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Competition in the Healthcare Sector – Contribution from Consumers International

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More documentation related to this discussion can be found at: oe.cd/chthc.

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Consumers International

Competition, Informed Choice and Consumer Welfare in Healthcare Markets¹

1. Introduction

1.1. Purpose and Context

1. Healthcare directly affects consumer welfare and social equity, and in recent years, OECD countries have spent an average of up to 9.7 per cent of GDP on this essential service (OECD, 2023[6]).
2. Because public funding predominates, the sector often resists traditional competitive dynamics; yet quasi-markets and contestable structures have emerged worldwide.
3. Consumers International advocates that competition in healthcare should be designed to serve patients as consumers – improving quality, access and value – not merely reducing expenditure.
4. The central policy question is not whether competition belongs in healthcare, but how it can be made to advance fairness, transparency and efficiency simultaneously.

1.2. Scope

5. The paper surveys major healthcare sub-markets – hospitals, pharmaceuticals, medical devices, professional services insurance and mental health care – across the UK, US, Australia and Canada. It evaluates how competition and informed choice function where government remains dominant as funder, commissioner and regulator.

1.3. Analytical framework

6. The analysis draws on four key traditions:
 - Arrow’s theory of uncertainty and information asymmetry (ibid.);
 - Le Grand’s design of quasi-markets (ibid.);
 - The Australian Productivity Commission’s operational criteria (ibid.); and
 - OECD case studies on competition in public and care markets (ibid.).

2. The landscape of healthcare markets

2.1. Multiplicity of markets

7. Healthcare is not a single market but a constellation:
 - hospitals and acute care: often state-owned, yet with growing private participation;

¹ By Professor Allan Fels.

- primary care: general practitioners, clinics and community health;
 - specialist Services: high-information asymmetry and fee variation;
 - pharmaceuticals and devices: global research and development (R&D) competition balanced against patent protection;
 - aged and disability care: long-term, mixed-funding markets;
 - mental health and community services; and
 - insurance and financing markets.
8. Each has its own degree of contestability, information availability and regulatory intensity.
9. Comparative national structures
10. United Kingdom: The National Health Service (NHS) combines universal funding with internal markets allowing hospitals to compete for commissioning budgets; consumer choice is expanding through patient-charter rights.
11. United States: Highly privatised, with strong price competition but fragmented risk pools and high administrative costs.
12. Australia: A hybrid system, as public Medicare coexists with regulated private insurance and private hospital competition.
13. Canada and Continental Europe: Predominantly public finance with limited provider competition; prices often administratively set.

2.2. Policy observation

14. No system is purely market or purely state.
15. Most now use competition selectively to raise quality and responsiveness while preserving equity through regulation and public finance.

3. Competition and Informed Consumer Choice

3.1. Conceptual foundations

16. Le Grand (ibid.) offers the most complete design blueprint for quasi-markets in healthcare.
17. He argues that competition and consumer choice, properly governed, can realign producer incentives towards service quality.
18. Key design principles include:
- public funding should follow the consumer ('money follows the patient');
 - choice must be genuine, informed and risk-adjusted;
 - entry and exit must be open yet quality-controlled; and
 - independent regulation must monitor outcomes, not only costs.

19. Le Grand’s analysis extends beyond his earlier ‘knights, knaves or pawns’ (Le Grand, 1997[7]) moral framework to a pragmatic institutional design: competition as a tool for accountability in publicly funded sectors.

3.2. Productivity commission

20. Australia’s Productivity Commission (ibid.) outlines the case for introducing competition and informed user choice into human services.

21. It identifies potential consumer gains – better quality, innovation and responsiveness – conditional on four enabling conditions:

- consumers can exercise meaningful choice;
- providers face competitive pressure;
- funding and information systems reward outcomes; and
- regulation protects vulnerable users.

22. It also warns that without these conditions, competition may erode equity or quality.

23. In healthcare, those preconditions require transparent pricing, comparable performance metrics and robust consumer information.

3.3. Competition in public markets

24. Fels and Biggar’s OECD paper (ibid.) distinguishes between contestability (the threat of entry) and consumer choice (actual switching behaviour).

25. Even limited contestability can discipline incumbent providers.

26. The lesson for healthcare: where direct choice is constrained, benchmarking and comparative performance publication can create virtual competition.

3.4. Consumers International perspective

27. Competition must serve patients as consumers, ensuring value and dignity.

28. Information transparency, fair complaint mechanisms and consumer representation are essential.

29. The purpose is not deregulation but empowerment within accountable systems.

4. Government roles and market stewardship

4.1. Multiple roles

30. Governments act simultaneously as:

- Funder – allocating budgets, setting reimbursement prices.
- Provider – operating hospitals and clinics.
- Commissioner – purchasing services from external providers.
- Regulator – ensuring safety, competition and equity.

4.2. Market stewardship

31. Borrowing from Le Grand and Australia's Productivity Commission, stewardship means active design and oversight of quasi-markets rather than withdrawal from them.

32. Core stewardship tasks:

- define clear market objectives;
- enable fair entry/exit;
- safeguard information transparency;
- monitor quality and consumer outcomes; and
- intervene promptly against provider failure or capture.

4.3. Competition in care markets

33. In their OECD paper, Fels and Cullen (ibid.) show that competition can stimulate innovation and efficiency if regulators maintain clear quality standards and accountability.

34. Stewardship requires governance as much as economics: performance auditing, complaint systems and proportional enforcement.

4.4. Policy implication

35. Governments must reconcile dual roles as purchaser and regulator without distorting markets – ensuring neutrality, transparency and independence of oversight bodies.

5. Barriers to effective competition

5.1. Information asymmetry

36. Arrow (ibid.) demonstrates that healthcare deviates from textbook markets because consumers cannot assess quality or need ex ante. Subsequent research developed the ideas of moral hazard and adverse selection.

5.2. Moral hazard and adverse selection

37. Providers act as both advisors and sellers, generating moral hazard. Policy responses include outcome measurement, accreditation and mandatory disclosure of performance data.

38. Insurance attenuates consumer price sensitivity (moral hazard) and encourages insurers to avoid high-risk clients (adverse selection).

39. Public regulation (community rating, risk equalisation) can correct these failures while preserving choice.

5.3. Professional self-regulation and anti-competitive conduct

40. Medical boards and colleges protect standards but may entrench provider interests by:

- limiting entry of foreign-trained practitioners;
 - restricting advertising; and
 - maintaining fixed-fee recommendations.
41. Competition authorities must distinguish legitimate safety regulation from exclusionary practices.

5.4. Market concentration and vertical integration

42. Hospital mergers, insurer-provider conglomerates and pharmaceutical consolidation can raise barriers to entry.
43. Regular competition review and merger control are essential to preserve consumer choice and prevent price escalation.

5.5. Behavioural and cultural factors

44. Consumers' deference to medical authority, complexity of pricing and fear of risk limit switching behaviour.
45. Behavioural economics-based disclosure tools can help overcome inertia.

6. The role of insurance markets

6.1. Structural models

46. Public insurance: Universal single-payer schemes (e.g. NHS, Medicare) ensure equity and cost control but rely on administrative, not market, discipline.
47. Private insurance: Introduces competition and choice but risks segmentation and complexity.
48. Regulated competition models: (e.g. Netherlands, Switzerland, Australia) combine universal coverage with insurer rivalry under risk-equalisation rules.

6.2. Economic analysis

49. Because illness risk is unpredictable and asymmetric, unregulated insurance markets fail to provide optimal coverage (Arrow, *ibid.*).
50. Government intervention (mandated participation, subsidies, reinsurance) is required for efficient risk pooling.

6.3. Competition and consumer impact

51. Competition among insurers can drive administrative efficiency and product innovation; however, excessive product differentiation confuses consumers.
52. Standardised disclosure and portability rules improve comparability.

6.4. Consumers International position

53. Insurer competition should be assessed on consumer outcomes (claims transparency, coverage clarity, dispute resolution) rather than on profitability or market share.

7. Sectoral case studies

7.1. Pharmaceuticals

54. Innovation vs. access: Patents encourage R&D but confer temporary monopolies. Generic entry post-expiry restores competition and lowers prices.

55. Policy tools: Reference pricing, compulsory licensing, joint procurement and transparency of R&D costs.

56. Consumer concerns: High out-of-pocket costs, marketing influence on prescribing, unequal global access.

57. OECD lesson: Competitive procurement plus global cooperation on essential medicines improves both efficiency and equity.

7.2. The medical professions

58. Regulatory monopoly: Licensing, credentialing and self-discipline maintain quality but can restrict competition.

59. Common issues include:

- entry barriers for nurse practitioners and allied health;
- bans on comparative advertising; and
- price opacity and fee dispersion.

60. Reform directions: Separate public-interest functions from professional self-interest; empower independent regulators; enable multidisciplinary and telehealth models.

7.3. Mental health

61. Market characteristics: Fragmented providers, uncertain quality signals, persistent stigma.

62. Competition potential: Can stimulate diversity and innovation (e.g. digital therapies), yet coordination and continuity are vital.

63. Consumer perspective: Priority on access, cultural appropriateness and long-term support, not transactional choice alone.

64. Policy needs: Integrated funding and outcome measurement frameworks linking competition with cooperation.

7.4. Developing countries

65. Structural challenges: Scarce resources, weak regulation, dominant informal sectors.

66. Consumer risks: Counterfeit drugs, unqualified practitioners, absence of redress mechanisms.
67. Donor and global dynamics: External procurement can distort local markets but also introduce quality benchmarks.
68. International support: OECD and partner agencies should assist with capacity building, transparency initiatives and fair intellectual-property regimes.

8. A policy framework for pro-consumer healthcare markets

8.1. Design principles

69. Competition should be used selectively where it enhances quality and efficiency.
70. Information is the foundation of choice: consumers need clear, comparable data.
71. Equity safeguards must be integral, not afterthoughts.
72. Regulation should be proportionate and independent.
73. Market design requires continuous evaluation and adaptation.

8.2. Information and transparency

- Public performance dashboards for hospitals and practitioners;
- plain-language cost and outcome reporting;
- disclosure of ownership, incentives and conflicts of interest; and
- support for health-literacy and digital-comparison tools.

8.3. Institutional arrangements

- Independent competition and consumer authorities with health expertise;
- cross-agency coordination between health, finance and competition ministries; and
- inclusion of consumer representatives in rule-making and oversight.

8.4. Balancing efficiency and equity

- Universal coverage and targeted subsidies protect access.
- Competitive procurement can deliver efficiency without undermining fairness.
- Evaluate reforms by their consumer welfare outcomes – quality, safety, affordability and trust.

8.5. International cooperation

- The OECD can foster peer-learning on market stewardship, merger control and transparency; and
- exchange of best practice on digital-health competition and cross-border pharmaceutical policy.

9. Conclusion

74. Healthcare markets illustrate both the power and the limits of competition.
75. Poorly designed reforms risk inequity and confusion; well-governed competition, guided by informed consumer choice, can improve quality and accountability.
76. For Consumers International, the essential tests of any competitive reform are:
- Does it empower consumers with reliable information?
 - Does it improve access, safety and fairness?
 - Does it sustain innovation without exploitation?
77. Governments must therefore act not merely as regulators but as market stewards: shaping incentives, enforcing fairness and safeguarding the public interest.
78. Future OECD collaboration could develop a best-practice framework for pro-consumer healthcare markets – defining when and how competition works, and how consumers can be its principal beneficiaries rather than its passive subjects.

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