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HEALTH ECONOMICS, POLICY and LAW

EDITORIAL

Financial investors and for-profit providers as new players in global healthcare: the politics and practices of health system financialisation

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Private for-profit providers and internationally operating financial investors are gaining influence in health systems around the world. Governments of tax-funded national systems (NHS) and social health insurance systems have historically been reluctant to let for-profit actors operate within them. Many now welcome private equity (PE), venture capital and institutional investors as sources of capital and as providers of rapid solutions to pressing policy concerns such as workforce shortages. Examples include the role of private providers in addressing long waiting lists for hospital or nursing home care, and the development of digital infrastructure for technology-enabled home care. Proponents argue that private capital fills funding gaps that public budgets cannot. Critics point to the risks for costs, quality, and system stability and ask how the interests of patients and healthcare workers can be placed above, or at least alongside, those of shareholders.

To gain an understanding of how for-profit providers and financial investors operate within domestic health systems and across national borders, we organised a workshop with the Commonwealth Fund of New York and the Health Policy and Management Department at Columbia University in New York City in May 2025. European observers often regard the United States (US) as the birthplace of healthcare capitalism and look across the Atlantic for evidence on what financial ownership does to health outcomes and expenditure. Yet the rapid entry and consolidation of financial actors is an evolving policy challenge in the US too, with many unknowns, not least because financial (trans)actions are fast moving and volatile. American policy experts and scholars, in turn, look to Europe for regulatory strategies. The workshop brought policy experts, clinicians, and PE representatives together with a large group of international scholars, and we invited participants to write comparative papers on the role of for-profit providers and financial investors across health systems. Several of the resulting author teams had never written together, and some had not met before the workshop. The collaborations produced informed and searching debate, and this special issue of *Health Economics Policy and Law* publishes the results. Alongside perspective articles and research papers, the issue includes a paper based on an expert panel we hosted in July 2026, in which Professor David Blumenthal, Professor Erin Fuse Brown, and Rob Coppedge discussed how financial actors are gaining ground in US healthcare, how this affects traditional, profession-based arrangements for organising care, and where the opportunities for regulation lie. The full panel discussion is available on the website of *Health Economics Policy and Law*.

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On the back of this interview, we present the expert panel paper (Wallenburg and Friebel, 2026), in which all three experts discuss how investor logic has taken hold in US healthcare and where to go from here. The panellists trace this development to the market-based choices of the 1980s, to a 10- to 15-fold rise in annual venture capital investment in the sector since the 1990s, and to the more recent payment reforms of the Affordable Care Act, which made healthcare attractive to financial actors from outside the traditional system.

This special issue includes three perspective papers. Bugbee (2026) starts off by arguing that PE 'investment' in healthcare is better understood as extraction. Because leveraged buyouts load debt onto acquired providers while limiting investors' liability, moral hazard is built into the PE model. In the US, Bugbee links this structure to bankruptcies and facility closures, cost-cutting that affects patient care, rising prices, and the erosion of clinical autonomy, and calls for policies that target extractive practices such as dividend recapitalisations and sale-leasebacks directly. Mercille (2026) reflects on PE in Irish primary care, where financial actors have gained ground since the 2008 financial crisis, and proposes a research agenda to improve our understanding of the nature of PE in healthcare. Turning back to the US, Makhoul *et al.* (2026) offer a contrasting view to Bugbee. Consolidation, which health policy scholars commonly criticise for driving up costs and strengthening the market power of financial actors relative to regulators, should in their view also be understood as a response to structural pressures, including rising practice costs, stagnant physician reimbursement, and growing administrative complexity. They contend that the current policy debate on private capital lacks nuance and risks obscuring more fundamental drivers of cost growth. Read together, the two US perspectives frame the central question of this issue: whether private capital is a cause of health system dysfunction or a response to it.

The research papers explore, both empirically and theoretically, the issues raised by the expert panel and the perspective articles. Lunt *et al.* (2026), Nijboer *et al.* (2026), and Tracey *et al.* (2026) provide the theoretical background. They situate financialisation within a longer shift from the internal market and regulated competition models of the 2000s, the neoliberal turn (Wallenburg and Friebel, 2025), to what we term a financial turn. Tracey *et al.* (2026) conduct a critical interpretative synthesis of the literature, theorising financialisation of health systems and their governance. They find that this literature defines financialisation as a transformative process marked by the entry of private investors and financial instruments, and that it identifies accountability and transparency as a principal governance challenge. Drawing on theories about marketisation in healthcare, Lunt *et al.* (2026) distinguish seven trajectories of privatisation. They apply them to the NHS of England and Italy, two countries that experience greater use of financialisation like the use of on-demand staff. They show how these shifts blur the traditional boundaries between public and private healthcare provision. Nijboer *et al.* (2026) push these insights further by applying the concept of assetisation, the transformation of things into rent-yielding assets for investors to the health systems of Canada, England, and the Netherlands. Rather than deploying uniform strategies, they show that investors respond strategically to system frictions and perceived crises, position themselves as problem solvers, and, in doing so, embed investor logic in healthcare provision.

Anderson *et al.* (2026) expand on these insights by providing an overview of the evidence on provider ownership and performance. Based on an umbrella review of high-income countries, they show that for-profit hospitals tend to serve wealthier patients, select less complex or costly patients, and charge more for care than public hospitals. In long-term care, for-profit providers generally had poorer workforce outcomes than not-for-profit or public providers, including lower staffing levels, higher workloads, and lower job satisfaction. Singh *et al.* (2026), in turn, map PE investment across OECD countries outside the US. Outpatient specialty care is the most popular target, with elderly care and hospitals attracting investment in selected markets. Deal volume is highest in the United Kingdom, Germany and France, and higher deal volume is associated with higher health expenditure.

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The next set of papers examines how for-profit providers and financial investors gain ground and reshape the organisation and delivery of care. Stringer *et al.* (2026) explore changes in the commissioning, contracting and provision of NHS-funded cataract surgery in England over the last decade, focusing on the growing role of independent sector providers. They argue that the shift to the independent sector was largely unplanned, driven by long NHS waiting lists, favourable payment tariffs, and low barriers to entry. Although independent sector providers have helped to reduce waiting times and raise productivity, concerns have grown about contract management, service quality, and value for money. Pearcy *et al.* (2026), in turn, take Discovery Group, a private health insurance active in both South Africa and the United Kingdom, as a central case of private insurance operating within universal health systems. Their comparative analysis examines how the company shapes health financing, workforce dynamics, service delivery, digital infrastructure, and governance in each setting. They reveal that its effects are fundamentally context-dependent, mediated by institutional frameworks, regulatory environments, and the stage of universal coverage development. Gusmano *et al.* (2026) shift our gaze to PE in long-term care in Poland, the US, and Ireland. They demonstrate that policy responses to population ageing and rising care needs are deeply political, producing a variety of solutions shaped by institutional legacies, cultural contexts, and the balance of power between states, markets, and civil society.

Vrangbæk *et al.* (2026) compare for-profit ownership in primary care in Denmark and Sweden, two tax-funded Nordic systems that have traditionally relied on self-employed general practitioners and publicly operated health centres, respectively. Externally funded for-profit provision has grown in both countries, but on very different scales. The authors attribute the divergence to regulation. Sweden liberalised provider entry in 2010, while Denmark retained public planning of practice entry and location alongside proprietary GP ownership. PE ownership in Swedish primary care has declined over time, and the authors find examples of risk selection, gaming and profit-maximisation practices in both countries. Their conclusion, that regulatory design shapes the opportunity structure for investors, leads directly into the final two papers.

In their paper, Schuurmans *et al.* (2026) examine regulatory and policy responses to private investment in residential long-term care in Ontario (Canada), Lombardy (Italy), the Netherlands, and England. They show that these responses are driven primarily by institutional characteristics and are reactive rather than anticipatory. This reveals institutional voids, the absence of regulatory arrangements, and institutional ignorance, the lack of knowledge among policymakers and other healthcare actors. Berardi *et al.* (2026), finally, seek to close part of this gap knowledge by examining the heterogeneity of investor ownership and its consequences for market behaviour. Drawing on five countries, they present a typology of investor types and a policy framework for regulation. Based on this framework, they argue that entry regulation must be combined with behavioural oversight if investor incentives are to align with public health objectives.

This special issue of *Health Economics Policy and Law* shows that for-profit providers and financial investors are transforming healthcare through market consolidation, asset sales and financial engineering. They are not simply organising care differently. They are embedding investor logic in the system that funds and delivers it. The neoliberal wave of the late 1990s and 2000s appears to be giving way to a financial wave, whose contours are only beginning to emerge. The distinction matters for policy. Governments designed managed competition and retained the authority to set its rules. The financial turn has largely arrived unplanned, through gaps that states did not know they had left open. Tracey *et al.* (2026) find that the literature on financialisation has not yet examined its consequences for policy capacity, and the papers in this issue suggest that this is precisely where governments are weakest. Yet the Nordic comparison shows that regulatory design can contain investor entry where governments choose to use it (Vrangbæk *et al.*, 2026). How the financial turn unfolds will therefore depend on how governments, purchasers and regulators respond as they begin to recognise their institutional voids and their limited understanding of the actors now operating within their systems. We hope this special issue contributes to that understanding and provides fertile ground for further scholarly exchange.

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