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What are the policy options for regulating private equity involvement in health care? A review of policies implemented or considered in seven high-income countries

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ABSTRACT

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

Research in context

• **What is already known about the topic?** Private equity firms have become active in European and North American health care systems. There are concerns that their involvement may not align with the social values of care delivery.

• **What does this study add to the literature?** This study identifies proposed or implemented policies–from seven high-income countries–which attempt to address private equity involvement in health care. We categorize identified policies using a novel conceptual framework.

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• **What are the policy implications?** European and North American countries have attempted to regulate private equity involvement in health care. To date, policies largely focus on disclosure, and most have not been evaluated. There is a need to study the effectiveness of implemented policies aimed at addressing private equity activity in health care.

1. Background

Private equity investment in health care has proliferated in the last two decades, particularly in the United States where the investment model originated, and more recently in Canada and Europe [1–4]. Private equity firms pool private funds, often from institutional (e.g., pension) and high-wealth investors, and possess several traits that distinguish them from other for-profit entities [5]. They operate on a relatively short time frame, with a goal of selling acquired assets at a substantial profit within 3–7 years; [6,7] they assume substantial debt, using as collateral the assets of the organization that they are acquiring; and, finally, private equity firms are generally not publicly-traded. This has important implications for how they behave vis-à-vis their investors, the firms they acquire, and patients (or consumers). In 2010, there were approximately 400 private equity healthcare deals globally (9 % of all private equity acquisitions for that year). This figure increased to over 1000 deals globally (21 % of all private equity acquisitions) in 2021. The total annual value of disclosed buyouts increased 900 % during the same period [8]. Its entry into the health sector has corresponded with broader, related economic and policy trends, notably the financialization and the privatization of social goods [9].

The discourse from within the financial sector claims that private equity firms can deliver new sources of funding for health systems [10–14], overcome fragmented service provision through economies of scale, provide more efficient service delivery, increase capacity, leverage network effects, adopt new technologies and reduce waste [11, 13]. Some studies suggest they may also be more effective at providing cost-efficient care [11,15], and improving patient outcomes [11,16]. Critics warn that the business model of private equity firms does not align with the social values of healthcare [17–19]. Rapid expansion via mergers and acquisitions may increase market power and render these businesses 'too big to fail' [6,20]; the use of high levels of debt may place financial strain on acquired health sector organizations and pressure them to excessively cut spending on essential care, staffing, and equipment; and private equity firms may 'cherry-pick' profitable services over those less profitable, potentially reducing access to the latter (e.g., primary care, mental health service) [21].

Research from within the health disciplines (e.g., public health, health policy, health systems research, health economics) has produced a body of evidence demonstrating that private equity ownership of health sector organizations can often lead to negative outcomes at the patient, organizational, and health system levels [1,19]. While the evidence is largely unfavorable towards private equity acquisitions, some studies find that private equity ownership has a net positive or neutral impact [1]. Despite the available evidence, there are gaps in the literature. There is a lack of publicly available information on where private equity funds are active and how much of a given market share they occupy. Purchasing and ownership can be opaque, and it is often left to the researchers evaluating trends to individually identify the ownership structure of a given health sub-sector, which may lead to underestimates of private equity involvement. There is also a lag in recognition and scholarship within health-related fields, particularly outside of the United States, on the extent of private equity activity within healthcare, how it operates, and particularly the effects it has on individual health and wellbeing outcomes.

There is, however, sufficient evidence for policymakers to be concerned about the potential negative impact that private equity can have and to consider whether, and to what extent, regulatory intervention is called for in their respective contexts. To date, there is scant research investigating the policy responses from a health systems or policy perspective. The primary aims of this study were a) to identify examples of such proposed or implemented policy options in selected countries in North America (US and Canada) and Europe (Finland, France, Germany, Ireland, and The Netherlands), and b) to elucidate the options available to policymakers who are considering intervening in healthcare markets in which private equity has a presence.

2. Methods

We conducted a narrative review to identify proposed or implemented policy instruments in seven high-income countries to address private equity activity in health care [22]. The search included Canada, Finland, France, Germany, Ireland, The Netherlands and the United States. These countries were selected for several reasons. First, each country has recorded a substantial level of private equity activity in health care in recent years. Second, this work builds on several co--authors' previous work examining private equity activity within Europe [3]. Finally, authors with expertise in specific countries' health systems were invited to collaborate on this paper.

The authors worked independently to review the literature on their respective country case studies. Each author/country expert conducted internet searches for peer-reviewed academic, and grey literature in online databases, including PubMED/MEDLINE, Google, Google Scholar and parliamentary and legislative records. Searches were conducted in June-October 2024, and limited to sources published between 2010 and 2024, given the comparatively recent emergence of private equity in health care in the selected countries, as well as this article's emphasis on public policies to deal with private equity in healthcare. As up-to-date country-specific statutory and regulatory information is not often found in academic literature, we incorporated grey literature, such as media sources, government and non-governmental organization websites, information brochures and analysis from legal and consulting firms, into our searches. Literature was eligible for inclusion if it (a) contained reference to private equity activity within healthcare, and (b) specified an implemented or proposed policy addressing this activity. Since the objective of this narrative review was to identify examples of policy options, and not to systematically review all policy options, we did not track the total number of documents included and excluded from this analysis.

2.1. Policy options framework

Identified policies were grouped according to a policy options framework (Table 1) that we developed based in part on Milton Friedman's writings on government intervention in markets [23]. Friedman identifies three degrees of regulation, and his analysis is helpful in conceptualizing the different ways policymakers can intervene in the operation of private equity firms. The framework builds from the most

Table 1
Conceptual framework for policy options to address private equity involvement.

Category	Definition
1. Disclosure	When governments require organizations to notify the government of their existence or activity.
2a. Regulation: financial arrangements	When governments ensure quality of care by regulating who is able to operate services.
2b Regulation: process	Ensuring quality of care through regulating how care is provided and received.
2c. Regulation: outcomes	Ensuring quality of care through regulating the effects of care on patients and populations, including patient satisfaction.
3. Prohibition	When governments prevent organizations from carrying out specific actions.

Source: Authors.

lenient categories of intervention, namely *disclosure*, then *regulation*, through to the most stringent, *prohibition*. Most of the examples identified fall into the category of *regulation* (adapted from Friedman's category of *licensure*).

Disclosure is when governments require organizations to alert government authorities of their existence or activity. While this is more lenient than the other forms of policy response, it is a necessary first step before enacting more stringent forms. Governments may require a private equity firm to disclose that they own, or intend to acquire, a healthcare entity, or disclose information about a firm's financial behavior in the marketplace.

The category of *regulation* is based, in large part, on ensuring that the quality of care provided to patients meets minimum standards and that prices can be justified based on input costs and, to a larger extent in the European context, to ensure a degree of equity in access, including affordability. While quality was once considered something of a black box, in recent decades great strides have been made in measuring and – certainly as a result – improving the quality of care. Notable early work in this field was done by Avedis Donabedian, who based his view of quality improvement on the three pillars of structure, process, and outcomes [24,25].

Within our framework, regulation is separated into three subcategories. The first is *financial arrangements*. Regulators may choose to disallow vertical financial arrangements that can result in anti-patient conflicts of interest [23]. This is based on Donabedian's pillar of structure, which "denotes the attributes of the settings in which care occurs," (p. 1745) including facilities, staffing, and organization. The other two subcategories are *process*, which "denotes what is actually done in giving and receiving care," (p. 1745) such as a physician's work in diagnosis and treatment; and *outcomes*, or "the effects of care on the health status of patients and populations" (p. 1745) and includes patient knowledge and satisfaction [25].

The most interventionist category is *prohibition*. It can be done directly, by prohibiting private equity firms from purchasing or merging with particular healthcare facilities or other market participants [23]. It can also be done indirectly. As an example, many countries prohibit for-profit insurance companies from selling coverage in the public/-statutory market, indirectly preventing private equity from owning such companies.

3. Results

Looking at the seven case study countries collectively, we identified policy interventions corresponding to all five categories of the policy options framework: 1) Disclosure; 2a) Financial Arrangements; 2b) Regulation: Process; 2c) Regulation: Outcomes; and 3) Prohibition. Individually, however, none of the seven countries recorded interventions in each category, and many of the identified interventions do not specifically target private equity. In addition, many are in the proposal stage, i.e. have not yet been adopted or implemented, as seen in Table 2.

There are examples of policies in the disclosure category in place in each country, aimed at increasing transparency of the role of private equity in health care. Most countries also report interventions to regulate private equity firms' financial arrangements; Ireland and The Netherlands are exceptions. Conversely, interventions to regulate behavior are less prevalent, particularly with regard to private equity firms' behaviors as they impact on patient outcomes. Table 3 presents detailed information on each of the interventions identified in the review. We summarise the key findings in each category of the policy options framework below.

3.1. Disclosure

We identified interventions in the category of disclosure in each of the seven countries covered. The most commonly reported intervention consisted of requirements by national or sub-national authorities that firms notify the relevant authorities and disclose financial information related to mergers and acquisitions above certain thresholds.

In Canada, under the Competition Act, parties must submit a pre-merger notification to the Commissioner of Competition if the transaction exceeds (as of 2024) $93 million CAD, or if the assets or annual gross revenues of parties involved in the merger exceed a certain threshold [26,27]. The Commissioner may review any merger, regardless of size, within one year of the merger date.

Under the Finnish Competition Act, notification of a merger to the Finnish Competition and Consumer Authority (FCCA) is required if the combined turnover of the parties generated in Finland exceeds €100 million and the turnover generated in Finland by at least two of the parties exceeds €10 million each.

In France, since 2009, proposed merger and acquisitions involving companies with worldwide turnover of more than €150 million and turnover in France of more than €50 million - for at least two companies involved in the merger - must be declared to the French antitrust authority. Review by the antitrust authority results in one of three possible outcomes: an approval, an approval subject to conditions that the company must comply with, or a ban.

In Ireland, the Competition and Consumer Protection Commission (CCPC) requires merging parties to notify of transactions where two firms generate more than €10 million in Ireland, with a combined turnover of €60 million [28]. Since 2023, the CCPC requires merging parties to notify it of 'below threshold deals' where an effect on competition in a given market may occur.

In The Netherlands, proposed mergers and acquisitions must be reported to the Authority for Consumers and Markets (ACM) if the merging companies have an annual turnover of €150 million or more globally; or if two of the merging companies have an annual turnover of €30 million in The Netherlands. In addition, the Dutch Healthcare Authority must approve mergers in healthcare when an acquired organization has >50 employees. In May of 2024, the ACM indicated that it would like to have the authority to examine mergers below the €30 million threshold.

Table 2
Existence and status of policy interventions in private equity markets across seven case study countries.

Country	Disclosure	Regulation			Prohibition
		Financial arrangements	Behavior (process)	Behavior (outcomes)	
Canada	Y	Y			Y
Germany	Y	Y			Y*
Finland	Y*	Y*			
France	Y	Y*	Y*		
Ireland	Y		Y		Y*
Netherlands	Y*			Y	
United States	Y	Y*	Y*		Y

Note: 'Y' indicates the existence of at least one intervention in a given policy options category. An asterisk (*) indicates that one or more interventions in the category are in the proposal stage or have not yet been implemented.
Source: Authors.

Table 3
Mapping policy interventions addressing private equity firms' activity in health care across seven countries.

	Disclosure	Regulation			Prohibition
		Financial arrangements	*Behavior (process)*	*Behavior (outcome)*	
CA	1) Parties must submit a pre-merger notification to the Commissioner of Competition if the transaction exceeds $93 million CAD, or if the assets or annual gross revenues of parties involved in the merger exceed a certain threshold. The Commissioner may review any merger, regardless of size, within one year of the merger date.	1) Certain provinces specify that only health profession corporations can provide health profession services. Health profession corporations are those in which the sole or majority shareholder is a member of a regulated health profession. For example, private, non-hospital surgical facilities in Quebec must be owned and controlled by practicing physicians.			1) The Ontario *Fixing Long-Term Care Act* of 2021 prohibits non-profit entities from transferring long-term care licenses or beds to for-profit entitles except in the circumstance that such a transfer is specified within the license, or the non-profit entity is in default on preexisting obligations. The same act prohibits non-profit entities from issuing or transferring shares to for-profit entitles, with similar exceptions.
DE	1) The German Federal Council had noted in 2018 that corporatist-like, profit-oriented structures are increasing across the primary healthcare system in Germany, potentially leading to poorer access to care. What is problematic in Germany is that most acquisitions of primary care practices by PEFs go unnoticed as the threshold for an acquisition to be disclosed to the anti-monopoly office is at €17.5 million. Euro yearly turnover, and most practices are below this.	1) The Social Health Insurance Act of 2012 imposed restrictions on acquisitions of ambulatory healthcare centres (MVZs), limiting ownership to physicians, hospitals and providers of dialysis centres. [This did not deter private equity firms from acquiring MVZs]			1) In 2022, the Federal Minister of Health announced a law prohibiting PE acquisitions of MVZs forthcoming in 2023. At the time of writing (third quarter of 2024), this law has not yet been brought forward.
FI	1) Under the Finnish Competition Act (948/2011), notification of a merger to the Finnish Competition and Consumer Authority is required if the combined turnover of the parties generated in Finland exceeds €100 million and the turnover generated in Finland by at least two of the parties exceeds €10 million each. 2) Proposed intervention in FI (see *Financial arrangements No.2*) includes *Disclosure* element.	1) The FCCA is empowered to assess whether a proposed transaction would result in a significant impediment to competition in the Finnish market. If a merger is found to have such adverse effects, the FCCA may approve the merger with conditions; or, if the parties do not come up with effective remedies, propose to the Finnish Market Court that the merger be prohibited. 2) To address roll-up acquisitions occurring *below* the statutory thresholds, the FCCA has proposed adoption of a 'call-in power'. This would empower the FCCA, under certain circumstances, to require parties to disclose mergers that fall below the statutory turnover thresholds. The call-in power would enable the FCCA to scrutinize, for example, roll-up acquisitions that may have anti-competitive effects, particularly in local markets.			
FR	1) Since 2009, proposed merger and acquisitions involving companies with worldwide turnover of more than €150 million and turnover in France of more than €50 million - for at least two companies involved in the merger - must be declared to the French antitrust authority, unless it is the responsibility of the European Commission. Review can result in 3 outcomes: an approval, an approval subject to conditions	1) To avoid extreme consolidation and the risk of a multiplication of (unnecessary) biological examinations, Law 2013–442 (article 11), specific to the sector of medical biology, empowers regional authorities to block the opening of a medical laboratory if it would increase the supply of biological services to >25 % above population needs.	1) To limit the presence and the market power of private equity funds in the medical biology sector, and to ensure that biologists stay in control of their practice, Law 2013–442 (article 10) requires the majority of shared capital and voting rights to be held directly or indirectly by medical biologists practicing within the company. Also, the capital cannot be shared by >25 % with people or companies outside of the medical biology sector. These rules also		

(*continued on next page*)

Table 3 (*continued*)

	Disclosure	Regulation			Prohibition
		Financial arrangements	*Behavior (process)*	*Behavior (outcome)*	
	that the company must comply with, or a ban.		apply to the radiology sector since 1990 through the regulation of private companies of self-employed professionals.		
	2) In 2023, a law was adopted to protect companies of regulated liberal professions (i.e. justice, veterinarians, notaries and health practitioners) from takeovers by private equity funds, by increasing transparency on the ownership of companies and the composition of their capital. In practice, these elements must be sent each year to the representatives of each profession (e.g. the "French medical association" for doctors), who must ensure the independence of liberals.	2) Abusive dominant market positions in the medical biology sector are also addressed by authorising regional authorities to block any proposed merger or acquisition plan that would result in the acquiring company holding a market share of 25 % or above. [However, in practice, it has not been possible to achieve the ambitions set out in the law due to a delay in the publication of the decrees and a lack of information from the regional authorities.]	2) A report by the French Senate on the financialization of healthcare published in September 2024 formulates 18 regulatory recommendations, including greater protection of practitioners' decisions by ending the misappropriation of voting rights by private equity funds through the creation of preferred shares. Among others, the report also recommends a minimum investment period for private equity funds when they invest in private liberal companies in order to prevent the sudden withdrawal of capital in speculative strategies.		
	3) French authorities have set up an interministerial task force to increase knowledge on financialisation in the health sector and quantify the phenomenon. The French National Health Insurance contributes to this task force and on top of that, advocates for the creation of a National Observatory of the financialisation of the healthcare system.				
IE	1) Managers of private equity funds must be registered with and authorised by the Central Bank of Ireland and satisfy compliance requirements.		1) Qualifying Investor Alternative Investment Funds (QIAIFs) are among the most common type of AIF authorised by the Central Bank of Ireland (CBI). A QIAIF can only be invested in by professional investors (i.e. no retail investors) subject to a minimum initial subscription for €100,000 or the equivalent in foreign currency. In exchange for registering and complying with the Central Bank of Ireland as a QIAIF, the private equity fund gains access to an EU-wide marketing 'passport'.		1) The Screening of Third Country Transactions Act 2023 (the Foreign Direct Investment Act or STCTA, expected to come into effect in Q4 2024) empowers Ireland's Minister for Enterprise, Trade and Employment to prohibit or impose conditions on transactions that meet the following criteria: 1) Acquirer is from outside the Single Market; 2) Low value of transaction threshold is met: the cumulative 'value of the transaction' and other transactions between the parties is at least €2 million in a period of 12 months before the date of the transaction; 3) Not an internal reorganisation; 4) Transaction relates to, or impacts on, one or more critical sectors (as defined by the EU Critical Entities Resilience Directive (CER)), including healthcare.
	2) Residential long-term care service providers must register with the Health Information and Quality Authority (HIQA) and provide details of ownership and any changes to ownership				
	3) Since 2023, the Competition and Consumer Protection Commission (CCPC) requires merging parties to notify of 'below threshold deals' where an effect on competition in a given market may occur. The				

(*continued on next page*)

Table 3 (*continued*)

	Disclosure	Regulation			Prohibition
		Financial arrangements	*Behavior (process)*	*Behavior (outcome)*	
	current thresholds are deals where two firms generate more than €10 million in Ireland, with a combined turnover of €60 million.				
NL	1) Proposed mergers and acquisitions must be reported to the Authority for Consumers and Markets (ACM) if the merging companies have annual turnover of €150 million or more globally; or if two of the merging companies have an annual turnover of €30 million in NL.			1) Under Dutch law, healthcare insurance companies have an obligation to ensure the continuity of care for their clients. When an insurer judges a care provider to provide inadequate care, e.g. because of inadequate staffing, it can postpone or deny payments to that provider.	
	2) The ACM has indicated in May of 2024 that it would like to have the authority to examine mergers below the €30 million threshold. In addition, the Dutch Healthcare authority must approve mergers in healthcare when an acquired organization has >50 employees.				
US	1) State of New York requires healthcare organizations to notify the state Department of Health about mergers, acquisitions, contracts, partnerships, and joint ventures at least 30 days in advance of the transaction. Applies to all transactions that exceed $25 million over a 12-month period.	1) A legislative proposal in the State of Oregon would prevent those in charge of private equity companies from holding positions in a medical corporation, to help ensure that medical decisions are made by health professionals.	1) Two U.S. Senators have introduced a bill that would create a new penalty of up to 6 years in prison for private equity "executives who loot healthcare entities, e.g. nursing homes and hospitals, if that looting results in a patient's death." It also allows for the clawback of all compensation to private equity executives over a 10-year period if the acquired entity "experiences serious, avoidable financial difficulties due to that looting."		1) The State of Minnesota prohibits private equity firms and real estate investment trusts from acquiring or increasing ownership in healthcare entities after 1 August 2024, as well as acquiring or increasing operational control over providers.
	2) Federal government requires nursing homes accepting Medicare/ Medicaid patients to report detailed ownership and operating information	2) Proposed legislation in California would prevent private equity firms that are involved with medical, dental, or psychiatric practices from interfering with professional judgments of practitioners.			

Source: Authors.

In the United States, the State of New York requires healthcare organizations to notify the state Department of Health about mergers, acquisitions, contracts, partnerships, and joint ventures at least 30 days in advance of the transaction; this applies to all transactions that exceed $25 million over a 12-month period [29].

Concerned that private equity transactions in the health sector are falling below existing thresholds, and thereby circumventing the need to notify authorities, some countries are calling for the lowering of notification thresholds and the strengthening of relevant authorities' powers. In Germany, for example, the German Federal Council noted in 2018 that corporatist-like, profit-oriented structures are increasing in primary care, potentially leading to poorer access to care. However, most acquisitions of primary care practices by private equity funds go unnoticed as the threshold for an acquisition to be disclosed to the anti-monopoly office is at €17.5 million yearly turnover of the acquired company, and most practices are below this [30].

In Finland, the FCCA has proposed adoption of a 'call-in power' to address, inter alia, roll-up acquisitions. This would empower the FCCA, under certain circumstances, to require parties to disclose mergers that fall below the statutory turnover thresholds. The call-in power would enable the FCCA to scrutinize, for example, roll-up acquisitions that may have anti-competitive effects, particularly in local markets [31,32].

Other interventions identified in the area of disclosure include Ireland's requirement that all residential long-term care providers register with the Health Information and Quality Authority (HIQA) and provide details of ownership and changes to ownership [33].

Similarly, in the United States, the federal government requires nursing homes accepting patients with Medicare or Medicaid health insurance to report detailed ownership and operating information [34].

Lastly, in France, a law was adopted in 2023 to protect certain self-employed professionals, notably including healthcare providers, from takeovers by private equity funds by increasing transparency of the ownership of companies and the composition of their capital [35]. In practice, these elements must be sent each year to the representatives of each profession (e.g. the "French medical association" for doctors), who must ensure the independence of liberal (i.e., autonomous) professions. French authorities have set up an inter-ministerial task force to increase knowledge on financialization in the health sector and quantify the phenomenon [36]. The French National Health Insurance Fund contributes to this task force and on top of that, advocates for the creation of

a National Observatory of the financialization of the health system.

3.2. Regulation

3.2.1. Financial arrangements

Implemented or proposed policy interventions in the category of financial arrangements were identified in five of the seven reported countries. This makes it the most common type of intervention reported after disclosure. Interventions in this category largely took one of three forms: prohibiting non-medical professionals from directly operating health services, as in some Canadian provinces; preventing (total) private ownership of certain kinds of healthcare providers, as in Germany and the United States; and empowering government authorities to prevent *below threshold* mergers and acquisitions in specific circumstances, as reported in Finland and France.

In certain Canadian provinces, only health profession corporations can provide health profession services. Health profession corporations are those in which the sole or majority shareholder is a member of a regulated health profession. For example, private, non-hospital surgical facilities in Quebec must be operated by practicing physicians, or 50 % of shareholders must be physicians [37,38]. Private equity firms can potentially work around this requirement, however, by acting as a management corporation offering services to health profession corporations.

In Germany, following the establishment of ambulatory healthcare centres (MVZs) in 2004, private equity firms bought out these types of entities at scale, ultimately occupying a major market share of the primary healthcare sector. In response, Germany passed the Social Health Insurance Act of 2012, imposing restrictions on such acquisitions by limiting ownership of MVZs to physicians, hospitals, and providers of dialysis centres [39]. Evidence suggests, however, that the legislation has not effectively deterred private equity firms from acquiring MVZs and additional interventions are being called for. In 2022, the Federal Minister of Health announced that a law specifically prohibiting private equity acquisitions of MVZs would be forthcoming in 2023. At the time of writing (third quarter of 2024), however, this law had not yet been proposed.

In the United States, proposed legislation in the state of Oregon would prevent managers of private equity firms from holding management/board positions in a medical corporation, to ensure that clinical, medical decisions are made by health professionals [40]. Somewhat similarly, proposed legislation in the state of California would prevent private equity firms invested in medical, dental, or psychiatric practices from interfering with professional judgments of health practitioners [41].

Finland and France have both empowered national or regional authorities to prevent mergers and acquisitions in certain cases. Finland's FCCA does not intervene in mergers involving private equity firms per se, but assesses whether a proposed transaction would result in a significant impediment to effective competition in the Finnish market. If a merger is found to have such adverse effects, the FCCA may approve the merger with conditions, or, if the parties do not come up with effective remedies, propose to the Finnish Market Court that the merger be prohibited [42].

Horizontal mergers, i.e. mergers involving companies operating within the same market, are considered the most potentially harmful, as they directly reduce the number of competitors and eliminate direct competitive pressure. Harmful horizontal effects may arise, for instance, when a private equity firm acquires several companies within a specific sector, such as healthcare, and thereby strengthens its market position in a manner detrimental to competition and, ultimately, to consumers. To address recent proliferation of roll-up acquisitions—where private equity firms engage in serial acquisitions of small or mid-sized companies within the same market—that are below the statutory turnover threshold, the FCCA has proposed the adoption of a call-in power. This would empower the FCCA, under certain circumstances, to require parties to notify mergers that fall below the statutory thresholds. The call-in power would enable the FCCA to scrutinize, for example, roll-up acquisitions that may have anti-competitive effects, particularly in local markets [42].

To prevent extreme consolidation and the risk of a proliferation of (unnecessary) laboratory examinations, France has introduced legislation specific to medical laboratories, providing regional authorities with the right to block the opening of a new medical laboratory if it would increase the supply of laboratory services to >25 % above the population's healthcare needs [43]. Potentially dominant market positions are also addressed by allowing regional authorities to block any proposed merger or acquisition that would result in the acquiring company holding a market share of 25 % or above. In practice, however, it has not been possible to achieve the ambitions set out in the law, due to a delay in the publication of legislation and a lack of information forthcoming from regional authorities.

3.2.2. Processes

Interventions regulating private equity behavior at the process level exist in France, Ireland and the United States. In France, legislation limits the presence and market power of private equity funds, specifically in the laboratory sector, aiming to ensure that professionals stay in control of their clinical practice [43]. The law requires that the majority of shared capital and voting rights of laboratory services be held directly or indirectly by professionals practicing within the company. Also, >25 % of capital cannot be shared with individuals or companies operating outside of the laboratory sector. Since 1990, these restrictions also apply to the radiology sector through the regulation of private companies held by self-employed professionals, including healthcare professionals. In practice, private equity companies can bypass this regulation through the creation of preference shares or secret shareholder agreements that separate voting rights from the financial rights attached to shares held. In doing so, it becomes possible for private equity firms to confer 75 % of the voting rights to clinical practitioners, yet retain virtually all the financial rights for the firm, thereby exerting control over the company. A report by the French Senate on the financialization of healthcare, published in September 2024, formulates 18 regulatory recommendations, including greater protection of practitioners' decisions by ending the misappropriation of voting rights by private equity funds through the creation of preferred shares [36]. Among others, the report also recommends a minimum investment period for private equity funds when they invest in private companies to prevent the sudden withdrawal of capital in speculative strategies.

In Ireland, what are known as Qualifying Investor Alternative Investment Funds (QIAIFs) are among the most common type of AIF authorised by the Central Bank of Ireland. Regulation stipulates that a QIAIF can only be invested in by professional investors (i.e. no retail investors), subject to a minimum initial subscription for €100,000 or the equivalent in foreign currency. In exchange for registering and complying with the Central Bank of Ireland as a QIAIF, the private equity fund gains access to an EU-wide marketing 'passport' [44].

In the United States, federal legislation has been proposed "to root out corporate greed and private equity abuse in the health care system." It would create a new penalty of up to 6 years in prison for "executives who loot health care entities like nursing homes and hospitals, if that looting results in a patient's death" [45]. It would also allow for the claw-back of all compensation to private equity executives over a 10-year period if the acquired entity "experiences serious, avoidable financial difficulties due to that looting." However, this legislation is very unlikely to pass.

3.2.3. Outcomes

One instance of regulation to address private equity behavior specifically and its impact on outcomes was identified. Under Dutch law, healthcare insurance companies have an obligation to ensure the continuity of care for their clients. When an insurer determines that a care

provider has provided inadequate care, for example as a result of inadequate staffing, it can postpone or even deny payments to that provider. In the case of CoMed, a private provider of GP care, several health insurers canceled their contracts with this company, denying it further payments for its services on the grounds that it could not deliver the required quality of care. This led to the bankruptcy of the company in 2024.

3.3. Prohibition

Four of the countries exhibited regulatory activity in the third and most stringent of the policy option categories in our framework: Canada, Germany, Ireland, and the United States. Of these, Germany's is not yet even in the legislative proposal phase, and Ireland's has been enacted, but has not yet come into effect/been implemented. The US example applies to only one state in the country.

At the sub-national level in Canada, Ontario has prohibited non-profit entities to transfer long-term care licenses or beds to for-profit entities, or issue shares to them [46]. In Germany, as noted earlier in the section on Regulation, in 2022 the Federal Minister of Health called for a law prohibiting private equity firms from acquiring primary healthcare centres. For the present, however, no such law has been developed or proposed.

In Ireland, the Screening of Third Country Transactions Act 2023 (the Foreign Direct Investment Act or STCTA), which came into effect on 6 Janurary 2025, empowers Ireland's Minister for Enterprise, Trade and Employment to prohibit or impose conditions on transactions that meet certain criteria. They include that 1) the acquirer is from outside the European Single Market, 2) that the low value of transaction threshold is met, i.e. the cumulative value of the transaction and other transactions between the parties is at least €2 million in a period of 12 months before the date of the transaction, 3) that it is not an internal reorganization, and crucially, that 4) the transaction relates to, or impacts on, one or more critical sectors including healthcare [47].

Lastly, the state of Minnesota in the United States proposed legislation to prohibit private equity firms and real estate investment trusts from acquiring or increasing ownership in healthcare entities. It would have also prohibits private equity firms from acquiring or increasing operational control over healthcare providers, however it was not implemented [48].

4. Discussion

The primary purpose of this study was to identify examples of implemented and proposed policy options for regulating private equity activity within healthcare markets, using a novel policy framework for categorizing policy examples across seven countries. In this section we briefly summarize the findings, consider future research needs, and discuss limitations of the study's design.

4.1. Summary of findings

The most common type of policy option identified is requiring some form of disclosure. Among the seven countries examined in this study, each has implemented disclosure requirements that affect the private equity market in healthcare, although most examples did not single out private equity specifically. In most cases, regulatory agencies must be notified if mergers or acquisitions exceed a monetary threshold. Regulation of financial arrangements has either been implemented or proposed in five of the seven countries. The policies vary, with a number of them providing protections for healthcare professionals to maintain clinical decision-making control or restricting the activity of private equity firms in certain healthcare sub-sectors. We identified proposed or implemented policy examples related to the behavior of firms in four of the seven countries, and a single example from one country related to patient outcomes. Finally, prohibition of private equity involvement in healthcare is in the incipient stage. We report on efforts in three countries, but none of them yet have been fully implemented or have cast a wide net nationally. These findings show that the countries included in this analysis are to varying extents addressing private equity in healthcare markets, with most focusing on disclosure. The findings also indicate that many policies are still in the proposal stage–especially true in the United States–and even in those countries where they have been enacted, many have yet to be fully implemented. Finally, there is a need to develop evaluation frameworks to determine the impact of implemented policies aimed at addressing private equity activity in health care.

4.2. Future research

There is growing concern about the role of private equity funds within healthcare markets, particularly regarding the consequences for accessing services and providing quality care, but also – at least in the United States – the potential for higher consumer prices. As demonstrated in Table 3, most of the seven countries are embarking on developing policies to regulate private equity firms in health care. However, we did not identify any proposed or implemented policies from Canada which specifically regulate private equity. Most identified policies are recent or are only in the process of being developed and therefore their effectiveness has not yet been tested.

The first need for future research is to collect data on other countries' policy efforts, as undoubtedly there is activity beyond the seven countries considered here. With information from more countries, it will be easier to determine any patterns in the types or degree of regulations that are being proposed and implemented, as well as whether particular types of health systems have been more amenable to private equity involvement and regulation. It will be noteworthy to see which of the policy realms – disclosure, regulation, or prohibition – are garnering the most legislative and regulatory attention outside of the seven countries covered here. Over time, of course, research is needed to carefully track the impact of private equity takeovers.

A second research need is to consider the role supranational organizations can play in regulating private equity involvement in healthcare and long-term care. This is particularly relevant to the European Union, as supranational regulation can be both more efficient and consistent across countries.

Research is needed to address what policies work – and do not work – in regulating private equity. This requires careful studies of the implementation and efficacy of alternative policies. On a related note, it remains largely unanswered whether regulatory measures that limit private equity investments have the desired effects. Do they work towards bringing about better access and equity, or alternatively, might they have the opposite effect, for example, by acting to restrict the provision of healthcare services in areas that are already underserved?

Finally, there is a need to study the possible knock-on effects – if any – that a federal law on regulating private equity investments in one country, e.g. the one currently under discussion in Germany [49], might have for other countries and their health systems and health financing streams, especially across a single market like the European Union.

4.3. Limitations

This study has several limitations. First, it only examines seven countries, all from Europe and North America, which were chosen according to the authors' expertise. While we focused on countries with known private equity activity in healthcare, this does not mean that omitted countries have experienced less such activity. Furthermore, our aim was not to systematically identify all policies that affect private equity activity within the even countries, but to identify examples. For these reasons, the results are not comprehensive.

Second, in most cases, we limited the review to private equity's involvement in countries' mandatory or statutory healthcare systems.

We did not focus on the private sector outside of that realm with the exception of long-term/social care. Dental care in most countries is an example.

Third, in countries with more decentralised health systems, we focused on national rather than subnational (e.g., provincial) reform, although again, an exception was the United States, where nearly all activity has been at the state level, and Canada, with regulation at both levels.

Fourth, regarding our analysis framework, the regulation sub-categories (financial arrangements, process and outcomes) are to some extent overlapping and the examples could be grouped into more than one sub-category (e.g., adequate staffing), making an explicit assessment along the regulation sub-types difficult.

Lastly, due to the newness of most private equity regulatory policies, we were unable to address whether policies have had any noticeable impact on private equity investment in healthcare. However, as stated, most policies have yet to be implemented, and efficacy remains an open question.

5. Conclusions

This review of seven high-income countries identified proposed and implemented policies which aim to address private equity activity within health systems. The research demonstrates that states are acting to address this issue. Most of the policies addressed the disclosure of mergers and acquisitions, while some addressed regulatory matters, and few were outright prohibitions on healthcare activity. Importantly, few policy options have been implemented, and none have been evaluated. Future research is required in order to better understand the breadth of policies and their effectiveness.

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CRediT authorship contribution statement

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Declaration of competing interest

None

References

[1] Borsa A, Bejarano G, Ellen M, Bruch JD. Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: systematic review. The BMJ 2023;382:e075244. https://doi.org/10.1136/BMJ-2023-075244.
[2] Nolte TN, Miedaner F, Sülz S. Physicians' perspectives regarding private equity transactions in outpatient health care-A scoping review and qualitative analysis. Int J Environ Res Public Health 2022;19(15480). https://doi.org/10.3390/ijerph192315480.
[3] Rechel B, Tille F, Groenewegen P, Timans R, Fattore G, Rohrer-Herold K, Rajan D, Lopes S. Private equity investment in Europe's primary care sector-a call for research and policy action. Eur J Public Health 2023;33(3):354–5. https://doi.org/10.1093/EURPUB/CKAD061.
[4] Feldman M, Kenney M. Learning from the United States' experience: private equity and financing healthcare in Canada. Healthc Manage Forum 2024;37(6):440–4. https://doi.org/10.1177/08404704241268414. Epub 2024 Aug 2. PMID: 39092572.
[5] Cai C, Song Z. A policy framework for the growing influence of private equity in health care delivery. JAMA 2023;329(18):1545. https://doi.org/10.1001/JAMA.2023.2801.
[6] Scheffler R.M., Alexander L.M., Godwin J.R. Soaring private equity investment in the healthcare sector: consolidation accelerated, competition undermined, and patients at risk. Washington, D.C.: American Antitrust Institute. 2021 May 18. Available from: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3860353.
[7] Offodile II AC, Cerullo M, Bindal M, Rauh-Hain JA, Ho V. Private equity investments in health care: an overview of hospital and health system leveraged buyouts, 2003–17. Health Aff 2021;40(5):719–26. https://doi.org/10.1377/hlthaff.2020.01535.
[8] Bain & Company. Global healthcare private equity report 2024. 2024. Accessed October 5, 2024, https://www.bain.com/globalassets/noindex/2024/bain_report_global_healthcare_private_equity_2024.pdf.
[9] Bruch JD, Roy V, Grogan CM. The financialization of health in the United States. N Engl J Med 2024;390(2):178–82. https://doi.org/10.1056/NEJMMS2308188.
[10] American Investment Council. A partner to Health care: how private equity complements and strengthens the health Care industry. Washington, D.C: American Investment Council. 2024Feb. Available from: https://www.investmentcouncil.org/wp-content/uploads/2024/01/AIC-2023-Health-Care-Report.pdf.
[11] Beyer KM, Demyan L, Weiss MJ. Private equity and its increasing role in US healthcare. Adv Surg 2022;56(1):79–87. https://doi.org/10.1016/j.yasu.2022.02.003.
[12] Frances C. Private equity investment in health care. JAMA 2019;322(5). https://doi.org/10.1001/JAMA.2019.7844. 468-468.
[13] Rao V, Shaffrey EC, Attaluri PK, Wirth PJ, Rao VK. The looming future of private equity in plastic surgery. Aesthet Surg J 2023;44(4):428–35. https://doi.org/10.1093/asj/sjad384.
[14] Robbins CJ, Rudsenske T, Vaughan JS. Private equity investment in health care services. Health Aff 2008;27(5):1389–98. https://doi.org/10.1377/hlthaff.27.5.1389.
[15] McKeon KE, Wei DH. Private equity: an emerging practice model. J Hand Surg Am 2023;48(10):1051–5. https://doi.org/10.1016/J.JHSA.2023.06.015.
[16] Powers BW, Shrank WH, Navathe AS. Private equity and health care delivery: value-based payment as a guardrail? JAMA 2021;326(10):907–8. https://doi.org/10.1001/JAMA.2021.13197.
[17] Bruch JD, Gondi S, Song Z. COVID-19 and private equity investment in health care delivery. JAMA Health Forum 2021;2(3):e210182. https://doi.org/10.1001/JAMAHEALTHFORUM.2021.0182.
[18] Fuse Brown E, Hall M. Private equity and the corporatization of health care. Stanf Law Rev 2024;76:527–96. https://papers.ssrn.com/abstract=4373557.
[19] Matthews S, Roxas R. Private equity and its effect on patients: a window into the future. Int J Health Econ Manag 2023;23:673–84. https://doi.org/10.1007/s10754-022-09331-y.
[20] Scheffler R.M., Alexander L., Fulton B.D., Arnold D.R., Abdelhadi O.A. Monetizing medicine: private equity and competition in physician practice markets. Washington, D.C.: American Antitrust Institute. 2023 Jul 10. Available from: https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf.
[21] Cerullo M, Yang KK, Roberts J, McDevitt RC. Offodile II AC. Private equity acquisition and eesponsiveness to service-line profitability at short-term acute care hospitals. Health Aff (Millwood) 2021;40(11):1697–705. https://doi.org/10.1377/HLTHAFF.2021.00541.
[22] Sukhera J. Narrative reviews: flexible, rigorous, and practical. J Grad Med Educ 2022;14(4):414–7. https://doi.org/10.4300/JGME-D-22-00480.1.
[23] Friedman M. Capitalism and freedom. Chicago: University of Chicago Press; 1982.
[24] Donabedian A. Explorations in quality assessment and monitoring. Washington, D.C.: Health Administration Press; 1980.
[25] Donabedian A. The quality of care: how can it be assessed? JAMA 1988;260(12):1743–8. https://doi.org/10.1001/JAMA.1988.03410120089033.
[26] Competition Act, R.S.C., 1985, c. C-34. 1985. Available from: https://laws-lois.justice.gc.ca/eng/acts/c-34/fulltext.html.
[27] Competition Bureau Canada. Pre-merger notification transaction-size threshold to remain at $93M in 2024. Ottawa: Competition Bureau Canada. Avalable from: https://www.canada.ca/en/competition-bureau/news/2024/02/pre-merger-notification-transaction-size-threshold-to-remain-at-93m-in-2024.html.
[28] *Competition (Amendment) Act,* No. 12. 2022.Available from: https://enterprise.gov.ie/en/legislation/competition-amendment-act-2022.html.

[29] N.Y. Pub. Health Law, § 4552. 2023. Available from: https://www.nysenate.gov/legislation/laws/PBH/4552.
[30] Bundeskartellamt. Obligation to notify a merger and key aspects of merger control. Bonn: Bundeskartellamt. 2024. Available from: https://www.bundeskartellamt.de/EN/Tasks/Merger_control/Obligation_notify/obligation_notify_key_aspects_node.html.
[31] Kilpailu-ja kuluttajavirasto. Markkinoiden Haitallisen Keskittymisen Torjuntaan Tarvitaan Tehokkaampia Työkaluja. Helsinki: Kilpailu-ja kuluttajavirasto. 2024 May 22. Available from: https://www.kkv.fi/tutkimus-ja-vaikuttaminen/julkaisut/policy-brief-sarja/markkinoiden-haitallisen-keskittymisen-torjuntaan-tarvitaan-tehokkaampia-tyokaluja-policy-brief-1-2024/.
[32] Buri R, Heinonen M, Parhiala T, Pietola M, Syrjälä S. Selvitys Yrityskauppa-Valvonnan Ilmoitusvelvollisuuden Muutostarpeista. Helsinki: Kilpailu-ja kuluttajavirasto; 2021 Jul. Available from: https://www.kkv.fi/uploads/sites/2/2021/11/2021-kkv-selvityksia-7-2021-selvitys-yrityskauppavalvonnan-ilmoitusvelvollisuuden-muutostarpeista.pdf.
[33] Provider Portal. Health Information and Quality Authority. 2024. https://www.hiqa.ie/guidance-providers/provider-portal.
[34] Department of Health and Human Services. *Medicare and Medicaid programs; disclosure of ownership and additional disclosable parties' information for skilled nursing facilities and nursing facilities*. Washington, D.C.: Department of Health and Human Services. 2023 Nov 17. Available from: https://www.federalregister.gov/documents/2023/11/17/2023-25408/medicare-and-medicaid-programs-disclosures-of-ownership-and-additional-disclosable-parties.
[35] *Relative à l'exercice En Société Des Professions Libérales Réglementées.* N° 2023-77. 8 Feb 2023. Available from: https://www.legifrance.gouv.fr/jorf/id/JORFTEXT000047106119.
[36] Imbert C, Henno O, Jomier B. Rapport d'information fait au nom de la comission des afaires sociales (1) sur la financiarisation de l'offre de soins. Paris: Sénat. 2024 Sep 25. Available from: https://www.senat.fr/rap/r23-776/r23-7761.pdf.
[37] Loi Sur Les Services de Santé et Les Services Sociaux, S-4.2. 2023. Available from: https://www.legisquebec.gouv.qc.ca/fr/document/lc/s-4.2.
[38] Allin S, Sherar M, Church Carson M, et al. Public Management and Regulation of Contracted Health Services. North American Observatory on Health Systems and Policies; 2020. Available from: https://naohealthobservatory.ca/wp-content/uploads/2020/02/NAO-Rapid-Review-23_EN.pdf.
[39] Bobsin R. Private Equity im Bereich der Gesundheits- und Pflegeeinrichtungen in Deutschland: Grundlagen, Entwicklungen und Kontroversen. Hannover: Offizin Verlag; 2021.
[40] *Relating to the Practice of Health Care; Prescribing an Effective Date,* HB 4130B. 2024. Available from: https://olis.oregonlegislature.gov/liz/2024R1/Measures/Overview/HB4130.
[41] Health Care System Consolidation, AB-3129. 2024. Available from: https://calmatters.digitaldemocracy.org/bills/ca_202320240ab3129.
[42] *Competition Act.* No. 948/2011. 2011. Available from: https://www.kkv.fi/en/competition-affairs/competition-act/.
[43] *Portant Réforme de La Biologie Médicale*, LOI n°2013-442. 2013. Available from: https://www.legifrance.gouv.fr/loda/id/JORFTEXT000027478077.
[44] Central Bank of Ireland. AIF Rulebook. Dubland: Central Bank of Ireland; 2024. Available from: https://www.centralbank.ie/regulation/industry-market-sectors/funds/aifs/guidance.
[45] Elizabeth Warren. Senators Warren, Markey introduce the Corporate Crimes Against Health Care Act of 2024. 2024 Jun 11. Washington, D.C.:Sentaor Elizabeth Warren. Available from: https://www.warren.senate.gov/newsroom/press-releases/senators-warren-markey-introduce-the-corporate-crimes-against-health-care-act-of-2024.
[46] *Fixing Long-Term Care Act, 2021,* S.O 2021, c. 39, Sched. 1. 2021. Available from: https://www.ontario.ca/laws/regulation/220246.
[47] Kelly T, Lord C, Grace M. Screening of Third Country Transactions Act 2023. Dublin: Mayson Hayes & Curran. Available from: https://www.lexology.com/library/detail.aspx?g=d5b79a90-acde-4546-9a99-f592c87315c1.
[48] Private Equity Companies and Real Estate Investment Trusts Prohibited from Acquiring or Increasing Control over Providers of Health Care Services, MN 2024, HF4206. Available from: https://www.billtrack50.com/billdetail/1712006.
[49] SPD-Politiker hält Ausschluss von MVZ-Investoren für unrealistisch. Deutsches Ärzteblatt [Internet]. 2023. Available from: https://www.aerzteblatt.de/nachrichten/146101/SPD-Politiker-haelt-Ausschluss-von-MVZ-Investoren-fuer-unrealistisch.