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HOSPITAL CONSOLIDATIONS IN INDIA: IS THERE 'HEALTHY' COMPETITION?[+]

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ABSTRACT

*The authors believe that India needs its healthcare industry and specifically the hospital constituent, to grow multi-fold to ensure that all consumers have access to quality -driven yet affordable healthcare services. However, the increasing trends of acquisitions, horizontal and vertical mergers witnessed in the market for owning and/or operating hospitals in India cast a shadow on whether sufficient number of competitors would remain in the market to compete with each other for the end consumers be able to reap the benefits of healthy competition amongst the hospitals. These concerns are in line with the international trends in consolidation of hospitals, primarily in the United States ["**USA**"], where the competition agencies have attempted to block such consolidations on account of higher costs for consumers and coordination amongst competitors. Recently, similar apprehensions have been caste by the US President in his executive order highlighting the urgency to combat the perils of hospital consolidation. The authors, while relying upon international and domestic judicial precedents, have attempted to list the anti-competitive issues that may arise as a result of such consolidations along with suggestions that maybe curated and implemented.*

[+] The views presented in this paper are personal and do not in any manner represent the views of the Competition Commission of India (CCI).

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I. INTRODUCTION

Good Health is the greatest asset possessed by any human being. With the prolongation of the pandemic, the importance of receiving timely, effective and affordable healthcare across jurisdictions cannot be undermined. Niti Aayog, in its report on Investment Opportunities in India's Healthcare Sector, has highlighted "*In addition to these demographic and epidemiological trends, COVID-19 is likely to catalyse long-term changes in attitudes towards personal health and hygiene, health insurance, fitness and nutrition as well as health monitoring and medical check-ups. The pandemic has also accelerated the adoption of digital technologies, including telemedicine*". [30] Therefore, access to an affordable and holistic healthcare system in any situation is essential.

The Indian healthcare industry, comprising of hospitals, medical devices, clinical trials, outsourcing, telemedicine, medical tourism, health insurance, and medical equipment,[31] has been one of the largest contributors to the economy of the country, as it is expected to reach $372 billion in revenue by 2022[32]. With respect to the hospital constituent of the healthcare industry in India, it attracts 80% of the total healthcare market and is expected to reach $132 billion by 2023 from $61.8 billion in 2017.[33]

Recently during the pandemic, and otherwise, the Indian medical sector, in particular the hospital constituent has made great strides. However, the country still has an acute shortage of healthcare infrastructure, health human resources, and capacity to provide basic preventive, curative & rehabilitative healthcare services across the country, for ensuring that each citizen has access to affordable healthcare[34]. India currently has 1.3 hospital beds per 1,000 population, with an additional 3 million beds needed for India to achieve the target of 3 beds per 1,000 people by 2025.[35] There is also a shortage of health human resource, with only 0.65 physicians per 1,000 people, (the World Health Organisation standard is 1 per 1,000

[30] NITI Aayog, 'Investment Opportunities in India's Healthcare Sector' (2021) <https://www.niti.gov.in/sites/default/files/2021-03/InvestmentOpportunities_HealthcareSector_0.pdf> accessed 24 February, 2022.
[31] India Brand Equity Foundation, 'Healthcare' (2021) < https://www.ibef.org/download/Healthcare-November-2021.pdf> accessed 12 March 2022.
[32] Invest India, 'Healthcare – Industry Scenario' < https://www.investindia.gov.in/sector/healthcare> accessed 13 March 2022.
[33] ibid.
[34] Fifteenth Finance Commission, *A Report of High-Level Group on Health Sector*, Section 1 – Regulatory Framework.
[35] ibid 4.

people) and 1.3 nurses per 1,000 people[36]. In order to meet the international acceptable standards of healthcare, India will require another 1.54 million doctors and 2.4 million nurses.

Investment opportunities in the healthcare system are ripe to be picked at this stage. Recently, it has been reported that Max Healthcare Institute Ltd., India's second-largest hospital chain operator, plans to invest $450 million over the next four years as it gears up to add capacity after the country's health care system last year was overwhelmed by the Covid-19 pandemic.[37] Moreover, there are nearly 464 investment opportunities worth USD 25.17 billion in the hospital/medical infrastructure sub-sector on Indian Investment Grid (IIG), a platform maintained by Invest India for showcasing investment opportunities[38]. During the period of April 2000 – June 2021, the hospital and diagnostic centres constituent of the healthcare industry, has received $ 7.4 billion in the form of Foreign Direct Investment[39], largely through investors such as (i) venture capital/private equity funds, e.g., KKR & Co. and Temasek Holdings acquiring shareholding in Max Healthcare India Limited and Manipal Health Enterprise, respectively, or (ii) international healthcare providers such as IHH Berhad acquiring Fortis Healthcare Limited.

Therefore, it appears that there will be growing demand for investment in entities engaged in owning and/or operating hospitals in India, either in the form of mergers or acquisitions. The authors believe that enforcement and upholding of the principles of competition law is of utmost importance at this stage, as it will go on to ensure that India witnesses an equitable and sustainable growth in the hospital constituent of the healthcare sector for all the stakeholders involved, ranging from the enterprises operating the hospitals to the human resource involved in operations of the hospitals, and ultimately the consumer who will be the beneficiary.

This paper analyses the consolidation activity witnessed in the hospital market of US and the manner in which their competition agencies like the FTC have responded by either attempting to block the transactions or by issuing statements in the public domain. At the

[36] Demand Supply Gap, Sarwal R and others, *Investment Opportunities in India's Healthcare Sector,* (NITI Aayog, 2021)
[37] P R Sanjai 'Max Healthcare to invest $450 mn over next 4 years to double India capacity', (*Business Standard* January 18 2022) <https://www.business-standard.com/article/companies/max-healthcare-to-invest-450-mn-over-next-4-years-to-double-india-capacity-122011800720_1.html> accessed 18 March, 2022.
[38] India Investment Grid, 'Medical Infrastructure' <https://indiainvestmentgrid.gov.in/opportunities/nip-projects/social-infrastructure?subSector=129 > accessed 13 March, 2022.
[39] Invest India (n 32).

same time, the authors aim to holistically address the changes that may be observed with respect to the consolidation trends of the Indian hospitals, based on their categorization, either through private equity backed acquisitions or horizontal and vertical mergers, by determining the plausible theories of harm and how the CCI has responded to the initial few cases of hospital consolidation.

II. METHODS OF CONSOLIDATION IN THE HEALTHCARE SECTOR

A. Horizontal Mergers

Generally, a Horizontal Merger is a "*Merger between firms that produce and sell the same products, i.e., between competing firms. Horizontal mergers, if significant in size, can reduce competition in a market…*". [40]

Simply put, a horizontal merger would be the culmination of two firms that operate or function within the same sector or industry. For example, between Nike and Adidas or BMW and Mercedes, or Nescafe and Bru. Generally, the incentives for pursuing horizontal mergers are synergies, increased market power, economies of scale etc.

Horizontal Mergers as a method of consolidation, especially in the healthcare sector, can be lethal if the concentration of hospital consolidation remains unchecked. Hospital consolidations could lead to prominent specialist medical practitioners concentrated with one hospital (geographic area) or specialist medical facilities provided only by select hospitals. This means specialist healthcare facilities, established physician practise etc associated with a particular hospital will be monopolized at the cost of the patients. A study on healthcare consolidation had found that *"physicians in the most concentrated markets charged fees that were 14% to 30% higher than the fees charged in the least concentrated markets*".[17]

B. Vertical Mergers

Consolidation associated with vertical mergers means consolidation between firms operating at different levels of production. In the health care sector this could mean consolidation

[40] Organisation for economic co-operation and development, 'Glossary of Industrial Organisation Economics and Competition Law' < https://www.concurrences.com/IMG/pdf/oecd_-_glossary_of_industrial_organisation_economics_and_competition_law.pdf?39924/e9f9a49f59fa42b7de2397532968788aa2855447> accessed 10 March 2022.

between health care firms operating in different, yet associated product markets, such as insurers and physicians, insurers and hospitals, or hospitals and physicians[41].

There can be a cocktail of anti-competitive harms that can arise out of hospital mergers. However, it is the mergers that cement vertical integration at all levels of the supply chain that may cause immense harm to the end-consumers. Vertical Mergers in hospitals or associated services can lead to issues in the different levels of medical aid provided. Vertical mergers may be problematic if they *"discourage a company from entering the upstream or downstream market because, to compete successfully post-merger, the entrant would need to enter at both the upstream and downstream levels"*[42]. Keeping these issues in mind vertical merger enforcement in the United States "*has assumed a higher profile in recent years*[43].

There was a study conducted on highly concentrated hospital markets in California that found that *"an increase in the share of physicians in practices owned by a hospital was associated with a 12% increase in premiums for private plans sold in the state's Marketplace".*[20] Another study looking at Medicare beneficiaries' patterns of health care utilization found that "*patients are more likely to choose a high-cost, low-quality hospital when their physician is owned by that hospital."*[23]

C. Stealth Consolidation

Another form of solidification/reinforcing alliances is 'stealth consolidation' wherein minor acquisitions are made slowly and steadily over a few years. These acquisitions are too small to be captured by the regulatory radar and therefore miss antitrust scrutiny. "*Smaller transactions that fall below legal thresholds are exempt from the notification reporting requirement, meaning that many take place under the radar*"[44]. However, in the long run, these stealth acquisitions cumulatively build up a monopolist goliath which is very difficult to unscramble.

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[41] Haas-Wilson 'The Effects of Vertical Consolidation in Health Care Markets' <https://www.smith.edu/sites/default/files/media/Faculty/Haas-Wilson_Effects_of_Vertical_Consolidation_in_Health_Care_Markets.pdf> accessed 02 December 2022.

[42] Alexis J. Gilman and Akhil Sheth, 'Antitrust Analysis of Vertical Health Care Mergers' (Practical Law, April/May 2020) <https://www.crowell.com/files/20200401-Antitrust-Analysis-of-Vertical-HC-Mergers.pdf> accessed 12 March 2022.

[43] Lisl J. Dunlop & Cristina M. Fernandez, 'Navigating Vertical Mergers in Healthcare Through a Shifting Enforcement Landscape < https://www.competitionpolicyinternational.com/wp-content/uploads/2019/05/CPI-Dunlop-Fernandez.pdf > accessed 10 March 2022.

[44] Sarah Kuta, ''Stealth Consolidation' Is Leading to Kidney-Failure Deaths' (Chicago Booth Review , October 04, 2021) <https://www.chicagobooth.edu/review/stealth-consolidation-leading-kidney-failure-deaths> accessed 22 November 2022.

III. PARALLELS FROM CONSOLIDATION IN THE US HOSPITAL MARKET

A. Background

The authors have drawn reference to the hospital sector in the US, which has witnessed the primary antitrust enforcement authorities, i.e., the Federal Trade Commission ["**FTC**"] and the Department of Justice ["**DOJ**"], challenge several mergers involving hospitals when they were thought to be resulting in (i) higher costs for the consumers/patients without the corresponding improvement in the quality of care, or (ii) coordination between competing providers in any particular service or speciality[45].

The US had witnessed a wave of mergers among competing hospitals from the 1980s to the mid-1990s[46]. However, during the next few years, hospital merger enforcement was stalled due to a series of lost litigated hospital merger cases[47]. The lull experienced in appropriate enforcement may[48] "*have resulted in a number of hospital systems with substantial market power and in many highly concentrated hospital markets"*[49]. Further, "*Health care industry firms involved in merger activity often claim that consolidation will result in greater efficiency, lower costs, and more coordinated patient care. However, research shows that such efficiency often does not materialize; even when it does, savings are not passed on to consumer".*[50] "*In addition to consolidation between like firms—hospitals acquiring other hospitals or pharmacy chains merging together—the health care sector is also experiencing increased vertical consolidation, that is, integration among companies that provide different sets of services*"[51].

B. Private Equity Acquisitions in the US Healthcare Industry

Keeping up with the global trend, private equity funds have been leading the way in acquiring hospitals and physician practices as the US healthcare industry is approaching 20% of the gross domestic product and given the fragmented nature of many other sectors in the

[45] Marina Lao, Francine Lafontaine, and Debbie Feinstein, 'Not just an opinion: competition really is key to healthy health care markets' (Federal Trade Commission, July 8 2015) <https://www.ftc.gov/news-events/blogs/competition-matters/2015/07/not-just-opinion-competition-really-key-healthy-health> accessed 3 March 2022.
[46] ABA Section of Antitrust Law, Antitrust Health Care Handbook (4th Ed. 2010), 216.
[47] ibid 217.
[48] ibid 217.
[49] ibid 217.
[50] Emily Gee and Ethan Gurwitz, 'Provider Consolidation drives up Health Care Costs' < https://www.americanprogress.org/article/provider-consolidation-drives-health-care-costs > accessed 10 March, 2022.
[51] ibid.

economy. In the early 1990s, there were only a handful of private equity firms actively seeking healthcare services investments, vis– a–vis today when virtually all of the 4000 private equity funds in 2019 having an interest in healthcare services[52]. In 2018, the valuation of private equity deals in the US health care sector (spanning across all subsectors, from physician practices to retail health and mobile application companies) surpassed $100 billion—a twenty-fold increase from the year 2000, when it was less than $5 billion[53]. Gradually, the investments have shifted from hospitals to outpatient clinics and other specialty services such as where value-added services offer more lucrative cash flow.

The former commissioner of the FTC, Ravi Chopra in his statement had publicly expressed concerns regarding 'roll up transactions' consummated by private equity funds, through which they bolt smaller entities to the larger groups that they control. These median consideration of these transactions executed by the private equity funds are generally between $60 - $70 Million, thereby escaping the purview of the Hart – Scott – Rodino Antitrust Improvement Act. Presently, for transactions in excess of $ 101 million, a notification is required to be filed with the FTC.

With respect to the health care markets, it was specifically stated that private equity firms are actively acquiring physician practices, with a particular focus on specialties like anaesthesiology and emergency medicine[54]. In addition, concerns were also pointed out with respect to collateral consequences, such as surprise medical billing, thereby urging for rolling up transactions which result in higher costs and reduction of quality of care, to be halted[55].

Similarly, apprehensions have also been expressed in the US, about how within a matter of the last three decades, the share of independent dialysis facilities has shrunk drastically and only two national chains now own the majority of dialysis facilities, earning nearly all of the industry's revenue, with most of the rolling up acquisitions occurring below the aforementioned thresholds.[56]

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[52] Staff, 'Private Equity in the Healthcare Space: Transaction Trends and Lessons Learned' (Becker's Hospital Review, 26 April 2019) < https://www.beckershospitalreview.com/hospital-transactions-and-valuation/private-equity-in-the-healthcare-space-transaction-trends-lessons-learned.html > accessed 13 March 2022.
[53] ibid 15.
[54] Rohit Chopra, 'Regarding Private Equity Roll-ups and the Hart-Scott Rodino Annual Report to Congress Commission File No. P110014' (FTC, July 8, 2020) <https://www.ftc.gov/system/files/documents/public_statements/1577783/p110014hsrannualreportchoprastatement.pdf > accessed 10 March 2022.
[55] ibid.
[56] Statement of Commissioner Christine S. Wilson, Joined by Commissioner Rohit Chopra, Concerning Non-Reportable Hart-Scott-Rodino Act Filing 6(b) Orders, (FTC, February 11, 2020)

C. Worries raised about consolidation in the hospital market

The Executive Order recently issued by the US President pertaining to promoting competition in the American Economy, has opened a pandoras box by stating "*Hospital consolidation has left many areas, particularly rural communities, with inadequate or more expensive healthcare options*."[57] The aforesaid order carries great weight and signifies the thinking of the current administration in reigning on the harmful effects of monopolies and monopsonies in the healthcare markets including hospitals[58], albeit it does not have the force of law or regulation[59].

Additionally, support has been extended towards promoting existing price transparency initiatives for hospitals, along with any new price transparency initiatives or changes made necessary by the No Surprises Act.[60]

D. Prominent Case Laws of the US Jurisprudence

"Section 7 of the Clayton Antitrust Act of 1914 is the principal federal substantive law governing mergers, acquisitions, and joint ventures. Section 7 prohibits not only the acquisitions of "stock" but also the acquisitions of "assets" where "the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly[61].

The FTC devotes a substantial share of its resources to healthcare antitrust enforcement. During the fiscal years from 2016 – 2020, 21% of the FTC's competition enforcement actions were in the general healthcare sector (e.g., hospitals, physicians, etc.)[62].

In Hackensack Meridian Health, Inc./Englewood Healthcare Foundation[63] "*The Federal Trade Commission filed an administrative complaint and authorized a suit in federal court,*

<https://www.ftc.gov/system/files/documents/public_statements/1566385/statement_by_commissioners_wilson_and_chopra_re_hsr_6b.pdf> accessed 10 March 2022.

[57] The White House, 'Executive Order on Promoting Competition in the American Economy' (July 09 2021) <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/07/09/executive-order-on-promoting-competition-in-the-american-economy/ > accessed 7 March 2022.

[58] ibid.

[59] American Hospital Association, 'President Signs Executive Order to Promote Economic Competition', (July 09 2021) <https://www.aha.org/news/headline/2021-07-09-president-signs-executive-order-promote-economic-competition-provisions> accessed 7 March 2022.

[60] Invest India (n 32)

[61] Summary of Section 7 of The Clayton Act, AAI Public Interest Advocacy Workshop on Mergers, The American Antitrust Institute <https://www.antitrustinstitute.org/wp-content/uploads/2018/09/Section-7.pdf> accessed 13 March 2022.

[62] Federal Trade Commission – Stats and Data 2020

[63] C-9399, FTC File No. 2010044 (administrative complaint filed December 3, 2020; federal complaint filed December 8, 2020; preliminary injunction granted August 4, 2021) <https://www.ftc.gov/newsevents/press-releases/2021/08/statement-ftc-office-public-affairs-director-lindsay-kryzak> accessed 13 March 2022.

to block Hackensack Meridian Health, Inc.'s proposed acquisition of Englewood Healthcare Foundation."[64] Hackensack Meridian Health was the largest healthcare system in New Jersey while Englewood was a non-profit independent hospital and healthcare network located in northern New Jersey, providing very similar services to Hackensack University Medical Centre[65]. If approved the merged healthcare system would control three of the six inpatient general acute care hospitals in Bergen County, New Jersey, eliminate close competition between Hackensack Meridian Health and Englewood in Bergen County and leave insurers with few alternatives for inpatient general acute care services. If such a merger would be allowed, Hackensack Meridian Health would be able to demand higher rates from insurers for the combined entity's services, which, in turn, may lead to higher insurance premiums etc.[66] On August 4, 2021, the U.S. District Court for the District of New Jersey issued a preliminary injunction, halting the transaction pending an administrative proceeding.[67] The hospitals appealed to the Third Circuit.

The opinion of the Third Circuit affirmed the decision of the district court on the grounds that he the post-merger HHI (a economic yardstick to measure concentration) would be 2,835—a number that crosses the highly concentrated market threshold. The District Court correctly concluded that these numbers demonstrate the merger is presumptively anticompetitive. the modest quality improvements and upgrades likely to occur because of this merger, were not significant enough and was likely to substantially lessen competition.

In Methodist Le Bonheur Healthcare/Tenet Healthcare Corporation[68] "the Federal Trade Commission filed an administrative complaint, and authorized a suit in federal court, to block the proposed $350 million acquisition by Memphis-based Methodist Le Bonheur Healthcare of two Memphis-area hospitals, known as Saint Francis, from Dallas-based healthcare system Tenet Healthcare Corporation"[69]. The issue was that the "proposed acquisition would substantially lessen competition in the Memphis area for a broad range of inpatient medical and surgical diagnostic and treatment services that require an overnight hospital stay, known as inpatient general acute care services, sold to commercial insurers and their insured

[64] ibid.
[65] ibid.
[66] ibid.
[67] ibid.
[68] C-9396, FTC File No. 1910189 (complaint filed November 13, 2020; complaint dismissed December 29, 2020) <https://www.ftc.gov/news-events/press-releases/2020/11/ftc-sues-block-proposed-acquisitiontwo-memphis-area-hospitals> accessed 13 March 2022.
[69] ibid.

members".[70] "The proposed acquisition would reduce the number of hospital systems providing general acute care services in the Memphis area to three, giving the combined health system an approximately 60 percent market share"[71]. According to the complaint, if the proposed acquisition was consummated, healthcare costs would rise, and the incentive to expand service offerings, invest in technology, improve access to care, and focus on quality of health care provided in the Memphis area would diminish. On December 23, 2020 Methodist and Saint Francis announced that they were abandoning the acquisition, of certain healthcare facilities, assets, and operating rights from Tenet and its subsidiaries and a joint motion was filed to dismiss the administrative complaint. The Commission granted this motion on December 29, 2020.[72]

In another case regarding US Healthcare OSF Healthcare System/Rockford Health System[73], the grievance was that OSF's proposed acquisition of Rockford Health System would reduce competition in two markets in the Rockford area i.e. general acute-care inpatient services, and primary care physician services. As a consequence, OSF would control 64% of general acute-care inpatient services in the Rockford area post-acquisition and OSF and Swedish American Health Systems would be the only significant competitors in this market. Cumulatively they would control more than 99% of the market for general acute-care services in the Rockford area[74]. During the evaluation it was noted that in the market for primary care physician services there are currently only three significant physician groups in the Rockford area[75]. Consequently, post the acquisition, OSF and Swedish American would control almost 60% of all primary care physician services. This presumably would have enabled OSF with a greater ability to leverage rates, imposing a significant financial burden on local employers and employees, either directly or through higher insurance premiums, co-pays and other out-of-pocket expenses. It was also stated that "the proposed acquisition would also increase the incentives and ability for the two remaining hospital systems in Rockford to engage in coordinated anticompetitive behaviour, including sharing confidential information, deferring competitive initiatives or aligning managed care contracting strategies.[76] Keeping these concerns in mind, the Complaint was dismissed after OSF abandoned the transaction. Anti-

[70] ibid.
[71] ibid.
[72] ibid.
[73] D-9349, FTC file No. 1110102 (complaint dismissed April 13, 2012) <https://www.ftc.gov/enforcement/cases-proceedings/111-0102/osfhealthcare-system-rockford-health-system-matter> accessed 12 March 2022.
[74] ibid.
[75] ibid.
[76] ibid.

competitive transactions like these are generally abandoned when there is a foresight of regulatory hurdles to overcome. The anti-trust approvals by the regulator act as a deterrent for unhealthy consolidation.

IV. TRENDS OF CONSOLIDATION IN THE INDIAN HOSPITAL MARKET

A. Categorization of Hospitals in India

As per the Associations of Healthcare Providers Indian (AHPI), there are approximately 68,000 hospitals (inclusive of public and private sector) operating across the country, which can be categorized as following:

(i) Hospitals owned and/or managed by doctor entrepreneurs, i.e., nursing homes, with less than 30 beds being close to 40,000;

(ii) hospitals with the number of beds between 30 – 100 beds being 25,000; and

(iii) tertiary care hospitals with the number of beds being over 100 amounting to 3,000. It is estimated that nearly 70% of these beds belong to the private sector hospitals[77].

With respect to competition assessment of combinations involving hospitals, the CCI has in its decisional practice[78] has classified hospitals on the basis of facilities and treatment offered by the hospitals, as (i) primary hospitals, i.e., serving as a first point of contact between individuals and the health system chain, wherein the treatment is generally delivered by single physician outpatient clinics and dispensaries providing basic medical and preventive healthcare facilities, (ii) Secondary hospitals which are the key healthcare facility for patients who are referred for further treatment in cases with greater complexity as compared to cases under primary care facility, (iii) tertiary level of the healthcare system involves higher complexity of cases that require strong diagnostics and clinical support systems, and (iv) quaternary healthcare involves highly advanced and complex procedures such as organ transplants. The approach of CCI in this regard mirrors that of the FTC which also follows a similar classification of healthcare services and then conducts the competition assessment of the consolidating hospitals, by defining the relevant product markets on the basis of overlapping healthcare services.

[77]Ruhi Khanduri, 'Will India save its hospitals before they save India?' (The Ken, 16th April, 2020) < https://the-ken.com/story/will-india-save-its-hospitals-before-they-save-india/> accessed on 10 March 2022.

[78] Order dated 08.01.2021 in Combination Registration No. C-2020/11/789 (*Manipal Health Enterprise Limited/Columbia Asia Hospitals Private Limited*).

In contrast, the CCI while dealing with an antitrust matter, as mentioned in the dissenting order of Shri Ramakant Kini v. Hiranandani Hospital[79], had relied upon the Guidelines of National Accreditation Board for Hospitals & Health Care Providers (**'NABH'**)[80], to conclude that super speciality hospitals are those which provide services such as Cardiology, Clinical Haematology, Clinical Pharmacology, Endocrinology, Immunology, Medical Gastroenterology, etc. A perusal of the aforementioned guidelines also suggests that the NABH then bifurcated services as being broad or super specialities and considered *inter alia* services such as General Medicine, Paediatrics, Dermatology to be in the former category.

B. Concerns faced by small hospitals

Markets such as Delhi NCR have witnessed hospitals chains namely Max Healthcare acquiring (i) Saket City Hospitals[81] and (ii) Pushpanjali Crosslay Hospital[82]. Otherwise, small category hospitals sign an operations-and-management (O&M) contract with a hospital and focus their entire attention on patients[83]. Such brand names can be leveraged for better buying power, negotiating with insurers and optimal utilisation of resources, as the hospitals with a large number of beds and many specialities across a large geography, are given preference by insurers[84].

C. M&A Activity of Indian Hospitals

Recently there has been a trend of healthcare consolidations[85] and the Indian healthcare is going through an unprecedented consolidation phase[86]. The total value of mergers and acquisitions in the hospital sector in the financial year 2018 – 2019 posted a record rise of 155 per cent, totalling Rs 7,615 crore — the highest in over five years — against Rs 2,991

[79] Dissenting Order by Member Geeta Gouri in Case No. 39 of 2012.
[80] Available on: https://www.nabh.co/international/pdf/ApplicationForm-Hospitals.pdf.
[81] Capital Market, 'Max Healthcare gains on hiking stake in subsidiary' (Business Standard, 16th March 2021) <https://www.business-standard.com/article/news-cm/max-healthcare-gains-on-hiking-stake-in-subsidiary-121031600208_1.html> accessed on 10 March 2022.
[82] Press Release, 'Max Healthcare to Acquire 76% Stake In NCR based Pushpanjali Crosslay Hospital For Rs 287 Cr.' (Max Healthcare, 13th January 2016) <https://www.maxindia.com/press-release/max-healthcare-to-acquire-76-stake-in-ncr-based-pushpanjali-crosslay-hospital-for-rs-287-cr/> accessed on 10 March 2022.
[83] Order dated 08.01.2021 (n 78).
[84] ibid.
[85] Consolidation in Healthcare (Business Today. In, 18 April, 2021) <https://www.businesstoday.in/magazine/industry/story/consolidation-in-healthcare-292227-2021-03-31> accessed 10 March 2022.
[86] ibid.

crore in financial year 2018.[87] For instance, a prominent transaction has resulted in the creation of the large hospital chain in India with a combined strength of hospitals in several cities.

D. Private Equity Acquisitions in the Indian Hospital Industry

India recently witnessed its largest private equity acquisition in the healthcare industry with Radiant Life Care Private Limited, backed by the private equity goliath KKR & Co., acquiring Max Healthcare Institute Limited, and gaining control of marquee hospitals like BLK Hospital and Max Hospital, Saket in geographic markets like Delhi NCR along with a chain of several smaller hospitals spread across the region. It had been proposed that the aforementioned marquee hospitals as hubs will encompass 16 hospitals centred in NCR. About five of these would be hubs or sizeable tertiary care hospitals with average revenue per operational bed of over INR 50,000 and the rest would make the spokes with average revenue of about Rs 30,000.[88]

Another global private equity giant, i.e., TPG Growth has also floated an investment vehicle valued at INR 1,800-2,000 crore, with 30 – 35% of the investment amount to be invested by Canadian pension fund *Caisse de dépôt et placement du Québec* (CDPQ), Singapore's sovereign fund *Temasek Holdings Pvt. Ltd* and American PE fund *Warburg Pincus LLC*. [89]

E. Prominent Case Laws of the Indian Jurisprudence

The CCI in its order of *Radiant Life Care Private Limited, Kayak Investments Holding Pte. Limited, Max Healthcare Institute Limited and Max India Limited*[90] [involving (i) KKR Group through its affiliate, (ii) Radiant Life Care which operates hospitals in Delhi and Mumbai, (iii) Max Healthcare which then ran a network of 14 hospitals in Delhi NCR, Mohali, Dehradun and Bhatinda], had considered the participants in the market for provision of healthcare services through hospitals to include corporate hospitals, standalone private multi – specialty hospitals, private/semi private beds of trust/autonomous hospitals, and

[87] Himani Chandana, 'Fortis, Max, Medanta — Why private Indian hospitals are selling out to foreign players' (The Print, 1st July, 2019) < https://theprint.in/economy/this-is-why-private-indian-hospitals-are-selling-out-to-foreign-players/255874/ > accessed on 10th March 2022.
[88] Ruhi Khanduri, 'KKR's divide-and-rule vision for Max after Radiant merger' (The Ken, 4th November, 2019), <https://the-ken.com/story/kkr-radiant-max-hospital/#:~:text=The%20KKR%20empire%20grows&text=In%20December%20last%20year%2C%20Max,from%2012%25%20to%207%25.> accessed on 10 March 2022.
[89] Reghu Balakrishnan, 'Temasek, Warburg, CDPQ eye stake in TPG's Asia Healthcare' (LiveMint, 28th November, 2017) <https://www.livemint.com/Companies/amUdfvyA6Z8b28G9WrPrzM/Temasek-Warburg-CDPQ-eye-stake-in-TPGs-Asia-Healthcare.html> accessed on 10 March 2022.
[90] Order dated 29.10.2018 in Combination Registration No. C-2019/01/629.

excluding smaller hospitals and nursing homes (fewer than 100 beds) in the geographic market of Delhi and Delhi NCR.

The competition assessment had been carried out on the basis of (i) total number of hospitals, total number of relevant operational beds and, for the broad market of hospital infrastructure; and (ii) number of procedures conducted for (a) secondary, tertiary procedures pertaining to cardiac care, neurosciences, orthopaedics, renal sciences and oncology) and (b) quaternary procedures separately, e.g., organ and tissue transplants.

Vertical overlaps involved (i) Panasonic Healthcare Co. Ltd., a seller of healthcare devices and services in the form of in vitro diagnostic devices and life science devices and services, in the position to sell its devices and services to the hospitals forming a part of the combined entity; and (ii) Max Labs providing diagnostic services to the hospitals of the combined entity. However, these overlaps were deemed to be insignificant to cause any adverse effect on the competition in the relevant market, specifically for the latter as Max Labs faced formidable competition from SRL Diagnostics, Thyrocare, Dr Lal Pathlabs.

Accordingly, the CCI held that (i) at a broader level of hospital infrastructure, the parties to the combination will not gain significantly, (ii) for the secondary and tertiary procedures, the combined entity will face significant competitive pressure from other competing players such as Apollo Hospitals, Fortis, Medanta and Sir Gangaram Hospital; and (iii) with respect to the quaternary procedure, from a patient's perspective, the choice of a hospital is based on perceived expertise of the doctor and likelihood of success of the procedure, with patients willing to travel across the country for specific doctors.

Also, the CCI in its previous order of *Northern TK Venture Pte. Ltd./Fortis Healthcare Limited*[91] [involving (i) IHH, an international provider of integrated healthcare services operating in Malaysia, Singapore, Turkey and India; (ii) Fortis Healthcare owning and/or operating 35 healthcare facilities in 18 Indian cities], while following the same approach for the relevant product market, had considered the relevant geographic market to be (i) nation – wide for requiring complicated procedures (such as quaternary procedures) and (ii) Bengaluru, Chennai, Kolkata and Mumbai, for the tertiary hospitals.

Moreover, IHH through its subsidiary, i.e., Gleneagles Development Pte. Ltd. (GDPL) and Apollo Hospitals Enterprise Limited operated the Apollo Gleneagles Hospital in Kolkata, a

[91] Order dated 29.10.2018 in Combination Registration No. C-2018/09/601.

50:50 joint venture ["**JV**"] between them. Because, Apollo and Fortis were competing with each other at a national level, there were concerns regarding the JV becoming a platform for coordinated behaviour. The CCI had accepted the voluntary commitments of the Acquirer, Northern TK Venture Pte. Ltd, and the primary commitment was to ensure that the JV and the combined entity to be formed by acquisition of Fortis Healthcare, will operate as a separate, independent and competitive business. To ensure this, the Acquirer assured the CCI that (i) No common directors appointed by IHH / its subsidiary Gleneagles Development Pte. Ltd., on the Board of the JV and the Combined Entity; (ii) there will be no sharing of commercially sensitive information relating to pricing data and day to day operations through a 'rule of information control' approach; and (iii) submitting an annual certificate of compliance with the voluntary commitments to the CCI, supported by affidavits from an authorized Director of the Acquirer and the IHH / Gleneagles nominated Directors on the JV within 60 business days of the yearly anniversary of the date of receipt of the order of the CCI.

V. CONCERNS REGARDING PROFITEERING OF PRIVATE EQUITY FUNDS VIS – VIS HOSPITALS

Transactions involving private equity funds in the healthcare services sector have been gaining traction all across the world, with investments amounting to $79 billion in 2019, equivalent to 18 percent of private equity deals worldwide.[92] Private equity transactions, specifically those pertaining to hospital sector, have been viewed, as a force that are changing how the healthcare systems function, and these changes are happening under the radar. The discerning factors are the lack of transparency surrounding private equity investment in general, coupled with the obligation to protect the health and safety of populations[93].

To have a holistic understanding of how private equity funds are causing tectonic shift in the functioning of the hospitals, it is fundamental to comprehend the reasoning behind most of the investments of private equity funds in general. In the view of the authors, private equity funds generally follow two models for acquiring.

[92] Anaeze C. Offodile II, Marcelo Cerullo, Mohini Bindal, Jose Alejandro Rauh-Hain, and Vivian Ho,'Private Equity Investments In Health Care: An Overview Of Hospital And Health System Leveraged Buyouts, 2003–17' (2021) 40(5) <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01535> accessed 10 March 2022.

[93] Richard M. Scheffler, Laura M. Alexander and James R. Godwin,'Soaring private equity in the healthcare sector: Consolidation accelerated , competition undermined, and patients at risk' (2021) <https://publichealth.berkeley.edu/wp-content/uploads/2021/05/private-equity-i-healthcare-report-final.pdf>

Pursuant to this, the private equity funds may subsequently have the ability to exercise control over the target businesses (on the basis of material influence), i.e., (i) a mere investment into the holding company of the particular business and then endeavour to direct the operations in the capacity of a shareholder, or execute an operations agreement with the business for managing the operations on behalf of the promoters/holding company of the business, while collecting the management fee; and (ii) through the second route, the private equity funds also attempt to integrate the target business more closely with the other investee entities of its portfolio, e.g., asking the doctors of its investee hospital to direct patients for having tests done at diagnostic labs owned and/or operated by the same private equity fund[94].

In return the private equity fund managers receive a management fee equal to around two percent of the assets managed and also typically receive 20% of any return on capital above a certain threshold even though there is little of his/her own capital at risk but enjoys a large share of any profits.[95] The private equity funds have great appetite to invest as the liability of failure will squarely fall upon the investors of the private equity funds, i.e., limited partners such as sovereign funds and banks.[96]

Short – term revenue generation is the bedrock of the private equity investment business. Primarily, a private equity fund is always formed with a pre-determined expiration date. On that date, all of the money must be returned to the investors[97]. Therefore, the private equity funds invest in companies for an average of 4-7 years, with a goal of selling (or exiting) the investment at the end of that period for as much as possible[98].

VI. PLAUSIBLE THEORIES OF HARM

To evaluate and assess any kind of existing or perceived competitive harm for a defined market, it is constructive first to understand what we are up against. Therefore, formulating credible theories of harm will have to be to be encouraged and cultivated for a holistic evaluation of future novel challenges and for setting a reliable benchmark standard.

[94] Heather Perlberg, 'How Private Equity Is Ruining American Health Care', (Bloomberg Law, 21st May 2020), <https://www.bloomberg.com/news/features/2020-05-20/private-equity-is-ruining-health-care-covid-is-making-it-worse> accessed 10 March 2022.
[95] Richard M. Scheffler, Laura M. Alexander and James R. Godwin, 'Soaring Private Equity Investment In The Healthcare Sector: Consolidation Accelerated, Competition Undermined and Patients at Risk', <https://publichealth.berkeley.edu/wp-content/uploads/2021/06/AAI-Petris-Private-Equity-Healthcare-Report.pdf> accessed 10 March 2022.
[96] ibid.
[97] ibid.
[98] ibid.

Some of the theories of harm pursued by the US Agencies are (i) Foreclosure (input/customer)*: An "input foreclosure," could be "where an upstream merger partner either refuses to supply critical inputs to downstream rivals or supplies them only on disadvantageous terms"*[99]. An instance of *"customer foreclosure," could be "whereby the downstream firm refuses to purchase products from competitors of the upstream supplier, cutting off an important route to market for the upstream company's competitors."*[100] (ii) Barriers to entry[101]can arise when new competitors are unable to enter the market due to deliberate hindrances or roadblocks created to hinder the arrival of new competition. (iii) Exchange of Information that puts the Competitor at a disadvantage[102]: for instance, *"Where a merger could generate access to competitively sensitive business information of an upstream or downstream rival that was not previously available*."[103]

The possible theories of harm could be when a dominant hospital merges with an insurance company. In that situation, the rival insurance provider's health plan may be less attractive to prospective buyers. Further, rivals might have to pay more to be included.[104] This could force rival insurers to raise the premiums charged to consumers, or even allow the merged company to raise its insurance premiums. Another instance is if a hospital merges with a dominant insurer in a particular market. The merged company might then refuse to include rival hospitals in the merged insurer's network[105]. As a result, rival hospitals would be foreclosed from accessing[106] customers of the dominant insurer, driving those patients to seek care from the merged hospital.[107] Another theory of harm could be if a hospital plans to launch a health insurance plan, but instead merges[108] with an insurer. This merger may eliminate potential health plan competition in the area.[109]

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[99] Lisl J. Dunlop & Cristina M. Fernandez, 'Navigating Vertical Mergers in Healthcare Through a Shifting Enforcement Landscape' < https://www.competitionpolicyinternational.com/wp-content/uploads/2019/05/CPI-Dunlop-Fernandez.pdf > accessed 10 March 2022.
[100] ibid.
[101] Order dated 08.01.2021 (n 83).
[102] ibid.
[103] ibid.
[104] Alexis J. Gilman and Akhil Sheth, 'Antitrust Analysis of Vertical Health Care Mergers' (Practical Law, April/May 2020) <https://www.crowell.com/files/20200401-Antitrust-Analysis-of-Vertical-HC-Mergers.pdf> accessed 12 March 2022.
[105] ibid.
[106] Ruhi Khanduri (n 88).
[107] ibid.
[108] Alexis J. Gilman and Akhil Sheth, 'Antitrust Analysis of Vertical Health Care Mergers' (Practical Law, April/May 2020) <https://www.crowell.com/files/20200401-Antitrust-Analysis-of-Vertical-HC-Mergers.pdf> accessed 12 March 2022.
[109] ibid.

The plausibility of the leveraging theory of harm for a hospital merger is not farfetched. Leveraging can occur when an enterprise with market power in one market, leverages that advantage to catapult into another market and to capture it. By virtue of this advantage, the hospital will now be able to influence both the markets in its favour. This advantage can tilt the scales in favour of the ones with market power to venture into new markets and unchartered territories in the physical realm or digital space (telemedicine). Super hospital consolidations that also have presence in the pharmacy sector, medical equipment, insurance sector can leverage their advantage into those markets as well.

Further, the hospitals may also be able to capture the 'after sales' (dialysis patients'/post-surgery/patient retention/postnatal care) markets. These markets have a distinct characteristic of catering to vulnerable post-surgery patients who are either unable to take care of themselves or need regular medical assistance.

Another area of concern could be acquisitions of physician practise. Generally, physicians that have a good practise have a huge repeat patient clientele. Depending on the physicians' popularity, patients may even choose to travel far for medical attention. Therefore, when a hospital with considerable market power (by previous acquisitions) acquires a specific physician's practise' for its specialization or patients, associated network effects may also raises concern. It is very probable that the patients are also happy to move to the hospital where the physician relocates because of a sense of familiarity with the physician.

Interestingly, in the United States, the FTC in its statement regarding the complaint filed by them in order to block the merger of Lifespan Corporation and Care New England Health System had indicated towards the emerging situation of labour monopsony and stated that the loss of competition from mergers may be especially pernicious in the health care sector where skilled medical professionals are uniquely limited in employer options within their local geographic area, and increased employer labour market power via hospital mergers can contribute to wage stagnation for skilled health care professionals. A parallel could also be drawn with the recent landmark verdict given by the United States District Court for the District of Columbia in the favour of DOJ for blocking of the merger between Penguin Random House and Simon & Schuster[110], wherein it was held that the Big Five publishers offer significant advantages to the authors such as (i) offering advances upfront before publication: (ii) selling, publicity and marketing of the books. These benefits ensured that

[110] Memorandum Opinion in Civil Action No. 21-2886-FYP of the United States District Court for the District of Columbia.

authors would mostly give preference to the dominant publishers in order to increase their chances of a bigger and fatter advance payment along with royalties to be earned after the release of the book, rather than resorting to small publishers or self – publishing as the probability of the success of the book is drastically reduced. However, with the proposed merger of these mammoth publishing houses, the authors would no longer receive the advances that they had in the past, as a result of the publishing houses now stopping to compete with each other.

The CCI in its orders regarding the hospital mergers has also recognized the role that doctors have to play as from a patient's perspective, the choice of a hospital is based on perceived expertise of the doctor and likelihood of success of the procedure. Further, for quaternary procedures such as organ transplants, patients are often willing to travel large distances across the country to get themselves treated by a "specific" doctor team. Therefore, instances of hospital consolidation will only increase the pressure on doctors in terms of the opportunities available to them and their increase in remuneration as the merging hospitals will look to cut down on costs.

Some of the other issues regarding "*Doctor-hospital nexus*", "*Compulsory tying of consumables*" and "*Compulsory tying of diagnostic services*" were highlighted in the Policy Note on Making Markets work for Affordable Healthcare by the CCI[111]. It states the consumers' choice of a hospital is often guided by a doctor's reference[112]. The policy note further highlights that hospitals often have exclusive arrangements with in-house pharmacies, diagnostic labs etc. and may provide multiple services in a bundle or a package. Such arrangements driven purely by efficiencies are reasonable but when guided by private interests of the healthcare providers, result in vitiating the market dynamics.[113] There are instances where the patient is forced to purchase consumables such as medicines, syringes etc. at printed MRP from the in-house pharmacy of the hospital when the same is available at significantly lower prices outside the hospital premises. It was also been observed that hospitals commonly reject even recent reports of diagnostic tests conducted outside the hospital and mandates repeat tests from their in-house diagnostic labs. Further with no

[111] Competition Commission of India, 'Policy Note on Making Markets work for Affordable Healthcare' (October 2018) <https://www.cci.gov.in/sites/default/files/POLICY_NOTE.pdf> accessed 18 March 2022.
[112] ibid.
[113] ibid.

regulatory framework that ensures and governs portability of patient data, the switching cost for a patient becomes high.[114]

Recently it has been reported, that Max Healthcare, Fortis Healthcare and Apollo Hospitals, which run hospitals in the National Capital Region, received notices from CCI asking them to furnish details on the pharmacies, vendors and companies from which they procure their bestselling drugs and medical devices[115]. Apparently, this CCI investigation is the first such action against the high out-of-pocket prices of medicines set by hospitals, which operate unencumbered by regulation. The CCI scrutiny could potentially rein in the prices of medicines and healthcare equipment. or at the very least, bring in transparency in the way hospitals sell these items[116].

VII. POTENTIAL EFFICIENCIES

The authors 'don't suggest that all consolidations in the hospital sector are harmful *per se*. For instance, the failing firm theory can be cultivated where a weak competitor[117] may be absorbed/consolidated if its exit does not impact the market. "*Efficiencies that are frequently identified and considered in vertical merger analysis include: Elimination of double marginalization[118], New and better services and products, aligned incentives and Increased incentive to Invest*"[119]. Some hospital mergers may also lead to the end consumer paying less insurance premiums. Post-merger efficiencies can also take the form of expert know-how and coordinated care for the patients and better allocation of the available resources. Efficiencies may also include lower cost of equipment, devices and consumables.

A substantial positive impact of investments by private equity funds is the creation of the necessary healthcare infrastructure. With respect to the Indian healthcare sector, investments beyond the metropolitan areas are the need of the hour and are urgently required to expand

[114] ibid.
[115] Binoy Prabhakar, 'Big hospital chains face CCI scrutiny over inflated prices of medicines and medical devices' (Moneycontrol, 1st April 2022) <https://www.moneycontrol.com/news/business/hospitals-face-cci-scrutiny-over-high-prices-of-medicine-and-medical-devices-8304261.html> accessed 04 April 2022.
[116] ibid.
[117] Scott & White Healthcare/King's Daughters Hospital, FTC File No. 0910084 (investigation closed December 23, 2009) (https://www.ftc.gov/public-statements/2009/12/ftcs-closure-itsinvestigation-consummated-hospital-merger-temple-texas).
[118] Double marginalization arises when both the upstream and downstream markets exhibit some degree of economic market power, and thus firms at each level mark up their prices above marginal cost.
[119] Scott & White Healthcare/King's Daughters Hospital, FTC File No. 0910084 (investigation closed December 23, 2009) (https://www.ftc.gov/public-statements/2009/12/ftcs-closure-itsinvestigation-consummated-hospital-merger-temple-texas).

access to healthcare.[120] This will lead to help raise the standards and quality of healthcare, upgrade technology and create employment opportunities, with potential benefits to the economy.[121]

VIII. WAY FORWARD AND THE ROLE OF THE REGULATOR

While privately owned hospitals in India may have managed to provide healthcare/speciality services at a fraction of the cost of the developed world, the consolidation pattern is indeed a worrying sign of the times to come, as the hospital chains will stand to gain market power which could potentially cause harm to not only the end consumers but also the enterprises/persons involved in providing the services, i.e., (i) the staff at the hospitals including doctors, nurses; (ii) the enterprises manufacturing/supplying the equipment and services engaged for provision of healthcare services; and (iii) the insurance providers. At this point, it may be noted that CCI must include these factors as well, when conducting the competition assessment of combinations involving hospitals, as the aforementioned stakeholders too are equally affect by any AAEC that may potentially arise from such combinations. The perils of the labour monopsony situation have been greatly highlighted in the recent past, and the CCI too has recognized the importance of the doctors and their success as a key component for the patients to decide their choice of hospital.

The recent trend of private equity investments, as observed in India and elsewhere, also present a unique challenge to competition agencies such as the CCI, as the private equity funds may end up using commercially sensitive information obtained from the hospitals, with the purpose of coordinating with their other investee entities, leading to harming not only the consumers but also the competitors.

In its limited exposure towards combination filings received in relation to hospital consolidation, the CCI has adopted the suitable mechanism for competition assessment, being in line with competition agencies of the developed jurisdictions such as the FTC. However, it is the shortcomings in the healthcare sector observed by the likes of agencies including the FTC which the CCI needs to pay attention to, in order to ensure that the provisions of the relevant legislations and the competition policy at large, are well suited to deal with the

[120] Raghuram Bommaraju, Ratna Geetika and D V R Seshadri, 'Private equity in healthcare a blessing or bane?', (The New Indian Express, 30th July 2021), <https://www.newindianexpress.com/opinions/columns/2021/jul/30/private-equity-in-healthcare-a-blessing-or-bane-2337390.html > accessed 10 March 2022.
[121] ibid.

plausible theories of harm that may arise in pattern with the consolidation of hospitals as observed by the USA. The authors strongly believe that the USA is the perfect jurisdiction to rely upon as the hospitals there operate in a for – profit manner and India too will have to grow in the same direction for all of its citizens to receive similar standards of the quality of healthcare.

As a good confidence building measure, the CCI may initiate conducting a market study or roundtable on the healthcare sector with the specific focus on hospitals and their relationship with the doctors, insurance providers and manufacturers/suppliers of equipment. This will assist the CCI in understanding how the relevant stakeholders in such combinations, are firstly affected and what they expect from the CCI in order to protect their interests, thereby allowing them to negotiate with the hospitals, without having to compromise their business in an unreasonable manner. The CCI also needs to conduct or commission a study to increase the public awareness of the interplay of regulations governing the medical fraternity, the medical device manufactures/suppliers and the Act, as the current lack of literature in India regarding these aspects leads to ambiguity in how certain actions of government/regulatory authorities across the country affects the competition of the healthcare sector.

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