Organisation for Economic Co-operation and Development

DAF/COMP/WP2/M(2026)1/ANN1/FINAL

Unclassified

English - Or. English

12 November 2026

DIRECTORATE FOR FINANCIAL AND ENTERPRISE AFFAIRS
COMPETITION COMMITTEE

Working Party No. 2 on Competition and Regulation

Summary of Discussion of the Roundtable on Competition and Regulation in the Healthcare Sector

Annex to the Summary Record of the 81st meeting of Working Party 2

22 June 2026

This document prepared by the OECD Secretariat is a detailed Summary of Discussion of the Roundtable on Competition and Regulation in the Healthcare Sector, held by the Working Party 2 on Competition and Regulation on 22 June 2026
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It presents a factual summary of the views expressed by speakers and delegations that intervened during the discussion. It was produced using Artificial Intelligence (AI) tools subject to human oversight and review in line with the OECD AI Principles.

More documents related to this discussion can be found at https://www.oecd.org/en/events/2026/06/competition-and-regulation-in-the-healthcare-sector.html

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JT03597973

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Summary of Discussion of the Roundtable on Competition and Regulation in the Healthcare Sector

Introduction

The Chair, Natalie Harsdorf, opened the session by emphasising the economic and social importance of healthcare. Across the OECD, healthcare goods and services account for nearly 10% of GDP, with expenditure rising significantly in some jurisdictions and representing a growing share of household budgets. The Chair underlined that healthcare is not an ordinary market: patients often cannot assess the necessity or quality of treatment, governments frequently fund and shape healthcare services, and regulation is structural rather than temporary. Against that background, the Chair framed the discussion around the role of competition policy and competition advocacy in helping to contain costs, improve efficiency and support better outcomes without compromising access or quality.

The Secretariat introduced the background paper by focusing the presentation on regulatory barriers to competition. It argued that competition advocacy is important because pro-competitive reforms can help use limited resources efficiently, improve access and maintain or enhance quality. It also noted that health systems differ substantially across countries and that no single model stands out as universally superior, making incremental regulatory improvements particularly valuable. The Secretariat organised the presentation around the three main issues of licensing and entry requirements, payment systems, and digital health innovation. It highlighted selected examples of regulatory issues under each heading. Specifically, it discussed minimum activity thresholds for complex procedures and possible alternatives such as collaboration between hospitals, the competitive neutrality implications of preferential funding or contracting arrangements, and the need for regulation to keep pace with electronic health records and AI-enabled healthcare tools.

1. Setting the scene: Competition in healthcare

The Chair thanked the Secretariat and asked Dr. Susan Mendez to set the scene by providing a brief overview of the main features of demand and supply, leading to market failures.

Dr. Mendez set out the demand- and supply-side features that distinguish healthcare from ordinary markets. On the demand side, she identified information asymmetry, uncertainty, moral hazard, adverse selection and potential large social externalities such as the social returns generated by vaccination and preventive care, which however individuals may not consider when making choices about their own healthcare. On the supply side, she explained how providers may be able to generate demand beyond clinical need, particularly under fee-for-service systems, and how uniform pricing or insurance arrangements can create incentives for cream skimming. She also referred to licensing and training requirements, noting that entry barriers may protect quality but can also limit competition, while concentrated hospital and specialist markets may contribute to higher prices, reduced access and geographic inequities.

The Chair thanked Dr. Mendez and invited Professor Marco Varkevisser to discuss the role of provider competition and under what circumstances it can improve outcomes in healthcare.

Professor Varkevisser placed healthcare provider competition within a broader health economics framework. He emphasised that no other market of comparable importance departs so radically from the assumptions of perfect competition, meaning that competition and regulation must operate together. He warned that competition should be treated as an instrument rather than an ideology and that its effects depend heavily on institutional context. Proper policy design, strict antitrust enforcement, monitoring and readiness to adjust or withdraw reforms are essential. He also stressed that competition is not a panacea: in some areas, regulation or government intervention may be needed to secure access, equity and quality, and competition is unlikely to improve all healthcare objectives simultaneously.

The Chair thanked Professor Varvekisser and invited Chinese Taipei to share a case in its contribution, concerning a concerted practice between two hospitals that simultaneously increased fees, facilitated by the submission of information to relevant authorities.

Chinese Taipei explained that while most medical expenses are reimbursed under the National Health Insurance programme, registration fees are administrative fees outside reimbursement and therefore one of the few areas where hospitals can compete on price. The competition authority investigated a complaint that two major hospitals in the same city had raised outpatient and emergency registration fees by the same amount on the same day. The hospitals argued the increases reflected lower reimbursement rates, inflation and pandemic-related staffing costs. The authority found that the hospitals were close substitutes, geographically proximate and operating in a market with high entry barriers. It concluded that they were aware of each other's intended price increases, partly because submissions to local authorities became public information, and sanctioned concerted action. Following the decision, the health ministry rescinded its reporting guideline for registration fees.

The Chair thanked Chinese Taipei and opened the floor to delegations wishing to share their perspectives and experience about competition in healthcare.

Consumer International intervened to caution against treating healthcare solely through a market failure paradigm. Its representative accepted that pro-competitive arrangements can improve many markets, but argued that public health policy is also driven by commitments to equity, equal opportunity and universal access. Competition analysis should therefore be situated within broader healthcare objectives rather than assuming that better-functioning markets are the sole starting point.

The **United Kingdom** described recent work by the competition authority in pharmaceuticals, focusing on excessive and unfair pricing and misleading communications. In the phenytoin case, the competition authority found that Pfizer and Flynn charged unfairly high prices for an anti-seizure medicine, leading National Health Service (NHS) annual costs to rise sharply, and the Court of Appeal had recently ruled that the Competition Appeal Tribunal was wrong to set aside the competition authority's decision. In hydrocortisone, the competition authority imposed fines for unfair pricing abuses and anticompetitive market-sharing agreements, with appeals ongoing. It also secured commitments from Vifor Pharma addressing concerns that it spread misinformation to healthcare professionals about the safety of a rival iron deficiency treatment, including payment to healthcare systems and corrective communications. The delegate added that the competition authority's annual plan commits it to supporting government by identifying regulatory barriers to growth, investment and innovation, including in life sciences and public procurement.

2. Pro-competitive regulation in healthcare

The Chair thanked the delegates and opened the second part of the roundtable, focussing on regulatory barriers to competition and, conversely, on regulations that can help competition work better. She mentioned the topics that would be discussed, as follows: regulatory barriers to entry for healthcare providers, restrictions created by professional licensing, regulations that can help patients and insurers make better decisions, regulations that can hinder the development of digital services, remunerations systems and their incentives, and competitive neutrality between State-owned and privately owned medical providers.

2.1. Barriers to entry and regulation of the professions

The Chair invited the United States to present the wide-ranging work of the US agencies in healthcare markets, including enforcement, regulatory review and advocacy concerning state-level restrictions.

The **United States** presented extensive Federal Trade Commission (FTC) and Department of Justice (DOJ) activity. The delegation described a healthcare task force co-ordinating enforcement and advocacy across competition and consumer protection, and highlighted enforcement involving medical devices, intermediate care facilities, insulin pricing and outpatient surgery facilities. The delegation described cases challenging hospital contracting practices that allegedly restricted lower-cost or innovative insurance plans, including OhioHealth and New York-Presbyterian, and referred to a criminal wage-fixing case involving home healthcare nurses. The agencies then explained ongoing review of federal regulations and advocacy at state level. They identified Certificate-of-Need laws as barriers requiring approval for entry, expansion or new services by healthcare suppliers, and argued that these rules can constrain supply, protect incumbents, reduce choice and slow innovation without reliably reducing costs or improving quality. They also discussed Certificate of Public Advantage laws, which can immunise hospital mergers from antitrust scrutiny through state supervision, and cited FTC research suggesting such arrangements often fail to prevent higher prices, reduced quality or depressed wages. The delegation further addressed scope-of-practice restrictions for advanced practice registered nurses, physician certification rules and optometry restrictions as well as interagency efforts to lower drug prices through generic and biosimilar competition.

The Chair invited France to share its experience advocating for pro-competitive regulation for healthcare professionals and the specific challenges compared with other advocacy work on the professions.

France emphasised that the competition authority has repeatedly recommended the removal of rules constituting unjustified restrictions on competition. In particular, it discussed its opinions concerning the ethical rules for healthcare professions, which are issued by their professional associations. Recommendations addressed rules prohibiting professionals from lowering their fees based on vague provisions about the need to show “tact and moderation” and non-compete rules, for example when another professional has already established an office in a building. Another example concerned restrictions of communication which seem unjustified and place disproportionate limits on the professionals’ conduct.

The Chair gave the floor to Professor Varkevisser to discuss some of his research into the challenges for the regulation of healthcare, specifically how to respond to different types of private ownership and how to help the demand side to make better decisions.

First, **Professor Varkevisser** responded to Consumer International by agreeing that competition should not be the sole paradigm for healthcare. He noted that some areas of the system may require little or no competition and, where competition is introduced, it may need strong regulation to protect access, equity and other societal objectives. Turning to his research on private investor ownership, he argued for a nuanced approach. Private investment may strengthen providers' equity, resolve financial problems, increase market dynamics and support innovation, but it can also intensify supplier-induced demand, unreasonable prices, cost-cutting that harms quality and risk selection. He distinguished different investor models and warned that traditional private equity can be particularly problematic where short-term profit expectations, leverage and aggressive profit maximisation conflict with healthcare policy goals. However, he argued against blanket bans and instead favoured tailored regulatory strategies combining entry regulation, rules on profit distribution, behavioural oversight and strict competition policy to deter harmful investors while allowing long-term investors that support equity, efficiency and quality.

2.2. Demand-side regulations

Professor Varkevisser also discussed price transparency regulation in the Netherlands, in the context of insurer-hospital negotiations to set prices. He described a mandate requiring transparency for hospital products priced below EUR 885, which is the maximum deductible. Research using negotiated price data for more than 200 hospital products across three major insurers found that price dispersion decreased after the introduction of price transparency regulation. He cautioned that the mechanism for this effect was not entirely clear: it was not necessarily consumer price shopping, since consumers may not use the information; rather, the mandate likely influenced insurer-hospital negotiations. He also noted possible limitations, including cross-subsidisation through higher prices above the threshold, but concluded that the transparency mandate reduced random out-of-pocket payments for patients.

Before moving to the discussion of other types of price transparency regulations by Dr. Mendez, the Chair invited the Netherlands to comment on Professor Varkevisser's presentation from its competition authority perspective.

The Netherlands drew a parallel with a recent market study into veterinary healthcare, noting similarities with human healthcare from the standpoint of consumer behaviour as pets are increasingly treated as family members. The veterinary market was described as highly unregulated and increasingly affected by private equity investment. The study found that in regions where competition was reduced to two or three providers, private-equity-backed clinics were associated with price increases and incentives that could undermine consumer value, including in the prescription of medicines. The delegation emphasised that private equity can be beneficial or harmful depending on circumstances, and expressed particular concern about exit strategies rather than entry itself. It agreed that stringent regulation is needed where competition law cannot solve the incentives created by investor ownership, including contractual earn-outs that may encourage practitioners to maximise profits after selling their practices.

The Chair thanked the Netherlands for their intervention and asked Dr. Mendez to discuss her research on price transparency regulation, in the context of unregulated prices and out-of-pocket expenses.

Dr. Mendez explained that Australia combines tax-funded universal healthcare with subsidised fee-for-service outpatient and private hospital care, allowing out-of-pocket costs to vary from zero to whatever the market can bear. In a referral-based market where general practitioners gatekeep specialist services, patients may forego specialised care because of

cost. Australia's Medical Cost Finder sought to improve fee transparency, but the speaker cautioned that urgency, uncertainty, long wait times and limited doctor choice make healthcare price shopping difficult. Her research found substantial fee dispersion for common procedures and that, after adjusting for patient risk and specialty level, a large share of variation remained unexplained by observable doctor-level characteristics. In such settings, publishing raw prices may not discipline markets as expected and could even facilitate co-ordination, while shifting risk onto vulnerable patients. Transparency should therefore be understood not only as information provision, but as a mechanism that may reshape market beliefs, norms and prices.

The Chair invited Mexico to outline recommendations from its health insurance market study on publishing price-quality indicators for hospital services.

Mexico explained that its competition authority recommended that the Federal Consumer Protection Agency develop and disseminate indicators measuring the price-quality ratio of hospital services, using existing quality assessments and patient satisfaction metrics. The recommendation responded to high concentration in private health insurance and hospital services, as well as information asymmetries that lead consumers to rely on reputation or brand recognition rather than value. The authority considered that reliable comparable indicators could reduce information asymmetries, encourage value-based competition, empower insurers and consumers in contracting and purchasing decisions, and constrain the bargaining power of dominant hospital chains by making providers more transparent and comparable.

2.3. Digital health services and payment design

Dr. Mendez introduced the discussion on digital health by explaining that electronic records, telehealth, remote care and artificial intelligence can reduce duplication, improve communication, manage conditions in a timely manner, reduce hospital demand and make care more convenient for patients by reducing travel costs and enhancing choice. She described Australia's rapid expansion of subsidised telemedicine during the COVID-19 pandemic, when uptake rose quickly after telehealth was extended beyond remote areas and specialised services. Telemedicine can extend geographic reach and introduce competition into thin local markets, but rules such as established relationship requirements to support continuity of care and limit 'doctor shopping' behaviour may limit that potential. Similarly, strong government support through funding both in-person consultations and telemedicine, played a key role in uptake, as was the case during the pandemic. The speaker also discussed electronic health records and interoperability, noting that hospital discharge records may not communicate with outpatient data, practice systems may remain proprietary, privacy rules designed for traditional care may not cover commercial apps or wearables, and private platforms may operate outside administrative records, raising quality and safety concerns.

The Chair thanked the speaker and invited Korea to explain how its competition assessment of the bio-healthcare sector addressed regulatory barriers to telemedicine while balancing patient safety and competition.

Korea explained that under the National Health Insurance System, medical fees are mostly set administratively, so competition primarily occurs through quality and innovation. In its 2023 bio-healthcare competition assessment, the competition authority examined telemedicine restrictions that had historically required medical services to be provided within medical institutions for patient safety reasons. During the pandemic, temporary authorisation allowed a platform sector to emerge, but that sector contracted when authorisation ended. Using the competition assessment toolkit, Korea considered whether

patient safety could be achieved through less restrictive measures, such as limiting telemedicine to follow-up consultations with an existing doctor-patient relationship and subjecting intermediary platforms to reporting and oversight. Korea adopted a targeted approach allowing telemedicine on a limited basis, mainly for follow-up consultations concerning the same condition, and allowing platforms to operate under a reporting system. The delegation emphasised that the objective was not deregulation for its own sake, but achieving health policy objectives in the least competition-restrictive way.

The Chair thanked Korea and invited Sweden to discuss discrepancies between remuneration models for in-person medical visits and digital providers, and the competition challenges created by those differences.

Sweden described a 2022 report by the competition authority on digital healthcare providers. Physical primary healthcare centres are mainly funded through capitation, whereas private digital providers were largely paid fee-for-service through an out-of-region reimbursement mechanism originally designed for patients travelling or living near regional borders. Because digital providers concentrated operations in a few regions while serving patients nationwide, many consultations were reimbursed per visit. Sweden explained that this created diametrically opposed reimbursement systems for providers serving the same patients within regional healthcare choice systems. The concerns included possible cherry-picking of simpler cases, higher visit volumes for minor ailments, financial burdens on publicly funded primary care, and difficulty for physical healthcare centres in competing with similar digital services given their capitation funding. The authority suggested that direct contractual relationships between regions and digital providers could integrate digital services into regional healthcare choice systems, and noted recent government inquiry proposals requiring remote-only providers to have an agreement with the relevant region.

The Chair noted that remuneration is an area where only very few competition authorities have published opinions or studies. However, as the remuneration structure drives the incentives of market players, it is central for their behaviour. The Chair highlighted that this is one of the topics investigated in the market study of private healthcare and private health insurance conducted by Greece. She therefore invited Greece to explain competition considerations arising from hospital remuneration models, particularly where different providers were subject to different reimbursement rules.

Greece described a sector inquiry into healthcare and insurance services, including a reimbursement reform introduced for public hospitals using diagnosis-related groups (DRGs). The reform aimed to better reflect real healthcare costs but initially increased reimbursement substantially, partly because cases were categorised by hospitals rather than through an automated horizontal system. Greece explained that continued efforts are underway to group diagnoses and treatments using algorithms. The question is whether DRGs should also apply to private hospitals. Insurance providers favoured the extension, while healthcare providers were less supportive. From a competition perspective, Greece identified both benefits and risks: DRGs can improve cost comparability and incentivise cost reduction, but may also encourage upcoding into more expensive categories, premature discharge or quality reductions. The authority therefore recommended careful consideration, emphasising that any extension depends heavily on accurate case categorisation.

The Chair thanked Greece and invited Ukraine to discuss the challenges of integrating public and private healthcare providers into the national health system from a competition perspective.

Ukraine explained that healthcare reform initially operated in a system centred on public and municipal providers, with private providers mostly outside publicly financed care. The introduction of the medical guarantee programme and the National Health Service of Ukraine as a single strategic purchaser created a common contracting framework under which municipal, state-owned, private providers and individual doctors could receive payment for services actually provided. The competition authority nevertheless found that formal access was not enough and discussed some examples of regulations that were not competitively neutral. Independent doctors faced rules limiting their ability to extend sick leave certificates without co-operation from larger institutions, often municipal providers, creating dependence that could weaken their competitive position. Similar competitive neutrality concerns arose in pharmacy reimbursement where local authorities contracted mainly with municipal pharmacies. Ukraine concluded that integrating public and private providers is beneficial but requires transparent access to public funding, digital infrastructure and continuous competition assessment of sectoral regulation.

The Chair thanked Ukraine invited comments from the floor, and Croatia intervened to discuss ongoing enforcement work in healthcare procurement.

Croatia reported two ongoing potential bid-rigging cases in the health sector. One concerns medical equipment supplied to a general hospital, based on an anonymous report alleging that one bidder asked another to submit a higher-price bid in exchange for future reciprocal support. The second concerns medical consumables supplied to hospitals and was also initiated after an anonymous complaint. The investigation had identified behavioural patterns suggesting possible bid rigging, including a group of six operators regularly participating in the same procurement procedures while each bid only for specific lots and avoided lots contested by other group members, despite tender rules allowing bids across lots. Croatia was examining whether economic or technical justifications explain the pattern or whether it indicates market sharing or co-ordination among bidders.

3. Related markets: Equipment, pharmaceuticals and public procurement

The Chair opened the third part of the discussion by noting that, while the roundtable focussed on the services provided by hospitals and doctors, the provision and quality of these services were also related to the competitive conditions for medical equipment and medicines. Several contributions to the roundtable addressed these products, often in the context of public procurement.

The Chair invited Hungary to elaborate on its analysis of the medical imaging devices market and its conclusions on tender specifications in public procurement.

Hungary identified several procurement design issues affecting competition in medical imaging devices. First, brand loyalty and fear of switching suppliers may reduce competitive pressure, even though switching brands does not typically create higher costs or functional disadvantages. Second, bundled or package-type tenders can exclude smaller or specialised firms where suppliers must bid for broad packages that include services or unrelated product areas. Third, unclear or overly rigid technical specifications can reduce bidder participation or raise prices, while more direct involvement of medical professionals can improve requirements. Hungary recommended wider use of early market consultations so contracting authorities understand available products and avoid accidentally tailoring specifications to a single manufacturer. The key message was that competition can be improved through less bundling, clearer and more realistic technical specifications, stronger end-user involvement and structured market consultations.

Moving to the pharmaceuticals market, the Chair invited Romania to explain its clawback framework and how its design can distort competition.

Romania explained that its clawback mechanism requires pharmaceutical companies to contribute when public expenditure on reimbursed medicines exceeds the state budget. Initially, the mechanism applied a uniform rate to all reimbursed medicines, which risked disproportionately affecting lower-margin generic medicines compared with more expensive innovative medicines. The delegation also noted concerns that Romanian-manufactured generics benefited for a period from a lower rate than generics produced abroad, potentially undermining competitive neutrality. The mechanism has since become more differentiated, taking account of the characteristics and market positioning of innovative, generic and off-patent innovative medicines. Romania also discussed the immunoglobulin case, where suppliers covering most national demand were found to have co-ordinated a strategy to restrict or interrupt supply to pressure authorities to exempt products from the clawback tax. The competition authority imposed significant fines. The lesson was that reimbursement and taxation design should avoid unnecessary distortions, while firms must not co-ordinate market behaviour to influence policy.

The Chair invited Peru to discuss their advocacy on public procurement in pharmaceuticals and the lessons learnt on tender design.

Peru recalled a landmark medicinal oxygen cartel involving subsidiaries of three suppliers, which divided the Peruvian market into geographic areas between 1999 and 2004. The case was notable because it was sanctioned using circumstantial and economic evidence. Peru explained that after 2002, changes to procurement requirements lowered barriers for smaller and medium-sized firms, including requirements related to bidder experience and ability to supply quickly. Once new firms could compete, prices fell significantly and the investigated firms began bidding outside their previously allocated areas, contrary to their earlier claims of lack of capacity to do so. Peru considered the case an important example of how public tender design can facilitate or undermine cartel conduct, and noted that since 2018 the competition authority has issued guidelines to help procurement officials identify collusion and structure tenders to foster broader participation.

The Chair invited Paraguay to outline the main findings and recommendations from its market study on pharmaceuticals, medical supplies and public procurement.

Paraguay explained that its first study of the pharmaceutical and procurement markets examined 2012 to 2022 data, focussing on public purchases by three institutions, with the Ministry of Health and Social Security Institute accounting for most procurement. At an aggregate level, concentration concerns were not obvious, but when the market was divided into 33 subsectors, 13 were found to be moderately concentrated and eight were highly concentrated. The study also compared prices and suggested that substantial savings could have arisen under more competitive conditions. It identified delayed public-sector payments as a barrier for small and medium-sized enterprises, because only larger firms could sustain supply while waiting for payment. Paraguay recommended addressing these payment issues and continued advocacy with other public agencies, while also noting red flags that could support future investigations into bid rigging.

4. Advocacy, co-operation with health authorities and impact

The Chair moved to the last part of the roundtable to discuss advocacy for pro-competitive regulation and co-operation with health authorities. It invited Spain to explain how evidence from an ex-post impact assessment of recommendations can help demonstrate the benefits of pro-competitive regulation.

Spain described an impact assessment of two market studies on retail and wholesale medicine distribution. The studies had made 20 recommendations across the distribution chain, and the Ministry of Health had taken several wholesale recommendations into account in a draft Medicines and Medical Devices Bill, while uptake in retail remained lower. Spain quantified the potential benefits of recommendations relating to generic and biosimilar competition, citing international evidence that greater uptake reduces prices. Applying econometric estimates to Spain, the competition authority estimated that increasing the generic market share from 47.4% to 70% could generate annual savings of EUR 1.8 billion, including EUR 1.2 billion for the national health system and EUR 0.6 billion for patients. Spain also analysed pharmacy siting rules, noting that Navarre's shift towards a minimum-number model led to substantial pharmacy growth. Implementing similar flexibility elsewhere could increase pharmacy openings and improve access to pharmaceutical services, savings and qualified employment.

The Chair invited Chile to identify the benefits of the authority's healthcare work and to reflect on its influence in the regulatory and policy sphere.

Chile highlighted the benefits of both enforcement and advocacy in healthcare. It referred to a pharmacies cartel, bid-rigging cases, and collusion involving specialist physicians. In unilateral conduct, the Celecoxib case addressed use of a secondary patent to extend monopoly conditions, with commitments opening the market to generics; an ex-post assessment found substantially lower public procurement prices and significant savings. Chile argued that the competition authority's influence is especially visible in the regulatory and policy sphere. This is because of the complexity of the sector. Healthcare comprises interconnected markets shaped by dense regulation, information asymmetries and fragmented decision-making, with the state acting as regulator, insurer, purchaser and provider. The 2020 pharmaceuticals market study diagnosed problems across the full value chain, producing 15 regulatory recommendations. Some were implemented, others stalled legislatively, and the competition authority has just launched a new study to assess implementation and examine issues such as patent-protected and biosimilar medicines.

The Chair invited Brazil to explain whether the Secretary for Economic Reforms' role within the pharmaceutical market's inter-ministerial body facilitates co-operation with health authorities.

Brazil explained that the Secretariat's permanent seat on the body responsible for economic regulation of the pharmaceutical sector makes co-operation easier because it enables the competition perspective to be present throughout the regulatory cycle, from agenda-setting to drafting and implementation monitoring. However, decisions are reached by consensus among ministries, so competition arguments must be integrated into broader policy objectives and sustained persuasion remains necessary. Brazil emphasised that co-operation works best when grounded in shared evidence and concrete sector-specific data. It described PARC, the Regulatory and Competition Assessment Procedure, as a formal mechanism for identifying regulations that may unnecessarily restrict competition through public consultation and assessment using the OECD competition assessment checklist. In pharmaceuticals, PARC identified distortions in medicine pricing rules, including price asymmetries between identical medicines and rules that could discourage generic entry, and several recommendations were incorporated into the most significant reform of Brazil's pharmaceutical pricing framework in more than two decades.

The Chair opened again the floor for discussion.

Croatia intervened to describe an expert opinion on the Croatian Dental Act, which proposed that the Croatian Dental Chamber adopt price lists setting minimum prices for dental and dental technician services outside the public health service network. The

competition authority considered that the Chamber may set professional and technical standards to ensure quality, but should not directly or indirectly set prices for market services. It emphasised that dental service providers operating on the free market are undertakings under competition law and must be free to set prices independently. Croatia concluded that Chamber price-setting for services covered by voluntary, additional or private health insurance would conflict with competition rules, while standard-setting to improve quality, expand supply and benefit patients could be permissible. It recommended revising or clarifying the relevant provisions through the Act or Chamber by-laws.

Consumer International closed the substantive debate by reflecting on professional regulation. It accepted that regulation is essential for patient safety and quality, but argued that licensing, scope-of-practice rules and self-regulation can become disproportionate. It drew attention to the risk of professional self-interest in regulation, noted that competition regulators cannot regulate healthcare alone and must work with health departments, and observed that those departments may share the values of health professions. It also suggested that monopsony in healthcare labour markets merits future discussion. At the same time, it recognised that medical training is long and demanding and that healthcare professionals should earn reasonable returns, while emphasising that this does not justify unnecessary barriers to competition.

Closing remarks

The Chair closed the roundtable by thanking delegates, the expert speakers and the OECD team. She observed that the discussion had provided substantial food for thought on how competition authorities can use enforcement and advocacy in healthcare. The session illustrated that pro-competitive regulation in healthcare requires careful calibration: competition can improve efficiency, quality, access and affordability, but it operates within systems defined by public funding, insurance, professional regulation, patient vulnerability and broader equity objectives. Delegations repeatedly emphasised that good regulation should achieve legitimate health policy goals in the least competition-restrictive way, supported by evidence, sector expertise, co-operation with health authorities and continued monitoring of outcomes.