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Competition in the Healthcare Sector – Contribution from Saudi Arabia

- Session II -

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This contribution is submitted by Saudi Arabia under Session II of the Global Forum on Competition to be held to be held on 1-2 December 2025.

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

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Saudi Arabia

1. Introduction

1. Healthcare plays an important role in Saudi Arabia's socioeconomic transformation. Under Saudi Vision 2030, specifically the Health Sector Transformation Program (HSTP), the Kingdom is restructuring service delivery, widening access, and inviting greater private participation to raise quality and efficiency¹. Pillars of transformation include reorienting care to focus on prevention and outcomes, expanding private investment and public-private partnerships, and building digital infrastructure to integrate payers and providers across the healthcare value chain.

2. Within this reform, healthcare insurance is central. Healthcare insurance has become the largest segment within the insurance market and an important channel for purchasing healthcare in the private sector. In 2024, healthcare insurance represented about 55.5% of total Gross Written Premiums (GWP)², and under the new Insurance Authority (IA), the sectoral reforms aim to deepen the penetration and strengthen competition.

3. The overall insurance penetration (premiums as a share of GDP) rose from 1.64% in 2023 to 1.87% in 2024, and the overall insurance sector's contribution to non-oil GDP increased from 2.38% to 2.59% over the same period.³ These trends highlight the importance of insurance sector.

4. In revenue terms, nominal healthcare insurance premiums reached 42.2 billion SAR in 2024, up from 38.6 billion SAR in 2023, reflecting robust demand and indicating compliance with regulatory requirements for mandatory coverage and e-health claims.⁴

5. The General Authority for Competition (GAC) conducted a market study *Structure of the Healthcare Insurance Sector and the Impact of the Behavior of Establishments Operating in it on Competition* in 2022.⁵ The study concluded with a clear policy to allow health insurer-healthcare provider integration, which expands limited primary care capacity and improves access throughout the Kingdom. However, beneficial results may (will) only be obtained under strict safeguards (open, non-discriminatory access, data protection and claims neutrality, transparent referral pathways, targeted oversight, and merger review).

6. This structural shift brings the vertical integration between healthcare providers and health insurance as an instrument for efficiency (e.g. better care coordination, reduced duplication, and stronger cost control through aligned incentives). This vertical integration can be achieved either through economic concentrations (e.g. merger and acquisitions) or by organic growth (expansion into vertically related markets).

7. However, we have identified potential risks, including:

¹ Saudi Vision 2030, Health Sector Transformation Program: <https://www.vision2030.gov.sa/explore/programs/health-sector-transformation-program>

² Gross written premiums are the total premiums an insurer records for all policies written in a period before any deductions.

³ The Saudi Insurance Market Report 2024, <https://www.ia.gov.sa>

⁴ The Saudi Insurance Market Report 2024, <https://www.ia.gov.sa>

⁵ See: <https://gac.gov.sa/#/page/market-studies-list/details/40d5b6cc-3209-4ffc-a367-c03169c9f880>

- Foreclosure of rival insurers or healthcare providers through selective and exclusive contracting.
- Discrimination in access to data or claims processing.
- Worsening bargaining asymmetries that may raise premiums or narrow networks.
- Weakening innovation following the emergence of dominant integrated groups.

2. Status of Competition

8. Saudi Arabia's healthcare system consists of two different segments, first the public segment, and second the private segment. The private segment consists of health insurers and a different set of health care providers (e.g. hospitals, clinics, and pharmacies) who are paid either by private insurers or directly by patients. Public entities (e.g. the Ministry of Health) also purchase services from private hospitals in some situations (e.g. in the face of capacity constraints with public health care providers). Public sector purchases became an important revenue source for private hospitals during the COVID-19 period. While public and private payors operate within one ecosystem, they serve different beneficiary groups.

9. Saudi healthcare's value chain features:

- Concentrated insurance purchasing against a fragmented healthcare provider base.
- Bilateral price-setting under limited tariff regulation.
- Governance mechanisms (e.g. unified contract).

10. The pricing of medical services delivered by private healthcare providers (e.g. tariffs and negotiation mechanisms) is not comprehensively regulated, which implies that prices are determined principally through bilateral bargaining. The insurance market itself is predominantly fee-for-service and group-policy business, calibrated to employer risk pools and priced via highly customized designs. These choices combined with defined minimum benefits, shape incentives along the value chain and can generate risks of overdiagnosis, over-referral, and overtreatment.

11. In Saudi Arabia, a standard unified contract (published in February 2021) governs the insurer–healthcare provider relationship. The standard unified contract contains several pro-competitive provisions like dispute resolution mechanisms, fraud controls, service-level agreements for reconciliation and billing, beneficiary choice within networks, conflict-of-interest clauses, and a prohibition on exclusivity. In the factual context in 2022, GAC found no evidence of problematic vertical clauses or collusion.

12. The findings in the aforementioned study include that the two largest insurance companies accounted approximately for more than 75% of the total market share in the health insurance market, while the remaining companies accounted for less than 25% of the total market shares. This high and growing levels of concentration, combined with the low levels of entry, make the market vulnerable to market exit or future changes.

13. Based on our findings, the HHI index in the health insurance sector was 3,116.⁶ Therefore, efforts should still be pursued to reduce barriers to entry, and thus ultimately reduce concentration.

⁶ Herfindahl–Hirschman Index (HHI) measures market concentration.

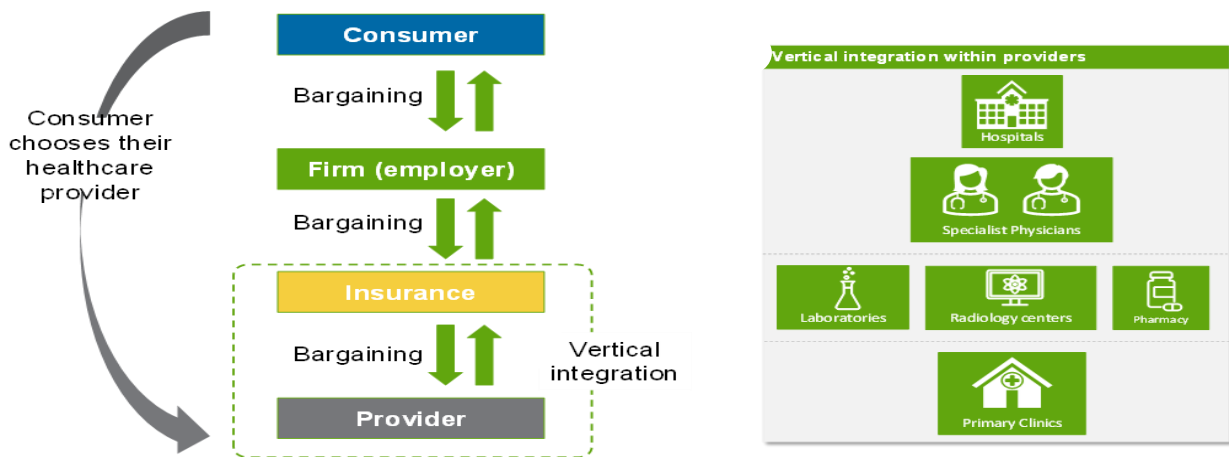
14. Despite the high level of concentration, there is no compelling evidence of consumer harm that would result from this level of concentration of the supply side of health care insurance. Furthermore, the relative changes in market shares by health insurers appear to be based on their relative ability to compete effectively.

2.1. Vertical Integration

15. The Saudi healthcare sector value chain comprises several contracting agreements that define the competitive landscape and dynamics.

16. Figure 1. illustrates the value chain in the healthcare sector which includes multiple vertical relationships at different levels.

Figure 1. Types of vertical relationships within the health insurance & healthcare value chain



17. Consumers choose their healthcare provider within the insurer network based on their preferences. Then firms (employer) engage health insurers shaping competition on price, service, and coverage. Therefore, health insurers combine risk and purchasing power through building and maintaining healthcare provider networks.

18. Based on GAC’s healthcare insurance study, fewer than 50 independent primary care providers existed across Saudi Arabia. Due to this lack of independent primary care physicians and the structure of incentive for primary care there is a conflict of interest risk potential between patients and healthcare providers. This incentive structure may encourage internal referral and bonus payments with potential negative implications on cost, quality, and patient choice.

19. There are two potential forms for the vertical integration. First is between health care providers and this form of vertical integration was never prohibited. Second is the insurer-healthcare provider integration, this form of vertical integration used to be illegal prior to GAC’s study and adoption of its recommendations. After the study, GAC recommended to permit the insurer-healthcare provider integration in primary care, and it was implemented in 2023.

3.3. Competition Policy Role

20. Saudi Arabia's healthcare transformation has created new relationships between healthcare insurers and healthcare providers that promised efficiency gains but includes potential competitive risks. GAC's mission is to improve market efficiency, protect and encourage effective competition, prevent monopolistic practices, and promote quality and innovation.

3.1. Intervention by GAC

21. Based on our findings, structural and behavioral barriers can hinder entry and expansion in healthcare insurance, and in time increase concentration at the supply side. Most direct effects on competition in healthcare insurance arise not just from ownership-based foreclosure, but also from data advantages at renewal and network access.

22. Addressing the above barriers through (1) enforceable data-sharing, (2) gradual movement toward value-based payment (e.g. Diagnosis-Related Groups (DRG)-based system of negotiation), and (3) continued improvement of unified-contract safeguards would strengthen competition while preserving output quality benefits.

23. One of GAC's intervention based on the study was accelerating the operation and implementation of the National Platform for Health and Insurance Exchange Services (NPHIES) due to the integration of financing and service delivery via digital channels which is an outstanding feature of Saudi Arabia's health transformation.⁷

24. The digitalization and automation in the healthcare sector reduce transaction costs, ease access to healthcare services, and create data linkages that can improve risk management and clinical quality.

3.2. GAC Recommendations for Vertical Integration

25. In the healthcare provision market, GAC found that the central structural weakness is the scarcity of independent primary care capacity. In particular, the fact that a risk-averse patient has an incentive to request care it is not limited by costs as these are borne by the health insurance providers results in overdiagnosis and overtreatment.

26. In line with the Saudi Arabia's National Transformation Program, Saudi Arabia has already started shifting focus and investment from secondary and tertiary healthcare facilities toward reforming and restructuring primary healthcare, aiming to achieve the pillars of the Health Sector Transformation Program (HSTP).

27. The objectives are to improve systemic value for money within the healthcare system by addressing overdiagnosis, over testing, overtreatment and over referrals and reducing access to specialists without prior GP referral.

28. To address the scarcity of independent primary care capacity, GAC have set and proposed policies and recommendations in the health insurance study to increase the capacity of independent primary care by allowing the vertical integration between health insurance company and healthcare provider as followed:

- Allow health insurance companies to set up primary care centers under the condition of ensuring equal patient access.

⁷ NPHIS platform: Acts as a single interchange connecting insurers, third-party administrators, and 6,600-plus provider organizations for eligibility, preauthorization, and e-claims. <https://nphies.sa>

- Vertical integration within the healthcare sector can follow two pathways, either whereby insurers organically set up fully-owned primary care facilities, or where insurers purchase existing primary care facilities. In both cases, GAC will be involved to prevent or negate any potential competition concerns.
- As long as patients enjoy equal access to primary care providers regardless of the ownership of the facilities.

29. Saudi Arabia can capture a sustainable health system without compromising effective competition and quality. Therefore, addressing the challenges identified within the healthcare sector will lead to a more vibrant market and improved conditions for competition and investment within the overall healthcare value chain.

4. Conclusion

30. Saudi Arabia's healthcare sector reform under Saudi Vision 2030 places the system into digitalization and automation for a more connected system of healthcare. Competition policy is an instrument that can align vertical integration with Saudi Vision 2030's aims which are broader access, higher quality, and sustained innovation.

31. The policy aim is to provide conditions to integration to protect competition and other interest rather than prohibit it. Therefore, approvals for vertical integration are conditional. Complementary payment reforms (e.g. value-based or DRG elements) can align incentives inside integrated provision group and have a positive implication on healthcare output quality and competition.