

[SCOPING REVIEW]

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Private equity and large-scale investment in healthcare delivery systems: a scoping review

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Abstract

Background: External institutional capital increasingly shapes healthcare delivery, yet evidence is fragmented across sectors, investment structures and outcomes.

Objectives: To map the extent, characteristics, findings and policy implications of research on private equity (PE) and other large-scale investment in care-delivery organisations.

Methods: Following JBI and PRISMA-ScR guidance, PubMed/MEDLINE, Europe PMC and OpenAlex were searched from 1 January 2000 to 22 August 2026, supplemented by citation and targeted policy searches. Eligible empirical studies, reviews and mapped policy syntheses examined institutional investment that changed ownership, control, financing or operating incentives in a delivery organisation. Evidence was charted by country, sector, investment type, design and outcome; heterogeneous findings were narratively synthesised.

Results: Of 1,997 records retrieved, 1,414 remained after deduplication and 117 sources were included. The evidence was 88.0% US-based and 95.7% PE-related; 47.9% appeared in 2025–2026. Physician/specialty practices (42.7%) and hospitals (22.2%) predominated. Comparative studies most consistently associated acquisition or affiliation with higher prices, allowed amounts or spending. Quality effects were heterogeneous, with adverse signals in hospital safety and mortality, nursing-home staffing and outcomes, hospice care intensity and experience, alongside neutral findings in some settings. Reported mechanisms included roll-up concentration, price and volume strategies, staffing or service-line changes, sale-leasebacks and higher clinician turnover.

Conclusions: Binary ownership labels obscure the pathways through which capital affects care. Oversight should link beneficial ownership and transaction finance to longitudinal workforce, service, quality, access and solvency data across acquisition, ownership and exit.

Keywords: private equity; healthcare delivery; financialisation; ownership; investment; scoping review

Received: 17 August 2026

Revised: 23 August 2026

Accepted: 29 August 2026

Published: 01 September 2026

Cite this article

Pallivathukkal JK, Agarwal P, Sasikala SP, Nagarajan MD. Private equity and large-scale investment in healthcare delivery systems: a scoping review. J Evid-Based Med Res. 2026;2(3):13–21.

DOI: <https://doi.org/10.66687/jebmr.2.03.2026.36>

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1. Introduction

External institutional capital has become a consequential form of ownership in healthcare delivery. Private equity (PE) funds now acquire hospitals, physician practices, nursing facilities, hospices and other providers through leveraged buyouts, minority growth investments and platform-and-add-on strategies. Real-estate investment trusts (REITs), infrastructure funds and corporate investment vehicles can separate operating companies from clinical assets or introduce related-party rents. These structures may supply capital, management expertise and scale, but they also impose return targets and finite investment horizons on organisations whose social purpose, payment streams and failure costs differ from those of ordinary firms [6–8].

The policy problem is not simply whether an owner is labelled “private equity.” Ownership chains, debt, management fees, sale-leasebacks, physician-practice management agreements and exit transactions can change incentives without appearing in standard provider datasets. Effects may emerge through negotiated prices, coding and volume, service-line selection, staffing, referral patterns, asset maintenance or closure. Conversely, new capital may expand capacity, professionalise

operations or sustain otherwise fragile providers. These mechanisms vary with payment policy, labour markets, regulation and the acquired organisation’s baseline condition.

The literature has expanded rapidly. A 2023 systematic review found 55 empirical studies, 47 from the United States, and reported the most consistent evidence for higher costs to patients or payers, with mixed evidence on quality [13]. Since then, quasi-experimental studies have examined hospital adverse events and staffing, specialty prices, hospice care intensity, access and REIT transactions; cross-national work has documented more than 8,400 reported PE healthcare deals worth US\$1.4 trillion across 25 OECD countries during 2013–2023 [121]. The evidence is therefore broader but also fragmented across clinical sectors, transaction forms and outcome families.

Contribution of this review. We update and widen the evidence map through 22 August 2026, treating large-scale investment as a family of control, financing and asset structures rather than a single ownership label. We make four contributions: (1) map where evidence exists by country, sector, investment type and design; (2) distinguish primary causal studies from descriptive studies and prior reviews; (3) organise findings through a capital-to-care pathway linking transaction structure to

operational mechanisms and public outcomes; and (4) derive a lifecycle oversight framework spanning entry, ownership, operations and exit. This approach identifies both recurring signals and the limits of generalisation, and it specifies the data needed to test policy responses.

The review asks: What forms of external institutional investment in healthcare delivery have been studied; what delivery, financial, workforce, access and quality outcomes have been reported; through which mechanisms are effects plausibly transmitted; and where are the principal evidence and policy gaps?

2. Methods

2.1 Design and reporting.

We conducted a scoping review using the Arksey-O'Malley framework, subsequent methodological refinements and JBI guidance [1–3]. Reporting follows PRISMA-ScR and the search is documented in accordance with PRISMA-S principles [4,5]. A scoping design was selected because the review addresses heterogeneous transaction forms, sectors, methods and outcomes; effect estimates were not pooled. No protocol was prospectively registered.

2.2 Eligibility.

The population-concept-context framework comprised organisations delivering clinical or long-term care (population); external institutional capital that changed ownership, control, financing or material operating incentives (concept); and any country or care setting (context). Eligible investment forms included PE buyouts or growth equity, PE-backed management service organisations (MSOs) and platforms, REIT or sale-leaseback structures, and other institutional investment when linked directly to a delivery organisation. We included empirical quantitative or qualitative studies, systematic or scoping reviews, and policy or governance syntheses with mapped evidence, published from 1 January 2000 through 22 August 2026. We excluded biotechnology, pharmaceuticals, devices, insurers and digital-health ventures unless a care-delivery organisation was directly controlled; routine public capital grants; generic public-private comparisons without an identifiable investor mechanism; commentaries without mapped evidence; conference abstracts and unverifiable preprints.

2.3 Information sources and search.

PubMed/MEDLINE, Europe PMC and OpenAlex were searched on 22 August 2026. Searches combined investment terms (including private equity, venture or growth capital, financialisation, institutional investment and REITs) with healthcare-delivery settings. OpenAlex was used to broaden interdisciplinary coverage; for each of five queries the first 200 relevance-ranked records were retrieved, or all results when fewer than 200 were available. Targeted grey-literature and citation-chain searches identified regulatory and intergovernmental sources. Exact strings, dates and yields are reported in Table 1.

2.4 Selection and charting.

Records were merged and deduplicated using DOI, PubMed identifier and normalised title. Titles and abstracts were screened against prespecified rules; potentially eligible records underwent a second-pass full-record assessment using bibliographic pages, abstracts and accessible full text. Machine-assisted keyword ranking prioritised records but made no final inclusion decision. For each included source we charted year, country, investment type, delivery sector, design and primary outcome domain. Designs were grouped as quasi-experimental, observational comparative, descriptive/market, systematic/scoping, qualitative/case or policy/governance. Reviews and primary studies were retained to show how the

synthesis base evolved, but reviews were not treated as additional independent observations when describing primary findings.

2.5 Synthesis.

We calculated descriptive frequencies and narratively synthesised patterns within sectors and outcome domains. Directional statements such as “higher” or “lower” were used only where the underlying source reported a comparative association; absence of a pooled effect precludes a common magnitude. A capital-to-care framework was developed iteratively from repeatedly reported mechanisms-leverage and return targets, roll-ups, price or volume strategies, asset separation and labour or service-line changes-and linked to public outcomes. Because the purpose was evidence mapping rather than intervention-effect estimation, no study was excluded by risk-of-bias score; design strength, consistency and limitations were considered in interpretation.

3. Results

3.1 Selection and evidence base.

The searches retrieved 1,997 records (PubMed 647, Europe PMC 513 and OpenAlex 837). After 583 duplicates were removed, 1,414 unique titles and abstracts were screened; 392 reports were sought for full-record assessment, eight were not retrievable or had unverifiable outcomes, and 384 were assessed. We excluded 267 full records, most commonly because they contained no eligible empirical, systematic or mapped policy evidence ($n=206$). The final map comprised 117 evidence sources [9–125] (Figure 1).

The evidence base was recent and geographically concentrated (Table 2; Figure 2). Fifty-six sources (47.9%) appeared in 2025–2026 and 103 (88.0%) focused on the United States. Only 14 sources addressed other or multiple jurisdictions. PE featured in 112 sources (95.7%); REITs and other financing structures were rarely studied independently. Physician and specialty practices were the primary setting in 50 sources (42.7%), followed by hospitals ($n=26$; 22.2%), multi-sector or system-wide analyses ($n=20$; 17.1%), nursing or long-term care ($n=14$; 12.0%) and hospice or home care ($n=7$; 6.0%). Thirty-six studies were quasi-experimental, 28 observational comparative and 33 descriptive/market analyses; the remainder were reviews, qualitative/case studies or policy syntheses.

Evidence outside the United States was dispersed across Germany, Ireland, the United Kingdom, Australia and New Zealand, India, Turkey, Brazil and the Netherlands, plus cross-country analyses [16,27,29,45,60,68,84,88,89,106,114,121,123]. Much of it described investment patterns, financing or governance rather than estimating acquisition effects. The English care-home study linked chain ownership and PE financing to selected quality indicators [106], while Irish, German and Australasian studies mainly documented market entry and institutional context [27,60,88,89,114]. Consequently, regulatory and payment-system differences remain plausible effect modifiers rather than tested explanations.

3.2 Market structure and prices.

Descriptive studies consistently documented acquisition clusters and platform consolidation in procedural specialties, emergency medicine, behavioural health, primary care, hospice and home-based care [22,28,33,41,44,49,50,61,66,69,79,82,83,91,101,105,124]. Market penetration was uneven and often locally concentrated. Across OECD countries, outpatient clinics were the dominant target, while hospitals and elder care attracted investment in selected jurisdictions [121]. These patterns matter because local market power, not the investor label alone, shapes bargaining leverage and access.

Comparative evidence most consistently linked PE or corporate affiliation to higher prices, allowed amounts or spending. Examples included anesthesia management contracts [18], multispecialty physician acquisitions [116], dermatology [94], ophthalmology and retina services [96,117], oncology [90], otolaryngology [99], and hospital- or PE-affiliated cardiology and gastroenterology [14]. In the latter study, PE-affiliated prices were 6.0% higher for cardiology and 10.0% higher for gastroenterology procedures than independent-practice prices [14]. After acquisition, physician practices across dermatology, gastroenterology and ophthalmology had an 11.0% higher allowed amount per claim relative to controls [116]. Results were not uniform: PE acquisition of ambulatory surgical centres was not associated with significant changes in cost, volume or unplanned hospital visits [56], and acquisition of primary-care practices did not significantly change low-value service use [120].

Provider-level financial outcomes were distinct from payer spending. One hospital cohort reported higher net income, charges and charge-to-cost ratios after acquisition [55], while other studies documented heterogeneous operating effects, financial vulnerability after resale and differences related to property transactions [11,59,73,109]. These findings indicate that improved reported earnings can coexist with higher payer prices, reduced staffing expenditure or weaker balance-sheet resilience; none of those outcomes alone establishes the welfare effect of a transaction.

3.3 Operations, workforce and service mix.

Evidence suggested several routes from financial strategy to delivery. Hospitals altered services in the direction of revenue opportunity, adding selected profitable technologies and services while being less likely to add or continue some unreliable-revenue services [71]. PE-acquired practices increased advanced-practice-provider representation [58], while a later primary-care study found modest clinician growth accompanied by higher exits, especially among advanced practice providers [51]. Hospital studies reported average reductions in salary expenditure, with substantial variation across firms and departments [110,111]. These findings argue against treating PE as a uniform intervention: business models, baseline assets and local payment conditions modify operational responses.

Asset separation is an underdeveloped but important pathway. REIT ownership of healthcare property is measurable at scale [57]. In a quasi-experimental hospital study, REIT acquisition and leaseback were followed by 31.0% lower total fixed assets and 40.8% lower building assets relative to matched controls; other financial and quality outcomes were less consistently different [59]. Nursing-home research also described shifts toward interest, lease payments and monitoring fees alongside staffing and compliance changes [25].

3.4 Quality, access and continuity.

Quality findings were heterogeneous by setting and measure (Table 3). Hospital evidence included a 25.4% relative increase in Medicare hospital-acquired conditions after acquisition [108], lower emergency-department and intensive-care salary expenditure with higher emergency-department mortality [110], and a 2.7-percentage-point rise in 30-day mortality after common inpatient surgery, driven by failure to rescue [9]. Other studies found no significant change for selected acute medical outcomes [72] or particular procedures and settings [35,36,53–56]. This mix does not support a universal harm claim, but signals were more concerning for staffing-sensitive and emergent care than for narrowly defined elective services.

Long-term-care studies linked PE ownership to lower staffing or quality in several analyses [25,32,43,93,104,106], although results varied with identification strategy and jurisdiction. Hospice studies reported lower visit intensity after acquisition

[52], high profits with low patient-care spending under PE ownership [15], reduced family-reported experience across several domains [122], and persistent opacity in ownership [83]. Access effects were likewise selective: reduced provision of retinal-detachment repair [119], reduced Medicaid labour-and-delivery market share at acquired hospitals [115], and mixed findings for appointment access or insurance acceptance in dermatology, urology and otolaryngology [10,20,48,86].

3.5 Governance and policy evidence.

The literature repeatedly identified incomplete beneficial-owner data, fragmented transaction reporting and limited linkage between ownership, finance, workforce and patient outcomes [17,57,77,80,83,121]. Policy responses have therefore concentrated on disclosure and pre-transaction review, while fewer rules address leverage, related-party transactions, staffing, quality covenants or exit continuity. Recent US interagency scrutiny and European guidance similarly emphasise transparency, purchasing capacity and protection of continuity [126–128]. Figure 3 integrates these concerns into a capital-to-care pathway and lifecycle oversight model.

4. Discussion

4.1 Principal findings.

This review maps a fast-growing but structurally imbalanced literature. The strongest recurring signal is not a single clinical effect but a sequence: investment structures create return and debt obligations; value strategies exploit consolidation, prices, volume, labour or assets; delivery organisations change staffing, services and autonomy; and consequences appear in spending, quality, access and resilience. Price and spending increases were the most consistent comparative findings. Quality and access effects varied, but adverse signals clustered where outcomes depend on workforce intensity, timely rescue, continuity or services with weak margins. Neutral findings in ambulatory surgery, low-value primary care and some disease-specific hospital outcomes are important counterevidence.

The evidence does not justify equating every PE transaction with harm. Selection into acquisition is non-random, investors differ, facilities may be distressed before acquisition, and contemporaneous consolidation by hospitals and corporations creates difficult counterfactuals. Nevertheless, recurrent changes across independent datasets—higher prices, service-line responsiveness, staffing expenditure reductions, asset separation and selective access-support evaluating the transaction architecture and operating plan, not merely ownership status.

The review's interpretive contribution is to separate four causal layers that are often collapsed: the capital structure determines obligations and control rights; the value strategy selects revenue, cost and asset levers; delivery mechanisms change clinical operations; and outcomes depend on patient need and system context. This distinction explains why a transaction can improve an accounting measure while worsening continuity, or leave an average quality indicator unchanged while reducing a low-margin service. It also prevents consolidation effects from being attributed automatically to a particular fund structure.

4.2 Policy implications.

Oversight should follow the investment lifecycle (Table 4). At entry, beneficial owners, debt, management agreements, related parties and property transfers should be disclosed in a linkable identifier system. Pre-transaction review should examine local concentration, payer mix, workforce capacity, asset condition and service continuity, including acquisitions below conventional merger thresholds. During ownership, regulators and purchasers need audited data on staffing, prices, denials or coding intensity, service openings and closures, rents, fees, dividends, capital expenditure and quality. Where public payment finances delivery, leverage or related-party safeguards,

enforceable workforce and quality covenants, and restrictions on asset stripping may be proportionate to the risk.

Exit deserves equal attention. Secondary buyouts, dividend recapitalisations, bankruptcy, hospital resale and lease obligations can transfer risk to patients, workers and local governments after the original deal. Continuity reserves, advance exit plans, notification requirements and successor liability should be evaluated. Policy design should preserve useful capital and operational innovation while making owners accountable for externalised costs. Disclosure is necessary but insufficient unless data are timely, machine-readable, publicly accessible and linked to enforcement.

4.3 Research priorities.

First, ownership datasets should record controlling and minority interests, fund and platform identity, MSO relationships, debt, fees, property owners and transaction dates. Second, studies should expand beyond US Medicare and commercial claims to social-insurance, tax-funded and low- and middle-income settings. Third, comparative work should evaluate competing acquirers-PE, hospitals, insurers, public companies and nonprofit systems-using common outcomes. Fourth, researchers should study longer horizons and exits, including maintenance, solvency, closures and regional access. Fifth, patient experience, equity, clinician autonomy, labour conditions and unmet need require greater attention. Prospective natural experiments around disclosure, review thresholds, staffing standards and payment reform could determine which safeguards work.

4.4 Strengths and limitations.

Strengths include an explicit scope that extends beyond PE labels, a search through August 2026, a traceable record flow, separation of study designs, and a framework connecting financial arrangements to delivery mechanisms. Limitations are substantial. Searches did not include subscription-only Embase, Scopus or Web of Science; OpenAlex retrieval was capped at the first 200 relevance-ranked results for four high-yield queries. Screening and charting were completed in two passes but were not independently duplicated. Some charting relied on abstracts and bibliographic records when full reports were inaccessible. We did not conduct a source-level risk-of-bias appraisal, and reviews overlap with primary studies. Publication and commercial-data biases are likely; acquisition data are incomplete; and the extreme US and PE concentration limits generalisability.

5. Conclusion

Large-scale investment is reshaping healthcare delivery through ownership, financing, asset and operating channels. Evidence most consistently indicates higher prices or spending, while quality, workforce and access effects are heterogeneous but include important adverse signals in staffing-sensitive services. Policy and research should move from binary ownership labels to transparent, lifecycle evaluation of who controls the provider, how returns are generated, what changes in care delivery, and who bears risk at exit.

Declarations

Ethics approval and consent to participate

Not applicable; the review used published and publicly available evidence.

Patient and public involvement

Patients and members of the public were not involved in the design or conduct of this review.

Consent for publication

Not applicable.

Availability of data and materials

The exact search strings, record-flow counts and source-level bibliographic audit trail are reported in the manuscript and reference list. All data underlying the descriptive results are contained in the article.

Competing interests

None.

Funding

None.

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Tables and Figures

Table 1. Reproducible search strategy and eligibility framework

Source	Exact query or approach	Records
PubMed/MEDLINE	("private equity"[Title/Abstract] OR "venture capital"[Title/Abstract] OR "growth equity"[Title/Abstract] OR financialization[Title/Abstract] OR financialisation[Title/Abstract] OR "institutional investment"[Title/Abstract] OR "institutional investor"[Title/Abstract] OR "real estate investment trust"[Title/Abstract] OR "sovereign wealth"[Title/Abstract] OR "infrastructure fund"[Title/Abstract]) AND (healthcare[Title/Abstract] OR "health care"[Title/Abstract] OR "health care delivery"[Title/Abstract] OR "healthcare delivery"[Title/Abstract] OR hospital*[Title/Abstract] OR "health system"[Title/Abstract] OR "physician practice"[Title/Abstract] OR "medical practice"[Title/Abstract] OR "nursing home"[Title/Abstract] OR "care home"[Title/Abstract] OR "long-term care"[Title/Abstract] OR clinic*[Title/Abstract] OR hospice*[Title/Abstract] OR "home health"[Title/Abstract] OR dialysis[Title/Abstract] OR dental[Title/Abstract] OR dentistry[Title/Abstract] OR dermatology[Title/Abstract] OR ophthalmology[Title/Abstract] OR anesthesia[Title/Abstract] OR anaesthesia[Title/Abstract] OR "ambulatory surgery"[Title/Abstract] OR "behavioral health"[Title/Abstract] OR "mental health"[Title/Abstract] OR fertility[Title/Abstract] OR radiology[Title/Abstract]) AND ("2000/01/01"[Date - Publication] : "2026/08/22"[Date - Publication])	647
Europe PMC	((TITLE_ABS:"private equity" OR TITLE_ABS:"venture capital" OR TITLE_ABS:"growth equity" OR TITLE_ABS:financialization OR TITLE_ABS:financialisation OR TITLE_ABS:"institutional investment" OR TITLE_ABS:"institutional investor" OR TITLE_ABS:"real estate investment trust" OR TITLE_ABS:"sovereign wealth" OR TITLE_ABS:"infrastructure fund") AND (TITLE_ABS:healthcare OR TITLE_ABS:"health care" OR TITLE_ABS:"health care delivery" OR TITLE_ABS:hospital OR TITLE_ABS:"health system" OR TITLE_ABS:"physician practice" OR TITLE_ABS:"medical practice" OR TITLE_ABS:"nursing home" OR TITLE_ABS:"care home" OR TITLE_ABS:"long-term care" OR TITLE_ABS:clinic OR TITLE_ABS:hospice OR TITLE_ABS:"home health" OR TITLE_ABS:dialysis OR TITLE_ABS:dental OR TITLE_ABS:dentistry OR TITLE_ABS:dermatology OR TITLE_ABS:ophthalmology OR TITLE_ABS:anesthesia OR TITLE_ABS:anaesthesia OR TITLE_ABS:"ambulatory surgery" OR TITLE_ABS:"behavioral health" OR TITLE_ABS:"mental health" OR TITLE_ABS:fertility OR TITLE_ABS:radiology)) AND FIRST_PDATE:[2000-01-01 TO 2026-08-22]	513
OpenAlex	Queries (each searched 22 Aug 2026): "private equity" healthcare delivery (retrieved 200; reported 2762); "private equity" hospital nursing home physician practice (retrieved 200; reported 478); financialization healthcare delivery systems (retrieved 200; reported 426482); "real estate investment trust" nursing homes healthcare (retrieved 132; reported 132); "venture capital" healthcare delivery clinic (retrieved 200; reported 1022). First 200 relevance-ranked records were retrieved per query, or all records when fewer than 200 were available.	837 unique
Supplementary	Backward/forward citation chaining and targeted searches of regulator and intergovernmental sites for ownership, transaction-review and purchasing guidance. RePEc/IDEAS test queries returned no records. Policy sources did not enter the database flow unless indexed.	Not pooled

Table 2. Characteristics of included evidence sources (n=117)

Dimension	Category	n	%
Country	United States	103	88.0
	Other or multiple jurisdictions	14	12.0
Investment	Any private-equity involvement	112	95.7
	No private-equity involvement	5	4.3
Setting	Physician/specialty practices	50	42.7
	Hospitals	26	22.2
	Multi-sector/system-wide	20	17.1
	Nursing/long-term care	14	12.0
Design	Hospice/home care	7	6.0
	Quasi-experimental	36	30.8
	Descriptive/market analysis	33	28.2
	Observational comparative	28	23.9
	Systematic/scoping review	9	7.7
	Qualitative/case study	7	6.0
Publication year	Policy/governance synthesis	4	3.4
	2025–2026	56	47.9
	2023–2024	22	18.8
	2011–2022	39	33.3

Table 3. Sector-level synthesis of reported outcomes and evidentiary boundaries

Primary setting	n	Recurring findings	Boundary conditions	Representative sources
Physician/specialty practices	50	Higher negotiated prices, allowed amounts or spending across several specialties; roll-up concentration; changing clinician mix; selective service expansion or contraction.	Results varied by specialty, payer and service. Neutral findings occurred for some access and low-value-care measures.	[14,18,35,51,56,58,90,94,96,99,116–120]
Hospitals	26	Higher charges/income in some cohorts; service-line responsiveness; lower salary expenditure; adverse-event and mortality signals in staffing-sensitive or emergent care.	Selection into acquisition, firm heterogeneity and distressed baseline assets complicate causal interpretation; several clinical outcomes were neutral.	[9,11,23,34,36,55,59,71–73,108–111,115]
Nursing/long-term care	14	Lower staffing or quality and higher mortality/spending in several US studies; related-party payments and lease structures; cross-national regulatory differences.	Older studies use heterogeneous ownership definitions; results do not transfer directly across financing and care systems.	[16,25,31,32,43,84,89,92,93,98,104,106,123]
Hospice/home care	7	Rapid acquisition with opaque ownership; lower care intensity and patient-care spending; deterioration in several family-experience domains.	Few acquirers drive some estimates; evidence is almost entirely US-based and payment-specific.	[15,38,52,83,87,95,105,122]
Multi-sector/system-wide	20	Expansion of PE across OECD delivery systems; recurring concerns about transparency, leverage, asset extraction and market power; policy emphasis on disclosure and review.	Transaction data are incomplete and reviews overlap with primary studies; non-PE institutional capital is under-studied.	[13,19,29,45,47,57,60,68,70,75,77,78,80,88,114,121]

Table 4. Lifecycle oversight framework derived from the evidence map

Stage	Observable risk	Minimum data	Illustrative policy option	Evaluation metric
Entry / acquisition	Hidden control; serial add-ons below review thresholds; local concentration	Beneficial owner, fund/platform, price, debt, property transfer, MSO and related parties	Mandatory machine-readable disclosure; aggregation of add-ons; pre-transaction review using local market and service-risk tests	Ownership completeness; reviewed share of transaction value; post-deal concentration

Stage	Observable risk	Minimum data	Illustrative policy option	Evaluation metric
Ownership / finance	Leverage, fees, dividends, rent escalation and deferred maintenance	Debt service, fees, dividends, rents, capital expenditure, asset condition and liquidity	Related-party and leverage safeguards; minimum capital/maintenance rules where continuity risk is high	Debt-service coverage; capital expenditure; days cash; covenant breaches
Operations	Staff cuts, clinician turnover, coding/volume incentives and service-line selection	Staffing by unit, turnover, wages, prices, coding, volume, closures/openings and referral patterns	Workforce and quality covenants; payment reform; public dashboards; targeted audits and enforcement	Risk-adjusted quality; staff hours; turnover; price and utilisation changes
Exit / distress	Secondary buyout, recapitalisation, bankruptcy, abrupt closure and stranded leases	Buyer, proceeds, new debt, lease obligations, solvency, closure plans and successor arrangements	Advance notification; continuity reserve and exit plan; successor liability; orderly-transfer powers	Service interruption; insolvency; transfer time; patient displacement
Market / system	Cumulative consolidation, access inequity and public fiscal exposure	Linked ownership–claims–workforce–quality data with geography and payer mix	Cross-agency data linkage; threshold-free surveillance; periodic sector review and policy evaluation	Prices/spending; travel time; network adequacy; market concentration; closures

Identification and selection of evidence sources

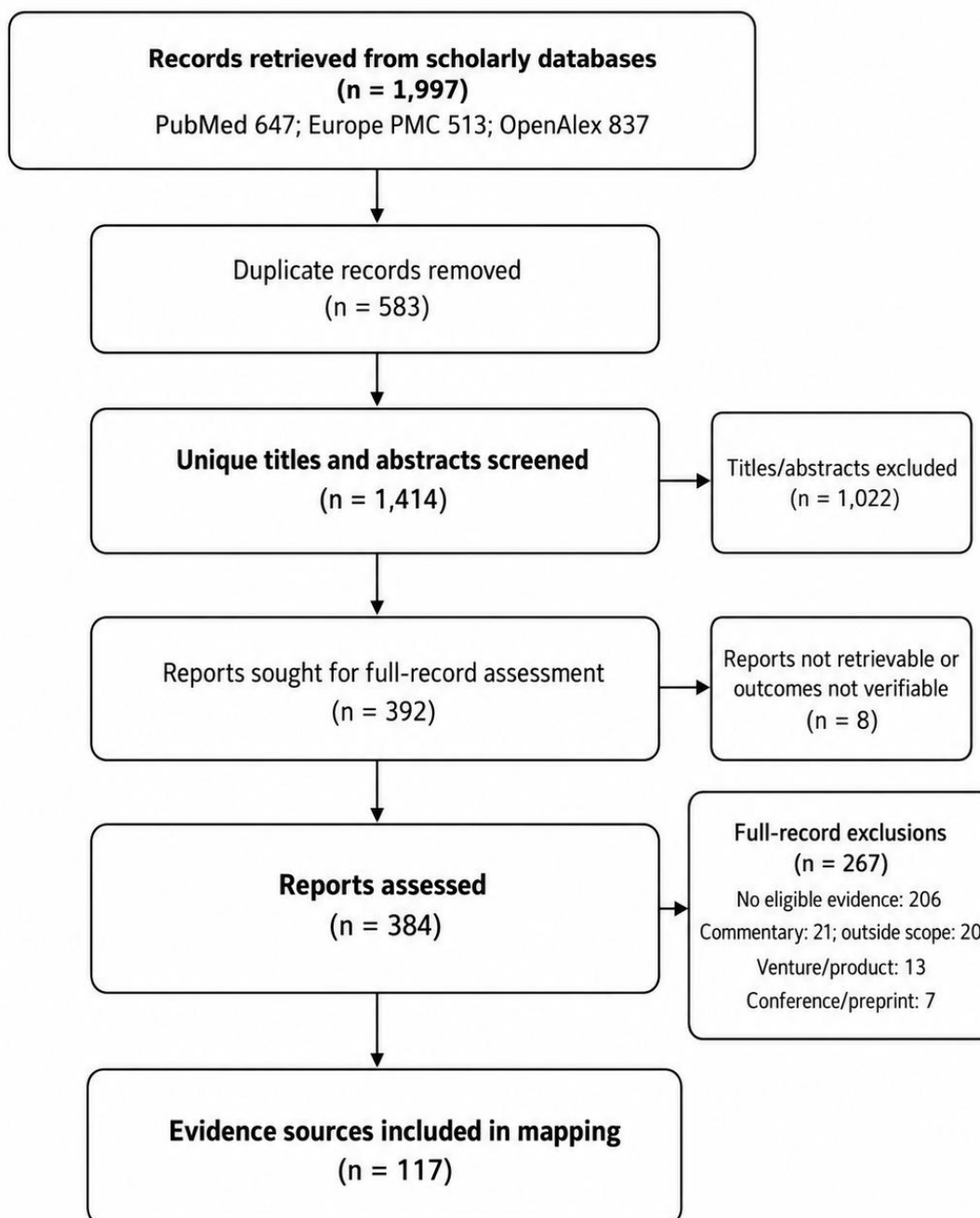


Figure 1. Prisma Flowchart

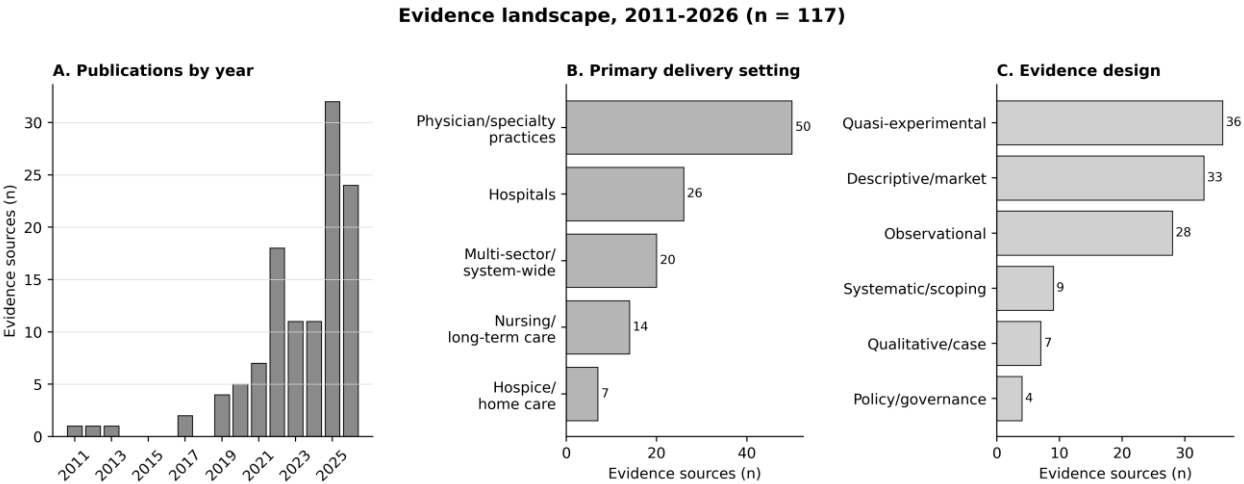


Figure 2. Evidence landscape, 2011–2026 (n=117).

Capital-to-care pathway and lifecycle oversight points

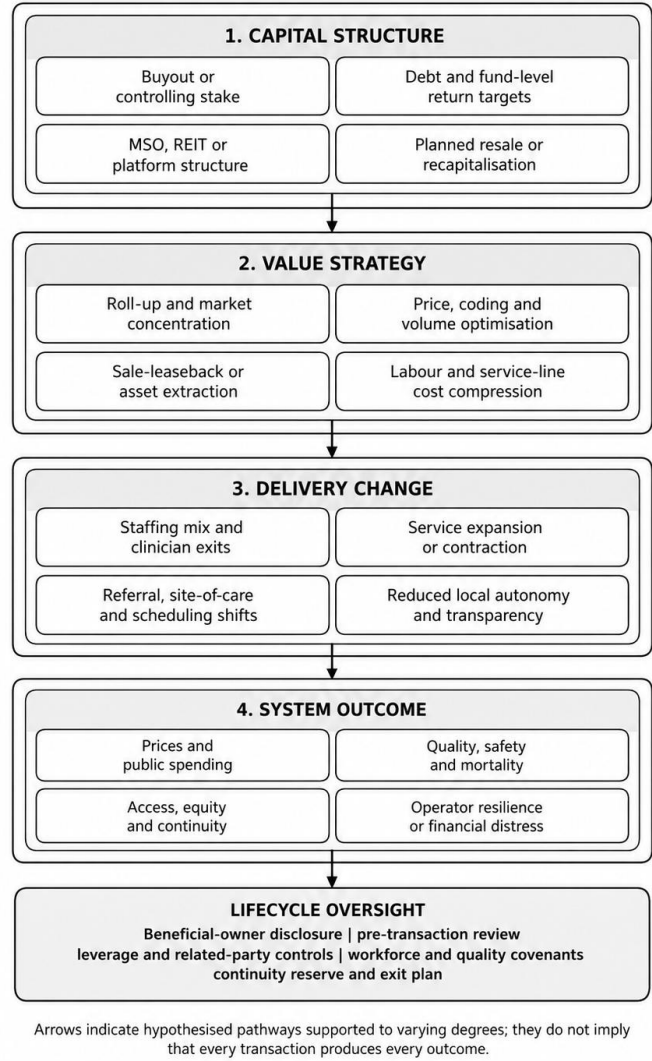


Figure 3. Capital-to-care pathway and lifecycle oversight points.
Note. Arrows represent hypothesised pathways supported to varying degrees across the mapped evidence; they do not imply that each transaction uses every mechanism or produces every outcome. MSO, management services organisation; REIT, real-estate investment trust.

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