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Competition and regulation in the healthcare sector

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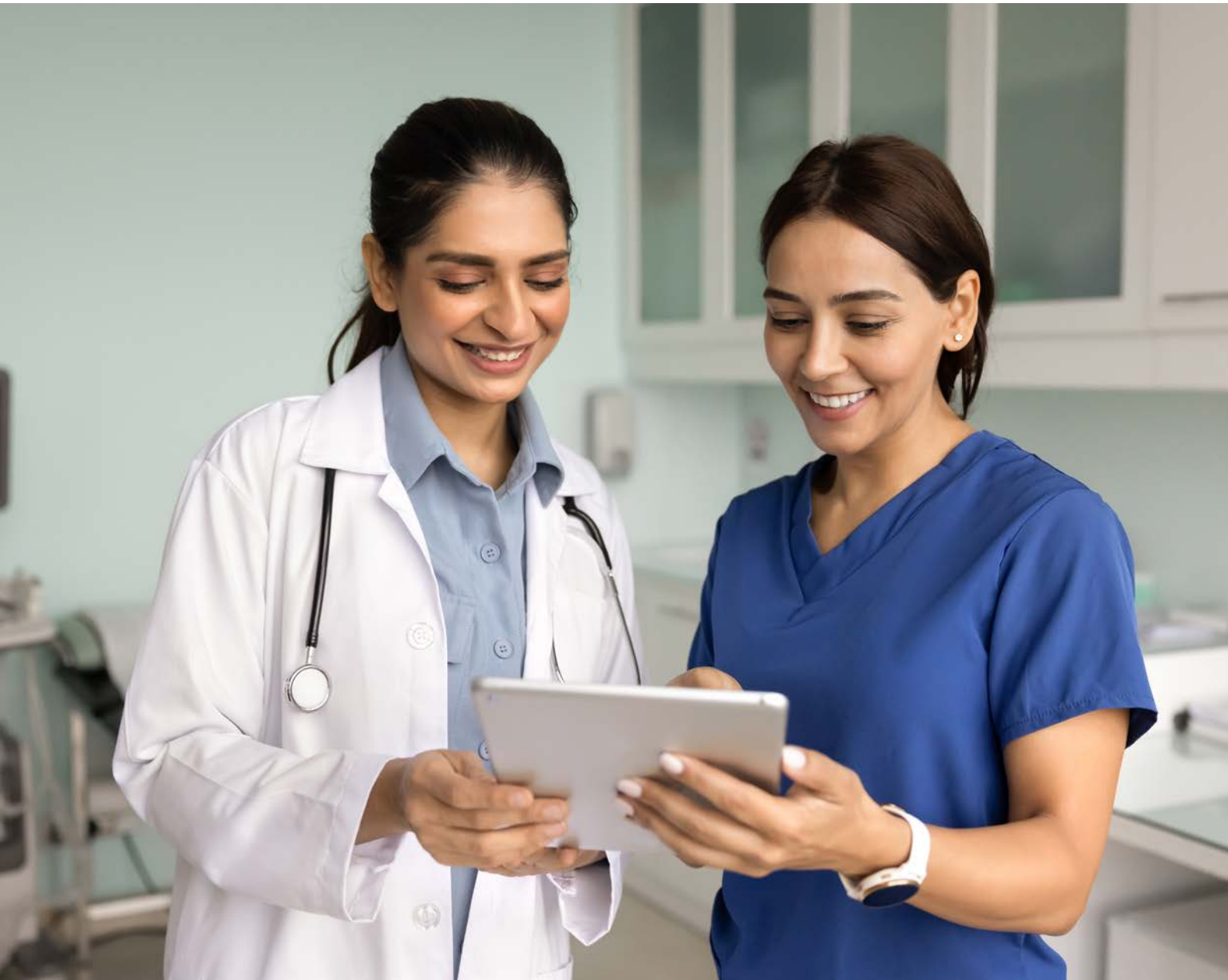

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Abstract

Competition can control costs and incentivise efficiency in the healthcare sector. This paper examines how regulation interacts with competition in healthcare markets and identifies areas where competition authorities can advocate for pro-competitive regulation. It presents a framework for identifying and reviewing regulatory barriers to competition, and it discusses empirical evidence and relevant experience by competition authorities. It finds that rules such as needs-based entry restrictions, or incumbents' involvement in licensing decisions, can limit entry and reduce capacity. Similar concerns arise in professional regulation, where restrictive definitions of tasks and limited portability of licences can exacerbate workforce shortages and reduce access. The development of digital services can also be slowed down by regulatory barriers, such as the lack of interoperability between electronic records systems. Finally, pro-competitive regulation can support patients and payers by providing them with usable information.

Keywords: Advocacy, Competition, Healthcare, Hospitals, Pro-competitive reforms, Professional licensing, Regulatory barriers to competition.

JEL classification: L5, L8, I11, I18, L4, L44.

Table of contents

TABLES

BOXES

Executive summary

Healthcare accounts for about 10% of GDP and around 15% of public expenditure on average in the OECD.[1] Spending has risen over the past decade in several OECD countries and is projected to continue increasing as populations age. Beyond its economic weight, healthcare is central to quality of life, labour participation and social welfare. These features help explain why governments intervene extensively in healthcare markets, through funding, regulation and, in many cases, direct provision. They also underscore why the design of regulation matters.

Poorly designed rules can entrench inefficiencies, weaken incentives for quality improvement and limit the scope for competition to contribute to better outcomes. This paper examines how to bring a competition lens to the regulation of healthcare markets, where market failures are persistent and regulation is not a temporary response but a permanent feature of system design.

Key messages include:

Introducing competition in healthcare markets can contribute to efficiency in delivery and quality of care. Many OECD countries allow some form of competition, particularly through patient choice of providers and, in some cases, insurer choice. At the same time, healthcare markets require ongoing regulation to address information asymmetries, equity concerns and safety. Competition is therefore not a substitute for regulation, but an instrument whose effects depend on regulatory design.

Healthcare systems differ widely and no model consistently outperforms others. This diversity does not weaken the case for the scrutiny of regulation. On the contrary, pro-competitive reforms within existing systems can yield gains. The central challenge for policymakers is to ensure that regulation and competition reinforce rather than undermine each other.

Regulatory interventions introduced to address market failures or equity concerns can inadvertently restrict competition. Licensing and entry requirements are a prominent example. While licensing of providers is necessary to assure minimum quality, specific rules such as needs-based entry restrictions, minimum activity thresholds applied broadly, or incumbents' involvement in licensing decisions can limit entry, reduce capacity and weaken incentives to improve quality.

Professional regulation poses similar concerns. Licensing and scope-of-practice rules protect patients from low-quality care, but overly restrictive definitions of tasks and limited portability of licences can exacerbate workforce shortages, reduce access and increase waiting times. Professional bodies are typically granted regulatory powers to set entry and conduct requirements, raising the risk that they may restrict entry and limit professionals' ability to compete, for example by restricting commercial communications.

Provider payment mechanisms play a central role in determining how providers compete. Each mechanism creates distinct incentives, such as encouraging overprovision or fostering efficiency, and typically has both desirable properties and detrimental effects. Awareness of these effects can help competition authorities develop their advocacy to help align incentives with objectives for quality, efficiency and access, and avoid unintended distortions.

The development of digital services can also be slowed down by regulatory barriers, such as the lack of interoperability between electronic records systems. The use of digital technologies in healthcare, such as telemedicine and electronic health records (EHR), is becoming more widespread, offering opportunities for greater efficiency and better access to healthcare. Regulations about professional licensing, as well as pricing and reimbursement rules, have the potential to slow down the development of telemedicine. The lack of access to health data and the lack of interoperability are among the regulatory barriers that are more relevant for the use of data and of EHR to support healthcare services.

Competition cannot work effectively unless patients and payers are equipped with usable information. Healthcare services are complex and marked by information asymmetries. Even when patients are free to choose providers, they often lack clear information on quality, outcomes and costs. The paper reviews policies aimed at improving information disclosure, including price transparency and publication of quality indicators. These information policies do not remove the need for regulation or enforcement, but they enable choice and competition to discipline providers and reward better performance.

1 Introduction

Expenditure on healthcare products and services accounted for almost 10% of GDP in 2024 in the OECD, with increases of about one-third in the last ten years in some OECD countries (OECD, 2025[1]).[2] Moreover, one out of nine jobs across the OECD is in health or social care (OECD, 2025[1]).[3] For households, OECD data show that healthcare goods and services represented 3.2% of their total spending in 2023 (OECD, 2025[1]).[4] All these figures are projected to increase further,[5] driven by factors such as an aging population.

Beyond the economic importance of the sector, access to affordable healthcare is necessary for quality of life and society's well-being, as well as to enable individuals to lead a productive life. However, the characteristics of the sector make it prone to market failures, for example information asymmetries and externalities, which make the outcome produced by markets alone not optimal. In particular, patients do not have information on the quality of the service provided by doctors or hospitals when they select a service provider. In fact, due to the complex and specialised nature of the service, they are not able to assess quality even after they have been provided a service ("credence" good) and they cannot assess whether prescribed treatments are necessary. Moreover, there are benefits to society from a healthy population, but individuals are unlikely to take these broader benefits into consideration when they choose the quantity and quality of service to consume, for instance with respect to vaccination or prevention.

Due to market failures, and to promote affordable access to healthcare, governments intervene in the market by providing, funding and regulating services. The government's role is substantial in most health systems, and healthcare makes up 15% of government spending in the OECD (OECD, 2025[1]).[6] In addition to providing services and funding, governments shape healthcare markets through *"the application of minimum regulatory standards, and the careful use of choice and competition"* (OECD, 2018[2]). As a result, markets in different countries may look significantly different, depending on the government's health policies and the extent and nature of government intervention.

There are several reasons for focussing on the sector. Its importance in social and economic terms and the rising expenditure in healthcare for households and governments were already mentioned above. Given limited government budgets, competition can help deliver services more efficiently and make the best use of scarce resources. Indeed, pro-competitive reforms in OECD countries have been introduced to help control costs and incentivise efficiency (OECD, 2012[3]), while continuing to promote quality. Another reason for a discussion of healthcare regulation is that, given the serious market failures in the sector, government regulation is not temporary but is a long-term phenomenon (OECD, 2018[2]). For this reason, it is especially important that it is proportionate, does not restrict competition more than necessary, and indeed works hand in hand with competition to help spur efficiency and incentivise quality, as any positive changes to regulation will have long-term benefits. Finally, health systems vary significantly across countries and there is no altogether 'best' system among the available models (OECD/The Health Foundation, 2025[4]). Given this, the aim of this policy paper is not to propose one specific system or to question any of them but to suggest that small changes improving policy in any system can deliver better services to society.

Given the specificities of the sector, it is important to clarify that competition is not a synonym of entry by private suppliers or by financial investors, even though in some cases there may be merit in both. Moreover, competition is introduced in the context of a detailed regulatory framework that promotes affordable access to good-quality healthcare.

The topic of this background paper is related to several roundtables held by the OECD Competition Committee and the Global Forum on Competition (GFC). Most recently, the GFC discussed "Beyond price in healthcare markets: Access, quality and equity (OECD, 2025[5]) and "Risks across the pharmaceutical value chain" (OECD, 2025[6]). Working Party No. 2 on Competition and Regulation (WP2) held a roundtable on "Designing publicly funded health markets" (OECD, 2018[2]) and one on "Competition in hospital services" (OECD, 2012[3]).

More generally, this topic is related to the OECD Competition Assessment Recommendation [OECD/LEG/0455] and Toolkit (OECD, 2019[7]), which provides a methodology to identify and review regulations that unnecessarily restrict competition, and to develop alternatives that still achieve the policymakers' objective.[7]

While the earlier WP2 work focussed on policy choices to inject competition into health markets, this policy paper and session will take as a given that some market-based mechanisms have been introduced in the healthcare system and investigate regulatory barriers that unnecessarily constrain competition in the market. It will provide evidence, when available, to support competition authorities' advocacy. Given the very wide variation in healthcare systems, some regulatory barriers may be specific to a certain system and conclusions may therefore not be generally applicable. Nonetheless these case studies aim to guide the reader into how a competition lens was applied to a healthcare regulatory barrier and to suggest potential barriers for competition authorities to assess.

The remainder of the paper is organised as follows. Section 2 provides some context about the sector, reviews the main characteristics of demand and supply, and discusses the evidence on the impact of competition in healthcare, thus motivating pro-competitive regulation in the sector. Section 3 summarises the OECD methodology for identifying and reviewing regulatory barriers to competition and suggests areas where competition authorities could advocate for pro-competitive regulation. Section 4 concludes.

2 Market characteristics and the introduction of competition

This section provides an overview of the main institutional features in the healthcare sector and of key characteristics of demand and supply for healthcare services, highlighting those leading to market failures. These market failures, together with equity considerations, explain why governments intervene extensively in healthcare markets, through funding, regulation and, in many cases, direct provision.

Against the backdrop of similar market failures across countries, different jurisdictions have responded in different ways, creating the variation of healthcare systems seen across the OECD.

The economic literature on healthcare markets is extensive and has greatly contributed to the approach of competition authorities to these markets. This text simplifies and summarises only high-level results to explain the basic rationale for government intervention and for introducing competition, as well as the regulatory barriers to competition resulting from this intervention.

2.1. Healthcare systems vary significantly

Health systems vary in several important respects, such as how they are structured, funded and how services are delivered. Key policy choices that can help distinguish different systems are as follows: *"degree of user choice of basic coverage; degree of private provision of primary care and outpatient specialist services; patient choice of providers; health insurance as a secondary source of coverage ("over the basic" coverage); role of primary care in the health system (gate-keeping)"* (OECD/The Health Foundation, 2025[4]).[8]

Depending on these policy choices, market mechanisms may be more or less developed, and demand and supply behaviour will differ too. The implications of selected criteria are described below by way of example:

- Degree of user choice of basic coverage: this is related to the importance of health insurance in a country. Some countries, such as Germany and the Netherlands, have a system of mandatory insurance where consumers can choose an insurer for their basic coverage. In others, such as Australia, Canada and France, user choice is not possible and basic cover is provided by public insurance, complemented by private insurance beyond basic coverage.
- Patient choice of providers: patients' choice in selecting hospitals or doctors, which is another policy lever, is a necessary condition for competition in the market for medical services. In France, patients can choose their provider but cannot choose a provider for their basic coverage, which is provided by the public insurer.
- Role of primary care in the health system: the role of primary care also varies, with general practitioners (GPs) having a "gate-keeping" function for patients' access to specialist care in countries such as in Denmark, Norway and the UK. This limits the extent to which patients are free to access specialist services, at least when they are publicly funded. It may also restrict patients' ability to choose the specific specialist provider.

In addition to the private provision of outpatient services, which is one of the criteria in OECD/The Health Foundation (2025[4]) mentioned above, the degree of private provision of hospital services gives a sense

of the extent to which market mechanisms are in place. For example, the government may rely on private hospitals (or services) to alleviate congestion in the public system, raising questions of whether government funding of public hospitals may distort the playing field (see Box 4 below).

From a competition point of view, it is also important to consider whether prices can be set by providers, are negotiated between providers and insurers or are otherwise regulated, or indeed whether patients face any prices at all, as this will affect how suppliers compete and how patients behave (OECD, 2025[5]). A related policy question concerns the relative shares of government-funded and voluntary / out-of-pocket expenses. This has a range of implications, including for access to affordable care and for how it affects the healthcare market, for instance because patients that face negligible out-of-pocket payments may tend to demand more services, as discussed below.

The significant variation in health system is demonstrated, for example, by the cross-country differences in the proportion covered by government financing and compulsory insurance. In 2023, this proportion covered about 89% of spending on hospital care and 78% of spending on outpatient medical care on average in the OECD.[9] However, the share for hospital care varied widely and ranged from 53% in Brazil to 99% in Norway and Sweden.

There is no evidence that one model is superior in all respects to other models in delivering efficient care. Healthcare systems that have very similar characteristics display different efficiency levels. Moreover, there are efficient health systems in all types of models and similarly there are systems that do not perform well in all models (OECD/The Health Foundation, 2025[4]). The finding is relevant for this policy paper because it suggests that incremental changes within a given model, for example pro-competitive regulation, could be valuable.

2.2. Demand and supply characteristics

Demand and supply for healthcare services are significantly shaped by the extent of government intervention in designing the healthcare system and developing regulations, but also by the government's role as a provider and as a payer of healthcare services. In turn, government intervention is motivated by certain characteristics of healthcare services that lead to market failures, as well as by equity considerations.

2.2.1. Demand-side considerations

Patients face complex choices such as whether to initiate a treatment, whether to seek ambulatory or hospital care and to select a specific provider. These decisions are affected by significant information asymmetries, as patients are generally unable to assess whether treatment is necessary, which type of treatment is most appropriate, and (where possible) how to differentiate between the quality of providers. In addition, in systems where there is no public coverage, they can choose the extent of health insurance coverage and the specific plan. They can also select private insurance on top of the public coverage already provided by the state.

This view of patient choices is complicated by the fact that patients do not always pay for the medical services they are provided, because medical coverage is provided by the public health system or by insurance. This leads to moral hazard phenomena, both before and after an illness has occurred. In particular, moral hazard may result in higher demand for healthcare since the expenditure will be covered, in part or fully, by the state or private insurance (Zweifel and Manning, 2000[8]).

Demand's responsiveness to price depends on the extent to which healthcare is provided for free (either because it is fully funded by the state or the service is provided for free, given that the patient has already purchased health insurance), whether it involves out-of-pocket payments or whether the patient pays the full price. Empirical work on the demand for healthcare showed that patients paying a share of the costs

use fewer services than those benefitting from free services, without having an adverse effect on health apart from the poorest and sickest patients (Brook et al., 2006[9]).

Moreover, demand responsiveness to price depends on how complex medical services are and how pricing information is presented. When patients pay full prices or out-of-pocket contributions, comparing price information for simple services (e.g. lab tests) is straightforward. However, the consensus in the healthcare literature is that patients may not be able to process price information for more complex treatments, such as inpatient care involving medical interventions and overnight stays in hospital. Nonetheless Prager (2020[10]), while confirming that demand is inelastic, shows that patients are price sensitive also for complex treatments. For this to happen, patients need to know precisely how much they will pay in out-of-pocket contributions, which is not often the case because of the complexity of health insurance plans.

Distance appears to be the main driver of patient choice, at least for some services, even though the quality of healthcare is a key consideration (Siciliani, Chalkley and Gravelle, 2022[11]). Confirming earlier results on other countries and services, Pitkänen and Linnosmaa (2021[12]) find that patients prefer "*high-quality providers within short distances*." Despite the importance of quality, individuals may not be in a position to fully assess the quality of healthcare either before or after they have experienced the service.[10] This asymmetry of information between the patient and the healthcare provider has led to a debate on the extent to which a patient can actually make informed choices, based on complete and unbiased information provided by healthcare professionals (Zweifel and Manning, 2000[8]). Some quality dimensions, such as waiting times, are easier to understand than others and impact patient choices (Propper, 2026[13]; OECD, 2018[2]).

2.2.2. Supply-side considerations

As outlined in OECD (2025[5]), the healthcare sector is a complex ecosystem characterised, on the supply side, by a variety of actors, including those that fall in the scope of this policy paper, as follows:

- Primary care providers, such as General Practitioners (GPs) or family doctors;
- Outpatient practitioners or ambulatories that provide specialised medical services;
- Hospitals and clinics;
- Payers, including public health systems and private insurers. Patients may also contribute to expenditure through out-of-pocket payments.

Other market segments, namely pharmaceuticals and medical equipment, are closely intertwined with healthcare services, affecting prices and quality, but fall outside the scope of this paper.

Each of the above market segments can look different in terms of structure and, depending on the health system, the role of public providers may be central. Physicians traditionally practice individually or in small groups, and markets tend to be fragmented, while hospital markets have shown increasing concentration since the 1990s (Gaynor, Ho and Town, 2015[14]). More recently, a wave of consolidation has affected also other market segments, mostly driven by financial actors. The entry of financial actors, such as private equity (PE) funds, in the sector is referred to as financialisation (see Section 2.2.3).

The variables on which medical providers compete crucially depend on the features of the health system. When prices are set by the state,[11] providers compete on quality to attract patients (Gaynor, Ho and Town, 2015[14]). To enable medical providers to compete on quality, their workforce is a crucial supply-side factor. Professional qualifications and regulatory frameworks play a key role in shaping this quality, while also needing to balance the risk of unduly restricting the supply of qualified professionals (see Section 3.4).[12] Hospitals may have limited autonomy in recruiting staff and influencing their pay, which constraints this competitive lever (OECD, 2012[3]). Conversely, in systems where insurers or hospitals have greater autonomy, professionals compete to co-operate with insurers and hospitals or large practices. If selection criteria focus heavily on cost containment, professionals may face distorted incentives, e.g. selecting low-cost treatments even when not suitable or delivering low-quality care.

While providers may compete on quality when prices are set exogenously, they may choose not to compete for certain types of patients. If prices are uniform, medical providers have an incentive to select low-cost patients in the absence of government intervention. Similar mechanisms of adverse selection will also be relevant for health insurers, when the latter can choose low-risk clients (e.g. with a lower probability to need treatment because they do not have prior conditions or because they are younger) in order to minimise the expected cost of covering patients' treatments. Due to these market failures, governments intervene to promote access to medical services and to health insurance.

Competition takes place in local markets. Proximity is a key consideration in the choice of hospitals, general practitioners (GPs) and family doctors, while renowned specialists or hospitals may attract patients from distant areas (Propper, 2026[13]).[13]

Finally, insurers build networks of medical providers for their enrolees. Medical providers negotiate with health insurers to be included in their networks as well as the reimbursement rates for treating enrolees. Insurers compete with each other based on premiums they charge to enrolees (or companies, if insurance is provided by employers), the quality of medical providers they contract with and the extent of their provider network (Gaynor, Ho and Town, 2015[14]).[14] The potential for anti-competitive behaviour arising from the contracts between insurers and providers is not considered here since it is related to private negotiations rather than the regulatory framework.[15]

2.2.3. Financialisation trends in medical services

Financialisation is often observed through: (i) increasing investor ownership of provider organisations; (ii) consolidation into corporate chains, sometimes via serial acquisitions of small practices; and (iii) organisational structures that may separate operating entities from management services and/or real estate (Suzuki et al., 2025[15]).[16] The trend is especially marked in outpatient care. Evidence from an OECD survey of 20 countries suggests that investor ownership in outpatient care has been rising in about half of responding countries in recent years, and that private equity is frequently reported as among the most active investor types (Suzuki et al., 2025[15]).[17]

These structural features give rise to incentive distortions, compared with public providers, not-for-profit providers and even other types of for-profit providers. The extent to which profitability objectives affect quality and pricing is an important question for policymakers with implications for the regulatory framework and for competition in the healthcare sector, as shown by the debate about ownership restrictions (see Section 3.2.3). It is also relevant for competition authorities, beyond their advocacy role, given that this wave of transactions may lead to significant consolidation in several markets.

A review of empirical studies on private equity (PE) ownership concludes that PE ownership is most consistently associated with higher costs to patients or payers, and mixed to harmful impacts on quality (measured through patient safety indicators, staffing levels, clinical outcomes, and patient experience scores).[18] Strategies to increase profits include upcoding of billing (i.e. billing for more complex or costly services than those actually delivered), and selection of more profitable patient profiles, that are confirmed in empirical work (Gondi and Song, 2019[16]). The evidence on quality is more heterogeneous because it depends on the setting and measures used (staffing, safety, patient experience, avoidable hospital use and mortality). Still, several studies raise concerns that some forms of financialisation can be associated with worse staffing or worse patient outcomes, particularly in high-acuity or staffing-sensitive settings (see Annex A below).

2.3. Competition in the healthcare sector

As mentioned in Section 2.1, many OECD countries allow some form of competition, particularly through patient choice of providers and, less frequently, choice of insurers in those health systems that are not based on a public insurer. Before moving to a discussion of regulatory barriers to competition, this section

briefly discusses some evidence about the introduction of competition, with a view to supporting competition authorities' advocacy on the benefits of competition and pro-competitive regulation. It focusses on the impact of competition on quality, integrating evidence included in OECD (2012[3]) and OECD (2018[2]) with more recent evidence and reviews by Siciliani, Chalkley and Gravelle (2022[11]) and Propper (2026[13]).

When providers face prices set by the authorities above cost, providers compete on quality and the evidence shows that competition does deliver better quality. Studies have focussed on hospitals, producing positive results about the impact of competition on the quality of emergency care, while evidence is more mixed for elective procedures. Evidence on competition among primary care practices is scarcer, but it shows that providers facing more competition are driven to improve at least some aspects of service quality such as waiting times. In several countries, reforms introducing greater competition and patient choice were not accompanied by the systematic provision of information on provider quality. As a result, in certain settings it is not clear what impact reforms have had on the quality of care. Moreover, the absence of accessible and comparable quality information limited consumers' ability to make informed choices, thereby potentially constraining the effectiveness of pro-choice policies.

Introducing competition in healthcare markets does not mean that regulation will be phased out, as regulation will still be needed on several issues such as verifying the quality of providers entering the market and the level of services they provide. To the extent that competition has been introduced in the healthcare sector as an instrument to improve healthcare provision, regulation should not undermine it or restrict it. Section 3 will address how to identify regulatory barriers to competition and will discuss areas in which competition authorities could focus their advocacy for pro-competitive regulation.

Patient choice under regulated prices, removing the possibility of price competition, has been implemented in several countries, such as France, Italy, Korea, Norway and the United Kingdom (OECD, 2018[2]). By way of example, patient choice under administered prices became a central element of the National Health Service (NHS) reform in the 2000s in the UK. The reform aimed to make referral decisions more sensitive to differences in hospital quality and, by doing so, to strengthen incentives for providers to improve. The empirical literature that followed confirmed this prediction, both in the UK and in other countries (see Annex B).

Competition between general practitioners (GPs) differs from hospital competition in several respects, with GPs operating in small geographic markets with few competitors. Patient choice can incentivise GPs to compete on quality, but evidence is very limited and seems to point to distance as the main driver of patient choice, as opposed to quality (Siciliani, Chalkley and Gravelle, 2022[11]).

These results should be contrasted with settings where providers compete also on prices, where conclusions are more ambiguous and depend on factors such as whether demand is more responsive to price or to quality, and whether quality is observable (Gaynor, Ho and Town, 2015[14]). There are few countries where prices are set by the market, for instance through negotiations with health insurers, including the Netherlands and the United States. In this case, depending on the relative bargaining powers of the various market players, there may be different levels at which competition takes place and different outcomes for patients. For example, if insurers were to choose doctors based on low prices, this would have the potential of negatively affecting quality.

In addition, the United Kingdom offers a useful example, since it allowed hospitals to compete on both price and quality following a reform from the early 1990s, before moving to a system of administered prices as discussed above. Evidence on UK hospitals in the 1990s point toward adverse quality effects (Gaynor and Town, 2012[17]). Similar conclusions on the negative impact of price competition on quality were reached for the US even though in a very specific setting, that is a change from a regulated system, where price was based on incurred hospital costs, to a system where insurers could negotiate with hospitals to set prices (Volpp et al., 2005[18]).[19] In contrast, results from the Netherlands do not show adverse effects of price competition on quality. [20]

3 Regulatory barriers to competition

As discussed in previous sections, competition is often introduced in healthcare markets to improve service provision and efficiency, given limited resources. Empirical evidence shows that competition also contributes to delivering better quality to patients in a number of settings. This raises the question of how to design regulatory frameworks that address market failures and equity considerations, without unnecessarily distorting competition.

This section briefly presents the OECD methodology to analyse regulatory barriers to competition and applies it to the most frequent barriers identified in this sector by competition authorities. These concern the following types of regulations:

- Requirements for private providers to enter the market and operate, which are increasingly important if public health systems rely to a greater extent on the private sector to ensure access to quality services and lower waiting times.
- Payment models shape providers' incentives and can greatly affect competition. As policymakers try to devise blended systems that can better incentivise efficiency and quality at the same time, the analysis of these new systems presents new analytical challenges for competition authorities.
- Professional licensing is pervasive in the health sector and has attracted significant scrutiny by competition authorities, for its potential to restrict entry and competition more than necessary and for the role of professional associations.
- Digital technologies are becoming widespread in the healthcare sector, and competition authorities are alert to challenges, such as access to data and interoperability, as well as restrictions arising from professional licensing and the uneven treatment of online and offline consultations in payment systems.
- On the demand side, pro-competitive regulation is needed to help the market work better, namely by supporting patients and payers to make better-informed decisions based on quality and price.

Competition authorities are active in this area through opinions and market studies. A number of jurisdictions, such as Canada, Colombia, Germany, Greece, Mexico and the Netherlands, have carried out market studies into some aspects of the healthcare sector and more authorities, including Spain and the UK, are in the process of conducting market studies. In addition, competition authorities have issued opinions on issues such as barriers to entry, compensation mechanisms and professional licensing.

Access to affordable and good quality healthcare depends not only on the services included in the scope of this roundtable but also on several products, such as medical equipment used by hospitals and physicians, equipment for personal use and consumables. For example, significant advocacy efforts by the US FTC contributed to improving the availability and price of hearing aids in the US (Federal Trade Commission, 2022[19]).

3.1. Assessing regulatory barriers to competition

A number of jurisdictions have developed guidelines for the competition assessment of laws and regulations, including Canada, Italy, Korea, New Zealand, Spain, UK and US. These set out the

competition authorities' recommended approach to competition assessment and are typically designed to be used by policymakers when developing new regulations or when reviewing existing regulations.

To illustrate the overall approach, the steps suggested by the OECD Competition Assessment Toolkit are as follows (OECD, 2019[7]):

- Scope: define the scope of the assessment, which could range from a specific provision in a regulation to an entire sector. Moreover, the assessment could concern existing or proposed regulations.
- Potential barriers: review the regulation in scope to identify potential barriers to competition, using a set of questions (the so-called Competition Assessment Checklist).
- Policy objective and harm to competition: for those potential barriers that warrant an in-depth analysis, identify the policy objective and assess the harm to competition.
- Policy alternatives: develop alternative ways to achieve the policy objective, if a regulation is indeed found to harm competition.
- Implement the least restrictive option: recommend the adoption of the regulatory measure that is least restrictive of competition.
- Ex-post review: once a certain policy has been put in place, it is recommended to perform an ex-post evaluation of its impact after some time, for example after three years.

The methodologies for competition assessment developed in the different jurisdictions share a common goal, which is to try and achieve a policy objective in a way that is the least restrictive and distortive of competition. For this reason, once a potential regulatory barrier has been detected, an important step in all these methodologies is to identify the policy objective that the regulation is trying to achieve. This will allow developing potential alternatives that can reach the same objective while restricting competition to a lesser extent.

The methodologies differ, to some extent, in the criteria used to identify the regulations that have the potential to restrict or distort competition. Table 1 below lists the main questions from the OECD Competition Assessment Checklist, along with examples from selected jurisdictions. This comparison is useful to suggest more effects to consider. For example, New Zealand explicitly includes regulations that affect competitive neutrality, while the UK flag regulations that have the potential of limiting innovation. In addition, the OECD Competitive Neutrality Toolkit contains further criteria that aim specifically at levelling the playing field, such as whether regulations exempt incumbents from new and stricter requirements (OECD, 2024[20]).

Table 1. Criteria to identify potential barriers in selected competition assessment methodologies

Does the policy…

OECD	Canada	Korea	New Zealand	UK	US
limit the number or range of suppliers	impact if businesses can easily enter and expand	restrict the number of business operators and business scope	have the potential to limit the ability for businesses to enter, exit or expand from markets	directly or indirectly limit the number or range of suppliers	induce a change in the number or range of competitors
limit the ability of suppliers to compete	impact if businesses can freely set the price, quality and quantity of their products and services	restrict on the competitive capacity of business operators	have the potential to limit the ability and incentive for businesses to compete	limit the ability of suppliers to compete	limit or enhance the ability of firms to compete
reduces the incentive of suppliers to compete	impact a business's incentive to compete	hinder competitive incentives for business operators	have the potential to limit the ability for consumers to choose	limit the incentives for suppliers to compete	weaken or strengthen the incentives for firms to compete vigorously
limits the choices and information available to customers	impact if consumers can easily switch between competitive alternatives	restrict consumer choice and information	have the potential to limit the competitive neutrality in markets	limit the information and/or choices available to consumers	affect or is affected by the supply chain
				affect suppliers' ability or incentive to introduce new technologies, products or business models	affect or is affected by labour market competition

Note: The Korean Fair Trade Commission document was machine translated into English.
Source: OECD (2019[7]), *Competition Assessment Toolkit 3 Operation Manual,* https://www.oecd.org/content/dam/oecd/en/publications/reports/2019/01/competition-assessment-toolkit-principles-version-4-0-volume-3_54214c74/1f253011-en.pdf; Canada Competition Bureau (2020[21]), *Strengthening Canada's economy through pro-competitive policies: A step-by-step guide to competition assessment*, https://competition-bureau.canada.ca/en/strengthening-canadas-economy-through-pro-competitive-policies, Korean Fair Trade Commission (2023[22]), *Guidelines for reviewing competition restrictions such as laws and regulations* https://law.go.kr/LSW/admRulInfoP.do?admRulSeq=2100000233826; New Zealand Commerce Commission (2023[23]), *Competition assessment guidelines – January* 2023, https://www.comcom.govt.nz/about-us/our-policies-and-guidelines/competition-assessment-guidelines/; Competition and Markets Authority (2023[24]), *Competition assessment: guidelines for policy makers*, https://www.gov.uk/government/publications/competition-impact-assessment-guidelines-for-policymakers; Office of Information and Regulatory Affairs and Office of Management and Budget (2023[25]), *Guidance on Accounting for Competition Effects when Developing and Analysing Regulatory Actions* https://bidenwhitehouse.archives.gov/wp-content/uploads/2023/10/RegulatoryCompetitionGuidance.pdf

The guidelines are not specifically tailored to healthcare, but can be particularly useful in the sector given the significant amount of regulation affecting the sector across OECD jurisdictions. Indeed, the following subsections will show several examples of competition authorities' recommendations that have driven pro-competitive reforms of regulation in this sector. Some jurisdictions even have specific initiatives targeting healthcare. The US FTC has recently launched a Healthcare Task Force that will address the sector holistically, from enforcement and advocacy perspectives (Federal Trade Commission, 2026[26]). The sector was also among the priorities flagged by the US agencies in their call for inputs about anticompetitive regulation, issued in 2025. The European Commission has a specific focus on pharmaceuticals and publishes reports on competition enforcement in the sector across the EU, together with the competition authorities of the member states (European Commission, 2026[27]).

Co-operation with health authorities is a fruitful approach to enhance advocacy and better align the objectives of different authorities (see Box 1). On the one hand, this co-operation can help competition authorities gain a better understanding of policy goals and technical details about the functioning of the

sector. On the other hand, health authorities can better appreciate the unintended consequences of certain policies. Co-operation may take the form of structured initiatives addressing specific issues, such as the joint market study on health insurance conducted in the Netherlands. More broadly, establishing Memoranda of Understanding, as well as engaging in informal exchanges of information or internal workshops, can support collaboration. Building a common understanding of the interplay of competition and regulation in the sector is particularly important when competition authorities are required to provide opinions at short notice, as is often the case during public consultations on draft legislation.[21]

Box 1. Examples of co-operation between competition authorities and health authorities

Brazil's Conselho Administrativo de Defesa Econômica (CADE) and the National agency for supplementary health (ANS) signed an agreement in 2019 to establish technical co-operation through various actions including the exchange of documents and information and sharing of databases, reports, diagnoses and statistics. Under a Memorandum of Understanding, the Canadian Competition Bureau (CCB) and Health Canada co-operate on health-related matters involving potential false, misleading, or deceptive advertising or marketing practices. Examples of co-operation between the CCB and Health Canda occurred in 2020, where the CCB co-ordinated its efforts with Health Canda on deceptive marketing claims about Covid-19 prevention or treatment.

In the Netherlands, the Dutch Healthcare Authority (NZa) co-operated with the Authority for Consumers and Markets (ACM) by conducting a joint study into the Dutch health-insurance market. The study revealed that the market still offers an excessive number of health-insurance plans that are largely indistinguishable. This overabundance undermines effective consumer choice, as many consumers cannot readily discern differences and thus face difficulties selecting the plan most suited to their needs. ACM and NZa have put forward recommendations to policymakers, the Dutch legislature, and health insurers for making it easier to choose health-insurance plans, including legislative and regulatory measures to reduce the number of near-identical policies offered by insurers within the same corporate group, remove restrictions on consumer access to supplementary packages, and simplify reimbursement rules for non-contracted care.

Under a Memorandum of Understanding, the UK Competition and Markets Authority (CMA) and NHS Improvement co-operate in relation to their concurrent competition powers and with respect to UK merger control. Co-operation includes engaging in open dialogue and regular liaison, both bilaterally and through the UK Competition Network (UKCN), in which NHS Improvement holds observer status; sharing resources and expertise, including secondments; consulting each other before acting on any case where concurrent powers may apply; sharing information relevant to their concurrent powers and to merger functions.

Source: CADE (2019[28]), *Technical Co-operation Agreement* https://www.ans.gov.br/images/stories/noticias/pdf/Acordo_Cooperacao_CADE_ANS.pdf; Competition Bureau (2023[29]), *Memorandum of Understanding between the Competition Bureau and Health Canada*, https://www.canada.ca/en/health-canada/services/drugs-health-products/regulatory-requirements-advertising/policies-guidance-documents/memorandum-of-understanding-between-competition-bureau-health-canada.html; Competition Bureau (2020[30]), "Competition Bureau cracking down on deceptive marketing claims about COVID-19 prevention or treatment" https://www.canada.ca/en/competition-bureau/news/2020/05/competition-bureau-cracking-down-on-deceptive-marketing-claims-about-covid-19-prevention-or-treatment.html; ACM (2024[31]), "Choosing a health-insurance plan is still difficult for consumers", https://www.acm.nl/en/publications/choosing-health-insurance-plan-still-difficult-consumers; CMA (2016[32]), *Memorandum of understanding between the Competition and Markets Authority and NHS Improvement* https://assets.publishing.service.gov.uk/media/5a815b4840f0b62305b8e828/NHS_Improvement_MoU.pdf.

3.2. Licensing and entry requirements

Several methodologies, including the OECD Competition Assessment Toolkit, identify regulations that can limit the number or range of suppliers as potential barriers to competition (see Table 1). This section discusses some of these barriers, spelling out their underlying policy objectives and the harm to competition they are likely to create, in line with the steps outlined in the previous section. It finally illustrates recommendations on similar barriers drawing on opinions and market studies carried out by competition authorities. The licensing of medical professionals is addressed in a separate section below.

3.2.1. Overview of the potential barriers and policy objectives

While a licensing system for hospitals, ambulatories and physicians' practices appears necessary, the specific requirements may prove unnecessarily restrictive and are therefore worth analysing with a competition lens. A first distinction is between public and private providers, which may be governed by different statutes. Any differences in substantive requirements, especially if one group of providers is subject to stricter requirements than the other, should be justified in light of the underlying policy objective. In some countries, incumbents and new entrants may be subject to different licensing requirements and different regulatory frameworks are applied in parallel (Hellenic Competition Commission, 2025[33]).

As for the requirements to enter the market, potential regulatory barriers include:

- Certificate of need requirements to demonstrate that the new supplier or the new capacity added by an existing supplier is necessary to address real needs.
- Minimum requirements in terms of staff, facilities or capacity defined otherwise (e.g. minimum number of procedures per year).
- Ownership restrictions, for example preventing non-medical professionals from owning capital and controlling voting rights in medical suppliers or preventing financial investors from owning medical suppliers, in line with similar regulations of other professions (OECD, 2024[34]).

The private providers that would like to contract with the public health system face additional requirements. In addition to licensing and quality regulations, "*purchasing policies (e.g. eligibility criteria, contract specifications, payment models and monitoring arrangements) are used to ensure that [private healthcare providers] PHPs bear appropriate incentives and are held to account for their performance*" (World Health Organization, 2025[35]).

The policy objectives underpinning this type of regulations mainly revolve around screening the quality of suppliers. The objective is thus to screen suitable suppliers, without stifling competition that will provide incentives for quality provision. For example, in Germany and in Spain, no new GPs can enter regions where GP coverage reaches a given threshold and "*most countries regulate the distribution of general practitioners (GPs) by balancing market mechanisms and entry restrictions*" (Brüll, Rostam-Afschar and Schlenker, 2025[36]).

In addition to the quality objective, certificate of need requirements aim at controlling health expenditure. The latter element was in fact among the main considerations that justified the introduction of certificate of need (CON) laws in the US, which were passed to address the risk of supplier-generated demand and to encourage the substitution of ambulatory care with less expensive care, as well as to promote quality and access in underserved areas, where presumably it was thought to be more straightforward to demonstrate the need for a new supplier (Mitchell, 2024[37]).

3.2.2. Impact on competition

Needs-based systems such as CON laws restrict the number of suppliers, potentially giving pricing power to incumbents, limiting service availability and reducing incentives to compete on quality. These impacts have been confirmed by empirical evidence. CON laws in US states are associated with higher spending and lower access to healthcare compared with states that do not have CON laws (Mitchell, 2024[37]).[22]

Evidence on the needs-based planning system adopted in Germany confirms these results. Brüll, Rostam-Afschar and Schlenker (2025[36]) find that the threat of entry in local markets contributes to higher quality among German general practitioners (GPs).

Research into the effects of certificate of need laws has established their negative impact decades ago and federal legislation lifted the need for these laws in 1986. Nonetheless, they have proved remarkably hard to remove from state-level legislation, with only 15 US states fully lifting the laws as of 2021 and 24 more states relaxing them during the Covid-19 pandemic (Mitchell, 2024[37]). A notable feature of the laws in some US states is the incumbents' involvement in the licensing process, which could explain both the difficulty to change the laws and their significant restriction of competition.[23]

Moving on to minimum requirements in the healthcare sector, their impact is less clear-cut, and the answer will depend on the specific requirements and on the services in question. On the one hand, there is a risk that minimum requirements are set too high and end up restricting entry, potentially limiting the availability of services and reducing the scope for competition to deliver lower prices and better quality. Moreover, while requiring minimum staff or bed numbers may contribute to promoting access and reducing waiting times, it does not guarantee other dimensions of quality. On the other hand, minimum scale may matter for some types of services, for example because of learning by doing effects or of significant investments in equipment. For example, France's quality regulation in hospital care includes minimum activity thresholds to steer complex procedures toward higher-volume providers. Or et al. (2020[38]) confirm that hospital volume is an important marker of quality and innovation for breast cancer procedures. At the same time, the study finds that markets need to remain competitive for benefits to materialise: in local markets where patients have no choice, hospitals display lower quality and innovation. Van der Schors et al. (2022[39]) investigate a similar question in the Netherlands, where hospitals are equally subject to minimum thresholds for breast cancer. The study finds limited impact of volume on quality, which the authors explain by "*intensified regional collaboration and […] a strict quality assurance system*" among other factors, which may have reduced the difference between high-volume and low-volume hospitals, making minimum activity thresholds less effective.

Requirements that only qualified physicians can own medical practices or bans on cross-speciality integration may limit the resources available to invest, for instance in more advanced equipment that could deliver better quality treatment. These types of regulations have been effectively removed or relaxed in several jurisdictions.[24] This has also opened the door to the entry of financial investors that either own medical practices directly or have implemented contractual controls (Rooke-Ley et al., 2025[40]). As discussed in Section 2 about supply considerations, the evidence shows that financial investors often have a detrimental effect on prices and quality, even though they may help to expand supply.

Regulations that create unnecessary barriers for qualified suppliers to enter state purchasing arrangements prevent more capacity from being brought into the market. In turn, this has a negative impact on access and waiting times, and restricts competition on quality. The regulations' objective to ensure effective administrative oversight and control over private contractors needs to be achieved in the least distortive way possible.

3.2.3. Recommendations by competition authorities and policy debate

Competition authorities have advocated for the removal of needs-based rules (see Box 2) because of their harmful effects. Some US states eliminated their CON laws immediately, while others have favoured a more gradual approach to smooth out transition costs for providers. Different approaches may be suitable to different services, for example phasing out these rules over time in services that are more capital-intensive and therefore need more time to adjust (Mitchell, 2024[37]). Certain requirements, however, such as the incumbents' involvement in the licensing process should be lifted immediately for their direct anticompetitive effects.

As for minimum requirements and incentives for high-volume procedures, these types of regulations seem to be more suitable for complex procedures, where specialisation and innovation matter more. Therefore they should not be imposed in all types of treatment, but only focus on those areas where they are strictly necessary. Even in this narrow context, given that centralisation results in less competition and longer distances for patients to have access to healthcare, alternatives should be explored. For instance, Or et al. (2020[38]) suggest the creation of hospital networks where the expertise accumulated in larger hospitals can be shared with low-volume institutions. Indeed, this type of regulations seems to be among the reasons for increased collaboration among hospitals to create clinical networks where each hospital remains autonomous (van der Schors, Kemp and Varkevisser, 2020[41]). Competition authorities may be called to assess whether these arrangements are anticompetitive and whether they can be justified by benefits for patients. In 2015, the Netherlands Authority for Consumers and Markets (ACM) issued a non-binding opinion about the collaboration between three hospitals, accepting that the positive effects were likely to outweigh any negative effects.[25]

Regulatory frameworks around ownership were designed for private medical suppliers prior to the recent financialisation trends and especially the rise of private equity. However, there are significant differences between different ownership models, such as non-profit, partnership models and private equity. Research shows that these models result in different "*financial, strategic and operational attributes of private investor-owners*" which, in turn, affect behaviour and incentives (Berardi, Hellowell and Varkevisser, 2026[42]). In line with these findings, some jurisdictions such as Germany and the Netherlands are discussing regulations addressing specific types of ownership.

Finally, complex and often changing regulatory frameworks, as noted by Colombia's Superintendencia de Industria y Comercio (SIC) in a study into the treatment of chronic kidney disease, can also discourage investment or make compliance more costly than needed (Superintendencia de Industria y Comercio, 2023[43]). Box 2 shows examples of recommendations to reduce regulatory uncertainty and complexity of processes.

Box 2. Examples of recommendations on licensing and entry requirements

In the United States, Certificate of Need (CON) laws were adopted over 40 years ago by numerous states and required new entrants and incumbent providers to obtain state-issued approval before constructing new facilities or offering certain healthcare services. CON laws aimed to curb duplication of healthcare services by new entrants and prevent unnecessary expansion of existing services by incumbent providers. The US Department of Justice (DOJ) and Federal Trade Commission (FTC) have advocated for the repeal of all CON laws, including Tennessee's, Virginia, Florida and Alaska's. The agencies identified three main problems: CON laws raise entry barriers, they enable incumbents to delay or block pro-competitive entry, and they can undermine effective remedies after anticompetitive mergers. Advocacy for repealing various states CON laws was done through a mixture of invitations to comment on bills, joint statements, and testimony to states congressional committees.

In 2021, Portugal's Autoridade da Concorrência (AdC) undertook a competition analysis of the haemodialysis care sector and found that the sector was highly concentrated, geographically imbalanced and had several barriers to opening new facilities and expanding existing ones. The state procures the service mostly from private operators at regulated prices, subject to quality controls.

In order to reduce regulatory uncertainty, the AdC issued a series of recommendations including the timely publication of the standard clauses for the agreement between the state and the haemodialysis centres (under the convention regime) and introduce a deadline for the state to respond to convention

requests. Moreover, it recommended streamlining procedures for the operators and ensuring that quality requirements are technology neutral. To improve patient choice, the AdC recommended creating a system comparing different centres based on quality and outcome indicators, and informing patients when, under the rules of the public health system, they can be transported to several alternative centres.

Note: the document by the Autoridade da Concorrência (AdC) was machine translated into English to review.
Source: DOJ (2023[44]), "Healthcare Competition Advocacy", https://www.justice.gov/atr/health-care-competition-advocacy; DOJ (2023[45]), "Proposed Repeal of Alaska's Certificate-of-Need Laws", https://www.justice.gov/d9/2023-08/415865.pdf; Autoridade da Concorrência (2021), Autoridade da Concorrência (2021[46]), *Competition in program Care Provision in Portugal*, https://extranet.concorrencia.pt/PesquisAdC/EPR.aspx?IsEnglish=True&Ref=EPR_2019_7.

3.3. Payment mechanisms

Provider payment mechanisms create the incentive structures within which providers make medical and organisational decisions, and within which they compete. If determined by regulation, they fall under the group of regulations that potentially restrict suppliers' ability to compete (see Table 1).

While a full review of payment systems is beyond the scope of this paper, it is useful to sketch the implications of some of the main payment mechanisms for competition. In practice, most OECD health systems use blended payment models that combine elements of several mechanisms, and pure forms are increasingly rare (OECD, 2016[47]). Innovative payment models are also being developed and tested, to enhance efficiency and reduce waste in healthcare, while trying to improve quality and value to patients (Lindner and Lorenzoni, 2023[48]).

3.3.1. Overview of potential barriers and policy objectives

When regulation sets specific payment models, it affects providers' incentives in terms of pricing and volume of activity, as well as their incentives for cost efficiency. The main models are as follows:

- Fee-for-service (FFS): the provider is paid a predetermined fee for each discrete service, procedure, or consultation delivered. Revenue is directly proportional to the volume of activity: the more services provided, the higher the payment. FFS is the traditional payment model for physician services in many OECD countries and remains the predominant method for outpatient specialist care (OECD, 2016[47]).
- Capitation: the provider receives a fixed payment per enrolled patient for a defined period (typically a year), regardless of the volume of services actually delivered. The payment may be risk-adjusted to reflect the expected healthcare needs of the enrolled population (e.g. by age, chronic disease burden) (OECD, 2016[47]).
- Case-based payment: hospitals receive a fixed amount per patient admission, classified into Diagnosis-Related Groups (DRGs) or equivalent case-mix categories. The payment is prospectively determined based on the patient's diagnosis, procedures performed, and other clinical characteristics, and is intended to reflect the average cost of treating that type of case. DRG-based payment is now used in inpatient care in the large majority of OECD countries, typically alongside cost-containment mechanisms (OECD, 2016[47]; Scheller-Kreinsen, Quentin and Busse, 2011[49]).
- Global budget: the provider receives a fixed total payment for a defined period, intended to cover all or most operating costs regardless of the volume or mix of services delivered. Global budgets may be set historically (based on prior-year spending), adjusted for population characteristics, or linked to case-mix measures. They are used in several OECD countries either as the primary hospital payment mechanism or as a ceiling on DRG-based payments (OECD, 2016[47]).

- Bundled payment (also called episode-based payment) provides a single fixed amount for the complete set of services related to a defined clinical condition or care episode, typically spanning multiple providers and settings over a specified period. For example, a bundled payment for hip replacement surgery might cover the pre-operative assessment, the surgical procedure, the hospital stay, rehabilitation, and any readmissions within 90 days. Bundled payments have been implemented in varying forms in some OECD countries, including the United States (Bundled Payments for Care Improvement – BPCI), the Netherlands (for chronic conditions such as diabetes), and England (best practice tariffs) (OECD, 2016[47]; de Lagasnerie et al., 2015[50]).
- Pay-for-performance (P4P): it is not a standalone payment system, but an adjustment layered on top of any base payment mechanism. Under P4P, providers receive additional payments or face payment reductions linked to measured performance on quality indicators such as clinical process measures, patient outcomes, patient experience scores, or efficiency metrics.

3.3.2. Impact on competition

Payment systems affect providers' incentives and how they compete in different ways. Some may have desirable features that promote efficiency and favour lower prices, but at the same time may provide adverse incentives, for example in terms of cream skimming or quality deterioration. This section provides some insights into how the different payment systems affect incentives and competition, based on the economic literature.

The fundamental incentive under FFS is to increase the volume of services, subject to the fee being sufficient for the provider to profit. Since each additional service generates additional profit, providers face no financial penalty for delivering more care and no financial reward for restraint. Providers therefore compete on quantity while price is typically set administratively or negotiated between providers and insurers. The volume incentive may also contribute to market dynamics in which providers invest in capacity expansion and service proliferation — potentially feeding into the consolidation dynamics discussed in the context of financialisation, where investor-backed chains may exploit FFS incentives through upcoding and service volume expansion. This incentive to expand volume and capacity creates a well-documented risk of supplier-induced demand: providers may recommend or perform services beyond what is clinically necessary, particularly where information asymmetries prevent patients from evaluating the appropriateness of care (McGuire, 2000[51]).

Capitation inverts the FFS incentive: since revenue is fixed per patient, the provider's financial interest lies in minimising the cost of care delivered. This creates incentives for efficiency but also for underprovision, that is delivering fewer services than clinically warranted, and for risk selection (or 'cream-skimming'), that is preferentially enrolling healthier patients who are cheaper to treat while avoiding sicker ones. Under capitation, competition shifts from volume to patient enrolment: providers compete to attract and retain patients (or, in managed-competition systems, insurers compete to attract enrolees). This can in principle generate positive quality competition: providers improve care to attract patients; the risk selection incentive may however partially undermine this. Capitation may also encourage consolidation and vertical integration, since providers can capture savings from co-ordinating care across settings. Systematic reviews in the context of physician payment methods find that capitation, relative to FFS, is associated with lower utilisation of services and somewhat lower healthcare costs, but also with shorter consultations and, in some contexts, lower patient satisfaction (Gosden et al., 2000[52]; Scott et al., 2011[53]).

DRG-based payment creates the conditions for yardstick competition among hospitals: because payment rates are standardised, hospitals that treat patients more efficiently earn surpluses, while inefficient hospitals incur losses. This competitive pressure can drive improvements in productive efficiency. However, the upcoding and selection incentives can distort competition, rewarding strategic coding rather than genuine efficiency. DRG systems also interact with market structure: in concentrated markets, hospitals may face weaker competitive pressure to reduce costs, while in more competitive markets, the

benchmarking properties of DRGs may amplify quality competition. Similarly to FFS, DRGs provide incentives to increase the number of patients treated, without rewarding quality of care and outcomes (Lindner and Lorenzoni, 2023[48]). The introduction of DRG-based payment has been extensively evaluated. Meta-studies confirm that DRGs significantly reduce average length of stay without a consistent adverse effect on in-hospital mortality, though readmission effects are more ambiguous (Chen et al., 2023[54]). Upcoding has also been documented: a study of France's DRG refinement found that the introduction of a finer classification triggered a learning effect in which hospitals (particularly for-profit ones) systematically classified patients into higher-paying groups, resulting in a measurable budget transfer from public to for-profit hospitals (Milcent, 2020[55]).

Global budgets can dampen competition because they disconnect provider revenue from the ability to attract patients. A hospital under a global budget has limited financial incentive to compete for additional patients, since additional volume does not generate additional revenue and may increase costs. This means that, in the absence of quality-linked adjustments, global budgets can insulate providers from competitive pressure. The trade-off between financial stability and efficiency incentives explains the temporary suspension of activity-based payments in England during the Covid-19 pandemic to ensure that revenues were predictable, and the subsequent transition back to activity-based elements to incentivise efficiency (Waitzberg et al., 2024[56]; Milstein and Schreyögg, 2024[57]).

Bundled payments reshape the competitive unit from the individual service to the care episode, which can have effects on how suppliers compete. They favour providers capable of managing the full care pathway (typically larger, more integrated organisations) and may disadvantage smaller or more specialised providers unable to absorb the financial risk of the full episode. This can accelerate consolidation and vertical integration, as providers seek to internalise the co-ordination gains that bundled payment rewards. It also creates a tension: bundled payments may improve allocative efficiency by incentivising value, but the resulting provider consolidation may reduce competitive pressure in the longer term. The design of the bundle (breadth of services included, episode duration, risk adjustment, and shared-savings mechanisms) is therefore critical for balancing efficiency incentives against market power concerns. Empirical reviews conclude that the evidence base remains modest in scale and that implementation outside the United States has been limited (Lindner and Lorenzoni, 2023[48]).

P4P interacts with competition in important ways. Where quality indicators are publicly reported alongside payment incentives, P4P can strengthen the link between quality and patient choice. However, P4P may place at a disadvantage those providers serving low-income patients, since socioeconomic factors affect health outcomes independently of care quality, potentially penalising safety-net providers. If P4P rewards are poorly calibrated, they may also entrench existing market positions: well-resourced providers invest in equipment, data infrastructure and quality improvement, while resource-constrained ones fall further behind.

3.3.3. Recommendations by competition authorities and policy debate

Most competition authorities have not issued opinions in the area of pricing and reimbursement rules, possibly because of this complexity and shifting priorities and payment systems in healthcare. When designing funding mechanisms, however, policymakers should be made aware of their interplay with competition, if they are to fully leverage the benefits that competition can contribute to the healthcare sector. For this reason, competition authorities could review funding and pricing regulations to assess if these policies restrict or distort competition among providers, and whether they achieve the policymakers' objectives of increasing efficiency, while ensuring quality healthcare at affordable prices.

Competition authorities could draw on the extensive literature, exemplified by the studies mentioned in the section on harm to competition, that has analysed various dimensions of access, quality and efficiency and could therefore inform competition authorities' advocacy. For example, the German Monopolies

Commission, an independent advisory body to the German Government, has examined the interplay between payment systems, efficiency and equity (see Box 3).

The incentive properties of the different payment systems are complex and their impact on competition is not straightforward, as discussed above. Each payment system may have both desirable properties, such as an incentive to raise output and reduce costs, and less desirable features, such as leading to overprovision, for instance (Wagenschieber and Blunck, 2024[58]). Given this, it is not surprising that governments have implemented several variations on the basic systems, such as supplementing DRGs with volume ceilings to limit overprovision, and quality adjustments (Milstein and Schreyögg, 2024[57]). For example, in 2024, the German Parliament passed legislation to move hospital payments from DRGs to a blended system, between DRGs and global budgets to contain overprovision and increasing expenditure (World Health Organization, 2025[35]).

DRGs are seen as necessary for competition to work, and policy changes that reduce health systems' reliance on DRGs should be viewed cautiously. Some blended systems combine fixed payments with below cost DRGs. While this may address overprovision, it dampens quality competition since it reduces hospitals' profit margins from additional patients (Siciliani, Chalkley and Gravelle, 2022[11]).

Apart from the features of payment systems, competition authorities may identify specific rules that harm competition, such as distortions between providers or between competing services. For example, the Swedish Competition Authority found that different payment systems were applied to physicians' visits conducted in person and online, which distorted competition (Konkurrensverket, 2022[59]).[26] Similarly, Canada Competition Bureau noted that the FFS model that is prevalent among physicians does not provide the right incentives for digital healthcare services (Competition Bureau Canada, 2022[60]) (see Box 6).

Box 3. Germany's Monopolies Commission's work on reforming hospital payment systems

In 2022, Germany's Monopolies Commission published a special report on the hospital system and identified issues in the case-based payment system (DRGs). While the Monopolies Commission was, in principle, supportive of DRGs because they can create competitive incentives for hospitals to improve efficiency, it argued that the current system was not sufficiently transparent, was not clearly anchored to average cost levels, and did not adequately reflect regional differences in operating costs, such as labour costs. It also warned that a case-based payment system can be ill-suited to financing hospitals in regional areas where low patient volumes make provision of services economically unattractive.

The Monopolies Commission therefore recommended a series of reforms to the DRG framework. In particular, it recommended that hospitals' average cost figures be published to help inform payment levels, and that regional price differences be better accounted for through regional price indices. It also recommended that the DRG system be complemented by additional structural financing elements, especially a legally defined minimum care threshold ("security threshold") below which authorities must provide a minimum safeguard coverage in order to finance necessary hospital capacity that cannot be secured through activity-based reimbursement alone.

In a 2023 policy brief, the Monopolies Commission reviewed the Hospital Commission's proposal to reform Germany's hospital funding system. The Hospital Commission proposed that a greater share of hospital funding should come not from case numbers, as was done through the existing DRG system, but through standby payments (payments based on the population actually served in a service group and distributed within regions according to hospitals' historical market shares in treatment cases) and lump sum availability payments (fixed payments to hospitals to maintain necessary care).

The Monopolies Commission, while supportive of the introduction of standby payments, argued that the Hospital Commission's reform proposal was too similar to the existing system. Because funds would be allocated according to the population actually treated and hospitals' historical case shares, hospitals

treating more cases would still receive larger standby budgets. The Monopolies Commission also warned that a larger fixed-payment component may weaken quality competition.

To address these issues the Monopolies Commission recommended that the standby budget be linked to factors such as low population density or regional labour-cost differences rather than to variables linked to case volume. The Monopolies Commission also recommended that compensation factors be empirically examined through an expert report.

Note: the sources were machine translated into English.
Source: Monopolkommission (2022[61]), *Hospital Care After COVID-19: Reorganizing Competition, Planning, and Financing (Special Report 83)*, https://www.monopolkommission.de/images/PDF/SG/SG83_volltext.pdf; Monopolkommission (2023[62]), *Policy Brief: Adjusting maintenance allowances for hospitals, securing supply needs, maintaining competition (Issue 11)*, https://www.monopolkommission.de/images/Policy_Brief/MK_Policy_Brief_11.pdf

Given the importance of both public and private providers in the healthcare sector, combined with the prominent role of state funding in several countries, competitive neutrality issues are likely to arise between public and private providers. These may concern different payment models applied to different types of providers or different funding (see Box 4).

Box 4. Examples of recommendations on competitive neutrality on payment and funding

Between 2017 and 2025, the Icelandic Competition Authority (SKE) issued a series of recommendations to the Ministry of Health, which committed to systemic changes starting 1 January 2026. These reforms included the implementation of a flat unit price for hospital research services regardless of the provider's form of operation, instead of preferential rates to public hospitals, and a commitment to distribute funding for specialist doctor training equally between public and private practices. The ministry also began developing new regulations to ensure that public health centres are subject to the same oversight and requirement specifications as their private counterparts.

In a 2025 market examination of secondary outpatient and inpatient care, the Latvian Competition Council identified several distortions stemming from the state's funding model of health services. A key issue was the level of tariffs set by the National Health Service (NHS), which frequently do not cover the cost of care. As a result, public providers are incentivised to cross-subsidise state-funded services with revenue from paid services, often prioritising privately paying patients. This dynamic contributes to longer waiting times for publicly funded care and shifts part of the financial burden onto patients, raising concerns about efficiency and equity. The Competition Council recommended revising NHS tariff-setting methodologies to ensure full cost coverage and introducing a dedicated "State-Funded Service Development" component accessible to both public and private providers. It also advocated for equal access to financing instruments, regardless of ownership, and for the implementation of strict cost separation rules to ensure transparency in how infrastructure and resources are allocated between publicly funded and paid services. Additionally, the authority proposed improvements to provider selection procedures, such as bundling services into larger lots and placing greater emphasis on quality indicators rather than purely quantitative criteria. In particular, it stressed that public authorities should systematically assess whether private providers are already able to meet demand before expanding public service provision.

In 2025, the Lithuanian Competition Council intervened in the legislative process regarding two major reforms proposed by the Ministry of Health. The first initiative sought to establish a regulation that would prioritise public providers when signing contracts for services funded by the Compulsory Health Insurance Fund (CHIF) at the expense of private healthcare providers. The Council advised the government to maintain elements of competition between private and public entities. A second

regulatory proposal aimed to eliminate the possibility for patients to make additional payments for higher-quality services or materials not fully covered by the CHIF, in order to prevent potential abuses by private providers, such as requesting undue payments. In response, the Competition Council successfully advocated for a more balanced alternative instead of a total ban, that is a transparent and clear list of services and prices for which additional payments are permitted. This regulatory alternative was accepted by policymakers and included in the draft law.

Note: the press release by the Latvian Competition Council was machine translated into English.
Source: Samkeppniseftirlitið (2026[63]), Ministry of Health announces increased equity in healthcare following SKE recommendations – it is important that they are implemented, https://www.samkeppni.is/en/release/news/the-ministry-of-health-is-calling-for-increased-equity-in-healthcare-following-recommendations-it-is-crucial-that-these-are-implemented/; https://www.samkeppni.is/en/release/news/the-ministry-of-health-is-calling-for-increased-equity-in-healthcare-following-recommendations-it-is-crucial-that-these-are-implemented/OECD (2025[64]), Competition in the Healthcare Sector – Contribution from Latvia, Global Forum on Competition, DAF/COMP/GF/WD(2025)52, https://one.oecd.org/document/DAF/COMP/GF/WD(2025)52/en/pdf; Konkurences padome (2026[65]), Competition Council concludes market supervision on competition conditions in the healthcare services sector in Latvia, https://www.kp.gov.lv/lv/jaunums/kp-nosledz-tirgus-uzraudzibu-par-konkurences-apstakliem-veselibas-aprupes-pakalpojumu-joma-latvija; OECD (2025[66]), Competition in the Healthcare Sector – Contribution from Lithuania, Global Forum on Competition, DAF/COMP/GF/WD(2025)50, https://one.oecd.org/document/DAF/COMP/GF/WD(2025)50/en/pdf

3.4. Professional licensing

Key roles in the healthcare sector are subject to professional licensing and related regulation. Most regulations concern the requirements to enter the market and, as such, would fall under one of the criteria in competition assessment methodologies, i.e. limit the number or range of suppliers (see Table 1). Several conduct requirements are also common in professional services. OECD (2024[34]) provides more details on the rationale and the regulation of the professions in general, as well as on conduct regulation, and those arguments will not be duplicated in this paper.

In addition, for some professions their representative body also has a regulatory function. Based on the OECD Competition Assessment Toolkit and other methodologies, this regulatory or quasi-regulatory function has the potential to reduce the incentive of suppliers to compete.

3.4.1. Overview of potential barriers and policy objectives

Professionals are subject to licensing, which means that only an individual holding a licence can legally provide the service and can use the title of doctor, nurse, or other medical professional. OECD (2024[34]) lists other options for entry requirements, such as certification and registration. While specific requirements may depend on the country, typically these will include holding a degree or a certification and having undergone on-the-job training. As an implication, professionals are allowed to practice only in the jurisdiction that issued the licence and this is the case also in federal states such as Canada, Switzerland and the US, where some licences are issued by state or regional authorities. Moreover, licensing in the medical field sets a “scope of practice”, that is the actions that the holder of a specific licence can perform. Barriers to entry can be found also in the regulatory framework of universities and other training institutions that are relevant to the medical professions. These include admission policies that restrict the number of students below market needs and limits to the entry of private universities and other institutions (Comisión Nacional de los Mercados y la Competencia, 2016[67]).

The objective of these regulations is typically to address asymmetric information and ensure the quality of medical services. As there are several other factors that can affect the outcome, it is not easy for those not trained in medicine to be certain about the quality of the professional that treated them. The introduction of professional regulation is credited with having reduced mortality and improved the quality of medical professionals. Law and Kim (2005[68]) focus on physician licensing, finding that it increased quality and

contributed to lower mortality rates, while other studies conclude that midwifery laws delivered important reductions in maternal and infant mortality (Anderson et al., 2020[69]; Lazuka, 2018[70]; Högberg, 2004[71]).

Similarly, in view of the highly specialised nature of the medical profession, in many countries the professional association is also granted regulatory powers to set entry and conduct requirements, as well as to enforce codes of conduct and ethical rules. In other words, associations act both as representatives of professionals and as regulators, in contrast with several other sectors where independent regulators are the norm. The objective is to ensure that the rules are well-informed and based on the actual practice of the profession, therefore professionals themselves are considered better placed than outsiders to set those rules and enforce them.

In addition to entry requirements, the regulatory framework or the professional bodies' statutes encompass conduct regulation, such as guidance on fees or restrictions on advertising. As is the case with the professions more generally, both rules concerning fees and advertising restrictions are motivated by the concern that advertising prices will result in low-price / low-quality suppliers expanding and driving more qualified professionals out of the market (OECD, 2024[34]). Moreover, advertising is thought as a commercial practice that is not in line with the features of the profession, specifically the relationship of trust between patient and doctor.

3.4.2. Impact on competition

While it is hard to question that some form of licensing is necessary to exercise the medical profession, specific requirements associated with licensing may be improved. As noted by Dillender et al. (2023[72]), "*the debate regarding occupational licenses in the healthcare sector is rarely about whether these professions should be licensed or not*". The debate focusses instead on the specific tasks that require a physician as opposed to another medical professional ("scope of practice"), the specific requirements for obtaining the licence or for practicing in countries other than those that issued the licence, and conduct requirements such as the possibility of advertising. At the same time, the proliferation of professional titles, when the underlying need is not clear, risks protecting professionals rather than consumers, by closing off markets.

Entry requirements, such as those concerning scope of practice, may be stricter than needed with the result that the framework constrains the number of suppliers in the market, potentially limiting the availability of medical expertise to patients (both in hospitals and in ambulatories). In addition, to the extent that prices are not regulated for some types of services, the scarcity of professionals may negatively impact the fees charged to patients, for instance in private outpatient ambulatories. These considerations highlight the tension between the objective to ensure that medical professions are suitably qualified, on the one hand, and the objective to ensure that there are enough medical professionals to cover the needs of the population, on the other. With respect to scope of practice, it appears that with the appropriate safeguards it is possible to expand service provision by allowing nurses to perform a greater range of tasks independently. Studies tend to conclude that "*the adoption of full NP SOP [practising nurses without supervision by physicians on certain tasks] either improved or did not impact patient outcomes*" (Dillender et al., 2023[72]).

Similarly, conduct requirements risk limiting the professionals' ability to compete, for example limiting the information available to patients through responsible and factual commercial communications, and for this reason generalised advertising bans can be expected to be anticompetitive. These negative effects may result also from unclear definitions of what type of communication is allowed, therefore creating uncertainty among professionals, which is one of the arguments in an opinion by the French Competition Authority on several professions (see Box 5).

If it is a professional association that issues licences, instead of the state, there is the additional risk that incumbents deliberately restrict entry by competing suppliers by setting standards that are higher than necessary. Moreover, professional bodies may be more inclined to protect their members than to protect consumers, which may lead to poor enforcement of quality standards and ethical rules (Collier, 2012[73]).

3.4.3. Recommendations by competition authorities and policy debate

Several competition authorities have issued recommendations about professional licensing and the statutes and codes of ethics issued by professional bodies, especially concerning scope of practice, restrictions to professionals' mobility and conduct restrictions (e.g. recommended fees, advertising) (see Box 5). Moreover, competition authorities intervene in this area through enforcement interventions, which are however outside the scope of this paper.

The debate on scope of practice, with the objective to improve capacity in the healthcare sector, is long-standing and led to the introduction of nurse practitioners (nurses trained to perform some medical tasks) in the US already in the 1960s (Dillender et al., 2023[72]). The question is still relevant, though, for example in relation to the requirements imposed on nurse practitioners and the extent to which they can practice independently of doctors. In a recent letter to the Mississippi legislature, the FTC reiterates that undue restrictions to practising without supervision can reduce supply, harm patients, providers and payers, and invites policymakers to assess if claimed safety justifications of supervision by doctors are "*supported by credible evidence and consider whether less restrictive alternatives would protect patients without imposing undue burdens on competition and patients' access to health care services*" (Federal Trade Commission, 2026[74]).

Some of the recommendations issued by competition authorities aim at alleviating the scarcity of professionals by strengthening the mechanisms to allow qualified medical professionals to practise in other countries. As mentioned, this barrier to mobility is also present in federal states, which is precisely where mutual recognition would seem to be more feasible and language barriers less important. It is therefore not surprising that recommendations to improve mobility have been issued by competition authorities (Competition Bureau Canada, 2022[60]; COMCO, 2025[75]) and other advisory bodies (Productivity Commission, 2023[76]). In the US, the Interstate Medical Licensure Compact is designed to improve mobility and has been found to indeed reduce barriers to move across US states, with more physicians "*opening or joining new practices*" (Deyo, Ghosh and Plemmons, 2024[77]).

Box 5. Examples of recommendations on professional licensing

In March 2026, the Spanish Competition Authority (CNMC) evaluated the proposed new Ethics Code for the Nursing Profession. A central concern was the requirement for mandatory registration with the professional body, which the CNMC viewed as a significant market entry barrier that should only be imposed by a law rather than a professional code. Furthermore, the authority criticised the use of subjective terms in fee-setting, such as "dignified, fair, and proportionate", warning that such language could encourage anti-competitive price alignment. The CNMC also scrutinised restrictions on advertising and unfair competition, urging that they align strictly with existing national legislation without creating additional unjustified hurdles. The CNMC recommended that the code explicitly emphasise the freedom of price-setting and include a provision stating that mandatory registration only applies if required by law.

Following a similar approach, the French Competition Authority issued an opinion in late 2019 on several draft decrees amending the ethics codes of various health professions, including doctors, dentists, nurses, midwives, physiotherapists, and podiatrists. The opinion was delivered in a context shaped by recent Court of Justice of the European Union case law (Vanderborght judgment, C-339/15), which had clarified that absolute prohibitions on advertising by regulated professionals are incompatible with EU internal market rules.

The authority found that, even if the draft decrees formally removed the notion of a general prohibition on advertising, they often maintained unjustified and disproportionate restrictions on professional communication. It highlighted that broad bans on "commercial" practices, without defining this concept,

created “grey zones” that discouraged practitioners from engaging in legitimate informational and promotional activities. The authority also noted the fragmented and inconsistent regulatory approach across professions and identified specific restrictions (such as limits on communication when setting up new practices, and prohibitions on competitive fee reductions) as particularly detrimental to competition and patient access to information.

To address these issues, the authority recommended establishing a “common core” of rules applicable to all health professions, clearly defining permissible forms of communication and explicitly allowing commercial communication and digital referencing subject to general ethical principles. The authority also advocated liberalising communication related to the creation of new practices by removing prior approval requirements from professional bodies and allowing professionals to inform the public through all media. Finally, the authority recommended strengthening transparency obligations regarding fees and abolishing ethics rules that prohibit practitioners from competing on price.

Source: Comisión Nacional de los Mercados y la Competencia (CNMC) (2026[78]), Report on the proposal for the Ethical and Deontological Code of Spanish Nurses, INF/CNMC/018/26, https://www.cnmc.es/sites/default/files/6454502.pdf; Autorité de la concurrence (2019[79]); Opinion No. 19-A-18 of 31 December 2019 on draft decrees amending the codes of conduct of certain healthcare professions, https://www.autoritedelaconcurrence.fr/sites/default/files/integral_texts/2020-06/19a18_0.pdf.

3.5. Provision of innovative services

The use of digital technologies in healthcare, such as telemedicine and electronic health records (EHR), is becoming more widespread, offering opportunities for greater efficiency and better access to healthcare. For example, the availability of EHR to citizens has significantly improved over the last few years, even though barriers to data accessibility and interoperability “*reduce efficiency, hinder continuity of care, and limit the potential of advanced analytics and AI*” (OECD, 2025[1]). Telemedicine is another promising innovation that can expand access and reduce waiting times, and the share of doctor consultations taking place online has reached about one consultation per patient per year in 2023 (OECD, 2025[1]), but service uptake has stalled.[27]

The regulatory framework can slow down the development of digital services in several ways. Some of the barriers already examined in previous sections are relevant for telemedicine too, as shown by the following examples concerning professional licensing, and pricing and reimbursement rules:

- Professional licensing frameworks can prevent medical professionals from visiting telemedicine patients that are based in other countries and even different states or provinces within federal states (see Section 3.4). For example, in its market study on digital healthcare, Canada Competition Bureau notes that medical licensing requirements across provinces and territories make it burdensome or impractical for providers to deliver virtual care across borders, leading many to avoid cross-jurisdictional digital services altogether due to unclear and inconsistent rules. It also highlights that variations in professional practice policies, including scope of practice regulations that limit the ability of qualified providers to offer virtual healthcare to patients and the refusal in some jurisdictions to recognise prescriptions or orders issued elsewhere constrain providers from using digital healthcare services (Competition Bureau Canada, 2022[60]). Some of these restrictions can be relaxed without significant changes to overall professional regulation, such as the amendments allowing US licensed professionals to simply register in states where their telemedicine patients are located, as opposed to obtaining separate licences (US Federation of State Medical Boards, 2024[80]).
- Pricing and reimbursement rules can also discourage the adoption of telemedicine, such as different pricing approaches for in-person and online consultations (e.g. see the recommendations issued by the Swedish Competition Authority, Section 3.3.3). The study by the Competition Bureau

flags that the current fee-for-service model mostly used by doctors is rigid and slow to change, requiring payors to list and price every type of eligible procedure or consultation. This structure can disincentivise practitioners from adopting digital healthcare tools, such as remote patient monitoring, because they may not be reimbursed under the current fee-for-service model (Competition Bureau Canada, 2022[60]). An OECD working paper recommends the "*utilisation of granular billing codes, by type and mode of telemedicine service, with clear and consistent guidelines*", while noting that only few OECD countries have made progress in modernising payment guidelines (Keelara, Sutherland and Almyranti, 2025[81]).

The lack of access to health data and the lack of interoperability are among the regulatory barriers that are more relevant for the use of data and of EHR to support healthcare services. The lack of data linkages between data held by different health providers prevents information sharing which could support "*safer, more efficient and patient-centred care*" (Mendez, Young and Zhang, 2025[82]). Despite significant improvements in the adoption of EHR, according to an OECD survey only half medical practices share electronic records, despite almost all using HER. This may be for various reasons, including regulations preventing data sharing among medical practices (OECD, 2025[83]). Privacy and data governance rules, while protecting legitimate objectives, may limit access to health data and information flows (OECD, 2025[84]). Conversely, data accumulated through digital tools, such as fitness trackers or apps, may be collected without significant safeguards. Unlike data collected by traditional medical practices and hospitals, digital tools may not be subject to privacy regulations if the rules were not updated to capture new market realities. More generally, the accumulation of a vast amount of data, combined with AI developments, may have repercussions on competition in various sectors, including healthcare (OECD, 2025[85]) which regulation is not yet designed to address.

Canada's market study of digital healthcare highlights another challenge, which is varying requirements imposed by privacy rules. The study finds that different rules across Canada's provinces and territories create regulatory barriers for digital services. They increase costs and complexity for digital healthcare solutions to scale nationally and make Canada less attractive to prospective market entrants (Competition Bureau Canada, 2022[86]). The recommendations issued by the authority are summarised in Box 6 below.

Technological factors are among other reasons explaining the limited sharing of data among medical practices (OECD, 2025[83]). The lack of technical interoperability has already attracted attention by competition authorities, for instance in Canada and in the Netherlands. The Competition Bureau's market study has highlighted that data held in primary care electronic systems are locked into proprietary platforms, which prevents patients and providers from accessing and sharing information with new digital healthcare solutions. These barriers undermine interoperability, impede innovation and lower the adoption of digital healthcare solutions (Competition Bureau Canada, 2022[86]), as also flagged in a broader context in the OECD work on data portability and interoperability to promote competition (OECD, 2021[87]). With a view to encourage innovation, reduce administrative costs and improve the quality of healthcare, the Dutch Authority for Consumers and Markets has recently recommended introducing legal obligations on the suppliers of IT services in the sector. Recommendations included mandating the opening of their IT systems, in a secure manner, to other suppliers and to healthcare providers so that they can develop new services and so that information systems can communicate more efficiently with each other (Authority for Consumers and Markets, 2025[88]).

Box 6. Canada Competition Bureau's market study on digital health services

The Competition Bureau of Canada (CBC) conducted a market study into digital healthcare. In its first report, the CBC identified two barriers limiting new companies that make electronic medical records (EMR) systems and other digital healthcare solutions from entering the Canadian market. In another report, the CBC identified several other barriers that limit competition and prevent healthcare providers from offering the best and newest digital products and services to patients.

In light of these barriers, the CBC proposed the following solutions. Regarding the barriers to new entrants in digital healthcare solutions, the CBC argued that the following steps should be taken to spur greater competition for digital healthcare solutions: (1) the harmonisation of privacy and data governance rules across Canada; (2) requiring primary healthcare EMR companies to comply with "anti-blocking" rules, including but not limited to requiring access on a fair, reasonable and non-discriminatory basis; and (3) establish interoperability standards for primary healthcare EMR systems, including but not limited to putting an independent organisation in place to establish, implement and enforce interoperability standards.

Regarding the barriers to providers from offering digital products and services, the CBC provided three recommendations. The first was to review provider payment models, to ensure that payment models adequately compensate providers for using modern, innovative healthcare solutions. This could involve expanding billing codes and digital programs while in the long-term reforming compensation models. The second was to harmonise provider licensing rules in Canada which would allow providers to serve patients in multiple provinces or territories. The third was to modernise policies to facilitate digital healthcare delivery, ensuring that virtual care policies do not unnecessarily restrict the use and adoption of digital healthcare solutions; empowering providers to use the best mode of care for their patients and adapting existing policies to enable the use of digital healthcare where appropriate.

Source: Competition Bureau Canada (2022[86]), *Unlocking the power of health data*, https://competition-bureau.canada.ca/en/unlocking-power-health-data; Competition Bureau Canada, (2022[60]), *Empowering health care providers in the digital era*, https://competition-bureau.canada.ca/en/how-we-foster-competition/education-and-outreach/publications/Empowering-health-care-providers-in-the-digital-era.

3.6. Pro-competitive regulations supporting patient choices

As discussed in Section 2, patients face information asymmetries and, more generally, complex choices for healthcare services. For this reason, even when patient choice is possible under the regulatory framework, it is not sufficient to guarantee good outcomes. Policymakers have therefore put in place tools to support patients' ability to make well-informed choices. Unlike the rest of Section 3, this section does not identify regulatory barriers to competition but discusses policy tools that can help competition work better.

These policies aim at providing information about quality and outcomes and about healthcare costs, for example clearly communicating services that are covered by the NHS or insurance policy, reimbursement rules and making out-of-pocket contributions predictable. Moreover, in systems where patients choose insurers and insurance plans, there is an additional layer of patient choice where demand-side policies should be considered.

Price transparency regulations require hospitals or doctors to publish their prices to facilitate patient choice. In practice, the effectiveness of these regulations depends heavily on which prices are disclosed (list charges versus negotiated rates versus out-of-pocket costs), to whom (patients, insurers, or both), and through what channels (public websites, machine-readable files, or direct reporting to purchasers). As can

be expected, empirical results show that price transparency has more impact on the behaviour of those patients that pay the cost of their treatment, more specifically on elective treatments, that is when demand elasticity is higher. Moreover, publishing list prices is less effective than publishing the actual prices paid. These findings link back to the evidence in Section 2, showing that patients are responsive to information about out-of-pocket costs when the information provided by their health insurance plan is clear and predictable (Prager, 2020[10]).

Evidence on these policy measures largely draws on the US and the Netherlands, as these are among the countries where prices are negotiated between hospitals and insurers, instead of being set administratively (see Box 7). Experience from outpatient services in Australia, a market where out-of-pocket expenses are significant, also shows that simply providing price information to patients may have limited impact. Providing price and quality information to GPs, who refer patients to outpatient services in Australia, appears a more promising option (Méndez et al., 2026[89]). The relevance of price transparency regulation is more limited in systems where prices are set administratively (e.g. DRG-based hospital payments with regulated tariffs), though transparency of cost and quality data may still serve competition and accountability objectives.

With these caveats in mind, price transparency remedies can be designed to help competition work better, for example to support patient choice among private health providers and among health insurers (Hellenic Competition Commission, 2025[90]). The Mexican competition authority has also recommended introducing price and quality indicators to empower consumers and insurers, among other measures aiming at improving information availability, reducing search costs and supporting switching (Cofece, 2022[91]).

Box 7. Evidence on price transparency regulations in the US and in the Netherlands

Price transparency benefits self-pay patients

The US Hospital Price Transparency Rule requires hospitals to publish standard charges in machine-readable files and in consumer-friendly displays for a set of services.

Pan and Yaraghi (2025[92]) find that the US federal transparency rule does not broadly reduce hospital charges. However, for self-pay patients seeking elective procedures (that is, the group most directly exposed to price signals and with the greatest flexibility to shop) compliant hospitals did reduce charges, driven by both lower unit prices and reduced care complexity (e.g. shorter length of stay and lower resource intensity). Insured patients, who are largely shielded from list prices by their coverage, showed no significant behavioural response. The authors conclude that price transparency primarily benefits cost-conscious patients with the flexibility to compare providers, but does not by itself reshape pricing for the majority of insured care.

Disclosure should concern actual prices and not list prices to have an impact

Kwon and Zhang (2025[93]) study the launch of Maine's price transparency website and identify a 2.74% reduction in average prices. They decompose the effect into three mechanisms: (i) patient switching to lower-cost providers (accounting for roughly half of the total effect); (ii) intensified insurer-provider negotiation (the competition effect); and (iii) provider-side adjustments. Importantly, the study also finds that price transparency can widen market power asymmetries: better-informed large insurers may be able to negotiate more aggressively, while smaller insurers and providers with weaker bargaining positions may not benefit equally.

Price convergence through negotiations, not patient shopping

The Dutch Government mandated in 2016 the public disclosure of insurer-provider negotiated prices for hospital products priced below the maximum deductible at the time, with the aim of fostering price

competition. Franken, Douven, van der Geest and Varkevisser (2025[94]) study the effects of the regulation using negotiated price data from three major health insurers covering over 200 hospital products. They find that price dispersion for homogeneous hospital products decreased by an average of 29% between 2016 and 2022, and that this convergence was not accompanied by a price-level increase exceeding general inflation. The authors interpret the mechanism as operating primarily through the insurer-provider negotiation channel: mandatory disclosure raised awareness of largely unexplainable price differences across providers, prompting insurers and hospitals to reduce these differences through renegotiation.

Complementary evidence from Husiatynski et al. (2021[95]) reinforces the finding that price transparency in the Dutch setting does not operate through patient demand. Studying an earlier episode in which a major Dutch insurer unexpectedly published negotiated prices for dermatological procedures, the authors find that despite a surge in visits to the price transparency website, there was no effect on patient spending, the likelihood of visiting a new provider, distance travelled, or type of provider chosen.

Source: Franken et al. (2025[94]), Price transparency in the Dutch market-based health care system: did price dispersion for similar hospital services reduce over time?, https://doi.org/10.1007/s10198-025-01759-6; Husiatynski et al. (2021[95]), Increasing price transparency in the Dutch healthcare market does not affect provider choice, https://cepr.org/publications/dp15981; Kwon, M. and L. Zhang (2025[93]), Price Transparency in Healthcare: Understanding the Impacts of the Price Disclosure Policy in Maine, https://doi.org/10.1177/10591478251408901; Pan, X. and N. Yaraghi (2025[92]), From Hidden Fees to Open Books: An Empirical Examination of the Impact of Hospital Price Transparency Rule on Costs and Quality of Medical Services, https://doi.org/10.1177/10591478251367520.

Information on quality, such as certification decisions by health authorities and indicators about outcomes and performance of healthcare providers, is also collected and published in order to better support patient choice. Traditional performance indicators may not be enough to support choice, though, since they do not capture dimensions that are important for patients, such as effective communication by healthcare providers and continuity of care. OECD countries have committed to develop patient-reported indicators, such as in the OECD Patient-Reported Indicator Surveys (PaRIS) initiative, with the objective to develop standardised indicators to support comparisons (OECD, 2025[83]).

Finally, while measures to empower patients are crucial for competition to work, the enforcement of competition law and consumer protection law remain important tools to promote quality. For example, competition authorities may focus on quality of care in merger control and antitrust enforcement (OECD, 2025[5]; Mariani et al., 2022[96]).

4 Conclusions

Access to affordable healthcare is necessary for quality of life and for society's well-being, as well as to enable individuals to lead a productive life. Healthcare expenditure accounts for a significant proportion of GDP across OECD countries and it is projected to increase further, placing pressure on households and government budgets.

Introducing competition in healthcare markets can contribute to efficiency and quality. Many OECD countries allow some form of competition, particularly through patient choice of providers and, in some cases, insurer choice. At the same time, healthcare markets require ongoing regulation to address information asymmetries, equity concerns and safety. Competition is therefore not a substitute for regulation, but an instrument whose effects depend on regulatory design.

Healthcare systems differ widely and no model consistently outperforms others. This diversity does not weaken the case for the scrutiny of regulation. On the contrary, pro-competitive reforms within existing systems can yield gains. The central challenge for policymakers is to ensure that regulation and competition reinforce rather than undermine each other.

Complementing their enforcement activities in healthcare markets, competition authorities also play a constructive role, one that could be further strengthened in some cases, through advocacy and co-operation with health authorities. By identifying regulations that are more restrictive than necessary and proposing pro-competitive alternatives that preserve legitimate policy objectives, they complement enforcement efforts and help competition function more effectively, ultimately delivering greater benefits.

While licensing of providers and professionals is necessary to ensure minimum quality standards, certain rules, such as needs-based entry restrictions, broadly applied minimum activity thresholds, or the involvement of incumbents in licensing decisions, can unduly limit entry, reduce capacity, and weaken incentives to improve quality. Similar concerns arise in professional regulation. Licensing and scope-of-practice rules play an important role in protecting patients from low-quality care, but overly restrictive task definitions and limited licence portability can exacerbate workforce shortages and constrain access.

Provider payment mechanisms also play a central role in shaping competitive dynamics. Each mechanism creates distinct incentives, such as encouraging overprovision or fostering efficiency, and typically combines desirable features with potential drawbacks. Greater awareness of these effects can help competition authorities advocate more effectively for quality, efficiency, and access, while avoiding unintended distortions

Competition between healthcare service providers can only be effective if, on the demand side, patients and payers can make informed choices. Disseminating price and quality information, in a format that is understandable and usable, can support choice. Pro-competitive regulation that incorporates these requirements is therefore a tool that complements the competition assessment of the regulatory framework to identify unduly restrictive regulation.

Digital technologies such as telemedicine and electronic health records offer significant potential to improve efficiency, access, and quality in healthcare, but their uptake and impact remain constrained. Regulatory barriers, such as those potentially arising from professional licensing, pricing and reimbursement, data access, and interoperability, have the potential to slow the scaling of digital health services and cross-border provision. Addressing these regulatory and technical constraints, while preserving legitimate public policy objectives such as patient safety and data protection, is essential to unlocking the full benefits of digitalisation in healthcare.

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Annex A. What are the consequences of private equity ownership for prices and quality?

Evidence on outpatient practices

Using data on acquisitions of outpatient physician and dental practices in Finland, a study by Burri, Heinonen and Pietola of the Finnish Competition and Consumer Authority (2024[97]) finds post-acquisition price increases in acquired clinics compared to non-acquired clinics by about 20% for auxiliary services (primarily diagnostic tests and imaging such as X-rays), 10% for appointments with physicians, and around 10% in dental markets. The authors attribute these price changes to "price harmonisation" to the practices owned by the acquiring companies, rather than of increased concentration in local markets.

A study covering ten physician specialties in the United States finds that private equity-acquired practices are associated with price increases in eight of them. In markets where a single private equity firm held over 30% of a specialty, price increases are roughly 1.5 to 3 times larger than average (Scheffler et al., 2023[98]).

La Forgia et al. (2022[99]) finds that when outpatient facilities in the US contract with physician management companies (PMCs) - for-profit entities that manage billing and contracting for physician groups - allowed amounts and unit prices for anaesthesia increase (about +16.5% and +18.7% respectively), with larger increases when PMCs are private-equity backed (e.g. allowed amounts around +26% in a subsample analysis).

Evidence on hospitals

Bruch, Gondi and Song (2020[100]) find that private equity-acquired hospitals in the US show relative increases in total charges per inpatient day and in the emergency department charge-to-cost ratio following acquisition compared to non-acquired hospitals, suggesting that the upward pressure on prices documented in outpatient settings extend to inpatient and emergency care.

Beyond pricing, evidence on US hospitals also suggests "cherry-picking", a strategic reorientation toward higher-margin patient profiles (Richards and Whaley, 2024[101]).

A study of US hospitals acquired by private equity reports reductions in staffing expenditures (notably in Emergency Department (ED) and Intensive Care Unit (ICU) settings) and an increase in ED mortality of about 7 additional deaths per 10 000 visits (a 13.4% increase from the baseline reported), alongside increases in transfers of patients to other hospitals (Kannan et al., 2025[102]). By contrast, a study of private equity acquisitions in ambulatory surgery centres finds no significant changes in unplanned hospital visits relative to non-acquired centres (Lin et al., 2023[103]).

Annex B. Impact of patient choice on quality and welfare

When prices are set above marginal cost, providers competing for patients are expected to set quality at a level that is increasing in the number of rivals (Gaynor, 2006[104]). The intuition is that in systems with regulated prices, competition can improve outcomes when (i) patients can choose, (ii) quality is at least partially observable by patients, and (iii) providers benefit financially or reputationally from attracting additional patients. Several extensions have adapted this framework to the institutional specifics of the sector without significantly changing its results (Gaynor, Ho and Town, 2015[14]).

Gaynor, Moreno-Serra and Propper (2013[105]) analyse the UK reform and conclude that "*increased competition saves lives without raising costs*", examining both clinical outcomes and measures of productivity and expenditure. Gaynor, Propper and Seiler (2016[106]) find that after choice constraints were relaxed in the UK, patients became more responsive to clinical quality. This is associated with a modest reduction in mortality and a substantial increase in patient welfare, with hospitals improving quality in response to stronger demand incentives. The authors quantify the resulting consumer welfare gains in monetary terms. In particular, the implied travel time reduction yields a welfare effect of approximately USD 6 226 per person. A similar calculation based on mortality rates and the statistical value of life yields around USD 309 900 per person.

The positive impact of competition on quality is not robust across all specifications, outcome measures or patient groups. Moscelli, Gravelle and Siciliani (2023[107]) demonstrate that results are highly specific to the diagnosis. The reforms significantly reduced mortality for hip fracture patients but found less consistent effects for heart attacks and strokes.

A similar reform in Norway is examined in Brekke et al. (2021[108]), which finds that, following the introduction of patient choice, hospitals in more competitive areas reduced both some measures of mortality rates and the duration of hospital stays, while they increased readmissions to a small extent.

Or et al. (2020[38]) discuss the impact of competition on quality in breast cancer surgery in France, using the adoption of innovative technologies as a proxy of quality. The study finds that more competitive markets are associated with higher likelihood of innovative procedures.

Notes

[1] This policy paper was prepared by Federica Maiorano, with the assistance of Lorenzo Garofalo, Hayden Chan and Sandra Barreiro Cabanas, of the OECD Competition Division. Helpful comments and review were provided by Ori Schwartz, Maria Canedo and Connor Hogg, also of the OECD Competition Division, Natalie Harsdorf (Chair of the Working Party No. 2 on Competition and Regulation), and Alberto Heimler, Italian National School of Public Administration.

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[2] Chile, Korea and Latvia, see Figure 1.6 in (OECD, 2025[1]).

[3] Executive summary, (OECD, 2025[1]).

[4] See Figure 5.8, (OECD, 2025[1])

[5] "Given that public health spending is expected to grow faster than overall economic growth, public health spending as a share of GDP across OECD countries is projected to rise by 1.5 p.p., reaching 8.4% by 2045 in the base scenario", see Chapter 7 (Health spending projections), (OECD, 2025[1]).

[6] See Figure 7.12 in (OECD, 2025[1]).

[7] It is also related WP2 work on identifying regulatory barriers to competition in several sectors, most recently the sessions on the care industry and on professions and occupations, in June 2024 and December 2024 respectively.

[8] Some of these policy choices, alongside with several case studies, were discussed in an earlier WP2 paper and roundtable (OECD, 2018[2]).

[9] See Figure 5.7, (OECD, 2025[1]).

[10] Despite this, there is evidence that prestigious hospitals attract large shares of patients (Prager, 2020[10]), which may however be related to availability of quality information to patients including information that is mandated by regulation.

[11] For example, this is the case in single payer systems where the state fully funds basic health coverage and sets prices administratively (see OECD (2018[2]) for the economic rationale for fixed prices in these systems, when there is patient choice but no co-payment by the patient). Prices could also be set for some patients, but not all, as is the case for the rates set by Medicare in the US, which is a government programme for people above 65 years old or people with disabilities.

[12] The OECD (2024[34]) has recently surveyed the competition policy considerations when imposing regulatory restrictions on the supply of professional services (including healthcare providers).

[13] Identifying the geographic boundaries of hospital markets in an appropriate way has been pivotal in merger control (Varkevisser, Capps and Schut, 2008[114]).

[14] Anticompetitive practices can arise in the context of negotiations between medical providers and insurers, such as doctors' agreements to fix minimum prices charged to insurers or hospitals using their

market power to prevent insurers from contracting with lower-cost hospitals or offering enrolees budget-conscious plans.

[15] For a recent discussion on anticompetitive practices, see (Sinaiko, 2026[116]).

[16] Financialisation trends were also discussed in previous OECD competition policy roundtables, in the Competition Committee roundtable on serial acquisitions and industry roll-ups (OECD, 2023[110]) and in the discussion on competition and regulation in the care industry (OECD, 2024[111]) by WP2.

[17] This is consistent with deal-flow data documenting over 8 400 private equity transactions in healthcare across 25 OECD countries between 2013 and 2023, with outpatient clinics representing the dominant investment target (Singh et al., 2026[109]). In the US, the number of private equity-acquired physician practice sites grew more than sevenfold between 2012 and 2021, from 816 sites across 119 metropolitan areas to 5 779 sites across 307 metropolitan areas, with single firms exceeding 30% market share in over 100 specialty markets (Abdelhadi et al., 2024[112]).

[18] Much of the evidence base is US-focussed and may have limited international generalisability (Borsa et al., 2023[113]).

[19] Under the new system, hospitals competed for patients on both price and quality. The authors found that reforms had a negative effect on mortality for some conditions, but the results may be affected by other changes, beyond the move from set prices to negotiated prices. For example, the reform led to a reduction in subsidies to hospitals for uninsured patients which affected the hospitals' budgets.

[20] In the Netherlands, insurers negotiate with hospitals to set prices and therefore the Dutch market provides another example of a market where hospitals compete on quality and price. Roos et al. (2020[115]) focusses on elective surgery in the Netherlands but does not find evidence of lower quality driven by price competition. Van der Schors et al. (2022[39]) finds evidence that cancer patient survival was higher in hospitals with more competitors within a 30-Km radius, even though the effect was small and other variables, such as patient and treatment characteristics, were more important to explain survival.

[21] OECD (2022[117]) provides an overview of available co-operation tools between competition authorities and sector regulators.

[22] Two-thirds of the 45 empirical studies investigating the impact of the CON laws on spending find an increase associated with CON laws. Slightly over half of the 190 empirical studies about the effect of CON laws on access conclude that CON is associated with lower access, 38% find "negligible results" and only 10% find that CON laws are associated with greater access.

[23] As reported by (Mitchell, 2024[37]), "the decision to grant a CON is made by a board whose members may work for incumbent providers". Moreover, "in all but 6 CON states, incumbent providers are allowed to participate in the process and object to the application of a would-be competitor".

[24] While laws restricting ownership may still be nominally in force, there are exceptions such as "*permitting professional medical corporations (owned by licensed physicians) or certain health care entities (like hospitals or managed care plans) to employ physicians*" (Rooke-Ley et al., 2025[40]).

[25] "*An informal opinion is a non-binding informal decision from the ACM on whether a proposed form of collaboration is presumed to be permissible under the Competition Act, with the aim to provide guidance*" (van der Schors, Kemp and Varkevisser, 2020[41]).

[26] The document was machine translated into English to review.

[27] Figure 9.15.

OECD Roundtables on Competition Policy Papers

Competition and regulation in the healthcare sector

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Competition can control costs and incentivise efficiency in the healthcare sector. This paper examines how regulation interacts with competition in healthcare markets and identifies areas where competition authorities can advocate for pro-competitive regulation. It presents a framework for identifying and reviewing regulatory barriers to competition, and it discusses empirical evidence and relevant experience by competition authorities. It finds that rules such as needs based entry restrictions, or incumbents' involvement in licensing decisions, can limit entry and reduce capacity. Similar concerns arise in professional regulation, where restrictive definitions of tasks and limited portability of licences can exacerbate workforce shortages and reduce access. The development of digital services can also be slowed down by regulatory barriers, such as the lack of interoperability between electronic records systems. Finally, pro-competitive regulation can support patients and payers by providing them with usable information.