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IMPLICATIONS OF DOMINANCE IN THE HEALTHCARE PROVIDER SECTOR IN INDIA – A COVID-19 PERSPECTIVE

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ABSTRACT

With increased reliance on private healthcare infrastructure during public health emergencies such as COVID-19, the most efficient means of regulation that makes sure such services are affordable must be investigated. As an alternative to methods such as price capping, this paper seeks to propose an increased involvement of the Competition Commission of India (CCI) so that that high, inelastic demand and lack of countervailing buyer-power is not misused.

This paper covers the issues faced in delineating relevant markets, followed by an examination of the traditional approaches towards dominance and how they fall short, along with an analysis of its alternate conceptions in EU jurisprudence. Finally, the paper discusses the circumstances under which the abuse of dominance may arise, and the best approach to correct such market failure, fostering a pro-active and vigilant CCI.

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I. INTRODUCTION

The COVID-19 pandemic has exposed the fault lines of India's healthcare system, with the second wave causing an incredible strain on the country's resources unlike any event in the recent past.[1] The need for reconfiguring how to think about the healthcare sector is more evident than ever.[2]

With the rapid rise in the number of cases and lack of adequate public healthcare infrastructure, various state governments had "*taken over*"[3] the facilities of private hospitals, and ordered certain portions of hospital beds to be reserved for the treatment of COVID patients only.[4] More importantly, various charges for treatment (rate to be charged for Personal Protective Equipment [*hereinafter* "**PPE**"] kits, diagnostic tests, ICUs with and without ventilators) had been price capped through various state and central Clinical Establishment and Epidemic Diseases Acts.[5] Private

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[1] Sujita Kumar Kar et al., *Second wave of COVID-19 pandemic in India: Barriers to effective governmental response*, 36 ECLINICALMEDICINE 1, 1 (2021).

[2] Tanzin Dikid et al., *Responding to COVID-19 pandemic: Why a strong health system is required*, 151 INDIAN J. MED. RES. 140, 140-145 (2020).

[3] Ipsita Chakravarty, *Coronavirus: Three states take over private hospitals. What does the fine print say?*, SCROLL.IN (Mar. 30, 2020, 06:30 AM), https://scroll.in/article/957556/coronavirus-three-states-take-over-private-hospitals-what-does-the-fine-print-say.

[4] Express News Service, *80% beds in private hospitals to be reserved for Covid patients*, NEW INDIAN EXPRESS (Apr. 25, 2021, 04:42 AM), https://www. newindianexpress.com/cities/bengaluru/2021/apr/25/80-beds-in-private-hospitals-to-be-reserved-for-covid-patients-2294530.html.

[5] Sharangee Dutta, *Telangana caps cost of Covid-19 tests, treatment at private labs and hospitals*, HINDUSTAN TIMES (Jun. 23, 2021, 06:09 PM), https://www.hindustantimes.com/india-news/telangana-covid-19-tests-treatment-cap-private-labs-hospitals-101624449333033.html. *See also* Neetu Chandra Sharma, *Private hospitals seek revision in prices of covid tests, treatment*, MINT (Apr. 16, 2021, 06:57 AM), https://www.livemint.com/news/india/private-

hospitals were penalized or had their licenses revoked for exceeding the price caps as fixed by their respective governments.[6]

The efficacy of such a solution is questionable. Price caps are applied indiscriminately to large, medium and small enterprises, with the latter two lacking the capacity to cross-subsidize or recover losses arising due to the prices being capped too low. This has the capacity of pushing them out of the market, which would cause additional stress to an already burdened healthcare sector.[7] Such a phenomenon is observed in the pharmaceutical industry as well, wherein price capping of important medicines in certain concentrations results in the proliferation of non-common concentrations (priced high) and exit of medium and small manufacturers.[8] The impact of taking over private operations on efficiency in the allocation of resources and its effect on non-COVID patients who still need regular healthcare access remains to be fully assessed as well.[9]

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hospitals-seek-revision-in-prices-of-covid-tests-treatment-11618513331635.html & Maitri Porecha, *Refusal to treat a patient warrants cancelling of licence, warns govt*, BUSINESS LINE (May 1, 2020), https://www.thehindubusinessline.com/news/national/non-refusal-to-treat-a-patient-warrants-cancelling-of-licence-warns-govt/article31474648.ece

[6] Jamal Ayub, *Government revokes licence of 60 private hospitals in Madhya Pradesh,* THE TIMES OF INDIA (Aug. 1, 2021, 05:32 AM), https://timesofindia.indiatimes.com/city/bhopal/govt-revokes-licence-of-60-private-hospitals-in-madhya-pradesh/articleshow/84937510.cms.

[7] Kathryn Langwell, *Price Controls: On the One Hand… And on the Other*, 14 HEALTH CARE FIN. REV. 5, 5 (1993).

[8] Rhea Reddy Lokesh, *The Anti-Competitive Effect of Price-Controls: Study of the Indian Pharmaceutical Industry,* 43 WORLD COMPETITION L. AND ECON. REV. 283, 283 (2020).

[9] Raju Vaishya, Anupam Sibal & P. Shiva Kumar, *Severe impact of COVID-19 pandemic on non-COVID patient care and health delivery: An observational study from a large multispecialty hospital of India*, 73 IJMS 159, 162 (2021).

In such a scenario, where regulatory mechanisms may harm consumers and the competitiveness of the sector beyond the pandemic, the role that competition law can play needs to be looked into. This paper specifically looks at the issue of dominance within the healthcare provider industry, and the interventions that can be taken up by the Competition Commission of India [*hereinafter* "**CCI**"] in light of extraordinary public health emergencies such as the COVID-19 pandemic, incidents of epidemics and outbreaks (as are increasingly common).[10]

Section 4 of the Competition Act, 2002 [*hereinafter* "**Act**"] provides that for establishing dominance three steps are to be followed: (i) narrowing down the relevant market; (ii) analysing if the enterprise is dominant in that market; and (iii) if the enterprise has abused such dominant position.[11] Hence, this paper shall proceed with reference to foreign jurisprudence for analysis of collective and relative dominance, wherever necessary. However, it should be noted that due to the varying nature of the healthcare systems in leading competition law regimes such as the European Union (Beveridge Model or Bismarck Model or a combination of both)[12] and the USA[13], a direct transposition of their concepts to the Indian system is not possible. With the overall health infrastructure being woefully inadequate, private

[10] Katherine F. Smith et al., *Global rise in human infectious disease outbreaks*, 11 J.R. SOC. INTERFACE 1, 5 (2014).
[11] ABIR ROY, COMPETITION LAW IN INDIA: A PRACTICAL GUIDE 157-224 (Kluwer Law International 2016) ("**ROY**").
[12] Lorraine S. Wallace, *A View of Health Care Around the World*, 11 ANN FAM MED 84 (2013).
[13] GODDARD, *infra* note 44.

infrastructure accounting for more than half of the system,[14] and lack of adequate insurance cover[15] to compensate exorbitant costs, India has a vastly different healthcare delivery sector in comparison to the EU and the USA.

II. ON ASCERTAINING RELEVANT MARKETS

The abuse alleged by the informants before the CCI plays a very important role in the beginning to delineate the relevant market in which dominance of an enterprise is further sought to be proved.[16] It helps kickstart an identification of market substitutes/alternatives as well, based on the "*characteristics, price and intended use*" of the products/services in question.[17]

Therefore, it is important to understand the potential abuse in context of Section 4 of the Act, so that the relevant markets can be delineated. Potential abuse of dominance by healthcare providers may fall under either Section 4(2)(a)(i) or (ii), *i.e.*, "*imposition of unfair conditions in purchase or sale*" or "*unfair price in purchase or sale of goods and services,*" respectively.[18] Commonly reported issues faced, such as compulsory buying of medications (that do not require much quality control), or compulsory

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[14] Christophe Jaffrelot & Vihang Jumle, *Private Healthcare in India: Boons and Banes*, INSTITUTE MONTAIGNE (Nov. 3, 2020), https://www.institutmontaigne.org/en/blog/private-healthcare-india-boons-and-banes.

[15] Kumar Anurag & Sarwal Rakesh, *Health Insurance for India's Missing Middle*, OSF PREPRINTS (Oct. 27, 2021), https://osf.io/s2x8r.

[16] Surinder Singh Barmi v. BCCI, Case No. 61/2010 (CCI).

[17] *Id.* at ¶ 28.

[18] The Competition Act, 2002, No.12, Acts of Parliament, 2003 (India), § 4.

testing in hospital diagnostic centres as a condition to be admitted may potentially fall under Section 4(2)(a)(i). While, excessively charging for PPE kits, hospital beds or rooms, medications, consumables, and tests to be undergone during hospitalisation may fall under the latter.[19] Taking the occurrence of such events during the pandemic as a case study, the relevant product market would be COVID-19 care hospitals.

The CCI also observed multiple times in various mergers/combinations that-

> "…*while primary and quaternary treatments are relatively well defined, the treatments offered at the secondary and tertiary level often cannot be strictly compartmentalised. In this regard, it has been submitted that most hospitals provide comprehensive and integrated healthcare services which include out-patient services, in-patient services, diagnostic services, pharmacy services etc. Therefore, the manner in which healthcare services are provided by hospitals is typically integrated across multiple specialties and services.*"[20]

While primary care deals with the most basic of treatments and diagnoses and are out-patient in nature, secondary care is referred to, by primary care doctors on showing persistent symptoms of the disease or an

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[19] *See infra* notes 99-108 and accompanying text.

[20] Competition Commission of India, Notice under Section 6(2) of the Competition Act, 2002 jointly given by Radiant Life Care Private Limited (Radiant), Kayak Investments Holding Pte. Limited (Kayak), Max Healthcare Institute Limited (MHIL) and Max India Limited (MIL), C-2019/01/629 (Issued on Mar. 6, 2019) ("**Radiant**"). *See also* Competition Commission of India, Notice under Section 6 (2) of the Competition Act, 2002 given by Northern TK Venture Pte. Ltd., C-2018/09/601 (Issued on Oct. 29, 2018).

expected rise in symptoms due to associated co-morbidities, where patients are either to be treated by specialists and/or put under observation. Tertiary care is when further complications arise and there is a need for "*strong diagnostics and clinical support systems,*"[21] such as oxygen beds and ventilators. However, almost all levels of care are integrated in various private hospitals, and such classification is merely conventional in nature. Hence, in light of the potential abuses of dominance in the examples cited above, it would be appropriate to narrow down in-patient care, *i.e.*, in-patient COVID care hospitals as the relevant product market. The integrated and oscillating nature of secondary and tertiary care as well, where patients are frequently shifted back and forth between observation and care by specialists (secondary care) to clinical support such as by ventilators (tertiary care) based on the severity does not allow them to be divided into two distinct product markets.

Now, the question arises – whether only private COVID care hospitals form the product market? While in the case of mergers, the CCI has preferred to keep the contours of the product market open, it acknowledged the submissions of the proposed merger parties, which usually did not differentiate between public and private enterprises unless the former is specifically reserved for a particular section of the community,

[21] Competition Commission of India, Notice under Section 6 (2) of the Competition Act, 2002 filed by Manipal Health Enterprises Private Limited, C-2020/11/789 (Issued on Jan. 8, 2021), ¶ 6.

such as the Economically Weaker Section.[22] Hence, usually, "*market for provision of healthcare services through hospitals*" is proposed.[23]

Further, in the case of *Dr. L. H. Hiranandani Hospital v. CCI,*[24] while the CCI found no abuse of dominance and only contravention of section 3(4)[25], with even the latter being ultimately overturned by the Competition Appellate Tribunal, the arguments presented by the hospital, the opposing party [*hereinafter* "**OP**"] are worth considering. On the allegation that the OP has abused its dominant position and unfairly tied its maternity delivery services with one stem cell banking service only, the Director General [*hereinafter* "**DG**"] established the product market as maternity services offered by super-speciality hospitals.

This was despite the presence of different establishments which offer substitutable services such as maternity homes, other non-speciality private hospitals, nursing homes and municipal establishments. It was of course contended that even on the exclusion of low-end nursing homes, at least establishments other than super-speciality hospitals with comparable price ranges must be considered. But there was nothing to prove this non-substitutability except the vague aversion by the DG that:

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[22] *Radiant*, *supra* note 20, at ¶ 13.
[23] *Id.* at ¶ 12.
[24] Dr. L.H. Hiranandani Hospital v. Competition Commission of India and Ramkant Kini, 2014 SCC OnLine CCI 15 ("***Hiranandani***").
[25] "*Any agreement amongst enterprises or persons at different stages or levels of the production chain in different markets, in respect of production, supply, distribution, storage, sale or price of, or trade in goods or provision of services.*"

> "*[i]n the present case factors, such as, economic and social strata of the consumer (patient) peer pressure, social perceptions, brand value of the hospital at par with the social status, complication attached with the maternity, other health issues, relation with the doctors, relation of the family with the hospital and doctors etc. matters to the patient and her family in deciding a Super Speciality Hospital. Therefore, one cannot include all sorts of hospitals/clinics in a sweeping manner within one single market as contended by the OP without any regard to the features and pricing of the product in question.*"[26]

In *Shri Vivek Sharma v. Max Super Speciality Hospital* [*hereinafter* "***Max Super Speciality Hospital***"],[27] the hospital was alleged of abuse of dominance by excessively pricing syringes, which were to be compulsorily bought from the in-house pharmacy. Herein, the CCI directed the DG to re-investigate by changing the relevant product market from private multi-speciality hospitals to *all* multi-speciality hospitals in the given area. Thus, given the CCI's experience in determining product markets in the healthcare delivery sector, comparable public enterprises can be taken into consideration.

However, due to the nature of a pandemic (or localized epidemics or outbreaks), such a conclusion immediately brings into question the effect of strained resources in public hospitals and similar enterprises.

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[26] *Hiranandani*, *supra* note 24, at ¶ 20.
[27] Shri Vivek Sharma v. Max Super Speciality Hospital and Ors, Case No. 77/2015 (CCI). ("***Max Super Speciality Hospital***")

Due to the extraordinary strain on the entire healthcare industry as a whole during the second wave in the most affected states such as Maharashtra,[28] public hospitals were at their breaking point. Due to the continued lack of resources and inadequate manpower, there was no other choice but to rely on the private healthcare delivery sector, which as mentioned, already has more than twice the amount of infrastructure as public hospitals.[29] The evidenced lack of manpower and shortage of important facilities in public hospitals drove many to private hospitals, especially those of the super-speciality nature. While dominance due to lack of countervailing buyer power can be noticed at this stage itself, for now, it should be considered if this limits the relevant product market by asymmetric substitution.[30]

For, while the functions of public hospitals can be taken up by private hospitals, one shall be constrained to find public hospitals offering all the services offered by private hospitals.[31] Therefore, in a given geographic market, it is entirely possible that due to lack of appropriate facilities from the very beginning or due to overcrowding for those limited

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[28] Kalyan Ray, *Maharashtra has 8 of top 10 worst Covid-19 hit districts,* DECCAN HERALD (Mar. 11, 2021, 09:47 PM), https://www.deccanherald.com/national/maharashtra-has-8-of-top-10-worst-covid-19-hit-districts-960866.html.

[29] Priya Gauttam et al., *Public Health Policy of India and COVID-19: Diagnosis and Prognosis of the Combating Response*, 13 SUSTAINABILITY 1, 6-9 (2021) ("**Gauttam**").

[30] One product or service might be a substitute for another, but the vice versa is not possible. Hence, relevant market for the former might include the latter as substitute, but when ascertaining the position of the latter, the former cannot form a part of the same relevant market. *See generally*, Commission Decision of 17 April 2002 declaring a concentration to be compatible with the common market and the EEA Agreement (Bayer/Aventis Crop Science), 2004 O.J. (L107) 1.

[31] Gauttam, *supra* note 29.

important resources, private COVID care centres remain the only option. The most appropriate example would be the critical supply shortage of ventilators.[32] When such care cannot be offered by certain enterprises, the question of why the relevant market should not be limited to those which do, arises. At the very least, in such cases, only super-speciality public hospitals (irrespective of their capacity) must be considered as substitutable, and the relevant product market would be super-speciality hospitals for COVID care in the given geographic area.

The precise determination of the product market can only be on a case-to-case basis depending upon the ground situation, the intensity of the health emergency and the amount of infrastructure that can be readily used. But CCI should not be precluded from defining the relevant product market as private in-patient COVID care centres/hospitals *only*.

Such a determination depends upon the delineation boundaries of the relevant geographical market as well, which has been relatively uncontroversial in nature. In mergers, the CCI has left the definition of relevant geographical market open too, but has considered the parties' submissions that the limits be the respective cities and surrounding areas the hospitals are located in.[33] In *Max Super-Speciality Hospital,* the re-investigation was ordered by taking into consideration all super speciality hospitals in Delhi, as compared to only those within a 12-kilometre radius

[32] *Id.*
[33] *Radiant*, *supra* note 20, at ¶ 17.

from the OP hospital.[34] Similar considerations were seen in Rotary Hospital, where "*Vapi and surrounding areas*" was taken to be the geographic market.[35] It should be noted that private hospitals (where abuse of dominance is likely to arise) are heavily concentrated in cities and industrialized areas of districts, with denizens of 'surrounding areas' living in areas of sparse health infrastructure approaching such hospitals. Hence, in such cases, the probability of dominance will be seen in the city/area located and surrounding (mostly rural/peri-urban) areas.[36]

III. THE TRADITIONAL APPROACH TOWARDS DOMINANCE

Post-establishment of the relevant markets as in-patient private and/or super-speciality COVID care hospitals within municipal limits and surrounding areas, the next step is to analyse the dominance of the enterprise through various factors of inquiry as under Section 19(4) of the Act. Under this Section, there is no bright-line distinction between dominant and non-dominant firms depending upon the market share. This is as opposed to some jurisdictions, such as South Africa, where having

[34] *Max Super Speciality Hospital*, *supra* note 27, at ¶ 11.
[35] Shri Tarun Patel v. Haria Lakhamshi Govindji Rotary Hospital, Case No. 49/2015 (CCI).
[36] There is a heavy concentration of private hospitals in metro cities, then Tier I and Tier II cities. *See* Indian Brand Equity Foundation, *Healthcare Industry in India, Indian Healthcare Sector, Services,* IBEF.ORG, https://www.ibef.org/industry/healthcare-india.aspx (last updated Sep. 21, 2021).

more than a 45 percent market share would irrefutably be evidence of dominance.[37]

The Raghavan Committee Report[38] highlighted that defining an arithmetic figure explicitly to establish dominance might allow "*real offenders*"[39] to escape. The Report enumerated that

> "*[…] this ambiguity has a justification having regard to the fact that even a firm with a low market share of just 20% with the remaining 80% diffusedly held by a large number of competitors may be in a position to abuse its Dominance, while a firm with say 60% market share with the remaining 40% held by a competitor may not be in a position to abuse its Dominance because of the key rivalry in the market.*"[40]

This has been reiterated a number of times in foreign jurisdictions such as in the case of *ABG/Oil* (as will be discussed later) and Indian cases such as *Belaire Owners' Association v. DLF Limited* [*hereinafter* "***DLF***"].[41] In this case, it was held that when "*sufficient and undisputed*" data on market shares in a relevant market is not available, or the differences in margins of the

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[37] John Oxenham et al., *COVID-19 Price Gouging Cases in South Africa: Short-term Market Dynamics with Long-term Implications for Excessive Pricing Cases*, 11 J. EUR. COMPETITION L. & PRAC. 524, 524 (2020).
[38] SVS Raghavan Committee, *Report of High-Level Committee on Competition Policy Law*, PLANNING COMMISSION, GOVERNMENT OF INDIA (2007).
[39] *Id.* at ¶ 4.4.5.
[40] *Id.*
[41] Belaire Owners' Association v. DLF Limited, HUDA & Ors., Case No. 19/2010 (CCI). ("***DLF***")

market shares do not disclose the true capacity of an enterprise in acting independent of competitive forces of the market, other corroborative data through factors such as mentioned in Section 19(4) become particularly important.[42]

For example, under Section 19(4)(j), market structure of the healthcare delivery sector should be seen. Here, private hospitals have almost double the infrastructure as public hospitals in many leading hotspots for COVID as in various metropolitan cities.[43] This is the standard mode of operation in various low and middle-income countries [*hereinafter* "**LMICs**"], which has led the likes of Maria Goddard, a health economist, to distinguish between how competition regimes ought to operate in countries with developed competition law regimes, as compared to the LMICs.[44]

The scalability of operations of private healthcare centres and the commercial advantages that they have over other competitors (Section 19(4)(d)) can be advantageous in terms of reduced costs (which are nevertheless covered by public insurance policies) in developed countries.[45] But in LMICs, due to lack of adequate competition from the inadequately equipped public healthcare sector or the private sector itself due to an

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[42] *Id.* at ¶ 12.54.
[43] Gauttam, *supra* note 29.
[44] Maria Goddard, *Competition in Healthcare: Good, Bad or Ugly?,* 4 IJHPM 567, 567-569 (2015) ("**Goddard**").
[45] These were also the reasons cited by the 8th Circuit Court of Appeal in upholding a merger by overturning a District Court judgement that did not approve it by considering low cost hospitals only, in Federal Trade Commission v. Tenet Health Care, 186 F.3d 1045 (8th Cir. 1999). *See* Hiranandani, *supra* note 24, ¶15.

unforeseen glut for demand, there is a high probability of exclusion and disproportionate increase of costs of treatments availed (Section 19(4)(l)).

As evidenced by the CCI's reiteration in the mergers,[46] the healthcare delivery sector is still at a nascent stage in India. Lack of a more stringent and nuanced interpretation of dominance can preclude necessary action to be taken during the times of a public health emergency. Thus, there is a need to move away from an interpretation, which although acknowledges market share as not the only factor in determining dominance, still privileges it.[47]

The asymmetric substitutability for specialized care facilities also helps us understand how the lack of adequate public healthcare facilities skews the market in the favour of private hospitals. As mentioned in the previous Part, dependence of consumers (Section 19(4)(l)) on such hospitals shoots up in such times. A policy note released by the CCI itself points to the asymmetry of information available to consumers, and the proliferation of the "*doctor-hospital nexus*"[48] due to it. Here, consumers should not be looked at as rational choice-makers, as their decisions for the most part rest on the information and suggestions provided by professionals in the field. This lack of proper information to a vulnerable populace, the

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[46] *Radiant*, *supra* note 20, at ¶ 18.

[47] In various cases, while the CCI specifies the market share is not the only criteria for assessing dominance, it still continues to revere it as a major indicator, perhaps as a bid of legitimacy of such regulation. *See DLF*, *supra* note 41.

[48] Policy Note, *Making Markets Work for Affordable Healthcare*, CCI.GOV.IN, https://cci.gov.in/search-filter-details/590 (last visited Jun. 24, 2022) ("**Making Markets Work**").

urgency of hospitalization, and the rapidly diminishing number of available beds in such crises[49] must be considered. Further, while the doctors may be in the best position to decide for the consumer, as the policy notes, the incentives offered by hospitals for referrals is usually very high, thereby negating the assumption of an informed consumer choice even in the best of circumstances.[50]

There is little countervailing buying power (Section 19(4)(i)) in such conditions as well and this is best explained through *DLF* itself – a dominant developer was able to impose unfair one-sided conditions onto thousands of prospective buyers. The latter was essentially reduced to the role of mere "*price-takers*"[51] and did not have any negotiating power with the enterprise.[52] The situation is much more dire in our paradigm example of a health emergency.[53] A cost-benefit analysis done in light of social obligations and social costs (Section 19(4)(k)) would reveal that allowing the enterprise to remain dominant does not serve any long-lasting benefits of efficiency or scalability, as the lack of both in the overall healthcare delivery system itself may render it dominant.

A. DOMINANCE IN THE AFTERMARKET

[49] Mukesh Rawat, *Just before 2nd Covid wave hit India, ICU beds decreased by 46%, oxygen ones by 36%,* INDIA TODAY (May 3, 2021, 4:10 PM), https://www.indiatoday.in/coronavirus-outbreak/story/just-before-2nd-covid-wave-hit-india-icu-beds-decreased-by-46-oxygen-ones-by-36-1796830-2021-05-03 ("**Rawat**").
[50] Michael Porter & Elizabeth Teisberg, *Redefining Competition in Health Care*, HARV. BUS. REV. (2006), https://hbr.org/2004/06/redefining-competition-in-health-care.
[51] *DLF*, *supra* note 41, at ¶ 12.75.
[52] ROY, *supra* note 11.
[53] Rawat, *supra* note 49.

Dominance could also be established through its analysis in the aftermarket/secondary market. *Shri Shamsher Kataria v. Honda Siel Cars India Ltd. [hereinafter* "***Automobile Spare Parts***"][54] is perhaps the most illuminating Indian case. Here, there was a lack of availability of spare parts (for cars already sold in the primary market) in the open market, and those available with the authorized sellers were priced highly. The Original Equipment Suppliers which would supply the parts were prohibited to sell in the open market and had to supply to the authorized Original Equipment Manufacturers only. The CCI held that even if the brand is not dominant in the primary market, such actions can render it so in the secondary market. There was a lock-in effect[55] on the customers, who had no option but to heed to the monopoly of the OP as per Section 19(4)(g), where "*monopoly or dominant position whether acquired as a result of any statute or by virtue of being a Government company or a public sector undertaking or otherwise*" is evident of a dominant position. Here, a monopoly over operations in the secondary market was obtained by virtue of the OP's initial agreement with the consumers in the primary market for the sale of automobiles.[56]

This ratio is based on the landmark judgment of the US Supreme Court in *Eastman Kodak Company v. Image Technical Services Inc.*,[57] where Kodak stopped supplying spare parts to its previous agents and asked the

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[54] Shri Shamsher Kataria v. Honda Siel Cars India Ltd, Case No. 03/2011 (CCI). ("***Automobile Spare Parts***")
[55] Laure Schulz, *The Economics of Aftermarkets,* 6 J. EUR. COMPETITION L. & PRAC. 123, 123 (2015).
[56] *See DLF*, *supra* note 41, at R. Prasad Member (Supplementary) ¶ 4.
[57] Eastman Kodak Company v. Image Technical Services Inc, 504 U.S. 451 (1992).

customers to approach the company itself for any after-services, thereby limiting its maintenance and repair services in the aftermarket. The majority opined that while there was no dominance in the primary market, customers were "*locked-in*" the secondary market after initial purchase, with "*switching and information costs*" being "*sufficiently high to expose a number of consumers to exploitation.*"[58] The monopoly obtained by the enterprise in the secondary market cannot be offset by its position in the primary seller market, thus legitimizing the former as the relevant market for antitrust analysis.

Therefore, such a monopoly obtained in the secondary market becomes the relevant market for establishing abuse of dominance. This form of lock-in effect has been observed, along with the delineation of a new relevant market as the product/service's aftermarket. In a case concerning the National Stock Exchange,[59] removing the interface between two separately owned platforms to lock in and force consumers to move from one platform to another was held as abuse by a dominant enterprise. In another similar case,[60] OP (here, a movie theatre) denying consumers from bringing beverages from outside was held to be an abuse of dominance as the only option left was to buy highly marked up beverages offered by the OP. In the primary market, the consumer has a choice to

[58] *Id.* at 465-478.
[59] MCX Stock Exchange Ltd. v National Stock Exchange of India Ltd, 2011 SCC OnLine CCI 52.
[60] Cine Prakashakula Viniyoga Darula Sangham v. Hindustan Coca Cola Beverages Pvt. Ltd, Case No. 26/2011 (CCI).

approach a different establishment and hence the OP is not dominant, but once the consumer becomes privy to the OP, it exercised a dominant (monopoly) position in the secondary market of selling beverages.

In *Max Super-Speciality Hospital* too,[61] the CCI *prima facie* held that even if the hospital was not dominant in the primary market, there is a possibility of it abusing its dominance in the secondary markets of medicines. However quality control over products is an important factor to consider. If such products are required for urgent medical intervention, or requires a high degree quality control, it is reasonable for the enterprise to have monopoly control over it.[62]

Excessive pricing claims can be established nevertheless. But this still leaves many issues of abuses that do not fall under aftermarket dominance such as increased costs of hospital beds/rooms, diagnostic tests, and safety-wear such as PPE kits, all of which are intrinsic to the primary service provided. Another problem we run into is the estimation of dominance over time. While it is logically consistent to hold in the likes of *DLF*, dominance of an enterprise is usually acquired gradually over many years, and not in a "*in a transient moment in time*".[63] Here, the author seeks to establish how in times of distress, a position of dominance can be temporarily and immediately achieved by an enterprise.

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[61] *Max Super Speciality Hospital*, *supra* note 27, at ¶ 9.
[62] *Id.*
[63] *DLF*, *supra* note 41, at ¶ 12.82.

IV. ALTERNATIVE MODELS OF DOMINANCE

There is a need to further solidify our stance for establishing dominance of hospitals in the relevant market, and to prove that transient market power may also give rise to dominance. For this purpose, we turn towards EU Competition jurisprudence.

A. COLLECTIVE DOMINANCE

The concept of collective dominance offers one way in which dominance during exceptional times can be viewed. The behaviour of various enterprises, even if they do not hold sufficient market share individually may point to dominance as per Article 102 of the Treaty of Functioning of the European Union [*hereinafter* "**TFEU**"], where "*any abuse by one or more undertakings of a dominant position within the internal market or in a substantial part of it shall be prohibited.*"[64]

The words "*one or more undertakings*" remained contested for a while, with the EU Courts holding that such enterprises need to belong to a single group until the position was clarified in the *Italian Flat Glass*,[65] which held that:

> "*There is nothing, in principle, to prevent two or more independent economic entities from being, on a specific market, united by such economic links that, by virtue of that fact, together they hold a dominant position vis-à-vis the other operators on the same market.*

[64] Consolidated Version of the Treaty on the Functioning of the European Union art. 102, Oct. 26, 2012, 2012 O.J. (C326) 89.
[65] Cases- T-68/89, T-77/89 and T-78/89, Società Italiana Vetro SpA, Fabbrica Pisana SpA and PPG Vernante Pennitalia SpA v. Commission, 1992 E.C.R. II-01403.

> *This could be the case, for example, where two or more independent undertakings jointly have, through agreements or licences, a technological lead affording them the power to behave to an appreciable extent independently of their competitors, their customers, and ultimately of their consumers.*"[66]

This opened the doors to the idea that there might be a kind of "collusion" between different competitors that might not fall under any definitions of horizontal agreements as there is a lack of one, expressed or implied. The kind of "collusion" referred to here may be something as simple as following the price leadership or price signalling, which will not result in a reduction of prices to consumers as there is no incentive for enterprises to undercut each other. They have a common interest in maintaining the status quo and do so without entering into any form of agreement.

The price set by a single large (if not already dominant) private hospital can set the stage for other hospitals to similarly overcharge consumers (price leadership) due to the inelastic demand. Tacit price signalling can exist when there exists no agreement between two or more enterprises, but they are merely aware of each other's charges and have an incentive to charge non-competitive prices as they estimate that consumers

[66] *Id.* at ¶ 358.

will be willing to take up whatever price proposed.[67] In other words, they expect consumers to be *price-takers.*

This is explained best in *Airtours*[68] by the Court of First Instance in the EU-

> "*A collective dominant position significantly impeding effective competition in the common market or a substantial part of it may thus arise as the result of a concentration where, in view of the actual characteristics of the relevant market and of the alteration in its structure that the transaction would entail, the latter would make each member of the dominant oligopoly, as it becomes aware of common interests, consider it possible, economically rational, and hence preferable, to adopt on a lasting basis a common policy on the market with the aim of selling at above competitive prices, without having to enter into an agreement or resort to a concerted practice within the meaning of Article 81 EC* (now Article 101 of TFEU, similar to Section 3 of the Competition Act) *and without any actual or potential competitors, let alone customers or consumers, being able to react effectively.*"[69]

[67] ROBERT O'DONOGHUE & A JORGE PADILLA, THE LAW AND ECONOMICS OF ARTICLE 102 TFEU 168 (2d ed. 2013) ("**DONOGHUE & PADILLA**").
[68] Case- T-342/99, Airtours plc v. Commission, 2002 E.C.R. II-02585.
[69] *Id.* at ¶ 61.

A checklist for assessing collective dominance was also proposed here and improved upon in *MCI WorldCom/Sprint*,[70] where it was held that, for establishment of collective dominance either jointly (*i.e.*, a merger) or for undertakings (enterprises) acting independently, four criteria have to be fulfilled- (i) there must be incentives for such undertakings to engage in parallel behaviour; (ii) it must be easy to monitor each other's behaviour; (iii) there are disincentives for undertakings to deviate from parallel behaviour; and (iv) it is not possible for demand/consumer behaviour to constrain such behaviour. While these are not airtight conditions, the inability to prove countervailing buyer power as in (iv) is fatal to establishing such a position.

In our paradigm example, hospitals clearly have a reason to engage in such behaviour as the crisis offers them an opportunity to earn extraordinary profits, and hence there is a disincentive to lower their prices. Tracking each other's behaviour is also relatively easy, with the hospitals and hospital associations responding to the price caps imposed by state governments, combined propositions to provide leniency,[71] or simply

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[70] Case- COMP/M.1741-MCI, Commission Decision of 28 June 2000 declaring a concentration incompatible with the common market and the EEA Agreement art. 8(3), Regulation (EEC) No. 4064/89.

[71] Many private hospitals (especially small and medium enterprises) and their associations have passed resolutions and approached governments with regards to the unsustainability of price caps in the long run, and its adverse effects on sustaining their operations. *See* Ridhima Saxena & Thomas Tanya, *Citing losses, private hospitals want Maharashtra govt pricing caps rolled back*, MINT (May 04, 2020, 7:51 PM), https://www.livemint.com/companies/news/citing-losses-private-hospitals-want-maharashtra-govt-pricing-caps-rolled-back-11588601029043.html; Express News Service, *Private hospitals lay out terms as government stands firm on price cap,* NEW INDIAN EXPRESS (Jun. 19, 2020, 07:48 AM),

through publicly available information. And due to inelastic demand and the lack of any countervailing buyer power as in the previous section, hospitals are able to sustain such pricing – thus, fulfilling the most important condition.

An equally important tenant is that the previous establishment of dominant position of a single enterprise in a relevant market does not preclude the later establishment of collective dominance, as was held in *Almelo*.[72] This aligns with how competition can be affected by price leadership, where a dominant enterprise's supra-competitive prices can be endorsed by other enterprises in the market after the latter takes stock of the dire market conditions.[73] Such an analysis is required to ascertain the conduct of enterprises in extraordinary periods of stress and has been suggested for use in the EU as well, with the onset of COVID-19.[74] Therefore, the argument in the Competition Law Review Committee Report that collective dominance provisions in the EU are rarely enforced

https://www.newindianexpress.com/states/telangana/2020/jun/19/private-hospitals-lay-out-terms-as-government-stands-firm-on-price-cap-2158526.html; Shainu Mohan, *Private hospitals up in arms against Kerala government*, NEW INDIAN EXPRESS (May 17, 2021, 03:05 AM), https://www.newindianexpress.com/states/kerala/2021/may/17/pvt-hosps-up-in-arms-against-govt-2303415.html *&* K. Shiva Shanker, *Cap on COVID treatment charges impractical, insensitive,* THE HINDU (Jun. 27, 2021, 07:26 PM), https://www.thehindu.com/news/cities/Hyderabad/cap-on-covid-treatment-charges-impractical-insensitive/article35003648.ece.

[72] Case C-393/92, Municipality of Almelo and others v. NV Energiebedrijf Ijsselmij, 1994 E.C.R. I-01477.

[73] ANTONIO BAVASSO, COMMUNICATIONS IN EU ANTITRUST LAW: MARKET POWER AND PUBLIC INTEREST 163 – 220 (Kluwer Law International 2003).

[74] Giosa, *infra* note 80.

and are not in the European Commission's enforcement priorities falls short.[75]

Similarly, the argument in the Report that there is no need for such a provision in India due to the presence of Section 3(3) does not completely grasp the relevance of collective dominance. Under Section 3, horizontal agreements have to be proven beyond a doubt and are per se violations. As was made certain in *Rajasthan Cylinders and Containers v. Union of India,*[76] mere evidence of parallel pricing is not enough to prove cartelization. Additional evidence (although circumstantial) that makes it very probable is *sine qua non*.

However, in collective dominance there is no such high burden of proof, and the entire market structure is analysed to see if independent enterprises have the capacity to act in such a manner. It is important to note that such a position by itself does not mean abuse, as there is no such presumption. A burden of proof has to be discharged by the competition authorities in showing that lack of counter-vailing buyer power allows for this, followed by proof of abuse. Hence it precludes a Type I error of overregulation as in cases such as *Rajasthan Cylinders and Containers v. Union of India* itself, where an analysis of the market structure would reveal that the sellers tried to match prices to remain in competition in an oligopsony, where there are very few concentrated buyers with disproportionate buying

[75] Competition Law Review Committee, *Report of Competition Law Review Committee*, MINISTRY OF CORPORATE AFFAIRS (2019).
[76] Rajasthan Cylinders and Containers Ltd. v. Union of India, 2018 SCC OnLine SC 1718.

power. This goes against the most important condition for establishing collective dominance.

In order to deal with unprecedented scenarios as COVID-19 pandemic, it is apt to amend the Act by adopting the wording that was proposed in the 2012 amendment, where the new Section 4(1) would read as "*[n]o enterprise or group shall abuse,* jointly or singly *its dominant position*"[77]. This can help overturn the various cases in which the CCI has held that collective dominance is not recognized in Indian competition jurisprudence.[78] This also shows a better understanding of economics in the manner described below. While classical thought righty holds that when enterprises charge excessively, other competitors emerge; considering the skewed market structure, urgency of (inelastic) consumer need, barriers and time taken for entry of new players,[79] it is reasonable to see why the lacuna in the market for affordable services is not filled up immediately.

B. RELATIVE DOMINANCE

While dominance usually has to be observed throughout a certain period of time, competition law experts such as Penelope Giosa[80] have proposed the adaption of the concept of relative dominance (economic

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[77] The Competition (Amendment) Bill, 2012, Bill no. 136 of Parliament, § 4 (India) (Dec. 10, 2012).
[78] Neeraj Malhotra v. Deutsche Post Bank Home Finance, 2010 SCC OnLine CCI 28. *See also* Shri Sonam Sharma v. Apple Inc. USA & Ors., 2013 CompLR 346 (CCI).
[79] Competition Act, 2002, No.12, Acts of Parliament, 2003, § 19(4)(h) (India).
[80] Penelope Giosa, *Exploitative Pricing in the Time of Coronavirus – The Response of EU Competition Law and the Prospect of Price Regulation,* 11 J. EUR. COMPETITION L. & PRAC. 499, 499 (2020) ("**Giosa**").

dependence) as in the *ABG/Oil*,[81] to deal with the exceptional circumstances.

In this case, during the 1973 Oil Crisis, imports to countries such as the Netherlands reduced drastically up to 50 percent, and many suppliers of crude oil decreased production and increased prices substantially. ABG Oil, a buyer, alleged abuse of dominance by various multi-national oil supplier companies, when they did not equitably distribute the scare supplies, discriminated between it and other long-standing customers, and charged it extraordinarily high prices. While the charges of abuse were ultimately overturned on appeal in the European Court of Justice, the European Commission's initial interpretation of relative dominance was not. It was held that due to exceptional circumstances as the shortage of resources, the complete *economic dependence* of ABG Oil put the suppliers in a dominant position *relative* to it:

> "*Economic restrictions such as existed in the Netherlands during the oil crisis can substantially alter existing commercial relations between suppliers who have a substantial share of the market and quantities available and their customers. For reasons completely outside the control of the normal suppliers, their customers can become completely dependent on them for the supply of scarce products. Thus, while the*

[81] Commission Decision of 19 April 1977 relating to a proceeding under Article 86 of the EEC Treaty (IV/28.841 - ABG/Oil companies operating in the Netherlands) 77/327/EEC, 1977 O.J. (L 117) 1, 8.

> *situation continues, the suppliers are placed in a dominant position in respect of their normal customers.*"[82]

The market share of the supplier in question was 26 percent, which might not ordinarily result in the position of dominance. But with ABG Oil having no other supplier to rely on, the enterprise became *relatively* dominant to it.[83] This helps understand how even comparatively small players in a relevant product market can become a dominant crisis, as in Giosa's example of local producers of masks and sanitisers suddenly finding themselves in the position of dominance, which allows them to charge excessively.[84]

There is nothing in Section 4 of the Act that prevents such an interpretation during extraordinary times. The criteria for inquiry into dominance under Section 19(4)(b) and 19(4)(f) – "*size and resource of the enterprise*" and "*dependence of consumers on the enterprise*", respectively – further support it. Excessive charging in hospitals in the relevant market for beds, diagnostic tests, medication, consumables, or PPE equipment can be looked into if it is in a dominant position *relative* to its consumers vying for scarce resources.

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[82] *Id.* at ¶ II(A).
[83] Pranvera Këllezi, *Abuse below the Threshold of Dominance? Market Power, Market Dominance, and Abuse of Economic Dependence, in* ABUSE OF DOMINANT POSITION: NEW INTERPRETATION, NEW ENFORCEMENT MECHANISMS? 77, 77 (Beatriz Conde et al. eds, 2008).
[84] Giosa, *supra* note 80, at 500.

Worries about overregulation can be offset by the fact that this interpretation was not accepted under normal conditions in EU jurisprudence. Such was the decision in *Metro*,[85] wherein a market share of 10 percent was held not indicative of dominance, unless under exceptional circumstances. Therefore, a similar interpretation in Indian competition jurisprudence would not be completely unfounded. At times of exceptional strain on healthcare infrastructure, it is quite easy to see how certain enterprises can become *relatively* dominant to their consumers, with their continued *dependence* resulting in exploitation.

V. ESTABLISHING ABUSE OF DOMINANCE

Any potential abuses are bound to fall within either Section 4(2)(a)(i) and (ii), *i.e.*, "*imposition of unfair conditions in purchase or sale*" and "*unfair price in purchase or sale of goods and services*", respectively. While the former is easier to establish and has more precedence in Indian competition law, it has limited application in our example as was discussed in Part III.

Diagnostic tests cannot be said to be unfairly tied to the treatment provided, since it is intrinsic to the latter, and the hospital needs to exercise a high degree of control over it for utmost care. Specific medications to be given in exact dosages according to a doctor's estimates are also not unfairly tied.[86] The same is with the case of hospital bed/room charges and

[85] Case C-26/76, Metro SB-Großmärkte GmbH & Co. KG v. Commission, 1977 E.C.R. 1875.
[86] *Max Super Speciality Hospital*, *supra* note 27, at ¶ 11.

prescribed diet-specific consumables. This is comparable to the ruling in *Fx Enterprise Solutions India Pvt. Ltd v. Hyundai Motor India Limited*,[87] where cancellation of warranty if the consumer uses non-authorized CNG kits was held to be justified on quality concerns, as otherwise, the OP would have to bear the price of repairs arising out of usage of such lesser quality kits. Imposing the condition of buying only authorized CNG kits is then, only rational. This is why claiming a tie-up arrangement under Section 3(4) are bound to fail as well.

The only option that remains is establishing unfair/excessive pricing. While hospitals can claim quality control as a requirement to disprove unfair conditions even in relatively standardized products such as glucose solutions,[88] a charge of excessive pricing would be harder to disprove. However, the general reluctance to go ahead with excessive pricing cases in various jurisdictions such as India, the EU and the USA needs to be addressed.[89] The common assumption that overcharging would naturally induce competitors into the market, which helps it become self-regulating, does not find much evidence in nascent or undersaturated markets such as the healthcare industry in India. Both supply and demand side factors – high natural and legal barriers to entry[90] and excessive inelastic

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[87] Fx Enterprise Solutions India Pvt. Ltd v. Hyundai Motor India Limited, 2017 SCC OnLine CCI 26.

[88] Nina Bernstein, *How to Charge $546 for Six Liters of Saltwater,* N. Y. TIMES (Aug. 25, 2013), https://www.nytimes.com/2013/08/27/health/exploring-salines-secret-costs.html.

[89] Ariel Ezrachi & David Gilo, *Are Excessive Prices Really Self-Correcting?*, 5(2) J. COMPETITION L. & ECON. 249, 249 (2009) ("**Ezrachi & Gilo**").

[90] In addition to being a heavily capital intensive and high risk enterprise, compliance with at least 20 laws and regulations is to be expected depending upon the state. *See* Indian

demand for a limited set of readily available resources in a given geographical market – prove this hypothesis unlikely. Any new entrants, as rare as they may be, are likely to stay on the "*fringe*"[91], with a limited share of the local market, still allowing major market players to continue charging excessively. Even if the new entrants have an advantage of the scalability of operations resulting in the capture of a comparatively larger market share, it goes against the understanding of collective dominance where both the incumbent and new enterprises have an incentive to keep the prices high in the face of lack of countervailing buyer power.

Hence, strict adherence to this *laissez faire* principle resulting in the reluctance to investigate excessive pricing abuses can cause insurmountable harm. Holding that the goal of a National Competition Authority ought to be focused on preserving competition rather than serving the ends of consumer welfare would preclude observing the structural issues in the market that led to such abuses.

However, there have been some cases that expound how to assess excessive pricing as in the EU. In *General Motors Continental NV v. Commission*,[92] it was held that abuse would exist if a price excessive to the products economic value is charged;. This decision was furthered in *United*

Medical Association, *Clinical Establishment Act Standards for Hospital (LEVEL 1A 1B),* CLINICALESTABLISHMENTS.GOV.IN (Feb. 29, 2016, 01:36 PM), http://clinicalestablishments.gov.in/WriteReadData/147.pdf.

[91] Ezrachi & Gilo, *supra* note 89, at 255.

[92] Case C-26/75, General Motors Continental NV v. Commission, 1975 E.C.R. 1367.

Brands Company v. Commission[93] through a two-step test – (i) what is the profit margin, *i.e.*, if the difference between the costs of production and price charged in excessive?; and (ii) whether the price charged is unfair in nature by itself, compared to other competing products, or over time, or in reference to difference geographical markets (the same product by the dominant firm in a different geographical market)?

This was approved and followed through in later cases,[94] where it was reiterated that mere existence on an excessive price is not abuse in itself. It must be looked into if such a price is unfair by itself – unfair by virtue of the extreme profit margin (ranging from 2000 to 5000 percent in many pharmaceutical company cases)[95], unfair when compared to other (albeit imperfectly substitutable) products (such as with many branded drugs in comparison with generic drugs after the expiry of patents), unfair due to sudden change over time (such as with the cost of face masks before and after the pandemic),[96] or unfair due to excessive variance in the price charged in different geographical locations (prices charged for diagnostic

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[93] Case C-27/76, United Brands Company and United Brands Continental BV v. Commission, 1978 E.C.R. 207.

[94] Case C-226/84, British Leyland Public Limited Company v. Commission, 1985 E.C.R. 3300, 3300-3306. *See also* Case COMP/A.36.568/D3, Scandlines Sverige AB v. Port of Helsingborg, 4 C.M.L.R. 1298 (2006).

[95] *Such as the UK Competition and Markets Authority, which applied the principles in United Brand and held that a margin of 2600 percent is excessive in itself. See* Napp Pharmaceutical Holdings Limited v. Director General of Fair Trading, [2002] EWCA (Civ) 796.

[96] Press Trust of India, *Coronavirus scare grips India: Price of N95 mask shoots up to Rs 500, sanitiser shortage in stores*, THE ECONOMIC TIMES (Mar. 19, 2020, 10:25 AM), https://economictimes.indiatimes.com/magazines/panache/coronavirus-scare-grips-india-price-of-n95-mask-shoots-up-to-rs-500-sanitiser-shortage-in-stores/articleshow/74476650.cms?from=mdr.

testing).[97] Hence, in the *United Brands Company v. Commission* itself, although it was claimed that the price was excessive, in comparison with other competitors it was found to be a mere difference of seven percent and not unfair, precluding abuse. This was adapted in the *Automobile Spare Parts*,[98] where it was found that there was a mark-up of 100 to 5000 percent on the parts as sold to the consumer, which in accordance with the test is excessive pricing.

In our relevant markets, as consumers have devolved into *price-takers,* many private hospitals, for example, had charged excessively for the PPE kits used by their staff.[99] Patients were being charged flat rates of around Rs. 10,000 per day, which would be equivalent to around 27 kits per day, if charged at the wholesale price.[100] The central government's guidelines[101] on rational usage of protective equipment, as well as the FICCI's estimates[102] apportioned the requirement as 3 to 4 kits per patient,

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[97] Economic Survey, *infra* note 108.
[98] *Automobile Spare Parts*, *supra* note 54.
[99] Anjaya Anparthi, *Private hospitals violating government norms on PPE cost, number,* THE TIMES OF INDIA (Sep. 13, 2020, 11:01 AM), https://timesofindia.indiatimes.com/city/nagpur/pvt-hospitals-violating-govt-norms-on-ppe-cost-number/articleshow/78083016.cms.
[100] Anoo Bhuyan, *Higher fees in private hospitals for personal protective equipment; Shortage in government hospitals*, INDIA SPEND (Jun 12, 2020), https://www.indiaspend.com/ppe-priced-high-in-private-hospitals-while-public-hospitals-face-shortage/.
[101] Ministry of Health and Family Welfare, Directorate General of Health Services, *Guidelines on rational use of Personal Protective Equipment*, MOHFW.GOV.IN (Mar. 24, 2020, 04:58 PM) https://www.mohfw.gov.in/pdf/GuidelinesonrationaluseofPersonalProtectiveEquipment.pdf.
[102] Federation of Indian Chambers of Commerce & Industry (FICCI), *FICCI Representation for Costing of COVID-19 beds for Private Sector,* FICCI.IN (Jun. 4, 2020, 02:55 PM), https://www.indiaspend.com/wp-content/uploads/2020/06/FICCI-Representation-on-Costing-of-COVID-19-beds-in-private-sector.pdf.

taking into consideration the shared usage of kits for a given patient load of the entire hospital. Even before the onset of the pandemic, the National Pharmaceutical Pricing Authority found the charges of a single injection to be marked up by over a 1000 percent, from the wholesale price of Rs.13.64 to the hospital charge of Rs. 189.95.[103] Co-ordination with the National Pharmaceutical Pricing Authority would also reveal the markup in prices of scheduled drugs, which in many cases has resulted in excessive profiteering of hundreds of crores.[104] Efforts to charge above the coverage offered by insurance schemes, such as Ayushman Bharat, can also be seen as excessive pricing, with marking up costs of the requisite medicines and beds/hospital rooms,[105] further exacerbated during health emergencies. These are cases of excessive pricing *in itself*.

Additionally, while there has always been a high markup on diagnostic tests, with a variance of around a 1000 percent,[106] there has been

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[103] Priyanka Vora, *Private hospitals are inflating medical bills, says drug pricing authority*, SCROLL.IN (Feb. 20, 2018, 06:39 PM) https://scroll.in/latest/869412/new-drugs-being-made-to-avoid-price-controls-private-hospitals-overcharging-hugely-nppa-report.

[104] National Pharmaceutical Pricing Authority of India (NPPA), Ministry of Chemicals and Fertilizers, Government of India, *Year wise overcharging up to March 2021*, NPPAINDIA.IN https://www.nppaindia.nic.in/en/utilities/overcharging-status/year-2021/ (last updated Aug. 17, 2021).

[105] Kamala Thiagarajan, *Covid-19 exposes the high cost of India's reliance on private healthcare*, 370 BMJ 3506 (2020). *See also* Sunitha Rao R, *Hospitalisation is 6 times more expensive in private sector: Study,* THE TIMES OF INDIA (Jan. 1, 2020, 06:35 AM), https://timesofindia.indiatimes.com/city/bengaluru/hospitalisation-is-6-times-more-expensive-in-private-sector-study/articleshow/73052991.cms.

[106] Economic Survey 2018*, Over 1000% difference in medical test prices across cities: Will govt standardise rates?* THE ECONOMIC TIMES (Jan. 29, 2018, 05:11 PM), https://economictimes.indiatimes.com/wealth/personal-finance-news/over-1000-difference-in-medical-test-prices-across-cities-will-govt-standardise-rates/articleshow/62696175.cms ("**Economic Survey**").

a significant rise in the price of tests such as D-dimer, which are required for regular monitoring of COVID patients.[107] Extreme and sudden price hikes before and after the pandemic, as well as over different geographical locations such as in areas of high stress with a greater number of COVID cases than the national average are also hotspots for such abuses.[108] Along with the information available in the public domain, advocacy efforts[109] to spread awareness would help bring out even more incidents of such abuse.

However, the difficulties in reaching an aggregable methodology to determine excessive pricing have been highlighted in EU Competition jurisprudence,[110] and *HT Media Limited v. Super Cassettes Industries Limited*[111] in India. In this case, a radio station alleged that due to the dominant position of the OP (which had the licencing rights to the most popular music, without which radio stations found fewer listeners tuning in), they were able to levy an excessive price of Rs. 661 per needle hour of music, as compared to its competitors. It was also charging radio stations commitment charges of around 30-50 percent of the revenue arising out of

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[107] Gauttam, *supra* note 29.

[108] Ayshee Bhaduri, *Kerala, Maharashtra continue to top list of worst-hit Indian states,* HINDUSTAN TIMES (Aug. 10, 2021, 04:49 PM), https://www.hindustantimes.com/india-news/covid19-kerala-maharashtra-continue-to-top-list-of-worst-hit-indian-states-101628592618893.html.

[109] United Nations Conference on Trade and Development (UNCTAD), *Competition advocacy during and in the aftermath of the COVID-19 crisis*, TD/B/C.I/CLP/58 (April 28, 2021) available from https://unctad.org/system/files/official-document/ciclpd58_en.pdf ("**UNCTAD**").

[110] DONOGHUE & PADILLA, *supra* note 67.

[111] HT Media Limited v. Super Cassettes Industries Limited, 2014 SCC OnLine CCI 120.

playtime, irrespective of whether the former's music is played. The CCI noted that:

> "*[…] determining whether a price is excessive is an uncertain and difficult task. The opposite party has submitted that cost analysis for setting the license fee is not possible as the cost of a sound recording is reflected in the acquisition price paid as 'royalty' to the owners, whereas if the sound recording is developed in-house, the cost is categorized as 'recording expenses'. As against the said direct costs, the opposite party has various avenues for commercially exploiting the same and it is very difficult to apportion the cost of acquisition of sound recording to different revenue streams. Moreover, certain sound recording may be expensive to acquire but the music may turn out to be a flop, the reverse may also be true. Therefore, the value of a particular sound recording would depend upon its popularity and not its cost.*"[112]

Due to the difficulty in ascertaining the concrete costs incurred by the OP in the production and distribution of the music, along with a variation in cost depending upon the popularity of the music, the CCI held that excessive pricing could not be proved. While the kind of methodology to be used in ascertaining prices (such as whether a calculation of marginal costs, long-term average costs or so on, is appropriate, and whether the scalability of its operations and cross-subsidization must be considered)[113] is an issue that arises with manufacturers/producers charging excessive

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[112] *Id.* at ¶198.

[113] Alla Pozdnakova, *Excessive Pricing and the Prohibition of the Abuse of a Dominant Position under Article 82 EC,* 33 WORLD COMPETITION L. & ECON. REV. 117, 120 (2010).

prices, excessive pricing claims in hospitals as discussed above arise as a result of markup of prices brought from wholesalers/producers.

Therefore, since the means of production does not have to be looked into, apportioning the costs, and assessing how excessive and then unfair they are is relatively easier. This can be done taking into consideration the supply disruptions due to the onset of the pandemic,[114] and the additional wages given to a staff working in such precarious conditions as additional costs.[115] The task becomes even easier in cases where state governments supplied hospitals with the likes of ventilators and PPE kits.[116] While there is no benchmark on what can be held as excessive, taking into consideration the prevailing situation, markups that exceed the usual standards of overall profitability can be determined as abuse. In a majority of excessive pricing cases, the unfair profits ranging from hundreds to thousands of percent were held *ex facie* excessive.[117]

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[114] Anu Sharma et al., *COVID-19: Impact on Health Supply Chain and Lessons to Be Learnt*, 22 J. HEALTH MGMT. 248, 248 (2020).

[115] K. Shiva Shanker, *Corporate hospitals to pay more for COVID duties*, THE HINDU (Jul. 26, 2020, 8:22 AM) https://www.thehindu.com/news/national/telangana/corporate-hospitals-to-pay-more-for-covid-duties/article32194992.ece. *See also* Gulal Salil, *Junior doctors on Covid-19 duty are demanding better pay and work conditions*, SCROLL.IN (Jul. 20, 2021, 1:30 PM), https://scroll.in/article/1000080/junior-doctors-on-covid-19-duty-are-demanding-better-pay-and-work-conditions.

[116] Manoj More, *PCMC donates 35 ventilators to 7 top private hospitals*, THE INDIAN EXPRESS (Apr. 27, 2021, 12:31 AM), https://indianexpress.com/article/cities/pune/pcmc-to-donate-35-ventilators-to-top-private-hospitals-amid-rising-demand-7289667/. *See Also* Legal Correspondent, *10,300 PPE kits given to frontline workers daily,* THE HINDU (Jul. 30, 2020, 12:21 AM), https://www.thehindu.com/news/national/tamil-nadu/10300-ppe-kits-given-to-frontline-workers-daily/article32226082.ece.

[117] Giosa, *supra* note 80, at 504.

Now, onto the question of penalty. While the amount of penalty, directions to stop abusive behaviour, and power to pass compensation to the aggrieved under the residuary power of Section 27(g)[118] of the Act are obvious solutions, two issues arise – (i) it does not resolve the issues present with the market structure that allowed such abuse to take place; and (ii) it is a time-consuming process, much like the different alternatives consumers can pursue such as in consumer fora.

Firstly, the asymmetry of information that reduces the informed choice of the consumer must be remedied. In such crises, real-time approximation of charges per day in terms of differentiated hospital beds such as ICU oxygen and non-oxygen beds, ventilator beds, rooms, diagnostic tests (taking into consideration the past history of treatment of the patients), the wholesale or average prices at which the likes of PPE kits, saline solutions, syringes, medications and consumables are bought by the hospital, should be provided.

In cases where price leadership or signalling is being followed, or even differential but excessive prices are present, enterprises experience a downward pressure to cut prices or undercut each other, now that consumers have information to choose which hospital (as compared to services taken up by word of mouth or limited knowledge).[119] To a lesser

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[118] "*Orders by Commission after inquiry into agreements or abuse of dominant position.—Where after inquiry the Commission finds that any agreement referred to in section 3 or action of an enterprise in a dominant position, is in contravention of section 3 or section 4, as the case may be, it may pass all or any of the following orders, namely:—(g) pass such other order as it may deem fit.*"

[119] Id.

extent, it can help stabilize rates across different geographical locations as well. Various state governments already maintain databases for the number of vacancies in COVID-19 hospitals.[120] Through competition advocacy and policy efforts,[121] even without reference of a dispute to the CCI, such a system can be actualized.

Secondly, to keep up with the time constraint, motivating enterprises to set lower prices by making available the option of 'commitment decisions' as in the EU should be considered.[122] While not a perfect solution, and should not be used in more severe violations such as in cartelization cases, commitment decisions offer a mid-way between time-consuming litigation to take punitive measures and the need to immediately remove market distortions. Thus, this has been a recent trend in pharmaceuticals in the EU.[123] The European Commission gives the enterprise an option to "self-correct" deviant tactics used, which could otherwise be laid bare if the former continues the investigation. Legally binding undertakings to correct behaviour in exchange for a halt on

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[120] Various states such as Andhra Pradesh, Madhya Pradesh, Karnataka, Kerala Odisha, Meghalaya, Punjab, Rajasthan and so on keep such databases. E.g., Covid-19 Jagartha Hospital/CFLTC/CSLTC Dashboard, NATIONAL INFORMATICS CENTRE KERALA (2021) https://covid19jagratha.kerala.nic.in/home/addHospitalDashBoard (last visited Nov. 2, 2021).

[121] The Competition Act, 2002, No.12, Acts of Parliament, 2003 (India), § 49**.** *See also* UNCTAD, *supra* note 109.

[122] Giosa, *supra* note 80, at 505.

[123] Darach Connolly et al., *Learning the Lessons on Excessive Pricing from Aspen,* KLUWER COMPETITION LAW BLOG (Jun. 1, 2021, 06:10 PM), http://competitionlawblog.kluwercompetitionlaw.com/2021/06/01/learning-the-lessons-on-excessive-pricing-from-aspen/.

investigation takes place, while a violation or inadequacy of efforts to remove alleged behaviour can re-open litigation. Inclusion of collective jurisprudence would certainly be helpful here, as it can serve to bring under the CCI's purview, multiple instances of abuse in a geographical market.

The Competition (Amendment Bill), 2020[124] suggested an explicit inclusion of such commitment decisions into the Act, but the same is still possible by virtue of the aforementioned residuary power of the CCI in Section 27(g), as already upheld by the Madras High Court with regards to similar consent agreements such as settlements.[125] Both these measures also put to rest the worry of heavy-handed interference in the market as is with the case of price capping,[126] sustaining the principle of freedom of trade, and still protecting the interests of consumers.

VI. CONCLUSION

The COVID-19 pandemic has again brought to light, the various ways in which enterprises in healthcare delivery sector may abuse their dominant positions in LMIC markets. While countries with developed public-funded healthcare systems such as the UK and in the EU debate on the extent of competition to be permitted amongst publicly funded undertakings and the level of state aid that ought to be given without

[124] The Draft Competition (Amendment) Bill, 2020 (India), § 48B (Feb. 12, 2020).
[125] Tamil Nadu Film Exhibitors Association v. CCI & Ors, (2015) 2 Comp LR 420 (Mad).
[126] Murali Neelakantan, *Is Competition Law The Analgesic For The Indian Healthcare Sector?,* 27(2) NLSIR 157, 157-167 (2015).

distorting competition,[127] the need for better public healthcare infrastructure is felt in countries like India.

While competition law can offer behavioural (and to a limited extent, structural) remedies in such times of crises, it cannot fill the perennial gap left by inadequate public healthcare, even during non-emergency periods. There is an urgent need to increase resource spending, increase the efficiency and number of public healthcare centres, increase the doctor and nurse to population ratios and so forth.[128] To that extent, taking into consideration this limitation of India's healthcare delivery systems, an attempt has been made to harmonize the extraordinary circumstances of such health emergencies with existing national and international jurisprudence, and expand upon the role of CCI in correcting market distortions.

[127] Goddard, *supra* note 44.
[128] Anup Karan et al., *Size, composition and distribution of health workforce in India: why, and where to invest?*, 19 HUM. RESOURCES FOR HEALTH 39, 39 (2021).