



## Private Equity Ownership in U.S. Health Care Puts Patients and Communities at Risk

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Over the past decade, private equity (PE) firms have shifted from peripheral investors to **dominant owners** of organizations that provide health care in the United States. Where PE-backed hospitals once accounted for fewer than 5% of acute-care beds, they now represent **more than 15%**—a growth mirrored in post-acute and outpatient settings. Health care is a reliable target because people need medical services regardless of economic conditions, giving PE firms market power to raise prices and negotiate favorable terms. Initially focused on **hospitals, nursing homes, and home care**, PE has expanded into specialties such as **dermatology, urology, and cardiology**, targeting high-margin services before moving into larger hospital systems.

When PE-backed entities buy health care provider organizations, most of the purchase price is **borrowed** and the **debt is placed** on the acquired health care entity. Then, the hospital, nursing home, or physician practice inherits this debt and becomes responsible for paying it off using its own operating cash flow. To generate quick profits, PE owners may pull money out of the organization through fees, new loans, or by selling off assets such as hospital buildings and then renting them back. These tactics drain cash from patient care and increase financial risk for the facility. Prioritizing profit in the short term erodes **staffing**, inflates costs, undermines quality, and leaves safety net providers **financially fragile**.

Because health care delivery is a fundamental public need that shapes **patient outcomes**, workforce stability, and community health, the **risks of unchecked PE activity** extend far beyond investor returns. Oversight is essential to ensure financial strategies do not compromise care quality or community stability.

### The Problem with Private Equity Ownership of Health Care Organizations

Private equity ownership reshapes health care delivery in several interlocking ways. First, the business model involves purchasing organizations and then selling them after short periods of time to maximize profits. These short timeframes nudge owners toward rapid cost-cutting measures rather than the long-range quality initiatives that hospitals traditionally pursue, such as gradual workforce development or phased technology upgrades.

Second, the drive to improve profitability often manifests as reductions in clinical staffing. Analyses of **American Hospital Association** data from 2023–2024 show that, on average, registered-nurse headcounts at PE-owned hospitals fall between 5–12% in the first 2 years after acquisition. Those staffing declines translate directly into higher patient-to-nurse ratios, longer wait times, and, in many cases, compromised patient safety.

Third, the financing structure of most PE deals leaves the acquired entity bearing a **heavy debt burden**. The debt burdens for PE-backed hospitals is now more than double the burden observed at comparable non-PE institutions. Such leverage squeezes cash flow, limiting the funds that can be allocated to essential services, equipment replacement, or community health programs. Heavy borrowing has been linked to higher readmission rates and accelerated price increases for services, particularly in rural or safety-net hospitals that already operate on **thin margins**.

Fourth, PE-owned entities often expand profitable specialized services while **scaling back** less lucrative but essential services such as mental health or primary care. Finally, physicians in PE-acquired practices are frequently pressured to meet aggressive productivity targets, such as high patient quotas. In practice, this means shorter visit times and pressure to prioritize higher paying procedures. Such conditions can drive clinicians to leave, weakening the independent practice sector and worsening physician shortages, especially in rural and underserved communities.

Lastly, the way ownership is structured in many PE transactions is deliberately opaque. Complex layers of holding companies and undisclosed owners make it difficult for regulators, insurers, and the public to identify who holds decision-making power. This lack of transparency hampers effective oversight and erodes accountability, leaving patients and communities with little insight into the forces shaping their local health care landscape.

Taken together, this creates a cyclical effect: short-term profit motives drive staffing cuts and create cash constraints, which in turn degrade care quality and increase financial vulnerability, all while the PE owners remain hidden from public view.

## **HCA Healthcare as a Case Study**

HCA is the nation's largest hospital chain, making it a telling example of how PE strategies ripple across the health care system. In **2006**, a consortium of PE investors executed a \$33 billion buyout of the company, financing roughly 85% of the purchase price with debt. The massive borrowing load was transferred onto HCA's balance sheet, obligating the organization to make substantial interest payments from its operating revenues.

In the years that followed, HCA's new owners extracted cash to satisfy the debt and generate investor returns. They borrowed additional funds to pay shareholders and simultaneously trimmed staffing levels to reduce operating expenses. These moves attracted the attention of state regulators, who raised concerns that the cost-cutting measures were beginning to erode key quality metrics, such as readmission rates and **patient satisfaction** scores.

By 2011, HCA had gone public again, providing the PE investors an exit route that realized more than \$10 billion in profit. Yet the hospital system remained **burdened with the debt** incurred during the buyout, meaning that the financial obligations created by the initial transaction continued to shape HCA's operational decisions **long after the PE owners had departed**. The case underscores how a short-term profit extraction strategy can leave a health care provider with lasting financial strain, with downstream effects on staffing, quality, and community trust.

## Policy Solutions

The following are policy solutions that can mitigate the negative impact of PE on health care. All actions should be phased in over a 24-month period, with the transparency and cash reserve requirements taking effect within the first 12 months to allow providers time to adjust reporting systems.

- **Level the tax playing field.** Congress should close the carried interest loophole so that PE earnings are taxed as ordinary income. This change would align investor incentives with fiscal fairness and reduce the after-tax rewards that encourage aggressive cost cutting.
- **Protect cash for care.** Federal and state regulators should cap debt-funded dividends and require organizations that provide health care to maintain a minimum cash flow reserve equal to one year of operating expenses. These safeguards would keep funds available for staffing, equipment, and essential services rather than investor payouts.
- **Increase transparency.** Congress should require all PE-owned health care entities to publicly disclose their true owners, debt structures, and financial dealings between related companies. Transparency would give regulators, insurers, and patients the information needed to assess risk and hold owners accountable.
- **Regulate sale-leasebacks.** States should require prior approval for any arrangements that involve the sale and leaseback of properties or other assets, and cap rent increases by linking them to inflation. Oversight would prevent unsustainable lease obligations that can force facilities to cut services or close altogether.

Private equity has brought **capital and managerial expertise** into health care, but its financial strategies come with serious **risks**. Heavy debt, cost cutting, and hidden ownership structures threaten access to care and weaken the stability of hospitals and clinics. Lawmakers can act now: close the carried interest loophole, cap debt-funded cash extractions, mandate transparency, and protect competition and facility stability. These reforms would realign incentives so that health care providers are judged by the quality of care they deliver, not the speed of investor returns. Stronger oversight will protect patients, support health workers, and safeguard the community institutions essential to our health system.