

ANTITRUST, VAMPIRES, AND BLOODY ACQUISITIONS

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Private equity has rapidly seized control of large swaths of the U.S. healthcare system. This Essay argues that its takeover is not a story of efficiency or innovation but one of extraction. Drawing on a substantial body of research, it shows that private equity acquisitions are associated with rising healthcare costs, inferior care, reduced access to essential services, and deteriorating working conditions for physicians and nurses—harms that fall most heavily on marginalized communities.

These outcomes are not accidental. They stem from the private equity business model, which relies on leveraged buyouts, aggressive cost cutting, and roll-up strategies designed to generate short-term profits. In healthcare, these incentives manifest as staff reductions, service line closures, physician burnout, and the erosion of population health. As access to care shrinks and health outcomes worsen, civic participation declines, deepening inequality and undermining democratic inclusion.

Despite these predictable harms, antitrust enforcers have largely failed to confront the harm private equity's expansion in healthcare poses to Americans. Many acquisitions evade review under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, and enforcers have, thus far, not considered how private equity buyouts in healthcare harm labor. This Essay argues that existing antitrust law—particularly section 7 of the Clayton Act—already provides the tools to act. It calls on enforcers and courts to block private equity buyouts that are likely to increase prices, harm quality, or reduce access to care and to treat labor harms as central anticompetitive effects. Antitrust law cannot cure every ill, but it can stop the bleeding.

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INTRODUCTION

Private equity increasingly dominates American healthcare, with far-reaching and often detrimental consequences for healthcare workers and population health. The COVID-19 pandemic left many hospitals financially vulnerable after patients were instructed to cancel elective surgeries—a primary source of revenue for most providers.¹ This sudden decline in clinical income destabilized numerous medical practices and accelerated private equity’s expansion across the U.S. healthcare sector.² By 2022, nearly 5 percent of physicians were employed by private equity–owned practices, and by 2023, private equity firms controlled a majority share in several specialty physician markets, including anesthesiology, emergency medicine, and dermatology.³

Private equity’s growing presence in healthcare has sparked vigorous debate. Proponents argue that private equity’s involvement can help medical

1. See Sierra Lear, *Private Equity Involvement in Medical Care*, RENAL & UROLOGY NEWS (Oct. 26, 2023), <https://www.renalandurologynews.com/features/private-equity-in-medical-care/> [https://perma.cc/4NKW-MFCC].

2. Press Release, Am. Med. Ass’n, AMA Examines Decade of Change in Physician Practice Ownership and Organization (July 12, 2023), <https://www.ama-assn.org/press-center/ama-press-releases/ama-examines-decade-change-physician-practice-ownership-and> [https://perma.cc/5Y8H-V8ZE].

3. Lear, *supra* note 1.

practices streamline operations, reduce costs, and enhance efficiency.⁴ By incentivizing practices to eliminate waste and standardize care, private equity, proponents contend, promotes growth, innovation, and the adoption of new care models. Improved efficiency, they argue, may also help limit unnecessary or duplicative services.⁵ Opponents, however, offer a starkly different assessment. They emphasize that private equity acquisitions are often associated with higher healthcare costs, reduced quality of care, and diminished access⁶—especially for vulnerable populations already facing systemic barriers to accessing healthcare.⁷ This Essay demonstrates that these risks are not merely theoretical: private equity’s pursuit of outsized, short-term profits undermines both health equity and the delivery of affordable, high-quality care.

Several factors help explain these outcomes. Private equity firms raise capital from institutional investors and high-net-worth individuals to purchase controlling stakes in companies, like hospitals, often through leveraged buyouts (LBOs).⁸ In an LBO, the acquisition is financed primarily with debt secured by the target company’s assets and future earnings rather than the private equity firm’s own equity.⁹ This financing structure transfers substantial financial risk to the acquired healthcare provider, burdening it with debt that limits its capacity to invest in innovation, workforce development, or improvements in care quality.¹⁰ Consequently, healthcare providers under private equity ownership are often compelled to allocate a large portion of their revenue to debt servicing, leaving them financially fragile and more susceptible to distress or bankruptcy.¹¹ Firms acquired through LBOs face roughly an 18 percent higher risk of bankruptcy.¹²

In addition, although private equity firms typically contribute only about 2 percent of the total capital in a given transaction, they capture roughly 20 percent of the profits, incentivizing aggressive risk taking to rapidly increase

4. Laura O. Karas, *The Private Equity Takeover of Medicine*, SYSTEMIC JUST. J., July 2021, at 1, 7, <https://systemicjustice.org/article/the-private-equity-takeover-of-medicine> [<https://perma.cc/N56Y-PXQV>].

5. *Id.*; see also Sajith Matthews & Renato Roxas, *Private Equity and Its Effect on Patients: A Window into the Future*, INT’L J. HEALTH ECON. MGMT., May 2022, at 1, 1.

6. David Blumenthal, *Private Equity’s Role in Health Care*, COMMONWEALTH FUND (Nov. 17, 2023), <https://www.commonwealthfund.org/publications/explainer/2023/nov/private-equity-role-health-care> [<https://perma.cc/3YLF-E86Z>].

7. Maya Brownstein, *Private Equity’s Appetite for Hospitals May Put Patients at Risk*, HARV. T.H. CHAN SCH. OF PUB. HEALTH (Dec. 18, 2024), <https://hsph.harvard.edu/news/private-equitys-appetite-for-hospitals-may-put-patients-at-risk/> [<https://perma.cc/K37S-XBCQ>] (noting that “many . . . disadvantaged patients belong to racial or ethnic minorities and already suffer worse health outcomes”).

8. Erin C. Fuse Brown & Mark A. Hill, *Private Equity and the Corporatization of Health Care*, 76 STAN. L. REV. 527, 527 (2024).

9. *Id.* at 530.

10. Valentina Dabos, *Private Equity Bankruptcy Tracker*, PRIV. EQUITY STAKEHOLDER PROJECT (Feb. 12, 2025), <https://pestakeholder.org/reports/private-equity-bankruptcy-tracker/> [<https://perma.cc/HS3L-9ZM9>].

11. *Id.*

12. Brian Ayash & Mahdi Rastad, *Leveraged Buyouts and Financial Distress*, 38 FIN. RSCH. LETTERS, Jan. 2021, at 1, 1.

short-term returns.¹³ Private equity firms also generally aim to double or triple their investment within four to seven years, a timeline that intensifies the pressure to cut costs and maximize immediate profitability—often at the expense of patient care.¹⁴

Not surprisingly, these incentives drive firms to liquidate valuable assets for quick cash flow. For example, private equity owners of hospitals frequently engage in sale-leaseback transactions, in which the hospital's real estate is sold to a third party and leased back.¹⁵ While such transactions generate short-term liquidity, they leave hospitals with fewer tangible assets and higher ongoing lease obligations, further compromising long-term financial stability and the ability to ensure continuity in care.¹⁶

Private equity firms also routinely impose sizable management and advisory fees on the companies they acquire—charges that can drain millions of dollars from operating budgets each year.¹⁷ In many cases, firms have even extracted payment for services that are never provided through so-called “accelerated monitoring fees.”¹⁸ Such practices further divert scarce financial resources away from patient care and hospital operations, redirecting them toward investor enrichment and short-term profits.¹⁹

To satisfy their appetite for rapid, immediate returns, private equity firms also employ “roll-up” strategies: acquiring and consolidating multiple firms within the same industry segment under a unified corporate structure.²⁰ This approach is often promoted as a way to achieve economies of scale and operational efficiency.²¹ However, a substantial body of empirical research shows that such consolidation among healthcare providers is consistently linked to higher costs for private insurers and public programs, including Medicare.²²

What's more, following a private equity buyout, nurses and physicians experience higher levels of burnout and job dissatisfaction as their primary

13. Brown & Hill, *supra* note 8, at 537.

14. PESP Private Equity Hospital Tracker, PRIV. EQUITY STAKEHOLDER PROJECT (Apr. 2025), https://pestakeholder.org/private-equity-hospital-tracker/#key_findings [<https://perma.cc/U6EX-YE8P>].

15. *When Health Care Becomes Wealth Care: How Corporate Greed Puts Patient Care and Health Workers at Risk: Hearing Before the S. Committee on Health, Educ., Lab. & Pensions*, 118th Cong. 11 (2024) (statement of Eileen O'Grady, Rsch. and Campaign Dir., Healthcare, Priv. Equity Stakeholder Project).

16. Brian Spegele, *How a Small Alabama Company Fueled Private Equity's Push into Hospitals*, WALL ST. J. (Feb. 14, 2022, at 09:56 ET), <https://www.wsj.com/finance/investing/hospitals-private-equity-reit-mpt-steward-11644849598> (on file with the *Fordham Law Review*).

17. EILEEN APPELBAUM & ROSEMARY BATT, FEES, FEES AND MORE FEES: HOW PRIVATE EQUITY ABUSES ITS LIMITED PARTNERS AND U.S. TAXPAYERS, CTR. FOR ECON. & POL'Y RSCH. 28–29 (2016), <https://cepr.net/images/stories/reports/private-equity-fees-2016-05.pdf> [<https://perma.cc/9B5G-8S84>].

18. PRIV. EQUITY STAKEHOLDER PROJECT, *supra* note 14.

19. APPELBAUM & BATT, *supra* note 17, at 9; PRIV. EQUITY STAKEHOLDER PROJECT, *supra* note 14.

20. Brown & Hill, *supra* note 8, at 538.

21. Matthews & Roxas, *supra* note 5, at 1.

22. PRIV. EQUITY STAKEHOLDER PROJECT, *supra* note 14.

responsibility shifts from treating patients to boosting shareholders' financial returns on investment.²³ As a result, providers are leaving the profession at increasing rates, exacerbating the current shortage of nurses and physicians.²⁴ In other words, private equity fosters a "vicious cycle toward a higher-cost, lower-quality, less equitable U.S. healthcare system, albeit with record-breaking profits for investors."²⁵

The sudden closure of Hahnemann Hospital, just months after its acquisition by private equity,²⁶ underscores the risks of a profit-driven mission in healthcare. In 2018, American Academic Health System (AAHS), a hospital management company owned by the private equity firm Paladin Healthcare Capital, acquired Hahnemann.²⁷ Joel Freedman, who controlled both Paladin and AAHS, promised staff and the local community that the acquisition would bring significant investment and resolve the hospital's long-standing financial struggles.²⁸ In reality, Freedman's management showed a limited understanding of hospital operations, prioritizing financial engineering over improvements in quality of care.²⁹ Under AAHS, Hahnemann's losses mounted, reaching millions per month.³⁰ The company responded by laying off hundreds of employees, closing outpatient offices, and cutting clinical services.³¹ By June 2019, the hospital shuttered, and AAHS filed for bankruptcy.³² More than 2,000 physicians, nurses, and staff lost their jobs, and over 500 residents and fellows were displaced, struggling to secure placements at other programs.³³ Just months later, the COVID-19 pandemic compounded the impact: thousands of primarily Black and

23. See generally THE PHYSICIANS FOUND., 2024 SURVEY OF AMERICA'S PHYSICIANS: EXAMINING PHYSICIAN, RESIDENT AND STUDENT WELLBEING AND IMPACT OF THE CURRENT HEALTHCARE LANDSCAPE (2024), <https://physiciansfoundation.org/wp-content/uploads/2024-Survey-of-Americas-Current-and-Future-Physicians.pdf> [<https://perma.cc/57L4-PFPV>].

24. Theodosia Stavroulaki, *How Private Equity Hurts the Healthcare Workforce*, PROMARKET (May 22, 2025), <https://www.promarket.org/2025/05/22/how-private-equity-hurts-the-healthcare-workforce/> [<https://perma.cc/SJZ5-LBWN>].

25. *Id.*

26. Chris Pomorski, *The Death of Hahnemann Hospital*, NEW YORKER (May 31, 2021), <https://www.newyorker.com/magazine/2021/06/07/the-death-of-hahnemann-hospital> (on file with the *Fordham Law Review*).

27. Congresswoman Mary Gay Scanlon, Comment on Dep't of Just., Dep't of Health and Hum. Servs., and the FTC Request for Information on Consolidation in Health Care (June 5, 2024), <https://www.regulations.gov/comment/FTC-2024-0022-2041> [<https://perma.cc/Q9PM-J5FC>].

28. *Id.*

29. *Id.*; Pomorski, *supra* note 26.

30. Sonja Sherwood, *FAQ: How Hahnemann's Closing Impacts Drexel*, DREXEL NEWS (July 22, 2019), <https://drexel.edu/news/archive/2019/july/how-hahnemann-closing-impacts-drexel> [<https://perma.cc/444R-FZYP>].

31. Jonathan Jaffery on behalf of the Ass'n of Am. Med. Colls., Comment on Dep't of Just., Dep't of Health and Hum. Servs., and FTC Request for Information on Consolidation in Health Care (June 3, 2024), <https://www.regulations.gov/comment/FTC-2024-0022-1838> [<https://perma.cc/Y2US-97YN>].

32. *Id.*

33. *Id.*

low-income patients, Hahnemann's primary population, were left with no access to care.³⁴

When marginalized communities are denied essential care, health inequities in the United States are likely to worsen. "Clinical evidence indicates a strong link between social determinants of health and health inequities."³⁵ Decades of research show that "the relationship between social advantage and health is incremental—with less advantaged groups experiencing a disproportionate burden of poor health and even relatively advantaged groups showing a deficit."³⁶ Vulnerable populations face greater structural barriers to adopting healthier lifestyles, and racial and ethnic minority groups in the United States are at higher risk for chronic respiratory diseases, hypertension, and diabetes.³⁷ Consequently, private equity's growing involvement in healthcare disproportionately harms these communities, which already suffer from poorer health outcomes.

Unfortunately, when large segments of the population are systematically deprived of access to quality care, the health of democracy may also be at risk. Poor health can limit individuals' ability or motivation to vote or otherwise engage civically.³⁸ As these citizens withdraw, elected officials and policies increasingly reflect the interests of the well-resourced,³⁹ reinforcing inequality and eroding trust in public institutions. In this way, the degradation of healthcare access driven by private equity not only deepens social divides but also undermines the very foundations of democratic participation.

Despite these harmful effects, antitrust enforcers have failed to prevent the harms private equity acquisitions cause to millions of Americans. Since many mergers and acquisitions fall below the reporting thresholds for regulatory review established by the Hart-Scott-Rodino Antitrust Improvements Act of 1976⁴⁰ ("HSR"), they often escape antitrust scrutiny.

34. Harold Brubaker, *The Loss of Hahnemann Resonates a Year Later as COVID-19 and Black Lives Matter Protests Roil Philadelphia*, PHILA. INQUIRER (June 20, 2020, at 05:00 ET), <https://www.inquirer.com/business/health/hahnemann-closure-resonates-black-lives-matter-covid-19-pandemic-20200620.html> (on file with the *Fordham Law Review*); Brownstein, *supra* note 7.

35. Theodosia Stavroulaki, *Mergers That Harm Our Health*, 19 BERKELEY BUS. L.J. 89, 96 (2022).

36. Ana Penman-Aguilar, Makram Talih, David Huang, Ramal Moonesinghe, Karen Bouye & Gloria Beckles, *Measurement of Health Disparities, Health Inequities, and Social Determinants of Health to Support the Advancement of Health Equity*, 22 J. PUB. HEALTH MGMT. & PRAC. SUPPLEMENT S33, S34 (2016).

37. Elizabeth Brondolo et al., *Dimensions of Perceived Racism and Self-Reported Health: Examination of Racial/Ethnic Differences and Potential Mediators*, AM. J. PREVENTATIVE MED. 14, 14 (2011).

38. Anil Menon, Nolan M. Kavanagh, Michelle Falkenbach, Matthias Wismar & Scott L. Greer, *The Role of Health and Health Systems in Shaping Political Engagement and Rebuilding Trust in Democratic Institutions*, LANCET REG'L HEALTH—EUR., June 2025, at 1, 5.

39. Javier M. Rodriguez, *Health Disparities, Politics, and the Maintenance of the Status Quo: A New Theory of Inequality*, 200 SOC. SCI. & MED. 36, 41–42 (2018).

40. Pub. L. No. 94-435, 90 Stat. 1383 (codified as amended in scattered sections of 15 U.S.C.).

Additionally, over the past decade, the antitrust enforcers have not thoroughly assessed how acquisitions in the healthcare industry affect healthcare professionals' working conditions. In this way, they have contributed to the wounds these deals cause to the American healthcare workforce and the harm they pose to the health of the most vulnerable people. In light of these risks, this Essay asks: Can antitrust law prevent the harms private equity's takeover of hospitals and medical practices cause to patients, healthcare workers, and population health? And if so, how?

This Essay makes two proposals. First, the enforcers and the courts should challenge any acquisition that is likely to lead to increased prices, lower quality, or reduced access to care, especially for underserved populations. Second, rather than focusing only on the effects of private equity buyouts on the quality, access, and cost of care, the enforcers should also assess each deal's impact on healthcare professionals' working conditions. By addressing these harms under section 7 of the Clayton Act,⁴¹ the enforcers could also promote population health.

This Essay proceeds as follows. Part I examines how private equity firms operate as modern-day vampires, demonstrating that their relentless pursuit of financial gain drains the lifeblood of the U.S. healthcare system. As a result, patients face higher costs, lower quality care, and diminished access to healthcare services. Following a private equity buyout, the American healthcare workforce also suffers from increased burnout, which can lead professionals to leave the field entirely. Part II explains how antitrust enforcers can confront these harms: they can challenge these acquisitions on the basis of section 7 of the Clayton Act. Part III delves into the potential counterarguments private equity firms could present to escape antitrust liability.

I. HOW PRIVATE EQUITY PROFITS BY BLEEDING PATIENTS AND HEALTHCARE WORKERS

This part examines how private equity acquisitions in healthcare threaten both health equity and the quality of care, particularly for marginalized communities that already face numerous barriers in accessing essential services. Following a private equity buyout, healthcare entities often raise prices, lower care quality, and restrict access—all of which undermine population health.⁴² Moreover, these acquisitions frequently lead to higher workloads and greater job dissatisfaction among healthcare workers, prompting many physicians and nurses to leave the profession.⁴³ This trend exacerbates the nation's worsening provider shortages and contributes to hospital closures, especially in underserved areas.⁴⁴

41. 15 U.S.C. §§ 12–27.

42. *See* Stavroulaki, *supra* note 24.

43. *See id.*

44. Theodosia Stavroulaki, *The Healing Power of Antitrust*, 119 *Nw. U. L. REV.* 944, 949 (2025).

Beyond their impact on health outcomes, private equity buyouts may also endanger the foundations of a healthy democracy. When vulnerable populations are denied quality care, their capacity to engage in civic and electoral participation diminishes.⁴⁵ As marginalized voices go unheard, policymakers may overlook their needs, further deepening economic inequality and widening the health disparities that weaken the social fabric of the United States.

A. *Rising Healthcare Costs*

Private equity firms investing in healthcare practices often use a “platform and add-on” or “roll-up” model, acquiring a large established practice as the platform and then adding smaller ones to quickly expand market dominance.⁴⁶ This increase in market power enables them to demand higher reimbursement rates from health insurers,⁴⁷ driving up the premiums paid by consumers and employers and contributing to alarming numbers of uninsured and underinsured Americans.⁴⁸

Ordinarily, providers within a geographic region compete intensely for inclusion in health insurers’ networks, since these networks are a crucial source of patients who face lower out-of-pocket costs when treated in-network.⁴⁹ Robust competition enables insurers to negotiate lower reimbursement rates, ultimately reducing overall healthcare costs for patients and employers.⁵⁰ Once accepted into a network, providers seek to attract more patients—and increase profits—by improving care quality.⁵¹

Reimbursement rates are determined through negotiations between providers and private payers, where market bargaining power plays a

45. *Health & Democracy Index*, BLACK WELLNESS & PROSPERITY CTR., <https://www.blackwpc.org/health-democracy-index> [<https://perma.cc/9YRG-FR44>] (last visited Jan. 13, 2026).

46. Brown & Hill, *supra* note 8, at 538; *see also* Yashaswini Singh, Megha Reddy & Jane M. Zhu, *Life Cycle of Private Equity Investments in Physician Practices: An Overview of Private Equity Exits*, HEALTH AFFS. SCHOLAR, Apr. 2024, at 1, 1.

47. Loren Adler, Conrad Milhaupt & Samuel Valdez, *Measuring Private Equity Penetration and Consolidation in Emergency Medicine and Anesthesiology*, HEALTH AFFS. SCHOLAR, June 2023, at 1, 1.

48. *See generally* Complaint, FTC v. U.S. Anesthesia Partners, No. 23-cv-03560 (S.D. Tex., Sep. 21, 2023).

49. *See* Reply Brief of Appellants at 5, Saint Alphonsus Med. Ctr.–Nampa, Inc. v. St. Luke’s Health Sys., Ltd., 778 F.3d 775 (9th Cir. 2015) (No. 14-35173).

50. *See id.*

51. *See id.*; *see also* Complaint paras. 31–39, FTC v. Advocate Health Care Network, No. 15-cv-11473, 2017 WL 1022015 (N.D. Ill. Mar. 16, 2017) [hereinafter Complaint, Advocate Health Care Network]; Complaint paras. 31–38, The Penn State Hershey Med. Ctr., FTC Dkt. No. 9368 (Dec. 14, 2015) [hereinafter Complaint, The Penn State Hershey Med. Ctr.]; Complaint paras. 50–51, Cabell Huntington Hosp., Inc., FTC Dkt. No. 9366 (Nov. 16, 2015) [hereinafter Complaint, Cabell Huntington Hosp.]; Press Release, FTC, FTC Dismisses Complaint Challenging Merger of Cabell Huntington Hospital and St. Mary’s Medical Center (July 6, 2016), <https://www.ftc.gov/news-events/news/press-releases/2016/07/ftc-dismisses-complaint-challenging-merger-cabell-huntington-hospital-st-marys-medical-center> [<https://perma.cc/NPD4-G9RG>].

decisive role.⁵² When providers hold more leverage, rates rise;⁵³ when insurers hold more leverage, rates fall.⁵⁴ Providers depend on network access to grow profits, while insurers depend on provider participation to make their plans appealing to consumers.⁵⁵ Thus, whichever side holds greater bargaining power dictates the rate outcome.⁵⁶

Empirical evidence supports these concerns, showing that private equity acquisitions drive up reimbursement rates and, consequently, rates for health insurers.⁵⁷ One study examining how private equity buyouts impact hospital charges found that insurers faced an 11 percent increase in prices postacquisition.⁵⁸ For this reason, the study concluded that restricting or banning such acquisitions could substantially reduce healthcare spending.⁵⁹ Another study examining private equity acquisitions of dermatology practices found that prices rose moderately over time following a buyout.⁶⁰ Researchers attributed the increase to acquired practices' greater market power, which allowed them to negotiate higher reimbursement rates from health insurers.⁶¹

Similar patterns appear in other specialties. For instance, studies on anesthesiology practices found that anesthesiologists secured higher payments from insurers after private equity buyouts.⁶² Research on primary care practices reached comparable conclusions—their negotiated rates were about 8 percent higher following the private equity buyout than those of independent practices.⁶³ Likewise, private equity's acquisition of gastroenterology practices has been associated with significant hikes in physicians' professional fees.⁶⁴

52. THEODOSIA STAVROULAKI, HEALTHCARE, QUALITY CONCERNS AND COMPETITION LAW 103–04 (2023).

53. *Id.*

54. *Id.*

55. *Id.*

56. *Id.*

57. Tong Liu, *Bargaining with Private Equity: Implications for Hospital Prices and Patient Welfare* 47 (Nov. 30, 2022) (unpublished manuscript), <https://ssrn.com/abstract=3896410> (on file with the *Fordham Law Review*).

58. *Id.* (manuscript at 1).

59. *Id.* (manuscript at 48).

60. Robert Tyler Braun, Amelia M. Bond, Yuting Qian, Manyao Zhang & Lawrence P. Casalino, *Private Equity in Dermatology: Effect on Price, Utilization, and Spending*, 40 HEALTH AFFS. 727, 732–33 (2021).

61. *Id.* at 734.

62. Ambar La Forgia, Amelia M. Bond, Robert Tyler Braun, Leah Z. Yao, Klaus Kjaer, Manyao Zhang & Lawrence P. Casalino, *Association of Physician Management Companies and Private Equity Investment with Commercial Health Care Prices Paid to Anesthesia Practitioners*, 182 JAMA INTERN. MED. 396, 402 (2022).

63. Yashaswini Singh, Nandita Radhakrishnan, Loren Adler & Christopher Whaley, *Growth of Private Equity and Hospital Consolidation in Primary Care and Price Implications*, JAMA HEALTH F., Jan. 2025, at 1, 6.

64. Yashaswini Singh, Zirui Song, Daniel Polsky & Jane M. Zhu, *Increases in Physician Professional Fees in Private Equity–Owned Gastroenterology Practices*, 44 HEALTH AFFS. 215, 218–21 (2025).

Other studies have also examined private equity's effect on healthcare prices by evaluating how private equity acquisitions impact hospital income.⁶⁵ Following an acquisition, hospitals experienced “a mean increase of \$2,302,391 . . . in annual net income” as well as “an increase of \$407 . . . in total charge per inpatient day” compared to nonacquired hospitals.⁶⁶

Private equity ownership also drives up Medicare spending. A study on retina practices found that Medicare spending rose by over \$260,000 per acquired practice per year.⁶⁷ Similarly, another study examining urology practices found an 11 percent increase in inflation-adjusted Medicare payments following acquisition, while independent practices saw a 6 percent decline during the same period.⁶⁸

Increases in health insurance premiums can hurt patients and deepen the rising health and racial inequities for several reasons. First, the rising cost of health insurance premiums has been associated with declining annual wages and widening earnings inequality across racial, ethnic, and income groups.⁶⁹ Between 1988 and 2019, the share of total compensation (wages plus premiums) devoted to health insurance premiums for U.S. families with employer-based coverage increased from 7.9 percent to 17.7 percent, contributing to substantial wage stagnation among households receiving employment-based insurance.⁷⁰ The distributional effects of these rising costs were uneven: Black and Hispanic families with employer-sponsored insurance experienced a greater proportional reduction in wages due to premium growth than their White counterparts.⁷¹ Hence, the rising costs of employer-sponsored health insurance exacerbate structural income inequalities and effectively shift the burden of healthcare financing onto workers, particularly the least advantaged.

Moreover, when people's disposable income shrinks, their health is likely to deteriorate as well. As income declines, individuals have fewer resources to spend on goods essential to maintaining good health, such as nutritious food and safe, stable housing. Poor housing conditions are associated with

65. Joseph D. Bruch, Suhas Gondi & Zirui Song, *Changes in Hospital Income, Use, and Quality Associated with Private Equity Acquisition*, 180 JAMA INTERN. MED. 1428, 1429 (2020).

66. *Id.* at 1431.

67. Yashaswini Singh, Christopher M. Aderman, Zirui Song, Daniel Polsky & Jane M. Zhu, *Increases in Medicare Spending and Use After Private Equity Acquisition of Retina Practices*, 131 OPHTHALMOL 150, 153 (2024).

68. James Nie, Walter Hsiang, Soum D. Lokeshwar, Gregory McMahon, Patrick C. Demkowicz, Patrick A. Kenney, Benjamin N. Breyer & Michael S. Leapman, *Association Between Private Equity Acquisition of Urology Practices and Physician Medicare Payments*, 167 UROL 121, 121 (2022).

69. Kurt Hager, Ezekiel Emanuel & Dariush Mozaffarian, *Employer-Sponsored Health Insurance Premium Cost Growth and Its Association with Earnings Inequality Among US Families*, JAMA NETWORK OPEN, Jan. 2024, at 1, 2.

70. *Id.* at 7.

71. *Id.* By 2019, healthcare premiums represented 19.2 percent of total compensation for Black families and 19.8 percent for Hispanic families, compared with 13.8 percent for White families. *Id.*

higher rates of asthma and other chronic illnesses.⁷² Likewise, lower-income individuals frequently lack access to affordable, healthy food and are more likely to live in “food deserts.”⁷³ In these communities, residents often rely on convenience stores that offer limited or no fresh produce, increasing their risk of poor nutrition and ultimately poor health.⁷⁴ Residing in low-income neighborhoods with elevated crime rates also heightens the risk of physical and mental harm and discourages outdoor activity, further undermining health outcomes.⁷⁵

In addition, when health insurance is unaffordable, lower-income communities are more likely to forgo care which may further compromise their health outcomes.⁷⁶ One survey found that only 41 percent of lower-income individuals had a cholesterol test in the past year, compared to 64 percent of higher-income individuals.⁷⁷ Similarly, just 54 percent of lower-income women aged 50 to 64 reported having a recent mammogram, versus 80 percent of higher-income women; only 27 percent of lower-income older adults had undergone colon cancer screening, compared to 54 percent of their higher-income counterparts.⁷⁸ Because racial minorities in the United States are disproportionately uninsured,⁷⁹ the rising healthcare costs that often follow private equity buyouts further exacerbate both racial and socioeconomic health disparities nationwide.

B. Inferior Care

Private equity acquisitions do not just drive up costs—they also undermine the quality of care. For instance, a study compared the performance of acquired versus nonacquired hospitals and found that staffing ratios declined

72. *Quality of Housing*, U.S. DEP’T OF HEALTH & HUM. SERVS.: HEALTHY PEOPLE 2030, <https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/quality-housing> [<https://perma.cc/7NY2-UR3F>] (last visited Jan. 28, 2026).

73. Kelly Brooks, *Research Shows Food Deserts More Abundant in Minority Neighborhoods*, JOHNS HOPKINS MAG., Spring 2014, <https://hub.jhu.edu/magazine/2014/spring/racial-food-deserts> [<https://perma.cc/4BYB-RPTK>]. Food deserts are geographic areas where people are deprived of supermarkets, and hence, deprived of nutritious food. *Id.*

74. Theodosia Stavroulaki, *Feminist Health Antitrust*, 111 IOWA L. REV. 709, 713, 723 (2026); Christopher R. Leslie, *Food Deserts, Racism, and Antitrust Law*, 110 CALIF. L. REV. 1717, 1725 (2022); *see also* Press Release, Am. Cancer Soc’y, Living in Food Deserts is Associated with Shorter Life Expectancy in the US, New Research Shows (June 28, 2023), <https://pressroom.cancer.org/releases?item=1237> [<https://perma.cc/2TRT-SCVV>].

75. Peter J. Cunningham, *Why Even Healthy Low-Income People Have Greater Health Risks Than Higher-Income People*, COMMONWEALTH FUND (Sep. 27, 2018), <https://www.commonwealthfund.org/blog/2018/healthy-low-income-people-greater-health-risks> [<https://perma.cc/ZY9W-2LAD>].

76. *Id.*

77. *Id.*

78. *Id.*

79. Press Release, U.S. Census Bureau, Census Bureau Releases New Report on Health Insurance by Race and Hispanic Origin (Nov. 22, 2022), <https://www.census.gov/newsroom/press-releases/2022/health-insurance-by-race.html> [<https://perma.cc/QM4J-A3TR>]; Latoya Hill, Nambi Ndugga, Samantha Artiga & Anthony Damico, *Health Coverage by Race and Ethnicity, 2010–2023*, KKF (Feb. 13, 2025), <https://www.kff.org/racial-equity-and-health-policy/health-coverage-by-race-and-ethnicity/> [<https://perma.cc/RG7D-DTE2>].

significantly following private equity takeovers.⁸⁰ By restricting staffing growth, these hospitals sought to reduce expenditures and maximize profit margins.⁸¹ Staffing shortages, however, correlate with poorer patient outcomes and increased mortality rates.⁸² Another prominent study reached similar conclusions, finding that Medicare patients treated in private equity–owned hospitals experienced markedly worse outcomes—specifically, a higher incidence of adverse events like falls and bloodstream infections.⁸³

Recently, several studies have laid bare a stark reality: after hospitals are acquired by private equity, patients are left without quality care. For instance, a 2025 empirical study examined private equity’s impact on the performance of acute care hospitals and found troubling results.⁸⁴ Hospitals purchased by private equity experienced a 2.7 percent increase in thirty-day postoperative mortality and a 3.9 percent increase in failure-to-rescue rates compared to hospitals not owned by private equity.⁸⁵ Inadequate staffing levels and limited access to essential clinical resources were key drivers of these adverse outcomes.⁸⁶

Another study analyzing the effect of private equity ownership on patient-reported care experiences raised similar alarms.⁸⁷ The researchers observed that patient satisfaction declined significantly each year following

80. Anaeze C. Offodile II, Marcelo Cerullo, Mohini Bindal, Jose Alejandro Rauh-Hain & Vivian Ho, *Private Equity Investments in Health Care: An Overview of Hospital and Health System Leveraged Buyouts, 2003–17*, 40 HEALTH AFFS. 719, 723 (2021).

81. *Id.* at 725.

82. Katie Boston-Leary, Merton Lee & Sarah E. Mossburg, *Patient Safety Amid Nursing Workforce Challenges*, PATIENT SAFETY NETWORK (Apr. 24, 2024), <https://psnet.ahrq.gov/perspective/patient-safety-amid-nursing-workforce-challenges> [<https://perma.cc/UQT8-ZUKT>]; see also Adrian Diaz, Mitchell Mead, Stefanie Rohde, Nicholas Kunnath, Justin B. Dimick & Andrew M. Ibrahim, *Hospitals Acquired by Private Equity Firms: Increased Postoperative Mortality for Common Inpatient Surgeries*, 44 HEALTH AFFS. 554, 554, 557 (2025) (“Driven by the need to provide high, predictable returns to investors, [private equity] firms aim to restructure health care organizations to maximize profitability. This often involves cutting costs and streamlining services, a strategy that can result in the reduction of staffing and resources, which may affect care quality.”). See generally Atul Gupta, Sabrina T. Howell, Constantine Yannelis & Abhinav Gupta, *Owner Incentives and Performance in Healthcare: Private Equity Investment in Nursing Homes* (Nat’l Bureau of Econ. Rsch., Working Paper No. 28474, 2023).

83. Sneha Kannan, Joseph Dov Bruch & Zirui Song, *Changes in Hospital Adverse Events and Patient Outcomes Associated with Private Equity Acquisition*, 330 JAMA 2365, 2371 (2023) (“[P]rivate equity acquisition was associated with a 25% increase in hospital-acquired adverse events through up to 3 years after acquisition, which was driven by a 27% increase in falls and a 38% increase in the volume of central line–associated infections (despite the placement of 16% fewer central lines).”).

84. Diaz et al., *supra* note 82, at 554.

85. *Id.* at 557.

86. *Id.* at 560.

87. Anjali Bhatla, Victoria L. Bartlett, Michael Liu, ZhaoNian Zheng & Rishi K. Wadhwa, *Changes in Patient Care Experience After Private Equity Acquisition of US Hospitals*, 333 JAMA 490, 491 (2025). Patient-reported care is an essential measure of healthcare quality given that poor patient experiences can impede recovery and reduce adherence to medical advice and treatment. *Id.*

a private equity acquisition.⁸⁸ Declines in nursing staff levels following buyouts were closely correlated with the deterioration in patient satisfaction.⁸⁹

Other studies have further confirmed that when private equity firms cut frontline caregivers, they erode the very foundation of quality care. One study compared postoperative outcomes in private equity–acquired hospitals with those in nonacquired institutions for patients undergoing esophagectomy—a complex surgical procedure whose success depends heavily on both institutional resources and the clinical experience of the healthcare team.⁹⁰ Patients treated in private equity–owned hospitals experienced significantly worse surgical outcomes than those treated in independent hospitals.⁹¹ Specifically, mortality and complication rates were substantially higher in private equity–owned hospitals.⁹² Private equity–owned hospitals performed fewer esophagectomy procedures and maintained lower nurse-to-patient ratios—conditions that compromised the quality of surgical care.⁹³ By prioritizing cost cutting over clinical capacity,⁹⁴ private equity firms once again placed profit above patient safety and population health.

C. Shutdowns and Reduced Access to Care

Private equity ownership is also linked with reduced access to care for marginalized communities, thereby widening health inequities nationwide. Specifically, these firms often eliminate less profitable but vital healthcare services, leaving already underserved patients with no access to necessary treatments.

One study examined the impact of private equity acquisitions on retinal detachment surgery availability and found that such buyouts correlate with a nearly 20 percent reduction in access to this essential form of care.⁹⁵ Because the Medicare reimbursement rate that medical practices receive to offer this service does not cover their actual costs—and because private equity firms focus on generating short-term profits rather than ensuring access to care—these factors contribute to a reduction in access to a treatment that can prevent irreversible vision loss.⁹⁶ As a result, patients have no option but to travel long distances to receive this vital treatment, often leading to delayed care

88. *Id.* at 495.

89. *Id.*

90. Jonathan E. Williams, Sara L. Schaefer, Ryan C. Jacobs, Andrew M. Ibrahim & David D. Odell, *Esophagectomy Trends and Postoperative Outcomes at Private Equity–Acquired Health Centers*, 160 JAMA SURG 296, 296 (2025).

91. *Id.* at 300.

92. *Id.*

93. *Id.*

94. *Id.*

95. Yashaswini Singh, Geronimo Bejarano Cardenas, Hamid Torabzadeh, Christopher M. Whaley & Durga Borkar, *Private Equity-Owned Physician Practices Decreased Access to Retinal Detachment Surgery, 2014–22*, 44 HEALTH AFFS. 589, 593 (2025).

96. *Id.* at 590.

and poorer health outcomes.⁹⁷ Similarly, another study found that after private equity buyouts, practices cut back on essential but less profitable healthcare services, including outpatient psychiatry and pregnancy-related admissions.⁹⁸

In an attempt to reduce costs and maximize profits, private equity firms also incentivize medical practices to prioritize commercially insured patients while limiting care for those covered by Medicare and Medicaid—harming health equity and access to care.⁹⁹ Following acquisition, physicians are also encouraged to favor patients who are easier to treat over those with complex medical needs.¹⁰⁰ In some cases, private equity owners further drive practices to open new offices in affluent areas serving healthier, higher-income patients, rather than in underserved communities where care is most needed.¹⁰¹

Moreover, debt is central to the private equity model and a critical reason why these acquisitions often restrict access to care.¹⁰² In a typical LBO, private equity firms finance 60 to 90 percent of the purchase with borrowed money, using the acquired hospital or health system as collateral.¹⁰³ Hence, the debt falls on the hospital—not the investors—leaving it financially unstable.¹⁰⁴ Beyond the initial buyout, private equity firms push health systems to take on even more debt to fuel expansion and increase their dominance, acquiring new hospitals and medical practices.¹⁰⁵ As debt accumulates, the acquired entities must cover monthly loan payments on top of routine operating expenses, creating pressure to further cut costs and increase profits.¹⁰⁶ In some cases, private equity firms go further, closing entire hospitals to cut expenses, thus eliminating access to care for affected communities.¹⁰⁷

These dynamics are illustrated by the Steward Health Care saga, a poignant example of stripping communities of essential care.¹⁰⁸ By early 2024, growing local media coverage of Steward Health Care's worsening finances had drawn national attention to its for-profit system, which was owned by private equity firm Cerberus Capital Management from 2010 to 2020.¹⁰⁹ In April 2024, Massachusetts Senators Edward Markey and Elizabeth Warren held a field hearing in Boston, where witnesses criticized

97. *Id.*

98. Michael R. Richards & Christopher M. Whaley, *Hospital Behavior Over the Private Equity Life Cycle*, J. HEALTH & ECON., May 2024, at 1, 25.

99. See Jane M. Zhu & Daniel Polsky, *Private Equity and Physician Medical Practices—Navigating a Changing Ecosystem*, 384 NEJM 981, 982 (2021).

100. *Id.*

101. *Id.*

102. Mary Bugbee, *How Private Equity Has Looted Our Hospitals*, AFT HEALTH CARE (2024), <https://www.aft.org/hc/fall2024/bugbee> [<https://perma.cc/89ZT-W5UB>].

103. *Id.*

104. *Id.*

105. *Id.*

106. *Id.*

107. *Id.*

108. *Id.*

109. *Id.*

private equity investors for extracting value from Steward while leaving its hospitals insolvent.¹¹⁰ Soon thereafter, Steward filed for bankruptcy under Chapter 11 of the Bankruptcy Code,¹¹¹ reporting more than \$9 billion in liabilities.¹¹² In the years preceding Steward's bankruptcy, the health system closed multiple hospitals, laid off thousands of healthcare workers, and cut critical service lines, including obstetrics, behavioral health, and oncology.¹¹³

The consequences of such closures are severe for vulnerable communities.¹¹⁴ First, closures force patients to travel further for time-sensitive care like obstetrics, increasing mortality rates—especially among underserved populations, particularly women of color, as many obstetric emergencies require intervention within minutes.¹¹⁵ Similarly, when cancer patients must travel more than fifty miles to see a specialist, they have a worse prognosis, a more advanced stage of diagnosis, lower adherence to prescribed treatments, and a poorer quality of life.¹¹⁶ Second, hospital closures weaken local economies by prompting workforce migration, reducing local income and spending, and ultimately constraining economic growth.¹¹⁷ Third, closures push nurses and physicians to relocate for stable work. This dynamic creates a vicious cycle: because nurses and physicians are essential healthcare inputs, a diminished local workforce can precipitate further hospital closures.

D. Higher Levels of Burnout, Loss of Autonomy, and Job Dissatisfaction

Acquisitions by private equity firms are also associated with heavier workloads and inferior working conditions for the healthcare workforce. Not surprisingly, nurses and physicians are increasingly leaving the profession or retiring early. This worsens the healthcare worker shortage that is afflicting the nation—especially in underserved areas.¹¹⁸

A survey evaluating physicians' views toward private equity's increasing involvement in the healthcare industry illustrates these concerns.¹¹⁹ Over 60 percent of participants expressed negative views of private equity's

110. *Id.*

111. 11 U.S.C. §§ 1101–1195.

112. Bugbee, *supra* note 102.

113. Mary Bugbee, *Steward Health Care's Bankruptcy: One Year Later*, PRIV. EQUITY STAKEHOLDER PROJECT (May 6, 2025), <https://pestakeholder.org/news/steward-health-cares-bankruptcy-one-year-later> [<https://perma.cc/B3BZ-TU9C>].

114. *Id.*

115. Stavroulaki, *supra* note 44, at 947–48.

116. Massimo Ambroggi, Claudia Biasini, Cinzia Del Giovane, Fabio Fornari & Luigi Cavanna, *Distance as a Barrier to Cancer Diagnosis and Treatment: Review of the Literature*, 20 ONCOLOGIST 1378, 1379 (2015).

117. Stavroulaki, *supra* note 44, at 949.

118. *Id.*

119. See Jane M. Zhu, Andrew Zeveney, Susan Read & Ryan Crowley, *Physician Perspectives on Private Equity Investment in Health Care*, 184 JAMA INTERN. MED. 579, 579 (2024).

involvement in healthcare.¹²⁰ Compared with physicians in independent practices, those employed by private equity firms reported lower job satisfaction and autonomy and were less likely to remain with their employers.¹²¹ In their view, private equity's appetite for profits increases healthcare costs, undermines health equity and harms physicians' well-being. Similarly, a survey of early-career radiologists examining private equity's growing presence in their specialty revealed parallel concerns.¹²² Respondents reported that the corporatization of radiology practices has contributed to lower wages and heavier workloads, particularly for those at the beginning of their careers.¹²³

There are several reasons this may be true. After private equity acquires healthcare entities, staffing levels often fall.¹²⁴ Because private equity firms prioritize short-term profits over quality of care, they tend to hire lower-paid healthcare professionals—such as physician assistants and nurse practitioners—rather than higher-paid, experienced physicians.¹²⁵ Although advanced practice professionals, like physician assistants, can offer a wide range of medical services, including taking medical histories and conducting medical tests, some state laws require them to be supervised by physicians when practicing and prescribing.¹²⁶ Because physicians working for private equity firms may be required to monitor a higher number of physician assistants or nurse practitioners, they may suffer from a heavier workload.

In an effort to increase care utilization (and thereby boost profits), private equity-acquired entities face strong incentives to expose patients to unnecessary medical testing and treatment.¹²⁷ These practices include routine screenings, such as colonoscopies and biopsies.¹²⁸ Physicians

120. *Id.*

121. *Id.* at 580.

122. Daniel A. Ortiz, Lawrence R. Muroff & Arvind Vijayasarithi, *Early-Career Radiologists' Perceptions of National Corporations in Radiology*, 17 J. AM. COLL. RADIOLOGY 349, 351 (2020).

123. *Id.*

124. Joseph Dov Bruch, Canyon Foot, Yashaswini Singh, Zirui Song, Daniel Polsky & Jane M. Zhu, *Workforce Composition in Private Equity-Acquired Versus Non-Private Equity-Acquired Physician Practices*, 42 HEALTH AFFS. 121, 124 (2023).

125. Jose Lopez, *Private Equity Backed Radiology Considerations for the Radiology Trainee*, 50 CURRENT PROBS. DIAGNOSTIC RADIOLOGY 469, 470 (2021); see also Meliha Skaljic & Jules B. Lipoff, *Association of Private Equity Ownership with Increased Employment of Advanced Practice Professionals in Outpatient Dermatology Offices*, 84 J. AM. ACAD. DERMATOLOGY 1178, 1178 (2021); Jack S. Resneck, *Dermatology Practice Consolidation Fueled by Private Equity Investment: Potential Consequences for the Specialty and Patients*, 154 JAMA DERMATOLOGY 13, 14 (2018).

126. See *Physician Assistant Practice and Prescriptive Authority*, NAT'L CONF. OF STATE LEGISLATURES, <https://www.ncsl.org/scope-of-practice-policy/practitioners/physician-assistants/physician-assistant-practice-and-prescriptive-authority> (on file with the *Fordham Law Review*) (last visited Mar. 16, 2026).

127. Yashaswini Singh, Zirui Song, Daniel Polsky, Joseph D. Bruch & Jane M. Zhu, *Association of Private Equity Acquisition of Physician Practices with Changes in Health Care Spending and Utilization*, JAMA HEALTH F., Sep. 2022, at 1, 6 (indicating that after a practice is acquired by private equity, there is a 16.3 percent increase in the volume of healthcare encounters).

128. *Id.* at 8.

employed by private equity are also pressured to see higher volumes of patients,¹²⁹ even when doing so compromises patient care, and to meet minimum sales targets for medical products. Meeting these goals, though, requires physicians to work longer hours,¹³⁰ further deepening their job dissatisfaction.

But private equity requires more from physicians than simply compromising patient care. As explained, after a private equity buyout, physicians are often forced to exclude Medicare and Medicaid patients¹³¹ or to avoid treating complex patients.¹³² Because private equity's short-term profit goals require physicians to practice medicine in a way that conflicts directly with their moral duty to act in their patients' best interests, physicians suffer from "moral injury," a term military psychiatrists use to describe the psychological wounds soldiers incur from witnessing or committing grave acts, such as killing civilians.¹³³ Physicians experience a similar moral injury, often contributing to higher rates of burnout, when they are forced to balance pressures of making profits at the expense of vulnerable patients with the sacred obligations and duties of their Hippocratic Oath: "[F]irst, do no harm."¹³⁴ This moral strain is another reason why physicians increasingly choose to leave the profession and is particularly concerning given that the United States is expected to "face a physician shortage of up to 86,000 by 2036."¹³⁵ Undoubtedly, this trend will further undermine population health.

Notably, when communities suffer from poor health, the very foundations of democracy are weakened as well. Poor health can limit individuals' ability to participate in voting and civic life, as illness reduces their time, mobility, energy, and cognitive focus.¹³⁶ Lower levels of participation, in turn, mean that affected communities wield less influence over decisions that shape public resources and policy, including health services, community infrastructure, and social supports.¹³⁷ This dynamic creates a self-reinforcing feedback loop with civic disengagement and health disparities deepening over time. When marginalized communities are less able to engage politically, they are less likely to shape policy around housing, public transportation, environmental conditions, healthcare access, and economic

129. Singh et al., *supra* note 127, at 8. "Private equity acquisition was also associated with increased patient utilization, both by bringing established patients back more often as well as by increasing the numbers of new patients at a practice. . . . [I]ncreased patient utilization per practice was unlikely to be the result of new physician hires." *Id.*

130. Karas, *supra* note 4, at 6.

131. Zhu & Polsky, *supra* note 99, at 982.

132. *Id.*

133. Eyal Press, *The Moral Crisis of America's Doctors*, N.Y. TIMES MAG. (June 15, 2023), <https://www.nytimes.com/2023/06/15/magazine/doctors-moral-crises.html> (on file with the *Fordham Law Review*).

134. Stavroulaki, *supra* note 24.

135. *Addressing the Physician Workforce Shortage*, AAMC, <https://www.aamc.org/advocacy-policy/addressing-physician-workforce-shortage> [<https://perma.cc/D64K-K5KY>] (last visited Jan. 13, 2026).

136. BLACK WELLNESS & PROSPERITY CTR., *supra* note 45.

137. *Id.*

supports.¹³⁸ Consequently, public health needs may be overlooked, and resources may be allocated in ways that favor politically powerful groups, allowing long-standing health inequities to worsen.

Given these concerns, the following section examines whether and how antitrust law can halt the harm that private equity inflicts on patients, healthcare workers, and the healthcare system. It argues that antitrust enforcers and the courts should challenge any private equity acquisition that drives up healthcare costs or undermines the quality and accessibility of essential healthcare services. While antitrust law alone cannot eliminate all the harms private equity firms inflict on population health, it can serve as a critical bulwark against these modern vampires—stemming the bleeding in vulnerable communities and protecting the healthcare workforce.

II. ANTITRUST LAW AS A LIFESAVING MEDICINE: CURING THE PRIVATE EQUITY DISEASE

The U.S. Department of Justice (DOJ) and Federal Trade Commission (FTC) (together, “the Agencies”) evaluate the effects of mergers and acquisitions on competition and consumers under the 2023 Merger Guidelines (the “Guidelines”).¹³⁹ The Guidelines’ core principle is that mergers or acquisitions likely to create or enhance market power—and thus enable higher prices, reduced output, diminished innovation, or other consumer harm—violate section 7 of the Clayton Act, which prohibits any merger and acquisition that can reduce competition or create a monopoly in “any line of commerce.”¹⁴⁰ To assess potential harm, the Agencies use a two-step test: first, they define the relevant product and geographic market; second, they evaluate the merger’s anticompetitive effects.¹⁴¹ A merger may be anticompetitive if it increases the merging entity’s market power or significantly raises market concentration, which could facilitate collusion among competitors.¹⁴² Part I argued that acquisitions by private equity are associated with four main harms: higher healthcare costs, inferior patient care, reduced access to care, and higher levels of burnout for the healthcare workforce. This part demonstrates that all these harms can be condemned under section 7 of the Clayton Act.

138. *Id.*

139. U.S. DEP’T OF JUST. & FTC, MERGER GUIDELINES (2023), https://www.ftc.gov/system/files/ftc_gov/pdf/2023_merger_guidelines_final_12.18.2023.pdf [https://perma.cc/U5SF-34TH].

140. *Id.* at 2.

141. Stavroulaki, *supra* note 74, at 743.

142. *Id.*

A. *Section 7 of the Clayton Act
and Product Markets*

1. Higher Prices

Private equity acquisitions in the healthcare space are associated with higher healthcare costs. The employment of “roll-up” strategies increases market power, enabling firms to negotiate higher reimbursement rates from health insurers, which in turn drives up health insurance premiums.

In 2023, the FTC recognized this theory of harm in its lawsuit against U.S. Anesthesia Partners (USAP) and its private equity backer, Welsh, Carson, Anderson & Stowe (WCAS).¹⁴³ The FTC alleged that the defendants executed a long-running anticompetitive scheme to monopolize Texas’s anesthesiology market and drive up prices.¹⁴⁴ The FTC’s complaint further alleged that the defendants used a roll-up strategy to acquire nearly every major anesthesia practice in Texas, entered into price-fixing agreements with remaining independent providers, and neutralized a key competitor through a market-allocation deal.¹⁴⁵ This multipronged consolidation strategy allegedly gave USAP substantial market power, allowing it to demand higher prices and costing Texas patients tens of millions of dollars annually.¹⁴⁶ To the FTC, these tactics illustrated how private equity–driven consolidation can reduce competition and harm consumers.¹⁴⁷ Two years later, the FTC announced a settlement with WCAS.¹⁴⁸ Under a proposed consent order addressing the FTC’s concerns, WCAS would be required to restrict its involvement with USAP and inform the FTC of certain future acquisitions and investments in anesthesia and other hospital-based physician practices.¹⁴⁹

In the past, the FTC blocked several hospital mergers on the grounds that they were likely to lead to higher health insurance premiums. For instance, the FTC attempted to block the merger between Jefferson Health and Albert Einstein Healthcare Network, two major hospitals providing inpatient general acute care (GAC) and inpatient acute rehabilitation services in both Philadelphia County and Montgomery County, Pennsylvania. By significantly reducing competition between merging entities, the FTC maintained that the merger would increase their bargaining leverage with

143. Press Release, FTC, FTC Challenges Private Equity Firm’s Scheme to Suppress Competition in Anesthesiology Practices Across Texas (Sep. 21, 2023), <https://www.ftc.gov/news-events/news/press-releases/2023/09/ftc-challenges-private-equity-firms-scheme-suppress-competition-anesthesiology-practices-across> [<https://perma.cc/XC3W-Q9F6>].

144. *Id.*

145. *Id.*

146. *Id.*

147. *Id.*

148. Press Release, FTC, FTC Secures Settlement with Private Equity Firm in Antitrust Roll-Up Scheme Case (Jan. 17, 2025), <https://www.ftc.gov/news-events/news/press-releases/2025/01/ftc-secures-settlement-private-equity-firm-antitrust-roll-scheme-case> [<https://perma.cc/UF3L-ZM4S>].

149. *Id.*

health insurers.¹⁵⁰ Hence, it would improve merging parties' ability to achieve higher reimbursement rates, which would hurt the employers and consumers. Similarly, the FTC challenged a proposed \$350 million acquisition of two Memphis-area hospitals by Methodist Le Bonheur Healthcare.¹⁵¹ The FTC alleged that the merger would substantially reduce competition for inpatient and diagnostic services in Memphis, leading to higher reimbursement rates.¹⁵² After the FTC filed its complaint, the parties abandoned the transaction, and the merger was not further reviewed.

More recently, the FTC filed a lawsuit to block Novant Health's \$320 million acquisition of two North Carolina hospitals from Community Health Systems.¹⁵³ According to the FTC's complaint, the proposed deal would reduce competition in the provision of GAC services and increase the merged entity's bargaining power, which would ultimately lead to significantly higher reimbursement rates from health insurers.¹⁵⁴

As noted, increases in health insurance premiums can undermine health equity and population health in multiple ways. First, rising premiums have been associated with reduced wages, thereby shrinking the disposable income that households have available to invest in quality housing and nutritious food—both key social determinants of health. Moreover, when health insurance becomes unaffordable, lower-income households are more likely to forgo necessary care. Accordingly, challenging private equity buyouts in the healthcare sector that may contribute to higher insurance premiums can also promote population health.

2. Lower Quality Care

Acquisitions by private equity frequently correlate not only with higher healthcare costs but also with diminished patient care. Health entities acquired by private equity limit staffing growth and often reduce physician staffing in favor of physician assistants and other advanced practice providers who require physician supervision. Accordingly, the remaining physicians face heavier workloads, which can exacerbate burnout and job dissatisfaction. Because healthcare workers are essential inputs for the provision of healthcare services, workers who experience higher levels of burnout may be unable to offer the best possible care.¹⁵⁵

150. Complaint at 6, *FTC v. Thomas Jefferson Univ.*, 505 F. Supp. 3d 522 (E.D. Pa. 2020) (No. 20-cv-1113).

151. Complaint at 1, *FTC v. Methodist Le Bonheur Healthcare*, FTC Dkt. No. 9396 (Nov. 13, 2020).

152. *Id.* at 2.

153. Complaint at 1, *Novant Health, Inc.*, FTC Dkt. No. 9425 (Jan. 31, 2024).

154. *Id.* at 2.

155. Lambert Zixin Li, Peilin Yang, Sara J. Singer, Jeffrey Pfeffer, Maya B. Mathur & Tait Shanfelt, *Nurse Burnout and Patient Safety, Satisfaction, and Quality of Care: A Systematic Review and Meta-Analysis*, JAMA NETWORK OPEN, Nov. 2024, at 1, 10–11 (“The association of nurse burnout with patient safety was persistent over time, and the association with quality of care was increasingly negative over 3 decades, even after accounting for the COVID-19 pandemic. This finding is concerning considering decades of national and organizational efforts for quality improvement.”); *see also* Jin Jun, Melissa M. Ojemeni, Richa Kalamani,

The FTC has long challenged hospital mergers on the grounds that they can harm consumers by degrading the quality of care. This should not be surprising given that antitrust law rests on the premise that robust competition delivers both lower prices and higher-quality goods and services.¹⁵⁶ As a result, section 7 of the Clayton Act enables the prohibition of mergers that are likely to substantially lessen competition, including through harms to quality and innovation.

Consider Advocate Health Care Network's proposed merger with NorthShore University HealthSystem, involving two major hospitals offering GAC inpatient hospital services in Chicago's northern suburbs.¹⁵⁷ The FTC recognized that the merging parties, Advocate and NorthShore, (1) closely observe each other's quality and (2) significantly invested in expanding and improving their services to increase their market share. The FTC alleged that the proposed transaction would "dampen the merged firm's incentive to compete on quality of care and service offerings, to the detriment of all patients who use these hospitals" and thus concluded that the proposed merger should not move forward.¹⁵⁸

The FTC also considered care quality when assessing anticompetitive effects of hospital mergers in the Jefferson Health and Albert Einstein Healthcare Network matter¹⁵⁹ and the Methodist Le Bonheur Healthcare case.¹⁶⁰ In both cases, the FTC alleged that if the merger was accepted, the merging parties' incentives to enhance their performance and quality would diminish.

Members of health plans, the FTC maintained, often face similar out-of-pocket costs for in-network hospitals. For this reason, hospitals belonging to the same network severely compete to attract patients on the basis of specific nonprice dimensions. These include reputation, amenities, quality, access to services and technology, comfort and patient experiences.

In short, reductions in healthcare quality are a real antitrust harm. Section 7 of the Clayton Act empowers enforcers to block mergers that lessen competition, including by undermining incentives to invest in technology and patient care. As a result, acquisitions by private equity can and should be challenged whenever they threaten to lower the quality of care.

Jonathan Tong & Matthew L. Crecelius, *Relationship Between Nurse Burnout, Patient and Organizational Outcomes: Systematic Review*, INT'L J. NURSING STUDIES, July 2021, at 1, 1 (stating that nurse burnout is associated with worsening safety and quality of care, decreased patient satisfaction, and nurses' organizational commitment and productivity).

156. U.S. DEP'T OF JUST. & FTC, *supra* note 139, at 2.

157. Complaint, Advocate Health Care Network, *supra* note 51, at 18–20. The FTC takes analogous analyses in Complaint, The Penn State Hershey Med. Ctr., *supra* note 51, at 13–14; Complaint, Cabell Huntington Hosp., *supra* note 51, at 16–18.

158. Complaint, Advocate Health Care Network, *supra* note 51, at 18–20.

159. *See generally* Complaint, *supra* note 150.

160. *See generally* Complaint, *supra* note 151.

3. Shutdowns and Reduced Access to Care

As highlighted, private equity's emphasis on short-term profits over patient care often leads to increased risks of hospital closures and diminished access to essential healthcare. First, private equity ownership frequently pressures physicians to prioritize lower-risk, privately insured patients, often at the expense of Medicaid recipients leaving them with fewer choices for treatment.¹⁶¹ Second, such acquisitions are correlated with a heightened likelihood of bankruptcy and facility closures, further restricting the output of healthcare services offered to patients. Practices under private equity control tend to scale back essential but less profitable services, such as psychiatric care.¹⁶² Collectively, these factors contribute to a consistent pattern of reduced healthcare accessibility following a private equity buyout.

The Agencies can incorporate issues of access into their merger analysis in at least two ways. For starters, they could block a merger on the ground that it harms an important dimension of healthcare quality—namely, access. Dr. Avedis Donabedian, the father of health services research, conceives quality as a multidimensional concept whose main components are effectiveness, efficacy, efficiency, acceptability, optimality, equity, and legitimacy.¹⁶³ Donabedian further argues that the notion of acceptability consists of several narrower dimensions: (1) accessibility, or access, which evaluates the ease with which people receive care;¹⁶⁴ (2) the doctor-patient relationship, characterized by empathy, respect, willingness to take time, good manners, and truthfulness;¹⁶⁵ (3) the amenities of care, or the desirable aspects of the healthcare setting, including privacy, comfort, and cleanliness;¹⁶⁶ (4) patients' preferences concerning the risks, impact, and cost of treatment;¹⁶⁷ and (5) what patients consider fair and equitable.¹⁶⁸ By adopting this broader definition of healthcare quality, the Agencies could conclude that a merger that harms access also harms quality and, therefore, could be challenged.

Alternatively, the Agencies could take the view that a private equity buyout effectively reduces output. As explained, the enforcers and the courts can challenge any merger that harms competition and consumers by causing reduced output, higher prices, lower quality, or reduced availability of products and services. Private equity acquisitions that result in eliminating vital healthcare services reduce the availability and output of specific services—including obstetric care and cancer treatment—to nearly zero for

161. Zhu & Polsky, *supra* note 99, at 982.

162. *Id.*

163. AVEDIS DONABEDIAN, AN INTRODUCTION TO QUALITY ASSURANCE IN HEALTH CARE 4 (Rashid Bashshur ed., 2003); Theodosia Stavroulaki, *Mind the Gap: Antitrust, Health Disparities and Telemedicine*, 45 AM. J.L. & MED. 163, 186 (2019).

164. DONABEDIAN, *supra* note 163, at 18.

165. *Id.* at 19.

166. *Id.* at 20–21.

167. *Id.* at 21–22.

168. *Id.* at 22.

certain communities.¹⁶⁹ For this reason, the enforcers can successfully challenge such mergers.¹⁷⁰

The FTC has already embraced this reasoning. In 2024, the FTC opposed two hospital mergers that threatened patient access. First, it urged the Indiana Department of Health to prevent the merger of Union Health and Terre Haute Regional Hospital, proposed under a “Certificate of Public Advantage” (COPA) intended to shield it from antitrust scrutiny.¹⁷¹ The hospitals argued the merger would improve patient outcomes by consolidating services such as outpatient mammography, oncology, neonatal intensive care units, pediatrics, and intensive care.¹⁷² The FTC, however, warned that the merger could raise prices, lower quality, and reduce access.¹⁷³ Consolidation could lead to facility closures, depriving communities of essential care.¹⁷⁴ Any potential efficiencies, the FTC argued, would come at the expense of access.

Citing similar concerns, the FTC also opposed the merger of State University of New York Upstate Medical University and Crouse Health System, citing the same concerns.¹⁷⁵ Post-merger plans to consolidate services—including labor and delivery and emergency care—would require facility closures and workforce reductions.¹⁷⁶ While some efficiencies might be gained, the FTC concluded these benefits would be outweighed by longer travel times, limited-service access, and longer waits for emergency care.¹⁷⁷

Taken together, antitrust law already provides a viable framework for addressing the access-related harms posed by private equity acquisitions in healthcare. Whether framed as a degradation of quality or as a reduction in output, diminished access to essential services is a cognizable competitive harm—one that courts and agencies have recognized in practice. When following a private equity buyout where the reduction of essential healthcare services is likely, antitrust intervention can, and should, serve as a tool to preserve access to care, particularly for underserved communities.

169. See *supra* notes 115–16 and accompanying text.

170. For a similar discussion, see Christopher R. Leslie, *Banking Deserts, Structural Racism, and Merger Law*, 108 MINN. L. REV. 695, 762–63 (2023).

171. Press Release, FTC, FTC Staff Opposes Proposed Indiana Hospital Merger (Sep. 5, 2024) [hereinafter FTC Press Release], <https://www.ftc.gov/news-events/news/press-releases/2024/09/ftc-staff-opposes-proposed-indiana-hospital-merger> [<https://perma.cc/LE5V-QFLP>]; see FTC, KEY COPA FACTS, https://www.ftc.gov/system/files/ftc_gov/pdf/Key_COPA_Facts.pdf [<https://perma.cc/RM98-RBP8>]. “Certificate of Public Advantage (“COPA”) laws attempt to immunize hospital mergers from antitrust laws by replacing competition with state oversight.” *Id.*

172. FTC Press Release, *supra* note 171.

173. *Id.*

174. *Id.*

175. Off. of Pol’y Plan., Federal Trade Commission Staff Submission to New York State Health Department Regarding the Certificate of Public Advantage Application of State University of New York Upstate Medical University and Crouse Health System, Inc. 1–4 (Oct. 7, 2022), https://www.ftc.gov/system/files/ftc_gov/pdf/2210126NYCOPACOMMENTPUBLIC.pdf [<https://perma.cc/WE8K-KA5P>].

176. *Id.* at 34.

177. *Id.* at 32.

*B. Section 7 of the Clayton Act
and Labor Markets*

The previous section indicated that private equity acquisitions frequently increase physician burnout and job dissatisfaction. After such acquisitions, physicians are often forced to practice in ways that conflict with their commitment to patient care. Operating in such a profit-driven, toxic environment undermines physicians' well-being and prompts them to leave the profession.¹⁷⁸ Do the Agencies have the necessary legal techniques to challenge a private equity acquisition on the grounds that it significantly harms labor?

The Guidelines offer an affirmative answer to this critical question: the Agencies can challenge any merger that undermines labor competition.¹⁷⁹ Specifically, the Guidelines note that just as mergers among sellers can harm buyers, under section 7 of the Clayton Act, mergers among buyers (including employers) can harm sellers (including employees).¹⁸⁰ Reduced competition among employers resulting from the merger can drive down wages and degrade working conditions and benefits because firms no longer need to compete aggressively to attract talent.¹⁸¹ Hence, mergers among buyers that are likely to substantially lessen competition in the relevant labor market can violate section 7 of the Clayton Act.

But how would the Agencies evaluate whether a hospital merger is likely to reduce labor competition? Currently, when evaluating a merger's anticompetitive effects, the Agencies use the Herfindahl-Hirschman Index (HHI), which measures market concentration as the sum of the squares of market shares.¹⁸² Low HHI values indicate robust competition, while high values indicate concentrated markets—an HHI above 1,800, for example, signals a “highly concentrated” market. When two firms propose merging in a highly concentrated market and the merger would significantly increase the

178. In a public workshop, organized by the FTC, aimed at evaluating the impact of private equity acquisitions on the healthcare sector on output and labor markets, several physicians raised the concern that challenging working conditions prompt physicians to look for the exit. See Tania Pence, Comment on Department of Justice, Department of Health and Human Services, and the Federal Trade Commission Request for Information on Consolidation in Health Care (May 9, 2024), <https://www.regulations.gov/comment/FTC-2024-0022-1516> [<https://perma.cc/9NDD-HQA3>] (“My burnout has worsened and while I deeply enjoy my work and helping patients I don’t know if it is sustainable when there is no choice but to work for private equity. I am trying to figure out an exit strategy instead of working in this untenable environment for another 10 years. It deeply saddens me. My calling has become my nightmare.”); Karen Samski, Comment on Department of Justice, Department of Health and Human Services, and the Federal Trade Commission Request for Information on Consolidation in Health Care (Mar. 23, 2024), <https://www.regulations.gov/comment/FTC-2024-0022-0724> [<https://perma.cc/5Q8E-CDWY>] (“Why has private equity been allowed in healthcare at all? To exist at all? I’ve experienced . . . some of my own healthcare providers burning out and retiring because they are being treated like human chattel. Actually, they aren’t being treated like humans at all.”).

179. U.S. DEP’T OF JUST. & FTC, *supra* note 139, § 2.10.

180. *Id.*

181. Stavroulaki, *supra* note 74, at 734.

182. U.S. DEP’T OF JUST. & FTC, *supra* note 139, § 2.1.

HHI, the Agencies are likely to challenge it as harmful to competition and consumers.¹⁸³

Historically, the HHI has been applied to output markets rather than input markets like labor.¹⁸⁴ This reflects past economic assumptions that product markets tend to be highly concentrated, while labor markets do not necessarily exhibit the same characteristics.¹⁸⁵ However, the Guidelines clarify that the same or analogous tools used to assess mergers among sellers can be applied to mergers among buyers, including employers in labor markets.¹⁸⁶

The Agencies' willingness to consider labor harms in merger reviews was highlighted in the FTC's complaint aiming to block Kroger's proposed acquisition of Albertsons.¹⁸⁷ In its preliminary injunction request, the FTC argued that the merger would harm millions of Americans by raising grocery and household prices.¹⁸⁸ In addition, the FTC illustrated that the merger would reduce competition for union grocery workers: the combined firms would gain greater leverage in negotiations, limiting workers' ability to secure higher pay, better benefits, and improved working conditions.¹⁸⁹ The FTC pursued the challenge alongside a bipartisan coalition of nine state attorneys general.

The U.S. District Court for the District of Oregon sided with the FTC, blocking the merger.¹⁹⁰ Judge Adrienne Nelson found that the merger would substantially increase concentration in the supermarket and large-format store market, resulting in higher prices for consumers.¹⁹¹ Judge Nelson also found the FTC's argument—that the merger could reduce competition for union grocery workers—plausible.¹⁹² However, because the FTC had not presented evidence quantifying postmerger labor market concentration, Judge Nelson concluded that there was insufficient evidence to fully assess the merger's likely anticompetitive effects on the relevant labor market.¹⁹³

Earlier in 2021, the DOJ also filed a civil antitrust lawsuit to block Penguin Random House's proposed acquisition of Simon & Schuster, addressing the harm it would cause to authors.¹⁹⁴ In its complaint, the DOJ emphasized that authors rely on competition between publishers to secure fair pay, as

183. *Id.*

184. Ioana Marinescu & Eric A. Posner, *Why Has Antitrust Law Failed Workers?*, 105 *CORN. L. REV.* 1343, 1351–52 (2020); *see also* Hiba Hafiz, *Interagency Merger Review in Labor Markets*, 95 *CHI.-KENT L. REV.* 37, 46 (2020).

185. Marinescu & Posner, *supra* note 184, at 1351.

186. U.S. DEP'T OF JUST. & FTC, *supra* note 139, § 2.10.

187. Complaint paras. 9, 11, Kroger Co. & Albertsons Cos., Inc., FTC Dkt. No. D-9428 (Feb. 26, 2024).

188. *Id.* para. 6.

189. *Id.* para. 7.

190. *See generally* FTC v. Kroger Co., No. 24-cv-00347, 2024 LX 41963 (D. Or. Dec. 10, 2024).

191. *Id.* at *111.

192. *Id.* at *125.

193. *Id.* at *137–38.

194. Complaint at 2, 4, *United States v. Bertelsmann SE & Co.*, 646 F. Supp. 3d 1 (D.D.C. 2022) (No. 21-cv-02886).

advances are often their primary or sole earnings from a book.¹⁹⁵ Penguin Random House and Simon & Schuster compete directly to acquire top manuscripts, offering higher advances, favorable contract terms, and editorial and marketing support.¹⁹⁶ The merger would eliminate this head-to-head competition, concentrating nearly half of the market for anticipated bestsellers under a single buyer and significantly reducing authors' bargaining power.¹⁹⁷ Given these anticompetitive effects, the DOJ challenged the proposed merger.¹⁹⁸ The U.S. District Court for the District of Columbia sided with the DOJ.¹⁹⁹ Concluding that the merger would substantially reduce competition for U.S. publishing rights to anticipated top-selling books, it blocked the proposed merger.²⁰⁰

Summing up, the Guidelines, recent enforcement actions, and judicial decisions demonstrate that the Agencies already possess the analytical tools to challenge mergers that substantially harm labor markets. They also have the legal techniques and expertise to condemn private equity buyouts that may lead to higher prices, lower quality, and reduced access to care. Nonetheless, because many transactions fall below the reporting thresholds set forth in the HSR, they often escape antitrust scrutiny. Accordingly, lowering the HSR threshold for reportable transactions would further facilitate the Agencies' efforts to fully address the population-level harms caused by private equity buyouts under section 7 of the Clayton Act.²⁰¹

C. Counterarguments

Even if enforcers demonstrated that the proposed merger should be prohibited because it may lead to higher costs, lower quality, and reduced access to care, the analysis would not necessarily end there. The merging parties could seek to rebut these anticompetitive findings by arguing that the merger may generate substantial efficiencies benefiting competition and consumers. For example, as noted, private equity acquisitions often result in significant staffing reductions. One potential argument, therefore, is that the merger could lower costs of care, thereby reducing health insurance premiums for employers and consumers. This argument, however, is unlikely to succeed. First, cost savings arising from layoffs are not cognizable efficiencies. The Guidelines make clear that "[a]ny benefits claimed by the merging parties are cognizable only if they do not result from the anticompetitive worsening of terms for the merged firm's trading partners."²⁰² Likewise, as Professor Suresh Naidu, Professor Eric A. Posner and researcher Glen Weyl explain, "a merger that does create competitive concern should not be excused simply on the basis that it allows the firm to

195. *Id.* at 5, 11.

196. *Id.* at 23.

197. *Id.* at 4.

198. *Id.* at 25.

199. *Bertelsmann*, 646 F. Supp. 3d, at 12.

200. *Id.*

201. *See also* Brown & Hall, *supra* note 8, at 581.

202. U.S. DEP'T OF JUST. & FTC, *supra* note 139, § 3.3.

cut costs by destroying jobs. In such cases, antitrust doctrine does not allow efficiency gains in other markets to offset losses in one market.”²⁰³ This principle reflects the U.S. Supreme Court’s holding in *United States v. Philadelphia National Bank*,²⁰⁴ which established that procompetitive justifications in one market cannot outweigh anticompetitive effects in another.²⁰⁵ For this reason, even if enforcers recognized cost savings from the merger as a potential procompetitive benefit, they could properly reject it as an efficiency justification for the transaction.

Enforcers could also invoke *Philadelphia National Bank* to reject another potential procompetitive justification: postacquisition, patient care would improve rather than decline. A limited body of research suggests that, in certain contexts, private equity–owned facilities may perform better than nonacquired counterparts. For example, one study found that private equity–owned hospitals achieved higher scores on quality measures for acute myocardial infarction and pneumonia.²⁰⁶ Similarly, other research indicates that private equity ownership may reduce appointment wait times for Medicare and privately insured patients in private dermatology practices, although it may simultaneously increase wait times for Medicaid patients.²⁰⁷ These findings could provide private equity firms with a potential argument that acquisitions sometimes enhance quality of care and generate efficiencies. However, *Philadelphia National Bank* makes clear that procompetitive benefits in one market cannot justify a merger that produces competitive harms elsewhere.

To illustrate, consider a merger where enforcers allege that the acquisition will reduce access to dermatology services for Medicaid patients or harm access to obstetric care. The merging parties might argue that the same transaction increases access to dermatology services for privately insured patients and improves pneumonia treatment outcomes. Even if enforcers recognize these improvements, they could still block the merger if they treat Medicaid patients as a distinct product market from Medicare or privately insured patients and obstetric care as a separate market from pneumonia treatment.²⁰⁸ Under this framework, procompetitive quality improvements in one segment cannot offset anticompetitive harms in another, allowing enforcers to reject the claimed benefits and block the deal.

203. Suresh Naidu, Eric A. Posner & Glen Weyl, *Antitrust Remedies for Labor Market Power*, 132 HARV. L. REV. 537, 587 (2018).

204. 374 U.S. 321 (1963).

205. *Id.* at 371.

206. Bruch, Gondi & Song, *supra* note 65, at 1431.

207. Andrew Creadore et al., *Insurance Acceptance, Appointment Wait Time, and Dermatologist Access Across Practice Types in the US*, 157 JAMA DERMATOLOGY 181, 184 (2021).

208. Section 7 of the Clayton Act prohibits any acquisition that may significantly reduce competition or tend to create a monopoly “in any line of commerce.” 15 U.S.C. § 18 (emphasis added). For a thorough analysis on why a specific group of consumers can be a separate product market, see Stavroulaki, *supra* note 35, at 109–13.

CONCLUSION

Private equity acts like a modern vampire in healthcare, sucking profits while leaving patients, providers, and communities drained. By driving up costs, reducing access to essential services, and degrading working conditions for healthcare professionals, these acquisitions disproportionately harm marginalized communities, leaving them sicker, economically strained, and politically disempowered. Poor health and limited access to care reduce civic engagement, weakening the voices of those already most vulnerable and allowing policies to skew toward the interests of the wealthy.

Antitrust law, particularly section 7 of the Clayton Act, offers a critical tool to counter these harms. By evaluating mergers not just for effects on prices and quality but also for impacts on labor conditions and access to care, enforcement agencies can prevent consolidation that undermines both public health and democratic participation. Protecting healthcare from exploitative private equity practices is therefore not merely a matter of economics—it is essential to safeguarding equity, community well-being, and the ability of all citizens to participate meaningfully in democratic life.