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Competition and Regulation in the Healthcare Sector – Note by Greece

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1. Introduction[1]

1. The right to health care is provided for and protected by the Greek Constitution as a fundamental human right and a parameter of growth and welfare. In Greece, all of the population is covered for a core set of services. Greece spends 8.1% of GDP per capita on health (compared to 9.3% on average in the OECD) and 3.1% of total health spending on prevention in current health expenditure (similar to the OECD average of 3.4%)[2]. A large proportion of total health expenditure is covered directly by households (out -of- pocket), mainly in the form of co-payments for medicines and direct payments for services, with private insurance covering a small proportion of total health expenditure.

2. The regulatory framework for the provision of healthcare services is complex and in some cases in need of a rationalization. This complexity is attenuated by the fact that it concerns markets shaped by various characteristics such as increased quality concerns, information asymmetry and inelastic demand. It is also directly related to health insurance markets.

3. The Hellenic Competition Commission has advocated for a procompetitive design in the healthcare sector through a large scale sector inquiry completed in 2025 on the provision of private healthcare services and related insurance services[3].

4. This Sector Inquiry allowed the ICC to identify basic parameters of competition and propose targeted improvements in the regulatory framework. Based on some of the conclusions of this Sector Inquiry, this contribution outlines:

- Basic parameters of competition in health care and the directly related insurance markets,
- Regulation on the establishment and operation of health care providers,
- Regulation of pricing in health insurance companies and
- The introduction of a Disease Related Group (DRG) reimbursement model

[1] Contribution prepared by the Hellenic Competition Commission and Kyriaki Papa, PhD, Head of Legal Services Unit of the Directorate on Health and Related Products and Services of the Hellenic Competition Commission

[2] OECD (2025), *Health at a Glance 2025: OECD Indicators*, OECD Publishing, Paris, https://doi.org/10.1787/8f9e3f98-en. And country note for Greece https://www.oecd.org/en/publications/health-at-a-glance-2025_15a55280-en/greece_8b1399f8-en.html , which presents various important issues relating to health care, such as the available health care workforce service in Greece include the lack of nurses and long term care providers for the over 65s, as Greece has 6.6 licensed doctors per 1 000 population (OECD average 3.9 practicing doctors); and 3.8 practising nurses (OECD average 9.2), while the number of long-term care workers per 100 people aged 65 years and over in Greece is 0.2 (OECD average is 5.0) and the number of pharmacists is 110 per 100 000 population in Greece (OECD average is 86).

[3] For more information on the Sector Inquiry see https://www.epant.gr/en/information/sector-inquiries/health.html. For the Final Report of the Sector Inquiry see https://www.epant.gr/files/2025/teliki_ekthesi_health_2025.pdf

2. Health Care and Insurance Markets in Greece

2.1. Demand and Concentration in Private Health Services

5. Over the last five years, there has been an increase in demand for healthcare services in Greece and the public health system is under pressure, with public spending and investment in health falling below the European average, a reduction in the number of public hospitals and a large proportion of overall health expenditure (35% in 2019 and 34% in 2023) being covered directly by households (out-of-pocket expenditure), mainly in the form of co-payments for medicines and direct payments for services, with private insurance covering a small part of total health expenditure (4.3%).

6. The degree of market concentration is moderate, while acquisitions by foreign investment funds in recent years have not dramatically changed the degree of concentration over the period running from 2019 to 2025. A vibrant mobility landscape is still apparent in the acquisitions of primary and secondary healthcare providers in relation to insurance companies.

2.2. Demand and Concentration in Private Health Insurance Services

7. There has been a steady upward trend in demand for insurance policies in the three-year period 2021-2023 and growth of the health insurance market at an increasing rate (approximately 10%) in the two-year period 2023-2024 in Greece. At the same time there is a significant drop in the number of long-term health insurance contracts during the period 2021-2023 and significant increase in non-guaranteed renewability contracts (i.e., annually renewable contracts), which provide a higher margin for covering other expenses.

8. The market shows a moderate degree of concentration in the market for the provision of private health insurance services. Insurance companies cooperate with the largest hospital groups in Greece, either directly or through management companies. The four largest insurance companies negotiate the relevant contracts directly with hospital service providers. In addition, twelve of the thirteen insurance companies collaborate with at least one management company for the health insurance programs they offer, while nine of them collaborate with two management companies.

9. There is a trend toward vertical integration of insurance companies through theiractivities in the health sector which, may mainly lead to phenomena such as the patient steering effect and the enrollee steering effect. However, the private clinics surveyed in the context of the HCC's sector inquiry expressed the view that synergies between healthcare providers and insurance companies will spur most insurance customers towards large healthcare groups, which, in any case, is under examination by the competition authorities in the context of the ex-ante merger review. The phenomenon of vertical integration is also observed in Greece, initially with the acquisition of Ethniki Asfalistiki by the HHG group of CVC funds and the acquisition of Euroclinic by Generali.

3. Regulatory Barriers in the Provision of Private Health Services.

3.1. The framework

10. The framework for the establishment and operation of private clinics[4] is governed by three different regulatory frameworks[5]. These regimes are in force and apply in parallel and each clinic is governed by the latest regime that was implemented before the clinic was established[6]. In this context, older clinics are governed by older regimes while new clinics are governed by the more recent regime[7].This creates a very complex regulatory framework. For example if a clinic governed by an older regime carries out a building expansion accompanied by an increase in the number of beds, the provisions of the latest regime[8] apply to the part of the expansion, while the other parts of the clinic continue to be governed by the older regime the clinic is subject to[9]. For the establishment and operation of a private clinic, establishment and operation licenses are required, granted either to natural persons or to legal persons governed by private law and can be transferred.

11. The decision to grant the operating permit must record the total number of beds as well as all the departments of the Private Clinic, such as the specialty departments, the special units as well as the number of beds per department. The establishment and operating permits are amended in case of building expansion, creation of new departments or abolition of existing departments, increase or decrease or redistribution of departments or beds. Moreover, the above regulatory framework also provides for both a minimum number of beds and a maximum number of beds.

12. In relation to the provisions for a minimum number of beds, a total maximum number of beds and a number of beds per specialty department is provided for in the regulatory framework. In relation to the provisions for a maximum number of beds, a total maximum number of beds is provided for in the case of psychiatric clinics (and child psychiatric clinics), while a maximum number of beds per specialty department is provided for in the case of all other clinics. It is noted however that there is no limitation on the number of specialty departments that private clinics may develop.

[4] Private clinics provide secondary health care: They are health units which provide in-patient health care and in which patients are hospitalized.

[5] Law 4600/2019, as in force, Presidential Decree ("PD") 235/2000 as in force, and PD 247/1991 and PD 517/1991, supplementing PD 247/1991, as in force.

[6] Clinics established after 09.03.2019, the entry into force of law 4600/2019, are subject to the provisions of that law. Clinics established after the implementation of Presidential Decrees (PD) 247/1991 and 517/1991 and before the implementation of Law 4600/2019 and are governed by the provisions of these PDs. Older clinics, established before the implementation of PDs 247/1991 and 517/1991 and governed by older regimes, were obligated to adapt to the provisions of PD 235/2000 to modernize their operating conditions.

[7] It is noted that Law 4600/2019 contains transitional provisions, according to which older clinics that are subject to the provisions of older regimes may continue to be subject to these provisions, unless the holder of the clinic's license declares that Law 4600/2019 should be applied. The declaration is submitted to the competent Region

[8] See transitional provisions of Law 4600/2019.

[9] PD 235/2000, PD 247/1991 and PD 517/1991.

13. It is also worth noting that Private Clinics must publisize on their website, at reception and in the accounting office a price list of the services and products provided by them[10].

3.2. Health care providers have pointed to the existence of regulatory barriers.

14. The investigation of the HCC revealed the existence of regulatory barriers that prevent private clinics from entering or expanding in the market. In this context, the private health providers listed the following entry/ expansion barriers : the multiplicity of laws and/or the unclear and complicated legal framework, which creates confusion, the strict and inflexible provisions for establishing new clinics which are "suffocating" for new entrants, the bureaucratic and long/time-consuming procedures for licensing /establishing, converting and expanding of clinics -increasing of the number of beds, the high investment and operating costs and the differences in the licensing framework for the operation of old and new clinics.

15. In the same context, private clinics indicate that the parallel implementation of three different regulatory regimes may distort competition, as private clinics governed by an older legislative regime are required to meet fewer specifications over clinics that are governed by a more recent regime, operating with more demanding requirements and comparatively increased costs. Older clinics have thus an advantage over the latter. Although the provisions of minimum and maximum number of beds are reasonable and safeguard the quality of services and the viability of the clinic[11], the procedure for the increase in the number of beds requires the amendment of the establishment and operating licenses and is thus complex and time-consuming. It has also been pointed out that it is difficult for older clinics to proceed to an expansion/ increase in beds, given that the building expansion must comply with the requirements of the latest regime[12], which is difficult to achieve when the clinic's facilities are older.

3.3. Proposals of the HHC

16. The Sector Inquiry revealed the existence of regulatory asymmetries, originating from the parallel implementation of three different licensing and operation regimes for private clinics. These regulatory asymmetries may distort competition, as different

[10] See Law 4600/2019. According to the transitional provisions of the said law, the above provision applies to all private clinics that received a license to establish and operate until the publication of the said law. A corresponding obligation is also provided for in Law 5170/2025 according to which health service providers publicly announce the prices of their services, in particular for each type of medical or nursing procedure that they offer to consumers, as well as the amount of the price adjustment from the immediately previous price. The announcement shall be made in the form of a table - price list, in particular, on a separate page of the company's website. The announcement shall include at least the name of the medical service, the price at which it is offered to consumers, the time of entry into force of the adjustment, the time of application of the immediately previous price and the percentage of the price adjustment in relation to the immediately previous price.

[11] Conversely, some clinics state that the provisions concerning the minimum number of beds constitute an obstacle for entry into the market, especially for small/ medium sized clinics, given that there is a high initial investment cost for new entrants. Moreover, some clinics state that the maximum number of beds provision may limit the capacity of a clinic, with one of them specifying that specifically the maximum total number of beds provision constitutes an entry barrier, as clinics wanting to serve a larger number of patients will have to establish an additional unit, which entails additional investments and higher operating costs.

[12] Which is Law 4600/2019.

specifications are set regarding staff, equipment, premises and the minimum number of beds.

17. Moreover, there appears a need to facilitate capacity increase for private health providers, as ponted out by stakeholders. Indicatively, in a sample of 25 health units, participants in the Sector Inquiry, only 9 have increased the number of their beds.

18. Generally, the regulatory framework allowed older clinics to maintain their *status quo* with lower requirements and operating costs compared to new infrastructures. However, older clinics find it difficult to expand and increase their bed capacity. Conversely, private clinics that fall under the newer provisions operate with more demanding requirements and comparatively increased costs and are placed at a disadvantage in this regard compared to older clinics.

19. In view of the above, the HCC proposes to have the regulatory framework further rationalized (a project that was already initiated with the latest law[13]), to help clinics increase their capacity and respond to the growing demand for private health services.

20. Moreover, existing provisions concerning the obligation of private clinics to publish on their website a price list of their services is certainly beneficial to consumers and necessary at a time of increase in the cost of living including the cost of health care services. The Sector Inquiry highlighted the specific issue of lack of transparency in health services, but also health insurance charges. Although asymmetric information between the holder's knowledge about the good of health compared to the patient's knowledge is an inherent feature of health service markets, the lack of transparency, predictability and comparability in both health services and health insurance service prices intensifies this problem and deprives the consumer/patient of any ability to make his own choice of a private clinic or insurance provider on the basis of cost and, ultimately, to have control over their spending on such an important good. The HCC proposed that the services/products of the price lists should be codified/standardized, in order to enhance transparency and consumer awareness and further facilitate the consumers in comparing prices.

4. Regulation Concerning Pricing in Health Insurance

4.1. Pricing of long-term insurance premiums: the annual adjustment of premiums in long-term health insurance contracts

21. Until 2025, the annual adjustment of premiums in long-term health insurance contracts (often referred to as "lifetime contracts") was made on the basis of the Unified Health Index UHI). In 2025 the regulatory framework for the UHI was repealed and the UHI replaced with a new Index, the Annual Adjustment Index for Long-Term Health Insurance, implemented from 1 January 2026.

22. The UHI[14], introduced in 2022, was a numerical value, based on which premiums in long-term health insurance contracts may be adjusted annually. It represented the average annual percentage change in the hospitalization expenses of insurance companies, compared to the expenses of the previous year, in the context of long-term health insurance

[13] Law 4600/2019.

[14] The UHI was introduced by Presidential Decree 13/2022 ((Government Gazette A' 30/25.02.2022), issued under the authorization of article 2a of Law 2251/1994 (Government Gazette A'191/16.11.1994), Consumer Protection. Article 2a was added to Law 2251/1994 by virtue of article 268 of Law 4738/2020.

contracts. The Administrator of the UHI (the Foundation for Economic and Industrial Research), undertook the task of determining the HHI, following collection, analysis and processing of the necessary data specified in the law15. The UHI had to be approved by a decision of the Minister of Development and Investments, published in the Government Gazette16. The UHI provoked reactions, as it was estimated that it affected the premium increases of long-term contracts in the years 2024 and 2025. More particularly, the calculation of the UHI for 2021, representing the average annual percentage change in the hospitalization expenses, compared to the expenses of the previous year 2020 (5.7%) was published in November 2022, and it was thus estimated that it affected the premium increases of 2023. Subsequently, the UHI for 2022 compared to 2021 (14%) was published in November 2023, and it was thus estimated that it affected the premiums of 2024 and so on. This estimate is confirmed by public information, as insurance companies announced premium adjustments of 14% for the year 2024 and 14.6% for the year 2025, which corresponds to the UHI of 2022 and 2023 respectively.

23. In 2025 the UHI was repealed[17] and replaced with a new Index, the Annual Adjustment Index for Long-Term Health Insurance, which is described below.

24. As provided for in the relevant regulatory framework[18], the annual adjustment of premiums in health insurance contracts with a duration of more than one (1) year (long-term) depends on the Annual Adjustment Index for Long-Term Health Insurance (abbreviated in Greek "EDA") published by the Hellenic Statistical Authority (abbreviated in Greek EL.STAT.), in the month of December and implemented from 1 January 2026[19]. The E.D.A is a numerical value, formed annually, which is utilized to determine the part of the annual adjustment of premiums in long-term health insurance contracts that is related to average hospitalization costs. It shows the average annual percentage change, in relation to the previous year's price, of the hospitalization costs paid by insurance companies[20].

25. The data and factors taken into account for calculating the E.D.A. are the following: a) the time reference point, that is the date on which the data of cases b)-e) below were evaluated/measured b) the dates of notification of the insured events for which compensation was paid, c) the coverage limits determined in the insurance programs, as well as the amounts of the insured's potential participation in the total cost. d) the total

[15] See PD 13/2022 articles 1,2 and 6. The process of determining of the UHI was supervised by the General Secretariat of Commerce and Consumer Protection of the Ministry of Development and Investments.

[16] See PD 13/2022, articles 4 and 6. According to the Civil Courts, the relevant Ministerial Decision had not been issued and consequently the UHI could not be applied. See Athens Multi-Member Court of First Instance Decisions 1231/2025 and 1864/2024.

[17] PD 13/2022 and article 2a of Law 2251/1994 were repealed by virtue of Article 29, Law 5170/2025 (Government Gazette A` 6/20.01.2025).

[18] See article 29 of Law 5170/2025.

[19] The Index does not apply to long-term health insurance contracts in which no premium adjustment is provided, or in which a fixed premium adjustment is provided.

[20] See Joint Ministerial Decision No 74816 (Government Gazette B' 5170/30.09.2025), of the Ministers of Development and investments, of National Economy and Finance, of Health and of the President of EL.STAT.

amount paid by the contributing company for each case of compensation. e) the amounts due but not yet paid (pending compensation) for each case of compensation[21].

4.2. Competition concerns deriving from the use of the Indexes

26. The HCC raised the main competition in relation to the UHI and the EDA : The use of indexes may alleviate competitive pressures on insurance companies, depriving them from the incentive to negotiate lower compensation with health providers and thus leading them to pass on any increase of premiums to the consumers. The Index may also create a focal point for price increases. In this context, insurance companies no longer have the incentive to engage in price competition but can instead proceed to a harmonized adjustment of premiums. The publication of this index eliminates the need for communication (collusion) between companies, which would be subject to control under competition provisions.

27. Indeed, the UHI seems to have served as a focal point, as insurance companies announced premium adjustments of 14% for the year 2024 and 14.6% for the year 2025, which corresponded to the UHI of 2022 and 2023 respectively[22].

28. Moreover, price indexes may under certain circumstances be subject to manipulation for anti -competitive purposes. For example, companies may strategically submit misleading or even false reports of data used to calculate the index, artificially increasing its price, or coordinate their behavior (horizontal collusion) in the transactions that form the factors for calculating the index, in order to increase their profits in the other transactions in which the index is applied (the annual adjustment of premiums)[23].

29. The HCC pointed out in the context of the Secor Inquiry that it is crucial to promote and enhance competition when designing public policies. In this respect, the HCC has issued a relevant guide[24]. Competitive markets encourage companies to be efficient and innovative; thus, the strengthening and the protecting of competitive markets is a matter of public interest, as more choices for consumers are created, prices are reduced and the quality of goods and services -and consequently the economic performance of a country- is improved. State planning should therefore take into account the effects that a policy may have on competition and choose that course of action that leads to more competition and not to less competition, for the benefit of the consumers.

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[21] See Joint Ministerial Decision No 74816 (Government Gazette B' 5170/30.09.2025), of the Ministers of Development and investments, of National Economy and Finance, of Health and of the President of EL.STAT.

[22] It is, however, noted that long-term insurance program is a closed product portfolio, which is no longer offered to the consumer public. Consequently, in the absence of an adjustment index, it is doubtful that insurance companies would have an incentive to compete to retain existing long-term insurance program customers.

[23] See Levenstein, Margaret C. and Suslow , Valerie Y., Strategic Use of Public Price Indexes as a Collusive Device (July 27, 2023). CPI Antitrust Chronicle, July 2023, with examples from cases competition United States v. Socony-Vacuum Oil Co., Inc., 310 US 150 (1940), AT.39914 - Euro Interest Rate Derivatives (2013) , etc. https://ssrn.com/abstract=4597242

[24] https://www.epant.gr/en/information/publications/guides/item/2688-odigos-gia-dimosies-politikes-en.html

5. Regulatory Reform in the Reimbursement System (DRG)

5.1. Introduction of the DRG system

30. The introduction of the "Closed Greek Hospital Charges" system in the Greek healthcare regulation in 2011 marked the first implementation attempt in the Greek healthcare section of a reimbursement system based on the DRG system[25]. The DRG is a system for costing, pricing and reimbursing of health services. It categorizes the hospitalization cases on the basis of clinical and cost data gathered upon discharge of patients from the hospital and classifies these cases into diagnostic categories forming homogeneous groups of diseases, each of which reflecting a predetermined level of financial resources.

31. The formation of these homogeneous groups of diseases helps determine and standardize the clinical interventions needed. Subsequently, insurance organizations compensate hospitals by paying a pre-agreed fee for each hospitalization, which corresponds to the specific diagnostic category in which the patient was classified during his/ her hospitalization[26]. This system currently applies to public hospitals, but not to private clinics, which follow the fee-for-service reimbursement model. It regulates the reimbursement by the National Organization for the Provision of Health Services (in Greek abbreviated as EOPYY) of all medical services provided by hospitals.

32. In 2014 the system was succeeded by the Hospital Fee System (HFS)[27] , which was later, in 2017, renamed as "Costing System of Hospital Services" (CSHS and in Greek abbreviated as SY.K.N.Y)28.

33. SY.K.N.Y does not apply to private clinics, which are reimbursed for the provisions of their services on the basis of the fee-for-service model, based on the number and type of services they provide: as the volume/quantity of services provided increases, the amount of the provider's reimbursement also increases. However, bilateral agreements have been concluded with private clinics regarding the pilot implementation of SY.K.N.Y to private clinics.

5.2. Response from providers

34. The HCC assessed the views of the participants in the Sector Inquiry on the possibility of implementing a DRG-based system on private clinics (as it currently applies only to public hospitals).

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[25] See Joint Ministerial Decision Y4A/oik.85649/2011 (B' 1702/2011), applied from 1.10.2011 and amended by virtue of the Joint Ministerial Decisions Y4A/oik.13740/2012 (B' 940) and Y4A/oik.18051/2012 (B' 946) which defined as the date of the application of the system the 1.3.2012.

[26] See Audit Report of the Greek Court of Auditors, "Are the Closed Greek Hospital Charges a reliable system for costing hospital services? Did the system achieve its goals?", 1/2022. In the European Union, the countries that have adopted the DRG system are Austria, Germany, Spain, France, Italy, the Netherlands, Portugal, Sweden, Denmark, Finland, Ireland, the Czech Republic, Hungary, Norway, Poland, Slovakia, Estonia, Cyprus, Latvia, Slovenia, Bulgaria, Romania and Croatia. Other countries that have implemented the DRG system are the United States of America, Australia, the United Kingdom, Canada.

[27] See law 4286/2014, article 1 par. 2.

[28] See Law 4286/2014 as in force.

35. All the **insurance companies** expressed positive opinions regarding the implementation of a system based on DRGs for the reimbursement of hospitalizations in private clinics, stating that it would affect positively their transactions with hospital health providers. As they stated, the implementation of such a system facilitates cost comparison between hospitals and helps monitor and control hospital costs, preventing excessive charges on behalf of the hospitals. Moreover, a DRG system promotes transparency and efficiency, as it incentivizes clinics to provide care to patients with the consumption of fewer resources. The above factors facilitate cooperation between hospitals and insurance companies and in this context, the reimbursement claims are also settled faster. In the same context, insurance companies state that such a system is better than the one currently applied - the fee for service model - as the latter often causes conflicts and disagreements between insurance companies and hospital providers regarding the compensation paid. It is noted that the Association of Insurance Companies of Greece has also spoken out for the implementation of this system in the private sector.

36. On the other hand, the responses of the **private clinics** were mixed. About half of the clinics stated that the implementation of such a system could have positive results, like the ones mentioned above. On the contrary, the other half of the clinics expressed reservations stating that the implementation of such a system could have negative results as : the degradation of the quality of medical services provided, technical inconsistencies and errors in the implementation of the system, potential conflicts between insurance companies and hospital providers, delays in compensation, misclassifications resulting in the incorrect assessment of the hospitalization costs. In the same context, these providers emphasize that there are risks of undertreatment of patients, while also noting that the clinics' incentives for improving of the medical services may be reduced.

5.3. Proposals of the HHC

37. The DRG system has been adopted by many European countries due to the need for systematic monitoring of hospital activity, cost control, and improvement of efficiency, however the extent to which the objectives of this system have been met in each country varies[29].

38. In a certain sense, the implementation of the DRG system influences the behavior of hospital providers, helping them to remain competitive[30]. Particularly, the DRG system provides consumers (patients and insurance companies) with a way to compare the costs of hospital providers[31], and could also incentivize hospitals and clinics to reduce their costs[32],

[29] Study of the implementation of the DRG system internationally: results of a systemic review", National and Kapodistrian University of Athens, Department of Nursing, Laboratory for the organization and evaluation of health services, 2020.

[30] Alexandra Titopoulou, Eleftherios Vavoulidis, Chrysoula Margioula-Siarkou, Georgia Margioula-Siarkou, Aristarchos Almperis, Stamatios Petousis, Georgios Mavromatidis, Theodoros Dardavesis and Konstantinos Dinas, " *Diagnosis-Related Group-Based Financing of Gynecologic Oncology Clinics: A Systematic Review*", Healthcare 2025, 13, 349.

[31] See KETEKNY website , https://instdrg.gr/%cf%83%cf%8d%cf%83%cf%84%ce%b7%ce%bc%ce%b1-drg/ . See also Diagnosis Related Group (DRG), https://www.gethealthie.com/glossary/diagnosisrelated-group-drg#:~:text=They%20can%20also%20help%20to,can%20lead%20to%20provider%20burnout

[32] Βλ. OECD, Case-based payment systems for hospital funding in Asia: .an investigation of current status and future directions. M. Miraldo, M. Goddard, The Incentive Effects of Payment by Results, Centre for Health Economics, 2006, Research Paper 19,

thus increasing their profitability[33]. However, such a system can also have negative effects. More particularly, the implementation of the DRG system in Greece as well as in other countries has revealed deficiencies/problems, such as the incorrect categorization of cases into more expensive DRG categories, so that providers receive higher reimbursements, the premature discharge (before completion of recovery) of patients to reduce costs[34] the sacrifice of healthcare quality to reduce costs[35], the limitation of patients' access to medical services for treatments that do not receive sufficient reimbursement, and subsequently the limitation of technological innovation[36].

39. In this context, as regards the potential implementation of the DRG system in private clinics, the HCC highlights that such an implementation should be carefully planned, so that the potential negative effects can be avoided.

6. Conclusions

40. The Sector Inquiry revealed the existence of regulatory asymmetries among older and new clinics, originating from the parallel implementation of three different licensing and operation regimes for private clinics, that may distort competition. In this context, the HCC proposes to have the regulatory framework further rationalized.

41. Moreover, existing provisions concerning the obligation of private clinics to publish on their website a price list of their services is certainly beneficial to consumers and necessary at a time of increase in the cost of living including the cost of health care services. However, the HCC proposes that the services/products of the price lists should be codified/standardized, in order to enhance transparency and consumer awareness and further facilitate the consumers in comparing prices.

42. Furthermore, concerning the health insurance provision sector, the Sector Inquiry revealed competition concerns deriving from regulatory provisions introducing Indexes, used for the annual adjustment of premiums in long-term health insurance contracts. The use of indexes may alleviate competitive pressures on insurance companies. The Index may also create a focal point for price increases, as insurance companies can proceed to a harmonized adjustment of premiums. In this context, the publication of the index eliminates

[33] See "Study of the implementation of the DRG system internationally: results of a systemic review", National and Kapodistrian University of Athens, Laboratory for the organization and evaluation of health services, 2020.

[34] See "Study of the implementation of the DRG system internationally: results of a systemic review", National and Kapodistrian University of Athens, Department of Nursing, Laboratory for the organization and evaluation of health services, 2020). Other problems might be a) difficulties in proper coding mainly during the first implementation period, or incorrect coding b) Difficulty in accurately recording costs (c) Heterogeneity (in some cases) of cases that fall within the diagnostic category, either in terms of clinical relevance or cost (d) Developing behaviors (on the part of hospitals) of selective choice of patients who are classified in cheaper DRGs and transferring patients who are classified in higher-cost DRG to other hospitals.

[35] Zhang L, Sun L, "Impacts of Diagnosis-Related Groups Payment on the Healthcare Providers' Behavior in China: A Cross-Sectional Study Among Physicians", Risk Management and Healthcare Policy 2021:14 2263–2276.

[36] Shumin Ren , Lin Yang , Jiale Du , Mengqiao He , Bairong Shen, DRGKB: a knowledgebase of worldwide diagnosis-related groups' practices for comparison, evaluation and knowledge-guided application, Database, Volume 2024.

the need for communication (collusion) between companies, which would be subject to control under competition provisions.

43. Moreover, the HCC has documented a significant change in the healthcare sector regulation: the implementation of a reimbursement system for hospital services based on the DRG system, a system that currently applies to public hospitals, but not to private clinics. HCC pointed out that potential implementation of a reimbursement system based on the DRG on private clinics necessitates caution and careful planning so that the possible negative effects of the system can be avoided.

44. The Hellenic Competition Commission has generally stressed the need for the inclusion of competition issues in public policy making and has published a guide on this issue[37]. The creation, protection and strengthening of competitive markets is part of the wider public interest as competitive markets, including competitive healthcare markets and the directly related health insurance markets, encourage undertakings to be efficient and innovative, thereby creating more choice for consumers, reducing prices and improving the quality of goods and services and hence a country's economic performance. Government authorities should therefore also consider the impact of a policy or intervention on competition and opt for the course of action that is likely to lead to an increased, rather than reduced, competition between undertakings to the benefit of consumers. This assessment becomes even more effective when it is carried out from the outset of public policy making, so that it is included in the early stages of policy design in order to prevent distortions of competition which are detrimental for consumer welfare as well as the economy and citizens in general.

[37] Available on the HCC's website, at https://www.epant.gr/en/information/publications/guides/item/2688-odigos-gia-dimosies-politikes-en.html