasing presence of for-profit service providers in publicly-funded eldercare has transformed care in Nordic welfare states which have a strong tradition of public care provision. Macro-level research on care policies has mainly focused on public institutions, national policies, and marketization. The financialization of eldercare has not received much scholarly attention, and existing studies mostly focus on the UK. The financialization of eldercare refers to the ways in which care is both a site of profit extraction and financial engineering. The Nordic system is relatively universal, and, with rapidly ageing demographics,

there is a secured demand for eldercare services. However, these services have been heavily marketized over the past two decades, opening up lucrative possibilities for financialized actors who have established a stronghold over the markets. We analyse these processes through selected empirical examples from Finland, and argue that the financialization of eldercare in the Nordic context demands attention as we are witnessing a new configuration between the constitutional order of the welfare state, public finances, and private profit which is neither transparent, nor democratic.

Huang, S. s., et al. (2019). "The Growth and Geographical Variation of Nursing Home Self-Pay Prices" Ann Harbour Michigan Retirement Research Center. https://mrdrc.isr.umich.edu/publications/papers/pdf/wp397.pdf

Nursing home care is arguably the largest financial risk for the elderly without private or social insurance coverage. The annual out-of-pocket expenditure can easily exceed $70,000. Despite the substantial financial burdens on the elderly, the understanding of nursing home self-pay prices is rather sparse due to data limitation. To bridge the gap in the literature, we collected a unique and longitudinal price dataset from eight states, spanning from 2005 to 2010, to advance the understanding of the determinants and geographical variations of nursing home price and price growth. Overall, nursing home prices have consistently outpaced the inflation of consumer prices, particularly in California and Oregon. We also see faster price growth in markets where they face stricter capacity constraints and have higher for-profit market shares. Organizational structures are also significantly associated with price variations. We find that nonprofit nursing homes have higher prices than for-profit nursing homes and that chain-affiliated nursing homes charge higher prices than nonchains counterparts.

Louvel, A. et Monirijavid, S. (2025). "Ehpad : un résident sur dix est accueilli dans un établissement géré par l'un des cinq grands groupes d'Ehpad." Etudes et résultats (Drees)(1346)

La Direction de la recherche, des études, de l'évaluation et des statistiques (DREES) publie de nouveaux résultats sur les Ehpad privés à but lucratif en détaillant leurs caractéristiques selon l'appartenance ou non à un grand groupe d'Ehpad en 2022. Ces résultats s'appuient sur la base Badiane de 2022, qui rassemble des données administratives issues de plusieurs sources de données, ainsi que sur les données de l'Insee, issues du système d'immatriculation au répertoire des unités statistiques. L'étude analyse les spécificités des Ehpad appartenant à cing grands groupes d'Ehpad, en les comparant aux autres établissements privés à but lucratif.

O'Neill, N. et Mercille, J. (2025). "Private equity investment in long-term care: The case of Ireland." Health Policy **159**: 105378.

BACKGROUND: Private equity (PE) firms are key actors in the financialisation of health care systems. Yet, research rarely focuses directly on these firms and related private for-profit actors involved in financialisation. Moreover, existing work mostly concerns the United States, while several key health care sectors remain under-researched. OBJECTIVE: This study examines the factors driving PE investment in long-term care (LTC) and the strategies PE firms use to enter and expand within the sector. METHODS: We conduct a thematic analysis of 20 in-depth interviews with expert informants, including senior executives from PE firms, financial investors and private for-profit providers. These interviews shed light on the role of PE in Ireland's LTC sector, specifically within nursing homes and home care. RESULTS: Five key factors attract PE investment in Irish LTC: demographic trends, market composition, risk

diversification, and the characteristics of state funding and regulation. In nursing homes, PE uses the "OpCo/PropCo" (operating company/property company) model. In home care, PE enters via global investments in parent companies, direct acquisitions of Irish firms, and master franchise agreements. CONCLUSIONS: Examining private for-profit actors through key officials central to PE growth in LTC provides valuable insights into the financialisation of health care systems. This approach enhances our understanding of business interests driving investment in European LTC.

Or, Z. et Penneau, A. (2025). "The loose connection between pricing, costs and quality with regional inequalities across France" Copenhague O.M.S. Bureau régional de l'Europe

In France, the costs of medical long-term care (LTC) services are well covered by statutory health insurance for all patients, but the costs of personal and social care services faced by older people and their families can be quite high, depending on where they live. Accommodation fees for private nursing homes are paid by residents and are not regulated, although they are locally negotiated for public facilities. Prices vary largely within and among local government authorities, and appear to be disconnected from the quality of care provided.

Orewa, G. N., Karabukayeva, A., Pradhan, R., et al. (2025). "The effects of private equity ownership in U.S. nursing homes quality and financial performance: A systematic review." Health Policy **161**: 105388.

BACKGROUND Private equity (PE) investment in U.S. nursing homes has increased significantly over the past two decades. The emergence of this novel ownership model has prompted concerns regarding its effects on nursing home performance, especially quality. OBJECTIVE This systematic review examined the impact of PE ownership on U.S. nursing homes, focusing on quality of care and financial performance. The review was conceptually informed by agency theory and the structure-process-outcome (SPO) framework. METHODS Following PRISMA guidelines, a systematic search across five databases identified 12 studies published between 2000 and 2024. Eligible studies examined the effects of PE ownership on nursing home quality or financial performance. Data were extracted and synthesized across these two dimensions. RESULTS Across studies, PE ownership was linked to higher number of deficiencies, increased hospitalization rates, and higher mortality, although some improvements in care processes were noted. Financial outcomes showed initial financial gains but long-term challenges, primarily due to high debt loads. CONCLUSIONS Findings suggest that PE strategies may prioritize short-term profitability, which may compromise quality of care in some instances. These findings highlight the need for financial transparency, and reimbursement models that incentivize long-term quality.

Ponder, C. S., et al. (2021). "Contracting-out care: The socio-spatial politics of nursing home care at the intersection of British Columbia's labor, land, and capital markets." Environment and Planning C-Politics and Space **39**(4): 800-817.

The provincial health services labor market was fundamentally altered in 2002 with the introduction of a series of legislative and policy changes enabling the contracting-out, or subcontracting, of care workers in nursing home facilities in order to encourage private sector investment in nursing home infrastructure and provision. This legislation was intended to shrink provincial expenses and replace aging facilities through partnerships with the private sector that would keep debt off provincial books. Through in-depth interviews with front-line workers and provincial and Health Authority administrators, this research

foregrounds care as a political relationship by mapping how these legislative changes related to provincial budget concerns splintered a specialized labor market, eroding both working and caring conditions, and exposing eldercare in British Columbia, Canada to the speculative dynamics of finance.

Spagnolo, G. c., Bergman, M. a. et Lundberg, S. (2012). "Privatization and Quality: Evidence from Elderly Care in Sweden". Stockholm, Stockholm Institute of Transition Economics Working Paper 19
http://swopec.hhs.se/hasite/papers/hasite0019.pdf

Many quality dimensions are hard to contract upon and are at risk of degradation when services are procured rather than produced in-house. However, procurement may foster performance-improving innovation. We assemble a large data set on elderly care services in Sweden between 1990 and 2009, including survival rates - our measure of non-contractible quality - and subjectively perceived quality of service. We estimate how procurement from private providers affects these measures using a difference-in-difference approach. The results indicate that procurement significantly increases non-contractible quality as measured by survival rate, reduces the cost per resident but does not affect subjectively perceived quality.

Tiberghien, F. (2025). "La prise en charge de la dépendance par les secteurs public, privé non-lucratif et privé lucratif". Paris, Le Labo de l'Economie Sociale et Solidaire
https://www.lelabo-ess.org/la-prise-en-charge-de-la-dependance-par-les-secteurs-public-prive-non-lucratif-et-prive-lucratif

La parution en 2022 de l'ouvrage d'investigation Les Fossoyeurs de Victor Castanet a contribué à ouvrir un débat pérenne sur les pratiques du secteur privé lucratif (SPL) dans la prise en charge des services sanitaires et sociaux, et en particulier de la dépendance. Épinglés dans cet ouvrage, les Établissements d'hébergement pour personnes âgées (EPHAD) relevant de ce secteur sont particulièrement mis en cause, révélant les incidences néfastes de modèles économiques centrés sur la rentabilité, au détriment du bien-être des résidents. Au vu des limites et dérives du SPL – aujourd'hui encore minoritaire dans ce champ par rapport au secteur public (SP) et au secteur privé non lucratif (PNL) dont ESS France a récemment souligné les avantages – la question de sa régulation se pose, de même que celle, plus large, de l'avenir du modèle de l'EHPAD. Replaçant le sujet dans une histoire longue et une description de l'évolution récente des moyens de la prise en charge de la dépendance par les trois secteurs (SP, SPL, PNL) et de la législation l'encadrant, cette note propose une analyse fournie des enjeux à prendre en compte et formule des propositions concrètes pour mieux répondre aux besoins des personnes concernées.

Twyford, E., Rowe, R. et Andrew, J. (2025). "Financial gaslighting: The financialisation of care in later life." Critical Perspectives on Accounting **101**.

The world's population is ageing, and the provision and sustainability of aged care services are urgent. Like structural reforms in similar settings, aged care has been subjected to the logics of financialisation, yet few studies examine its mobilisation in aged care. Drawing on nearly 900 submissions to the Royal Commission into Aged Care Quality and Safety in Australia, we provide insights into how financialisation presents in an aged care setting and its implications for older people. The study draws on three features of financialisation to explore its effects on everyday life within this context: the 'assetisation' of the home; the rhetoric of choice used to shift risks from the state to people; and the discourse of financial

literacy, which has cultivated individual responsibility for the management of aged care. We argue that older people are 'financially gaslit' into believing that the provision of aged care is designed to support autonomy, choice, and information symmetries when, in reality, financialisation in aged care involves significant wealth transfer from individuals to private providers. Given the unevenness of home ownership at retirement, the variability in the capacity to exercise informed choice in later life, and the spectrum of financial literacy, we find that the current model displaces responsibility for funding aged care onto those in need of care. In turn, responsibilising people to make complex financial choices about the care needed in later stages of life ensures that substantive financial risks are shifted to those amongst the community's most vulnerable.

L'HOPITAL

Alles, L. et Da Silva, N. (2025). "The transformation of French hospital capitalism: financialisation and concentration." Review of Social Economy. 1–33.
https://doi.org/10.1080/00346764.2025.2545824

The aim of this article is to analyse the financialisation of for-profit hospitals in France as the central driving force behind the transformation of hospital capitalism. It shows that over the last 30 years, the for-profit hospital sector has undergone a process of financialisation that has led to a high level of concentration. At the end of the last century, the sector was mainly made up of independent structures, often owned by doctors, but now it is characterised by the existence of interdependent groups, the largest of which are financialised. Between 2004 and 2020, the number of independent structures has been divided by 4.3, while the number of structures belonging to a group has multiplied by 2. These transformations have been made possible by substantial funding from public insurance. Moreover, the business model of hospital capitalism is based on patient selection and task selection, to the detriment of public hospitals.

Arnold, D. et Radhakrishnan, N. (2025). "Foisted: The Spillover Effects of Hospital Mergers on Costs and Utilization". Rochester, S.S.R.N.
https://papers.ssrn.com/sol3/papers.cfm?abstract_id=5265291

Market power enables firms to restrict quantities and provide services to higher-paying consumers. We study this question using hospital mergers over the 2011 to 2022 period. Consistent with previous work, we find mergers lead to own-hospital reductions in staffing and patient volume, which are driven by decreases in lower-paying public patients. We also find decreases in births, which are heavily paid for by Medicaid. Where do these patients and providers go? We find corresponding increases in public payer volume, staffing, and procedure volume at non-merging neighboring hospitals. In addition, per-procedure discharge costs increase and operating margins decrease at non-merging hospitals. These increases in lower-paying patient populations and operating costs contribute to a nearly 40% increase in the likelihood of non-merging hospital exit. Overall, our collection of findings document how hospital mergers have understudied spillover effects on patient access to care and market stability.

Bai, G., Jimenez, D. et Phan, P. (2021). "The Financial Fragility of For-profit Hospitals: Evidence from the COVID-19 Pandemic". Cambridge, N.B.E.R. NBER Working Paper 29388

https://www.nber.org/papers/w29388

> We estimate the likelihood of financial distress of U.S. hospitals in 2020 due to the COVID-19 pandemic using AHA Annual Survey data for 2011-2019 and smartphone mobility data for 2020. We find that while the average likelihood of distress across all hospitals is 28.53 % in 2020, slightly increasing from 2019, for-profit hospitals are much more likely to be distressed. Their average likelihood of financial distress is 39.13 %---a 6.93 percentage point increase from 2019. For-profit hospitals are the main providers of specialty health care services, such as psychiatric and acute long-term care, so their increased likelihood of distress poses a risk to service provision in these specialty areas, and particularly in rural communities. Our prediction model based on mobility data performs very well in sample against actual data and can potentially help policymakers and hospital administrators to monitor financial distress in real-time when case mixes change, or other large shocks materialize

Berta, P., Martini, G., Piacenza, M., et al. (2019). "The strange case of appropriate C-sections:DRG-tariff regulation, hospital ownership, and market concentration". York, University of York HEDG Working Paper 19/02
http://d.repec.org/n?u=RePEc:yor:hectdg:19/02&r=hea

> The aim of this paper is to discuss how different types of hospitals respond to large financial incentives for vaginal deliveries and to financial disincentives for C-sections. We focus on a public health care system based on the quasi market model. We theoretically and empirically evaluate a government policy equalizing the tariff for C-section and vag inal deliveries at a level such that hospitals face monetary disincentives for C-section and monetary incentives for vaginal deliveries. We first theoretically show that hospital ownership matters insofar different types of hospitals are characterized by different ethical preferences; but ownership interacts with market concentration. We then consider the case-study of Lombardy in Italy. We exploit spatial variation in the presence of for-profit, not-for-profit and public hospitals and in the market concentration at the local level to evaluate the relationship between ownership and the probability of C-section. Our empirical results strongly suggest that competitive pressures from alternative providers tend to homogenize behaviors. However, in local monopolies, we do observe less C-section from private for-profit hospitals than from public and private non-profit hospitals especially when they are medically appropriate

Brot-goldberg, Z. c., Cooper, Z. et Craig, S. v. (2024). "Who Pays for Rising Health Care Prices? Evidence from Hospital Mergers". Cambridge, N.B.E.R. NBER Working Paper n° 32613
https://www.nber.org/papers/w32613

> We analyze the economic consequences of rising health care prices in the US. Using exposure to price increases caused by horizontal hospital mergers as an instrument, we show that rising prices raise the cost of labor by increasing employer-sponsored health insurance premiums. A 1% increase in health care prices lowers both payroll and employment at firms outside the health sector by approximately 0.4%. At the county level, a 1% increase in health care prices reduces per capita labor income by 0.27%, increases flows into unemployment by approximately 0.1 percentage points (1%), lowers federal income tax receipts by 0.4%, and increases unemployment insurance payments by 2.5%. The increases in unemployment we observe are concentrated among workers earning between $20,000 and $100,000 annually. Finally, we estimate that a 1% increase in health care prices leads to a 1 per 100,000 population (2.7%) increase in deaths from suicides and overdoses. This implies that approximately 1 in 140 of the individuals who become fully separated from the labor market after health care prices increase die from a suicide or drug overdose.

Bruch, J. D., Gondi, S. et Song, Z. (2020). "Changes in Hospital Income, Use, and Quality Associated With Private Equity Acquisition." JAMA Intern Med **180**(11): 1428-1435.

IMPORTANCE: Rigorous evidence describing the relationship between private equity acquisition and changes in hospital spending and quality is currently lacking. OBJECTIVE: To examine changes in hospital income, use, and quality measures that may be associated with private equity acquisition. DESIGN, SETTING, AND PARTICIPANTS: This cohort study identified 204 hospitals acquired by private equity firms from 2005 to 2017 and 532 matched hospitals not acquired by private equity. Using a difference-in-differences design, this study evaluated changes in net income, charges, charge to cost ratios, case mix index (a measure of reported illness burden), share of discharges for patients with Medicare or Medicaid coverage, discharges per year, and aggregate hospital quality measures associated with private equity acquisition through 3 years after acquisition, adjusted for case mix, hospital beds, calendar year, and adjustment for multiple hypothesis testing. In subgroup analyses, changes in outcomes for private equity-owned Hospital Corporation of America (HCA) hospitals and non-HCA hospitals relative to matched controls were assessed. PRIMARY OUTCOMES AND MEASURES: Eight hospital income and use measures and 3 aggregate hospital quality measures were examined. RESULTS: Relative to 532 control hospitals, the 204 private equity-acquired hospitals showed a mean increase of $2 302 391 (95% CI, $956 660-$3 648 123; P = .009) in annual net income, an increase of $407 (95% CI, $296-$518; P < .001) in total charge per inpatient day, an increase of 0.61 (95% CI, 0.48-0.73; P < .001) in emergency department charge to cost ratio, an increase of 0.31 (95% CI, 0.26-0.37; P < .001) in total charge to cost ratio, an increase of 0.02 (95% CI, 0.01-0.02; P = .007) in case mix index, and a decrease of 0.96% (95% CI, 0.46%-1.45%; P = .002) in share of Medicare discharges. Medicaid's share of discharges (-0.16%; 95% CI, -0.86% to 0.53%; P > .99) and total hospital discharges (98; 95% CI, -54 to 250; P > .99) did not change differentially in a statistically significant manner. The aggregate quality score for acute myocardial infarction increased by 3.3% (95% CI, 1.6%-5.0%; P = .002), and the aggregate score for pneumonia increased by 2.9% (95% CI, 1.8%-3.9%; P < .001) in private equity-acquired hospitals relative to controls. The aggregate score for heart failure (1.3%; 95% CI, -0.2% to 2.7%; P = .92) did not differentially change in a statistically significant manner. In subgroup analyses, HCA hospitals showed similar findings to the entire sample. Among non-HCA hospitals, the only statistically significant relative changes were the increase in the emergency department charge to cost ratio (0.30; 95% CI, 0.12-0.48; P = .02) and the decrease in Medicare's share (-1.15%; 95% CI, -1.88% to -0.43%; P = .02). Non-HCA hospitals showed a decrease in the aggregate heart failure score (-3.3%; 95% CI, -5.3% to -1.3%; P = .01) and no statistically significant changes in the aggregate score for acute myocardial infarction (2.4%; 95% CI, -0.7% to 5.4%; P > .99) or pneumonia (0.2%; 95% CI, -1.4% to 1.7%; P > .99). CONCLUSIONS AND RELEVANCE: Hospitals acquired by private equity were associated with larger increases in net income, charges, charge to cost ratios, and case mix index as well as with improvement in some quality measures after acquisition relative to nonacquired controls. Heterogeneity in some findings was observed between HCA and non-HCA hospitals.

Colla, C., Bynum, J., Austin, A., et al. (2016). "Hospital Competition, Quality, and Expenditures in the U.S. Medicare Population". Cambridge, N.B.E.R.

Theoretical models of competition with fixed prices suggest that hospitals should compete by Increasing quality of care for diseases with the greatest profitability and demand elasticity. Most empirical evidence regarding hospital competition is limited to heart attacks, which in the U.S. generate positive profit margins but exhibit very low demand elasticity – ambulances

usually take patients to the closest (or affiliated) hospital. In this paper, we derive a theoretically appropriate measure of market concentration in a fixed-price model, and use differential travel-time to hospitals in each of the 306 U.S. regional hospital markets to instrument for market concentration. We then estimate the model using risk-adjusted Medicare data for several different population cohorts: heart attacks (low demand elasticity), hip and knee replacements (high demand elasticity) and dementia patients (low demand elasticity, low or negative profitability). First, we find little correlation within hospitals across quality measures. And second, while we replicate the standard result that greater competition leads to higher quality in some (but not all) measures of heart attack quality, we find essentially no association between competition and quality for what should be the most competitive markets – elective hip and knee replacements. Consistent with the model, competition is associated with lower quality care among dementia patients, suggesting that competition could induce hospitals to discourage unprofitable patients.

Cooper, Z., Doyle, J. j., Graves, J. a., et al. (2022). "Do Higher-Priced Hospitals Deliver Higher-Quality Care?". Cambridge, N.B.E.R. NBER Working Paper 29809
https://www.nber.org/papers/w29809

We analyze whether receiving care from higher-priced hospitals leads to lower mortality. We overcome selection issues by using an instrumental variable approach which exploits that ambulance companies are quasi-randomly assigned to transport patients and have strong preferences for certain hospitals. Being admitted to a hospital with two standard deviations higher prices raises spending by 52% and lowers mortality by 1 percentage point (35%). However, the relationship between higher prices and lower mortality is only present at hospitals in less concentrated markets. Receiving care from an expensive hospital in a concentrated market increases spending but has no detectable effect on mortality.

Couty, E. (2010). "Hôpital public : le grand virage." SEVE : LES TRIBUNES DE LA SANTE(28): 39-48.

Les réformes qui font entrer l'hôpital dans le XXIe siècle (plan « Hôpital 2007 » et loi HPST) mettent en place une série de mesures d'inspiration libérale qui peuvent remettre en cause le secteur public hospitalier en France. La convergence des tarifs publics et privés dans le système de financement à l'activité et les effets de marchandisation qu'elle entraîne, les contrats de partenariat public-privé (PPP) pour la réalisation d'investissements et l'exploitation de services hospitaliers, enfin la suppression du service public hospitalier et l'avènement d'une gouvernance pour un hôpital-entreprise sont autant de signaux d'une rupture avec les valeurs qui fondent les missions de l'hôpital public et donnent sens à l'action de ses personnels. Cette rupture s'accompagne d'un retour en force de l'Etat central, la politique contractuelle étant biaisée par l'institution d'une ligne hiérarchique pyramidale qui va jusqu'aux services de proximité. L'article s'efforce d'analyser ce processus simultané de « privatisation » et de « nationalisation » qui se met en place dans un contexte économique et financier dont la gravité exige effort de solidarité et rigueur de la part de tous les acteurs (résumé de l'éditeur).

Dafny, L., Ho, K. et Lee, R. s. (2016). "The Price Effects of Cross-Market Hospital Mergers". Cambridge, N.B.E.R. NBER Working Paper n° 22106
https://www.nber.org/papers/w22106

So-called "horizontal mergers" of hospitals in the same geographic market have garnered significant attention from researchers and regulators alike. However, much of the recent hospital industry consolidation spans multiple markets serving distinct patient populations.

We show that such combinations can reduce competition among the merging providers for inclusion in insurers' networks of providers, leading to higher prices. The result derives from the presence of "common customers" (i.e. purchasers of insurance plans) who value both providers, as well as (one or more) "common insurers" with which price and network status is negotiated. We test our theoretical predictions using two samples of cross-market hospital mergers, focusing exclusively on hospitals that are bystanders rather than the likely drivers of the transactions in order to address concerns about the endogeneity of merger activity. We find that hospitals gaining system members in-state (but not in the same geographic market) experience price increases of 6-10 percent relative to control hospitals, while hospitals gaining system members out-of-state exhibit no statistically significant changes in price. The former group are likelier to share common customers and insurers. This effect remains sizeable even when the merging parties are located further than 90 minutes apart. The results suggest that cross-market, within-state hospital mergers appear to increase hospital systems' leverage when bargaining with insurers.

Diaz, A., Mead, M., Rohde, S., et al. (2025). "Hospitals Acquired By Private Equity Firms: Increased Postoperative Mortality For Common Inpatient Surgeries." Health Aff (Millwood) **44**(5): 554-562.

Private equity (PE) firms have increasingly invested in US hospitals, raising concerns about their effects on the quality of surgical care. We evaluated the impact of PE acquisition of acute care hospitals on outcomes from four common general surgical operations among Medicare beneficiaries, using a difference-in-differences approach. Our study included 67 hospitals acquired by PE and 634 control hospitals not acquired by or previously owned by PE. We found that PE acquisition was associated with a 2.7-percentage-point increase in thirty-day postoperative mortality compared with control hospitals, driven primarily by an increase in failure to rescue (3.9 percentage points), with no observed change in the rate of complications. Subset analysis revealed that the increase in mortality was particularly pronounced for unplanned (emergent) surgeries, whereas no significant changes were observed for planned (elective) surgeries. Our findings suggest that PE acquisition may adversely affect the management of emergent surgical cases, raising critical considerations for policy makers and health care stakeholders regarding the influence of PE ownership on patient safety.

Dranove, D., Gaynor, M. et Geddes, E. (2025). "Expecting Harm? The Impact of Rural Hospital Acquisitions on Maternal Health Care". Cambridge, N.B.E.R. NBER Working Paper 34159 https://www.nber.org/papers/w34159

While numerous papers document the effects of mergers on cost and quality, the effects of hospital mergers on access to care are less certain. Merging hospitals may limit access by closing one of the affected hospitals or eliminating individual service lines. However, hospital systems may have more resources to improve care delivery. We study the impact of hospital mergers on obstetric care in rural markets, where there may be heightened concern about the availability of local care options. Using a differences-in-differences approach, we find that when rural hospitals are acquired, there are substantial increases in the probability of obstetric unit closures, with resulting large reductions in the number of births at the hospital. We find mixed effects on health outcomes: there are small increases in maternal morbidity, but no changes in newborn outcomes on average. However, there are improvements of newborns with Medicaid coverage. Additionally, we find decreases in maternal transfers and increases in procedures consistent with women delivering in more resourced hospitals.

Duggan, M., Gupta, A. et Jackson, E. (2023). "The Impact of Privatization: Evidence from the Hospital Sector". Cambridge, N.B.E.R. NBER Working Paper 30824
https://www.nber.org/papers/w30824

> Privatization has been shown to increase growth and profitability of public firms. However, effects on consumers are understudied. We study potential trade-offs in the US hospital sector where public control declined by 42% over 1983–2019. Private operators may improve hospitals' financial performance, but a focus on profitability may adversely affect access to care for certain patients. Using national data across all hospitals and patients, we study 258 hospital privatizations over the 2000–2018 period. Private operators improve profitability so that hospitals generate a modest surplus, primarily by increasing mean revenue per patient. However, this is partly achieved by differentially reducing the intake of low-income Medicaid patients, who are typically less profitable than other groups due to lower reimbursement rates. While other patients appear to be absorbed by neighboring hospitals, Medicaid patients experience an aggregate decline in utilization at the market-level, which we interpret as a decline in access to care. Hospital privatization therefore partially offsets the benefits of providing publicly funded health insurance through Medicaid, and our estimates imply it is quantitatively important. The aggregate decline in Medicaid volume is detected only in more concentrated hospital markets, suggesting market power is a key driver.

Gaynor, M., Sacarny, A. et Sadun, R. (2021). "The Anatomy of a Hospital System Merger: The Patient Did Not Respond Well to Treatment". Cambridge, N.B.E.R. NBER Working Paper 29449
https://www.nber.org/papers/w29449

> There is an ongoing merger wave in the US hospital industry, but it remains an open question how hospital mergers change, or fail to change, hospital behavior, performance, and outcomes. In this research, we open the "black box" of practices within hospitals in the context of a mega-merger between two large for-profit chains. Benchmarking the effects of the merger against the acquirer's stated aims, we show that they achieved some of their goals: they harmonized their electronic medical records and sent managers to target hospitals; after the acquisition, managerial processes were similar across hospitals in the merged chain. However, these interventions failed to drive detectable gains in profitability or patient outcomes. Our findings demonstrate the importance of hospital organizations and internal processes for merger research and policy in health care and the economy more generally.

Gobillon, L. et Milcent, C. (2017). "Competition and Hospital Quality: Evidence from a French Natural Experiment". Bonn, I.Z.A. IZA Discussion Paper 10476
http://ftp.iza.org/dp10476.pdf

> We evaluate the effect of a pro-competition reform gradually introduced in France over the 2004-2008 period on hospital quality measured with the mortality of heart-attack patients. Our analysis distinguishes between hospitals depending on their status: public (university or non-teaching), non-profit or for-profit. These hospitals differ in their degree of managerial and financial autonomy as well as their reimbursement systems and incentives for competition before the reform, but they are all under a DRG-based payment system after the reform. For each hospital status, we assess the benefits of local competition in terms of decrease in mortality after the reform. We estimate a duration model for mortality stratified at the hospital level to take into account hospital unobserved heterogeneity and censorship in the duration of stays in a flexible way. Estimations are conducted using an exhaustive dataset at the patient level over the 1999-2011 period. We find that non-profit hospitals,

which have managerial autonomy and no incentive for competition before the reform, enjoyed larger declines in mortality in places where there is greater competition than in less competitive markets.

Graig, S., Grennan, M. et Swanson, A. (2018). "Mergers and Marginal Costs: New Evidence on Hospital Buyer Power". Cambridge, N.B.E.R. NBER Working Paper n° 24928
https://papers.nber.org/papers/W24926

We estimate the effects of horizontal mergers on marginal cost efficiencies – an ubiquitous merger justification – using data containing supply purchase orders from a large sample of US hospitals 2009-2015. The data provide a level of detail that has been difficult to observe previously, and a variety of product categories that allows us to examine economic mechanisms underlying “buyer power.” We find that merger target hospitals save on average $176 thousand (or 1.5 percent) annually, driven by geographically local efficiencies in price negotiations for high-tech “physician preference items.” We find only mixed evidence on savings by acquirers.

Nawaz, M. et Shakya, S. (2025). "Hospital Mergers and Acquisitions a Financial Profit Analysis". Rochester, S.S.R.N.
https://papers.ssrn.com/sol3/papers.cfm?abstract_id=5242773

We analyzed net profit margins for For-profit, Government, and Non-profit hospitals using the National Academy for State Health Policy’s Hospital Cost Tool database (2011-2022). We use generalized difference-in-differences and event-study frameworks to compare the net profit margin of the treatment group– hospitals with “one-time” mergers to the comparison group– hospitals without mergers. Government and Non-profit hospitals merging with For-profit hospitals increase net profit margins by 6.4 and 5.8 percentage points, respectively. Conversely, For-profit merging with Non-profit hospitals reduces net profit margins by 4.8 percentage points.

Nie, X. (2025). "Medical reterritorialisation: the spatial interests of healthcare, financialisation and hospitals in a city-region." Regional Studies **59**(1).
https://doi.org/10.1080/00343404.2025.2534690

Nolte, E., Pitchforth, E., Miani, C., et al. (2014). "The changing hospital landscape. An exploration of international experiences". Santa Monica, Rand Corporation
http://www.rand.org/content/dam/rand/pubs/research_reports/RR700/RR728/RAND_RR728.pdf

The nature of hospital activity is changing in many countries, with some experiencing a broad trend towards the creation of hospitals groups or chains and multi-hospital networks. This report seeks to contribute to the understanding of experiences in other countries about the extent to which different hospital 'models' may provide lessons for hospital provision in England by means of a review of four countries: France, Germany, Ireland and the United States, with England included for comparison. We find that here has been a trend towards privatisation and the formation of hospital groups in France, Germany and the United States although it is important to understand the underlying market structure in these countries explaining the drivers for hospital consolidation. Thus, and in contrast to the NHS, in France, Germany and the United States, private hospitals contribute to the delivery of publicly funded healthcare services. There is limited evidence suggesting that different forms of hospital cooperation, such as hospital groups, networks or systems, may have different impacts on hospital performance. Available evidence suggests that hospital consolidation

may lead to quality improvements as increased size allows for more costly investments and the spreading of investment risk. There is also evidence that a higher volume of certain services such as surgical procedures is associated with better quality of care. However, the association between size and efficiency is not clear-cut and there is a need to balance 'quality risk' associated with low volumes and 'access risk' associated with the closure of services at the local level.

Vilar-Rodríguez, M. et Pons, J. (2022). "The penetration of financial capital and the growth of private hospital groups in Europe: the case of Spain (1975–2022)." Medical History **66**(4): 339-359.

From the last decades of the twentieth century, above all, in the more service-oriented post-industrial economies, and in a context of debilitation of public health systems, health care became exponentially profitable, thereby attracting new types of investors. In fact, this new stage entails moving from the commercialisation of health care to its financialisation; that is, medical care becomes just one more financial asset and its price and quality are quoted on the stock exchange. This study intends to participate in the debate initiated by historians of medicine and economic historians with the aim of tracing capitalist traits and market participation in the evolution of health coverage, a process initially promoted by professional doctors who converted their consulting rooms into small clinics and larger hospital companies and which, over time, saw the incorporation of financial capital. In particular, this paper has two specific objectives for the case of Spain. First, to analyse the relationship of collaboration and/or competition between public and private hospitals under democracy and the factors that have conditioned this relationship. Second, to make an initial contribution towards understanding how, in this context, the large private hospital groups have been created in Spain during this period, especially in recent decades with concentration in the hands of financial capital, originating from both the traditional banking sector and investment funds.

Vilar-Rodríguez, M. et Pons, J. (2024). "The emergence of financial capital in the health insurance business in Europe: The case of Spain in the last fifty years." Revista de Historia Económica / Journal of Iberian and Latin American Economic History **42**(2): 217-242. https://doi.org/10.1017/s0212610924000016

Sickness insurance companies were developed in Spain by doctors and healthcare professionals, remaining outside the interests of general insurance companies. Their management was hardly professional, with limited actuarial techniques and they only accounted for a small percentage of total insurance business premiums. From the 1970s onwards, various factors changed this situation, driving processes of concentration, with numerous takeovers and mergers, first reducing the number of local and regional companies to the benefit of companies of national scope. Subsequently, the growth in demand for this type of coverage sparked the interest of national general insurance companies and multinationals, leading to a restructuring of the sector which has progressively acquired greater weight within the insurance business and become increasingly internationalised. This last stage immersed the health sector in Spain in the great processes of globalisation of the sector, characterised by a financialisation of capital promoted by the bank investment funds. These processes are little known and are the focus of analysis of this paper, with the aim of enabling comparison at international level.

LES SOINS AMBULATOIRES

Les conclusions d'un récent document de l'OCDE [6]révèlent que les services ambulatoires spécialisés sont devenus récemment une cible pour les institutions financières actives dans le secteur de la santé, notamment en dentisterie, ophtalmologie, radiologie, biologie et soins primaires. Si la financiarisation est une préoccupation pour la majorité des pays ayant répondu, ses modalités varient selon la structure des systèmes de santé. De plus, malgré un nombre croissant d'éléments probants concernant les impacts potentiels – souvent négatifs – des investissements de certains acteurs financiers, notamment les sociétés de capital-investissement, les pays ne disposent pas d'une vision globale de l'ampleur de l'augmentation des investissements de ces institutions dans leurs systèmes de santé.

En France

Amghar, Y. g., Bras, P. l. et Chapelet, C. (2025). "Pertinence et efficience des dépenses de radiologie". Paris, I.G.A.S.
https://www.igas.gouv.fr/pertinence-et-efficience-des-depenses-de-radiologie

> Le rapport conjoint Igas-IGF dresse un état des lieux du secteur de la radiologie diagnostique et interventionnelle, en ville et à hôpital, réalisée par des radiologues : 60 % de l'activité est portée par la radiologie conventionnelle, bien qu'en baisse par substitution progressive par l'imagerie en coupe (EML) ; La forte hausse des EML (+ 20 % pour les scanners et +31 % pour les IRM depuis 2019), en partie expliquée par la récente réforme des autorisations ; 60 % des dépenses sont liées à des examens d'imagerie en coupe (5,9 milliards d'euros de remboursements annuels, dont 1,7 milliards d'euros de forfaits techniques). Le bilan de la maitrise médicalisée est mitigé, malgré de nombreuses recommandations de bonnes pratiques de la Haute Autorité de Santé. La mission estime des économies potentielles à hauteur de 500 millions d'euros par an.

Amghar, Y. g., Bras, P. l. et Chapelet, C. (2025). "Pertinence et efficience des dépenses de biologie médicale". Paris Igas
https://igas.gouv.fr/pertinence-et-efficience-des-depenses-de-biologie-medicale

> Le rapport conjoint Igas-IGF dresse un état des lieux du secteur de la biologie médicale et de son organisation en ville et à l'hôpital : Une activité et des dépenses (8 milliards d'euros) portées à 55 % par les laboratoires de ville. Un maillage territorial satisfaisant avec 99,8 % de la population à moins de 30 minutes d'un site de prélèvement. La mission dresse un constat mitigé des actions de maitrise médicalisée et propose d'instaurer une prescription renforcée et/ou un remboursement conditionnel pour les analyses les plus suspectes de mésusage. Dans un contexte de suspension de la régulation prix volume jusqu'à fin 2026, la mission a identifié un potentiel d'économies à moyen terme de 650 millions €.

Bonnefont-Rousselot, D. et Delpech, M. (2022). "La Biologie Médicale en France : évolutions et enjeux". Paris, Académie nationale de médecine

[6] Suzuki, E., et a. (2025). "Trends in the financialisation of outpatient care across OECD countries". Paris, O.C.D.E

https://www.academie-medecine.fr/wp-content/uploads/2022/10/Rapport-avenir-de-la-Biologie-Medicale.pdf

> La Biologie Médicale est un maillon essentiel de la prise en charge des patients, tant pour le diagnostic et le suivi des maladies que pour certaines avancées thérapeutiques. Elle est toutefois, depuis quelques années, confrontée à des questions fondamentales concernant son avenir. Le présent rapport s'inscrit dans le prolongement de celui publié en 2018 par les Académies Nationales de Médecine et de Pharmacie et ne fait malheureusement que conforter une forte dégradation à tous les niveaux. Les pouvoirs publics n'assument pas leur rôle de régulateur, permettant ainsi que la financiarisation à outrance de la Biologie Médicale s'amplifie considérablement et conduise à des regroupements démesurés des Laboratoires de Biologie Médicale (LBM), destructeurs et sources de risques sanitaires. Le résultat est que les LBM de ville, dont on connait déjà la mauvaise répartition territoriale, deviennent progressivement de simples sites de prélèvement, les patients se retrouvant alors seuls, souvent angoissés, avec leurs résultats transmis par internet sans interprétation. Par ailleurs, bien que les progrès dans le domaine de la Biologie Médicale soient incroyables et devraient constituer un pôle d'attractivité majeur pour les jeunes, la désaffection de la discipline est totale et inquiétante. Enfin, l'innovation, dans le cadre des progrès technologiques actuels : dispositifs connectés, intelligence artificielle et mégadonnées (big data), représente un enjeu majeur pour l'avenir. Là encore rien n'est fait, ou presque, alors que les chantiers sont immenses. Après ces constatations alarmantes, le rapport se terminera par une série de recommandations visant à optimiser l'entrée des LBM dans une nouvelle ère.

Bourgain, C., Cassier, M., Gaudillière, J.-P., et al. (2021). " Les félicités du capital en santé" Revue Française de Socio-Economie(26): 127-147.
https://shs.hal.science/halshs-03464016

> Alors que le terme de « crise » est sans cesse mobilisé depuis le milieu des années 2000 pour décrire une industrie pharmaceutique financiarisée et spéculant sur un nombre limité d'innovations à valeur ajoutée clinique importante, cet article propose d'élargir la perspective en considérant les capitalismes pharmaceutiques des Nords et des Suds dans leur diversité. Nous présentons une analyse socio-historique de plusieurs modes de déploiements de ces industries de santé et des conditions de « félicité » de leur modèle scientifique et financier. Insistant sur l'importance des infrastructures politiques de construction des marchés et sur les ordres institutionnels dans lesquels les industries s'insèrent (et qu'elles contribuent à façonner), nous montrons qu'il est possible de lire le développement des capitalismes pharmaceutiques à l'aune de trois critères : le degré de financiarisation, les formes de propriété intellectuelle et la place prise par les biotechnologies. Cette analyse remet en cause la division entre des Nords industriels et innovateurs d'une part et des Suds gérant la pénurie d'autre part.

Cour des comptes (2025). "Les pharmacies d'officine : un modèle en mutation". Paris, Cour des comptes In : [La sécurité sociale : rapport sur l'application de financement de la sécurité sociale 2025] ; Paris : Cour des comptes
https://www.ccomptes.fr/fr/documents/75405

> Les pharmacies ont, en France, le monopole de la vente aux particuliers des produits de santé (médicaments et dispositifs médicaux). L'ouverture d'une officine, nécessairement par un pharmacien diplômé, est soumise à autorisation administrative, accordée en fonction d'un critère de population communale. L'essentiel des recettes des pharmacies est constitué par le remboursement, par l'assurance maladie, des médicaments dispensés à leurs clients.

Ces principes contribuent à caractériser le modèle officinal français. En 2017, la Cour des comptes a publié une analyse du coût de la distribution des médicaments, en portant une attention particulière au réseau officinal. Elle concluait à un excès de densité des pharmacies dû à des niveaux de revenus élevés, permis par une rémunération trop favorable de la vente des médicaments génériques et par les avantages offerts par l'exploitation sous statut de sociétés d'exercice libéral. Elle attirait toutefois l'attention sur des risques de difficultés d'accès aux médicaments dans les zones rurales. Depuis cette date, le modèle officinal a connu plusieurs évolutions. Le réseau s'est éclairci, plus rapidement dans les zones rurales, matérialisant le risque relevé dans le rapport de 2017. La Cour a examiné les dispositifs récents qui visent à y remédier (I). En parallèle, les missions des pharmaciens ont été étendues au-delà de la vente de médicaments, en réponse à la moindre disponibilité des médecins sur une grande partie du territoire. La pandémie de covid 19 a accéléré ce processus, conférant au pharmacien une place croissante dans le système de santé. Toutefois, les paramètres de la rémunération des officines n'évoluent que lentement au regard de ces changements de fond (II). Plusieurs facteurs peuvent aujourd'hui fragiliser ce modèle officinal : l'évolution démographique défavorable des pharmaciens, une financiarisation du secteur insuffisamment régulée et certains manques de transparence dans les relations des pharmaciens avec leurs fournisseurs. Ces risques appellent la vigilance du Gouvernement et des autorités chargées de l'encadrement et du suivi de ce secteur(III)

Cnam (2025). Enjeu des rentes économiques et de l'optimisation financière de certains secteurs. In :[Rapport charges et produits. Propositions de l'Assurance maladie pour 2026]. Paris, Cnam p.147-171

Daniel, C., Vienne, P. et Sivarajah, P. (2017). "Les centres de santé dentaires : propositions pour un encadrement améliorant la sécurité des soins. 2 tomes". Paris, I.G.A.S. http://www.igas.gouv.fr/spip.php?article690

L'Igas a été saisie en mai 2016 d'une mission relative aux centres de santé dentaires, notamment ceux dits 'low-cost'. Un premier rapport a porté sur la situation de patients souffrant de soins mal ou incomplètement réalisés à la suite de la liquidation judiciaire des centres Dentexia. Un second rapport a pour objet de proposer des modes de régulation des centres dentaires garantissant la qualité et la sécurité des soins. La suppression de l'autorisation préalable à l'ouverture d'un centre de santé en 2009, conjuguée à une demande des patients pour des soins dentaires moins coûteux, a abouti à un accroissement de 25 % du nombre des centres de santé dentaire entre 2011 et 2016. Cette progression n'a pas été régulée, dans un contexte où les contrôles des agences régionales de santé et de l'assurance-maladie sont rares. La mission préconise des régulations juridiques, financières et sanitaires renouvelées pour garantir la sécurité des soins délivrés aux usagers : - l'instauration d'une déclaration d'intérêts à remplir par les dirigeants des centres ; - un ciblage coordonné des contrôles des instances sanitaires et financières ; - de nouveaux référentiels de qualité pour la santé bucco-dentaire, élaborés par la Haute Autorité de Santé, et la définition de bonnes pratiques en concertation avec les professionnels.

Leymarie, A. (2025). "To sell or not to sell? The financialization of French medical professions: the case of medical biologists and radiologists." Review of Evolutionary Political Economy **6**(2): 325-352.

The financialization of healthcare is a major social and economic phenomenon of recent decades. Academic literature on the subject is flourishing, focusing mainly on the effects of financialization on the work of healthcare professionals and the strategies of healthcare providers. This article explores the financialization of healthcare organizations in a different

way: how is financialization spreading? The article examines the phenomenon in France through the case of medical biologists and radiologists, two professions that have undergone extensive financialization after a first wave of concentration. Today, nearly 80% of private medical laboratories, historically owned by medical biologists, are controlled by six groups, compared with 16% in 2010. Nearly 25% of radiology practices are now owned by a dozen groups backed by investment funds, following the arrival of the first fund in the sector in 2017. To understand why so many organizations have been bought by Private Equity funds and sold by healthcare professionals, the article explores the cases where professionals have chosen to sell and where they have chosen not to sell to explore both what has favored the "success" of financialization and what may resist it. The results highlight intergenerational, territorial, and relational issues within professions and organizations which structure conflicts between partners and benefit the development of financial groups. Conversely, a variety of professional organizations, cooperatives, seeking to propose alternatives and to strengthen the regulation of the sector to preserve their monopoly by challenging the State represent a real force of opposition.

Leymarie, A. (2025). "Transformations in the governance of French medical laboratories." Revue de la régulation **37**.

In France, private medical laboratories (PMLs) were at the heart of the fight against the Covid-19 pandemic. Each year biological examinations account for over 70 % of all medical diagnoses. Although the health crisis put the spotlight on this sector, no targeted social science work has been carried out on it. However, since the early 2000s, PMLs have undergone significant changes in terms of concentration, industrialisation and financialisation that has radically changed the landscape of the sector. In the space of two decades, the number of PMLs has fallen from 4000 to around 300 and almost 80% of them are now owned by six financial groups. This article traces the history of this sector, from its "birth" in the 1970s to the present day, and through it, that of a profession: medical biologists. To do so, we mobilize the Régulation theory "sectoral approach" – which focuses on sectoral idiosyncrasies – enriched by the sociology of the professions. In the first section, we analyse the historical dynamics of the "French medical biology model" and its rise during the 1980s. Secondly, we examine the crisis of this model in the early 2000s, further to various reforms and because of the strategies of Private Equity and professional players. In section 3, we put forward an analysis of the new mode of regulation – industrial and financial – as well as the organisational and professional transformations that medical biologists are facing.

Massoubre, B., Chatron, P., Sautel, M., et al. (2022). "La financiarisation des laboratoires de biologie médicale en France: quels sont les risques pour la profession et la santé publique?". Annales de Biologie Clinique, JLE Editions.

Les laboratoires de biologie médicale en France se sont toujours adaptés aux progrès techniques et médicaux, ainsi qu'à la réglementation imposée par des autorités de tutelle. Mais, depuis une dizaine d'années, cette évolution est si importante que les biologistes assistent à une révolution de leur mode d'exercice. Les autorités de tutelle ont souhaité accroître et harmoniser la qualité des résultats des laboratoires. Mais la nouvelle législation, parfois détournée, ainsi que la peur et le coût de l'accréditation, sont à l'origine de l'accélération démesurée de la financiarisation des laboratoires de biologie médicale. Nous verrons comment l'hégémonie des groupements financiers peut nuire à la qualité du service rendu aux patients et à l'indépendance du biologiste médical.

Robinet, A. et Touraine, J. l. (2016). "Rapport d'information sur la mise en application de la loi n° 2013-442 du 30 mai 2013 portant réforme de la biologie médicale". Paris, Assemblée nationale http://www.assemblee-nationale.fr/14/rap-info/i3441.asp

> Ratifiée par la loi du 30 mai 2013, l'ordonnance du 13 janvier 2010 relative à la biologie médicale a réformé en profondeur la biologie médicale. Plusieurs axes ont ainsi été identifiés :– l'affirmation du caractère médical de la profession au travers de la nouvelle définition de l'examen de biologie médicale, de la qualification du biologiste médical et de l'importance du dialogue entre ce dernier et le médecin-clinicien ; – la garantie de la même qualité d'examens à tous nos concitoyens sur l'ensemble du territoire national au travers de l'accréditation à 100 %. Les laboratoires, publics comme privés, ont jusque 2020 pour se mettre en conformité avec cette exigence, différents jalons ayant été fixés entre 2013 et ce terme ; – la lutte contre la financiarisation du secteur au travers de la préservation des droits des biologistes en exercice, la définition de règles prudentielles et la mise en place de contrôles exercés par les agences régionales de santé (ARS). Les rapporteurs ont souhaité réinvestir ces trois enjeux dans le cadre du rapport d'application.

A l'étranger

Allan, S. (2022). "Care home closure and the influence of domiciliary care supply: Evidence from England." Journal of European Social Policy **32**(3): 333-347.

> There is a general trend of increased marketization of long-term care (LTC) services across Europe, with the natural consequence that market forces will affect the supply of LTC. At the same time, there has been a rapid increase in the use of home-based provision for those requiring LTC support. However, there is little evidence about what the effects of growing domiciliary care provision has on the markets for institutional forms of care. This is important from a policy point of view in terms of managing local markets, access to services, the quality of services and inequality. Using data from England for all care homes and domiciliary care providers registered to provide care to older people during 2014-2016, we assessed if increased domiciliary care supply was linked to increased likelihood of care home closure. Using Cox proportional hazard models of care home closure controlling for care home characteristics including quality and local area measures of needs and income, the findings provide no evidence that domiciliary care provision is a substitute for care homes. In some specifications, there was even a complementary relationship between the two forms of social care: increased domiciliary care supply significantly reduced the likelihood of care home closure. Potential reasons for the complementary relationship and implications for European LTC policy are discussed.

Atkinson, C. et Crozier, S. (2020). "Fragmented time and domiciliary care quality." Employee Relations **42**(1): 35-51.

> Purpose The purpose of this paper is to examine the marketization of domiciliary care, its consequences for employment practice, specifically fragmented time, and the implications for care quality. Design/methodology/approach Focus groups and face-to-face or telephone interviews were conducted with care commissioners, service providers and care workers across Wales. There were 113 participants in total. Findings These demonstrate fragmented time's negative consequences for service providers, care workers and, ultimately, care quality. Originality/value The research extends the definition of fragmented time and

integrates with a model of care quality to demonstrate its negative consequences. Links between employment practice and care quality have only previously been hinted at.

Berquist, V., Klarnet, L. et Dafny, L. (2025). "Sale of Private Equity–Owned Physician Practices and Physician Turnover." JAMA Health Forum **6**(2): e245376-e245376.

Private equity (PE) acquisition of physician practices is increasing, with owners targeting sales, or exits, in 3 to 7 years. Little is known about the association of exit with physician retention and subsequent employment. To examine whether PE exit of physician practices is associated with changes in physician retention and subsequent choice of practice size. Using data from the Centers for Medicare & Medicaid Services Doctors and Clinicians National Downloadable File from December 31, 2014, to December 31, 2020, this case-control study compared employment changes for physicians at PE-exiting practices sold between January 1, 2016, and December 31, 2018 (treatment group), with employment changes for matched control physicians in practices not sold by PE owners but with the same specialty, hospital referral region, practice size, and time period. Physicians billing fee-for-service Medicare during the study period were eligible for inclusion. A difference-in-differences design was used to compare retention between the treatment and control groups in the 2 years before and after exit using a multinomial logit model that adjusted for physician decade of graduation. Data were analyzed from August 1, 2023, to November 9, 2024.Exit of a PE-owned physician practice.Physician employment outcomes included staying (continuing to bill through the initial practice), working elsewhere (only billing through other practices), and retirement (no longer billing). Whether a physician left to a join large (>120-physician) practice was also evaluated.Of the 1215 physicians included in the analysis (405 at 70 PE-exiting practices and 810 matched controls; 814 [67.0%] male and 401 (33.0%) were female. Physicians in all PE-exiting practices were typically in practices of more than 20 physicians (471 [65.2%]) and often in the South (373 [51.7%]). Dermatology was the leading specialty (216 [29.9%]), followed by family medicine (94 [13.0%]). Physicians employed in PE-exiting practices were 16.5 (95% CI, 10.6-22.3) percentage points less likely to continue working in that practice 2 years after exit compared with matched controls. There was no significant change in the probability of retirement (0 percentage points; 95% CI, −4.1 to 4.0). Physicians in PE-exiting practices were 10.1 (95% CI, 6.5 to 13.7) percentage points likelier than matched controls to join a large practice of more than 120 physicians.In this case-control study, PE exit was followed by an increase in physician turnover and subsequent employment at a large (>120-physician) practice relative to matched controls, notwithstanding similar turnover rates between these physicians and matched controls prior to exit. The increase in physician turnover and consolidation following PE exits has important implications for patients, physicians, investors, and physician markets.

Berquist, V. L. (2024). "Private equity investment in health care delivery, Australia, 2008-2022." Med J Aust **220**(7): 368-371.

OBJECTIVES: To examine the scale of private equity investment in Australian health care delivery assets (clinics, hospitals, imaging facilities, other doctor-led health care services). STUDY DESIGN, SETTING: Extraction of information about private equity acquisitions of hospitals, clinics, imaging centres and in vitro fertilisation facilities in Australia, 2008-2022, from a commercial database (PitchBook), supplemented by information from publicly available online media sources. MAIN OUTCOME MEASURES: Number and value of private equity acquisitions of health care assets, 2008-2022; numbers of clinic parent company and clinic acquisitions, 2017-2022. RESULTS: A total of 75 private equity acquisitions of health care delivery assets in Australia during 2008-2022 were identified; the annual number rose

from three acquisitions in 2008 to eighteen in 2022. During 2008-2010, five of seven acquisitions were of in vitro fertilisation providers; during 2020-2022, 22 of 39 acquisitions were of clinics or clinic groups, including eleven of eighteen in 2022. The total value of the 39 acquisitions for which purchase price could be ascertained (52%) was $24.1 billion. During 2017-2022, the clinic specialty with the greatest number of private equity acquisitions was general practice (256 of 446 clinics purchased within acquisitions). Seven companies owning ophthalmology clinics (24 clinics) were acquired by private equity. Four private equity acquisitions during 2017-2022 included 60 oncology clinics, all related to a single clinic group. CONCLUSIONS: The number of private equity acquisitions of Australian health care delivery assets increased during 2008-2022. Doctors should be aware of the motivations and dynamics of private equity companies, as they are increasingly likely to interact with these firms and assets owned by these firms.

Borsa, A. et Bejarano, G. (2023). "Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: systematic review." BMJ **382**: e075244.

OBJECTIVE: To review the evidence on trends and impacts of private equity (PE) ownership of healthcare operators. DESIGN: Systematic review. DATA SOURCES: PubMed, Web of Science, Embase, Scopus, and SSRN. ELIGIBILITY CRITERIA FOR STUDY SELECTION: Empirical research studies of any design that evaluated PE owned healthcare operators. MAIN OUTCOME MEASURES: The main outcome measures were impact of PE ownership on health outcomes, costs to patients or payers, costs to operators, and quality. The secondary outcome measures were trends and prevalence of PE ownership of healthcare operators. DATA SYNTHESIS: Studies were classified as finding either beneficial, harmful, mixed, or neutral impacts of PE ownership on main outcome measures. Results across studies were narratively synthesized and reported. Risk of bias was evaluated using ROBINS-I (Risk Of Bias In Non-randomised Studies of Interventions). RESULTS: The electronic search identified 1778 studies, with 55 meeting the inclusion criteria. Studies spanned eight countries, with most (n=47) analyzing PE ownership of healthcare operators in the US. Nursing homes were the most commonly studied healthcare setting (n=17), followed by hospitals and dermatology settings (n=9 each); ophthalmology (n=7); multiple specialties or general physician groups (n=5); urology (n=4); gastroenterology and orthopedics (n=3 each); surgical centers, fertility, and obstetrics and gynecology (n=2 each); and anesthesia, hospice care, oral or maxillofacial surgery, otolaryngology, and plastics (n=1 each). Across the outcome measures, PE ownership was most consistently associated with increases in costs to patients or payers. Additionally, PE ownership was associated with mixed to harmful impacts on quality. These outcomes held in sensitivity analyses in which only studies with moderate risk of bias were included. Health outcomes showed both beneficial and harmful results, as did costs to operators, but the volume of studies for these outcomes was too low for conclusive interpretation. In some instances, PE ownership was associated with reduced nurse staffing levels or a shift towards lower nursing skill mix. No consistently beneficial impacts of PE ownership were identified. CONCLUSIONS: Trends in PE ownership rapidly increased across almost all healthcare settings studied. Such ownership is often associated with harmful impacts on costs to patients or payers and mixed to harmful impacts on quality. Owing to risk of bias and frequent geographic focus on the US, conclusions might not be generalizable internationally. SYSTEMATIC REVIEW REGISTRATION: PROSPERO CRD42022329857.

Bruch, J. D., Foot, C., Singh, Y., et al. (2023). "Workforce Composition In Private Equity-Acquired Versus Non-Private Equity-Acquired Physician Practices." Health Aff (Millwood) **42**(1): 121-129.

Despite growth in private equity (PE) acquisitions of physician practices in the US, little is known about how changes in ownership influence workforce composition. Using clinician-level data linked to practice acquisition information, we estimated changes in clinician workforce composition in PE-acquired practice sites relative to non-PE-acquired independent practice sites for dermatology, ophthalmology, and gastroenterology specialties. We calculated a clinician replacement ratio (cumulative number of entering clinicians during 2014-19 divided by the cumulative number of exiting clinicians) across 213 PE-acquired practices and 995 matched non-PE-acquired practices. Using a difference-in-differences approach, we also examined practice-level changes in yearly clinician counts at PE-acquired practices before and after acquisition compared with non-PE-acquired controls. In aggregate and across the study period, the clinician replacement ratio was higher for PE-acquired practices compared with non-PE-acquired controls (1.75 versus 1.37), as well as within each specialty and clinician type (physician versus advanced practice provider). Relative to non-PE-acquired control practices, we also found significant yearly increases in the number of advanced practice providers at PE-acquired practices after acquisition. Taken together, these findings suggest differential changes in workforce composition at PE-acquired practices, especially a shift toward advanced practice providers for care delivery.

Bruch, J. D., Nair-Desai, S., Orav, E. J., et al. (2022). "Private Equity Acquisitions Of Ambulatory Surgical Centers Were Not Associated With Quality, Cost, Or Volume Changes." Health Affairs **41 9**: 1291-1298.

Busfield, J. (2020). "Documenting the financialisation of the pharmaceutical industry." Social Science & Medicine **258**.

The aim of this paper is to explore the growing financialisation of the pharmaceutical industry from the beginning of the 1980s onwards and to consider its implications. It examines a number of features that demonstrate the increasing influence of the financial sector on the industry, including changing patterns of shareholder ownership, the importance attached to the idea of maximising shareholder value, the pay and share options given to company chief executives and other senior managers, the use of share buybacks, the increase in the outsourcing of manufacturing and of research and development, along with the growing use of mergers and acquisitions and of new forms of borrowing to fund them. The paper examines data in relation to each of these areas in turn in order to provide evidence of the growing financialisation of the industry and to highlight some of its consequences for the industry's task of developing and manufacturing medicines that enhance population health.

Bůžek, R. (2025). "Dissociation of value extraction: the financialisation of solidarity-based German ambulatory healthcare." Finance and Space **2**(1): 1-22. https://doi.org/10.1080/2833115x.2024.2445503

This paper explores why the financialisation of physician practices by private equity (PE) and the resulting value extraction from Germany’s solidarity-based healthcare system go largely unexamined in healthcare studies and regulation, despite contestation by medical associations. It contributes to feminist political-economic critiques of finance’s impact on social reproduction, employing the perspectives of economisation and dissociation from heterodox economic geography. This framework reveals how a solidarity-based health economy has historically aligned with neoclassical logics and how value extraction falls from view in this framing. Drawing on analyses of corporate spatial structures of PE-led healthcare chains, as well as narrative patterns from expert interviews and a text corpus on the disputed

financialised restructuring of ambulatory healthcare, the paper identifies two dissociations that obscure value extraction and hinder effective regulatory oversight. First, the discursive framing of the ambulatory health economy through a neoclassical (health) economics lens makes value extraction seem implausible or invisible. Second, the opaque spatial ownership structures of PE-led healthcare chains prevent independent, evidence-based monitoring of these financialised healthcare providers. Therefore, the paper advocates for incorporating heterodox perspectives in health policy advising to rethink and foster definancialised investment and ownership models for a sustainable and solidarity-based future health economy.

Celebi, E. et Kemmerling, M. (2025). "Platformization of care in Europe: comparative analysis of marketization trends and business models." International Journal of Sociology and Social Policy. (in press)
https://www.emerald.com/ijssp/article/doi/10.1108/IJSSP-01-2025-0057/1310416/Platformization-of-care-in-Europe-comparative

Purpose We investigate how digital care platforms contribute to the marketization of care across the European Union (EU) by analyzing their business models and national variations. Design/methodology/approach Drawing on a dataset from the Centre for European Policy Studies (CEPS) and extensive hand-coding, we identify 100 care platforms and examine their characteristics using a novel three-dimensional analytical framework: scope of commodification, platform governance and distribution of market risks. Findings Our findings show that while care platforms share features with other digital labor platforms, the intimate, relational and non-standardized nature of care work limits algorithmic control and commodification. Nonetheless, care platforms contribute to marketization by intermediating a wide range of services, including emerging categories like pet care and tutoring and relying predominantly on marketplace models that shift risk onto workers. Importantly, we uncover cross-national variation: the Nordic countries, Spain, Belgium and the Netherlands host more regulated platform models with less reliance on market mechanisms, whereas Eastern Europe is dominated by marketplace models. These patterns align with broader care regime typologies and suggest that care platforms both adapt to and reshape national care markets. Originality/value Our study offers the first comparative empirical overview of care platform business models across the EU and highlights the need for more nuanced, context-sensitive research to understand their evolving role in care provision. This complements existing research on platform workers' experiences of precarity and informality by showing that these are linked to care platform business models. Our findings have implications for platform regulation, addressing issues of care provision and (informal) labor.

De Graaff, R. (2025). "Sickening Profits: Solving the Health Sector’s Addiction to Money and Power". Rochester, S.S.R.N.
https://papers.ssrn.com/sol3/papers.cfm?abstract_id=5234286

The Modern healthcare system has become more about profits rather than healing. This paper will go into and exposure the dark hidden truths of the Healthcare Industry and how this impacts wider society and how these can be resolved. Case Studies will be used to expose the dark hidden truths of entrapment practices false/misleading scientific research projects being conducted behind closed doors for profit and at the cost of human health and lives. The System needs to be repaired with focus to be put back into helping people rather than for fueling bank accounts and profits.

Dreux, C., Maquart, F. x. et et al. (2018). "La biologie médicale face aux défis de l'évolution des besoins de santé". Paris, Académie nationale de pharmacie http://www.acadpharm.org/divers/recherche.php?search=biologie+m%E9dicale

Accréditation lourde, coûteuse et chronophage, financiarisation, baisse de l'attractivité : dans ce rapport sur la biologie rendu, les Académies nationales de médecine et de pharmacie dressent un constat presque aussi accablant que les syndicats. Elles énumèrent une quinzaine de recommandations pour « stabiliser » la biologie médicale après la restructuration massive et « brutale » de ces dernières années, et surtout pour valoriser le rôle et l'expertise du biologiste dans la chaîne des soins.

Durvasala, M. m., Larrimore ouellette, L. et Williams, H. l. (2021). "Private and Public Investments in Biomedical Research". Cambridge, N.B.E.R. NBER Working Paper 28349 https://www.nber.org/papers/w28349

Recent policy attention has focused on proposals to reduce prices for drugs that have received public funding. From an implementation perspective, such policies rely on public disclosure of government support for research. In this paper, we highlight two conceptual problems with past attempts to measure these public disclosures, and construct a new data set which corrects for these problems. Our corrected measures suggest that under-reporting of public research support is less of an issue than previously thought.

Guennif, S. (2025). "What financialisation is doing to access to healthcare: price and value of medicines in financial capitalism." Review of Evolutionary Political Economy **6**(2): 273-298.

The article offers a review of the literature describing the embeddedness of financialisation in the innovation practices of pharmaceutical companies and its impact (Whitacre, 2024), through the prism of the accessibility of medicines. The argument is that financialisation is leading to a change in the business model of the pharmaceutical industry, marked by the transition from a broken ‘novo drug model’ to the gradual affirmation of a drug repositioning model, enabling more efficient management of the product life cycle. In doing so, and in order to maximise shareholder value, the pharmaceutical industry is abandoning the blockbuster model in favour of the nichebuster model. The latter favours the repositioning of drugs, intended for restricted patient populations, marketed at very high prices and generating substantial profits. This model thus accentuates the inaccessibility of drugs, which in a few decades has become a major global issue.

Jablonski, M. J., Matuszczyk, M. et Samardakiewicz, M. (2019). "The diversity of doctors' attitudes towards patients in the conditions of financialisation of the health care system. A survey study." Psychiatria I Psychologia Kliniczna-Journal of Psychiatry and Clinical Psychology **19**(2): 113-128.

Aim of the study: To get acquainted with the opinions of Polish doctors about selected economic, ethical and utilitarian aspects of the doctor-patient relationship in the context of the financing of medical services. Method: Online questionnaire with instructions and invitations to participate in the study, sent via a medical portal. Answers were received from 264 physicians, including 177 women and 87 men, aged between 24 and 67. The differences in sex, age, length of service, place of employment, specialisation and the type of funding were analysed. Results: Male physicians working in hospitals are more willing to make decisions based on simple economic calculations. The study showed age-related differences in professional motivation, willingness to make sacrifices for patients, distrust towards patients, ethical issues, willingness to depend on economic balance and willingness to refuse

treatment in order to protect the doctor's personal interests. The type of specialisation differentiated the group in terms of satisfaction with earnings and sense of professional prestige, the degree of distrust towards patients, attitudes to medical records, and readiness to refuse economically unprofitable procedures. The lowest satisfaction with earnings and the lowest sense of professional prestige were declared by psychiatrists. In addition, 77% of the participants did not attribute significant importance to medical standards. Conclusions: Polish doctors are a heterogeneous group in terms of professional motivation, professional prestige and declared attitudes towards patients, which should be taken into account in the organisation of medical services and training of physicians. Changing social and economic conditions influence the development of attitudes that are less focused on the interests of the patient, as indicated by the age-related differences among the surveyed physicians. The low level of importance assigned by doctors to medical standards can have a negative impact on the effectiveness of standardisation of medical services in Poland.

Koch, T. g. et Ulrick, S. w. (2017). "Price Effects of a Merger: Evidence from a Physicians' Market". Washington, F.T.C. Working Paper 333
https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3026344

Physicians' practices vary widely, as do their effectiveness and reimbursement. Using a merger of six orthopaedic groups in southeastern Pennsylvania, we find that such groups can generate large, anti-competitive price increases without any demonstrated increases in quality (indirectly measured by way of revealed preference) or efficiency. Further, we find that these price increases were targeted at certain beneficiaries, payors and codes, so any research design that omits care and billing along any of these dimensions is likely to be biased.

Lyu, Y. et Zhang, Z. (2024). "Impact of Primary Care Market Mergers on Quality: Evidence from the English NHS". Rochester, S.S.R.N.
https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4918321

The primary care market has witnessed a growing trend of provider consolidation through mergers and acquisitions, yet the implications of this concentration remain uncertain. This study addresses this gap by providing the first empirical evidence on the effects of provider mergers on quality, using evidence from the English primary care market. Examining all provider mergers from 2014 to 2018, we find predominantly negative effects of mergers on quality. Specifically, clinical quality remains unchanged at best, and patient satisfaction decreases dramatically. The impact varies with the size of the general practices involved: mergers between large practices show detrimental effects, whereas mergers between small practices can yield quality benefits. Additionally, the quality impact does not significantly differ between mergers within the same geographical market and those across different markets. An exploration of the mechanism reveals that changes in market concentration do not drive the observed decline in quality following mergers.

Mercille, J. et O'Neill, N. (2021). "The growth of private home care providers in Europe: The case of Ireland." Social Policy & Administration **55**(4): 606-621.

Private for-profit home care providers have grown unevenly in Europe and through varied processes. Yet, more research focusing directly on private providers is needed to identify and explain European patterns in their growth and in their modes of operation. This paper examines the case of Ireland, where private providers have grown significantly in recent years and transformed the national landscape of domiciliary care. First, it is shown that the

amount of public funding received by private providers increased from euro3 million in 2006 to euro176 million in 2019, in contrast to amounts allocated to non-profit and public providers that have increased only slightly. Second, those trends are explained through policy analysis and by drawing on in-depth semi-structured interviews (n= 12) with private home care providers and government officials who have been central to the privatization of care. The paper gives a direct voice to key figures in private home care, and through a critical reading of interview materials, argues that the neoliberal nature of the Irish state has driven the growth of private provision, in particular, through policies of competitive tendering and fiscalization. Providers' own lobbying activities have also played a role, albeit a secondary one. Ireland has traditionally followed a laissez-faire, family-based system comparable to Southern European countries. Its experience is thus directly relevant to that region, but further research should also compare and contrast the development of private providers operating in other European long-term care regimes.

Nasseh, K., LoSasso, A. T., Vujicic, M., et al. (2026). "Financial Incisors: Cutting Through the Effects of Private Equity on Dentistry Market Dynamics and Care Delivery." Health Services Research **61**(2): e70075.

ABSTRACT Objective To assess how private equity ownership affects prices, service mix, and Medicaid participation in dentistry at the practice level. Study Setting and Design We utilize a proprietary dental office database linked to administrative dental commercial claims data to estimate the effects of private equity ownership on the financial and operational outcomes of dental offices, employing a staggered difference-in-differences panel design that addresses the nonrandom acquisitions of facilities by private equity firms. Data Sources We rely on private equity transaction data from 2015 to 2021, longitudinal dental office data from the 2015 to 2017 and 2019 to 2021 American Dental Association dental office database, and aggregated commercial dental insurance price and utilization data from 2015 to 2021.Principle Findings Following acquisition, private equity-owned dental offices increased charges for dental care services by 3.3% (95% CI: 2.3%–4.4%), although allowed prices for these services remained statistically unchanged. Dental offices acquired by private equity firms tended to shift from diagnostic and preventive procedures to generally higher reimbursement restorative, specialty, and surgical procedures. Dental offices were more likely to become multispecialty practices after being acquired by a private equity firm. Conclusions Allowed or negotiated prices between dentists and payers did not change in dental offices after being acquired by private equity. Nevertheless, list prices for dental services increased in private equity-owned practices, meaning higher prices can still be passed on to patients. Private equity firms can enhance dental practice revenue by shifting from preventive procedures to higher-cost restorative procedures while not reimbursing providers at a higher amount. In other words, financial enhancement of dental practices under private equity may not translate into benefits for providers or patients. Policymakers should be aware of the effects private equity acquisition has on provider and patient welfare.

Persson, M. H., Mogensen, C. B., Sondergaard, J., et al. (2021). "Healthcare professionals' practice and interactions in older peoples' cross-sectoral clinical care trajectories when acutely hospitalized-a qualitative observation study." Bmc Health Services Research **21**(1).

Background Healthcare services have become more complex, globally and nationally. Denmark is renowned for an advanced and robust healthcare system, aiming at a less fragmented structure. However, challenges within the coordination of care remain. Comprehensive restructures based on marketization and efficiency, e.g. New Public Management (NPM) strategies has gained momentum in Denmark including. Simultaneously,

changes to healthcare professionals' identities have affected the relationship between patients and healthcare professionals, and patient involvement in decision-making was acknowledged as a quality- and safety measure. An understanding of a less linear patient pathway can give rise to conflict in the care practice. Social scientists, including Jurgen Habermas, have highlighted the importance of communication, particularly when shared decision-making models were introduced. Healthcare professionals must simultaneously deliver highly effective services and practice person-centered care. Co-morbidities of older people further complicate healthcare professionals' practice. Aim This study aimed to explore and analyse how healthcare professionals' interactions and practice influence older peoples' clinical care trajectory when admitted to an emergency department (ED) and the challenges that emerged. Methods This qualitative study arises from a hermeneutical stand within the interpretative paradigm. Focusing on the healthcare professionals' interactions and practice we followed the clinical care trajectories of seven older people (aged > 65, receiving daily homecare) acutely hospitalized to the ED. Participant observations were combined with interviews with healthcare professionals involved in the clinical care trajectory. We followed-up with the older person by phone call until four weeks after discharge. The study followed the code of conduct for research integrity and is reported in accordance with the Standards for Reporting Qualitative Research (SRQR) guidelines. Results The analysis revealed four themes: 1)"The end justifies the means - 'I know what is best for you'", 2)"Basic needs of care overruled by system effectiveness", 3)"Treatment as a bargain", and 4)"Healthcare professionals as solo detectives". Conclusion Dissonance between system logics and the goal of person-centered care disturb the healthcare practice and service culture negatively affecting the clinical care trajectory. A practice culture embracing better communication and more person-centered care should be enhanced to improve the quality of care in cross-sectoral trajectories.

Rechel, B., Tille, F., Groenewegen, P., et al. (2023). "Private equity investment in Europe's primary care sector-a call for research and policy action." Eur J Public Health **33**(3): 354-355.

Shah, S., Rooke-Ley, H. et Brown, E. C. F. (2023). "Corporate Investors in Primary Care — Profits, Progress, and Pitfalls." New England Journal of Medicine **388**(2): 99-101. https://www.nejm.org/doi/full/10.1056/NEJMp2212841

Recent multibillion-dollar acquisitions by Amazon and CVS reflect a trend toward corporate Investment in primary care, which could threaten equitable access to care, raise costs, and reduce physicians’ clinical autonomy.

Sofritti, F. (2022). "Medical hybridity and beyond: professional transitions in Italian outpatient settings." Social Theory & Health **20**(1): 90-106.

The marketization of public healthcare has brought about organizational transformations, affecting health professionals' ways of working in hospitals and outpatient organizations. As a result of the reforms in the 1990s, the principle of business-like healthcare has been introduced in the Italian health system. This paper presents the main findings of a study of specialist doctors working in two local health organizations in the Tuscany region. Drawing on semi-structured interviews with specialist doctors working in an outpatient setting, the article examines the manifold reactions to changes of the medical profession within outpatient settings. In particular, the combination of professional and organizational dimensions has been taken into consideration. The results show that a change is involving outpatient specialist doctors' identity: organizational change affects several dimensions of the medical professional ethos. The change has been understood by categorizing three major

types of approaches to medical professionalism, which are aimed to understand the complexity of the domain and to summarize professionals' reactions: the first is linked to a traditional model of professionalism; the second accepts partially business-like organizational issues, while trying to create individual spaces of autonomy in daily tasks; the third co-opts new organizational issues, which become part of the medical professional ethos.

van Dijk, T., Felder, M., Janssen, R. T. J. M., et al. (2023). "For better or worse: Governing healthcare organisations in times of financial distress." Sociology of Health & Illness **46**(5): 926-947.

Due to processes of financialisation, financial parties increasingly penetrate the healthcare domain and determine under which conditions care is delivered. Their influence becomes especially visible when healthcare organisations face financial distress. By zooming-in on two of such cases, we come to know more about the considerations, motives and actions of financial parties in healthcare. In this research, we were able to examine the social dynamics between healthcare executives, banks and health insurers involved in a Dutch hospital and mental healthcare organisation on the verge of bankruptcy. Informed by interviews, document analysis and translation theory, we reconstructed the motives and strategies of executives, banks and health insurers and show how they play a crucial role in decision-making processes surrounding the survival or downfall of healthcare organisations. While parties are bound by legislation and company procedures, the outcome of financial distress can still be influenced. Much depends on how executives are perceived by financial stakeholders and how they deal with threats of destabilisation of the network. We further draw attention to the consequences of financialisation processes on the practices of healthcare organisations in financial distress.

Winblad, U. (2023). "Private equity investment in Sweden's primary care sector and regulatory responses to avoid risk selection." European Journal of Public Health **33**(Supplement_2).

Until the 1990s primary care centres in Sweden were almost exclusively public and operated by the country's regions. A primary care reform in 2010 that increased competition between approved providers for public funding led to a rapid growth of private providers. Concerns were raised that profit-driven providers would select patients with lower risks. We analysed contracts between county councils and private care providers and reviewed strategies employed by local governments to avoid risk selection and whether there were any differences between left- and right-wing governments. By 2020 over 270 new private primary care centres had been established, most of which were for-profit. Of the overall approximately 1200 primary care centres, about 60% are still owned by the regions and about 40% are privately owned. About a third of the private for-profit practices were owned by international private equity firms in 2018. Three main strategies were used by local governments to avoid risk selection: risk adjustment of the financial reimbursements on the basis of health and/or socio-economic status of listed patients; design of patient listing systems; and regulatory requirements regarding the scope and content of the services that had to be offered by all providers. Left-wing local governments were more prone than right-wing governments to adopt risk adjustment strategies at the onset of the reform but these differences diminished over time. A variety of regulatory instruments can be used to avoid risk selection by private providers. However, due to a lack of systematic research, no firm conclusions can be drawn so far on the overall impact of private equity ownership on primary care provision in Sweden.

Winkelmann, J., Gomez rossi, J. et Van Ginnenken, E. (2022). "Oral health care in Europe: Financing, access and provision". Copenhague, O.M.S. Bureau régional de l'Europe Health systems in transition Vol. 24 No.2

https://eurohealthobservatory.who.int/publications/i/oral-health-care-in-europe-financing-access-and-provision

This study investigates major patterns and developments in oral health status, financing, coverage, access, and service provision of oral health care in 31 European countries. While most countries cover oral health care for vulnerable population groups, the level of statutory coverage varies widely across Europe resulting in different coverage and financing schemes for the adult population. On average, one third of dental care spending is borne by public sources and the remaining part is paid out-of-pocket or by voluntary health insurance. This has important ramifications for financial protection and access to care, leaving many dental problems untreated. Overall, unmet needs for dental care are higher than for other types of care and particularly affect low-income groups. Dental care is undergoing various structural changes. The number of dentists is increasing, and the composition of the health workforce is starting to change in many countries. Dental care is increasingly provided in group practices and by practices that are part of private equity firms. Although there are (early) signs of a shift towards more preventive therapies and policies of oral diseases, dental care overall remains focused on treatment. A lack of data affects all areas of oral health care. Current health information systems only collect very few indicators on oral health and oral health care. An improved evidence base would allow more meaningful assessments and comparisons of oral health systems performance. This in turn would allow better informed policy decisions and enable better targeted and more effective oral health interventions.

Les tentatives de régulation

Toujours selon le rapport de l'OCDE[7], bien que la financiarisation progresse, peu de pays ont mis en place des mesures de régulation ciblant spécifiquement les acteurs financiers. En France, une nouvelle loi, adoptée en 2023[8], cherche à mieux contrôler la financiarisation des activités ambulatoires (...). Elle impose une autorisation préalable des agences régionales de santé pour la création de nouveaux centres dentaires, ophtalmologiques et orthoptiques, ainsi qu'un suivi de leurs pratiques et un renforcement des sanctions en cas de non-conformité. ». L'Allemagne limite déjà certains investissements financiers :« Une loi adoptée en 2019 a restreint la capacité des hôpitaux (et donc des acteurs financiers) à investir dans les centres médicaux dentaires (MVZ) lorsque les services dentaires détenus par les hôpitaux dépassent un certain seuil. Cependant, l'opacité des données constitue le principal obstacle à la régulation de l'intervention des acteurs privés dans le secteur de la santé. D'une part, la complexité des montages financiers utilisés lors des acquisitions d'établissements ou d'équipements rend difficile l'identification des véritables détenteurs des capitaux. D'autre part, le manque de transparence sur les stratégies financières empêche de suivre les flux de capitaux, les niveaux d'endettement imposés aux structures de soins ou les retraits de fonds réalisés

Cai, C. et Song, Z. (2024). "Protecting Patients And Society In An Era Of Private Equity Provider Ownership: Challenges And Opportunities For Policy." Health Aff (Millwood) **43**(5): 666-673.

> Private equity (PE) acquisitions in health care delivery nearly tripled from 2010 to 2020. Despite concerns around clinical and economic implications, policy responses have remained limited. We discuss the US policy landscape around PE ownership, using policies in the European Union for comparison. We present four domains in which policy can be strengthened. First, to improve oversight of acquisitions, policy makers should lower reporting thresholds, review sequential acquisitions that together affect market power, automate reviews with potential denials based on market concentration effects, consider new regulatory mechanisms such as attorney general veto, and increase funding for this work. Second, policy makers should increase the longer-run transparency of PE ownership, including the health care prices garnered by acquired entities. Third, policy makers should protect patients and providers by establishing minimum staffing ratios, spending floors for direct patient care, and limits on layoffs and the sale of real estate after acquisition (forms of "asset stripping"). Finally, policy makers should mitigate risky financial behavior by limiting the amount or proportion of debt used to finance PE acquisitions in health care.

Imbert, C., Henno, O. et Jomier, B. (2024). "Financiarisation de l'offre de soins : une OPA sur la santé ?". Paris, Sénat
https://www.senat.fr/travaux-parlementaires/commissions/commission-des-affaires-sociales/financiarisation-du-systeme-de-sante.html

> Récemment entrée dans le débat public, la financiarisation de l'offre de soins demeure mal appréhendée et insuffisamment régulée par les autorités sanitaires, malgré les transformations de l'offre qu'elle induit. Au terme de neuf mois de travaux, la commission

[7] Ibid p.30

[8] loi n° 2023-378 du 19 mai 2023 visant à améliorer l'encadrement des centres de santé.

des affaires sociales formule 18 propositions visant à mieux maîtriser le phénomène, à limiter ses conséquences indésirables et à protéger l'indépendance des professionnels de santé.

Lavenir, F., Pilloux, A. et Mariani, L. (2025). "Causes et effets de la financiarisation du système de santé". Paris, I.G.A.S.
https://igas.gouv.fr/causes-et-effets-de-la-financiarisation-du-systeme-de-sante

Dans un contexte marqué par des évolutions profondes de l'offre de soins en France, des craintes se sont exprimées sur la « financiarisation de la santé » et sur ses conséquences. Pour faire le point sur ce que recouvre cette notion et sur ses enjeux, l'Igas et l'IGF ont analysé ses causes, ses mécanismes et ses conséquences. Soigner n'est pas une activité comme une autre : l'investissement privé ne doit pouvoir s'y déployer qu'en contribuant à l'amélioration durable de la qualité et de l'accessibilité des soins, dans le respect de l'indépendance d'exercice des professionnels. C'est pour le régulateur un défi nouveau, qui suppose une évolution du système réglementaire et tarifaire, notamment vers plus de transparence, de réactivité et de prévisibilité.

McKee, M. et Stuckler, D. (2012). "The crisis of capitalism and the marketization of health care: the implications for public health professionals." Journal of Public Health Research 1(3): 236-239.

The current economic crisis in Europe has challenged the basis of the economic model that currently prevails in much of the industrialised world. It has revealed a system that is managed not for the benefit of the people but rather for the corporations and the small elite who lead them, and which is clearly unsustainable in its present form. Yet, there is a hidden consequence of this system: an unfolding crisis in health care, driven by the greed of corporations whose profit-seeking model is also failing. Proponents of commodifying healthcare simultaneously argue that the cost of providing care for ageing populations is unaffordable while working to create demand for their health care products among those who are essentially healthy. Will healthcare be the next profit-fuelled investor bubble? In this paper, we call on health professionals to heed the warnings from the economic crisis and, rather than stand by while a crisis unfolds, act now to redirect increasingly market-oriented health systems to serve the common good.

Rechel, B., Tille, F., Groenewegen, P., et al. (2023). "Private equity investment in Europe's primary care sector-a call for research and policy action." Eur J Public Health **33**(3): 354-355.

Scheffler, R. M., Alexander, L. M. et Godwin, J. R. (2023). "Soaring Private Equity Investment in the Healthcare Sector: Consolidation Accelerated, Competition Undermined, and Patients at Risk." SSRN Electronic Journal.

Suzuki, E., Paris, V. et Joshi, N. (2025). "Trends in the financialisation of outpatient care across OECD countries". Paris, O.C.D.E. OECD Health Working Paper 179
https://www.oecd.org/en/publications/trends-in-the-financialisation-of-outpatient-care-across-oecd-countries_f5d88b41-en.html

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.

Tracey, M., Schulmann, K., Tille, F., et al. (2025). "What are the policy options for regulating private equity involvement in health care? A review of policies implemented or considered in seven high-income countries." Health Policy **156**: 105312.

Over the past two decades, private equity investment in health care has increased substantially. Proponents argue that private equity can optimize and improve health services, while critics warn that the business model of these firms is not aligned with the social values of care delivery and has harmful consequences for health systems and patients. It remains unclear to what extent - and how - subnational, national and supranational governments have attempted to regulate this activity. The purpose of this study therefore was to identify examples of implemented and proposed policy options for regulating private equity activity within health care, with the goal of elucidating the policy options available to regulators. We conducted a narrative review to identify proposed or implemented policy instruments in selected high-income countries, grouping them by type using a conceptual framework based on the works of Milton Friedman and Avedis Donabedian. Our search identified several examples of proposed or implemented policy options for addressing private equity activity in the countries under review. Most of these intervention examples fall into the category of disclosure, while only one focused on regulation of outcomes. Our study suggests that while some countries have started to develop policy interventions to directly address the role of private equity in health care, other countries do not specifically regulate private equity activity.

Winblad, U. (2023). "Private equity investment in Sweden's primary care sector and regulatory responses to avoid risk selection." European Journal of Public Health **33**(Supplement_2).

Until the 1990s primary care centres in Sweden were almost exclusively public and operated by the country's regions. A primary care reform in 2010 that increased competition between approved providers for public funding led to a rapid growth of private providers. Concerns were raised that profit-driven providers would select patients with lower risks. We analysed contracts between county councils and private care providers and reviewed strategies employed by local governments to avoid risk selection and whether there were any differences between left- and right-wing governments. By 2020 over 270 new private primary care centres had been established, most of which were for-profit. Of the overall approximately 1200 primary care centres, about 60% are still owned by the regions and about 40% are privately owned. About a third of the private for-profit practices were owned by international private equity firms in 2018. Three main strategies were used by local governments to avoid risk selection: risk adjustment of the financial reimbursements on the basis of health and/or socio-economic status of listed patients; design of patient listing systems; and regulatory requirements regarding the scope and content of the services that had to be offered by all providers. Left-wing local governments were more prone than right-wing governments to adopt risk adjustment strategies at the onset of the reform but these differences diminished over time.A variety of regulatory instruments can be used to avoid risk selection by private providers. However, due to a lack of systematic research, no firm conclusions can be drawn so far on the overall impact of private equity ownership on primary care provision in Sweden.

Winblad, U., Isaksson, D. et Blomqvist, P. (2021). "Preserving social equity in marketized primary care: strategies in Sweden." Health Econ Policy Law **16**(2): 216-231.

A primary care choice reform launched in Sweden in 2010 led to a rapid growth of private providers. Critics feared that the reform would lead to an increased tendency among new, profit-driven, providers, to select patients with lower health risks. Even if open risk selection is prohibited, providers can select patients in more subtle ways, such as establishing their practices in areas with higher health status. This paper investigates to what extent strategies were employed by local governments to avoid risk selection and whether there were any differences between left- and right-wing governments in this regard. Three main strategies were used: risk adjustment of the financial reimbursements on the basis of health and/or socio-economic status of listed patients; design of patient listing systems; and regulatory requirements regarding the scope and content of the services that had to be offered by all providers. Additionally, left-wing local governments were more prone than right-wing governments to adopt risk adjustment strategies at the onset of the reform but these differences diminished over time. The findings of the paper contribute to our understanding of how social inequalities may be avoided in tax-based health care systems when market-like steering models such as patient choice are introduced.

Ressources Multimedias

- La financiarisation favorise-t-elle les inégalités sociales de santé ? | *Colloque* - MG France sur Youtube, 29 janvier 2026 (vidéo, 3h31)

- https://podcast.ausha.co/parlons-peu-parlons-secu/financiarisation-du-systeme-de-sante

- GDPS - Séquence 5 – La financiarisation du système de santé est-elle un problème ? ENS3S sur Youtube, 2025(vidéo, 58 min)

- Rapport Charges et produits 2024 - La financiarisation émergente du système de santé, Cnam sur Youtube, 2023 (vidéo, 2min)