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Invited Commentary

Unanswered Questions on Private Equity in Gastroenterology

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A growing literature on private equity (PE) acquisitions of physician practices has found associated increases in health care prices and utilization,[1-4] but evidence specific to gastroenterology remains relatively new despite the specialty being a popular target for PE. More than 1 in 8 gastroenterology practices are now owned by PE,[5] with practice fragmentation, lucrative procedural reimbursements, and an aging population factoring into continuing investor interest.

In this issue of *JAMA Health Forum*, Arnold et al[6] contribute to the existing literature by assessing changes in colonoscopy prices and quality associated with PE acquisitions in gastroenterology among a commercially insured population. Colonoscopy is a key procedure performed by gastroenterologists in the community setting, with recent screening guidelines lowered to individuals aged 45 years. Consistent with prior studies, Arnold and colleagues[6] found a 4.5% increase in colonoscopy prices at PE-acquired gastroenterology practices, with slightly higher price increases where PE practices have a higher market share (6.7%). This price effect is smaller than has been identified elsewhere; Singh et al[1] previously found a 35.7% increase in charges per claim among a basket of gastroenterology procedures (albeit, excluding colonoscopies) in acquired practices compared to independent controls. Arnold and colleagues[6] also found evidence of increased colonoscopy spending per physician, as well as the number of colonoscopies and unique patients per physician, findings whose contours have been replicated in other specialties.[1-3] That these measures were trending upwards for PE practices prior to acquisition begs a key question of causality: is PE driving an increase in patient volume, or is it capitalizing on an existing trend? Future exploration of referral networks and operational changes after acquisition by PE could help clarify this mechanism.

A particularly valuable contribution of this analysis is the inclusion of a number of quality metrics. Quality has been understudied in the PE literature, with select studies assessing quality of care after PE acquisition of hospitals and nursing homes.[7,8] Findings in those settings have been concerning, but are unlikely to be generalizable to outpatient specialty practice, in which payment structures, pricing power, and operational models differ substantially. Arnold and colleagues[6] assessed 6 quality and process measures (polypectomy, a proxy measure for adenoma detection rate; incomplete colonoscopy; and 4 measures of postprocedural adverse events), finding no discernible effects on quality after PE acquisition compared to control practices. Capturing quality, however, can be akin to walking through fog—visibility can be limited, and interpretations ambiguous. As a measure of quality, for example, polypectomies could simultaneously indicate higher detection of abnormalities (eg, higher quality care) or could suggest overuse (procedural intensity on benign polyps that could be clinically unnecessary). Postprocedural adverse events, like colon perforation or serious bleeding, are also rare events, making these effects more challenging to detect.

Taken together with observations of increased utilization, there may be 2 interpretations of the data presented by Arnold and colleagues.[6] One interpretation of the findings may be that PE acquisition may focus on reducing inefficiencies, improving access by expanding practice capacity, and increasing throughput. Another interpretation may be that PE acquisition is focused on the strategic exploitation of market and pricing power. The latter may have less of an impact on clinical measures like quality of care, but potentially, both strategies could be at play. Finally, given that this analysis focused on the commercial population, understanding how patient demographics change after PE acquisition is another future avenue for exploration; for instance, a potential explanation for

both the price and utilization shifts might be if payer mix shifted toward more commercially insured patients at the expense of Medicaid or Medicare patients.

The effect of PE on prices and spending, by now replicated across settings and specialties, is far clearer than the effect of PE on access and quality. The analysis by Arnold et al[6] is a welcome addition to the literature, generating important questions for future study and transparent monitoring as investor-owners become increasingly influential in health care.

ARTICLE INFORMATION

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REFERENCES

1. Singh Y, Song Z, Polsky D, Bruch JD, Zhu JM. Association of private equity acquisition of physician practices with changes in health care spending and utilization. *JAMA Health Forum*. 2022;3(9):e222886. doi:10.1001/jamahealthforum.2022.2886

2. La Forgia A, Bond AM, Braun RT, et al. Association of physician management companies and private equity investment with commercial health care prices paid to anesthesia practitioners. *JAMA Intern Med*. 2022;182(4):396-404. doi:10.1001/jamainternmed.2022.0004

3. Braun RT, Bond AM, Qian Y, Zhang M, Casalino LP. Private equity in dermatology: effect on price, utilization, and spending. *Health Aff (Millwood)*. 2021;40(5):727-735. doi:10.1377/hlthaff.2020.02062

4. Borsa A, Bejarano G, Ellen M, Bruch JD. Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: systematic review. *BMJ*. 2023;382:e075244. doi:10.1136/bmj-2023-075244

5. Abdelhadi O, Fulton BD, Alexander L, Scheffler RM. Private equity-acquired physician practices and market penetration increased substantially, 2012-21. *Health Aff (Millwood)*. 2024;43(3):354-362. doi:10.1377/hlthaff.2023.00152

6. Arnold DR, Fulton BD, Abdelhadi OA, Teotia A, Scheffler RM. Private equity acquisition of gastroenterology practices and colonoscopy price and quality. *JAMA Health Forum*. 2025;6(6):e251476. doi:10.1001/jamahealthforum.2025.1476

7. Kannan S, Bruch JD, Song Z. Changes in hospital adverse events and patient outcomes associated with private equity acquisition. *JAMA*. 2023;330(24):2365-2375. doi:10.1001/jama.2023.23147

8. Gupta A, Howell ST, Yannelis C, Gupta A. Does private equity investment in healthcare benefit patients?—evidence from nursing homes. National Bureau of Economic Research. 2021. Accessed April 22, 2022. https://www.nber.org/papers/w28474