Organisation for Economic Co-operation and Development

DAF/COMP/WP2/WD(2026)2

Unclassified **English - Or. English**

26 May 2026

DIRECTORATE FOR FINANCIAL AND ENTERPRISE AFFAIRS
COMPETITION COMMITTEE

Working Party No. 2 on Competition and Regulation

Competition and Regulation in the Healthcare Sector – Note by Argentina

22 June 2026

This document reproduces a written contribution from Argentina submitted for Item 7 of the 81st meeting of Working Party 2 on 22 June 2026.

Federica MAIORANO
Federica.Maiorano@oecd.org

JT03587754

This document, as well as any data and map included herein, are without prejudice to the status of or sovereignty over any territory, to the delimitation of international frontiers and boundaries and to the name of any territory, city or area.

Argentina

1. The Argentine healthcare system provides a clear example of the complex interplay between competition and regulation within a mixed-provision model. In this sector, issues such as information asymmetries between patients and providers, the existence of barriers to entry, and varying degrees of market concentration justify public regulation aimed at ensuring access, quality and equity. However, at the same time, certain regulatory frameworks can generate unintended consequences by restricting competition, limiting the entry of new players and reducing incentives for innovation.

2. To address these issues, the text is structured into the following sections: firstly, it introduces the Argentine healthcare system and its tripartite organisation, describing the public, social security and private subsystems, as well as the main stakeholders within each, their regulatory framework, market size and levels of population coverage. Secondly, the paper addresses recent changes in the regulation of the health sector in Argentina, with a particular focus on the reform introduced by Emergency Decree 70/2023, explaining the changes regarding members' freedom of choice, price deregulation and the reduction of state intervention, as well as the objectives and immediate effects of this reform. In the third section, the article examines the case of the investigation into alleged anti-competitive conduct in the private healthcare market, analysing the facts that gave rise to the complaint, the arguments put forward by the companies involved, the analysis carried out by the competition authority, and the measures adopted by the competition authority. The fourth section analyses the market investigation into medical oxygen, identifying issues of economic concentration and regulatory barriers that limited competition and the adoption of alternative technologies, as well as the recommendations made to bring health regulation into line with international standards.

1. Structure of the Argentine Healthcare System

3. The Argentine healthcare system is organised into three coexisting subsystems. The first one is the public subsystem, which is universal in nature, given that in Argentina access to healthcare is a constitutional right guaranteed to all residents. The second is the social security subsystem, which provides cover to those in formal employment or who are registered under the so-called *Simplified Scheme for Small Taxpayers*. The third one is the private subsystem, which offers voluntary cover to those who choose to take it out, either directly or through contributions.

4. Within the social security system, a distinction is made between National Health Insurance Schemes, Provincial Health Insurance Schemes, the National Institute of Social Services for Retirees and Pensioners (PAMI, for its acronym in Spanish) and Special Regime Health Insurance Schemes. The private subsystem, which is voluntary, comprises private prepaid healthcare providers (EMP, for its acronym in Spanish), cooperatives, mutual societies, civil associations, foundations and enhanced schemes. Other insurers, such as Occupational Risk Insurers and Motor Insurers, provide specific cover for certain contingencies.

5. The private subsystem is ruled by Act No. 26.682, which is regulated by Decree 1993/2011 and was subsequently amended by Emergency Decree (DNU) 1991/2011. This law establishes the regulatory framework applicable to EMPs, cooperatives, mutual societies, civil associations, foundations, voluntary membership schemes and superior

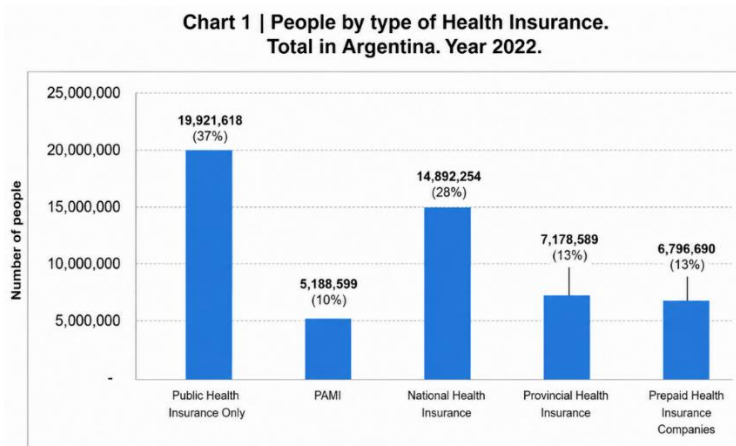
schemes. All these entities are supervised by the Superintendency of Health Services (SSS, for its acronym in Spanish) and are legally obliged to guarantee their members the minimum level of benefits established in the Compulsory Medical Programme (PMO).

6. As regards the size of the market, as of August 2022, the National Register of Private Healthcare Providers listed 674 organisations, of which 283 are commercial companies, 220 are mutual societies, 87 are social welfare organisations offering membership or supplementary schemes, and 40 are civil associations. There were also 27 cooperatives, 5 foundations, 1 sole proprietorship and 11 other types of entities.

7. With regard to population coverage, according to data from the Superintendency of Health Services for 2022, exclusive public coverage—intended for those without any other form of formal insurance—reached 19.9 million people (37% of total coverage). PAMI, a health insurance scheme exclusively for retirees and pensioners, covered 5.2 million people (10%). National health insurance schemes provided cover for 14.9 million (28%), with a notable concentration: the ten largest providers accounted for 40% of this total. Provincial health insurance schemes covered 7.2 million (13%). Meanwhile, the 674 private health insurance providers covered 6.8 million people (13%), with an even more pronounced concentration: the ten largest providers accounted for 83% of members, of whom two-thirds had their contributions channelled through a social security scheme, whilst one-third paid directly. It should be noted that these percentages are calculated on the basis of the total coverage within the system—which exceeds the total population due to the existence of dual coverage—and not on the basis of the census population.

8. This three-tier structure gives rise to specific incentives and competitive dynamics, with a significant degree of concentration in both the national/provincial health insurance and private health insurance sectors.

Figure 1. People by type of health insurance.



Source: Superintendencia de Servicios de Salud (SSS). Quoted on the Conduct 1848 Opinion (CNDC, 2024, paragraph 127)[1]

[1] Opinion Conduct 1848 (2024). Available on: https://www.argentina.gob.ar/sites/default/files/2024/04/resolucion_y_dictamen.pdf

2. Recent Changes to Healthcare Regulation

9. One of the most significant regulatory changes in recent years was the reform introduced by Emergency Decree No. 70/2023 of December 2023, which substantially expanded users' freedom of choice within the healthcare system.

10. The key measures of this reform include the following. Firstly, workers can now choose any insurer—whether a national/provincial health insurance scheme or a private health insurance provider—from the start of their employment, removing the previous obligation to remain for one year with the trade union health insurance scheme corresponding to their sector. Secondly, greater flexibility has been introduced for changing providers. Thirdly, private healthcare providers have been formally incorporated as "agents" of the National Health Insurance System. In Argentina, the social security health system is funded through compulsory worker contributions and employer contributions based on wages. Prior to the reform, these funds had to be channelled through a social security scheme, even when the beneficiary had taken out private cover. Under Emergency Decree 70/2023, workers can now direct these contributions directly to a private health insurance provider, without the need for a health insurance fund to act as an intermediary. Finally, the reform led to price deregulation and a reduction in state control: the state ceased to authorise increases in private health insurance premiums, and mandatory minimum tariffs for providers were abolished.

11. This reform marked a paradigm shift in the regulation of the sector, moving from a model characterised by heavy state intervention in pricing and barriers to members' mobility, towards a system offering greater freedom of choice and less price regulation. The stated aim was to increase competition among insurers and improve the efficiency of the system. However, its implementation caused immediate tensions in the market, particularly regarding the prices of private healthcare plans, as discussed in the following section.

3. Investigation Into Anti-Competitive Behaviour in the Prepaid Healthcare Market

12. The day after Emergency Decree 70/2023 came into force, on 21 December 2023, the president of the Argentine Health Union Confederation (UAS, for its acronym in Spanish) — who was also president of the private healthcare company Swiss Medical S.A. — gave a radio interview in which he publicly announced that the sector's leading companies would meet that very day at the UAS headquarters to define, in his own words, "practices to emerge from an extremely alarming situation in an orderly manner", and revealed that the expected average increase would be between 40% and 50%. The day after that meeting — 22 December 2023 — all the private healthcare companies, which were subsequently reported to the competition authority, simultaneously sent notices to their members announcing increases for January 2024 with striking uniformity: Galeno Argentina S.A. applied a 40.5% increase, Hospital Británico a 38% increase, Hospital Alemán a 39.8% increase, Swiss Medical a 40% increase and Medifé a 39% increase. By February 2024, the uniformity was repeated: Galeno announced a 28.5% increase, OSDE a 28% increase and Omint a 29.4% increase.

13. This sequence of events led to a complaint being lodged with the then National Commission for the Defence of Competition (CNDC) by national and Buenos Aires City legislators. The conduct complained consisted of a possible cartel, pursuant to the provisions of Section 2(a) of Act No. 27.442 on the Defence of Competition (LDC, for its acronym in Spanish), which involved the concerted fixing of prices and the exchange of information between competitors.

14. The CNDC ordered the complaint to be referred and received the companies' explanations. The companies against whom the complaint was lodged argued, broadly speaking, that the increases were necessary to make up for the shortfall accumulated over years of state tariff regulation that had failed to compensate for rising costs, and that the similarity in the percentage increases was due to the fact that all the companies had suffered the same effect of regulatory distortion, without this implying any coordination.

15. However, the CNDC considered that the available evidence was sufficient to issue a provisional injunction under Section 44 of the LDC. The analysis highlighted several elements which, taken together, constituted sufficient plausibility regarding the conduct complained of. Firstly, the market structure presented conditions that facilitated coordination: inelasticity of demand —particularly among older adults and people with pre-existing conditions with limited ability to switch providers—, relative homogeneity of the service, high concentration, and sectoral coordination through second- and third-degree associations such as the UAS itself. Secondly, public statements anticipating a meeting to coordinate exit policies were not mere circumstantial evidence, but an explicit manifestation of an intention to coordinate. Thirdly, the statistical uniformity of the price increases was difficult to explain by independent cost factors, given that the companies serve different segments of the population with unique business strategies and, therefore, should have dissimilar cost structures.

16. On this basis, and on the recommendation of the CNDC, the then Secretary of Industry and Trade decided to order a provisional injunction to ensure that the quotas for the first few months of 2024 could not exceed the December 2023 quota, adjusted in line with the national CPI published by INDEC. The measure was extended for six months from the date of its notification. Furthermore, an order was issued to cease all exchange of information between competitors — whether in the context of UAS meetings or in any other forum — concerning prices, costs or service conditions. In addition, companies were ordered to submit detailed information monthly to the CNDC regarding list prices, revenue and the number of members per plan, and to publish the full text of the resolution on their websites.

17. This case raises a policy question that goes beyond strict competition law: when prices are deregulated in markets with these structural characteristics, what oversight mechanisms are needed to ensure that liberalisation delivers the expected benefits rather than facilitating collusion? The Argentine experience suggests that the tool of *ex-ante* protection may be an effective response to situations of potential and irreparable harm to consumers with limited ability to switch, but that a fundamental solution must also address the structural conditions of the market.

18. This case is currently still under investigation by the National Competition Authority (ANC).

4. Market Research on Medical Oxygen

19. With regard to identifying regulatory barriers to competition in the healthcare sector, a notable example is the market investigation into medical oxygen carried out by the then CNDC. In the course of that investigation, it was found that the market was highly concentrated, with three companies controlling around 90% of sales nationwide.

20. The market investigation into medical oxygen was launched at the request of the then Ministry of Commerce, with the aim of monitoring prices, quantities and commercial conditions relevant from a competition perspective. Medical oxygen has been included on the World Health Organisation's (WHO) list of essential medicines since 2017 and is a

commodity with no substitutes and highly inelastic demand, making it particularly vulnerable to the exercise of market power.

21. The analysis revealed a high and stable level of market concentration over time. For the period 2013–2018, four companies—Air Liquide, Linde, Praxair and Indura Argentina, all local subsidiaries of multinationals in the sector—accounted for more than 90% of the national liquid oxygen market, with market shares that remained virtually unchanged. The Herfindahl-Hirschman Index (HHI) stood at around 2,700 points nationally, and rose to 3,892 points as a result of the merger between Linde and Praxair, which was analysed in parallel by the CNDC. At the provincial level, the rates were even higher: in Formosa, La Pampa, La Rioja, Santa Cruz and Tierra del Fuego, a single supplier accounted for 100% of the market.

22. The investigation also identified contractual barriers to competition that explained the lack of dynamic rivalry—the rate of supplier switching was virtually zero, with just 1.57% of annual cancellations for Air Liquide and 0.07% for Linde. Suppliers retain ownership of the cryogenic tanks installed in healthcare facilities, which are leased under exclusive contracts for filling and maintenance. Should a facility switch supplier, it must bear the costs of dismantling, civil works and supply disruption. Many contracts dated back to the 1990s and had been continuously renewed. Furthermore, several contracts included clauses obliging the facility to pay for the agreed minimum consumption even if it decided to install its own PSA generator, directly discouraging the adoption of alternative technologies.

23. Against this backdrop of high market concentration and significant structural barriers, the research found that current health regulations acted as an additional barrier preventing healthcare facilities from resorting to self-supply using PSA technology. This method enables oxygen to be produced directly within healthcare facilities through pressure swing adsorption, thereby eliminating dependence on the distribution chain of large producers. However, PSA technology produces oxygen with an average purity of 93% —ranging from 90% to 96%— which is below the 99.5% threshold established in the Argentine Pharmacopoeia, a threshold applied without distinction to both cryogenic oxygen and PSA. The situation was also internally inconsistent: ANMAT Provision 4373/2002 established a 98% requirement for PSA oxygen, but the Pharmacopoeia unified the criterion at 99.5%, and in practice operators applied the more restrictive standard, making the marketing of PSA oxygen as a medicinal product unviable.

24. This situation contrasted to widely adopted international standards, particularly following the COVID-19 pandemic. The European Pharmacopoeia, the United States Pharmacopeia and WHO guidelines accept medical oxygen produced by the PSA method with purity levels of between 90% and 96%, recognising its therapeutic equivalence for standard indications.

25. In Argentina, some provinces had already made progress in this area: since 2006, La Pampa had had operational PSA plants in three public hospitals, and by the end of 2022, the province of Buenos Aires had authorised the production and sale of PSA oxygen within its territory.

26. On the basis of these findings, in July 2023 the CNDC issued a Provision recommending that the Ministry of Health and the National Administration of Medicines, Food and Medical Technology (ANMAT) assess the inclusion of 93% medical oxygen in the Argentine Pharmacopoeia and adapt the regulations relating to the PSA method to enable its effective application and marketing throughout the country. Although the reform was not adopted at national level, provincial experiences demonstrated that lowering the

purity threshold is technically feasible and yields concrete results in terms of increased competition and cost reductions for health systems.

27. This case illustrates some of the challenges that can arise in highly concentrated markets in the face of significant regulatory changes, particularly when these alter the conditions under which prices are formed. In such contexts, the competition authority's role is crucial in assessing the existence of potential anti-competitive conduct.

5. Final Remarks

28. In conclusion, an analysis of the Argentine healthcare sector shows that the interplay between regulation, market structure and competition is key to ensuring efficient and equitable access to healthcare services

29. The tripartite structure of the system, combined with the high levels of concentration observed both in the private healthcare market and in other strategic segments of the sector, creates conditions that may limit effective competition and directly affect users. In this context, the recent regulatory reforms introduced by the Emergency Decree 70/2023 reflect a paradigm shift aimed at expanding freedom of choice and reducing state intervention, although they also highlight the risks that may arise in markets with structural characteristics conducive to coordination between competitors.

30. Furthermore, the cases analysed demonstrate the importance of having active competition authorities and early intervention tools capable of preventing significant harm to consumers and the functioning of the market.

31. Similarly, experience in the medical oxygen market shows that certain health regulations, even when pursuing legitimate aims, can become unjustified barriers if they are not periodically reviewed in line with scientific evidence and international standards.

32. In this regard, there is a clear need to design regulatory policies that reconcile health protection objectives with the promotion of competition, thereby fostering more dynamic and innovative markets that are geared towards the well-being of patients and members. In this context, the National Competition Authority can make a significant contribution to the review of existing public policies and sectoral regulations, and to the design of new ones.