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Competition and Regulation in Professional Services – Note by Argentina

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1. In Argentina, activities subject to professional regulation are mainly associated with liberal professions that require enrolment in professional councils or associations, which oversee professional conduct through a code of ethics, and set standards for the practice of the profession. Common examples of these professions include lawyers, accountants, architects, engineers, physicians and dentists. However, this category has expanded in recent decades to include activities such as pharmacists, opticians and biochemists, among others.

2. Professional services markets are characterised by the asymmetry of information that exists between the providers of such services, who have specific knowledge in a given field, and the buyers who, in general, do not have the means to easily assess the quality of the services purchased either before or after contracting them. For this reason, in some cases there may be government intervention in order to guarantee the quality of the services offered and to certify the level of qualifications of the professionals involved.

3. The National Commission for the Defence of Competition (CNDC, for its acronym in Spanish) has been increasingly active in investigating anticompetitive practices in the segment of professional services linked to health markets. This includes medical practitioners of various specialties, pharmacists, opticians and biochemists, among others.

4. The purpose of this contribution is to review some of the investigations into anticompetitive conducts carried out by the CNDC regarding health professional associations, in order to identify the measures ordered by the authority that have contributed to the increase of competition in professional health services markets.

5. The first section of this note provides an overview of the role of provider associations in health markets in Argentina, focusing on the general characteristics of this type of associations and the antitrust issues that might arise within them. The second section details CNDC's past investigations on anticompetitive practices regarding health-related professional associations, including the effects of these practices and the results of the investigations carried out. The third section describes some pro-competitive measures that the CNDC recommends in order to prevent anticompetitive practices from arising in professional associations. Finally, the fourth section presents the final remarks.

1. General Characteristics of Health Services Markets in Argentina

6. Health services markets comprise a significant segment of the economic activity of Argentina, with a considerable number of providers, as well as users.

7. The health services sector presents certain particularities that distinguish it from other markets, both in terms of the intrinsic characteristics of the services it offers, as in terms of its structure and functioning.

8. As in most markets, competitive mechanisms can play an important role in the functioning of health services markets by promoting values such as resource efficiency, stimulating innovation and improving quality, and reducing costs. However, health care markets can also be characterised by asymmetric information problems among the different economic agents involved.

9. A pattern that has become increasingly important in these markets over time is the emergence of entities that intermediate between the basic providers of such services –i.e. the health professionals themselves– and their end-users, commonly referred to as patients. These entities generally take the form of "provider associations" (professional boards, associations and circles) on the supply side,[1] and "health care fund managers" (social security, mutual associations, prepaid health insurance companies, etc.) on the demand side.[2]

10. An analysis of health services supply shows that, in general terms, medical-health care basically includes three different types of goods and services: medical, dental and ancillary services (provided by licensed professionals), medication (produced by pharmaceutical laboratories, distributed by drugstores and sold to the public in pharmacies) and hospital services (provided by public hospitals and private clinics and sanatoriums), including in this category both qualified services that involve the use of specific human and material resources in the health field, and basic hospital services.

11. Looking at the professional associations, although the emergence of provider associations can be explained by arguments based on efficiency considerations, in many cases their origin is linked to counteracting the significant negotiating power of health care fund managers.

12. Regarding considerations related to efficiency gains that may arise from professional associations, these relate to information sharing activities and to improved training of providers, to cost savings in administrative activities, to economies of scale in the use of resources such as emergency services and referrals to specialists, etc. In addition, the existence of a provider registry can bring benefits by reducing transaction costs, facilitating contracting with health service demanders and allowing them to have more direct access to a larger number of providers.

13. In Argentina, provider associations that bring together professionals (circles, boards, associations, unions or federations of doctors, anaesthesiologists, dentists, biochemists, pharmacists, etc.) tend to concentrate most of the professionals, and play a key role in the contracting of services provided by health care fund managers. This is partly due to the inconvenience of dealing individually with each provider and the dominance that provider associations have acquired in their role as intermediaries, negotiators and contract managers.

14. The regulations that govern health professional associations in Argentina are of a fragmentary nature, as this type of associations are subject to certain national regulations[3] as well as provincial legislation. The statutes of each association establish the governance of each body, setting the objectives –which usually have to do with ethical and technical aspects, performance and economic improvement and with the defence of the labour interests of its members– and the rules for the functioning of the association.

[1] A 'provider association' is any entity that brings together a group of health care providers and represents those providers in some of their interactions with direct or indirect users of their services.

[2] A 'health care fund manager' is an entity that administers the contributions that (mandatorily or voluntarily) its members provide to it, for it to contract on their behalf a group of health care providers, financing all or part of the health care expenses incurred by those members.

[3] For example, Section 29 of Act No. 23.661 establishes that, among other entities, associations representing health professionals or health care establishments that contract services on behalf of their members must be registered in a National Registry of Providers, which is currently controlled by the Superintendence of Health Services.

15. It is because of the characteristics and powers that these entities may have that the role of provider associations as aggregators of the supply of health care services may lead to the emergence of certain competition problems in these markets. In those markets where a provider association has a significant share and has established contracts with health care fund managers that represent a significant source of revenue for its members, it may take advantage of this position to impose anticompetitive conditions on its members and, by extension, on the users of the services they provide. In certain cases, as a tool to maintain the above practices, associations are able to use their market power to exclude their members from certain benefits provided by the association (e.g., from their provider register), usually as a punishment because those members have in some way departed from the practice advocated by the association.

16. The inclusion of exclusivity clauses in these cases functions as a means to maintain the market power that the association of providers has acquired, thus limiting the choices of health care fund managers, who can no longer contract independently with a diverse group of providers. These clauses have restrictive effects on competition, harming both users and providers. Providers may in fact prefer to offer their services independently, but are prevented from doing so if it means giving up the opportunity to participate in the contracts established by their association.

17. In the next section, we will review some cases in which provider associations have been investigated by the CNDC, highlighting the identified anticompetitive practices and the results of such investigations.

2. Cases of Anticompetitive Practices in the Health Care Service Markets

18. Many of the anticompetitive practices sanctioned by the CNCD, carried out by professional associations in the health care markets, were mostly linked to the imposition of exclusivity clauses, which aim to maintain a dominant position and perpetuate the abuse of this position, imposing on their members commercial practices that limit competition in the market. Another common practice within the framework of these associations is related to the setting of discriminatory conditions for obtaining membership of the professional association, raising barriers to entry and distorting market access.

2.1. Imposition of exclusivity clauses

19. In 2015, the CNDC sanctioned the Federation of Biochemists of the Province of Buenos Aires for the imposition of exclusivity clauses and the application of sanctions to its associated providers for delivering services to health care fund managers with or without agreements established with the Federation.

20. In this particular case, the market was defined as the provision of biochemical services to members of social security, mutual and prepaid medicine companies in the City and Province of Buenos Aires.

21. This market involves, on the one hand, the service providers, i.e. the biochemists registered in that geographical area, and, on the other hand, the end users, i.e. the patients. However, it is common for biochemical services to be contracted through health care fund managers, who contract biochemical laboratories, which are grouped into professional federations that bring together the supply of services and act as intermediaries between service providers and end-users.

22. The CNDC concluded that the Federation had a dominant position in the relevant market, as it accounted for 80% of the total number of registered biochemists in the City

and Province of Buenos Aires. At the same time, the Federation was contractually or *de facto* linked to most of the major health care fund managers. In this sense, the only possibility for biochemists belonging to the area of influence of this entity to access this large mass of affiliates of social security, mutual and prepaid health insurance companies was to be part of the Federation's registry of providers.

23. In addition, by bringing together a significant portion of the supply of biochemists, the Federation constituted an obligatory choice for most of the health care fund managers of the City of Buenos Aires and the Province of Buenos Aires.

24. As the Federation had a dominant position in the market, the imposition of clauses on its associated providers not to contract directly with entities that have or have had any contractual link with the Federation, as well as the prohibition to bill independently for services that were not covered by the signed agreements, had the potential to significantly alter the normal conditions for the functioning of the market from a competition perspective. These clauses were included in the Federation's regulations.

25. In the light of these elements, the CNDC considered that the Federation's conduct to restrict competition in the market for biochemical services in the Province of Buenos Aires and the City of Buenos Aires was proven, which constituted an abuse of a dominant position of an exclusionary nature, since the Federation controlled that its members, i.e. biochemists, did not contract with health care fund managers that had in force or had had a contractual relationship with this entity. This exclusion of competition allowed the Federation to charge higher prices on behalf of its associated biochemists than those that would have prevailed in the absence of the conduct, directly harming the general economic interest.

26. Another case investigated by the CNDC is that of the Dental Federation of the Province of Córdoba (FOPC, for its acronym in Spanish), a non-profit civil entity that brings together the dental entities of the province and agrees on benefit agreements with the health care fund managers.

27. The investigation arose from the complaint of a group of dentists who stated that they had been excluded from the FOPC's list of providers, because they provided services directly to two prepaid health insurance companies, and that this constituted a violation of the conditions for joining the Federation.

28. The FOPC asserted that those who were intending to participate in the agreements established with health care fund administrators had to refrain from providing dental services to those administrators that did not have an agreement with the FOPC. The Federation also acknowledged that the complainants were excluded from its list of providers when their names were detected on the dentist list offer displayed on the websites of two prepaid health insurance companies

29. In this context, the CNDC issued an interim measure, ordering the FOPC to reinstate the providers that had been excluded from its register. The FOPC complied with the measure, and offered the commitment to refrain from excluding providers from its list of providers, and from preventing, hindering or obstructing third parties from entering or remaining in the dental services market. The CNDC accepted the commitment, and after a three-year monitoring period, filed the proceedings, in accordance with the provisions of Section 45 of Act No. 27.442 on Defence of Competition (LDC).[4]

[4] Section 45 of the LDC provides that the alleged responsible of anticompetitive conduct may voluntarily offer a commitment involving the immediate or gradual cessation of the investigated facts or the modification of aspects related to it. The offending company must offer such a

30. Finally, there is a case in which the CNDC sanctioned the Tucumán Association of Pharmacists, the Tucumán Association of Pharmacies, and the Southern Circle of Pharmacies, entities that bring together pharmacists and pharmacies in the Province of Tucumán. In this case, as the practice involved associations that brought together both health professionals (pharmacists) and companies (pharmacies), the CNDC sanctioned two different anticompetitive conducts.

31. On the one hand, the CNDC sanctioned an abuse of dominant position by imposing exclusivity clauses, in line with the cases previously mentioned. On the other hand, it sanctioned the implementation of an anticompetitive agreement between pharmacies in the province to limit discounts on list prices and to restrict advertising and opening hours.

32. The aforementioned organisations, among other functions, negotiate agreements with health care fund managers for the provision of medicines at discounted prices to their affiliates. These associations accounted for the billing of all pharmaceutical services in the Province of Tucumán, representing 100% of the pharmacies in the province.

33. According to national and provincial legislation, only pharmacies are authorised to dispense medicines, both prescription and over-the-counter drugs, and pharmacies must be run by a professional pharmacist. Consequentially, the CNDC considered that the dispensing of medicines is an activity that pharmacies carry out under exclusive conditions and, therefore, without competing with any other type of retail dispensing channel.

34. In this case, the CNDC noted that the sanctioned associations conditioned supply, forcing their member pharmacies to behave in a certain way in the market, limiting their ability and willingness to compete. In addition, these associations obtained significant benefits, since most of their income comes from the percentage of the invoicing they retain from their members for intermediation with the different health care fund managers with which they have agreements.

35. According to the CNDC, the associations, as the activity is conceived, are essential actors for the affiliates of social security, mutual and prepaid health insurance companies, to have access to medicines.

36. Moreover, the statutes of the sanctioned entities were found to contain exclusivity clauses that restricted competition. The CNDC considered that these clauses let the entities establish and maintain the associations' market power, allowing them to abuse their dominant position by imposing conditions that were detrimental to social, mutual and other health care fund managers. These clauses denied these entities the option to contract independently with a significant group of pharmacies, which limited the geographic scope of their services. As a result, the effects on competition were restrictive, harming both the affiliates of these entities and the pharmacies' customers. Furthermore, these clauses affected those pharmacies willing to offer their services independently, if such action did not mean losing the possibility to participate in the contracts established by the associations.

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commitment prior to the issuance of the resolution of the case by the CNDC. The commitment is subject to the approval of the authority, which, if accepted, must suspend the proceedings. If, after three years, it becomes evident that the commitment has been complied with without any recurrence of the conduct, the proceedings must be closed. In order to corroborate compliance, the CNDC processes what is called a 'verification incident', in the framework of which it may consult competitors, customers, suppliers or any third party that may have been harmed by the offending person, about the evolution of the conditions of the market in which it operates after the beginning of the commitment, specifically, whether the conduct previously exercised has ceased. Verification of compliance with a commitment is often a complex process, especially in cases where the agreed measures are of a behavioural nature.

37. These exclusivity clauses were supported by the Code of Ethics of the providers' associations, which allowed them to sanction members for non-compliance. Based on these findings, the CNDC imposed fines on the associations and ordered the removal of the exclusivity clauses from both their statutes and their codes of ethics.

2.2. Discriminatory Practices of exclusionary nature

38. In 2021, the CNDC fined the Buenos Aires Province Opticians Association (COPBA, for its acronym in Spanish) for abuse of dominant position in the market for retail sales of sunglasses in the Province of Buenos Aires.

39. Provincial legislation grants COPBA a monopoly on the control of the registration that allows opticians to practise their profession in the Province of Buenos Aires. COPBA distinguished between two types of registration. On the one hand, those for professionals working in an optician's shop, and on the other hand, those working in an alternative sales channel, such as pharmacies, shopping centres, clothing stores, leather goods stores, internet sales, among others.

40. In this particular case, the COPBA, taking advantage of the fact that the setting of the registration fee is within its exclusive orbit, unjustifiably discriminated between these two categories of professionals, considerably raising the registration fee for professionals who carried out their activities in alternative channels to opticians' shops.

41. In this regard, the CNDC found that the COPBA artificially and unjustifiably raised barriers to entry and distorted market access by discriminating between the value of the registration fee for optical directors working in an optician's shop and those working in an alternative business. This amounted to a restriction of competition as it artificially increased the costs incurred by sunglasses manufacturers for the retail sale of their products outside the optical shop channel.

42. The CNDC emphasised that preventing the development of a marketing channel, through a discriminatory practice in the setting of license fees so that one of these channels incurs higher costs than the other, implies a reduction in consumer choice and purchasing options. In this scenario, the consumer is harmed, as fewer shops offer sunglasses in the affected market, and the variety of sunglasses brands available for purchase outside the optician's channel is reduced.

43. In its Opinion, the CNDC emphasised that business chambers, professional associations or similar institutions must ensure the principles of impartiality and non-discrimination in the conditions of membership. To this end, the requirements for membership of a business association or chamber must be objective, clearly outlined and not subject to discretion.

3. Pro-Competitive Recommendations

44. In order to reduce the risks of being sanctioned for violations of the LDC that provider associations in health markets may face, in December 2018, the CNDC published the *Antitrust Guidelines for Business Associations and Chambers and Professional Associations.*[5]

[5] See guidelines at:

https://www.argentina.gob.ar/sites/default/files/guia_para_camaras_y_asociaciones.pdf

45. In this guidelines, and as far as professional associations are concerned, the CNDC recommends not to establish rules that prevent their members from making independent commercial decisions. It also states that it is advisable not to use association or membership requirements as an element to exclude or discriminate against competitors. In this regard, it is recommended to ensure the principles of fairness and non-discrimination in membership conditions. To this end, the requirements for membership of a provider association should be objective, clearly outlined and not subject to discretion.

46. In particular, it is recommended that providers associations do not establish clauses limiting the direct contracting of their members with health care fund managers, and refrain from excluding from their provider register (or sanctioning in any other way) those professionals who provide services directly to managers with or without contractual links to the association.

4. Final Remarks

47. As we have explored throughout this note, professional associations, particularly in the health care services sector, can generate cost savings in administrative activities, economies of scale in the use of resources, and benefits by reducing transaction costs, facilitating contracting with health care service demanders and allowing them more direct access to a wider range of providers. However, they also pose significant challenges from a competition perspective, including the potential for anticompetitive practices and the imposition of restrictive conditions that harm both users and other health service providers.

48. The cases of anticompetitive practices in health care markets analysed by the CNDC which were describes throughout this note illustrate the risks inherent to the concentration of power by these associations. From price fixing to the imposition of exclusivity clauses, these practices can significantly distort competition and negatively affect both consumers and providers.

49. In Argentina, there is no comprehensive, nationwide regulation governing the operation of professional associations, so that anticompetitive practices promoted by the organisations themselves is a not infrequent occurrence. It is for this reason that the CNDC has published guidelines of recommendations for professional associations, with the objective of preventing these entities from engaging in this type of anticompetitive conducts.

50. Ultimately, it is essential that competition law enforcement actions ensure the promotion of efficiency and competition in health services markets, with the main objective of protecting the interests of users and fostering an appropriate environment that enables a continuous improvement of the quality of services.