Competition Commission Of India vs . Schott Glass India Pvt. Ltd & Anr., ... on 21 May, 2026

COMPETITION COMMISSION OF INDIA

Case No. 77(10) of 2015

In re:

Vivek Sharma — Informan

And

Indraprastha Medical Corporation Ltd. (Indraprastha Apollo Hospital), New Delhi — Opposite Part

CORAM

Ms. Ravneet Kaur
Chairperson

Mr. Anil Agrawal
Member

Ms. Sweta Kakkad
Member

Mr. Deepak Anurag
Member

PRESENT

For Indraprastha Medical Corporation Ltd. (Indraprastha Apollo Hospital), New Delhi (Opposite Party) : Shri Sajan Poovayya, Senior Advocate along with Shri Harman Singh Sandhu, Ms. Manika Brar, Ms. Supritha Prodaturi, Shri Rahul Shukla, Shri Shivek Sahai Endlaw, Ms. Varalika Mendiratta and Ms. Raksha Agarwal, Advocates, and Mr. C P Tyagi, CFO, IAH and Shri Ankit Gupta, GM, IAH

ORDER

1. Information in Case No. 77 of 2015 was filed under Section 19(1)(a) of the Competition Act, 2002 (the 'Act') by Shri Vivek Sharma (the 'Informant'), against Becton Dickinson India (P) Ltd. and Max Super Specialty Hospital, Patparganj, Delhi ('Max Patparganj'), alleging contravention of the provisions of Section 3 and Section 4 of the Act.

2. The Informant, inter alia, alleged that Becton Dickinson India (P) Ltd., a manufacturer of disposable syringes, in collusion with Max Patparganj, a procurer of disposable syringes,

deliberately printed a higher Maximum Retail Price ('MRP') on the disposable syringes of Becton Dickinson India (P) Ltd. being sold at the in-house pharmacy of Max Patparganj, in comparison to the MRP printed on the same product of Becton Dickinson India (P) Ltd. being sold in the open market.

3. Based on such information, and after holding preliminary conference with the parties, the Commission, forming an opinion that there exists a prima facie case of contravention of the provisions of Section 4 of the Act by the 02 (two) alleged parties, passed an order dated 17.11.2015 under the provisions of Section 26(1) of the Act, directing the Director General ('DG') to cause an investigation to be made into the matter and submit a report.

4. Accordingly, the DG submitted its investigation report in confidential and public version. The Commission considered the investigation report submitted by the DG and vide order dated 31.10.2017, forwarded an electronic copy of public version of the same to the Informant, Becton Dickinson India (P) Ltd., Max Patparganj and 04 (four) individuals of Max Patparganj who were identified by the DG in the investigation report to be liable in terms of the provisions of Section 48 of the Act, giving them all an opportunity to file their suggestions/ objections, if any, to the investigation report. Further, the Commission directed Becton Dickinson India (P) Ltd. and Max Patparganj to furnish their audited balance sheets and profit and loss account/ turnover details for the last 03 (three) financial years ('FYs') i.e., 2014-15, 2015-16 and 2016-17 and the 04 (four) individuals to furnish their income details including Income Tax Returns ('ITRs') for the same FYs. Max Patparganj was also directed to furnish its audited revenue/ profit details arising from the business of provision of healthcare services/ facilities for the said FYs. Thereafter, the parties were heard on the investigation report on 26.04.2018.

5. Based on the observations and findings of the DG in the investigation report, and the submissions made by the parties on the same, the Commission, vide order dated 31.08.2018, observed that the allegation of the Informant that Becton Dickinson India (P) Ltd., in collusion with Max Patparganj, has printed a higher MRP on the disposable syringes to be sold in the in-house pharmacy of Max Patparganj in order to cheat the patients, has not been substantiated in the investigation report. It was reported by the DG that Max Patparganj and Becton Dickinson have not entered into any exclusive agreement with respect to supply of disposable syringes as Becton Dickinson supplies its blister pack disposable syringes to Max Patparganj through M/s Shobham Surgical Works and its flow wrap syringes through M/s Hindustan Surgicals. Thus, according to DG, Max Patparganj and Becton Dickinson have not contravened any of the provisions of Section 3(3) of the Act. The Commission confirmed the finding of the DG that these 02 (two) entities have not contravened any of the provisions of Section 3(3) of the Act.

6. However, the Commission also noted that the DG has considered the market for 'provision of healthcare services/ facilities by private super-specialty hospitals within a distance of about 12 kms from Max Super Specialty Hospital, Patparganj' as the relevant market and found Max Patparganj to be abusing its dominant position in the same. The Commission noted that the DG has observed that Max Patparganj is earning huge profit margins by sale of different syringes and also shifted its procurement/ purchase from flow wrap syringes to blister pack syringes. Further, Max Patparganj

was found by the DG to be compelling its in-patients to purchase products only from its in-house pharmacy once they are admitted to the hospital. As such, the DG had concluded that such conduct of Max Patparganj amounts to contravention of the provisions of Section 4(2)(a)(ii) of the Act.

7. In light of the above, the Commission observed from the investigation report that while there is a reference to the conduct of Max Patparganj being akin to 'aftermarket abuse'; however, the DG has not investigated/ analysed the same in greater detail. Accordingly, the Commission, vide order dated 31.08.2018, in terms of Regulation 20(6) of the erstwhile Competition Commission of India (General) Regulations, 2009 ('General Regulations, 2009'), directed the DG to cause a supplementary investigation to be made into the matter.

8. Accordingly, the DG submitted the supplementary investigation report - confidential version on 24.12.2021, identifying 12 (twelve) super-specialty hospitals of Delhi including Max Patparganj for the purposes of its investigation, based on 05 (five) parameters, framing 05 (five) issues in the matter and concluding on each of them, as follows:

> 8.1 Issue No. 1: Whether the investigated hospitals are 'enterprise' within the meaning of Section 2(h) of the Act?

DG's Finding: Since revenue model of the investigated super-specialty hospitals show that they are involved in carrying out commercial activities i.e., providing medical services to patients in lieu of monetary consideration, they are 'enterprise' within the meaning of the Act.

8.2 Issue No. 2: What is the relevant market?

DG's Finding: Barring one hospital i.e., St. Stephen's Hospital, Delhi, all other 11 (eleven) hospitals do not allow purchase of consumables, medical devices, medicines and medical tests from outside the hospital. Thus, from point of view of providing medical services to their in-patients, these hospitals are self-contained and independent from each other. Therefore, relevant product market was delineated in terms of "market for provision of healthcare services/ facilities for in-patients admitted to the respective private super specialty hospital" and the relevant geographic market was taken as "Delhi". As such, 12 (twelve) separate relevant markets on these grounds were defined by the DG.

8.3 Issue No. 3: Whether the investigated hospitals are dominant in the delineated relevant market?

DG's Finding: All 12 (twelve) investigated hospitals are independent markets in themselves and no other hospital exercises any influence on control of management or policies of such hospitals; therefore, each investigated hospital is dominant in its respective relevant market.

8.4 Issue No. 4: If the answer to Issue No. 3 is in affirmative, whether the conduct of investigated hospitals is in contravention of the provisions of Section 4 of the Act?

DG's Finding: The conduct of all 12 (twelve) investigated hospitals is found to be in contravention of the provisions of Section 4 of the Act from 2015 to 2018 on the following 05 (five) parameters:

> 8.4.1 Room Rent: The DG found that all 12 (twelve) hospitals charged more room rent than nearby 3-star and 4-star hotels as well as other nearby hospitals.
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> 8.4.2 Medical Tests: The DG compared prices for 13 (thirteen) routine medical tests charged by all 12 (twelve) hospitals with 04 (four) diagnostic labs viz. Dr. Lal Path Labs, Goyal MRI, Focus Imaging and House of Diagnostics ('H.O.D'), and found that for one or more tests, each hospital charged more price during some point of time between 2015 to 2018, than the 04 (four) diagnostic labs.
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> 8.4.3 Medical Devices:
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> (a) The DG analysed the prices charged by the hospitals for 02 (two) types of Stents Bare Metal Stents ('BMS') and Bioresorbable Vascular Scaffold ('BVS')/ Biodegradable Stents, Knee Implants (whose prices were fixed by National Pharmaceutical Pricing Authority ('NPPA') in 2017 and 2018) and Hip Implants as well as the prices charged for Knee and Hip Procedures by the hospitals and found that the prices charged by the hospitals for one or more of the same showed an increasing trend from 2015 to 2018.
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> (b) The DG also compared the prices charged by Dr. Lal PathLabs, Goyal MRI and Dr. Lal PathLabs for 02 (two) categories of X-Rays, 02 (two) categories of MRI and 02 (two) categories of Ultrasound respectively, with those charged by the OP, and found that for one or more of such tests, the hospital charged more price during some point of time between 2015 to 2018, than the respective diagnostic lab.

8.4.4 Consumables: The DG compared the procurement prices (at which hospital procured the consumables) and selling prices of 20 (twenty) specific consumables as well as of 20 (twenty) top consumables of each hospital in terms of volume and value and noted that significant profit margins were registered by all the 12 (twelve) hospitals for multiple consumables during 2015 to 2018.

8.4.5 Medicines: Similarly, the DG compared the procurement prices (at which hospital procured the medicines) and selling prices of 19 (nineteen) specific medicines as well as of 20 (twenty) top medicines of each hospital in terms of volume and value and noted that significant profit margins were registered by all the 12 (twelve) hospitals for multiple medicines during 2015 to 2018.

8.5 Issue No. 5: If the answer to Issue No. 4 is in affirmative, who are the individuals of these hospitals liable in terms of Section 48 of the Act for the anti-competitive conduct of the respective hospitals?

DG's Finding: The DG held several individuals of each hospital liable in terms of Section 48 of the Act.

9. Thereafter, the Commission received confidentiality requests under the then existing sub-regulation (10) of Regulation 35 of the erstwhile General Regulations, 2009 from multiple hospitals.

10. On 11.01.2022, the Commission considered the supplementary investigation report (confidential version) submitted by the DG and the confidentiality appeals received. The Commission, considering that no contravention of any of the provisions of the Act had been found to have been committed by Becton Dickinson India (P) Ltd. in the investigation report and that no supplementary investigation had been ordered against it, decided to delete Becton Dickinson India (P) Ltd. from the array of Opposite Parties in Case No. 77 of 2015. Further, noting that the DG, in the supplementary investigation report, had investigated 12 (twelve) super-specialty hospitals in Delhi and given a finding of contravention against them, the Commission decided to implead the 11 (eleven) other super-specialty hospitals as Opposite Parties in Case No. 77 of 2015, along with Max Patparganj as originally impleaded. Accordingly, the cause title of Case No. 77 of 2015 was amended.

11. Further, the Commission noted that the investigation conducted by the DG in respect of each of the 12 (twelve) hospitals was separate and independent, and accordingly, information and data pertaining to a hospital, would have no relation to the inquiry conducted vis-a-vis the other hospitals. As such, the Commission was of the view that no purpose would be served by sharing the information and data submitted before the DG by 01 (one) hospital, with the other hospitals. Accordingly, the Commission directed the DG to prepare and submit 12 (twelve) separate non-confidential qua each Opposite Party Reports and correspondingly 12 (twelve) separate Public Version Reports keeping in mind that in every non-confidential qua specific Opposite Party Report and Public Version thereof, all information and data pertaining to the remaining hospitals be redacted. It was made clear that for all intent and purposes, the present matter shall be treated as 12 (twelve) separate sub-cases and hearings of the parties also, at the appropriate time, shall take place separately and accordingly.

12. The DG accordingly, submitted 12 (twelve) non-confidential qua respective Opposite Party versions and 12 (twelve) public versions of the supplementary investigation report on 04.07.2022.

13. The Commission considered the supplementary investigation report(s) and vide order dated 12.07.2022, forwarded electronic copies of the respective non-confidential qua respective Opposite Party version(s) to the respective Opposite Party and public version qua Max Patparganj, to the Informant. The Commission gave an opportunity to the parties to file their suggestions/ objections, if any, to the supplementary investigation report, and also directed the 12 (twelve) Opposite Parties to file their audited Financial Statements including Balance Sheets and Profit & Loss Accounts for FYs 2018-19 to 2020-21.

14. In the meantime, Regulation 35 of the erstwhile General Regulations, 2009 stood amended. Accordingly, under the amended Regulation 35, multiple applications were received from various hospitals seeking creation of a confidentiality ring.

15. As the Commission was of the view that the investigation conducted by the DG in respect of each of the 12 (twelve) hospitals in the present matter was separate and independent, and accordingly, information and data pertaining to one hospital, would have no relation to the inquiry conducted vis-a-vis the other hospitals, the Commission declined to form a confidentiality ring in the matter.

16. However, subsequently, vide order dated 24.04.2024, the Commission, considering, inter alia, the fact that multiple Opposite Parties had, time and again, sought confidential version of the supplementary investigation report, in the interest of justice, in exercise of the powers vested under Section 36(1) of the Act, directed the DG to prepare and submit 12 (twelve) separate unredacted supplementary investigation reports qua each Opposite Party along with corresponding public versions thereof. Each such report was to be complete vis-à-vis each Opposite Party and the same was to contain comprehensively, all information and data with respect to the said Opposite Party. It was again made clear that for all intent and purposes, the present matter shall be treated as 12 (twelve) separate sub-cases and hearings of the parties also, at the appropriate time, shall take place accordingly.

17. The DG accordingly, submitted 12 (twelve) revised unredacted supplementary investigation reports qua each Opposite Party and 12 (twelve) corresponding public versions thereof, on 18.09.2024.

18. The Commission considered the same in its ordinary meeting held on 29.01.2025, and forwarded electronic copies of the respective unredacted version of the supplementary investigation report(s) to the respective Opposite Party, and public version qua the Max Patparganj to the Informant, giving them an opportunity to file their suggestions/ objections, if any, to the respective report received by them, along with brief synopsis thereof (in hard and in soft copy). The Commission also directed the 12 (twelve) Opposite Parties to file their audited Financial Statements including Balance Sheets and Profit & Loss Accounts/ Income & Expenditure Accounts, for the FYs 2018-19 to 2020-21, if not already filed.

19. Subsequently, the Commission heard the Informant and the Opposite Party hospitals on the respective supplementary investigation report(s) received by them, including on the quantum of penalty to be imposed in case contravention is found, on 28.08.2025, 02.09.2025, 29.10.2025 and 30.10.2025, and decided to pass appropriate order(s) in the matter. The present order is one of such orders passed.

20. The Parties, on their request, were also given liberty to file written submissions/ arguments which were filed and are taken on record.

21. At the outset, it is noted that 12 (twelve) separate investigation reports qua each investigated hospital have been received in Case No. 77 of 2015 and hearing for each hospital also took place separately. It had also been, time and again, made clear to the parties that for all intent and purposes, Case No. 77 of 2015 shall be treated as 12 (twelve) separate sub-cases and the information and data pertaining to one hospital, would have no relation to the inquiry conducted vis-à-vis the other hospitals and would not be shared with them.

22. As such, in light of the above, the Commission decides to segregate Case No. 77 of 2015 into 12 (twelve) separate sub-cases and assign numbers viz. Case No. 77(1) of 2015, Case No. 77(2) of 2015... Case No. 77(12) of 2015 pertaining to each investigated hospital. The present matter i.e., Case No. 77(10) of 2015 relates to Indraprastha Medical Corporation Ltd. (Indraprastha Apollo Hospital), New Delhi ('OP'/ 'Apollo Hospital'/ 'IAH'). The cause titles of all matters stand modified accordingly.

23. Case No. 77 of 2015 pertains to a very imperative issue facing the Indian consumers i.e., whether private hospitals situated in the National Capital Territory of Delhi, like the OP, compel their in-patients to purchase medicines/ devices/ implants/ consumables from the hospital pharmacy only, and charge highly exorbitant prices for such items and earn supra normal profit margins.

24. The DG, after investigation, found that the hospitals abuse their dominant position in the after-market of admitted in-patients to the respective hospital.

25. Before delving into the specifics of the matter, the Commission notes the regulatory landscape governing the sale and purchase prices of medicines, medical devices, and medical procedures in India.

26. The regulatory landscape for medicines in India is governed by the Drugs and Cosmetics Act, 1940, which governs the manufacture, sale, and distribution of drugs, cosmetics, and medical devices in the country and ensures that only drugs meeting safety and efficacy standards are approved and sold in the market. Under the 1940 Act, the primary regulatory body is the Central Drugs Standard Control Organization ('CDSCO'), working under the Ministry of Health and Family Welfare ('MoHFW').

Though largely, the CDSCO does not interfere with or regulate the prices of medicines, medical devices, medical procedures etc., certain medicines that satisfy the priority healthcare needs of the majority of the population are brought within price control regulations by the government, through the medium of a National List of Essential Medicines ('NLEM'), which is a dynamic list, and is revised from time to time by the MoHFW. The list forms part of the Drug Price Control Order ('DPCO'), 2013 which is an order issued by the Government of India under Section 3 of the Essential Commodities Act, 1955, to regulate and cap the prices of certain drugs and medical devices (through Medical Devices Rules, 2017), with a view to ensure their affordability. The implementation of DPCO 2013 is overseen by the NPPA. Prices of such drugs are merely monitored by the NPPA and an annual increase in the MRP of up to 10% is permitted for such drugs.

27. The Hon'ble Supreme Court of India, in its recent judgment and order dated 04.03.2025 passed in Writ Petition (C) No. 337 of 2018 titled Siddharth Dalmia and Another v. Union of India and Others examined the issue as to whether the affairs of private hospitals, nursing homes, medical institutes, etc., with reference to fixation of prices of drugs, equipment, or other accessories sold from their pharmacies and/ or with whom they have some commercial agreement, can be regulated through administrative or legislative measures. The Hon'ble Apex Court noted that the issue primarily involves policy decisions for which policy-makers are best equipped to take a holistic view

and formulate guidelines as may be required, to safeguard patients or their attendants from exploitation, while simultaneously ensuring that there is no discouragement and unreasonable restriction on private entities from entering the health sector, and hence, it did not express any opinion on the merits of the case.

28. In its objections/ suggestions to the supplementary investigation report, during the course of oral arguments, and in its written arguments, OP has, inter alia, made the following submissions:

> 28.1 The DG has ignored IAH's and third-party submissions that hotel room rents are not comparable to hospital room rents. For example, Argon Hotels submitted that their prices 'fluctuate considerably during certain months of the year due to seasonality of demand'; Mohan International submitted that "since the guest house industry is dependent on various variable factors, therefore room tariffs also vary according to season and timing of the year". Yet, the DG compared hotel-room tariffs to IAH's room rents and concluded that IAH charges an excessive / unfair room rent in violation of Section 4 of the Act.
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> 28.2 IAH's and third-party submissions state that prices charged by diagnostic centres cannot be equated with prices charged by hospitals. In the response filed by Dr. Lal Path Labs dated 28.08.2019, it states that it "does not compete with the bouquet of services offered by super speciality hospitals". Yet, the DG compared the prices charged by Dr. Lal Path Labs for medical tests to those charged by IAH to conclude that IAH charges excessively / unfairly for medical tests and procedures in violation of Section 4 of the Act.
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> 28.3 IAH's financial evidence demonstrates that it earns only nominal profit in the healthcare services market and incurred net losses on room rents between 2015 and 2018. Yet, the DG found a violation of Section 4 of the Act for alleged unfair / excessive pricing.
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> 28.4 The DG has arbitrarily identified 12 hospitals (including IAH) out of 70 hospitals from whom information was sought. The parameters adopted by the DG in identifying hospitals for investigation are arbitrary and devoid of logic for the following reasons:
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> • First, the DG has defined each "super-specialty" hospital as a distinct market and, on that basis, concluded dominance of each such hospital. By that logic, and without prejudice to IAH's submissions, every one of the 70 hospitals from which information was sought and, potentially all hospitals across the country would qualify as dominant and warrant investigation.
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> • Second, even within the 12 hospitals identified, the inquiry is skewed. Six Opposite Parties are branches of Max Hospital and two Opposite Parties belong to Fortis Hospital. The scope of the investigation is thus narrowly and selectively confined.

Additionally, two of the institutions treated as "hospitals" namely Max Multi Specialty Centre, Panchsheel Park and Max Multi Specialty Centre, Pitampura are not full-fledged hospitals, but limited-service medical centers.

28.5 Investigation Report does not include an "effects analysis" to determine whether IAH's alleged abusive conduct has had an anti-competitive effect in any market.

This omission is contrary to precedent. The Hon'ble Supreme Court in Competition Commission of India vs. Schott Glass India Pvt. Ltd & Anr., (Civil Appeal No. 5843 of 2014) has unequivocally affirmed that an "effects-based analysis is an obligatory component of every inquiry under Section 4 of the Act"

and such analysis must be based on "hard evidence". The Investigation Report does not identify any consumer, competitor, or third party who has suffered harm from IAH's alleged conduct. As affirmed by the Hon'ble Supreme Court, the DG was required to carry out this analysis before concluding that IAH violated Section 4 of the Act. Since no such analysis was performed, no finding of a violation of Section 4 of the Act can be sustained.

28.6 The DG has erred in defining an overly narrow product market. The analyses of the DG in the Investigation Report is devoid of any valid reasoning or analysis and is cursory. Despite the specific direction given by the Commission in its order dated 31.08.2018 to look at the aspect of "after-market", the DG has not analysed, amongst other aspects, (i) whether there is an aftermarket in the present case; and if yes (ii) what is the primary and secondary market (i.e., aftermarket), and whether these constitute a single systems market.

28.7 An "aftermarket" is a market for the supply of products or services (secondary products) needed for or in connection with the use of a relatively long-lasting product that has already been acquired (primary product), as laid down in Shri Shamsher Kataria v. Honda Siel Cars & Ors, Case No. 03 of 2011 ('Shamsher Kataria Case'). In nearly all aftermarkets, consumers buy one product in the first instance and afterwards buy more products or services, which are required to be used with the already acquired product. In the present case there is no allegation pertaining to a service or product being delivered to the in-patient post discharge from the hospital.

28.8 Healthcare services market is one single market because the patient buys, and IAH provides interdependent services by entering into a single, indivisible contract for all the services and there are no individual contracts for each input (such as, medicines or consumables), as recognised in M/s. International Hospital Pvt. Ltd.

v. State of UP & Ors, 2014 SCC OnLine All 1956 and M/s. Fortis Health Care Limited & Anr. v. State of Punjab & Ors , 2015 SCC OnLine P&H 2018. Accordingly, healthcare service is a "cluster market" where several goods / services are jointly

> demanded and supplied, as laid down in California v. Sutter Health System, 130 F.Supp . 2d 1109 (N.D.Cal.2001). Further, in Shamsher Kataria Case, the Commission has recognised that medical services form a cluster market "since such medical services (consisting of a bundle of products/services which are not interchangeable with each other) are demanded together and are supplied together by such hospitals. The services provided by IAH are a "cluster"

of labour and non-labour inputs, services of doctors/physicians, surgeries, post- operative medical and nursing care, diagnostic services, and medicines/ consumables/ medical equipment and cannot be unbundled.

28.9 In the event it is considered that the healthcare services constitute a primary and secondary market, it is at best, a "systems market". A "system market" consists of a single market for a combination of primary products and the secondary products where, (i) the consumer is able to undertake whole life cost analysis when buying the primary product; and (ii) due to reputational concerns and the risk of losing market share in the primary market, the manufacturers are dissuaded from acting independently of competitive forces in the secondary market. Therefore, it is submitted that healthcare service is at best a "system market" or a single market consisting of both the alleged primary and secondary products, as:

> a. At the time of admission, consumers, i.e., patients, engage in a whole life cost analysis of the healthcare service they want to avail. IAH provides a cost estimate of the entire medical procedure - including any requisite medicines / consumables / medical equipment to each patient before a patient is admitted in the hospital; and b. The pricing strategy of IAH for alleged secondary products (i.e., consumables, and medical devices) is restricted by the estimate of the costs of medicines, consumables and medical devices provided before the admission and are constrained by competition as patients have sufficient choice to avail the services of a competing hospital in case the prices are considered to be high.

> 28.10 The DG has erred in defining an overly narrow geographic market. The correct relevant geographic market is at least the National Capital Region ('NCR') for the following reasons: (i) IAH regularly gets patients from across the NCR and patients are willing to travel long distances depending on the reputation of a hospital or its consultants/ doctors, quality standards, availability of insurance with empanelled hospitals, coverage under various Government schemes (such as CGHS) etc.; and (ii) conditions of competition for the provision of healthcare services are homogenous across the NCR and there are various hospitals, including IAH, which operate hospitals in Delhi and other NCR cities, offering similar quality of healthcare services.

28.11 IAH is not dominant in any relevant market for the reasons set out below:

> a. IAH does not operate independently of competitive forces.

b. IAH does not have the ability to affect its competitors or consumers in the relevant market. Patients have several options of hospitals to choose from; along with the ability to switch to another hospital after receiving an estimate or during the entire duration of the treatment without incurring any cost (given IAH provides services required by the patient to transfer to another hospital, such as, ambulance services).

c. IAH does not satisfy the test for dominance set out under Section 19(4) of the Act.

28.12 IAH has not abused its alleged dominant position. The DG has not considered IAH's submissions regarding its costs and revenue centres. The investigation report is driven by a presumption that IAH is making huge profit margins, which is factually incorrect. Any allegation of profiteering has to be seen in the context of overall costs and profits of IAH:

a. IAH is in the business of "healthcare services" and not in the business of selling only consumables, medicines etc. b. The annual profits of IAH are consistently decreasing and have come down to 2.8% in FY 2018 from 4.5% in FY 2015; and c. Even if department wise profits and profits per bed are considered, IAH does not make excessive profits.

28.13 In order to establish an unfair / excessive pricing violation under Section 4 of the Act, as recognised in United Brands Company v Commission, (1978) ECR 207 ('United Brands'), the DG must establish: (i) "whether the difference between the cost actually incurred and the price actually charged is excessive" (Excessive Limb); and (ii) "whether a price has been imposed which is either "unfair" in itself or when compared to competing products"(Unfair Limb). The DG has ignored the submissions made by the 3-star and 4-star hotels (Argon Hotel and Mohan International) where they specify that they offer amenities such as bars and leisure facilities and engage in seasonal pricing; whereas hospital room tariffs cover nursing care, ICU/HDU backstopping, sterilization protocols, biomedical waste management, and emergency readiness. Branding hospital prices "excessive" by reference to hotel tariffs reflects non-application of mind.

28.14 The DG's approach of comparing the room rents of 3- star and 4-star hotels with those of IAH to conclude excessive pricing contradicts the Commission's decisional practice where it has previously held that "the price in one relevant market cannot be compared with that in another market, which operates under distinct market conditions" while rejecting allegations of excessive pricing.

28.15 The DG's findings qua medical devices and medical tests do not satisfy the test for unfair / excessive pricing. The DG compared prices charged by IAH with those charged by diagnostic centres while ignoring the differences in quality, technical specifications, equipment, machines, technology and expertise. The DG has also cherrypicked certain diagnostic centres without any logical basis.

28.16 The costs of a diagnostic centre and a hospital are very different. The key differences between the costs of hospitals and diagnostic centres are as follows:

(a) diagnostic centres only function for fixed times in a day while hospitals operate throughout the day;

(b) diagnostic centres operate at a different volume - for example, they may collect 1000 samples for conducting particular types of tests in a day through a large number of collection centres available in the city. Such is not the case with the hospitals;

(c) diagnostic centres can be operated from a small premise as opposed to hospitals;

(d) diagnostic centres have comparatively low fixed costs as they usually do not own the machines/ equipment as opposed to hospital laboratories which invest in machinery.

(e) diagnostic centres provide certain services through their channel partners as opposed to hospitals which generally do not outsource the tests for quality purposes.

28.17 The DG's findings qua consumables do not satisfy the test for unfair / excessive pricing: Based solely on information received from consumable manufacturers, the DG has concluded that IAH has registered a 'larger margin/profit percentage' for the sale of certain consumables (Volume wise:

Wearon Apron, CG Electrode, Surgi-wear (Trolly Cover), Prolene J and Fentanyl; and Value wise: Prolene J, Omnipaque, Cautery Pencil, Guidewire J. Tip and Surgicel). This analysis and conclusion is flawed for the reasons set out below:

a. There is no obligation on an enterprise to pass on any discounts to the consumers when the product is being sold at MRP. The Commission has previously dismissed allegations of excessive pricing by stating that the Commission cannot go into the issue of MRP.

b. There is a very high degree of product differentiation in the medical consumables category (due to quality, raw material, technology, sizes, brand/ manufacturer etc.). Therefore, for most medical consumables, there is no one type of product that is used uniformly across the entire healthcare industry, and the prices could vary vastly. Therefore, to compare the prices of consumables primarily based on their name would be wholly inappropriate and would lead to incorrect comparisons. Consumables are available at a range of price points and considering only one price point for a consumable would lead to incorrect results. As a result of economies of scale arising from the bulk purchase of consumables, IAH is able to negotiate a lower procurement price for the consumables. However, this does not imply that IAH is indulging in profiteering.

c. The DG found that IAH has registered a large profit margin/percentage for certain medicines. However, the DG has made a blatant error by ignoring IAH's submission that it does not fix the MRP of medicines. The MRP for scheduled drugs is fixed under the DPCO, 2013 and the MRP of other medicines is determined by the manufacturers. IAH does not charge above the MRP.

Analysis of the Commission

29. The Commission has perused the Information, material available on record, the supplementary investigation report, the replies/suggestions/objections to the supplementary investigation report and the written submissions of oral arguments of OP, post hearing.

30. In the present matter, the DG, as a part of its supplementary investigation report, has found that the OP is an 'enterprise' within the meaning of sub-section (h) of Section 2 of the Act, is dominant in the relevant market of 'provision of healthcare services/ facilities for in-patients admitted to Apollo Hospital in Delhi', and has abused its dominant position by charging higher room rents and prices for certain medical tests, medical devices, consumables, and medicines from the in-patients admitted to the hospital.

31. Undoubtedly, since the OP is engaged in the economic activity of providing healthcare services to patients (in-patients as well as out-patients) in lieu of monetary consideration, it is an 'enterprise' within the meaning of sub-section (h) of Section 2 of the Act.

32. The Commission in its prima facie order dated 17.11.2015 was of the view that the relevant market in the instant case is the "market for provision of healthcare services by super speciality hospitals in Delhi".

33. After reviewing the DG investigation report, the Commission in its order dated 31.08.2018 inter-alia observed that while there is a reference to Max Patparganj's alleged conduct as being akin to 'aftermarket abuse'; however, DG has not investigated/ analysed the same in greater detail. The Commission is of the considered view that it would be desirable that a finding be given on the delineation of relevant product market considering the aspect of aftermarket abuse, if any.

Further, the Commission directed that the DG should focus on the following issues during re-investigation of the matter:

i.The relevant market definition as provided in the DG's investigation report may be revisited. The concept of 'aftermarket abuse' referred to in the DG's report may be used to define the relevant market as the market for healthcare service/ facilities in the after-market for in-patients in super speciality hospitals. With regard to the relevant geographic market, instead of considering "a distance of about 12 kms from Max Super Specialty Hospital, Patparganj', the DG may consider Delhi as the relevant geographic market, as considered by the Commission in its prima facie order.

> ii. Besides huge profit margin from the sale of syringes as pointed out in the DG's report, the scope of investigation should be broadened by covering all aftermarket healthcare products and services provided by super speciality hospitals across Delhi to their in-patients. The investigation may especially focus on the products sold by the super speciality hospitals to their inpatients which are not required on an urgent basis for any medical procedure / intervention or which do not involve any high degree of quality issue from the medical procedure point of view and for the purchase of which, the patients have the time and scope to exercise their rational choice to purchase such products from open market as well where such products may be available at lower rates.
>
> 34. The DG in the main investigation report distinguished the healthcare services offered by the super speciality hospitals from the healthcare services offered by other hospitals.

The DG further distinguished between the services offered by government hospitals from the services of private hospitals. The DG concluded that healthcare services/facilities provided by Super-specialty hospitals, general hospitals and other smaller hospitals are not substitutes or even comparable. Further, the Commission observes that patients getting treatment from a hospital can be broadly divided into 02 (two) categories i.e. inpatient and outpatient. An in-patient is a person who is admitted to a hospital and required to stay for treatment that usually involves continuous medical care, monitoring, and use of hospital infrastructure. An out-patient, on the other hand, receives medical consultation, diagnosis, or treatment without being admitted. From an economic perspective, in-patient care generally leads to significantly higher out-of- pocket expenses because it includes hospital bed charges, nursing services, diagnostic tests, procedures or surgeries, medicines, and other ancillary costs. In contrast, out- patient care entails relatively lower out-of-pocket expenditure, as costs are limited to consultation fees, basic investigations, and medicines, making it financially less burdensome for patients and households.

35. In-patients can be further distinguished into 02 (two) categories i.e. those admitted for emergency or critical care and those admitted for elective treatment. Elective treatment refers to a planned medical treatment/ procedure that is scheduled in advance and is not performed in response to an immediate serious condition. In contrast, emergency treatment/procedure is performed urgently to address a sudden, serious, or life- threatening condition such as trauma, internal bleeding, or acute infections. The Commission in its order dated 31.08.2018 observed that the investigation may especially focus on the products sold by the super speciality hospitals to their inpatients which are not required on an urgent basis for any medical procedure / intervention or which do not involve any high degree of quality issue from the medical procedure point of view.

36. In view of the above, the issue under consideration is whether the OP has indulged in abusive conduct by mandating the inpatients admitted in their hospital for elective treatment to use in-house medical products and services (medicines, consumables, medical equipment and medical tests etc).

37. In the aforesaid context, the issue for consideration is whether there exist 02 (two) separate relevant product markets i.e.

(i) the market for provision of healthcare services/facilities for treatment of ailment by private super speciality hospitals (primary product) and

(ii) the aftermarket for post-operative treatment of inpatients, including medical consumables, medicines, medical equipment, medical tests etc. (secondary product) or the aforesaid markets are to be considered a unified systems market.

38. As per the decisional practice, following conditions are inter-alia taken into account for deciding whether an aftermarket can be said to exist separate from the primary market:

I. customers do not engage in whole life costing.
II. reputation effects do not deter the provider from setting competitive p
the secondary product.
III. cost of the primary product: If the owner of the primary product can ea

switch to another competing primary product, the primary product and secondary product may be clubbed to form a systems market.

39. In this regard, it is generally observed that patients opting for elective hospital treatment typically ascertain the cost of the procedure for treating the ailment and other expenses such as medical consumables, medicines, medical equipment, medical tests, room rent, visit charges of doctor etc. required in connection with the treatment of the ailment. Procedures offered by hospitals are healthcare services and not standalone sales of components like room rents, medical tests, medical devices, consumables and medicines. The Commission observes that patients do not come to a hospital for goods (like medicines, consumables, medical devices etc.), but for treatment which is a healthcare service. Prior to admission, patients typically consult the doctors at the OP's premises and are provided with an estimate outlining the anticipated costs of their treatment, which is inclusive of the cost of relevant medical tests.

40. Patients are given the all-inclusive estimated cost. This disclosure ensures that patients are informed about the financial implications of their admission with the OP before making any commitment. At this stage, there is no obligation to proceed with treatment from the OP. Patients retain the freedom to accept or reject the estimated charges, seek a second opinion, or take treatment at another hospital. It is not a "take-

it-or-leave-it" scenario, patients are under no compulsion to admit themselves to the OP if they find the costs or services unsatisfactory. Patients are generally aware about the cost before taking healthcare services from hospitals and the patients are free to choose any hospital of their choice. In this regard, the Commission notes that, patients seeking admission are given an estimated cost based on the immediate apparent ailment and suggested line of treatment. The Commission observes that hospitals provide break up of charges towards various services required in the treatment viz, the procedure, drugs, medical consumables, room rent etc. The DG in the

investigation report fails to highlight inability if any, of the patients seeking treatment to undertake a holistic treatment cost analysis at the time of admission. The Commission is cognizant of the fact that the final cost of treatment may vary from patient to patient on the basis of health conditions, number of visits of doctors, tests undertaken and other diagnosis/complications that may arise during the treatment. There could be contingent expenses such as additional diagnostics, extended hospital stays, consumables, specialist consultations, or compulsory in-house services, which may accrue after admission. Accordingly, the estimated cost communicated ex ante may differ from the actual cost incurred ex post. Further, the estimated cost is based on broad heads and does not give granular cost of each consumable, which is known only during or after the treatment. However, from the perspective of the issue on hand, it emerges that the patients seem to have reasonable degree of information to undertake a comparative analysis of the total expenses relating to the treatment of the ailment and other incidental expenses and take an informed decision.

41. In view of the aforesaid, the Commission is of the opinion that the patients seeking elective treatment are able to take into account the approximate overall cost of the treatment, reasonably assess and compare the total cost he/she is likely to incur during the treatment including cost of the products and services, before seeking admission for treatment.

42. As regards the point whether reputation effects would deter the provider from setting competitive prices for the secondary product, the Commission finds that for well- established hospitals such as the OP, factors such as high demand, brand image, perception of high quality of their services, availability of expert and skilled/renowned doctors in their hospital, suggest that the risk of losing market share (in the primary market) may not effectively constrain hospitals from acting independently of competitive forces (in the secondary markets such as in-house diagnostics, medicines, consumables, and ancillary services).

43. As regards patients being locked into the secondary market, it is noted from the supplementary investigation report that while there may be no specific embargo, hospitals encourage the use/ purchase of consumables, medical devices, medicines and medical test results from the hospital's in-house pharmacy and laboratories located within the premises of the hospital. Where required, consumables, medicines, medical equipment and medical test may be procured by in-patients from outside the hospital as well, provided that the hospital's 'protocol' is followed. The Commission notes that due to ease of convenience as well as the hospital's 'protocol' and declaration to the patients regarding potential risks associated, in-patients, almost always, resort to usage of the hospital's in-house pharmacy and laboratories for their respective needs. This creates a 'locked-in' effect upon the admitted patients and may invariably ensure that the concerned hospital supplies almost the entire consumables, medical devices, medicines and medical tests to the patients admitted to that hospital.

44. However, in this context another important relevant factor, that the Commission has considered is whether a consumer can shift to another primary market product, i.e., another competing service provider, without bearing substantial switching costs or financial burden.

45. In this regard, the Commission is aware that the patients are free to leave their hospital anytime during the treatment and seek medical treatment from other hospitals and thus there is no lock-in or switching cost for patients seeking treatment. The Commission is also aware that certain switching costs may have to be borne by patients, in case they want to switch to another hospital to avoid high cost of secondary products. These may arise from procedural barriers to discharge such as process delays, disclaimers and waivers for liability, linked administrative requirements, information asymmetry, health risks in transition and the routine insistence by receiving hospitals on conducting fresh diagnostic tests leading to duplication of costs, etc. However, by and large there is sufficient flexibility with the patients to exercise choice of switching at various stages of the treatment subject to procedural requirements. Based on available facts, it does not appear to be the case that patients cannot switch to alternative service providers in the primary market without incurring significant switching costs.

46. On the basis of a holistic assessment of aforesaid facts and circumstances available on record, and in the absence of factors/evidence such as (a) consumer being not able to ascertain the life time cost of the product at the time of its availing the service and

(b) consumer not being able to switch the primary product without incurring substantial switching cost the Commission is therefore broadly inclined towards the view that it would not be appropriate to delineate separate primary and secondary market (aftermarket) for inpatients admitted with OP for elective treatment. Accordingly, a unified relevant product market in the instant matter is being delineated i.e. the "market for provision of healthcare services by super speciality hospitals".

47. As regards the relevant geographic market, the Commission in its prima facie order dated 17.11.2015, was of the view that "...owing to factors such as ease of access, language, lesser travel time, low transport cost, consumer's preference the geographic area of Delhi would be the relevant geographic market in the instant case. Further, the conditions of competition for the supply of relevant product are homogeneous throughout Delhi and can be distinguished from the conditions prevailing in adjacent areas of Delhi such as other regions of NCR. Furthermore, in normal circumstance, a person/ patient residing in Delhi will prefer to avail the healthcare services of a super speciality hospital located in Delhi, rather than from other regions of NCR. Accordingly, the Commission is of the view that the relevant market in the instant case is the market for "provision of healthcare services by super speciality hospitals in Delhi".

48. Further the Commission in its order dated 31.08.2018 inter alia directed the DG, instead of considering "a distance of about 12 kms from Max Super Specialty Hospital, Patparganj", the DG may consider Delhi as the relevant geographic market, as considered by the Commission in its prima facie order.

49. However, the DG in its supplementary report has stated that each hospital under investigation, is self-contained and independent market based out of Delhi and as a super speciality hospital renders specialized medical services to the patients. It has further been stated that the specialized medical services provided by the hospital selected for investigation are different from the other hospitals located in the neighbouring areas of Delhi. Therefore, the DG was of the view that Delhi

may be treated as relevant geographic market for the present case.

50. However, the Commission notes that the DG has not brought out any evidence in support of the finding that the geographic area of Delhi would be the relevant geographic market for the primary market in the instant case.

51. The Commission is of view that the patients do take services from super speciality hospitals across Delhi-NCR and there do not seem to be any regulatory or other constraints in doing so. Accordingly, the relevant geographic market in the instant matter is being considered as Delhi NCR. Thus, the relevant market in the matter could be the "market for provision of healthcare services by super speciality hospitals in Delhi NCR".

52. Notwithstanding the view that in-patient services provided by the super-speciality hospitals are part of a unified market of provision of healthcare services by super speciality hospitals, the Commission is cautious that there may exist a case for aftermarket in some limited situations of elective treatment like post-surgical stay, etc. where the switching cost for patients outweigh the cost of continuing treatment at the same hospital, even when the patients have time and scope to exercise choice to get tests done in nearby labs or purchase medicines and consumables from open market. Therefore, the Commission proceeds to examine the conduct of the OP in "market for provision of healthcare services/ facilities for in-patients admitted for elective treatment to the respective super specialty hospital".

Assessment of Conduct

53. The Commission observes that procedures offered by OP were healthcare services and not standalone sales of goods (like room rents, medical tests, medical devices, consumables and medicines). Further, patients do not come to a hospital for goods (like medicines, consumables, medical devices etc.), but for treatment which is a healthcare service. Thereby, from the demand side, hospitals cannot be substitutable with hotels for room rents, diagnostic labs for medical tests and devices, and manufacturers for consumables and medicines.

54. Patients get admission in hospitals to avail healthcare services in case of scheduled surgery/treatment as well as emergency. After admission in hospital, they require Room, Medical tests, Medical equipment, Medicines, Consumables etc. These are complementary product/ services used with the healthcare service. However, they are not unique in nature to be used in hospitals only. These products/services are also sold separately in the market. Healthcare products or services like Medical tests, Medical equipment, Medicines, Consumables sold in hospital and open market are substitutable or interchangeable. Out patients also purchase medicines, consumables medical equipments etc. and undergo medical tests/check-ups on the advice of a doctor.

55. However, the major question involved for consideration of the Commission in the present matter is whether the OP has indulged in abusive conduct vis-à-vis its in- patients by charging excessively higher prices from them for medicines, consumables, medical devices or medical procedures etc. Such abuse is what is termed under competition law as 'excessive pricing' by a dominant entity.

Excessive pricing is there when a dominant entity charges exorbitant prices for any goods or services that bear no reasonable relation to their economic value. Such practice is considered as an 'exploitative' abuse because the dominant entity is seen taking advantage of its market power to extract maximum value from the customers.

56. The test for establishing 'excessive pricing' is well-settled in United Brands, where a two-stage test was set out for ascertaining whether the price charged by a dominant enterprise for a product is abusive. First, whether in relation to cost, the price for the product can properly be termed 'excessive', and second, whether the price charged is 'unfair' in itself or when compared to competing products.

57. The Commission shall apply the afore-said tests to all aspects investigated by the DG, in the succeeding paragraphs across the 05 (five) parameters i.e., Room rent, Medical Tests, Medical Devices, Consumables and Medicines.

58. Allegations with respect to abuse of dominant position are not sustainable in the present matter due to reasons mentioned below:

59. Room Rent 59.1 The first finding rendered by the DG is that the OP charges higher rents for its various categories of rooms. In this respect, the DG has firstly, nowhere compared the rents charged for various categories of rooms by the OP with the associated costs, and secondly, compared the rents charged for various categories of rooms by the OP with the rents charged by nearby (i) government hospitals and (ii) three- and four-star hotels providing similar facilities of boarding and lodging. The DG has observed that the nearby government hospitals either charge no rents from its admitted patients or different rates (quite nominal in nature) are charged from non- entitled patients. Further, the DG found that the rates charged by nearby three and four-star hotels are also relatively cheaper than the OP.

59.2 The DG itself has excluded government hospitals from the scope of its investigation by categorising them as a separate class of hospitals altogether from private super-specialty hospitals, and three-star and four-star hotels can also not be said to provide services substitutable with those provided by a super specialty hospital.

59.3 Also, it is noted from supplementary investigation report that the comparison of room rents of neighbouring hospitals with some of the super speciality hospitals under investigation shows mixed results.

59.4 The Commission is of the considered opinion that hospital rooms and three/four-

star hotel's rooms are different relevant product and they are not substitutable as the rooms of hospital are not mere discretionary lodging facilities but are designed to cater to the clinical needs of patients, equipped with automatic patient beds, trained medical staff, emergency response mechanisms, etc. to provide immediate medical attention, which are entirely absent in hotel accommodations.

59.5 In the absence of comparative analysis cost of hospital rooms across different hospitals, it can not be said that the OP is charging excessive price. Thus, no finding on 'excessive' and 'unfair' pricing can be rendered by the Commission on this count.

60. Medical Tests 60.1 The DG has compared the prices for 13 (thirteen) separate medical tests charged by the OP with the prices for the same tests charged by certain diagnostic labs during the same period (2015-2018), and came up with mixed results. The DG has concluded that the prices charged for these certain tests by the OP between 2015- 2018 were higher than those charged by certain diagnostic labs.

60.2 The Commission notes that the Government departments including MoHFW, DGHS of Delhi Government, NPPA and CDSCO do not regulate the prices of medical tests within the private super specialty hospitals in Delhi.

60.3 The Commission notes the DG's findings that the price of following medical tests of the OP were more than the diagnostic centres:

> i. Liver Function Test ('LFT'), Renal Biochemical Profile (Basic), Amylase, LDH, Complete Blood Count ('CBC'), Prothrombin Time, Reticulocyte Count, Total Leukocyte Count, Bact/ Alert, HBV Monitor and ASMA tests (2015- 2018).
>
> ii. Anti HAV (2016 and 2018) and ALKMA (2017).
>
> 60.4 To examine whether the rates charged by the OP are excessive, the Commission compared the prices charged by OP with average rates charged by standalone labs.

Table 1: Comparison of rates of Medical tests in 2015 Rate of Medical Tests in 2015 % higher/ Apollo Dr. Lal Goyal Focus Average lower SL Tests Hospital H.O.D. Pathlabs MRI Imaging Rate than Average Rate Not 1 LFT 1244 700 780 700 727 71% provided Renal Not 2 Biochemical 1441 700 780 650 710 103% provided Profile - Basic Not 3 Amylase test 472 400 N/A 450 425 11% provided Not 4 LDH Test 603 320 N/A 450 385 57% provided Not 5 CBC 567 330 360 355 348 63% provided Prothrombin Not 6 559 330 380 250 320 75% Time provided Reticulocyte Not 7 298 320 160 100 193 54% Time provided Total Leukocyte Not 8 356 100 160 75 112 219% Count provided Not 9 ANTI HAV 99 1120 N/A 2700 1910 -95% provided BACT/Alert Not 10 Aerobic 1103 950 N/A 450 700 58% provided Culture(Aspirate) Not 11 HBV Monitor 16999 4050 N/A 8000 6025 182% provided Not 12 ASMA Test 2468 1600 N/A 2250 1925 28% provided Not 13 ALKMA Test 1787 1500 N/A 3200 2350 -24% provided Table 2: Comparison of rates of Medical tests in 2016 Rate of Medical Tests in 2016 % higher/ Average SL Tests Dr. Lal Goyal Focus lower Apollo H.O.D. Rate Hospital Pathlabs MRI Imaging than Average Rate 1 LFT 1201 700 780 700 350 633 90% Renal 2 Biochemical 1392 700 780 650 350 620 125% Profile - Basic 3 Amylase Test 452 400 N/A 450 200 350 29% 4 LDH Test 624 320 N/A 450 180 317 97% 5 CBC 539 330 360 355 190 309 75% Prothrombin 6 557 330 380 250 190 288 94% Time Reticulocyte 7 295 320 160 100 80 165 79% Time Total Leukocyte 8 355 100 160 75 90 106 234% Count 9 ANTI HAV 1260 1120 N/A 2700 750 1523 -17% BACT/Alert 10 Aerobic 1099 1000 N/A 450 N/A 725 52% Culture(Aspirate) 11 HBV Monitor 15443 4050 N/A 8000

N/A 6025 156% 12 ASMA Test 2407 1600 N/A 2250 N/A 1925 25% 13 ALKMA Test 1834 1500 N/A 3200 N/A 2350 -22% Table 3: Comparison of rates of Medical tests in 2017 Rate of Medical Tests in 2017 % higher/ SL 2017 Apollo Dr. Lal Goyal Focus Average lower H.O.D. Hospital Pathlabs MRI Imaging Rate than Average Rate 1 LFT 1290 700 780 700 350 633 104% Renal 2 Biochemical 1480 700 780 650 350 620 139% Profile - Basic 3 Amylase Test 520 420 N/A 450 250 373 39% 4 LDH Test 680 350 N/A 450 200 333 104% 5 CBC 570 350 420 355 190 329 73% Prothrombin 6 610 350 380 250 210 298 105% Time Reticulocyte 7 310 350 160 100 90 175 77% Time Total Leukocyte 8 390 110 160 75 100 111 251% Count 9 ANTI HAV 920 1190 N/A 2700 750 1547 -41% BACT/Alert 10 Aerobic 1190 1100 N/A 450 - 775 54% Culture(Aspirate) 11 HBV Monitor 16570 4400 N/A 8000 4200 5533 199% 12 ASMA Test 2460 1700 N/A 2250 2275 2075 19% 13 ALKMA Test 1770 1600 N/A 3200 1750 2183 -19% Table 4: Comparison of rates of Medical tests in 2018 Rate of Medical Tests in 2018 % higher/ SL Tests Apollo Dr. Lal Goyal Focus Average lower Hospital H.O.D. Pathlabs MRI Imaging Rate than Average Rate 1 LFT 1290 700 780 700 420 650 98% Renal 2 Biochemical 1490 700 780 650 420 638 134% Profile - Basic 3 AMYLASE Test 520 420 N/A 450 240 370 41% 4 LDH Test 650 350 N/A 450 200 333 95% 5 CBC 580 350 420 355 199 331 75% Prothrombin 6 600 350 380 250 210 298 102% Time Reticulocyte 7 300 350 160 100 90 175 71% Time Total Leukocyte 8 420 110 160 75 100 111 278% Count 9 Anti HAV 1090 1190 N/A 2700 750 1547 -30% BACT/Alert 10 Aerobic 1230 1100 N/A 450 500 683 80% Culture(Aspirate) 11 HBV Monitor 18180 4400 N/A 8000 4200 5533 229% 12 ASMA Test 2320 1700 N/A 2250 2275 2075 12% 13 ALKMA Test 1660 1600 N/A 3200 1750 2183 -24% 60.5 From the above tables, it is observed that for the following medical tests, the OP charged not only more than 50 % of average rate of 04 (four) standalone labs but also charged more than 50 % of the highest rate charged amongst the 04 (four) standalone labs:

a. LFT, Renal Biochemical Profile - Basic, Total Leukocyte Count and HBV Monitor during 2015-2018 b. CBC in 2015 c. LDH in 2017 d. Prothrombin Time in 2017 and 2018 60.6 The table also indicates that for some medical tests (e.g. Anti HAV and ALKMA), the price charged by the OP is lower than the average rate during the period from 2015-2018. Thus, a comparison of rates charged for medical tests by the OP with those charged by standalone labs shows mixed results.

60.7 In this regard, the Commission is of view that the cost of operation of hospital labs is not comparable with standalone labs due to the reasons mentioned below:

• Hospital's labs operate 24 x 7 and • Turnaround time in the hospital's lab is faster in comparison to standalone labs.

60.8 The Commission observed that the DG compared rates of medical tests charged by the OP with standalone labs and not with other hospitals providing similar services. In the light of the above submissions, the Commission is of the view that the price charged by the OP for certain medical tests may be termed as unfair only if it is significantly higher in comparison with prices charged by other hospitals providing similar services.

60.9 The finding of the DG that unfair prices were charged by the OP for medical tests cannot be conclusively established in the light of the facts brought out in the investigation report.

61. Medical Devices

61.1 With regard to medical devices, the Commission notes the DG's findings that the rates charged by OP were higher than that of a standalone lab for X-rays and MRIs:

• Details provided for X-Ray operations for both Knee (AP & Lateral) were found to be more than the prices charged by diagnostic lab (Dr. Lal Path Labs) during 2015-2018.

• Details provided for MRI operations charged for MRI Brain Plain and MRI Brain (Contrast) were found to be more expensive than the prices charged by Goyal MRI during 2015-2018 .

• Details provided for Ultrasound by the OP for Upper Abdomen, Whole Abdomen and Kidneys, Ureters and Bladder ('KUB') (2015-2018) have been found to be more expensive than the diagnostic centre i.e. Dr. Lal Path Labs during 2015-2018.

61.2 However, as far as procedural costs involved in Knee Implants and Hip Implants are concerned, the DG has found that the rate of operation costs charged by the OP for Knee Implants and Hip implants increased from 2015 to 2018.

61.3 With respect to BMS and BVS stents, the DG has found that no BVS Stents were used by the OP in 2017 and 2018. Further, BMS stents used by the OP in 2017 was within the price cap of NPPA. No contravention of breaching of ceiling prices set by NPPA for BMS and BVS Stents have been found during the investigation by the hospitals under investigation.

61.4 The DG has also made similar comparisons with respect to 02 (two) categories of X-Rays, 02 (two) categories of MRIs and 02 (two) categories of Ultrasound. The DG has compared the rates charged for the same by the OP with one diagnostic lab each during the same period (2015-2018), and concluded that the prices charged for such tests by the OP were higher than those charged by the compared diagnostic lab.

Table 5: Comparison of rates of X-Ray Operations during 2015-2018 Rate of X-Ray Operations 2015 2016 2017 2018 % % % % X-Ray Apollo higher Apollo higher Apollo higher Apollo higher Operations DLPL DLPL DLPL DLPL Hospital than Hospital than Hospital than Hospital than DLPL DLPL DLPL DLPL Chest PA 300 160 -47% 300 160 -47% 330 180 -45% 330 180 -45% (CXR) Both Knee 600 680 13% 600 700 17% 660 780 18% 660 800 21% (AP&Lateral) 61.5 The OP has not charged more than 50 % in comparison to the standalone lab i.e. Dr. Lal Path Labs during 2015-2018 for any X-Ray tests for which data is provided in the DG Report.

Table 6 : Comparison of rates of MRI Operations during 2015-2018 2015 2016 2017 2018 % % MRI % highe highe Operatio % Apollo higher r Apollo r Apollo ns Goyal Goyal Apollo Goyal Goyal highe Hospit than than Hospit than Hospit MRI MRI Hospital MRI MRI r than al Goyal Goya al Goya al DLPL MRI l l MRI MRI MRI Brain 6000 10640 77% 6000 10540 76% 8000 11890 49% 8000 12110 51% Plain MRI Brain 9000 16650 85% 9000 16540 84% 11000 18370 67% 11000 19300 75% Contrast 61.6 The OP has charged more than 50 % price in comparison to the standalone lab i.e. Dr. Goyal MRI during 2015-2018 for MRI Brain Contrast test for which data is provided in the DG Report. The OP has charged more than 50 % price in comparison to the standalone lab i.e. Dr. Goyal MRI in 2015, 2016 and 2018 for MRI Brain Contrast test for which data is provided in the DG Report.

Table 7 : Comparison of rates of Ultrasound Tests during 2015-2018 2015 2016 2017 2018 Ultrasound % % % % Operations Apollo higher Apollo higher Apollo higher Apollo higher DLPL DLPL DLPL DLPL Hospital than Hospital than Hospital than Hospital than DLPL DLPL DLPL DLPL Upper 800 1530 91% 800 1530 91% 900 1710 90% 900 1750 94% Abdomen Whole 1100 1770 61% 1100 1790 63% 1250 1990 59% 1250 2020 62% Abdomen KUB 800 1340 68% 800 1380 73% 900 1520 69% 900 1580 76% 61.7 The OP charged more than 50 % in comparison to the standalone lab i.e. Dr. Lal Path Labs during 2015-2018 for all the ultrasound tests (i.e., Upper Abdomen, Whole Abdomen and KUB) for which data is provided in the DG Report.

61.8 In this regard, the Commission is of view that the reason for charging comparatively higher prices than standalone diagnostic labs may be due to the higher cost of operations as the OP, being a hospital, has to provide 24 hours functional testing facility with available staff and infrastructure to support the same and ensure faster Turn Around Time ('TAT').

61.9 The Commission is of the considered opinion that the comparison of rate for X-

Ray/ MRI/ Ultrasound operations charged by the OP with only 01 (one) standalone lab each is inadequate. Further, the charges levied by the OP for certain X-ray and ultrasound procedures would qualify as unfair only where they are significantly higher than those charged by other hospitals for comparable services.

61.10 In view of the above, the finding of the DG that unfair prices were charged by the OP for certain medical devices is not sustainable.

62. Consumables and Medicines 62.1 The DG has also compared the procurement prices and selling prices of 20 (twenty) specific consumables, 20 (twenty) top consumables, 19 (nineteen) specific medicines and 20 (twenty) top medicines of the OP in terms of volume and value and noted that significant profit margins were registered by it from 2015 to 2018. The DG has further noted that no submissions were made by the OP to show that any of such profit margins realised by it were passed on to the patients admitted in the hospital in the form of any discount.

62.2 The Commission notes that the DG has compared the procurement price and selling price of consumables/medicines to ascertain profit margin with respect to Consumables and Medicines.

62.3 Also, it is noted from submission as well as supplementary investigation report that consumables and Medicines are sold as per MRP.

62.4 The Commission is of considered opinion that such methodology to ascertain profit margin is not relevant and appropriate as the procurement price does not cover overhead expenses including storage cost, supply chain management cost, operational cost, inventory management cost etc,. Further, price charged by the OP for certain consumables and medicines ought to be compared with prices charged in other super speciality hospitals or at least nearby pharmacies rather than comparing with procurement prices, in order to arrive at any finding regarding unfair pricing.

62.5 The Commission is also aware of the fact that there is no obligation under any law upon any hospital to pass on the profits earned by it upon sale of any product to its patients. Further, there is also no finding in the supplementary investigation report that the prices charged for any consumable or medicine by the OP went beyond the MRP for the said product fixed by the manufacturer. The sample size taken by the DG (of consumables and medicines) is also quite limited.

62.6 In view of the above, the finding of DG that the prices charged for certain consumables and medicines by the OP are excessive and unfair is not established against the OP.

63. In light of the above, the Commission is of the view that in the present matter, neither of the two tests laid down in the United Brands (Supra) stand established on any count, from the evidence gathered by the DG as part of its supplementary investigation.

64. Therefore, the Commission is of the view that no case of abuse of dominant position in contravention of Section 4 of the Act can be made out against the OP in the present matter, based on the material and evidence available on record. Accordingly, the present matter is directed to be closed. Pending IAs, if any, also stand disposed of.

65. Before parting, the Commission deems it appropriate to deal with the request of the parties seeking confidentiality over certain documents / data / information filed by them under Regulation 35 of the General Regulations, 2009 (as amended). Considering the grounds given by the OP for the grant of confidential treatment, the Commission grants confidentiality to such documents / data / information in terms of Regulation 36 of the General Regulations 2024, subject to Section 57 of the Act, for a period of 03 (three) years from the passing of this order. However, it is made clear that nothing disclosed in this order shall be deemed to be confidential or deemed to have been granted confidentiality, as the same have been used and disclosed for purposes of the Act in terms of the provisions contained in Section 57 thereof.

66. The Secretary is directed to communicate a certified copy of the present order to the OP, accordingly.

Sd/-

(Ravneet Kaur) Chairperson Sd/-

(Anil Agrawal) Member Sd/-

(Sweta Kakkad) Member Sd/-

Place: New Delhi
Date: 21.05.2026

(Deepak Anurag
Member