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Beyond Price in Healthcare Markets: Access, Quality and Equity

Competition in healthcare is multi-dimensional, going beyond pricing strategies to include access, quality and equity as core competitive parameters. Any potential harm to any of these parameters in healthcare markets can be as detrimental as pricing strategies. Understanding how competition tools can address these issues is crucial for competition authorities to ensure that healthcare systems do not only deliver cheaper care but also higher quality, accessible and inclusive products and service worldwide.

This note, prepared for the Global Forum on Competition and related to Competition in the Healthcare Sector, analyses sector-specific features of healthcare markets and focuses on potential competition concerns beyond pricing, particularly related to access, quality, and equity in healthcare systems.

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1 Introduction

1. Healthcare is a strategic sector and fundamental to public welfare, national security and sustainable economic growth. Healthcare may safeguard public well-being and improve quality of life representing cornerstones of social protection. At the same time, resilient healthcare systems are essential for sustainable development and for responding to crises and pandemics, which directly affect national stability. The healthcare sector itself is also a major driver of jobs, innovation and investments (BusinessatOECD, 2025[1]).

2. Competition authorities often assess healthcare markets through the lens of price parameters with the aim of reducing healthcare costs, preventing price-fixing strategies and ensuring affordability. While price is undeniable essential for providers and patients, it is not the only dimension for making healthcare systems fair, effective and sustainable. In many OECD countries, prices are absent in certain market segments and regulated in many others, thereby limiting price-based competition. Whether people can access care, the quality of care they receive and whether that care is delivered equitably across different countries and populations are equally important parameters in shaping healthcare outcomes (OECD, 2024[2]), (OECD, 2019[3]).

3. Competition in healthcare is therefore multi-dimensional, going beyond pricing strategies to include access, quality and equity as core competitive parameters. Any potential harm to any of these parameters in healthcare markets can be as detrimental as pricing strategies. Understanding how competition tools can address these issues is crucial for competition authorities to ensure that healthcare systems do not only deliver cheaper care but also higher quality, accessible and inclusive products and service worldwide (Health, 2023[4]).

4. This note, prepared for the Global Forum on Competition and related to Competition in the Healthcare Sector, provides background information and insight to inform one of the two break-out session discussions. It specifically analyses sector-specific features of healthcare markets and focuses on potential competition concerns beyond pricing, particularly related to access, quality, and equity in healthcare systems. We have also prepared a separate note on Competition Risks Across the Pharmaceutical Value Chain to inform the second break-out session.

2 Market dynamics in the healthcare sector

2.1. Essential features of healthcare markets

5. Healthcare whether in the form of products or services is not an ordinary commercial good. It is governed by fundamental rights, ethical and social duties as well as public responsibilities (OECD, 2023[5]), (OECD, 2019[3]), (Singer, 2017[6]).

6. In this context, healthcare markets are complex and shaped by a range of unique market features, such as the variety of market players, market structure, information asymmetry, and inelastic demand. All these factors are relevant for analysing access, quality and equity in healthcare, even beyond pricing strategies.[1]

7. **Variety of market players**: The healthcare sector is a multi-layered ecosystem where (i) care providers (e.g. hospitals and clinics, physicians), (ii) pharmaceutical suppliers (e.g. drug manufacturers, biotech firms, innovators) (iii) payers (e.g. public health systems, private insurers, out-of-pocket payments), (iv) patients and (v) policymakers interact. Its complexity stems from often conflicting incentives among the different stakeholders, such as providers' aim to maximize revenues as opposed to payers' need to contain costs (L. Betcheva, 2020[7]).

8. Intermediaries in the supply chain such as insurers, distributors, and pharmacy benefit managers[2] also play a significant role in the functioning of healthcare markets influencing access, quality and provider's incentives (L. Betcheva, 2020[7]).

9. **Market structure:** Healthcare market structures may be heavily concentrated, highly fragmented or involving a combination of public-private providers. The three distinct but often overlapping market structures (i.e. consolidated, fragmented and mixed) may give rise to different forms of market power and may have implications for competition enforcement. While in highly concentrated systems dominant providers can limit patient choice, in fragmented markets, market power may still matter due to regional monopolies, referrals arrangements (i.e. control over patient flows). Also, mixed systems in healthcare, where public and private providers coexist, may introduce additional complexity, potentially reinforcing market power and leading to competition concerns (M. Tvaliashvili, 2024[8]), (S. E. Li, 2025[9]), (GtR, 2025[10]).

10. **Information asymmetry**: Patients and payers may lack the information to assess quality, safety and appropriateness of healthcare products and services. Relying on providers or intermediaries may result in significant information asymmetries affecting system efficiency and increasing the need for public oversight and competition policy (OECD, 2024[2]).

11. **Inelastic demand**:[3] Healthcare demand is often inelastic as payments are largely covered by health insurance or public financing and patients typically require treatments regardless of price, particularly for essential and time-sensitive services.[4] Also, patients do not directly choose the type of medicine or treatment as this may be strongly influenced by caretakers' decision. These market dynamics may significantly affect both supply and demand-side substitutability in healthcare as well as the

relationship between competition and regulation,[5] making non-price parameters even more critical in policy and competition analysis (Hagiwara, 2024[11]), (R. P. Ellis, 2017[12]), (J. S. Ringel, 2017[13]).

12. Analysing these market characteristics is crucial for competition authorities to better understand how market dynamics may affect other key competitive parameters in healthcare systems such as access, quality and fairness and to identify potential enforcement interventions going beyond pricing strategies (M. Gainor, 2013[14]).

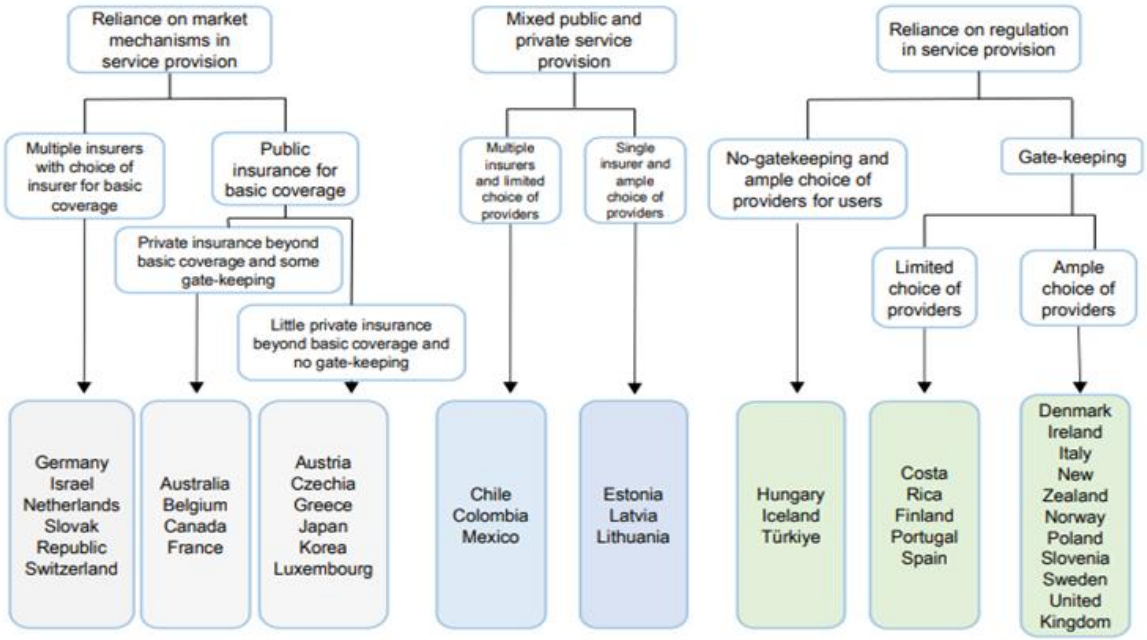
2.2. The regulatory framework in healthcare

13. Health systems are extremely complex and diverse, and no single regulatory framework exists across all countries. Moreover, the regulatory landscape within healthcare is governed by rules and governance frameworks that involve a wide range of regulatory agencies and actors beyond competition authorities.

14. Looking at key health systems characteristics can offer insight into the areas and depth of regulatory oversight, particularly as they may concern competition. These include market mechanisms for service provision, the level of choice in providers offered to patients, the level of competition allowed for in insurance markets, and gatekeeping arrangements.

15. Recent work by the OECD based on its Health Systems Characteristics Survey identified eight broad clusters of countries based on characteristics described above, ranging from systems that rely on market mechanisms and allow for broad competition to heavily regulated public systems that more strongly regulate service provision, implement gatekeeping and limit provider choice (OECD/The Health Foundation, 2025[15]).

Figure 2.1. Grouping of OECD health systems based on similar institutional characteristics



Source: (OECD/The Health Foundation, 2025[15]).

16. Further analysis explored links between these sets of characteristics and key health systems performance indicators and found that no single group of countries could be determined to perform “best”; indeed, high- and low-performing countries were found in each group. This suggests that rather than focusing on a specific type of regulatory structure, specific policy improvements can help to improve performance regardless of how the overall system is designed.

17. Beyond regulatory mechanisms that influence the market dynamics of the health system, a range of other regulatory frameworks guide how healthcare is structured and delivered. These include:

- Price regulation: The extent of regulation varies widely across OECD countries. In some, public authorities negotiate and strongly control the prices of medical services, medical products and insurance premiums, while others rely more heavily on price setting by markets and allow negotiations between private insurers and providers.
- Regulation of Health workforce and healthcare facilities: The healthcare workforce is very highly regulated across OECD countries, with strict accreditation and certification standards. Levels of regulation related to the establishment of new healthcare facilities (including outpatient clinics, pharmacies, and hospitals) are more mixed, with some countries strictly regulating the entry of new facilities. Improving health outcomes, reducing low-value care and patient harm, and ensuring patients receive high quality care from providers are fundamental objectives of health systems, and many countries have put in place reporting requirements and quality standards for healthcare practitioners or facilities.
- Product regulation: The entry (and public reimbursement) of healthcare-oriented products onto the market, including not only pharmaceuticals but also medical devices more generally, are highly regulated across countries, focused on ensuring quality and impact, as well as – in some cases and countries – cost-effectiveness.

3 Potential challenges in healthcare: non-price risks to access, quality and equity

3.1. Barriers to access in healthcare products and services

18. In healthcare, access to products and services is not only determined by price but also by a range of non-price parameters which may directly influence healthcare market dynamics and determine how patients can obtain products and services in a timely and consistent manner (OECD, 2024[2]) (OECD, 2023[5]).

19. This section will discuss access barriers related but not limited to geographic reach, providers' capacity, distribution networks and regulatory frameworks.[6] Addressing any potential challenges in these areas may require not only sector-specific regulation but also effective competition law enforcement, particularly against consolidation or firms' abusive practices aiming at restricting entry and foreclosing rivals. This section will also provide recent examples of enforcement activities and studies related to access, quality and equity.

3.1.1. Geographic reach

20. Healthcare services may be centrally located in profitable urban areas, limiting access for rural and undeserved regions. Physical distance, lack of basic infrastructure and limited transportation may all affect the use of healthcare services. Healthcare consolidation,[7] including both horizontal and vertical integration, may reduce the number of providers and limit access to essential healthcare products and services, particularly in less profitable areas reducing patients' choice and geographic reach.[8] Dominant firms may also limit supply or access to urban facilities creating "*healthcare deserts*"[9] in rural areas or strategically withdraw from less profitable but essential markets or regions to foreclose competition (E. P. Mseke, 2024[16]), (OECD, 2023[5]), (PHCPI, 2021[17]).

3.1.2. Providers' capacity

21. Even where products and services exist, insufficient providers' capacity in terms of healthcare infrastructure (e.g. hospitals with few beds or intensive care units, outdated equipment), workforce density and diagnostics may lead to long waiting times and ineffective care (OECD, 2023[5]), (R. Chinyakata, 2021[18]). Dominant firms may control or influence capacity (e.g. through regulatory, financial or institutional channels) to maintain market power and limit competitors' entry and expansion despite unmet demand, particularly in specialist services as well as in preventive and emergency care. Referrals arrangements or selective contacting by insurers may also limit demand to specific health facilities causing further delays (OECD, 2020[19]).

3.1.3. Distribution networks

22. Healthcare delivery systems are often complex, including multiple layers of suppliers, distributors and providers. Potential distribution bottlenecks (e.g. transport or logistics disruptions), particularly in concentrated and poorly regulated markets, may result in regional shortages of essential medicines and devices. These issues carry a high risk to the provision of healthcare in rural and under-resourced systems where infrastructure is typically weak and alternative supply options may be limited. Dominant distributors or vertically integrated manufactures may increase this product shortages, for example, by refusing access to critical distribution channels and essential inputs or by prioritising the supply of their own products though tying practices (M. Abir, 2024[20]), (OECD, 2022[21]).

3.1.4. Regulatory framework

23. Healthcare regulatory frameworks play a crucial role in shaping market outcomes (see section 2.2 above). While regulation can also contribute to mitigate market power, lengthy licensing, complex procurement rules and reimbursement schemes may also lead to potential barriers and affect timely availability of products and services. This is particularly true in rural areas where access may be further hampered by restrictive facilities regulations and limited operational working hours. Incumbent providers or dominant manufacturers may advocate for these restrictive rules which protect them from competition at the expense of patients, payors and other potential competitors (Mitchell, 2024[22]), (R. Chinyakata, 2021[18]).

Box 3.1. Recent competition cases and studies on access to healthcare

In 2025, the Administrative Council for Economic Defense ("**CADE**", **Brazil**) approved DaVita's acquisition of Brasnefro, subject to conditions. The company is a Brazilian branch of the German group Fresenius Medical Care. The proposed transaction which covers dozens of haemodialysis clinics in the country would have led to competition concerns due to high levels of concentration in local markets. By imposing structural and behavioural remedies, CADE ensured that patients would continue to have timely and reliable access to essential treatments.

In 2024, the Ministry of Industry and Commerce and the National Commission for the Defence of Competition ("**CNDC**", **Argentina)** sanctioned an association of anaesthesiologists for abusing its dominant position by imposing contracting clauses with an exclusionary effect and restricting access to essential services in the Chubut province. According to the CNDC, these provisions impose a restrictive condition preventing health fund administrators from contracting with anesthesiologists independently of the Austral Association of Anesthesia, Analgesia and Resuscitation, or through other associative entities. The proceedings began on 31 August 31, 2017 following a complaint made by the Social Work of Commerce and Civil Activities Employees (OSECAC).

In 2022, the Federal Economic Competition Commission ("**COFECE**", **Mexico**) published a study on competition and free market access in the private health insurance markets partially covering the need to move beyond price in healthcare markets, notably in terms of access and quality in private hospital services. The study suggests publishing price–quality indicators to empower consumers and insurers and emphasises how private insurance can relieve pressure on public services.

Source: CADE conditionally clears DaVita's acquisition of Brasnefro — Conselho Administrativo de Defesa Econômica.
La Secretaría de Industria y Comercio y la CNDC sancionaron a una asociación de anestesiólogos por abuso de posición dominante | Argentina.gob.ar.; Estudio-Seguro-de-Gastos-Medicos.pdf.

3.2. Quality of care

24. Even when healthcare products and services are accessible, they may be unable to enhance patients' outcomes, particularly if they are unsafe or ineffective.[10] The quality dimension in healthcare is often considered the primary parameter of competition, often outweighing pricing considerations e.g. in services where reputation, trust and patients' outcomes are decisive (OECD, 2017[23]).

25. Building on the definition set up by the WHO, IOM and AHRQ (see endnote 10), healthcare quality may appear in multiple attributes. Potential barriers, often identified as recurrent sources of quality failure by health regulators and competition authorities, may negatively affect dimensions – such as clinical effectiveness, patients' safety, access to information, supply reliability, and innovation[11] (OECD, 2025[24]), (OECD, 2024[2]), (EC, 2024[25]), (OECD, 2023[5]), (OECD, 2018[26]).

26. First, **clinical effectiveness** and **patient safety** may be difficult to achieve. Inadequate clinical protocols, poor coordination levels of care and insufficient training or supervision of healthcare professionals may undermine treatment outcomes and patient safety. These weaknesses may contribute, for example, to high rates of hospital admissions for conditions that should be treated in primary or other outpatient care and to inappropriate prescribing practices, both of which may compromise the quality of care. Healthcare systems with weak governance and surveillance systems may delay the detection of adverse effects and inconsistent treatment protocols may result in fragmented healthcare systems. While regulatory monitoring is critical, competition enforcement may also play a role, for example, in deterring misleading marketing practices by dominant firms that misrepresent product quality and delay safer alternatives.

27. Second, **information asymmetries** constitute another potential risk related to quality. Patients, providers and regulators often lack clear data on the performance of caretakers, medical institutions, insurers or drugs. They are unable to assess the true quality of healthcare services, making it difficult for them to differentiate between effective and less effective products or services.[12] This may become a competition concern when firms with market power deliberately distort the information flow.

28. **Supply chain weaknesses** may also give rise to quality concerns. For example, poor manufacturing practices and fragmented procurement systems that prioritise lowest-cost bids may lead to substandard products and services undermining patient safety. The OECD has often emphasised how bid rigging in procurement can also reduce incentives to compete on quality (in addition to price) and to supply high-quality goods and services with the objective of increasing the profit of the winning bidders.

29. High-quality standards are often also associated to **innovation** in medical devices and pharmaceuticals, with the most prominent healthcare benefit resulting from R&D into innovative therapies. Similarly, innovation may create new and more efficient technologies that lead to higher quality products being produced.[13] Firms active in these markets may however employ various strategies to ease the pressure of having to constantly innovate (e.g. defensive patenting). Such practices may in specific circumstances be anticompetitive and particularly harmful for patients and healthcare systems. Strong competition policies and regulation are necessary to ensure that innovation benefits patients rather than sustaining firms' market power.

30. While all these potential barriers are typically common to both health regulators and competition authorities, the way in which healthcare quality is measured and assessed differs between them. The former first determine who is authorised to deliver healthcare through licensing, accreditation and professional qualification requirements and they also often rely on established frameworks such as the Donabedian's structure, process and outcome model as well as the IOM's six dimensions of quality model to monitor and improve healthcare systems and standards.[14] By contrast, competition authorities do not apply these models formally, rather they treat quality as a non-price parameter of competition to assess the competitive dynamics of healthcare markets (OECD, 2024[2]).

Box 3.2. Recent competition cases and studies on quality of care

In 2023, the Belgian Competition Authority ("**BCA**") adapted its merger analytical framework to the specific characteristics of the hospital sector. Among the key questions for the BCA is "to what extent will [the proposed transaction] improve/maintain the range and quality of care services being offered (volume effects, expertise, equipment, personnel, organisation, etc.), also in comparison to a network cooperation". The BCA applied such framework in the 2024 hospital merger between Ziekenhuis Netwerk Antwerpen and GasthuisZusters Antwerpen, which was approved subject to conditions. In its assessment, the BCA examined potential effects on the markets for hospitalisations and for specialised ambulatory care with a focus on quality (in addition to accessibility of care and unregulated prices).

The Hellenic Competition Commission ("**HCC**") also considers that competition on quality is of core importance in the private healthcare sector, and it should be strengthened. In its recent Final Report of 2025 of the Sector Inquiry on private health services and related insurance services, the HCC emphasised, *inter alia*, the lack of transparency in health services and health insurance charges as well as the need to ensure competition in terms of quality and safety, and not only on price.

A 2019 economics working paper, co-authored by one the UK Competition and Markets Authority ("**CMA**") economist, also assessed how hospital mergers and concentration may affect healthcare quality using patient harm indicators. The paper found that reduced hospital competition may significantly increase rates of patient harm showing that competition is an important driver of patient safety and care quality.

Source:
BCA's press release of 18 October 2023 - 44/2023 and BCA's press release of 1 July 2024 - 20240701_Press_release_26_BCA.pdf.
Press release of the HCC – Final Report of the Sector Inquiry on private health services and related insurance services.
CMA's Economics Working Papers - Does Hospital Competition reduce rates of patient harm in the English NHS? - https://www.regulation.org.uk/library/2019-CMA-hospital_mergers_and_patient_harm.pdf.

3.3. Equity and unequal outcomes

31. In healthcare, equity refers to the fair distribution of healthcare products and services across populations to ensure that everyone can benefit from healthcare systems, regardless of their location, income, gender and ethnicity (WHO, 2010[27]).[15] It is often associated to access and quality of care: a product or service may exist and be accessible but not distributed fairly or it may be available but constantly of lower quality for some populations. As a result, equity barriers in healthcare are typically not assessed in isolation as they may appear through uneven access and unequal quality (OECD, 2024[28]). This can also be the direct consequence of market structure or anticompetitive conduct.

32. One of the key equity barriers may refer to **geographic disparity**. While urban populations are more likely to have easy access to medical facilities and advanced treatments, rural populations often struggle with a lack of adequate infrastructures, specialists and services. The latter appears first to be a question of access as products and services are not physically available but may become an equity issue once rural populations persistently and systematically face these constraints (H. Martínez Sanchez-Mateos, 2025[29]), (A. N. Sosin, 2024[30]). According to WHO, in 2021 approximately 4.5 billion people were not fully covered by essential health services with inequalities remaining a major challenge for universal health coverage and disproportionally affecting vulnerable populations (WHO, 2025[31]).

33. Another potential barrier related to equity may arise from **socioeconomic differences**. Poorer populations are frequently more affected by out-of-pocket costs and even in cases where patients are statutorily covered by healthcare systems, they may still have to face lower quality care and facilities (M. Marmot, 2010[32]), (ESPN, 2018[33]). For example, the relationship between quality and equity appears in maternal mortality where women in low-income countries have a lifetime risk of maternal death. In high income countries, this is 1 in 7933 versus 1 in 66 in low-income countries (WHO, 2025[34]). From an enforcement perspective, abusive practices such as refusal to supply or exclusive arrangements may deepen inequities by preventing lower-income patients from accessing essential medicines and services.

34. In addition to geography and income, equity issues also relate to **potential discrimination** in healthcare systems (P. Braveman, 2003[35]). For example, in Europe, 73.8% of natives reported better access to and use of healthcare service than migrants. These potential disparities may reflect in both access and quality barriers (P. Galanis, 2022[36]). Strict non-discriminatory rules and scrutiny of anticompetitive conduct may represent two complementary ways on how regulators and competition authorities can intervene respectively when discriminatory or exclusionary practices may likely lead to health disparities.

35. Finally, equity barriers are **global in scope** with essential products and services often concentrated in wealthier markets and regions, while leaving underdeveloped areas behind (Rad, 2025[37]), (Anderson, 2024[38]). For example, with respect to the COVID-19 pandemic, while 70.6% of people globally had received at least one vaccine dose as of 2024, in low-income countries only 32.7%. Based on Our World in Data, high-income countries had administered approximately 227 doses of vaccine per 100 people, compared to 45 doses per 100 people in low-income countries. This resulted in inequitable distribution that worsened global health outcomes (Minges, 2024[39]), (E. Mathieu, 2024[40]). Such barriers may also result from weak or distorted competition as market concentration and limited entry may reduce incentives to expand access and innovate in less profitable areas.

Box 3.3. Recent competition cases and studies on equity in healthcare

In 2023, the South African Competition Commission ("**SACC**") investigated Johnson & Johnson and its subsidiary for potentially abusing its dominance by relying on secondary patents to delay generic entry. In March 2024, SACC decided not to refer the case to the Competition Tribunal for prosecution following extensive negotiations with the firms. The latter agreed not to enforce its patent in 134 low-and middle-income countries, including South Africa, opening the market to generics.

Reports from policy advocacy groups in several low-and middle-income countries, including CUTS International in India, cover several aspects of the healthcare sector including equity. For example, the **India Competition and Regulation Report** of 2023 focused, *inter alia*, on "Regulatory Deficit in Access to Equitable Healthcare" and investigated several competition (and regulatory) aspects in the healthcare and pharmaceutical sector to ensure fair, equitable, and accessible quality healthcare in India.

Source:
SACC's press release of July 2024 - TUBERCULOSIS-PATENT-COMPLAINT-AGAINST-JOHNSON-JOHNSON.pdf.
Report Competition and Regulation in India of 2023 - Regulatory Deficit in Access to Equitable Healthcare Report - ICRR-2023.

4 Conclusion and issues for discussion

36. Access to healthcare is a fundamental human right that should be actively protected, promoted and guaranteed through coordinated actions by regulators, competition authorities and policymakers.

37. At the same time, competition in healthcare is inherently complex extending beyond traditional pricing strategies to include non-price parameters such as access, quality and equity. Unlike many other markets, patients are often unable to make rational decisions due to market-specific characteristic such as information asymmetries, urgency of care and public health objectives. Because of this unique structure, healthcare markets are not only shaped by competitive dynamics but also regulatory frameworks that attempt to strike a balance between market efficiencies and consumer welfare with broader social and policy objectives.

38. Access to products and services, quality of care and equity outcomes remain critical components to ensure fair, safe and effective healthcare systems. However, they are also the areas where the risk of potential barriers and competition concerns may arise in healthcare. High level of concentration, limited entry of providers and patients' choice, fragmented delivery systems as well as disparities in geographic coverage and capacity shortage make it challenging for competition alone to ensure access, quality and universal coverage without complementary policy measures. This interplay and coordination between competition policy and healthcare regulation is crucial emphasising the need for integrated governance that can respond both to market failures and broader social objectives.

39. Going forward, competition authorities, health regulators and internation organisations must continue focusing on the potential risks also associated with healthcare non-price parameters. Continuous monitoring and evaluation of patient safety, products and services accessibility as well as quality of care will be necessary while healthcare systems continue to evolve. This may involve developing new tools and methodologies for assessing healthcare risks and integrating patient needs into broader initiatives to build more comprehensive and sound healthcare systems, particularly in low- and middle-income countries where the risks of harm are often higher.

40. To support reflection on these themes, a list of potential questions is provided below. These questions are not intended to be exhaustive but rather to stimulate the discussion on how competition authorities can effectively address potential issues related to access, quality and equity in healthcare.

- How can competition policy contribute to improving access to healthcare products and services beyond lowering prices?
- In what ways have competition authorities considered quality of care as a relevant factor in merger analysis or antitrust enforcement? Please refer to practical examples from your jurisdiction.
- How can competition authorities co-operate with health regulators and other public and private stakeholders to ensure that enforcement and advocacy efforts support equitable and inclusive healthcare systems?

- What tools or methodologies can be used by competition authorities to assess non-price dimensions of healthcare markets e.g. access, quality and equity, notably when designing remedies or advocacy strategies?

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Endnotes

[1] This list of healthcare market features is not exhaustive and may vary across jurisdictions based on different regulatory frameworks and healthcare systems. For example, other relevant aspects may refer to the presence of externalities - which may lead to market failure when market price does not accurately reflect the full social cost or benefit of the activity (OECD, 2024[2]), (J. R. Leal, 2017[42]), the different financing arrangements (e.g. including funding sources, reimbursement schemes, and procurement models) and the role of payment models, which may provide different incentives for providers, ultimately affecting competition (OECD, 2023[5]), (OECD, 2016[41]).

[2] A specific feature of the US healthcare system, pharmacy benefit managers are firms that cooperate with health insurers, large employers, and other payers to manage their prescription drug benefits (Martin, 2025[53]).

[3] In this case, the quantity consumed of a product or service does not change significantly when its price changes (Hussain, 2025[45]).

[4] Healthcare demand is generally more elastic across other discretionary service categories (e.g. specialist visits) (AHealthcareZ, 2023[46]).

[5] In particular, the need to ensure that both frameworks – competition law and regulation - work closely together promoting outcomes that serve both public health objectives and market efficiencies.

[6] Other potential barriers may include, for example, the lack of health insurance or coordination between institutional frameworks (OECD, 2023[5]), (OECD, 2007[56]).

[7] For example, among hospitals, insurers, pharma suppliers or between manufacturers and distributors.

[8] Mergers falling below notification thresholds and that are not reviewed by competition authorities may also significantly affect access and competition (OECD, 2022[47]). These include killer acquisitions aimed at eliminating potential future competition and rolls-up or serial acquisitions often designed to build scale and concentration. In the latter case, healthcare has been a major focus for private equity investors, especially in the US, where local and regional markets have been consolidated across several medical specialities, though similar trends are beginning to appear also in Europe. These acquisitions may raise competition concerns by falling below authorities' radar while still increasing market power. Competition authorities may therefore be encouraged to strengthen monitoring of cumulative transactions, conduct market studies and develop tools to assess the aggregate effects of non-notifiable mergers, notably in sectors prone to fragmentation and private equity consolidation such as healthcare (OECD, 2023[57]).

[9] Healthcare deserts are defined as areas where people typically lack adequate access to key healthcare services such as (i) pharmacies, (ii) primary care providers, (iii) hospitals and hospital beds, (iv) trauma centres, and (v) low-cost health centres (Nguyen, 2021[52]).

[10] There is no single definition of healthcare quality. Different institutions define it based on their areas of focus and objectives. According to the World Health Organisation ("**WHO**"), healthcare quality should be (i) effective: providing evidence-based healthcare services to those who need them, (ii) safe: avoiding harm to people for whom the care is intended, and (iii) people-centred: providing care that responds to individual preferences, needs and values (WHO, 2025[49]). The US Institute of Medicine ("**IOM**") has defined quality of care as the degree to which health services for both individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (OECD, 2019[51]). The Agency for Healthcare Research and Quality ("**AHRQ**") has also defined quality healthcare as doing the right thing at the right time in the right way for the right person and having the best results possible (AHRQ, 2010[50]).

[11] This list is not exhaustive and other potential barriers may include, for example, limited human resources as well as digital constraints. The shortage of skilled, motivated and adequately supported staff may reduce the safety and effectiveness of care. Similarly, the use of temporary staff is often associated with worse hospital performance on quality indicators (B. Beauvais, 2024[48]) Also, digital health can potentially transform how health systems work. However, many countries are not yet prepared for such a digital transformation (OECD, 2023[5]).

[12] Information asymmetry may also lead to the principal-agent problem due to the potential conflict between the patient and the physician. Building trust and compatible payment systems in healthcare becomes therefore essential to promote patient safety and improve healthcare outcomes (OECD, 2023[54]), (L. Cerovic, 2012[55]).

[13] Innovation may also reduce the cost of treatments, for example, by developing production processes that make it viable for cheaper medicines to be commercially produced (EC, 2024[25]).

[14] The Donabedian's model is based on (i) structure: providers' expertise and organisational infrastructure for care, (ii) process: providers' and patients' activities in healthcare, and (iii) outcomes: results of care for patients and populations attributable to healthcare. IOM's six dimensions model refer to safe, effectiveness, patient-centred, timely, efficient, equitable. While these methodologies remain stable for most countries worldwide, there are different indicators to measure quality that may vary depending on health systems' priorities, resources and data availabilities as well as policy objectives (e.g. OECD's Health Care Quality Indicators, WHO, national systems) (OECD, 2010[44]), (OECD, 2006[43]).

[15] The WHO defines equity as the absence of unfair and avoidable or remediable differences in health services among groups of people, whether these groups are defined socially, economically, demographically or geographically (WHO, 2010[27]).