Private equity investment in long-term care in Europe: trends, impact and policy options

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Contents

Acknowledgements iv

Executive summary v

Key messages vi

1 Introduction 1

2 Methods 2

3 What are private equity funds? 3

4 Brief history of the emergence of private equity 4

5 Why is private equity investing in LTC? 6

6 Private equity expansion in LTC in Europe 8

7 Impact of private equity involvement on provider performance 10

8 Policy options to regulate private equity in LTC 13

Market interest 14

Company registration 16

Acquisition or association with a target operator 17

Operational changes 20

Exits 21

9 Conclusion 22

References 23

List of figures

Fig. 1 Selected findings of the Karamardian et al. systematic review extension related to nursing homes 11

Fig. 2 Policy options for the private equity lifecycle 13

List of tables

Table 1 Adapted results from Tracey et al. 18

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Executive summary

The increased presence of private equity in European long-term care (LTC) demands a review of current trends, impacts and possible policy options for ensuring safe, high-quality and affordable care. With demand rising alongside private equity interest, it is time to consider how to appropriately regulate the industry.

Some, including those in the industry itself, claim private equity can provide much needed financial support and innovation. Others have raised concerns about its impact on quality, outcomes, cost, employee satisfaction and long-term sustainability.

Private equity can make use of extensive capital and generally operates on short time horizons which incentivize quick revenue generation and cost-cutting to a greater extent than more traditional funders and operators. These and other factors have been identified as potentially harmful for resident care.

While private equity in LTC has enjoyed more attention from researchers in the last few years, the literature on its effects is still somewhat limited, with little attention paid to experiences and options in Europe. From the evidence that has emerged so far, private equity appears to have mixed to harmful effects on access, costs and quality.

To prevent potentially negative impacts, this report highlights potential policy options for regulating private equity investment in European LTC across the private equity lifecycle. Though targeted at LTC, these policy options may also help to prevent and reduce harmful impacts of private equity investment on other subsectors of healthcare.

Key messages

- Private equity or other private commercial investment in LTC has been increasing in many European countries, following similar developments in the United States (US).
- Concerns have been raised about the impact of this development for quality of care, access, affordability, equity and long-term sustainability.
- Private equity differs from more traditional operators such as publicly listed companies, small private companies, governments or civil society organizations. Large financial resources, command of information, limited transparency requirements, experimental business strategies, condensed time horizons and focus on a quick exit with large profit margins all give private equity firms distinctive options, incentives and approaches to investment and management. This is especially apparent in the common Operating Company (OpCo)/Property Company (PropCo) model.
- The record of private equity investment in healthcare – to the extent that it has been studied, and with most evidence related to the US – is somewhere between mixed or harmful for key aspects of access to care, quality of care and costs to payers. In the US, LTC is largely funded by the public Medicaid programme, which sets fixed prices, thus eliminating the potential for increased costs to payers. Variation in LTC funding by country may increase the relevance of cost to payers for some countries.
- Few studies have so far been undertaken that document the expansion of private equity in LTC in Europe, its impact and regulatory responses.
- There are a range of policy options that respond to the distinctive options and strategies of private equity investors. They can minimize the risks of private equity engagement, including flexible regulation, public sector competition, rules about transparency and ownership, and failure regimes that create accountability.
    - Policy options can be mapped to the private equity lifecycle.
    - Important considerations include:
        - transparency and disclosure
        - competition and anti-trust laws
        - health and safety standards
- Regulations that address potential problems associated with private equity expansion can also address some of the broader challenges associated with other forms of private provision of LTC.

1 Introduction

The LTC sector faces serious problems of quality, equity, access, staffing and financial sustainability almost everywhere. The sector is often fragmented – reliant on small, independent providers as it is in Ireland (Nicholas O'Neill, 2025) – undercapitalized – with generous room for profit extraction – and facilities can be poorly managed, with key providers such as local governments, small firms or religious organizations exiting over time. In this situation, private equity or other private commercial investment in LTC can appear to be a solution to the sector's financial problems. Private equity generally results in a net extraction of wealth from its investments, but it seems to offer immediate relief to struggling operators by introducing new sources of funding and commercial strategies. While tempting in the short term, these initial life-vests can ultimately create distinctive new risks to LTC systems.

Private equity ownership presents an intensified version of concerns over private, for-profit ownership in healthcare and is becoming a more prevalent ownership structure. The year 2024 witnessed a resurgence of private equity deals across the world, breaking records in the European healthcare sector (Bain & Co., 2025). Globally, Bain & Co. reported an estimated deal valuation of US$ 115 billion in the healthcare sector alone, with Europe accounting for 22% of the market in 2024 (Bain & Co., 2025).

While private equity has emerged across many sectors worldwide, this report focuses on LTC and policy options for Europe.

The aim of this report is to understand: (1) the scope of private equity involvement in LTC in Europe, (2) the impacts of private equity on quality of care, health outcomes, equity, cost, and resident and staff satisfaction in the European LTC sector, and (3) what policies can ensure that private equity involvement has no detrimental effects on European LTC.

This report summarizes evidence about the scope, impact and regulation of private equity in European countries, and identifies policy options to prevent problems developing for care quality, equity, financial sustainability, access or other policy goals. The bulk of this report is structured around hallmark strategies of private equity which make the industry different from other forms of private, for-profit ownership and which are likely to impact access, outcomes, cost and other key factors of a high-performing LTC system.

2 Methods

Academic literature for this work was identified by searches of Google Scholar, PubMed, ProQuest and EBSCO Host databases using the keywords "private equity", "real estate investment trust", "REIT", "leveraged buyout" and "LBO" in combination with "long-term care", "LTC", "nursing homes", "healthcare", "Europe" and "European". Grey literature was identified through Google and company websites using the same keywords.

Documents with titles relevant to: (1) the history and definitions of private equity, (2) trends in private equity and its involvement in healthcare, (3) impacts of private equity on LTC or another healthcare subsector, and (4) policy options relevant to private equity in LTC were set aside for further review.

Identified documents were analysed for relevance to the overall research aims based on the abstract or other highlighted information including key points and executive summaries. If relevance remained unclear, the document was read further until relevance was established. Given the European focus of this report, documents which referenced the European context were specifically prioritized. Similarly, while documents including information on other healthcare contexts were collected, those with a focus on nursing homes or other forms of LTC were prioritized for review.

Additional documents were added throughout the literature review based on reference lists from the sampled documents. The reference lists of the systematic reviews by Borsa et al. and Karamardian et al. on the impact of private equity involvement in healthcare were particularly useful (Borsa et al., 2023; Karamardian et al., 2024). This report does not attempt to be a systematic review, but instead aims to capture key research on the topic while refocusing on lessons for Europe.

3 What are private equity funds?

Private equity funds are pooled investment vehicles and are considered an alternative investment (Rydin, n.d.; US Securities and Exchange Commission, n.d.). Managed by a General Partner within a private equity firm, the capital in a private equity fund is solicited from institutional investors such as university endowments, pension funds and insurance companies, though some funds may come from high income and high net worth individuals, referred to as Limited Partners (Baldwin, 2025; USPEC, 2023). These funds generally have a very high investment minimum and multi-year investment timelines, meaning investors are unable to quickly withdraw their invested funds (Baldwin, 2025; US Securities and Exchange Commission, n.d.).

In addition to supplying a small percentage of a fund's capital, General Partners are responsible for identifying target companies and managing the fund's portfolio (Baldwin, 2025; Rydin, n.d.; USPEC, 2023). General Partners are fully liable to the market should the account suffer losses whereas Limited Partners are liable only for the amount they invest (Baldwin, 2025; USPEC, 2023). Still, liability ultimately lies with the acquired entity which services the debt. Thus, despite the length of the investment period, private equity investments are attractive to investors because they tend to offer high returns and the firm's legal form allows Limited Partners to bear relatively small risk compared to other types of investment (Rydin, n.d.; USPEC, 2023).

Private equity firms tend to exploit regulatory and tax arbitrage. In the United States, private equity firms are often registered as Limited Partnerships in Delaware, where reporting and transparency requirements are the weakest in the country (Rand, 2022; Rydin, n.d.). Like most companies registered in Delaware, private equity firms are typically a combination of multiple limited liability companies (LLCs), which are exempt from the detailed reporting requirements met by other company types (Bos & Harrington, 2017; Rand, 2022). As private equity limited partnerships are often based on private contractual agreements, private equity firms generally do not fall under US public reporting laws (Rydin, n.d.). We did not find evidence of a similarly clear pattern in Europe, but there are extensive opportunities for companies operating in Europe to exploit tax and regulatory arbitrage, and EU law is generally protective of their ability to do so (Guy, 2018, 2024).

While there are several types of private equity fund, the most relevant to healthcare and LTC are buyout funds and real estate investment trusts (REITs) (Abbasi, 2022; Committee on the Quality of Care in Nursing Homes, 2022; Montgomery, 2025; USPEC, 2023). The strategies employed by a General Partner and the firm's management team reflect the type of fund (USPEC, 2023). This report focuses on those most relevant to LTC as an established industry with existing potential portfolio companies that may benefit from additional capital to generate growth or to improve efficiencies and which sometimes sit on high value real estate. Still, legislation should reflect the extensive variation in firms, funds and strategies displayed in the private equity industry to be most effective.

Private equity differs from other forms of private ownership, making the policy concerns private equity raises distinct. Key policy concerns related to private equity include the leveraging of large amounts of debt against acquired entities, short time horizons for investment holding, and the necessity of a profitable exit before investors are paid. In LTC specifically, REITs separate ownership of the property from care operations which can make care homes more susceptible to closure.

4 Brief history of the emergence of private equity

Private equity today is international, with investors, firms, funds and investments in many sectors around the world, but its biggest impact and most analyses of its operation and impact within healthcare have been in the US. The result is that the literature on private equity often focuses on the US experience. That focus is not as big a problem as it may seem, since private equity firms entering new markets such as the European LTC sector will often deploy standard financial and managerial strategies that they developed, and which were successful and have been evaluated in the US context.

To understand where private equity came from, it is essential to first understand leveraged buyouts (LBOs), the most common way private equity invests in LTC (Montgomery, 2025). LBOs are transactions in which most of an acquisition expense is met through debt-financing (M&C Partners, 2020b).

LBOs began to dominate the US market following the devaluation of stocks and resulting deconglomeration of the 1970s and 1980s (M&C Partners, 2020a). They brought low-quality companies which had gone public during the 1960s back into the private sphere and gave rise to LBO firms (M&C Partners, 2020a).

The 1980s introduced the first big wave of LBOs in the US, facilitated in large part by the proliferation of high-yield bonds also known as "junk bonds" (Hurduzeu & Popescu, 2015; Singh, 2020). The original-issue high-yield debt instrument, the so-called "junk bond" innovation, was pioneered by Michael Milken of Drexel Burnham, providing many hostile bidders and LBO firms with the enormous amounts of capital needed to finance multi-billion-dollar deals. The history of these two instruments goes hand-in-hand, as for example, the conjunction between the recession in the United States in the early 1990s along with the junk bond market crash following the fall of the investment bank Drexel Burnham Lambert, brought the first LBO wave (the one that started in 1980). The decade of LBOs culminated in 1989 with the record-breaking and highly-publicized $25 billion KKR buyout of RJR-Nabisco (Hurduzeu & Popescu, 2015).

The junk bond market crashed soon after, in the early 1990s, and with it LBOs fell out of fashion. Now burdened with a reputation for inadequate liquidity in the face of financial downturn, LBOs went through a period of restructuring (Singh, 2020). A reduction in regulatory costs, shareholder scrutiny and tax obligations triggered a second wave of LBOs and coined the early 2000s as the "age of mega-buyouts" before the industry was stymied again in the fallout of the 2008 financial crisis (Singh, 2020).

Firms that specialize in LBOs today now refer to themselves as private equity firms (Kaplan & Strömberg, 2009). In addition to their reliance on debt-financing, private equity firms leverage the assets of portfolio companies against themselves and there is reason to believe that leveraged structures carry more risk (Kenton, 2024; Singh, 2020).

While the private equity industry struggled in recent years, historical evidence suggests a cyclical trend in private equity (Kaplan & Strömberg, 2009). In keeping with this trend, McKinsey's 2025 Global Private Markets Report described a resurgence of the asset class in the first half of 2024 with sponsors' distributions to Limited Partners exceeding capital contributions for the first time since 2015 (Edlich, Dahlqvist & Teichner, 2025). EY-Parthenon reported a similar 2024 rebound in European private equity deals, citing "the first increase in deal activity since 2021" (EY-Parthenon, 2025).

Private equity investments have spread across many industries with a growing interest in the healthcare sector (Brown & Hall, 2024). Researchers have mapped this push to a broader shift toward financialization of the sector (Brown & Hall, 2024).

REITs are particularly relevant to LTC and other infrastructure-focused sectors like housing. REITs rely on the OpCo/PropCo model in which one entity owns a private LTC facility – the real estate owner and PropCo part of the model – and another entity provides care at the LTC facility – the operator and OpCo part of the model. This creates a contractual separation between the real estate and operations of the facility (Walsh & Connolly, 2024).

Ireland is an example of relatively good access to data on OpCo/PropCo models in the country because of registration requirements with the Health Information and Quality Authority (Walsh & Connolly, 2024). This data listed 15 operators operating over 400 LTC beds and six property owners owning at least 500 beds in 2023 (Walsh & Connolly, 2024). REITs are popular in Ireland because they are exempt from corporation tax on property rental income and are not required to pay capital gains tax on property sales (Walsh & Connolly, 2024).

5 Why is private equity investing in LTC?

Of course, LTC can take many forms (Cylus et al., 2025). Still, like much of the healthcare sector, LTC can be considered relatively recession-resistant because of the inelasticity of demand for non-elective healthcare services (Dillender et al., 2021) and because rising demand for LTC is driven by demographic change rather than changing economic conditions. In this report we consider those forms of LTC in which residents reside at a facility, such as a nursing home or residential care home, and receive any level of care assistance from basic assistance with activities of daily living (ADLs) like showering or bathing, dressing, and continence to more intensive, round-the-clock clinical care (Cleveland Clinic, 2024; National Institute on Aging, 2023).

LTC offers investors an opportunity to contractually separate the property and physical buildings of a care home from its care operations through REITs and the OpCo/PropCo model. Private equity often separates individual assets such as real estate from the portfolio company and leases them back at a markup, in a process called asset-stripping and sale-leasebacks (Abbasi, 2022; Committee on the Quality of Care in Nursing Homes, 2022). Understandably, asset-stripping and sale-leasebacks have stirred concerns about increased costs to residents, LTC operators and payers.

Another characteristic of attractive targets is market fragmentation, which allows companies to compete at the local or regional level (Wall Street Prep, 2024). This makes LTC a good candidate for LBOs because it is fragmented in much of Europe and characterized by a lack of coordination both vertically and horizontally (European Commission, 2018). In many countries, LTC remains a non-consolidated sector, making it easier for private equity to buy up small ownership groups using the firms' massive capital.

LTC is also a target of private equity LBOs because of its growing demand and favourable market outlook. The number of older people is increasing worldwide and with it the need for LTC (European Commission, 2018; Greer et al., 2021). European policy-makers have identified the design and operation of health and social care systems supporting older people as a priority (European Commission, 2018).

Less extensive care needs are often supported by family or friends, who voluntarily provide a wide range of care (Costa-Font & Raut, 2022). Historically, the bulk of this informal care has been provided by women (European Commission, 2018). However, advances in gender parity have allowed women to participate more fully in the paid workforce, reducing their availability for unpaid informal care work (Bookman & Kimbrel, 2011; Costa-Font & Raut, 2022; European Commission, 2018). At the same time, changes in social norms and the transition to a global economy have loosened family ties between generations (Costa-Font & Raut, 2022). With children living further from their parents, it can be difficult for young people to provide the care they may have done in generations past (European Commission, 2018).

Those without family or friends available to provide LTC have often looked to religious or charitable institutions, which have been key providers of both childcare and LTC. However, young people's decreased engagement in organized religion and associated reductions in the religious labour force have raised questions about organized religion's ability to continue providing the same extent of care (Darrah, 2024; Hwang et al., 2021). The combination of more women in the paid, non-religious workforce and looser family ties has widened the gap between the demand for LTC and the supply of caregivers.

Governments across Europe have responded to these demographic and structural changes in LTC with expanded social insurance schemes. These schemes may offer cash or in-kind benefits to older people to subsidize the cost of care at home or at LTC facilities (Costa-Font & Raut, 2022). Others

may provide remuneration for informal care workers to incentivize at-home care (Costa-Font & Raut, 2022). State funding increases the attractiveness of this sector as a source of stable funding, which governments tend to increase over time.

Social insurance schemes can help offset the cost of LTC for residents and caregivers, but they do not fully address the predicted shortage of LTC over the next few decades. Private equity funds may view LTC as a particularly good investment due to the promise of growing demand. Therefore, there is a call for additional research on private equity investment in healthcare to ensure any negative health impacts imposed by private equity investment are outweighed by the potential benefits of the influx of capital in the sector (Rechel et al., 2023).

6 Private equity expansion in LTC in Europe

In addition to those registered in locations where they can avoid corporation or capital gains tax, like Ireland (Walsh & Connolly, 2024), many private equity firms are registered or operate in France, the US, Sweden, Luxembourg, the Netherlands and the United Kingdom, with a stable percentage of European private equity deals taking place in the healthcare sector (EY-Parthenon, 2025; Lange Guillen, 2022; Stevenson, 2023).

EY-Parthenon reported that private equity deals in Europe increased by 5% from 2023 to 2024 and that in the first half of 2024, 9% of European private equity deals took place within the healthcare sector (EY-Parthenon, 2025).

Regionally, the percentage of 2024 private equity deals in the healthcare sector were highest in Central and Eastern Europe (15%), Spain and Portugal (13%), Germany, Austria and Switzerland (12%), France (9%), Belgium, the Netherlands and Luxembourg (7%), Italy (7%), the Nordic countries (7%), and the United Kingdom and Ireland (7%). In fact, the world's third-largest private equity transaction of 2024 was the 50% takeover of French pharmaceutical firm Opella Healthcare Group (PWC, 2025).

While private equity firms first took root in the US, they have grown considerably across Europe. In Ireland, for example, a third of all nursing home beds are owned by only 10 firms, making it one of the most consolidated systems of LTC (O'Neill, 2025). Other highly consolidated markets include England, France, Spain and Germany, where 11–13% of their care home markets are made up by their five largest operators (Savills, 2022).

In fact, two of the most prominent instances of private equity failure in LTC were the collapses of England's Southern Cross in 2011 and of the Four Seasons care home chain in 2019. At the time of its collapse, Southern Cross was operating over 750 care homes and housing over 37 000 residents (Scourfield, 2011; The Standard, 2012). Purchased in 2004 by the private equity firm Blackstone, Southern Cross expanded by 1000% from 2001 and became responsible for over 10% of for-profit care beds in the country (Scourfield, 2011).

Blackstone set up a sale-leaseback in which Southern Cross property was sold to Blackstone-owned NHP (Bayliss & Gideon, 2020). NHP was then sold in 2006, leaving Southern Cross unable to pay its rents, especially given its lack of property on which to secure loans (Bayliss & Gideon, 2020). Southern Cross attempted to cut costs, leading to substandard care and, ultimately, closure (Bayliss & Gideon, 2020). This closure left residents stranded and limited-resource local authorities were obliged to manage the situation (Scourfield, 2011).

The Four Seasons collapse was loosely connected to the collapse of Southern Cross as many of the Southern Cross care homes were sold to Four Seasons Healthcare (Rowland, 2019). Income from local authorities was ultimately not enough to manage the high levels of debt leveraged on the company (Rowland, 2019).

Perhaps surprisingly, private equity once dominated the Swedish LTC market with companies such as Attendo, Humana and Vardaga controlling a large proportion of the market (Broms, Dahlström & Nistotskaya, 2024). Since the 2010s, which brought a surge of initial public offerings, private equity market share has dropped dramatically in the country, though the reasons for this are not yet documented in the literature (Broms, Dahlström & Nistotskaya, 2024).

The reasons why the LTC sector in Europe is attractive to private equity investment are a mixture of provider changes and policy. While provision is diverse within, let alone between, countries, there

is a wide range of types of provider that are common in LTC markets (Llena-Nozal, Barszczewski & Rauet-Tejeda, 2025). These include religious charities, local governments and very small-scale private providers. Efforts to improve quality can put pressure on the management and capital structures of smaller or weakly capitalized providers, while NGOs or local governments might lack capacity to make marked quality improvements.

7 Impact of private equity involvement on provider performance

Critics of for-profit healthcare provision claim that profit motives inhibit high-quality care. Broadly speaking, existing evidence supports this claim in the LTC sector. Systematic reviews by Hillmer et al., Comondore et al. and Bos have illustrated consistently worse quality of care in for-profit facilities (Bos, 2020; Comondore et al., 2009; Hillmer et al., 2005).

Private equity differs from other forms of private, for-profit ownership in ways that can worsen the negative impacts of profit motives on care quality. Broadly speaking, private equity reliance on debt financing, expedited timelines for profit-generation, intensified influence of non-healthcare financial experts and the intentionally opaque nature of the private equity industry mean that this type of private investment has had mixed to harmful effects on access, quality and costs.

Interest in this topic in the US spiked around 2019, when private equity was identified as a driver of the "surprise billing" crisis (Appelbaum & Batt, 2020), a phenomenon in which residents receive unexpected bills following emergency care unknowingly provided by out-of-network facilities or providers. This interest grew throughout the COVID-19 pandemic (Appelbaum & Batt, 2020), but research that specifically contends with the effects of private equity on healthcare remains limited.

Illustrating the limited size of available literature on the subject, a 2023 systematic review by Borsa et al. found only 55 studies meeting the inclusion criteria of "empirical research studies of any design that evaluated private equity owned healthcare operators" (Borsa et al., 2023). Studies that consider the impact of private equity ownership specifically in the LTC sector are even more sparse. The aforementioned Borsa et al. review retrieved only 15 studies that focused on nursing homes (Borsa et al., 2023). Research that examines impacts of private equity ownership of LTC facilities outside the US is sparser still, with 47 of the 55 total studies in the Borsa et al. review focusing on the US (Borsa et al., 2023).

An extension of this systematic review was later published by Karamardian et al., covering articles published after those included by Borsa et al. through April 2024 and those forthcoming at the June 2024 Academy Health Annual Research Meeting (Karamardian et al., 2024). In total, Karamardian et al. included a further 15 studies which, on the whole, corroborated findings in the earlier systematic review (Karamardian et al., 2024). Fig. 1 (page 11) shows the findings from the Borsa et al. and Karamardian et al. systematic reviews as represented by Karamardian et al. and as they relate to nursing homes. They demonstrate generally negative impacts of private equity in LTC, particularly with regard to costs to residents or payers. The review extension by Karamardian et al. made some small changes to the Borsa et al. coding strategy. Chief among these changes was differentiation between the Health Outcomes and Health Quality and Process Quality categories. Overall, the changes in coding improved specificity.

European LTC systems and their legal and policy environments might mean that private equity strategies, and effects, do not work the same in one European country as they do in another. The rest of this section reviews the scarce English-language evidence from empirical studies which consider the impact of private equity on LTC in Europe.

While studies have focused on a number of outcomes, these outcomes generally relate to quality, staffing and COVID-19. A study by Bos, which considers the rise of private equity in the Netherlands, found that nursing home clients consistently rated private equity-owned homes as having worse accommodation, employees, listening and information (Bos, 2020). Clients were also less likely to recommend private equity-owned homes (Bos, 2020).

Patwardhan et al. found similar client responses to private equity-owned nursing homes in England, with clients rating private equity-owned homes as less safe, effective and responsive (Patwardhan, Sutton & Morciano, 2022). However, the same study notes that private equity-owned homes had

Fig. 1 Selected findings of the Karamardian et al. systematic review extension related to nursing homes

Author [Original Citation #]	Year	Country	Health Outcomes (HO) and Health Quality			Costs to Patients or Payers		Costs to Operators	Process Quality			Coding Change from Borsa
			Mortality	Major HO	Other HO	Overall Costs	Payer/Patient Mix	Overall Costs	Validated Quality Metrics	Resourcing	Patient Experience	
Bos and Harrington [24]	2017	USA			Negative				Negative	Negative		Yes
Bos et al. [47]	2020	Netherlands									Negative	No
Braun et al. [48]	2021	USA		Negative	Neutral	Negative						Yes
Braun et al. [49]	2020	USA	Neutral	Negative						Mixed		No
Broms et al. [51]	2023	Sweden							Positive	Negative	Negative	No
Gandhi et al. [59]	2020	USA	Neutral	Positive						Positive		No
Gandhi et al. [60]	2020	USA							Positive	Mixed		No
Gupta et al.* [12]	2021	USA	Negative		Mixed	Negative	Mixed	Negative	Negative	Negative		Yes
Harrington et al. [61]	2012	USA							Negative	Neutral		No
Huang and Bowblis [62]	2019	USA			Mixed							Yes
Patwardhan et al. [69]	2022	England							Negative			No
Pradhan et al. [71]	2014	USA			Negative				Mixed	Negative		Yes
Pradhan et al. [70]	2013	USA				Negative	Neutral	Negative				Yes
Stevenson and Grabowski [73]	2008	USA			Positive				Positive	Negative		Yes
Winblad et al. [74]	2017	Sweden			Positive				Negative			Yes
Evers and Geraedts [34]	2023	Germany	Negative		Mixed							No

Positive Impact — Mixed Impact (positive and negative) — Neutral/No Impact — Negative Impact

* Indicates study was NBER working paper from 2021 in original Borsa et al. evaluation and has since been published

Source: Adapted from Karamardian et al., 2024

higher ratings with regard to leadership (Patwardhan, Sutton & Morciano, 2022). Patwardhan et al. also found that the private equity-owned homes were rated overall lower by the English Care Quality Commission than non-profit homes and that private equity-owned homes were more likely to be rated as "Requires Improvement" or "Inadequate" (Patwardhan, Sutton & Morciano, 2022).

Three studies assess either private ownership or private equity ownership impacts on nursing home staffing, all using evidence from Sweden. Broms et al. note lower staffing density and education (Broms, Dahlström & Nistotskaya, 2024). Winblad et al. also find stronger performance of public operators on staffing levels and individual accommodation but find that privately owned operators tended to perform better on medication review and screenings (Winblad, Blomqvist & Karlsson, 2017). Importantly, Winblad et al. note that while there are statistically significant differences between public and private ownership, no statistically significant differences were found between the forms of private ownership studied, including private equity.

Arfwidsson & Westerberg find evidence of a higher proportion of hourly employment, more resident participation in care plan design, reasonable durations between meals, and higher rates of screening

for falls, pressure ulcers and malnutrition at private equity-owned homes, findings which are reflected in privately owned operators in Winblad et al. (Arfwidsson & Westerberg, 2012; Winblad, Blomqvist & Karlsson, 2017). Winblad et al. also find that care plans are updated more often and that employees have more advanced competence, but they spend fewer hours with residents in privately owned facilities (Winblad, Blomqvist & Karlsson, 2017). Arfwidsson & Westerberg add that private equity-owned homes tend to have fewer employees per resident (Arfwidsson & Westerberg, 2012).

A final study by Evers & Geraedts examines the impact of private equity ownership on nursing homes in Hessen, Germany, during the COVID-19 pandemic. The researchers found a lower number of outbreaks at private equity-owned homes, but note that those outbreaks tended to be larger and lasted longer (Evers & Geraedts, 2023). They also found increased proportions of infected and deceased residents at private equity-owned homes (Evers & Geraedts, 2023).

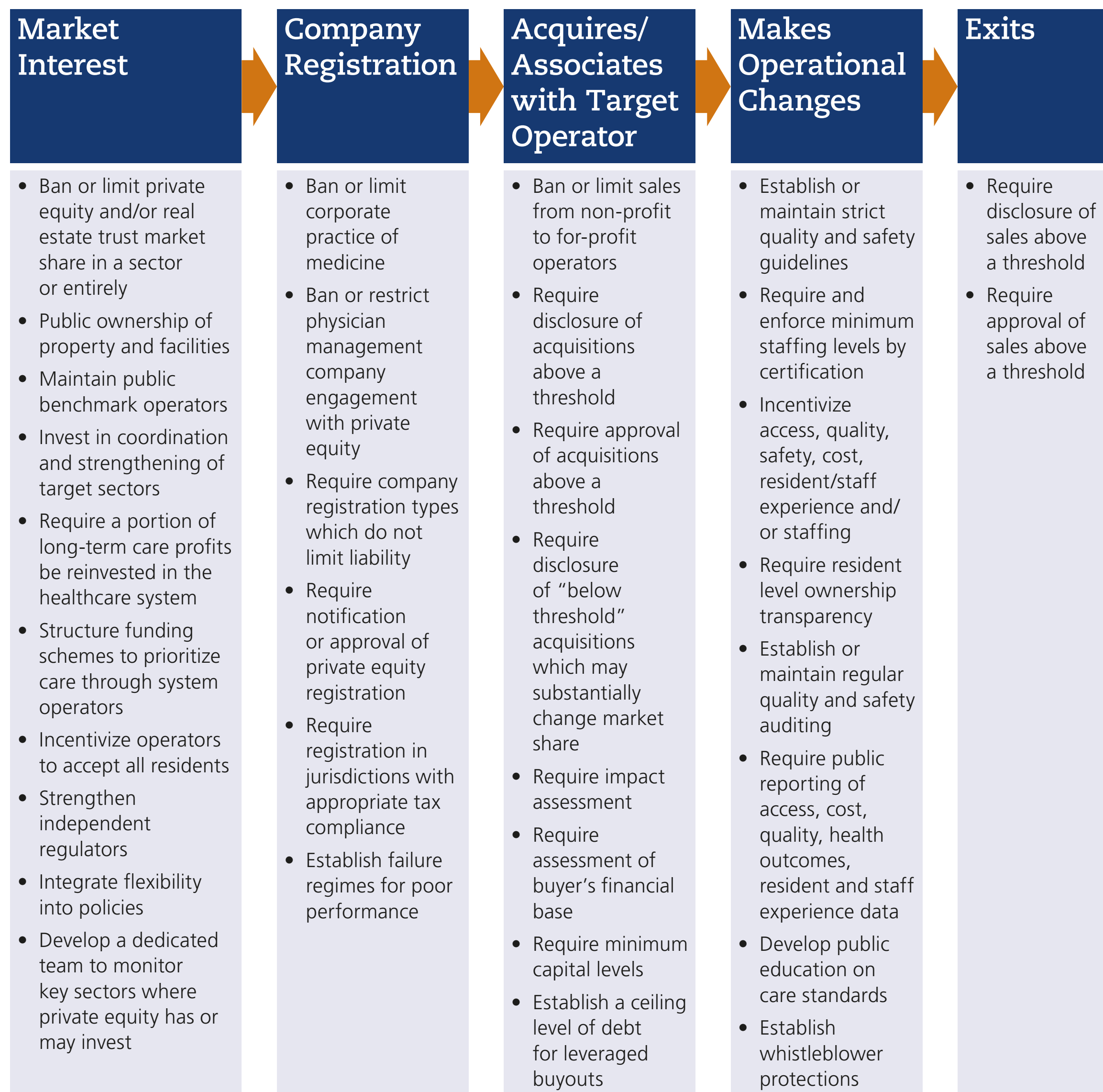
Overall, existing research, while still limited, raises concerns across national settings regarding staffing and quality in private equity-owned care homes.

8 Policy options to regulate private equity in LTC

A number of policy options exist that could help to minimize risks of private equity investment in LTC. Just as some negative effects are supported by more evidence than others, some policy options have more real-world experimentation than others. Each option listed in this report has been considered against the literature reviewed in preceding sections, even those with limited real-world examples, as they may still help to curtail negative effects.

The options shared are tailored to regulate private equity because it provides the most distinctive challenges, but they can be used as blanket policies covering many kinds of investors or operators in an LTC system. Policy options are organized by the stage of the private equity lifecycle which they may most effectively target (Fig. 2). Tables then present specific options for each stage in the lifecycle and the areas that they target, with indications of what kind of organization (such as a financially focused regulator, a care quality regulator) could develop and implement the policy and whether legislation is likely to be required.

Fig. 2 Policy options for the private equity lifecycle



Market interest

Policy	Policy Target	Policy-maker Concerned
Ban or limit private equity and/or real estate trust market share in a sector or entirely	Market entrance	Legislature; care quality regulators; anti-monopoly commissions
Public ownership of property and facilities	Market entrance; long-term sustainability	Governments; health system agencies; specific government body for LTC
Maintain public benchmark operators	Monitoring; long-term sustainability; health outcomes, cost, access	Governments; health system agencies; specific government body for LTC
Invest in coordination and strengthening of target sectors	Market entrance; long-term sustainability; health outcomes, cost, access	Health system agencies; care quality regulators; financial regulators
Require a portion of long-term care profits be reinvested in the healthcare system	Market entrance; long-term sustainability	Legislature; financial regulators
Structure funding schemes to prioritize care through system operators	Market entrance	Financing agency
Incentivize operators to accept all patients/residents	Market entrance; access	Financing agency; regulators; legislature
Strengthen independent regulators	Market entrance; health outcomes	Legislature; can require fees to fund regulator
Integrate flexibility into policies	Market entrance; monitoring	Creation of a strong and adaptable regulator
Develop a dedicated team to monitor key sectors where private equity has or may invest	Monitoring	Ministry; regulators

While a complete ban on private equity or REITs may not be politically feasible in many countries, varying levels of prohibition have been attempted. Tracey et al. highlight Ireland's 2023 *Screening of Third Country Transactions Act* which

> "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" (Tracey et al., 2025).

It is important to note that while a complete ban on private equity is an option, researchers are often skeptical of this option as it could mean facility closure in the absence of capital.

In what may be one of the most stringent regulations of private equity and REITs, Tracey et al. also note that the US state of Minnesota is considering the prohibition of private equity firms and REITS from "acquiring or increasing ownership in healthcare entities … as well as acquiring or increasing operational control over providers" (Lathrop GPM, 2024; Tracey et al., 2025), though it is not immediately clear how the government will identify private equity and REITs.

The trend in much of Europe over recent decades has been towards an increased role for private provision and private finance in LTC, reflecting the structural challenges of investing in care and managing facilities. Still, public provision of LTC could help to reduce private equity interest in the sector by increasing coordination among small operators and maintaining a high-quality

competitor in the market. In addition to these options, direct public provision or provision through state-supported undertakings that do not have profit as a goal can exercise a disciplining effect on the market, forcing private operators to raise standards. It is possible that even a relatively small scope of public sector provision in competition with private sector options can provide a benchmark that raises overall standards and enables some measure of resident choice regardless of other developments in the sector.

In contexts where a complete ban, major restrictions or public provision are infeasible, it may be possible to require a percentage of LTC profits to remain in the health system. Though this option would require the definition of strict health system boundaries and substantial administrative capacity for enforcement, it has been used in other contexts such as for private health insurance company profits.

Bos examines the growth of private equity and other for-profit actors in the Netherlands, a country which bans profit distribution in nursing home care. The study finds that changes in the regulatory structure and an embrace of extramural funding schemes – which allow recipients to adapt their care package and to organize and finance their own housing – allowed for-profit companies to skirt this ban leading to the ultimate financialization of the sector (Bos, 2020). Standardized funding schemes with less flexibility in care packages may disincentivize private equity investment, though it could also strain recipients who would prefer to remain at home or organize their own care based on their unique needs.

At the same time, Bos finds that for-profit providers were better able to meet demand, target affluent clientele and leverage the wider health system for specialist care (Bos, 2020). Requiring or incentivizing universal access to LTC operators could help to reduce private equity interest in the sector and improve access by disallowing the targeting of affluent clients.

One of the most salient characteristics of private equity is its ability to invest in an unparalleled level of industry research. Funds can invest heavily in financial, operational and legal expertise. These investments can mean that previously unknown, nonexistent or unused financial strategies and regulatory loopholes can suddenly become a core part of fund strategies and shape the sector. The result of this information asymmetry is that regulators and legislation that had regulated previous providers effectively might turn out to be insufficiently adaptable and unable to cope with new provider behaviours after private equity buyouts. The relative speed with which private equity funds can deploy capital and make acquisitions also means that they can implement strategies quickly, which can make it difficult for regulators to identify the strategies and for governments to amend legislation.

The solution, to avoid allowing strategies that endanger quality, equity, access, financial sustainability or stability across the sector, is to enable strong regulators with flexible policy instruments, a design and resources that allow them to monitor the sector (for example, identify concentration of providers), inspect facilities for quality and staffing on short notice, and adapt regulations quickly and transparently (for example, by setting new thresholds for local market concentration or updating definitions of corporate ownership to prevent gaming reporting requirements).

Company registration

Policy	Policy Target	Policy-maker Concerned
Ban or limit corporate practice of medicine	Health outcomes	Legislation; regulatory agencies
Ban or restrict physician management company engagement with private equity	Transparency; monitoring; health outcomes	Legislation; regulatory agencies
Require company registration types which do not limit liability	Market entrance; accountability	Legislation; regulatory agencies
Require notification or approval of private equity registration	Market entrance; monitoring	Legislation; regulatory agencies
Require registration in jurisdictions with appropriate tax compliance	Monitoring; accountability	Legislation; regulatory agencies
Establish failure regimes for poor performance	Long-term sustainability; health outcomes	Legislation; government regulatory framework; regulators

Banning or limiting corporate practice of medicine (CPOM) is a commonly cited policy option to maintain healthcare quality and safety. Tracey et al. highlight that several Canadian provinces only allow health profession corporations to provide health profession services (Tracey et al., 2025). A similar intervention was implemented in Germany, though without success (Tracey et al., 2025). A hallmark of private equity is complicated ownership structures and, in the US, CPOM laws have been avoided through the strategic use of physician management services. Additionally, bans or limits on CPOM are generally targeted at physician practices or physician employment and may not effectively translate to institutional facilities.

Banning or limiting the use of physician management services or explicitly requiring separate disclosure could help to manage this workaround. To further regulate against complex ownership structures, governments could require companies which acquire LTC operators to be registered under a company type which does not limit liability. This may also require a policy which mandates notification or approval of new registrations for private equity firms.

Requiring firms to be registered in jurisdictions with appropriate tax compliance may help to limit the use of tax havens to minimize costs. This could help to reduce private equity interest in the sector while encouraging accountability. Unfortunately, this option would likely have little effect in countries such as Luxembourg, the Netherlands, Switzerland or Ireland, where the domestic tax code does not require corporation or capital gains taxes of private equity (Walsh & Connolly, 2024; Zucman, 2015). This strategy is also unlikely to work in EU Member States where firms cannot be excluded on grounds of country of incorporation.

Lack of ex-post accountability could also be addressed through failure regimes. In this case, a failure regime has two key functions. One is to ensure that a failing facility can actually be closed once serious or irredeemable deficiencies are identified, and that whistleblowers who help detect these deficiencies (whether workers, residents or their families) are protected. Good quality regulation requires thoughtful failure regimes that can remove the risks to residents of particularly problematic homes without creating new risks from closure. Closing a poor-quality facility at short notice means rehousing people who might be vulnerable and can add new risks and quality problems to an already bad situation.

The second problem, which follows on from the first, is to ensure the credibility of inspectors and regulators. One of the problems with monopoly or oligopoly provision of services is that the purchasers (public sector or private individuals) become dependent on a limited number of providers, who in turn are less subject to market discipline. People who are offered no alternative cannot shop around for better quality. Public sector budgets and private sector strategies will often converge, in a sector like LTC, on very limited budgets that do not enable the new entrants and excess capacity that enable consumer choice. Very low-cost established providers (efficient or just poor-quality) that have learned to live within the existing payments system will dominate. As a result, such services depend heavily on regulation to ensure quality. Regulators, however, must cope with the problem that they

are responsible for the welfare of vulnerable people and it is not necessarily easy to sanction or close a facility without further endangering them. If closing a facility on grounds of serious threats to resident safety means rehousing vulnerable people late at night, for example, then the option will be less attractive to regulators, less credible to operators and less protective of residents. If closing a facility is not an option, it is all too easy to leave facilities open despite long lists of deficiencies until a disaster occurs. Once that is understood, it becomes easy for the regulator and provider alike to downplay deficiencies.

As a result, a failure regime must be constructed that makes the full range of regulators' penalties credible. That involves not just strong ex-post accountability (credible threats to prosecute individuals) but also clear organizational systems designed to enable closure by, for example, procedures to replace management and staff at short notice, legal systems that are flexible about what closure entails (for example, not demanding immediate removal after a court order), and financial mechanisms (for example, bonding or insurance) to ensure that the costs of a failed home are borne by the organization and investors responsible for the failure.

Private equity and other larger operators offer additional options not available when regulators are facing a very small or single-site operator. Larger chains respond differently to incentives and present different problems than smaller providers; for example, limiting new admissions across the chain on the basis of problems at one or more sites might be an effective way to punish serious breaches. In these cases, recognizing the actual ownership and links between companies is important, which leads to the next policy option, which is transparency about ownership.

Evidence from Norway illustrates as an example that municipal ownership of nursing home properties has helped to constrain for-profit chains (Harrington et al., 2017). Public ownership allows Norway to terminate contracts in the instance of heightened costs or lower care quality because terminated contracts do not result in resident transfers as they might if the property and building were not municipal-owned (Harrington et al., 2017).

Another option for preserving continuity of care through a failure regime could be requiring buyers to pay into a specific fund or purchase bonds from the government in order to generate financing for interim owners or resident transfers should the company fail.

Acquisition or association with a target operator

Policy	Policy Target	Policy-maker Concerned
Ban or limit sales from non-profit to for-profit operators	Market entrance	Legislation; financial regulatory agency; competition authority
Require disclosure of acquisitions above a threshold	Market entrance; competition	Legislation; financial regulatory agency; competition authority
Require approval of acquisitions above a threshold	Market entrance; competition	Legislation; financial regulatory agency; competition authority
Require disclosure of "below threshold" acquisitions which may substantially change market share	Market entrance; competition	Legislation; financial regulatory agency; competition authority
Require impact assessment	Market entrance; competition; access	Legislation; health systems regulators
Require assessment of buyer's financial base	Market entrance; long-term sustainability	Legislation; financial regulatory agency
Require minimum capital levels	Market entrance; long-term sustainability	Legislation; financial regulatory agency
Establish a ceiling level of debt for leveraged buyouts	Market entrance; long-term sustainability	Legislation; financial regulatory agency

Tracey et al. highlight the 2021 *Ontario Fixing Long-Term Care Act* which

> "prohibits non-profit entities from transferring LTC licenses or beds to for-profit entities except in the circumstance that such a transfer is specified within the license, or the non-profit entity

is in default on preexisting obligations … [and] prohibits non-profit entities from issuing or transferring shares to for-profit entities, with similar exceptions" (Tracey et al., 2025).

While not an outright ban on private equity specifically, policies like this one could limit private equity entrance into an LTC market.

One of the most popular policy options cited in the literature involves disclosure and transparency. In all seven countries analysed by Tracey et al., they identified disclosure-related policy measures, with the most commonly cited intervention being national or subnational requirements to report mergers and acquisitions above a certain threshold (Tracey et al., 2025). The authors constructed a particularly useful table of these interventions (Table 1).

Table 1 Adapted results from Tracey et al.

Country	Disclosure Policy
Canada	Parties must submit a premerger notification to the Commissioner of Competition if the transaction exceeds CAD$ 93 million, 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.
Germany	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 private equity funds go unnoticed as the threshold for an acquisition to be disclosed to the anti-monopoly office is set at €17.5 million yearly turnover, and most practices are below this.
Finland	Under the Finnish Competition Act (948/2011), 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.
	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.
France	Since 2009, proposed mergers 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 three outcomes: an approval, an approval subject to conditions that the company must comply with, or a ban.
	In 2023, a law was adopted to protect companies of regulated professions (such as 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 (for example, the French Medical Association for doctors), who must ensure the independence of professionals.
	French authorities have set up an interministerial task force to increase knowledge on financialization in the health sector and quantify the phenomenon. The French National Health Insurance Fund contributes to this task force and, on top of that, advocates for the creation of a National Observatory on the financialization of the health system.
Ireland	Managers of private equity funds must be registered with and authorized by the Central Bank of Ireland and satisfy compliance requirements.
	Residential LTC service providers must register with the Health Information and Quality Authority and provide details of ownership and any changes to ownership.
	Since 2023, the Competition and Consumer Protection Commission requires merging parties to notify of 'below threshold deals' where an effect on competition in a given market may occur. The current thresholds are deals where two firms generate more than €10 million in Ireland, with a combined turnover of €60 million.

continued on next page

Country	Disclosure Policy
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.
	The ACM indicated in May 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 more than 50 employees.
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 US$ 25 million over a 12-month period.
	Federal government requires nursing homes accepting Medicare/ Medicaid patients to report detailed ownership and operating information.

Source: Tracey et al., 2025

The US state of Oregon has also taken steps towards additional transparency in mergers and acquisitions in the health system by setting up the new state-level Health Care Market Oversight authority under the Oregon Health Authority, which is tasked with tracking transactions and monitoring their impacts (Oregon Health Authority, n.d.).

Evidence from the US and Europe indicates that many private equity-related mergers and acquisitions fall below reporting thresholds, allowing private equity to fly under the radar when it comes to amassing local market share and, over time, reducing effective competition. Similarly, private equity deals in LTC can skirt reporting by structuring them as real estate deals which generally do not require antitrust approval.

Private equity companies have been known to purchase a substantial proportion of various practices or service lines in a given area and use that additional market share to leverage higher allowed amounts from insurers. In parallel, private equity raises charges for residents while insurers raise premiums, essentially nullifying any consumer gains in insurer-allowed amounts.

It is clear, then, that while requiring disclosure of mergers and acquisitions above a certain threshold may help policy-makers and researchers monitor private equity in the sector, these thresholds should be carefully considered so as to catch smaller activity which still has the possibility of upending local competition.

Additionally, evidence from the US suggests that private equity firms are often registered as LLCs, which are exempt from certain reporting requirements. The registration of many small LLCs helps private equity firms to skirt reporting requirements as they relate to ownership structures and hide profits behind complex company designs. Similar patterns have been identified in Canada, Norway, Sweden and the United Kingdom (Harrington et al., 2017), though the actual company types and legal protections offered by them differ by country.

Private equity firms have been known to engage in both LBOs and sale-leasebacks. These strategies generate risk for portfolio companies who are responsible for paying back the debt used to purchase them and for inflated rent payments made to the purchasing private equity firm.

Any attempt to address private equity in LTC must contend with both the amount of debt leveraged on portfolio companies and the associated risk of closure, the impact of closure and ownership changes on care continuity, and the ex-post accountability of profit-motivated actors who extract wealth at the expense of residents and taxpayers. There are a number of potential policy options that may help to minimize these impacts and hold actors accountable.

Extant literature has recommended a number of policy options aimed at ensuring better financial sustainability following the private equity-acquisition of LTC facilities, in addition to methods of ensuring resident welfare should facilities have to shut down. Allan et al. have suggested more intensive assessment of buyers' financial base prior to purchases of LTC facilities and requirements

of minimum capital levels which are sufficient to maintain operations of the facilities (Allan, Irvine & Achterberg, 2022). The study also suggests a ceiling level of debt for LBOs which could help to curtail instances of default on said debt which could result in facility closures (Allan, Irvine & Achterberg, 2022). Policy-makers interested in this type of intervention might look to Finland, whose FCCA assesses whether acquisitions may disrupt a competitive market, or to France, where the law allows regional authorities to limit the opening of new laboratories perceived as impeding competition (Tracey et al., 2025).

Interventions meant to maintain financial sustainability and continuity of care must also consider the role of REITs, a hallmark of private equity in LTC, in which care operations are separated from the property on which they occur.

REITs have played a substantial role in Canada, the US, the United Kingdom and Ireland, in particular (Harrington et al., 2017). A cross-national study by Harrington et al. documented that at the time of the study, of the five largest nursing home chains in each country, three Canadian companies had separated property from operations, along with four in the US and five in the United Kingdom (Harrington et al., 2017). The authors note that most REITs use triple-net leases which "make individual nursing homes solely responsible for 3 types of costs: net real estate taxes on the leased assets, net building insurance, and net common area maintenance" (Harrington et al., 2017). These costs on individual nursing homes have in case studies proven unsustainable for many care home chains.

Operational changes

Policy	Policy Target	Policymaker Concerned
Establish or maintain strict quality and safety guidelines	Market entrance; monitoring; health outcomes	Care quality regulators
Require and enforce minimum staffing levels by certification	Market entrance; monitoring; health outcomes	Care quality regulators
Incentivize access, quality, safety, cost, resident/staff experience and/or staffing	Market entrance; health outcomes, access, cost	Payers; care quality regulators; professional associations
Require resident level ownership transparency	Transparency; competition; health outcomes, access, cost	Legislation; care quality regulators
Establish or maintain regular quality and safety auditing	Monitoring; health outcomes	Care quality regulators
Require public reporting of access, cost, quality, health outcomes, resident and staff experience data	Monitoring; transparency; health outcomes, access, cost	Care quality regulators; financial regulators
Develop public education on care standards	Competition; health outcomes	Government; care quality regulators
Establish whistleblower protections	Accountability; transparency; health outcomes; monitoring	Legislation; regulatory agencies

Resident care is a primary concern given the financialization of LTC. While the evidence presented above mentions some neutral to positive implications of this trend, most studies find that private equity-ownership of LTC facilities reduces care quality and worsens health outcomes (Borsa et al., 2023; Karamardian et al., 2024). Policy aimed at minimizing the harmful effects of private equity in this sector should prioritize regulations aimed at safeguarding care quality.

Establishing and enforcing strict quality and safety guidelines for LTC is a good place to start. Minimum staffing levels should be included in these guidelines and should be defined at the level of certification.

Transparency may also be a useful tool for improving resident safety and reporting may include data collection and sharing on ownership structures, profits, tax liability and resident outcomes. Reporting should be available to policy-makers and researchers as a minimum, but providing residents and the public with both information about the quality of operators and education on what high-quality care looks like could be useful tools to improve competition within an LTC market.

Unlike the markets for many goods, the market for LTC is generally considered uncompetitive. Most consumers hope to remain close to home or near family, choosing their care provider based on location rather than using available data to make an informed decision about the best "product". Lack of competition may hinder consumer choice policies which aim to arm consumers with useful information that will help them make smart care choices. Still, arming consumers with knowledge is likely to support some level of competition aimed at raising quality and safety across operators.

A number of studies call for public access to data on LTC facility ownership structures (Allan, Irvine & Achterberg, 2022) so that, at a minimum, potential clients are able to distinguish between government-owned, non-profit and for-profit facilities, in addition to whether the facility is backed by private equity or other types of highly profit-driven owners.

Beyond information on ownership, consumers may also benefit from better access to health outcome data at the facility level (Allan, Irvine & Achterberg, 2022). Designing clear, easily accessible public education for what high-quality LTC care looks like, along with required staffing levels, may help potential clients to better decipher which LTC facility is best for their needs (Allan, Irvine & Achterberg, 2022).

Exits

Policy	Policy Target	Policymaker Concerned
Require disclosure of sales above a threshold	Market entrance; competition; monitoring; long-term sustainability	Legislation; financial regulator
Require approval of sales above a threshold	Market entrance; competition; monitoring; long-term sustainability	Legislation; financial regulator

The final policy options highlighted in this report are partially related to the first several that were covered because they regulate the purchase and sale of operators and their assets. Again, requiring the disclosure or approval of sales above a certain threshold could help to reduce market entrance, improve competition and monitoring, and promote long-term sustainability.

9 Conclusion

The problems of LTC sectors are well known: a fragmented sector dotted with undercapitalized and poorly managed providers faces serious challenges in ensuring quality, financial sustainability, access and equity. Private equity investors, with their superior financial resources, novel strategies and often superior information, are increasingly willingly to enter the sector. The novelty of private equity in the LTC sector stems from its distinctive reliance on debt, short time horizons, information, financial resources, unusual business strategies (such as consolidation of small providers in an area) and operational approaches, but the problems associated with private sector operators can be addressed by the same kinds of policies that effectively regulate private equity. A regulatory system designed to prevent the negative effects associated with private equity investment is probably one that can also prevent problems created by other kinds of investors and actors. In particular, flexible and effective regulators that can move quickly to adapt regulations and take credible action against firms that violate standards are important because private investors' strategies can change far more quickly than legislative procedures can catch up.

The policy options we discuss might be particularly relevant to systems facing private equity investment that want to ensure quality and sustainability, but they should be broadly applicable to any LTC system whose policy-makers are attempting to balance cost, quality, equity and access among disparate investors and operators. Policy options that ensure private equity enhances, rather than damages, LTC provision should also help ensure that others in the system also provide the quality care, financial stewardship and dignity that everybody deserves.

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