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Trends in the financialisation of outpatient care across OECD countries: What do we know?

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Abstract

This paper summarises the findings of research into the financialisation of outpatient care across OECD countries. Outpatient specialised services have become a recent target of financial institutions active in the healthcare sector, notably across dentistry, ophthalmology, radiology, laboratories and primary care. While financialisation was reported to be a concern by a majority of countries who responded to the 2024 OECD Policy Survey on Financialisation in the Health Sector, how financialisation is taking place also varies depending on the way health systems are structured. Moreover, despite a growing evidence base around the impacts – often negative – 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.

Resumé

Ce rapport résume les résultats d'une recherche sur la financiarisation des soins ambulatoires dans les pays de l'OCDE. Les services spécialisés ambulatoires sont récemment devenus une cible privilégiée des institutions financières actives dans le secteur de la santé, notamment dans les secteurs de la dentisterie, de l'ophtalmologie, de la radiologie, des laboratoires de biologie, et des soins de premier recours. Bien que la financiarisation ait été signalée comme un sujet de préoccupation par la majorité des pays ayant répondu à l'enquête de l'OCDE de 2024 sur la financiarisation dans le secteur de la santé, les modalités de cette financiarisation varient en fonction de l'organisation des systèmes de santé. Par ailleurs, malgré un corpus croissant de données sur les effets – souvent négatifs – des investissements réalisés par certains acteurs financiers, en particulier les fonds d'investissement en capital-risque, les pays manquent d'une vision d'ensemble sur l'ampleur des investissements des firmes financières dans leurs systèmes de santé. Ce rapport présente également une série de pistes de réflexion en matière de politiques publiques permettant d'agir sur la financiarisation des soins ambulatoires.

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Key findings

1. Countries across the OECD have seen an increase in interest, investment and involvement in outpatient care practices from financial firms in recent years, including by private equity firms and for-profit chains. The increase in financialisation has spurred a debate about potential benefits and pitfalls of these trends. While the participation of for-profit actors in health care delivery is common across OECD countries, the extent and implications of the recent entry of more explicitly financially-driven actors into primary and outpatient care, including both the potential risks and benefits from this trend, are still not well understood.

2. Financialisation of the healthcare sector refers to the growing influence of financial actors and non-financial entities whose main business lies outside healthcare, in owning and operating healthcare delivery organisations. This paper focuses its attention on the outpatient sector, an area that has received comparatively less attention than hospitals and long-term care facilities.

3. To date, there has been very limited cross-country research on the topic. In an OECD survey conducted in 2024, many OECD countries indicate that **the financialisation of outpatient services appears to be increasing**, with half of 20 responding countries reporting that financialisation is a high or moderate trend. Across all types of financial actors, **private equity firms appear to be the most active** across responding countries.

4. The **most commonly impacted sectors in outpatient care are dentistry, ophthalmology, radiology, laboratories and primary care**. As an example, the share of practices run by dental service organisations in dental markets across North America and Europe has grown substantially in recent years, doubling in the three years between 2015 and 2018 in Denmark, Norway, Spain and the United Kingdom.

5. **Financialisation has also led to significant consolidation** taking place in some regions and specialties, with competition authorities in some countries raising concerns about the impacts of financialisation on competition in healthcare markets. In France, for example, laboratories have experienced a high trend of consolidation in recent years. Between 2010 and 2022, the share of outpatient laboratories directly owned by financial investors increased from 16% to 78%.

6. Key factors driving financialisation of the healthcare sector in OECD countries include growing, publicly financed healthcare demand from aging populations, which provide stable revenue streams to investors; potential for consolidation and productivity gains, especially in sectors with high capital costs such as radiology; evolving provider demographics and preferences, with older physicians looking to sell practices at the best possible prices before retirement and younger doctors more interested in salaried positions or unable to compete with financial firms on the purchase price of clinics; as well as a protective regulatory environment governing medical practices that can impact competition.

7. In a context of growing healthcare needs and increasingly strained public financing available for health, the interest of financial actors seems like a welcome opportunity. But **more evidence is urgently needed to better evaluate the potential impacts of financialisation on outcomes**, including on costs, patient safety, quality of care, access, patient experience, and staffing. Existing research points to likely increases in costs for patients and payers following acquisitions by financial investors, while evidence from the long-term care and hospital sectors has raised concerns about the potential impacts on quality of care, access and other patient outcomes. At the same time, further

evaluation is needed to understand whether and under what circumstances financialisation may lead to potential efficiency gains, as often cited by advocates of the trend.

8. To date, most evidence from the literature on the impact of financialisation in outpatient care has come from the United States. Further study of the impacts of financialisation in other health systems contexts is essential to developing a full picture of how financialisation may impact healthcare. Most countries surveyed reported that no evaluations were taking place, with just three reporting that national or regional authorities had published reports on financialisation in the health sector.

9. While financialisation is taking place across many countries, data reporting and monitoring remain insufficient. In many cases, **policymakers have limited information to understand the extent and impacts of financialisation in their health systems**. Across 20 surveyed countries, only two reported that data on healthcare practice ownership is collected and can be aggregated nationally. **Improving the data landscape on practice ownership would help countries to better monitor the potential impacts of financialisation on their health systems**.

10. Given continuing trends, it is **critical that policymakers gain a better understanding of the extent to which financialisation is taking place**. Certain health systems characteristics likely encourage or disincentivise the financialisation of different sectors. Understanding how current policies and regulations influence trends in financialisation and improving the evidence around its impact on health systems and outcomes are critical to developing an informed response that mitigates risk without closing the door to potential benefits.

11. Health systems should consider policy options that improve transparency and ensure that key standards of quality and access are ensured. These could include more systematically collecting and aggregating information related to the ownership of outpatient services, strengthening co-operation and exchange between competition authorities and Ministries of Health, implementing standards and measures to maintain quality of care, and ensuring that price and ownership regulations ensure access (to physicians and services), to avoid inappropriate shifts in activity, and discourage increases in costs to patients or payers.

12. Going forward, more work to better refine the definition of financialisation and better identify whether certain types of financial actors may have a particularly harmful or beneficial impact on health systems outcomes would allow for a more nuanced understanding of trends, and the development of more targeted policy tools. **A framework that helps to identify what characteristics of both firms and health systems drive these trends is needed**.

1 What is financialisation and why does it matter?

13. In recent years, financial investors have become increasingly involved in the health services sector. Many countries have seen an expansion in the types of actors with a stake in their health systems. In many of these cases, these new actors have purchased small-scale, often physician-owned clinics and transformed them into consolidated businesses that are meant to harness economies of scale to overcome low margins and high capital investments that are deterrents to market entry. This trend is driven by several factors, including the sector's relative stability through economic fluctuations, opportunities for consolidation in a fragmented market, and the potential for increased efficiency in care delivery (Appelbaum and Batt, 2020[1]). Health systems dynamics and changing demographics – among the population and the healthcare workforce – may also play a role.

14. In the health sector, financialisation typically involves the entry of for-profit financial firms and non-financial entities whose main business lies outside healthcare into the healthcare system through the purchase of practices and other healthcare services. This includes private equity firms, pension funds, and health insurers, as well as large commercial chains expanding from other sectors like food supply. This report does not consider the consolidation or integration of healthcare institutions into larger businesses or entities as financialisation, unless there is a financial investor behind the market consolidation. For example, a private hospital acquiring an outpatient practice or two hospitals merging into one are not included in this definition[1]. At the same time, a hospital owned by a private equity firm that purchases outpatient practices would be considered to be financialisation. This definition aims to focus specifically on the **entry of external financial actors into the healthcare sector**, and more particularly **private equity**, distinguishing it from broader trends of healthcare market consolidation[2].

15. Financialisation within the health sector has taken place in the context of a broader expansion of financial sector activities in the economy. Broadly defined, financialisation refers to the growing role that financial markets, financial actors and their attendant systems have played across the economy (Aalbers, 2019[2]). As Epstein (2005[3]) notes, financialisation entails "the increasing role of financial motives, financial markets, financial actors and financial institutions in the operation of the domestic and international economies". It can reshape how non-financial firms operate, with greater emphasis on financial activities and metrics. This often leads to changes in corporate governance and investment patterns across various industries. Financialisation can also influence government policies and public sector operations. Chiapello (2017[4]) refers to this as "the penetration of financialised logics and forms of evaluation in the formulation and implementation of [public] policies, even when these do not involve the financial sector".

[1] Some non-profit healthcare entities, particularly in the United States, have adopted practices similar to for-profit organisations. These include generating large revenues through consolidation and potentially reducing market competition. However, such practices are not included in this analysis which focuses on the entry of financial actors into the capital of healthcare providers.

[2] Consolidation refers to the practice of acquiring and merging multiple healthcare providers to increase market shares and negotiation power

16. Financial actors in the healthcare sector typically focus on four main investment domains: pharmaceuticals, health services, health data, and medical devices. Each of these areas attracts different types of investors and employs various financial mechanisms. This report concentrates specifically on health services, with a particular emphasis on outpatient care.

17. Importantly, financialisation does not refer to "privatisation". Nearly all OECD countries have at least some private provision of health services. In 2023, for example, 14 of the 25 respondents to the OECD Health Systems Characteristics Survey reported that outpatient specialist services were provided predominantly by private solo or group practices (OECD, 2023[5]). Many countries have a long history of private-sector participation in the health system, including both as government-contracted service providers within the public system and as providers of services outside of or in addition to publicly provided care.

18. This report includes 4 sections. The first describes trends in the financialisation of outpatient healthcare services in OECD countries; the second focuses on determinants of this trend; the third section reviews the impact of financialisation on healthcare systems and the last sections looks at policy options to limit the negative impacts of financialisation in healthcare. Methods used to elaborate this report are described in Box 1.

Box 1.1 Methods

The findings in this report were developed based on information gathered through a variety of channels. In addition to desk research and a literature review on the prevalence and impact of financialisation, further information was gathered via policy surveys and expert interviews.

Policy survey

The **OECD Policy Survey on Financialisation in the Health Sector** was circulated to countries in the summer of 2024. The questionnaire aimed to collect information on the extent of financialisation of outpatient services in the country (4-level scale from "not at all" to "high"), the types of firms involved, the most affected sectors, the availability of statistical information on prevalence and trends, the existence of impact assessment and any policy measures related to financialisation of health care services. Countries were invited to provide links to relevant documents and provide contact names. Twenty countries (Australia, Austria, Belgium, Costa Rica, Denmark, France, Germany, Greece, Iceland, Israel, Korea, Latvia, Luxembourg, the Netherlands, Norway, Slovakia, Slovenia, Switzerland, the United Kingdom, and the United States) responded to the survey.

Stakeholder and expert interviews

Eighteen semi-structured interviews were conducted with 23 experts from health ministries, competition authorities, legislative bodies, academics, representatives of the medical profession, and financial and legal firms. Countries were invited to submit the names of experts to interview via the Policy Survey; other experts were identified via desk research and a snowball approach. Findings based on the expert interviews have been included in the report but are not attributed to specific interviewees, in order to protect their anonymity.

2 Financialisation is well underway in outpatient care

Half of 20 OECD countries report that financialisation in outpatient care is a high or moderate trend in their countries

19. Even in countries with long-established private markets and private sector participation in healthcare, new types of actors, with new business models, are entering the health sector. Half of countries who participated in the *OECD Policy Survey on Financialisation in the Health Sector* consider financialisation to be a moderate or high-frequency trend in the outpatient sector in their country (OECD, 2024[6]).

20. In a number of countries, the financialisation of outpatient care was preceded by prior entry into the hospital and long-term care sector by a financial entity, including the purchase of nursing homes. Data from corporate analyses of financial investments in the healthcare sector point to the rapid growth of financialisation over recent years (Singh, Fuse Brown and Papanicolas, 2025[7]). Globally, the total disclosed deal value of private equity transactions in all sectors of healthcare grew from USD 112 billion in the five years between 2010-2014 to USD 446 billion in the five years between 2018-2022 globally (Bain & Company, 2024[8]). In the decade between 2012 and 2021, for example, the acquisition of physician-owned practices by financial entities in the United States increased more than six-fold, from 75 484 purchases in 2021, compared to 75 in 2012 (Fuse Brown and Hall, 2024[9]). Moreover, the share of transactions taking place outside of the United States appears to be growing, with buyout deals increasing in Europe and the Asia Pacific over the period (Bain & Company, 2024[8]). In Norway, financialisation has increased over the last four to five years, though data is more limited (OECD, 2024[6]).

21. In some countries, concerns over trends in financialisation have led to government investigations of the extent of the trend. In France, a cross-party Senate report published in September 2024 found that financialisation was prevalent across many sectors of the health system, while remaining poorly understood and underregulated (Imbert, Jomier and Henno, 2024[10]). A recent bipartisan Senate report in the United States, published in January 2025, raised concerns over whether the profit-driven approach of private equity investors in healthcare was aligned with the purpose of hospitals in the healthcare system, and recommended better transparency and oversight into the financial approaches used by private equity in healthcare (Senate Budget Committee, 2025[11]).

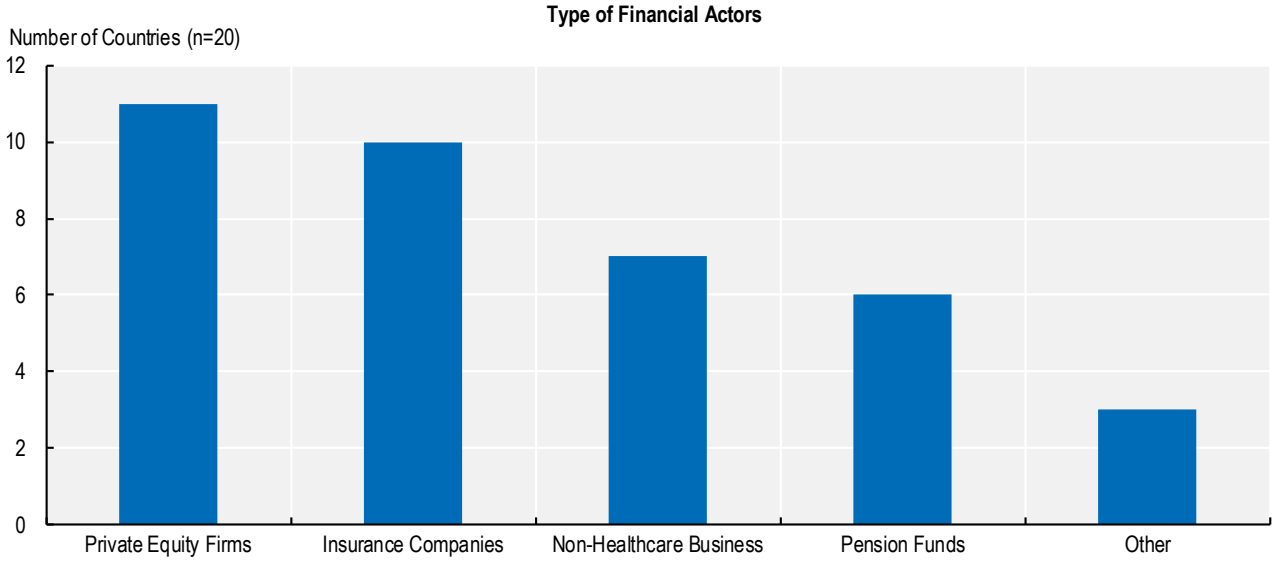
Private equity is the most common type of firm involved

22. More than half of responding countries reported that private equity actors are involved in financialisation activities in the outpatient sector in their country, more than any other type of financial firm or non-health business (see Figure 2.1). Given how recent private equity appears to have scaled-up acquisitions in outpatient care, this is particularly notable (see Box 2.1 for more information on private equity). Insurance companies and other non-healthcare businesses made up the next two most frequently reported financial firms involved in outpatient care.

23. In Germany, private equity funds have increased their investments in ambulatory health care centres (known as *Medizinische Versorgungszentren* or MVZs) in recent years, particularly following a 2015 law aimed at encouraging the development of ambulatory care practices[3]. This law, which strengthened outpatient care and removed rules limiting MVZ growth, made these centres more attractive for business, leading to a significant increase in new MVZs. By 2021, private equity owned about 21% of the 4,179 MVZs in Germany, with many being dental practices, though investments also extended to eye care, radiology services and orthopaedics (Deloitte, 2023[12])[4]. Private equity funds often establish these centres with a hospital partner, attracted by stable demand and growth potential due to an ageing population and a fragmented healthcare market. Most private equity funds employ a "buy-and-build" strategy, acquiring MVZs and expanding the network (Deloitte, 2023[12]).

24. In Sweden, a reform to primary care in 2010 has created a market for private providers in what was previously a largely publicly-provided system. As of 2020, some 40% of primary care centres were privately owned (Winblad, 2023[13]). A 2018 analysis of contracts identified that one-third of privately owned primary care centres were owned by international private equity firms, suggesting that as many as one in eight primary care clinics in Sweden may be owned by private equity firms.

Figure 2.1. Types of financial actors involved in the outpatient health sector in 20 OECD countries in 2024



Note: Countries could select more than one category in their response.
Source: OECD Policy Questionnaire on Financialisation in the Health Sector (OECD, 2024[6]).

[3] While investors are not allowed to invest directly in MVZ, they can do so via purchasing hospitals that can in turn own MVZ clinics.

[4] The overall share of private equity in outpatient care is smaller, as MVZ represent only one component of the ambulatory care sector.

Box 2.1. Defining private equity

What is Private Equity?

Private equity refers to investments normally made in private companies or assets that are not publicly traded on stock exchanges. It represents an important source of financing for businesses at various stages of development, from early-stage startups to mature companies.

Private equity firms raise capital from institutional investors and high net worth individuals to invest directly in private companies or conduct leveraged buyouts (LBOs) of public companies. The goal is to improve the performance and value of these companies over a period of typically 3-10 years before exiting the investment through a sale or public offering.

Unlike public equity markets where investors can easily buy and sell shares, private equity investments cannot be readily converted into cash and have long holding periods. This allows private equity firms to take a hands-on approach in managing their portfolio companies to drive operational improvements and growth.

How does private equity work?

The private equity model typically involves the following key steps:

- Fundraising: Private equity firms raise capital by establishing investment funds, usually structured as limited partnerships. Institutional investors like pension funds and endowments commit capital as limited partners.
- Deal sourcing: Firms identify potential investment opportunities and evaluate what they consider to be the company's potential.
- Investment: The private equity firm acquires a majority stake in the target company, often using a combination of investor capital and debt financing in the case of leveraged buyouts.
- Value creation: The firm, together with the company's management, implements changes aimed at driving growth and increasing profitability over a 3-10 year holding period. This may involve strategic shifts, cost cutting, acquisitions, or management changes. Some private equity firms are primarily financial investors and are less involved in the management decisions taken by the companies they invest in.
- Exit: The firm sells its stake in the company through a trade sale, secondary buyout, or initial public offering to realise returns for its investors.

Some analysts have criticised the private equity business model for prioritising the short-term financial interests of owners of equity compared with others with interests in the companies they purchase, such as (in the case of the health sector) healthcare workers, and have raised concerns about the potential of private equity practices to lead to over-consolidation and increase inequalities.

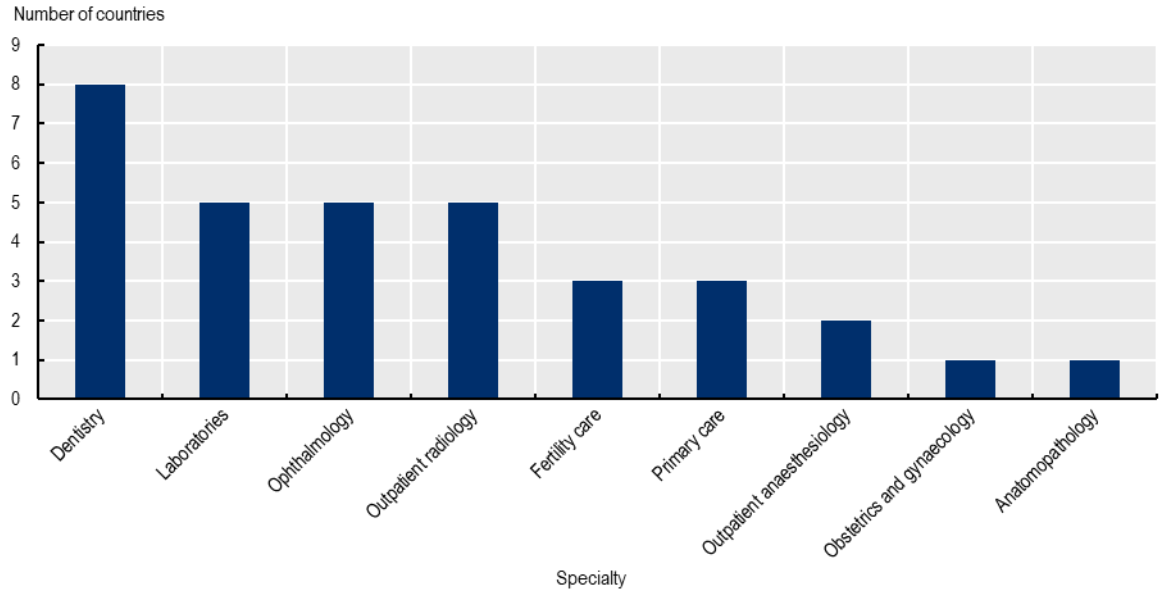
Source: (Demaria, 2020[14]) (Clark, 2009[15])

Dentistry, ophthalmology, radiology and laboratories report high financialisation

25. Certain outpatient specialities and services are more often reported to have been the focus of financialisation. Dentistry, ophthalmology, outpatient radiology, and laboratories were most frequently

reported by countries to be the top three outpatient services affected by financialisation (See Figure 2.2). Available data suggest that many of these specialities have undergone rapid consolidation and financialisation in recent years.

Figure 2.2. Specialties most affected by financialisation as reported by surveyed countries



Note: Number of countries refers to how many countries reported the speciality as among the top 3 impacted by financialisation, N=14
Source: OECD Policy Questionnaire on the Financialisation in the Health Sector (OECD, 2024[6])

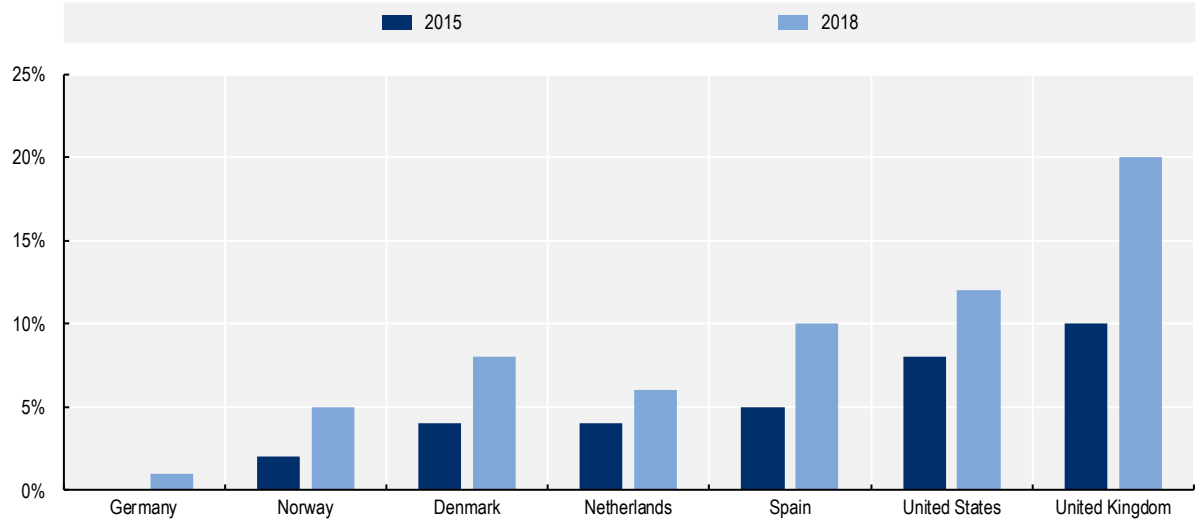
The financialisation of dental care is expanding rapidly in some countries

26. Dental services are particularly attractive for financial investors. The share of practices run by dental service organisations (DSOs)[5] in dental markets across North America and Europe has grown dramatically in recent years, at least doubling in the three years between 2015 and 2018 in Denmark, Norway, Spain and the United Kingdom (See Figure 2.3) (van der Schrier and Visscher, 2020[16]).

27. DSOs market shares in terms of revenues are generally higher than in terms of practices. In Norway, DSOs are estimated to capture 7% of the dental market share in terms of revenue, compared to 5% by practice size. In the Netherlands, 10-15% of the dental market by revenue is estimated to go to DSOs, compared to a market share of 6%. Similar trends have been found in Spain (10% of practices, 17% of revenue) and the United States (12% of practices, 16% of revenue) (van der Schrier and Visscher, 2020[16])

[5] Dental Services Organizations (DSOs) handle the business side of dental practices, such as administrative, marketing, bookkeeping, and financial services.

Figure 2.3. Market share (by number of practices) of dental service organisations



Source: *The dental chain opportunity II: Value creation beyond a consolidation strategy* (van der Schrier and Visscher, 2020[16]).

28. More than 80% (96 of 116) of the largest DSO deals conducted in Europe between 2017 and 2019 were found to be backed by private equity firms, who have previously been found to own 90% of the 30 largest dental service organisations (van der Schrier and Visscher, 2020[16]). Among the 25 largest mergers and acquisition (M&A) transactions for DSOs between 2005 and 2019, the value of transactions conducted by private equity or investment groups represented more than four-fifths (82%) of the value of all deals, amounting to 7.2 billion USD of 8.8 billion USD in M&A transactions over the period across six countries (Finland, Italy, the Netherlands, Spain, the United Kingdom and the United States) (van der Schrier and Visscher, 2020[16]).

High investments in radiology and radiotherapy

29. Australia has seen significant growth in its private oncology services in recent years. Of 104 radiation oncology facilities in Australia, 42 are public and 62 are private (OECD, 2024[6]). Moreover, at least 94% of private oncology clinics in Australia are run by one of two private equity-backed oncology chains (Australian Competition & Consumer Commission, 2024[17]). This would suggest that more than half of all oncology clinics in Australia may be financialised. The largest oncology chain in Australia, backed by private equity and investment funds, filed for bankruptcy in 2023 after taking on $2 billion AUD in debt following an unsuccessful attempt to expand into the US market (LaFrenz and Whyte, 2024[18])

30. In France, an estimated 15% of medical imaging services are owned by private equity (URPS Médecins Libéraux Auvergne-Rhone-Alpes, 2024[19]). Recent analysis suggests private equity penetration at the physician level grew from near zero in 2012 to approximately 5% by 2021 in the United States (Abdelhadi et al., 2024[20]). Several factors make radiology an appealing target for private equity investment. The radiology sector has historically been composed of many independent practices, offering opportunities for consolidation and economies of scale. It is also a technology-intensive field, requiring significant capital investments that private equity firms can provide, which as a result creates barrier to entry, even more so when the authorities control the number of authorised machines.

Financialisation of ophthalmology has accelerated in recent years

31. The ophthalmology sector has experienced a significant surge in private equity investment over the past decade. Between 2012 and 2019, private equity firms acquired 228 ophthalmology and optometry practices in the United States, associated with 1,466 clinical locations and 2,146 ophthalmologists or optometrists (Chen et al., 2020[21]). The pace of acquisitions accelerated markedly from 2017 onwards. While only 42 practices were acquired between 2012 and 2016, 186 practices were acquired from 2017 through 2019 (Chen et al., 2020[21]). By 2022, an estimated 1,400 ophthalmologists were practising under private equity ownership in the United States (Groothoff and Browning, 2024[22]). While the majority of reported private equity activity in ophthalmology has been concentrated in the United States, the trend is not limited to this market, even if equally comprehensive data remains missing for the European market. In France, “Point Vision” has become the leading national network of ophthalmological centers. The company was created in 2011, had 27 centers in 2018, and now has 562 (Imbert, Jomier and Henno, 2024[10]). The rush of investors on ophthalmology practices in the United States has been impressive in financial terms. As of 2019, the large ophthalmology platform practices, generally worth more than USD 2 million of earnings before interest, taxes, depreciation and amortisation (EBITDA), were purchased eight or more times the adjusted EBITDA, while smaller practices received five to eight times the adjusted EBITDA (Brill et al., 2022[23]).

32. Several factors make ophthalmology an attractive target for private equity investment. These include high procedural volume, the outpatient nature of services, additional revenue from ancillary services such as optical shops, and an ageing population increasing demand for eye care services (Patel, Groth and Sternberg, 2019[24]).

Laboratories and pathology services: early targets of healthcare financialisation

33. The pathology sector has experienced consolidation at different periods and under different forms in OECD countries (Satta and Edmonstone, 2018[25]). While it started in the 1980s in the United States with mergers and acquisitions of private pathology practices, the consolidation in the United Kingdom occurred mainly between public (hospital) institutions in the 2010s. This means that consolidation does not always involve financialisation. The outpatient pathology sector is also highly concentrated in Australia, where 3 companies accounted for 95% of all payments made to all private pathology practices in 2018 (Centre for International Economics, 2019[26]).

34. In France, the laboratory sector has experienced a high trend of concentration and financialisation since 2010. Between 2010 and 2022, the share of sites directly owned by financial investors increased from 16% to 78%, while the number of companies shrunk from more than 3400 to 400. While public authorities had encouraged consolidation and industrialisation of the sector in the 1990, they are now trying to slow down this trend (see Box 2.2) (Leymarie, 2022[27]).

Box 2.2. The financialisation of laboratories in France

In France, about 85% of all lab tests were performed by the private sector in 2022. Between the mid-1970s and 1990s, regulations mandated ownership and management of laboratory practices by health professionals exercising in the practice and prohibited their participation in other practices. Despite a very fragmented supply dominated by small enterprises, the sector was the most profitable of all health sectors, due to a favourable (negotiated) fee schedule.

In reaction, policymakers decided to encourage the consolidation of the sector. To that aim, a 1990 law created a new type of society, allowing participation of non-professionals to the capital up to 25% and easing the acquisition of practices. The trend towards consolidation remained modest. Another law in 2000, allowing laboratory biologists to own shares in several practices, accelerated consolidation. Although participation of non-professional (e.g., non-physicians or non-pharmacists) remained in principle limited to 25%, commercial actors from other EU countries have been able to purchase shares that exceed this limit, by leveraging differences in ownership requirements between countries. Because not all EU countries have similar ownership rules, non-professional individuals have been able to establish laboratory companies in other countries and invest in the French laboratory sector – via their laboratory companies abroad – without their investments counting towards the non-professional threshold of 25%. Backed by financial or industrial actors, these companies launched the financialisation of the sector. Finally, a 2010 law imposing new, higher, standards of accreditation, to increase the quality of routine tests and analyses, made the system costly for small companies, and further encouraged consolidation.

In 2013, policymakers attempted to slow down this trend. Since then, regional health agencies can oppose to opening, acquisition or merger of laboratory practices if this leads to a group earning more than 25% of the revenues or control more than 33% of supply in a given territory, or if the total supply is expected to exceed 25% of what was planned for this territory. In addition, the 2013 law removed the possibility for non-professional investors to create new groups. However, this law left unchanged rules applicable to existing financialised groups, still allowed to acquire new practices, the consolidation of the sector continued. Biology groups earned significantly during the covid-19 crisis and continue to have high levels of profitability. In 2021, the profit rate was 32%. According to the national health insurance fund, high earning during Covid-19 enabled early exit of investors and secondary and tertiary LBOs, with high valuations disconnected from the real values of assets (CNAM, 2023[28]).

Source: (Leymarie, 2022[27])

Financialisation in primary care: still limited but on the rise

35. While primary care does not appear to be the centre of financialisation activity as some other specialities, 9 of 14 responding countries reported some financialisation in the primary care sector.

36. In Sweden, a reform of 2010 aimed to increase competition between public and private providers of primary care services. Since then, two-fifths of primary care centres are estimated to be privately owned, and one-third of private centres owned by international private equity firms – corresponding to ownership of more than one in eight primary care centres overall (Winblad, Isaksson and Blomqvist, 2020[29]; Rechel et al., 2023[30]).

37. Finland has seen a high concentration of primary care since the 2000s thanks to a roll-up strategy of private investors. In 2022, three groups supplied 70% of primary care services (CNAM, 2023[28]). In France, where payments for primary care health centers do not make them very attractive, investors may

benefit from new experimental payment methods to design a profitable model of care (Imbert, Jomier and Henno, 2024[10]).In Australia, nearly one-fifth (18%) of GPs are estimated to work in corporate group practices (Royal Australian College of General Practitioners, 2023[31]).

38. In 2023, NIVEL looked at the different forms of commercialization of primary care services in the Netherlands (Groenewegen and Timans, 2023[32]). They described four types: vertical integration of GP practices by health insurers (prohibited since 2014), the constitution of for-profit General Practice Chain Organisations, the development of online services for general practices and apps for communication for patients. Focusing on the two first categories, the authors note that the number of commercialised practices is uncertain but ranges between 45 and 230 general practices, out of 4874 practices registered in 2022 (Groenewegen and Timans, 2023[32]).

39. In the United States, Cutler and Song (2024) observed a recent increase in private investments in new primary care models, aiming to improve access to primary care to reduce further health needs (Cutler and Song, 2024[33]). These models are often based on intensive outreach and target sicker populations than traditional models and are more high-tech and prioritise remote care. Authors also observed a high increase in the financial valuation of these models despite the scarcity of evaluations.

40. In Australia, private equity acquisitions of care delivery services – including both primary and specialist care – has risen in the last 15 years, from 3 in 2008 to 18 in 2022 (Berquist, 2024[34]). Of the 39 acquisitions that occurred between 2020 and 2022, more than half (22 of 39) represented acquisitions of clinics or chains of clinics (Berquist, 2024[34]). The majority of these clinics (256 of 446) were in primary care (general practice) (Berquist, 2024[34]). Since 2017, close to 3% (2.6%) of general practice clinics were estimated to have been acquired by private equity firms, or sold between private equity firms (Berquist, 2024[34]).

The degree of financialisation can vary even within countries

41. Financialisation has not been distributed evenly across countries, with certain regions or even metropolitan areas more impacted than others. In the United States, for example, while 7.2% of private practice urologists were estimated to be working for practices affiliated with one of five large private equity firms across the country, more than one in four urologists in New Jersey and Maryland were working for practices owned by these firms (Nie et al., 2022[35]).

42. In some cases, firms employ “roll-up” strategies to increase their market share in an area, making multiple purchases under the thresholds required for notification or authorisation to competition authorities, until they control a sizeable part of the local market. Researchers have identified near total capture of specific markets in the United States: In Idaho Falls, Idaho, for example, 91% of radiology physician groups were controlled by private equity firms, while 80% of anaesthesiology physician groups were owned by private equity funds in Wilmington, North Carolina (OECD, 2023[36]).

43. Similarly variable distribution of financialisation has been observed in Germany, where the share of ambulatory care centres operating under the structure of MVZ has grown in recent years. Estimates have suggested that more than one-fifth of MVZ are owned by private equity firms (Deloitte, 2023[12]). Across all dental planning areas in Germany, investor-owned MVZs are estimated to be present in less than one-fifth (18.6%), with very low activity in the majority of areas. However, investor-owned MVZs have been estimated to represent 10-19% of dentists within six planning areas, indicating high variability in the concentration of investor-owned services across the country (Deutscher Bundestag, 2023[37]).

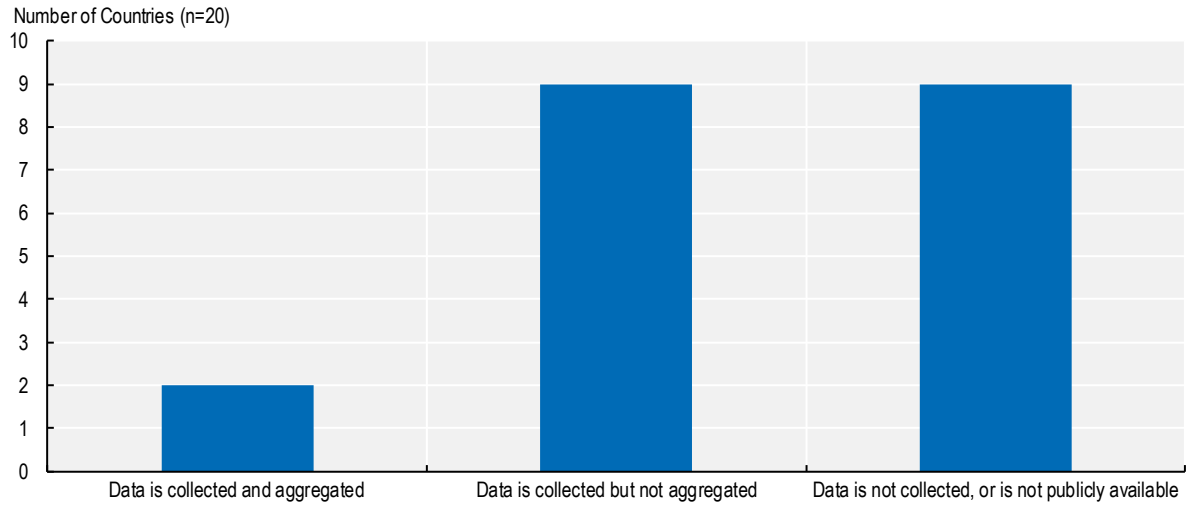
Countries are flying blind in understanding the extent and impacts of financialisation

44. The first condition to monitor trends and impact of financialisation of outpatient services is to collect and analyse information on the ownership of healthcare practices. Better information related to ownership is also critical to monitoring the impact of any subsequent policies adopted to mitigate potential risks. Considering the detailed data collected by health systems on activity, outcomes and system characteristics, the lack of easily accessible data on practice ownership is noteworthy, particularly given the growing evidence around the potential impacts of different types of ownership on outcomes of interest, including healthcare cost, quality and access.

45. Across the 20 countries OECD countries responding to the OECD Survey on financialisation, only two – Costa Rica and Iceland – reported that data on healthcare practice ownership is collected and can be aggregated (see Figure 2.4). The vast majority report that information on the ownership of healthcare practices is either not collected or publicly available (9 countries) or is collected but not aggregated in a way that would enable this information to be analysed (9 countries).

Figure 2.4. Most countries do not have a good picture of the scope of financialisation of healthcare practices

Country responses to the question, "Does your country collect and monitor information on the ownership of healthcare practices?



Source: OECD Policy Questionnaire on Financialisation in the Health Sector (OECD, 2024[6]).

46. Where data is not aggregated, this creates significant challenges to better understanding how financialisation – or ownership changes more broadly – might impact healthcare outcomes, costs, access and quality. Without aggregating data on ownership into a national or regional-level database, the only way to collect this information in countries where this data is publicly available at some level is to go into the filing information of each individual practice to identify ownership information directly.

47. In the absence of national data on practice ownership, several researchers have constructed their own datasets using data from research firms specialising in mergers and acquisitions, private equity and venture capital, such as PitchBook or Orbis. However, relying on these data sources poses challenges. Data provided through private research firms is not exhaustive and needs to be complemented with data

with exhaustive newspaper searches and other approaches to identify further publicly-reported acquisitions (OECD, 2024[38]). Moreover, acquisitions below a certain monetary threshold may not be included – an issue that becomes particularly problematic if acquisitions are undertaken as part of a "roll-up" strategy of purchasing and merging multiple small practices or businesses into a larger company (see previous section). Lastly, the purchase of private research firm data is expensive, creating a further barrier for researchers and policymakers to access it.

48. In some cases, data exist that were not previously put to use. In the United States, for example, the Department of Health and Human Services and the Centers for Medicare and Medicaid published a new rule requiring more information from nursing homes on ownership, to better allow for research into the impact of certain types of ownership – notably private equity – on outcomes (Leonard and Homchick, 2023[39]). The Centers for Medicare and Medicaid published ownership information on hospitals for the first time in December 2022, in an effort to improve transparency (Welch et al., 2023[40]). Such requirements, however, do not appear to have been applied to outpatient practices.

3 What drives the financialisation of healthcare?

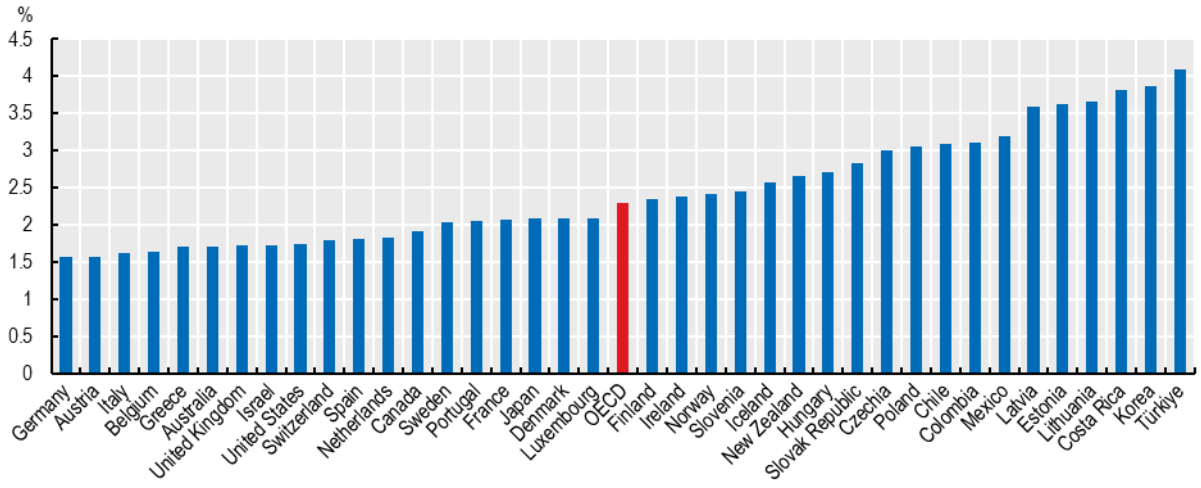
49. A number of factors have been identified as conducive to the financialisation of outpatient services. These include an expected growth in revenue streams due to increasing demand from ageing populations, (financed substantially by public funds); an openness to private provision of health care services and the regulatory dynamics around ownership of healthcare facilities/practices; the development of private supply for services which are provided in a limited manner by public providers; capital-intensive activities with a potential for consolidation and economics of scale; and demographic shifts in healthcare workforces and changing aspirations of younger professionals.

Ageing and increasing demand for health services, largely publicly financed, can offer stable revenues

50. The financialization of the outpatient healthcare sector is influenced by a combination of factors, including growing demand for care and investment opportunities on the supply side. As populations across OECD countries age, demand for health services has grown and is projected to continue to do so in the decades ahead. Population ageing and its attendant demands for healthcare, coupled with substantial government involvement and financial support in health systems in all OECD countries, may have helped attract many investors to the sector. Investments in healthcare may be seen as relatively stable investment opportunities that can help to offset riskier investments in other sectors.

51. According to projections by the OECD (Figure 3.1), health spending from public sources across the OECD is projected to grow at an average annual per capita rate of 2.3% in real prices for 2019-40 for the base scenario (OECD, 2024[41]). This results from several factors, with ageing and increases in income representing the largest contributors.

Figure 3.1. Projected increase of health spending for 2019-40 in real terms (Average annual growth, base scenario)



Source: OECD (2024), Fiscal Sustainability of Health Systems: How to Finance More Resilient Health Systems When Money Is Tight?, OECD Publishing.

The openness of health systems to private provision of care can influence the extent of financialisation

52. All countries and sectors are not equally attractive for financial investors. The structure of health systems often delineates the types and roles private practices can play. Broadly, four different situations can be identified:

- Systems with a long-standing tradition of private practices providing publicly-funded services (e.g. health systems based on social insurance, like Austria, Canada, France and Germany). In OECD countries, primary care is most often predominantly delivered by private providers. In at least 14 OECD countries, outpatient specialist services are predominantly provided by private physicians in solo or group practice, providing potential targets for investors (Table 3.1).
- Systems with more recent possibilities for private provision of publicly-funded healthcare services. These include national health systems which organised purchaser-provider splits from the 1980's (e.g. some autonomous communities in Spain) or who authorise private provision of care when underfunded public providers are not in the position to provide timely care (e.g., Denmark, Portugal).
- Systems where private practices provide health care services that are mainly financed through out-of-pocket payments or private voluntary health insurance (e.g. dentistry in many countries).
- Systems where private providers deliver services that can be covered when delivered by public providers but are delivered at the expense of patients or their voluntary (duplicate) private insurance, largely targeting wealthier individuals.

53. Another health system characteristics influencing the attractivity for investors is the regulation of ownership of private healthcare facilities. This regulation varies across countries, sometimes within countries for federal states, and also across sectors of care (Table 3.1). Unfortunately, systematic international comparisons of ownership regulations in health care are not publicly available.

Table 3.1. Predominant modes of provision of outpatient primary care and specialist services in OECD countries

	Countries
Primary care services	
Solo private practice	Austria, Canada, Czechia, Korea, Slovak Republic, Switzerland,
Group private practice (own patients)	Estonia, Hungary, Luxembourg, Norway,
Group practice (shared patients)	**Private:** Australia, Belgium, Finland, Iceland, Ireland, Latvia, Lithuania, Netherlands, Poland, Sweden, United Kingdom **Public:** Portugal, Spain
Multispecialty group practice	Greece, Slovenia
Other	Costa Rica, Germany, Israel, Japan, United States
Outpatient specialised services	
Outpatient departments of public hospitals	Estonia, Finland, Ireland, Norway, Portugal, Slovenia, Sweden, United Kingdom
Public multi-specialty clinic	Costa Rica, Hungary, Israel, Latvia, Lithuania, Poland
Private solo practice	Austria, Belgium, Canada, Czechia, Germany, Greece, Korea, Luxembourg, Slovakia, Switzerland
Private group practice	Australia, France, Iceland, Netherland,

Source: OECD 2023 Health Systems Characteristics Survey and authors. Missing countries did not respond to the survey or to this specific question.

Box 3.1. Ownership of healthcare practices

Professional autonomy has traditionally been presented by the medical profession as a driver of quality and ethics of healthcare provision. Although preserving professional autonomy is not a final objective, it is often perceived by policy makers as a means to protect quality of care, even as physicians also respond to financial incentives. This is why some countries regulate the ownership of private facilities in healthcare. Such regulation mandates that facilities are owned and managed - at least in majority- by health professionals with the aim to promote professional values and ethics over conflicting goals such as profit seeking or cost-cutting. Systematic international comparisons of ownership regulations in health care are not publicly available.

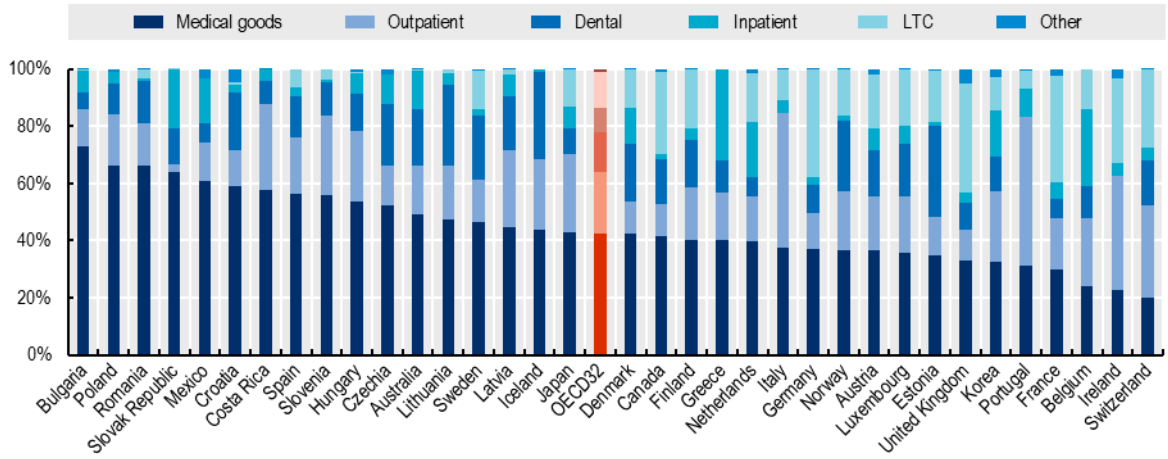
- In the United States, there is no federal regulation of ownership of healthcare practices. In most US States, however, private equity firms are prohibited from directly owning physician practices. To circumvent these regulations, firms typically link a private-equity owned physician management company with a well-established and large physician-owned medical group. Then, firms recruit additional physicians by acquiring smaller practices. Similarly, in most US states, dentists are legally required to own their practice. To circumvent this, investors create separate entities that provide related practice management and business services. Dental Services Organizations handle the business side of dental practices, such as administrative, marketing, bookkeeping, and financial services.
- In the **European Union**, national authorities have some flexibility to regulate ownership of healthcare practices and restrict EU-wide "freedom of establishment", in order to protect public health. In France, for example, ownership of physician practices is regulated. Non-professional stakeholders cannot own more than 25% of a medical practice (Imbert, Jomier and Henno, 2024[10]). This regulation, however, has been circumvented in some cases, enabling financial firms to take majority controls of practices.

Services with poor public coverage are also targets for financial investors

54. The private sector may also play a role in countries with predominant public provision of outpatient services, especially under two circumstances. Private providers may provide services that are not or only marginally publicly funded (typically, adult dental care). They may otherwise provide private services to patients who cannot be treated in a timely fashion by the public sector due to waiting times, or who otherwise prefer to be treated in the private sector with higher copayments or full out-of-pocket payments because of increased choice of provider and timing of care.

55. For example, adult dental care is only poorly covered, if at all, by social insurance or national health systems in many countries. Across 32 OECD countries, out-of-pocket payments for dental services made up 14% of all out-of-pocket spending on average, and comprised at least one-fifth of out-of-pocket expenditures in eight countries (Figure 3.2). This leaves significant room for the private provision of dental care, especially for people with sufficient income and willingness to pay.

Figure 3.2.Composition of out-of-pocket spending on health, by type of service, 2022 (or nearest year)



Note: 2021 or nearest year. The "Medical goods" category includes pharmaceuticals and therapeutic appliances. LTC refers to long-term care. The "Other" category includes preventive care, administrative services and services unknown. For countries that do not report spending on dental, this is typically reported under outpatient care which can affect the coverage rate.
Source: OECD Health Statistics 2024.

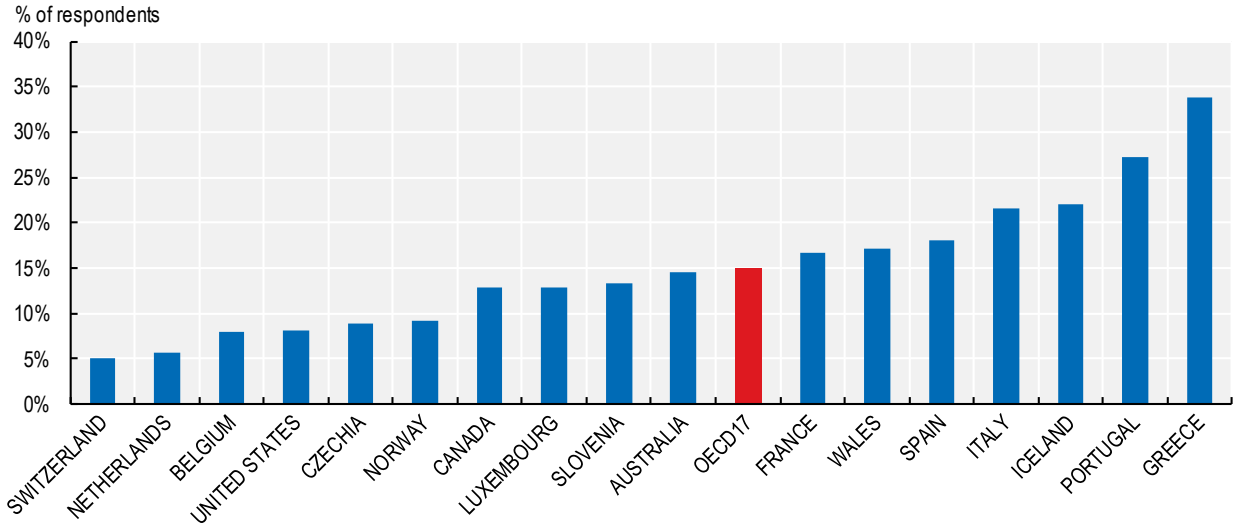
Long waiting times create market opportunities for financialised health services

56. Waiting times for healthcare – both for services like general practitioner (GP) and specialist appointments, as well as for more complex care such as elective surgeries – are an important factor in patient experience and satisfaction with health services and can impact both healthcare access and experience of care. Across OECD countries, waiting times were reported to be an issue for elective treatments (21 countries) and specialist care (20 countries) in more than four-fifths of the 24 countries responding to the 2019 OECD Waiting Times Policy Questionnaire, while half of countries reported that waiting times were also an issue in primary care (OECD, 2020[42]). The COVID-19 pandemic also resulted in backlogs for care, including cancellations in elective procedures, which have resulted in increases in waiting times that in some cases have persisted even as medical activities rebounded (OECD, 2023[43]).

57. Recent evidence from the OECD Patient-Reported Indicators Survey (PaRIS), a survey of primary care patients 45 years and older, underscores the impact of delays in seeing a health professional on patient experience and outcomes of care. 30% of responding patients across 17 OECD countries who waited for a week or more for an appointment reported finding these waiting times to be problematic, compared with just 11% among those who were able to get an appointment within a week, and 4% who reported getting an appointment on the same or next day. Overall, on average across 17 OECD countries, 15% of patients reported that the amount of time they waited to see a GP or specialist was a problem for them (Figure 3.3).

Figure 3.3. Waiting times are a concern for an important proportion of patients

% of respondents who found the amount of time they waited to be a problem



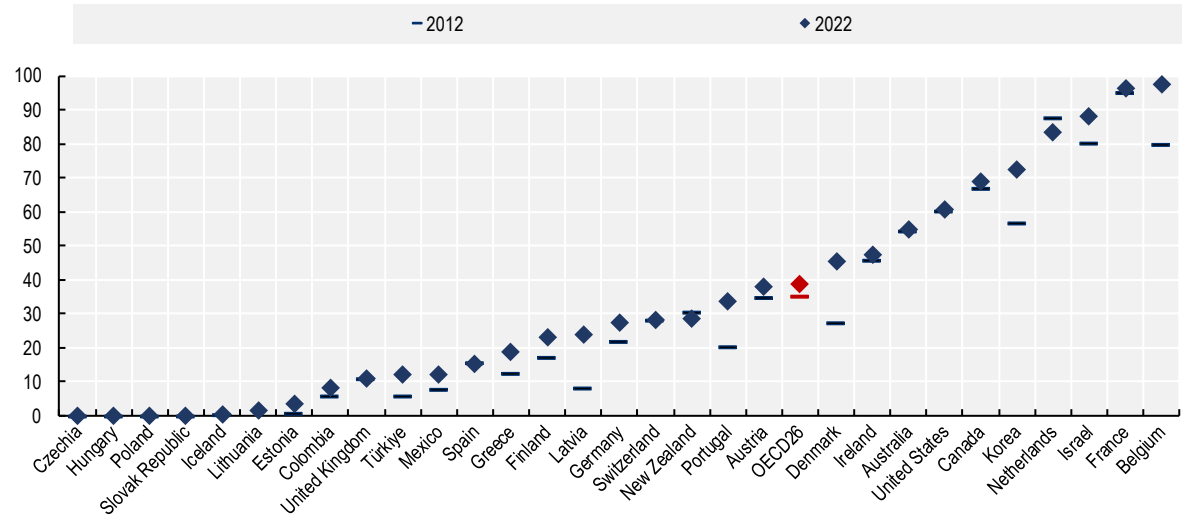
Note: Author's analysis based on OECD PaRIS survey data
Source: OECD Patient-Reported Indicators Survey 2024 (OECD, 2024[44]).

58. In some countries, long waiting times have led patients to seek alternatives to the public system. In Denmark and Portugal, patients have a right to seek treatment in the private system when waiting times exceed a certain threshold. Patients in Denmark may go to a private hospital when their guaranteed waiting time between a GP or specialist referral and treatment exceeds 30 days, while patients in Portugal may use a voucher to seek care through any provider, including those working in the private sector, if they have waited for at least 75% of the maximum allowed waiting time for treatment (OECD, 2020[42]).

59. Seeking faster access to services in private hospitals has also been cited as one reason why more people in Poland have purchased private health insurance in recent years (OECD, 2020[42]). The share of the population covered by voluntary health insurance has grown between 2012 and 2022 in many OECD countries with private health insurance markets, with significant increases in Latvia Portugal, Denmark, Korea, Slovenia and Belgium (Figure 3.4).

60. The proportion of the population covered by voluntary health insurance rose to nearly 40% in 2022 on average across 26 OECD countries. VHI plays very different roles in health systems (OECD, 2022[45]). It can provide supplementary coverage for services not included in the public benefit package (in Israel or Canada, for example); complementary coverage covering co-payments needed to use services included in the public benefit package (e.g. France, Slovenia); or duplicate coverage, for services delivered by providers not included in the public benefit package, to obtain faster access or increase the choice of providers (e.g. Australia, Ireland). All types of VHI can potentially contribute to the development of financialised services. The contribution of VHI to expenditures for outpatient services is relatively high in the Netherlands, Canada, France and Switzerland for example.

Figure 3.4. Proportion of the population with voluntary health insurance coverage



Source: OECD Health Statistics 2024

61. The lack of availability of usual primary care networks to respond to urgent responses, particularly out-of-office-hours, has also encouraged the development of private groups providing 24/7 services on site or by telemedecine, as has been reported in France (OECD, 2024[38]).

Outpatient services requiring high capital investments and with potential for market consolidation and scale economies are attractive to investors

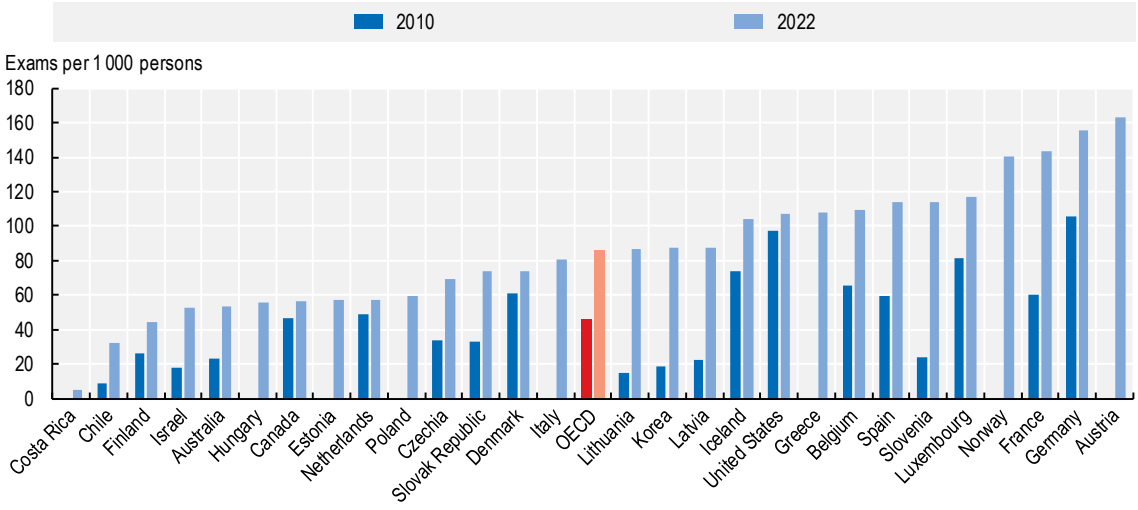
62. Some sectors of care, such as imaging, radiotherapy, dentistry, biology, and ophthalmology, require high capital investments[6], increasing with technological progress. Such investments are very expensive for health professionals and may incentivise them to seek opportunities to partner with financial investors. *De facto*, outpatient sectors reported to be most impacted by financialisation often have high upfront investment costs, with expensive equipment purchases required to set up and run a practice and high capital costs to upgrade and maintain equipment and facilities. In theory, easier access to capital and the ability to spread these costs across a larger number of physicians, practices and patients – as in the case of consolidated networks – may make these sectors more attractive to capital-rich financial investors.

63. Moreover, trends in health service utilisation suggest rising demand for services within these sectors. For example, on average, across OECD countries, magnetic resonance imaging (MRI) exams have risen substantially over the last decade, by 89% per inhabitant between 2010 and 2022 (Figure 3.5).

[6] In many health systems, private providers of healthcare services generally invest in the equipment they need to provide care and are compensated for these investments through their remuneration, although some public support to finance investment may also be available to specific private providers in some countries. For outpatient healthcare services, existing data suggests that governments' direct investments in capital or transfers to private providers for investments in capital only account for a small proportion of governments capital expenditure in health care. In the Euro Area, for example, only 1 in 10 Euros of all government spending on Gross Fixed Capital Formation in the health sector was for outpatient services (ESTAT, 2024[95]). For capital transfers such as investment grants, this share was even smaller.

Similar trends can be seen in the utilisation of other imaging technologies, including computerised tomography (CT) scans. Although some of this increase might be due to increased utilisation of a given machine, the number of diagnostic machines has also increased markedly in recent years in many countries. Overuse of medical imaging has been identified as a frequent source of low-value care and waste in health systems; whether the increasing trend of medical imaging utilisation is always clinically warranted is far from clear (Kjelle et al., 2021[46]).

Figure 3.5. MRI exams have nearly doubled on average in recent years



Note: 2020 data for Iceland, 2021 data for United States.
Source: OECD Health Statistics 204.

64. Consolidation of fragmented healthcare provision into a smaller number of larger providers may present further opportunities to realise efficiency gains. Economies of scale can be obtained through shared administrative resources and pooled purchasing practices, while enhanced management can help cut costs and better allocate resources. Medical technology development is also expected to facilitate efficiency gains in healthcare delivery. For example, advancements in diagnostic technologies, such as liquid biopsy and point-of-care testing, have expanded the role of diagnostic laboratories in chronic condition management. In radiology and pathology, digital workflows and artificial intelligence-enabled decision-support tools are deemed to offer significant efficiency gains. Private investments can facilitate the acquisition of advanced diagnostic equipment and the implementation of these technologies, potentially improving diagnostic accuracy and patient care and reducing costs.

65. Entry barriers, such as regulations over the installation of expensive equipment or certain activities, shapes the market structure by deterring the entry of competitors. This is, for example, the case for medical imaging in Austria, France, and certain US states, where the quantity of high-cost equipment is limited by authorities in order control supply relative to population health needs and to moderate increases in healthcare costs (Rakotoniaina and Butler, 2020[47]; Dreger, Langhoff and Henschke, 2021[48]; Or et al., 2023[49]). Such regulations are of particular interest for financial stakeholders because they can help secure the medium-term profitability of their investments.

66. The potential for financial actors and the private sector more generally to realise productivity gains in their operation of healthcare services has been frequently cited as a reason to promote the role of private providers in health systems. Yet previous reviews have suggested that there is no clear evidence that

private providers are systematically more efficient than public providers (Herrera et al., 2014[50]; Kruse et al., 2018[51]).

67. Where efficiency gains do result, they are often captured by investors. While public payers often regulate and adapt the prices of private healthcare services based on resource use, fee schedules are not always adjusted in real time to take into account efficiency gains or scale economies. One notable exception relates to US Medicare payments for physician services, which are annually updated to take into account the "relative values" of physicians' activities (Barber, Lorenzoni and Ong, 2019[52]). The Centers for Medicare & Medicaid Services does not revise every fee based on new costing information but focuses on new, revised, and some potentially mis-valued services (Barber, Lorenzoni and Ong, 2019[52]).

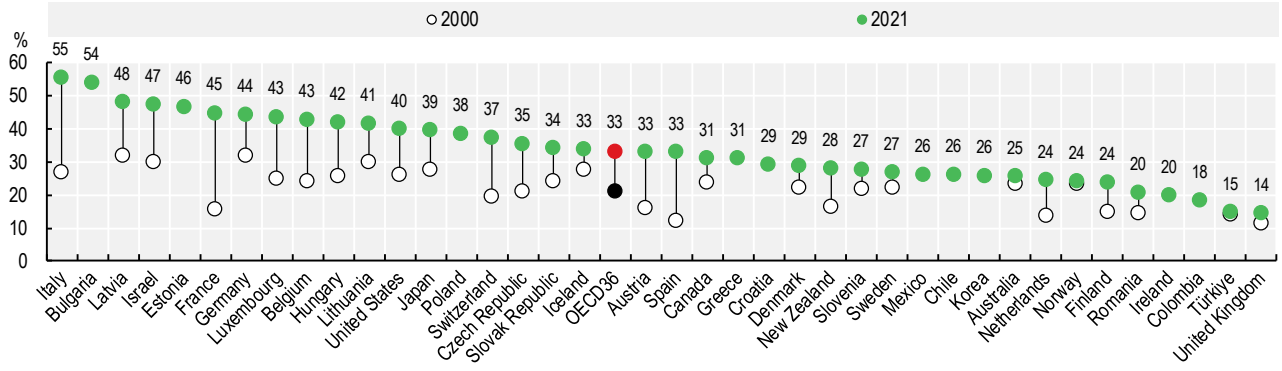
68. If all productivity gains ultimately benefit private investors — without improving outcomes or reducing costs for patients or the health system — their added value to the system is questionable. While some positive spillovers may occur, such as the diffusion of effective practices or competitive pressure driving broader efficiency, these are neither automatic nor guaranteed. It is essential to ensure that productivity gains are shared more equitably and do not accrue solely to private investors.

Evolving provider demographics and practice models make external investment attractive to clinicians

An ageing workforce can create business opportunities for financial firms

69. Changing career preferences among younger physicians, alongside the ageing of the clinical workforce, have at times resulted in a disconnect between the supply of clinics coming up for sale and the demand from clinicians to buy them. Across OECD countries, the clinical workforce is ageing rapidly: between 2000 and 2021, the share of the workforce aged 55 and over increased by 56% (Figure 3.6). By 2023, one-third of physicians, including more than half in Italy and more than 40% in a further ten OECD countries, were at least 55 years old (OECD, 2023[53]).

Figure 3.6. Share of doctors aged 55 and older, 2000 and 2021



Source: OECD Health Statistics 2023 (OECD, 2023[54]).

70. Several countries also report shortages of health professionals (OECD, 2016[55]). This situation leads to increased demand for contract workers and outsourced staffing solutions but also brings growth opportunities for clinical staffing organisations and enterprises offering workforce management solutions. Investors have found potential in businesses that assist healthcare providers in managing utilisation variability and in reducing administrative burdens associated with human resources functions.

Changing aspirations and preferences among younger healthcare workers may foster financialisation

71. Shifting preferences among younger healthcare workers may be – perhaps inadvertently – driving further financialization. The potential impact of the purchase of physician-owned clinics by financial actors merits further scrutiny, particularly as some of the trends that may be driving these actions continue and even accelerate.

72. In some countries, younger doctors in particular appear to be moving away from the model of private practice ownership. Surveys of clinicians suggest that a growing number of doctors report shifting preferences in their work life, moving away from the financial and administrative responsibilities of owning a practice towards greater perceived stability through salaried employment.

73. Between 2012 and 2022, practice ownership among younger doctors (those under 45 years) fell by 12 percentage points in the United States, dropping from just under half (44%) to less than one-third (32%) (Smith, 2023[56]). In Germany, the proportion of doctors and psychotherapists working as salaried employees within the statutory health insurance (SHI) system has nearly doubled over the last decade, rising from 15% in 2014 to 28% in 2023 (Kassenärtzliche Bundesvereinigung (KBV), 2024[57]). In Australia, the share of general practitioners (GPs) who owned their practice fell from 35% in 2008 to 25% in 2020 (Moel-Mandel and Sundararajan, 2021[58]). These trends reflect the expressed wishes of younger doctors, with medical school students reporting in surveys an increasing preference to work as a salaried employee, rather than owning their own practice. In France, 68% of new physicians in 2018 started their career as salaried workers, and this was also the case for 50% of new dentists in 2022 (Imbert, Jomier and Henno, 2024[10]).

74. Shifting professional and demographic preferences among physicians also appear to be driving a growing number of doctors to reducing their hours and working part time. These changes in preferences may reduce the appeal of practice ownership, which is accompanied by significant time and administrative investments that may not reflect changing priorities among the health workforce. The proportion of doctors working part-time has grown substantially in recent years across OECD countries. In Germany, the share of doctors and psychotherapists working part-time more than doubled between 2014 and 2023, from 15% in 2014 to 35% in 2023 (Kassenärtzliche Bundesvereinigung (KBV), 2024[59]). In the United Kingdom, just over one-fifth (21%) of medical practitioners worked part time in 2023 (Office for National Statistics, 2024[60]). In both countries, the share of women working part-time vastly dwarfed that of men, with female three times more likely than men to report working part-time. As more women enter the workforce, the overall share of physicians shifting to part-time work may continue to rise.

75. Shifting preferences in practice ownership, coupled with an increasingly ageing workforce, can compromise doctors' ability to sell their practices to young practitioners. The situation is particularly complex for physicians living in rural areas, where trends towards urbanisation have already further reduced the population of physicians interested in practicing, leading to "medical deserts" where local populations struggle to find general practitioners available. Sectors with high capital investments are also more attractive for financial institutions than for young physicians, in part due to the high-cost barriers of investing in expensive technologies (OECD, 2024[38]).

76. These changing workforce dynamics have meant that in many cases, there is a lack of demand from the healthcare workforce to purchase existing clinics, or to establish new practices. In the absence of interested physicians, financial firms may step in to purchase clinics from physicians who have trouble selling their practices to retire or leave their clinics. Given the increasing age of the workforce, these trends are likely to continue to amplify in the years to come.

77. At the same time, interviews conducted for this study suggest that where financial firms purchase practices from physician owners, they sometimes do so at valuations as high as two to three times the estimated market value (OECD, 2024[38]). Given the lack of competing demand for clinics, these inflated

prices suggest one of two possibilities: physicians may be reluctant to sell to a non-independent physician practitioner at lower prices, and/or firms see significant potential room for growth in the profitability of these practices.

4 How does financialisation impact health systems and outcomes?

78. The growing presence of financial investors in the health sector presents both risks and opportunities for policymakers, patients, and healthcare providers. While potentially offering opportunities for boosting investment, helping to keep practices on the market, and realising scale economies and other efficiencies, the financialisation of healthcare has raised concerns about potential conflicts between profit-seeking behaviour and the ethical imperatives of medical care.

79. Proponents argue that financial actors' involvement brings benefits such as an infusion of capital for investment in new technologies and facilities, operational efficiency through management expertise, and benefits from market consolidation of fragmented activities. By creating larger healthcare entities, it has been argued that private equity can stimulate economies of scale and improve negotiating power with insurers and suppliers. However, critics point to several drawbacks, including a short-term focus that prioritises financial gains over long-term patient care quality, increased costs due to leveraged buyouts debts for instance, quality concerns from cost-cutting measures taken to increase profits, access issues where private equity-owned facilities cherry-pick profitable patients or services, and reduction of healthcare providers' professional independence (Kirsh and Kapoor, 2021[61]).

80. Moreover, a main argument for the entry of financial actors into the health sector is that they have the capacity to bring capital investments, to improve supply in quantity and quality, and to realise efficiency gains through consolidation and management practices. Yet to date, data on the impact of financialisation on capital investments is extremely limited, while the evidence around efficiency gains in the private sector is ambiguous. Evaluating the impact of financialisation on these outcomes requires further research.

81. While the scope of this review focuses on evidence from outpatient care, it should be noted that the effect on acute and long-term care facilities is well documented in the literature. In these settings, private equity ownership is frequently associated with negative outcomes. According to recent systematic literature reviews (Borsa et al., 2023[62]; Karamardian et al., 2024[63]), private equity-ownership of facilities – mainly nursing homes and acute hospital care – is most often associated with negative impacts on outcomes for patients, such as mortality, major and other adverse health outcomes, and complications such as hospital acquired infections, with only one study finding better outcomes for patients (Borsa et al., 2023[62]). The impact on costs for patients and payers is also overwhelmingly negative, due to higher volumes, higher prices and shifts in practices. Impact on access is negative for some categories of patients, with reduced percentages of Medicare, Medicaid, or Dual-Eligible patients. The evidence on impact on costs for operator is mixed, with studies finding increase and others observing a decrease in these costs. This is the same for impact on process quality, showing mixed results, though no study found a positive impact on patient experience (Borsa et al., 2023[62]).

82. Much evidence on the impact of financialisation on healthcare services, however, is focused on the United States, and overwhelmingly on private equity actors. The unique features of the US health system may not make them generalisable. A recent scoping review of the impact of private equity on healthcare in New Zealand and Australia, for example, was unable to identify literature that evaluated the impacts of

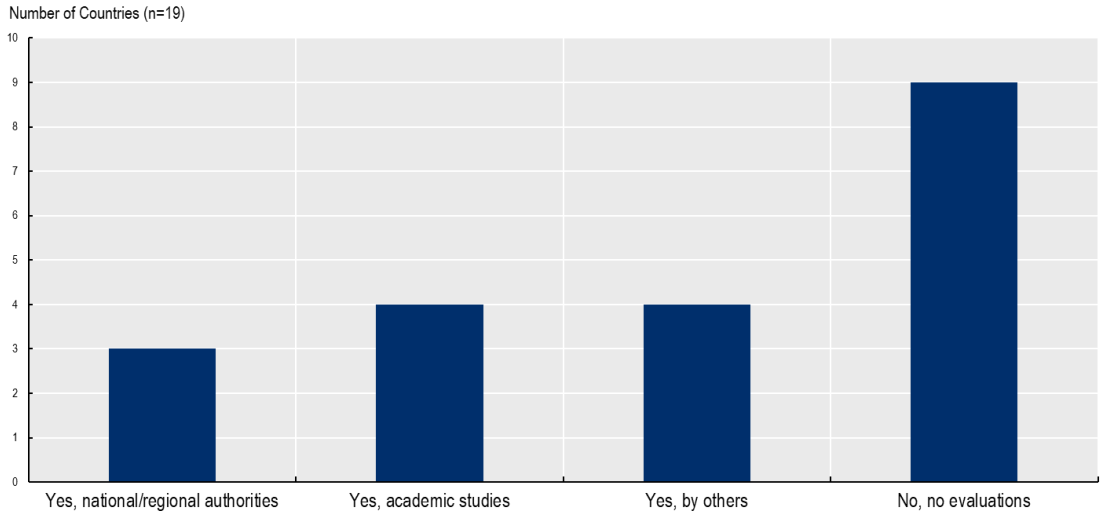
private equity investments in healthcare, even while noting a trend towards growing private equity ownership of clinics (McInerney et al., 2023[64]).

83. The paragraphs below summarise available evidence from the literature focusing on outpatient services[7] and, in some cases, report anecdotal evidence drawn from interviews or media coverage. The first part of this section looks at impact on access and quality of care, then at impact on costs. The last part of this section presents the views of competition authorities in some countries, as well as physicians' perception of the financialisation.

Most countries have not evaluated the impact of financialisation on health system policy objectives

84. The vast majority of countries responding to the 2024 OECD Policy Questionnaire on Financialisation in the Health Sector reported that, to date, no reports or other information have been published that look at either trends in or the impacts of financialisation on healthcare (Figure 4.1). Nearly half of countries (9 of 19) reported that no evaluations were taking place, while just three – France, Israel and Norway – reported that national or regional authorities had published reports on financialisation in the health sector.

Figure 4.1. Nearly half of countries report that no evaluations on financialisation in healthcare have been published



Source: OECD Policy Questionnaire on Financialisation in the Health Sector, 2024 (OECD, 2024[6])

Costs largely increase for payers after private equity acquisitions

85. Several studies have documented volume and price increases in specialist practices following private equity acquisition. The extent of these increases and their underlying causes vary by speciality and

[7] The literature review identified largely PE-backed practices.

market conditions but also depend on price regulation in the country. Researchers in the United States found that in eight of the ten specialties studied, private equity was associated with statistically significant increases in prices of physician services across multiple outpatient sectors. Price increases were found in gastroenterology (14%), dermatology (4%), orthopaedics (7.1%), oncology (16.4%), and primary care (4.1%). Where a single firm controlled over 30% of the market, price increases were even more pronounced, including increases in gastroenterology (18%), obstetrics and gynaecology (16%) and dermatology (13%). The same study found that per-patient expenditure also increased for six of the ten specialties, ranging from 4.1% in dermatology to 16.4% in gastroenterology (Scheffler et al., 2023[65]).

86. Impact of private acquisition of health care practice on cost for payers have been largely documented in several specialties:

- Ophthalmology, Gastroenterology, and Dermatology: An analysis of 578 practices found that private equity acquisitions were linked with a 20% increase in charges per claim alongside a 38% increase in new patient visits, and a 16% higher volume of encounters compared with non-private equity-owned practices. These trends indicate that private equity acquisition may drive higher healthcare costs through increased service utilization and possibly more intensive coding and billing practices (Singh et al., 2022[66]).
- Dermatology: A study on dermatology practices found that prices for routine visits were 3–5% higher 1.5 years after private equity acquisition compared to non-private equity-owned practices. This was accompanied by an increase in the volume of patients per private equity dermatologist compared to non-private equity dermatologists. Overall, this suggests that private equity firms may seek to utilise their dominance in a market to increase prices paid by health insurers, whilst also increasing patient volume to maximise revenue (Braun et al., 2021[67]). This is further supported by another study which found that dermatology practices owned by private equity firms and large corporations were linked to increased spending in Medicare (Konda et al., 2019[68]).
- Urology: Research found that before acquisition, urologists who later joined private equity groups had higher average Medicare payments and patient volumes compared to those who did not. After acquisition, private equity-affiliated urologists saw an 11.0% increase in Medicare payments and a 12.5% rise in patient volume, while non-private equity-affiliated urologists experienced a decline in payments and a more modest increase in patient volume. These results suggest that private equity firms target practices with already higher payments and volumes, and the gap between private equity and non-private equity practices may widen post-acquisition (Nie et al., 2022[69]).
- Ambulatory Surgical Centres (ASCs): One study found no statistically significant differences in total costs or total encounters for Medicare beneficiaries following acquisition compared to independent ambulatory surgical centres or those acquired by non-private entities. However, the authors note that further research and increased transparency on such acquisitions is necessary to monitor long-term effects on quality as well as financial sustainability (Bruch et al., 2022[70]).
- Anaesthesia Practitioners: Another study found that outpatient practices in the United States contracting with physician management companies (PMC) saw increases in allowed amounts and unit prices paid to anaesthesia practitioners of 16.5% and 18.7%, respectively, compared to facilities that did not partner with physician management companies. Furthermore, this impact was even more significant for companies with private equity investment, which experienced a 26% increase in allowed amounts and 25.6% increase in unit prices. This indicates that PMCs, especially those supported by private equity, may be able to negotiate higher rates for anaesthesia services, perhaps due to their enhanced market leverage and negotiating skills. The price increase may lead to higher insurance premiums and patient cost-sharing (La Forgia et al., 2022[71]).

87. A recent study of the Finnish Competition and Consumer Authority (FCCA) on private healthcare and dental markets shows significant price increases in acquired clinics, compared to non-acquired clinics: around 20% for auxiliary services (such as medical imaging and laboratory tests), and over 10% in the

dental market. These trends may partly be explained by differences between independent and chain clinics in digital service availability and objective functions (Buri, Heinonen and Pietola, 2024[72]).

88. It is important to note, however, that price increases may not occur in all health systems and all sectors of care, as many countries regulate the fees payable for healthcare services covered by the government or compulsory health insurance. Nonetheless, even in countries with stricter regulations on price, some concerns have been raised on the ability of payers to negotiate prices when consolidation has reduced the number of service providers in the market.

89. When practices backed by financial firms generate more volumes and higher costs than competitors, it is important to understand whether these result from greater access and response to unmet medical needs, attraction of patients from other providers, or overbilling and over-provision of services. Fuse Brown and Hall (2024) have identified numerous cases of fraud and overbilling in private equity-backed facilities (Fuse Brown and Hall, 2024[73]).

Effects on access following financial investment are mixed

90. Several studies have found that private equity firms tend to buy practices in urban areas (Chen et al., 2020[21]). One review found that private equity acquisitions in ophthalmology were predominantly located in metropolitan areas with a high percentage of privately insured individuals (Del Piero, Parikh and Weng, 2022[74]). Similar patterns have been observed in orthopedic practices and surgical groups (Boddapati et al., 2022[75]). Furthermore, Borsa and Bruch found that private equity-owned fertility clinics were concentrated in regions with higher median incomes (Borsa and Bruch, 2022[76]). In France, the consolidation of the laboratory sector has dramatically transformed supply in recent years, without changes observed in geographical access to laboratory services, but a reduction in the hours of availability (OECD, 2024[6]).

91. A few studies have found possible positive impacts of private equity ownership on access to outpatient services for certain patients in the United States. Creadore et al. (2021) explored insurance acceptance, appointment waiting times, and access to dermatologists, finding that private equity-owned clinics had slightly higher appointment success rates for Blue Cross Blue Shield (BCBS) and Medicare patients (Creadore et al., 2021[77]). However, Medicaid patients still faced significantly lower success rates and longer waiting times. Private equity-owned clinics were more likely to offer new patient appointments with non-physician clinicians and had greater next-day appointment availability. This study highlights that, despite some improvements in access and service availability, significant disparities for Medicaid patients persist, underscoring the complex and often mixed effects of financialisation on healthcare access.

92. While these findings to do not directly indicate whether access to care is reduced or enhanced, they offer valuable insights into the geographic and socioeconomic factors that private equity firms consider prior to investment. However, research examining the effects of these investments across different countries is still lacking, highlighting a critical gap in understanding how private equity ownership influences healthcare access. While it is possible that private equity ownership may help improve access among wealthier patients or those with more generous insurance coverage, the consistent findings in relation to higher costs suggest that financialisation may also introduce additional barriers to access for certain patients, with potential implications for inequalities in access to care.

Evidence on the impacts of financialization on quality of care is limited

93. Evidence on the impact of financialisation on quality of care in the outpatient sector is scarce, possibly because the measurement of quality of care in the outpatient sector is traditionally less developed than in hospitals.

94. La Forgia and Bodner (2023) analysed the effects of corporate ownership, including private equity investment, on US fertility clinics, finding significant improvements in both operational scale and clinical outcomes (La Forgia and Bodner, 2023[78]). After being acquired by corporate entities, clinics experienced a 28% increase in IVF cycles and a 14% rise in live birth rates, with full corporate acquisitions showing the strongest gains. Clinics backed by private equity investment, which accounted for 15% of all clinics by 2018, saw a similarly large expansion in IVF cycles (28%) but a more modest 2 percentage point increase in live birth rates. Private equity-backed clinics also employed aggressive marketing strategies, such as money-back guarantees, and expanded market share without reducing the volume of independent clinics. These findings contrast with other healthcare sectors where private equity ownership has been criticised for cutting costs at the expense of patient care. In the fertility industry, the transparency of IVF success rates aligned corporate and patient interests, incentivising both corporate and private equity owners to invest in quality and growth, though private equity firms focused more on scaling operations than immediate clinical improvements.

95. However, while private equity investments can lead to increased service volume and utilisation, they do not necessarily guarantee superior clinical success rates across all metrics. Borsa and Bruch (2023) found that private equity-affiliated fertility practices in the US accounted for 29% of assisted reproductive technology (ART) cycles reported to the CDC (Borsa and Bruch, 2022[76]). These practices were predominantly located in wealthier areas, with an average median household income of USD 83,610in their zip codes, compared to USD 72,161 for non-private equity-affiliated practices. Service utilisation patterns also differed significantly, with private equity-affiliated practices showing a higher use of pre-implantation genetic testing (PGT) (46.4% vs. 30.9%), a trend further confirmed in sensitivity analyses. Despite these differences, there were no statistically significant variations in key success rates, such as the percentage of intended retrievals, completed retrievals, or transfers resulting in live births between private equity and non-private equity-affiliated practices, indicating that while private equity-affiliated practices may offer more extensive services, they do not necessarily achieve higher success rates.

96. Beyond fertility care, the impact of private equity ownership has been assessed in other outpatient sectors as well. Braun et al. (2021) investigated dermatology practices in the United States and found that while private equity-owned clinics experienced a higher volume of cosmetic procedures and elective surgeries, but these increases were not necessarily accompanied by improved patient outcomes (Braun et al., 2021[67]). The study raised concerns about potential “upcoding” practices, where procedures are billed at higher rates without corresponding to improvements in clinical effectiveness or patient satisfaction. This highlights the potential risk of financialisation prioritising profitability over patient care. By contrast, a study on ambulatory surgical centers did not find statistically significant changes in unplanned hospital visits when comparing private equity-acquired centers with independent and non-private centers (Bruch et al., 2022[70]).

97. In some cases, financialisation facilitates the adoption of higher standards of care. For instance, in France, the law imposing the accreditation of laboratory practices to improve the quality of tests is being seen as the real accelerator of the consolidation of the sector since the costs and burden of accreditation could hardly been born by smaller enterprises (Leymarie, 2022[27]) (See Box 2.2).

Competition authorities are increasingly concerned about consolidation in the healthcare sector, often linked to financialisation

98. Competition authorities, who are responsible for ensuring market competition and regulating anti-competitive behaviour in countries, can play an important role in monitoring acquisitions and mergers that can impact who owns healthcare practices. Increasingly, competition authorities have expressed concern at rising trends towards financialisation and consolidation of healthcare activities in the health sector and have taken steps to better understand and influence the issue.

99. In the United States, the Federal Trade Commission (FTC) has worked with other federal agencies, including the Department of Justice and the Department of Health and Human Services, to look into the growing corporatisation of healthcare in the United States. A public FTC workshop on private equity in healthcare was organised in March 2024. The FTC has also sued a number of healthcare companies for anticompetitive behaviour. Given the size of the US healthcare market, the FTC cannot monitor all mergers and acquisitions taking place (though transactions over a threshold value are required to be reported), and instead selectively responds to potential cases that are brought to its attention, including by members of the public. Some cases are also handled at the state level state Attorneys General.

100. In Australia, the Australian Competition & Consumer Commission (ACCC) recently published information about lease acquisitions undertaken by one of the country's largest private providers of oncology services, which is owned by an international private equity firm. The ACCC reported concerns that further acquisitions of leases in the area would further strengthen its position in the market and reduce competition, allowing it to reduce service quality or increase prices (Australian Competition & Consumer Commission, 2024[79]).

101. In Finland, the Finnish Competition Authorities have drawn attention to "stealth" consolidation that has taken place in the health sector, finding that a very small proportion of all mergers in the health sector were notified to Competition Authorities, but that the resulting "roll-ups" in the sector have led to increases in prices at clinics that were acquired (Buri, Heinonen and Pietola, 2024[72]).

102. Interviewed experts suggested that co-ordination between competition authorities and health systems policymakers is fragmented, with poor information exchange occurring between the two actors. Improving information exchange between health policymaking and market regulators would help to ensure that policies within the health sector do not have unintended consequences for competition that could impact health systems performance – including cost, quality and access – in the longer term.

Physicians report widespread concerns over financialisation

103. The financialisation of healthcare has raised concerns among physicians about the impact on professional autonomy and patient care. In the United States, a survey of 602 early-career radiologists found that 85% were aware of this trend, with 86% believing it negatively affects radiology**.** Most of them preferred independent practices, citing fears that corporate ownership prioritised profit over patient care, potentially harming their earnings and work-life balance. Additionally, concerns about the lack of transparency in practice acquisitions were prevalent (Ortiz, Muroff and Vijayasarathi, 2020[80]).

104. Several radiologists have written about perceived negative impacts of increased corporatisation and consolidation. Many find that the potential benefits of private equity, such as economies of scale, are simply not enough to outweigh the negative impact firms can have on physician autonomy as well as overall physician well-being. Davis and D'Souza (2024) advocate for greater "physician ownership and physician control" (Davis and D'Souza, 2024[81]). They urge radiologists and physician groups to come together to make informed decisions about the future of radiology. A Health Policy Expert Panel of the Journal of American College of Radiology reiterated some of these arguments, along with potential ways of mitigating the risks of private equity involvement. One of the proposed ways of achieving this includes holding private equity firms accountable for their commitment to positive health outcomes, care quality, and technological innovation (Lee et al., 2023[82]).

105. Many of these concerns were echoed by another study focused on private equity acquisitions in ophthalmology (O'Donnell et al., 2020[83]). Researchers conducted 35 semi-structured interviews with stakeholders such as physicians, consultants, attorneys, and private equity leaders to understand the motivations and concerns surrounding these deals. Many physicians, particularly those approaching retirement, were drawn to private equity because of high sale prices and relief from administrative burdens.

Ophthalmology practices are especially attractive to private equity firms due to the specialty's fragmented structure, high demand for services, and diverse revenue streams. However, concerns emerged about the potential impact of private equity ownership on clinical care, with some physicians worried about increased pressure to maximise revenue through higher procedure volumes or costlier treatments. While private equity acquisitions may introduce efficiencies and capital for growth, physicians also feared a loss of professional autonomy and a shift toward more profit-driven clinical decisions. However, these considerations vary between early, mid, and late career physicians (Khan, 2022[84]).

106. Shah and Wolfe (2022) argue that successful partnerships between private equity firms and physicians requires alignment in values and objectives (Shah and Wolfe, 2022[85]). In one case of a company which consolidated many refractive surgery practices in the United States, the private equity entity required physicians to treat a greater volume of patients, resulting in 20% of the chain's physicians to leave, and a number to sue the company for putting profits over patient care (Shah and Wolfe, 2022[85]).

107. In a 2020 study conducted in the United States, Novice et al. surveyed 137 dermatology residents about their perceptions of private equity ownership of medical practices (Novice, Portney and Eshaq, 2020[86]). Most respondents expressed negative views, with 65% indicating an unwillingness to work for practices backed by private equity, and 70% believing that private equity involvement has had a negative impact on dermatology. Furthermore, 77.3% felt that private equity ownership would adversely influence their future career choices. There was a statistically significant association between residents' willingness to work for private equity-backed practice and their views on private equity's impact on physician autonomy, quality of care, and long-term earnings. These concerns are echoed in numerous editorials and opinion pieces authored by physicians (Konda et al., 2019[68]; Resneck, 2018[87]; Sharfstein and Slocum, 2019[88]). Furthermore, many dermatologists have expressed concerns about the utilisation of less qualified dermatology personnel, such as physician extenders[8] in private equity-backed practices. According to Konda et al. (2019), physician extenders can generate higher profits due to reduced salaries compared to dermatologists, and the level of supervision may vary significantly across practices (Konda et al., 2019[68]). Additionally, some practices may categorise physician extenders as physicians on their websites, which could create misunderstandings for patients.

108. A study in Germany similarly highlighted physicians' fears about losing professional autonomy and decline in care quality under private equity ownership (Nolte, Miedaner and Sülz, 2022[89]). Many physicians believed that private equity firms prioritise profits over patient care, which contrasts sharply with the core values of the medical profession. While some younger physicians noted potential benefits such as improved work-life balance and managerial expertise, apprehensions persisted about the sustainability of private equity-owned practices. Interviewees stated that private equity firms often lack the medical expertise needed to foster effective partnerships. Another significant concern was the short-term nature of private equity involvement, typically three to seven years. Furthermore, many interviewees criticised the practice of private equity firms removing profits from the German healthcare system, including the potential for profits to be moved offshore. Importantly, this study, along with others, highlighted a lack of adequate empirical support for many critical arguments surrounding private equity involvement (Nolte, Miedaner and Sülz, 2022[89]). This represents a limitation in the existing literature, indicating a need for more robust research.

[8] Physician extenders are healthcare professionals who work under the supervision of a physician to provide medical care to patients. This includes physician assistants and advanced practice nurses.

5 Shaping a policy response to financialisation

109. Trends toward financialisation in the health sector, and particularly the entry of private equity firms, have been found to be associated with largely – although not exclusively – negative outcomes for health systems and patients. At the same time, much of the evidence thus far has been published based on findings from one unique health system (the United States), calling into question the generalisability of current findings for other health systems.

Few countries have taken steps to regulate specific types of financial actors

110. The results of this analysis, including a review of the literature, expert interviews and a policy survey circulated to countries, indicate that while the financialisation of outpatient care and healthcare more broadly appears to be a growing concern in many countries, very little has been done to regulate how financial actors participate in healthcare markets.

111. Where regulations have been put in place, they have often addressed specific sectors rather than financialisation more broadly. In France, for example, a new law, adopted in 2023, also seeks to better control the financialisation of outpatient activities, in reaction to a series of malpractice scandals. This new regulation imposes prior approval from regional health authorities for the establishment of new dental, ophthalmologist and orthoptic centres, as well as a monitoring of their practices and a reinforcement of sanctions in case of non-compliance (Imbert, Jomier and Henno, 2024[10]) . In Germany, a law enacted in 2019 restricted the ability of hospitals (and by extension, financial actors) to invest in dental MVZs once hospital-owned dentistry services exceeded a certain threshold (Singh, Fuse Brown and Papanicolas, 2025[7]; Clifford Chance, 2019[90]).

112. Existing evidence from other sectors, nursing homes and hospitals in particular, and evidence from other non-health sectors that have experienced financialisation in recent years, provide a strong rationale for policymakers to consider policy action to minimise the risks for health policy objectives from the finacialisation in the health sector, particularly the entry of private equity firms, and to more actively monitor trends in, and the impact of, financialisation on outpatient services (see Table 5.1). This highlights the need to build an information system that enables improved monitoring, and for improved policies on how to draw benefits from financialisation while protecting patients and healthcare payers from harmful impacts.

Table 5.1. Policy options for reducing the risks of financialisation

Policy	Policy target	Policymaker concerned
Transparency (of ownership)	Evidence-based policymaking, accountability	Ministries of Health
Quality standards and reporting requirements	Quality of care	Ministries of Health
Ownership regulations (practices and equipment)	Access (to physicians, practices and services)	Ministries of Health
Price regulation, Update of fee schedules	Capture a share of efficiency gains Avoid inappropriate shifts in activity due to distortions in fee schedules	Ministries of Health
Competition reviews	Consolidation, access (to physicians/practices), price increases	Competition authorities

Source: OECD analysis, informed by Fuse Brown and Hall, 2024 (Fuse Brown and Hall, 2024[73]).

Better monitoring and data collection

113. Across the 20 countries OECD countries responding to the OECD Survey on financialisation, only two reported that data on healthcare practice ownership is collected and can be aggregated. The vast majority report that information on the ownership of healthcare practices is either not collected or publicly available or is collected but not aggregated in a way that would enable this information to be analysed.

114. Requirements related to collecting and aggregating information on the ownership of healthcare services should be enhanced to improve monitoring and facilitate the collection of quality metrics to understand more reliably the impacts of ownership structures on quality of care. In order to safeguard quality of care, policymakers could also consider establishing mandatory minimum requirements such as staffing levels, as research showed that private equity acquisition is frequently associated with staff reductions that can lead to adverse patient outcomes. Policy makers could implement requirements that protect against "asset stripping" such as the sale of critical assets post-acquisition which can undermine care quality.

Regulation to protect quality of care, access and cost

115. Research shows that private equity acquisitions frequently lead to higher prices, particularly through consolidation (see Chapter 4). To address this, regulators could consider strengthening antitrust oversight, including reconsidering how merger control frameworks can better capture acquisitions that collectively can create significant market concentration and are frequently not visible to authorities. Additionally, competition authorities could be empowered to review and potentially block acquisitions that would lead to anticompetitive pricing power under merger control frameworks. The analysis of mergers could also look at non-price factors, such as quality and access considerations (particularly for underserved areas or populations), compatibly with the country's legislative framework, or include requirements within healthcare regulations demonstrating maintenance or improvements in access and quality of care. Given that these facilities often serve as essential community providers, maintaining equitable access to care should be a critical policy consideration when reviewing acquisitions by financial entities.

116. Some of these policy options are outside of the scope of Ministries of Health. As described above, action by competition authorities represents an important policy tool for regulating financialisation. Stronger co-ordination between Ministries of Health, Ministry of Trade and Finance, and competition authorities could also help Ministries of Health address the harmful consequences of financialisation.

A better understanding of financialisation is urgently needed

117. While this paper has attempted to further refine the concept of "financialisation" within health systems, further work is needed to better define and frame both the concept and the specific actors involved. Interviews with experts across OECD countries made it clear that countries do not share a definition of financialisation, and that many countries still lack a clear idea of what types of financial actors and what kinds of activities are taking place or merit further scrutiny in their health systems. Developing a more refined typology of the types of financial actors involved in health systems, the approaches they have taken to invest in the health sector, and the health systems characteristics that facilitate or discourage the entry of financial firms into the health system would be important in helping to identify what kinds of policy tools would be appropriate for countries to consider.

118. Overall, this report suggests that while financialisation can bring capital to healthcare organisations, without proper safeguards it risks prioritising short-term financial gains over quality of care. As healthcare systems face mounting pressures from aging populations and increasing costs, policymakers must strike a careful balance between leveraging private investment and protecting public health objectives. This requires developing robust regulatory frameworks that ensure transparency, maintain quality standards, and preserve affordable access while allowing for beneficial private sector participation. Moving forward, policy makers should strengthen their capacity to monitor and evaluate the impact of financial ownership in healthcare, share best practices in regulatory oversight, and develop evidence-based policies that safeguard policy objectives of quality, and affordable healthcare for all.

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