

6 Conclusions

Introduction

6.1. Our inquiries were initiated by two references made on 5 September 1991 and on 8 October 1991. The references arose from bids for Macarthy PLC (Macarthy) made respectively by UniChem PLC (UniChem) and by Lloyds Chemists plc (Lloyds). Under our terms of reference (Appendix 1.1) we are required to consider in each case whether arrangements are in progress or in contemplation which, if carried into effect, would result in the creation of a merger situation qualifying for investigation under the Fair Trading Act 1973 (the Act) and, if so, whether the creation of that situation may be expected to operate against the public interest.

The companies involved

Macarthy

6.2. Macarthy owns the fourth largest chain of retail pharmacies in the United Kingdom, Savory & Moore Ltd (Savory & Moore), with 161 outlets. The stores are located mainly in Central Scotland, South Wales and the South-West and South-East of England. Macarthy also operates a chain of health food stores, mostly in the South of England, called Lifecycle Ltd (Lifecycle), and a wholesale business for health food products called Nature's Store Ltd (Nature's Store). It owns Farillon Ltd (Farillon), an exclusive distribution agency for the pharmaceutical and healthcare products of over 40 manufacturers in the United Kingdom and overseas. It also has subsidiaries involved in the manufacture and distribution of a range of renal dialysis products (Renalyte Services Ltd, trading under the name Renacare), other pharmaceutical products (Martindale Pharmaceuticals Ltd (Martindale)), and veterinary pharmaceutical products, surgical instruments and equipment (Arnolds Veterinary Products Ltd). Until August 1990, when its wholesale business was sold to Medicopharma NV (Medicopharma), it was also the third largest United Kingdom wholesaler of pharmaceuticals. Of its turnover of £373 million in the year to September 1990 (£330 million if intra-group turnover is excluded), £177 million related to this pharmaceutical wholesaling business. The bulk of its continuing businesses' turnover is accounted for by its retail pharmacy chain (£88 million) and sales by Farillon (£70 million). The health food retail and wholesale businesses contributed £13 million to turnover in 1990.

UniChem

6.3. UniChem is one of the two largest wholesalers of pharmaceutical products in the United Kingdom. Originally formed by a group of retail pharmacists to operate as a wholesale distributor of pharmaceutical products to independent pharmacists, it became a public limited company in 1990. It supplies the full range of ethical pharmaceuticals (that is pharmaceuticals supplied only on pre-prescription) and also pharmaceutical and other products sold over the counter without prescription (OTCs), including a UniChem own-label range of such products. It is one of two full-line wholesalers which operate nationally. During our inquiry it acquired a chain of 93 retail pharmacies, E Moss Ltd (Moss), to add to the 39 it already owned. It has four wholly-owned subsidiaries, a manufacturer of nappies, a travel agent, a company operating franchises for pharmacies and a company which provides warehousing services to the rest of the group. In 1990 UniChem had a turnover of £873 million, almost all of which related to its pharmaceutical business. In 1988 the arrangements UniChem had made in relation to the allotment of shares in its capital were the

subject of an MMC inquiry. The MMC concluded in that inquiry that the arrangements had increased the risks and costs and reduced the effectiveness of UniChem's competitors and operated against the public interest. Following publication of the MMC's report, UniChem terminated its share allocation scheme.

Lloyds

6.4. Lloyds owns the second largest chain of retail pharmacies in the United Kingdom, with 655 outlets. It also operates 201 drugstores (shops which sell OTC medicines and other products but not medicines-principally ethical products-that can only be sold in pharmacies), 194 health food stores trading as Holland & Barrett Ltd (Holland & Barrett), and four opticians. It acts as a wholesaler of OTC products and health foods to independent pharmacies and health food stores. Its pharmacies are located throughout England and South Wales (but not Scotland or Northern Ireland), with particular strength in the West Midlands and the South-East. They are predominantly community pharmacies rather than high street stores. Lloyds had a turnover in the year to June 1991 of £248 million, of which £190 million was accounted for by the retail pharmacy business.

The merger situations

6.5. In July 1991 UniChem made an offer for the entire share capital of Macarthy. In August 1991 Lloyds also made an offer for Macarthy. In each case the offer lapsed when the reference was made to the MMC (on 5 September and 8 October respectively). Both UniChem and Lloyds have confirmed that arrangements to acquire all the share capital of Macarthy remain in contemplation. We have already noted that Macarthy's business is carried on in the United Kingdom. We conclude that if UniChem's acquisition of Macarthy were to proceed, enterprises carried on in the United Kingdom by or under the control of Macarthy would cease to be distinct from enterprises carried on by or under the control of UniChem. We also conclude that if Lloyds' acquisition of Macarthy were to proceed, enterprises carried on in the United Kingdom by or under the control of Macarthy would cease to be distinct from enterprises carried on by or under the control of Lloyds. The gross assets of Macarthy at 29 September 1990 amounted to £79.8 million. We conclude that the assets test in section 64(1)(b) of the Act is satisfied in respect of each merger situation and accordingly the terms of the references preclude us from considering in each case the market share test in section 64(1)(a) of the Act. Neither merger has yet been effected and we therefore conclude that there is no merger in being in either case. We conclude in the case of UniChem's proposed acquisition of Macarthy that arrangements are in contemplation which, if carried into effect, will result in the creation of a merger situation qualifying for investigation. We also conclude in the case of Lloyds' proposed acquisition of Macarthy that arrangements are in contemplation which, if carried into effect, will result in the creation of a merger situation qualifying for investigation.

6.6. During the course of our inquiry, Lloyds requested that the reference relating to its proposal to acquire Macarthy should be laid aside on the grounds that following the withdrawal from the United Kingdom of the third largest wholesaler, Medicopharma (as described in more detail in paragraphs 6.18 to 6.20), Lloyds would not be acquiring a significant part of the previous activities of Macarthy (namely the sourcing of ethical pharmaceuticals from Medicopharma) and arrangements for supply alternative to those previously in contemplation would need to be put in place; accordingly, arrangements in progress or contemplation at the time of the reference had been abandoned. We gave careful consideration to the relevant evidence, but found that there was no abandonment by Lloyds, within the meaning of section 75(5) of the Act, of its proposal to make arrangements such as were mentioned in the reference.

6.7. We therefore now have to investigate and report on whether, in each case, the creation of the merger situation may be expected to operate against the public interest.

The pharmaceutical market

6.8. United Kingdom sales of pharmaceuticals (both ethicals and OTC medicines) amounted to almost £3,800 million in 1990. Of these, two-thirds were ethical products dispensed by retail pharmacies, 17 per cent were ethicals dispensed by hospitals or doctors and the remainder (17 per cent) were OTC medicines. Ethical pharmaceuticals include both branded products and generics. Generics are products sold by reference to their chemical formulation; there may be many different makes once a brand is out of patent. They may differ in tablet shape and so on. The market for pharmaceuticals is expected to grow steadily in the future, principally because of demographic trends, in particular an increase in the number of people aged over 65.

The retail pharmacy market

6.9. There are just under 12,000 retail pharmacies in the United Kingdom with contracts to dispense National Health Service (NHS) prescriptions. Retail pharmacies typically also sell a range of other products including OTC medicines, toiletries, baby foods and health foods. Some OTC medicines can only be sold in a retail pharmacy under the supervision of a qualified pharmacist. These are known as pharmacy-only medicines ('P' medicines). Others can be sold in any retail outlet and are often found, for example, in drugstores and supermarkets. On average, about 45 per cent of the turnover of retail pharmacies in 1990 was accounted for by NHS receipts. Pharmacies may supply a range of professional services to their customers including counselling and advice (on prescription and OTC medicines and other products), patient medication records, monitored dosage systems for residential nursing homes and pregnancy testing.

6.10. The largest retail pharmacy chain is Boots The Chemists Ltd (Boots) with 1,054 outlets, accounting for around 9 per cent of the total number of retail pharmacies and about 11 per cent of retail ethical pharmaceutical sales in 1990. Lloyds is the second largest, now accounting for under 6 per cent of outlets, with a similar current share of retail ethical sales. The proposed acquisition of the Macarthy chain would increase its share to just over 7 per cent. Having acquired the Moss chain, UniChem now accounts for just over 1 per cent of outlets with a similar share of retail ethical sales. The proposed acquisition of Macarthy would increase this to about 2.5 per cent. As Table 3.5 showed, there has been an increase in the share of retail pharmacies owned by large chains, but three-quarters of all retail pharmacies are still either single-outlet businesses or form part of a chain of fewer than six outlets.

Local competition

6.11. The catchment areas served by retail pharmacies are difficult to define but are often quite small. So-called community pharmacies are frequently sited within a short distance of doctors' surgeries and the location of the surgeries is, we were told, generally the most important factor in location decisions. Other factors include the number and geographical spread of local residents, the road and bus systems, car parking and location of hospitals.

6.12. Some pharmacies are in the high street (such as the Boots chain) and these will typically draw customers from a much wider catchment area. There are now also a growing number of pharmacies in major supermarkets. For example, a number of the pharmacies in the Moss chain acquired by UniChem are located in Asda stores.

6.13. Depending on where they are situated, pharmacies may have very different sales profiles. UniChem told us, for example, that the pharmacies in supermarkets had a much lower proportion of prescription business, whereas for community pharmacies prescription business may account for more than two-thirds of turnover.

6.14. The NHS generally pays for the cost of prescription drugs. The patient pays a fixed NHS prescription fee (from which a number of categories of people are exempt, representing around 80 per cent of prescriptions). There is therefore no retail price competition in the case of prescription products. Competition is primarily dependent on location and service (for example, the time taken to fulfil a

prescription and opening hours). In some areas, there is only one pharmacy, or where there is more than one, they are owned by the same company. No evidence was put to us, however, that in these areas service was less good than in areas where there were more pharmacies in different ownership. In part this may reflect the fact that some customers of the typical community pharmacy-the outlet close to the surgery-will have the option of obtaining medicines elsewhere. If there is no great urgency, the visit to the pharmacist may, for example, be combined with shopping. The presence of pharmacies in the high street and in out-of-town superstores (and thus often away from surgeries-see paragraph 6.12) reflects factors such as these. A single local pharmacy will therefore face competition for some of its business even if other customers have little choice.

6.15. For OTC medicines-both 'P' products and general sales list (GSL)-resale price maintenance is permitted pursuant to the Restrictive Trade Practices Act 1976 and we understand is generally enforced, but there may be, for example, own-label OTC medicines or different brands offered. Thus range of choice can be an important aspect of competition. GSL medicines may be sold in other outlets, in particular in drugstores. We would expect a proportion of the customers for GSL medicines to be prepared to shop around, and this should act as a constraint on an individual pharmacy unduly reducing choice or increasing prices. Nonetheless the competitive pressure from other types of outlet is not likely to be as great as that from other pharmacies, and this needs to be taken into account in looking at local concentration.

6.16. OTC products other than medicines, such as toiletries, baby foods and so on, are also sold in other outlets, such as drugstores and supermarkets. Thus even where there are no other pharmacies, there is likely to be some competition in the supply of OTC products from other outlets either locally or in the nearest town and there are no significant barriers to new entry. For most OTC products, the timing of the purchase will usually not be as critical as for medicines.

Wholesalers and direct supply by manufacturers

6.17. In 1990, three-quarters of pharmaceutical supplies to retail pharmacies, hospitals and dispensing doctors were handled by wholesalers. The remainder were supplied direct by manufacturers, by distribution agencies or by importers. The two largest retail chains, Boots and Lloyds, purchase the bulk of their requirements (and in particular the more frequently prescribed drugs) direct from manufacturers, but overall only 17 per cent of ethicals are supplied in this way to retail pharmacies. Over half of the requirements of hospitals is supplied direct by manufacturers. There are currently some 30 full-line pharmaceutical wholesalers, which stock the full range of ethical pharmaceuticals. Two of these, UniChem and AAH Holdings plc (AAH), operate throughout the United Kingdom, while others operate in particular regions. In addition, there are a large number of short-line wholesalers which sell a more restricted range, particularly of generics, as some pharmaceutical manufacturers supply branded ethical products only to full-line wholesalers which take their complete range. (Indeed, there are wholesalers which, in order to offer the full range, have to obtain the products of some prominent manufacturers from other wholesalers. It is thus not the case that a full-line wholesaler will automatically be able to secure direct supply from all manufacturers.) Most wholesalers offer twice-daily delivery, except to remoter pharmacies. There has been a significant decline in the number of full-line wholesalers in recent years. Membership of the British Association of Pharmaceutical Wholesalers (BAPW), which includes most full-line wholesalers, has declined from 39 in 1978 to 25 in 1991.

6.18. As shown in Table 3.8, UniChem and AAH together accounted for about 60 per cent of the wholesale market in 1990. They have similar market shares in respect of sales of all pharmaceuticals by wholesalers, with UniChem being the larger supplier of ethicals to retail pharmacies and AAH being slightly the larger supplier when sales to dispensing doctors and hospitals are also included. The third largest supplier was Medicopharma, which entered the United Kingdom market in 1990 through the acquisition of the wholesale businesses of E H Butler & Sons and of Macarthy. The businesses acquired by Medicopharma accounted for 8 per cent of sales of pharmaceuticals by wholesalers in 1990. In November 1991 Medicopharma withdrew from the market. Medicopharma told us that this decision formed part of a short-term strategy of reallocating resources towards its activities in the Netherlands, enabling the group's indebtedness to be substantially reduced. It also said that to remain competitive in the United Kingdom, Medicopharma would have had to commit substantially more financial resources which the Board

considered would be needed to consolidate and develop its core pharmaceutical production and wholesaling business in the Netherlands. The leases on three of Medicopharma's depots and certain other assets and stocks were acquired by AAH. A separate reference in this connection was made to us by the Secretary of State for Trade and Industry on 21 November 1991.

6.19. Medicopharma's largest customer was the Savory & Moore chain of pharmacies owned by Macarthy. Under the terms on which Macarthy sold its wholesaling business to Medicopharma in August 1990, a supply agreement for the Savory & Moore chain was negotiated which provided that for five years Savory & Moore would purchase not less than 90 per cent of its ethical requirements from Medicopharma, subject to annual negotiation of discount rates not less favourable by more than 0.5 per cent than Savory & Moore could obtain from other wholesalers. Following Medicopharma's withdrawal from the United Kingdom market, UniChem became the principal supplier of ethical pharmaceuticals to the Savory & Moore chain.

6.20. Medicopharma was the largest member of Numark Management Ltd (Numark), a voluntary trading organisation owned by independent full-line pharmaceutical wholesalers which undertakes central negotiation with manufacturers on OTC products (including a Numark own-label range) and on some generic and ethical drugs and also undertakes marketing initiatives.

6.21. We were told that the two national wholesalers have a number of advantages over the regional wholesalers. All wholesalers purchase branded ethicals at the same price (as discussed in paragraph 6.30), but larger wholesalers are likely to obtain better terms on generics, parallel imports, OTC medicines and other OTC products because of the scale of their purchases. We were told that the use of generics is increasing and this factor is therefore becoming more significant. There are also economies of scale in depot operation and distribution, for example through automated picking and other use of computer technology. Retail pharmacy chains tend to prefer to source from one main supplier, which means that regional wholesalers may find it hard to compete to supply chains which cover a wider region than their own.

6.22. The main parties told us that there were no significant constraints on pharmacies substituting one wholesaler for another. The evidence suggested, however, that retail pharmacies do not in practice frequently switch suppliers, which may make it more difficult for a new entrant to the wholesale market to become established.

6.23. The final demand for ethical pharmaceuticals is determined by what doctors prescribe, which is for the most part not related to cost. The prescriptions presented to pharmacies similarly determine demand by retail pharmacies from wholesalers or manufacturers. In the case of generics, there may be products from several companies which could meet the prescription, but where a branded ethical is prescribed, no other product can be substituted for it. This means that normal competitive pressures do not operate for branded ethicals.

6.24. It has been usual for retail pharmacies to use one wholesaler for the bulk of their supplies and also to have one or more additional or second-line suppliers, in order to ensure that all required ethical products can be supplied for patients. This may, however, change in future. Minimum purchasing requirements and sliding scale discounts offered by wholesalers give an incentive to source as much as possible from one supplier. UniChem also told us that problems of being out of stock of particular products tend now to occur less frequently than in the past and arise primarily when there is a shortage of supply from the manufacturer (such as in an epidemic), which would affect all wholesalers. Thus it was expected that retailers would tend in future to rely on fewer wholesalers for their supply.

6.25. We were told that hospitals may as a matter of policy in future carry less stock and rely to a greater extent on wholesalers. Increasing use of small packs of drugs has also meant that individual pharmacies now tend to hold lower stocks and rely to a greater extent on wholesalers. Both these factors suggest an increasing role for wholesalers. On the other hand, the use of generics, which pharmacies have tended to buy to a greater extent direct from manufacturers, is growing and self-supply by retail pharmacy chains may also increase.

6.26. Glaxo Pharmaceuticals UK Ltd (Glaxo), the largest United Kingdom ethical pharmaceutical manufacturer, recently adopted new arrangements for the distribution of its products to retail pharmacies. Under the new system, the physical distribution of Glaxo's ethical products will be undertaken by wholesalers acting as agents of Glaxo, and receiving an agency fee. The terms on which retail pharmacies will be supplied will be determined direct between Glaxo and the retail pharmacies, and will, we were told, initially be similar to those previously offered by wholesalers. It was suggested to us that other ethical manufacturers might consider adopting similar distribution arrangements in the future.

6.27. Most of those who gave us evidence described the pharmaceutical wholesale market as very competitive in respect of both ethicals and OTC products. It was generally argued that the terms enjoyed by retail pharmacies were no less favourable where there were a smaller number of wholesalers. Much of this evidence was received prior to the withdrawal from the United Kingdom of Medicopharma. Further evidence suggested that this withdrawal had not reduced the level of competition between wholesalers in the short term, as wholesalers were vying to capture the former Medicopharma business. A number of third parties did, however, express concern that the market was becoming increasingly dominated by the two national wholesalers and that this could lead in the future to reduced discounts or a reduced level of service.

6.28. Vertical integration in the pharmaceutical market has been increasing. A number of pharmaceutical wholesalers now own retail pharmacies. AAH currently has 138 and, as already noted, UniChem owns 132 pharmacies. Some regional wholesalers operate retail pharmacies as shown in Table 3.14. In some cases retailers have acquired pharmaceutical wholesalers or set up a wholesale business. There are also various links between wholesalers and retail pharmacies. There are over 2,000 loan guarantees (which include certain purchasing obligations) provided by wholesalers, and in particular by UniChem and AAH. Numark also operates a loan guarantee scheme but this does not include any purchasing requirements. UniChem argued that such arrangements did not effectively tie retail pharmacies as they could be ended at any time without penalty, but other evidence suggested that it was not so easy for retail pharmacies to switch to alternative sources of finance. Wholesalers may also supply retail outlets with computer terminals. These can provide benefits to the pharmacist as well as to the wholesaler. There were different views expressed to us on whether these effectively tied the pharmacist to the wholesaler.

6.29. The two largest retail pharmacy chains, Boots and Lloyds, supply a high proportion of their pharmaceutical requirements direct from manufacturers, and a number of the smaller pharmacy chains buy at least part of their ethical requirements direct from manufacturers or importers. Direct supply as a proportion of total purchases by retail pharmacies fell slightly over the period 1988 to 1990 (see Table 3.12). This was because more generics and parallel imports (that is branded ethicals manufactured abroad) were bought from wholesalers rather than direct from manufacturers or importers and because there was a switch by some self-supply chains towards greater use of wholesalers. One such chain, Kingswood GK Ltd, was, however, subsequently acquired by Lloyds.

The regulatory framework

6.30. Regulation affects the retail and wholesale pharmaceutical market in a number of ways. The profits earned by manufacturers of branded ethical pharmaceuticals are controlled by a voluntary scheme, the Pharmaceutical Price Regulation Scheme (PPRS), as described in paragraphs 3.6 to 3.8. If the Department of Health (DH) considers that a manufacturer's profits are higher than is reasonable, it may either negotiate repayment of profits or require the company to reduce prices. Under the PPRS manufacturers can make an allowance not exceeding 12.5 per cent of the NHS list price for the wholesale margin on the product. There is no incentive for manufacturers to offer greater discounts to wholesalers for volume purchases, and manufacturers generally supply branded ethical products to all wholesalers at list price less the 12.5 per cent discount. Within this margin, wholesalers can compete for pharmacists' business, and discounts on ethicals by wholesalers can, for the largest customers, amount to 10 per cent or more.

6.31. Pharmacies are reimbursed for dispensing NHS prescriptions for the cost of the drugs and also receive a professional dispensing fee. In assessing the cost of the drugs to be reimbursed, the DH makes a deduction for the average discounts achieved by pharmacies according to the bands of turnover in which

they fall. This system allows the DH to receive some of the benefits of price competition between wholesalers while providing pharmacies with an incentive to achieve a discount greater than average. The average level of discount recovery has increased from 5.5 per cent in 1980 to 9.7 per cent currently. The discount recovery system may, however, benefit retail chains compared with individual retail pharmacy outlets, as the retail chains are able to obtain higher discounts from wholesalers than the average assumed by the discount recovery scales.

6.32. The current arrangements for remunerating pharmacists for their professional service were introduced in 1989. Prior to that, the system was essentially based on a cost-plus approach; the DH told us that the number of pharmacies increased between 1980 and 1987 from 9,700 to 12,000, leading to higher costs for the NHS.

6.33. Entry into both pharmaceutical wholesaling and retailing is also subject to regulation. A licence is needed to operate as a pharmaceutical wholesaler, as described in paragraph 3.9. We received no evidence, however, that the requirements had in practice inhibited entry by new wholesalers into the market. As regards retailing, prescriptions cannot be dispensed (or 'P' medicines be sold) without a qualified pharmacist being on the premises, and the pharmacy must have a contract with the local Family Health Service Authority (FHSA). Until 1987 such contracts were awarded to any qualified pharmacist who applied. Since 1987, a pharmacist seeking a contract must show that a new pharmacy is 'necessary or desirable for the proper provision of pharmaceutical services in the area'. The DH told us that this new control was introduced in order to limit the number of retail pharmacies to ensure a cost-effective system of distribution (see paragraph 6.32) and to discourage 'leapfrogging', that is, for example, moving a pharmacy so as to bring it closer than its competitor to a doctors' surgery.

6.34. FHSAs are also responsible for taking disciplinary action against pharmacists for poor service. There are some 90 FHSAs in England (8 in Wales). Each has nine non-executive members including a doctor, a dentist, a pharmacist, a community nurse and five 'generalists' together with a general manager and a chairman. Their main functions are to manage the contracts with primary health care providers, maintain patient data registration, develop and monitor primary health care services, assess the health needs of the local population and provide information to the public on the availability of services. Investigation of complaints is only a small part of their functions. Although they have powers to fine or reprimand pharmacists, to permit a new contract or, in an extreme case, to withdraw an existing contract, such action is, we were told, rare. Similar functions to those of FHSAs are undertaken in Scotland by Health Boards and in Northern Ireland by Health and Social Services Boards. The Royal Pharmaceutical Society of Great Britain (RPSGB) has powers to take action against misconduct by a pharmacist, and it issues guidance on good practice as well as minimum requirements. We note, however, that in a recent Consumers' Association survey (see paragraphs 5.146 to 5.148) many pharmacists fell short of the RPSGB's Code of Ethics and of standards advised by the Consumers' Association's expert panel in such matters as asking sufficient questions of customers and recommending suitable remedies.

6.35. There have therefore been two significant recent changes in the regulatory system affecting pharmacies, the controls on entry introduced in 1987 (paragraph 6.33) and the change to the remuneration system for pharmacists in 1989 (paragraphs 6.31 and 6.32). Both of these changes would tend to discourage a proliferation of pharmacies and the number of retail pharmacies has indeed stayed broadly constant since 1987. We were told by some parties giving us evidence that the purchase price of retail pharmacies has increased significantly since 1987. This may in part reflect the acquisition strategy of some companies in the market, but it is also likely to reflect an increased value for an NHS pharmaceutical contract. We note in this context the study as described in paragraph 3.29. Lloyds told us that, based on its own experience of acquiring retail pharmacies, it estimated that goodwill values represented on average around 60 per cent of turnover and that this had not changed since 1986. We note, however, that it included, as tangible assets, amounts of £10.1 million and £21.3 million respectively in its 1990 and 1991 balance sheets, representing, it told us, the difference between the existing use values and the alternative use values of its shop premises. We calculated that these amounts were equivalent to an average of some £23,500 per shop at 30 June 1990 and £33,600 per shop at 30 June 1991.

6.36. The evidence suggests that the 1987 controls on entry have been acting as a significant barrier. Although individual FHSAs can allow additional contracts, in practice they would only do so where the service of existing pharmacies was clearly inadequate. Thus existing pharmacies do not face the full force of the threat of potential competition from a new pharmacy opening nearby and the risks associated with operating pharmacies are reduced. The DH suggested that this may have had a beneficial effect on investment in improvements in pharmacies. On the other hand, it is arguable that reduced potential competition may have the opposite effect, and may also reduce the spur to improve service to customers.

6.37. In so far as the controls have contributed to higher purchase prices for pharmacies, which we consider they must have, there are likely to be additional effects. We were told that they had reduced the ability of independent pharmacists to purchase pharmacies relative to the larger chains and wholesalers. The number of independents has indeed declined. The higher price of pharmacies is also likely to have led to an increase in demand for the loan guarantee schemes operated by wholesalers (which offer favourable finance terms and usually include a purchasing obligation in respect of pharmaceuticals). The controls also have to be seen against the background of the existing trend toward vertical integration which has been limiting the growth, and even the maintenance, of the potential retail customer base for non-vertically integrated wholesalers. If a wholesaler wishes to maintain or expand its customer base, acquisition of retail outlets becomes an important option, as opening of new pharmacies is inhibited by the controls.

6.38. This is thus a highly regulated market in which normal competitive pressures in many respects do not apply. The manner of regulating the various parts of this market is bound to have a significant effect on the way it operates, and should, in our view, be subject to regular review. The regulatory structure may itself be encouraging the trend toward vertical integration or horizontal concentration, at either wholesale or retail level. We consider that in reviewing the impact of the regulations, the DH ought to pay close attention to the possible effects on competition. It is not clear that sufficient weight is currently being placed on this aspect. It is against this background of regulatory intervention that the merger situations which have been referred to us have to be considered.

The health food market

6.39. There are almost 2,000 specialist health food stores in the United Kingdom. These stores sell a wide range of health food products, including cereals, pulses, health drinks and snacks, baby foods, sports and slimming aids, vitamin and dietary supplements, herbal products and homeopathic medicines. Many health food stores also sell non-food products such as environment-friendly household products, cosmetics which have not been tested on animals and books related to health.

6.40. Sales of health foods have grown from about £370 million in 1986 to about £600 million in 1990, of which 48 per cent were through specialist health food stores. As Table 3.17 showed, the proportion of health foods handled by health food stores has fallen progressively over the last five years, as supermarkets and other grocers in particular have increased their product ranges to include such products. Pharmacies and drugstores have also raised their share of the market, selling products such as vitamins and dietary supplements. Supermarkets and other retail outlets are unlikely, however, to offer as comprehensive a range of health foods as the specialist stores.

6.41. The largest retail chain is Holland & Barrett which has 194 outlets and which is owned by Lloyds. Macarthy operates the second largest chain, Lifecycle, which has 29 outlets. Together these two chains account for some 20 per cent of total sales by specialist health food stores and about 10 per cent of health food sales by all retail outlets. Both chains are mainly located in the South of England. UniChem has no involvement in the health food market.

6.42. The evidence we received suggested that demand is not very sensitive to price in the case of health foods. There are no significant barriers to entry to this market.

6.43. There are over 100 specialist health food wholesalers, the largest of which are Brewhurst Health Foods Supplies (Brewhurst), which is owned by Booker PLC, and Nature's Store, a subsidiary of

Macarthy. Nature's Store has about an 8 per cent share of total sales at wholesale level. About a quarter of Nature's Store's health food sales are to the Macarthy retail outlets and the remainder to independent specialist health food stores. Lloyds acts as a wholesaler to the Holland & Barrett chain and also, following its acquisition from the receiver of assets of SOT Health Food Ltd (SOT) which had about 2 per cent share of the wholesale sales, supplies independent health food stores and pharmacies.

The public interest

UniChem acquisition of Macarthy

6.44. The proposed merger would give UniChem, one of the two largest pharmaceutical wholesalers, which already owns a number of retail pharmacies, a significant enhancement in its retail pharmacy chain. In considering the implications for the public interest of this merger, we first consider possible effects on the wholesale market, then the effects on competition at the retail level and finally the implications of the acquisition of Farillon and of Renacare and Martindale. We do not consider that acquisition of the health food operations or of the veterinary pharmaceutical business by UniChem would give rise to concern for competition or other aspects of the public interest; UniChem has no current involvement in these areas.

Effects on the wholesale pharmaceutical market

6.45. At the time the merger was referred to us, the Savory & Moore chain was supplied by Medicopharma. An important concern raised in evidence to us was the possible effect of any acquisition on Medicopharma. During our inquiry, however, Medicopharma withdrew from the United Kingdom market and UniChem became the principal supplier to the Savory & Moore chain. It is in the light of these changed circumstances that we now have to consider the proposed merger.

6.46. As noted in paragraph 6.27, the evidence we received suggested that there is currently active competition in the wholesale market but there are concerns as to whether this will continue. The number of wholesalers has declined sharply in recent years. The number of wholesalers may drop further or their position may be weakened and that of the two main companies-UniChem and AAH-strengthened, which could, it was argued, lead to a reduction in service or discount levels. We considered whether in the light of these trends the nature of competition between wholesalers was likely to be adversely affected by the proposed merger.

6.47. There are some barriers to entry to this market, including the fact that some pharmaceutical manufacturers only supply branded ethical products to full-line wholesalers which take their complete range. As we have noted in paragraph 6.21, the national wholesalers already have a number of significant advantages over the regional wholesalers, including economies of scale both in purchasing and wholesale operations. We further note that retail pharmacy chains tend to prefer to source from one main supplier. There is also an increasing degree of vertical integration, as discussed in paragraph 6.28. We recognise that the growth of Lloyds (which uses self-supply for the bulk of its requirements), the purchases by wholesalers of retail outlets and the development of other ties (such as loan guarantee schemes) have reduced the number of 'free' retail pharmacies which can in practice be supplied by regional wholesalers. We found that there was a wide variation in financial performance between the regional wholesalers- whilst some made a loss in 1990, others earned profits as high as those achieved by the nationals-but overall the profit margin earned was around half that of the two national wholesalers.

6.48. It was suggested to us that if the Savory & Moore chain were owned by a company with no other interests in the industry, regional wholesalers would have the opportunity to compete for the business of part or all of the Savory & Moore chain and that this opportunity would be lost if UniChem acquired the chain. For a number of years, however, Savory & Moore has always been supplied for most of its requirements by one major source covering the whole chain-first, by Macarthy itself, then Medicopharma and subsequently UniChem. Apart from UniChem and AAH, no wholesaler covers all the locations of the Savory & Moore outlets. Savory & Moore outlets are mainly located in Central Scotland, South Wales and the South-West and South-East regions of England (see Figure 3.2). Macarthy told us that, when

Medicopharma withdrew, although some regionals had offered attractive terms for supplying part of the chain, the discounts achieved were likely to be highest if a single deal was struck for the whole chain. We therefore consider it highly questionable whether in practice a regional wholesaler or combination of wholesalers would in current circumstances gain this custom if the Savory & Moore chain remained in independent ownership.

6.49. We also note that the Macarthy shops account for only 1.5 per cent by value and by volume of the retail sales of pharmaceuticals. This proportion would be higher in some regions. In the South-West, the Macarthy shops account for 3 per cent of total ethical sales. Regional wholesalers do not, however, have significant turnover in that region. Although the merger might make new entry by a regional wholesaler somewhat more difficult, we consider that this would not be a significant effect. Another region where the Macarthy shops are more concentrated is in the central belt of Scotland, where regional wholesalers do operate. The Macarthy shops represent, however, under 6 per cent of the ethical sales in that region. Therefore if there was an effect on the ability to compete of independent wholesalers in particular regions, it would not be a very large one.

6.50. We considered whether the merger would have an effect on UniChem's buying power and whether this would make it more difficult for regional wholesalers to compete. As regards ethicals, the PPRS provides no incentive for manufacturers to give higher discounts to large purchasers. The evidence suggested that all wholesalers in practice receive the same level of discount. We therefore do not expect any effect to arise in this respect on ethicals.

6.51. On generics, UniChem argued that the merger would not give it any greater purchasing power relative to the manufacturers, noting that most generic manufacturers were owned by major drug companies. Nor did UniChem consider that there would be an effect on its purchasing of OTC products, although we noted its statement when it acquired the Moss chain of 93 outlets that it expected to achieve some benefits from increased purchasing power. We accept that there is some scope for the exercise of purchasing power on generics and OTCs in this market. We consider, however, that UniChem already has a strong buying position, by virtue of its market share as a wholesaler. It currently supplies the Macarthy chain, which represents about 3 per cent of its turnover. The merger would ensure that it retained the Macarthy business. We accept that this could have an effect on its buying position, but we do not think it would be a large one. Even if the merger did have such an effect, it could be argued that there would be public interest benefits. In so far as it led to lower prices on generics to retail pharmacies, this would be likely to lead over time to reduced costs for the DH and thus the taxpayer, as it would be reflected in the level of reimbursement to pharmacies for dispensing NHS pharmaceuticals. If it led to lower prices on OTC products, this could benefit consumers purchasing such products from pharmacies.

6.52. It was put to us that an increase in UniChem's purchasing power could be used to drive down prices to such an extent that a small manufacturer might be forced out of business or have to reduce its range. It would, however, in our view be unlikely to be in UniChem's commercial interest to reduce the number of its suppliers. Moreover, we do not consider that the size of the Savory & Moore chain is sufficiently large to have this effect, particularly as some OTC products are sold through other outlets as well as pharmacies.

6.53. We considered carefully the argument that the wholesaling market is likely to become less competitive and, against this background, that any change which strengthened the position of one of the two largest wholesale players was undesirable. The market has in recent years become more concentrated, and the withdrawal of Medicopharma (which occurred during our inquiry, as discussed in paragraphs 6.18 to 6.20) is a further move in this direction. We accept that there is a risk that the number and strength of regional wholesalers may fall in the future. However, although there are thus grounds for unease about the trends in concentration at the wholesale level, we do not consider that the competitiveness of the wholesale market will be materially weakened by this particular merger. We do, however, consider that the Director General of Fair Trading should scrutinise carefully any developments in this market, at wholesale or retail level, which might reduce competition. The point is also very relevant to the DH's regulatory policy (as discussed in paragraphs 6.30 to 6.38).

Effects on competition between retail pharmacies

6.54. During our inquiry, UniChem acquired the Moss chain of 93 outlets, the sixth largest chain of retail pharmacies. It thus now owns 132 retail pharmacies. These are dispersed throughout England and Scotland. The Savory & Moore chain is located in Central Scotland, South Wales and the South-West and South-East of England (as shown in Figure 3.2). The UniChem outlets have a market share at the retail level of just over 1 per cent by number of outlets and by value of NHS sales. The shares of the Savory & Moore chain are about 1.5 per cent in each case. If the merger were to proceed, UniChem would thus have a 2.5 per cent share of the national retail market. Given the controls on entry, and the increasing integration which has been occurring, we need to consider carefully any increase in concentration. We do not, however, think that a market share of 2.5 per cent would give grounds for concern.

6.55. We went on to consider whether, following the merger, there could be a conflict of interest between UniChem's role as a significant wholesaler and as a sizeable retailer, and whether there were grounds for concern for competition in particular localities.

Role as wholesaler and retailer

6.56. It was put to us that UniChem might discriminate between its own outlets and other outlets it supplied. We concluded, however, that this is not likely. If UniChem offered a less good service to independent outlets, for example by favouring its own outlets at times of shortage of particular drugs, or in terms of convenience of delivery times, we would expect another wholesaler to gain business.

Local competition between retail pharmacies

6.57. We consider, as discussed in paragraphs 6.11 to 6.16, that the nature of competition between retail pharmacies is to a large extent local. For the reasons given in paragraphs 6.14 and 6.15 there is no retail price competition for either prescription products or OTC medicines, but service levels and range of choice of OTC medicines could be of concern where there was a lack of competition at the local level. We consider that there is less cause for concern in relation to OTC products other than medicines for the reasons given in paragraph 6.16. As noted in paragraph 6.34, the FHSAs (in England and Wales), Health Boards (in Scotland) and Health and Social Services Boards (in Northern Ireland) have power to take action if pharmacy service levels fall below an acceptable level, although we note that they also have a wide range of other functions. Moreover we do not consider that such intervention is likely to be as effective as competition, or the threat of it. A natural market response if service levels fall would be for a new firm to come in. It is of some concern that entry has been severely inhibited if not foreclosed by the regulatory mechanisms in place at present. Against this background, we consider the particular overlap implied by the merger.

6.58. The Savory & Moore pharmacies are located mainly in Central Scotland, South Wales and the South-West and South-East regions of England. UniChem's pharmacies are fairly widely dispersed throughout England and Scotland as shown in Figure 3.2. The definition of catchment areas is not easy, for the reasons given in paragraph 3.31 and as noted in paragraph 6.11. We considered evidence from Macarthy, including some analysis of the post-codes of customers using each retail pharmacy. In six locations there is both a Savory & Moore pharmacy and a UniChem pharmacy, which after a merger would come under common ownership. However, in all of these cases there are at least two other pharmacies, as shown in Appendix 3.1, Table 2. We consider that the merger would not result in a significant reduction in competition in any of these localities.

6.59. Therefore, although we consider that a high degree of concentration in a particular area could give rise to concern, we do not consider that this would arise in this particular case.

Farillon

6.60. The merger would mean the acquisition by UniChem of Farillon, the largest United Kingdom exclusive distribution agency for pharmaceutical products, including branded ethicals. Farillon distributes on behalf of over 40 United Kingdom and overseas manufacturers (its principals) and provides a range of services for them according to their requirements. The package may include product licensing, financing of working capital and the provision of detailed management information, warehousing and distribution.

6.61. Farillon is an agency distributor, that is to say it does not have its own sales force, and does not engage in any promotional marketing of the products. It merely acts as the United Kingdom distribution arm of its principals. Supply by the manufacturer is via Farillon and onwards through the usual distribution chain of pharmaceutical wholesalers to pharmacies or direct to hospitals. OTC products are also supplied through the wholesaler to the pharmacy network to satisfy consumer demand at retail level created by manufacturers' marketing activities.

6.62. The marketing effort for Farillon's principals is carried out by those principals' own sales representatives/agents who service the customer base. Each principal also controls its own pricing and discount policies. Farillon distributes nationally to all full-line pharmaceutical wholesalers. Macarthy told us that it treated Farillon as a totally separate part of its business, a policy which had been in place for many years.

6.63. For the year ended 29 September 1990 Farillon's invoiced sales were approximately £70 million, of which some £5 million could be regarded as OTC products. Macarthy estimated that Farillon had about a 2 per cent share of the wholesale market for pharmaceuticals.

6.64. It was suggested that UniChem might favour supply to its own customers against supply to other wholesalers or would otherwise disadvantage its competitors which would be completely dependent on Farillon as its products were essential items. Macarthy and UniChem considered that the Farillon principals would not continue to use Farillon's services if such a policy was adopted. The price for Farillon products was set by Farillon's principals. On the basis of the way Farillon operates as described above, we consider there not to be a real risk of UniChem using the Farillon operations to its advantage in this way, particularly given the fact that a very high percentage of Farillon's sales are branded ethicals. If, contrary to our expectations, it did emerge that UniChem was withholding supply from its competitors in order to enhance its own position and the Farillon principals did not take action, we note that powers are available under the competition legislation.

6.65. It was also put to us that a conflict of interest could arise if the owner of Farillon also distributed competing products, especially OTCs, as would be the case with UniChem. If, however, UniChem favoured its own products over those of Farillon principals, it would be open to the Farillon principals at any time to make alternative distribution arrangements.

6.66. It was further suggested to us that this acquisition could affect competition as UniChem would thereby receive certain information about the trade of other wholesalers, which could enable it selectively to target other wholesalers. We asked six significant regional wholesalers whether the acquisition of Farillon by UniChem would indeed give UniChem an advantage in this respect. All but one of the wholesalers considered that the acquisition would be of concern. Several noted that, as a supplier, Farillon could request access to accounts and other detailed financial information before these were required to be published. Two said that Farillon had recently asked for such information. They noted that the ethicals Farillon supplied were essential items for them.

6.67. Both Macarthy and UniChem argued that potential access to financial and trading information would not add materially to market intelligence already available. Macarthy told us that Intercontinental Medical Statistics Ltd (IMS) gave information on sales data of pharmaceutical wholesalers on a monthly basis. Both Macarthy and UniChem argued that if a particular wholesaler was in financial trouble or was

doing particularly well, this would be known generally in the trade, particularly as their sales representatives regularly visited pharmacies to try to attract further business. They also noted that the terms as to credit were effectively determined by Farillon's principals. Macarthy said that Farillon used a credit reference agency to determine the creditworthiness of its customers.

6.68. The wholesalers also suggested that the developing trends in the scale of business between Farillon and wholesalers either in total or in relation to particular products could be representative of trends in the total business of those wholesalers. Macarthy agreed that trends in purchases of particular Farillon products which were in regular demand could indeed be a good indicator of trends in the total business of a wholesaler. The information would, however, only be an indicator of trends, with a significant time-lag, as Farillon delivered only fortnightly and there would frequently be sharp divergencies from one order to the next. Moreover, available market information-in particular the IMS data-would also give such an indication of trends. UniChem doubted whether meaningful conclusions could be drawn from Farillon sales data. Information provided by UniChem demonstrated that the purchases of one of its depots from Farillon gave no reliable indications on trends in that depot's total sales, but the combined purchases of all its depots showed a closer relationship to its total sales.

6.69. We would be concerned if the acquisition were to give UniChem access to data which would enable it selectively to target other wholesalers to take their business away, thus further strengthening its own competitive position. We are not persuaded, however, that this is likely. It is by no means clear that UniChem would request or be given financial information other than of strict relevance for credit-worthiness purposes or, if it did, that this would add materially to information available from other sources. We note that credit terms are determined by Farillon's principals. On the basis of the data provided to us, it also does not appear that the evidence from sales figures would be sufficiently reliable as an indicator of the total sales of particular wholesalers, especially as the wholesalers concerned would be aware that UniChem could potentially have access to this information. Again, market intelligence is available from other sources. We also take note of the fact that sales of Farillon products represent only 2 per cent of the wholesale market. For these reasons we do not expect a materially adverse effect to arise from the acquisition of Farillon by UniChem.

Renacare and Martindale

6.70. Two other businesses which would be acquired by UniChem would be Renacare and Martindale. It was suggested that this would increase UniChem's share of supply to hospitals through supplying renal dialysis fluids and certain pharmaceutical formulations and branded OTC lines. UniChem argued that as a result it would be in a stronger position to compete with the main national supplier to hospitals, AAH. The businesses also supply some products to retail pharmacies. The turnover of Renacare and Martindale is, however, quite small, being under £7 million combined, and represents less than 1 per cent of total hospital purchases. We see no reason to believe that these acquisitions would have adverse effects for the public interest.

Benefits of the merger

6.71. UniChem argued that the merger would give rise to efficiency improvements which could lead to a better service to both retailers and consumers. It would also enable UniChem to diversify into related areas where its existing skills could be developed further. As we have not identified adverse consequences it is not necessary for us to assess whether or to what extent any such benefits might arise.

Conclusion

6.72. We therefore have identified no adverse effects as likely to arise from the proposed merger and we conclude that it should be allowed to proceed.

Lloyds acquisition of Macarthy

6.73. Lloyds owns the second largest chain of retail pharmacies, with a current market share of 5.5 per cent by number of outlets and 5.7 per cent by sales of ethical pharmaceuticals. The Savory & Moore chain has a 1.5 per cent share by both measures. Lloyds acquires the bulk of its pharmaceuticals direct from manufacturers. The acquisition of Macarthy could thus have an effect on the wholesale market as well as at the retail level. We consider these aspects in turn and then consider possible effects of the acquisition on the market for health foods, and the possible effects of the acquisition of Farillon. We do not consider that issues for the public interest arise in relation to the acquisition by Lloyds of the other businesses of Macarthy; Lloyds has no current involvement in these areas.

Effects on the wholesale pharmaceutical market

6.74. As was the case in the UniChem inquiry, an important concern raised in evidence to us was the possible effect of any acquisition on Medicopharma, which was the wholesale supplier to the Savory & Moore chain at the time of the reference. As already noted, Medicopharma withdrew from the United Kingdom market in early November 1991 and it is in the light of these changed circumstances that we now consider the proposed merger.

6.75. Concern was expressed to us that while there was currently vigorous competition between wholesalers, this might diminish in future. The acquisition by Lloyds of a sizeable chain of retail outlets which is currently serviced by wholesalers would reduce the market supplied by wholesalers, and this would exacerbate the trend towards concentration at the wholesale level which was occurring because of the factors mentioned in paragraph 6.21. We have noted in paragraph 6.48, however, that the Savory & Moore chain has for a number of years in practice been supplied by one main wholesaler—first, Macarthy itself, then Medicopharma and, subsequently, UniChem. If the Savory & Moore stores remained in independent ownership it is questionable whether regional wholesalers would gain this custom. We consider, therefore, that in practice the effect of the merger would be to reduce the market available to the two national wholesalers. We also note that as a proportion of the wholesale market the Savory & Moore chain represented under 1.5 per cent of sales. For these reasons we do not consider that the competitiveness of the wholesale market would be materially weakened by this merger.

6.76. We are nonetheless concerned about the trends in concentration at the wholesale level and we recognise that further increases in self-supply by retail chains may exacerbate the difficulties faced by smaller wholesalers. We consider that the DH should take this into account in considering the regulatory structure as we have already suggested in paragraph 6.38, and that, as mentioned in paragraph 6.53, the Director General of Fair Trading should continue to keep developments in this market under close review.

Effects on competition between retail pharmacies

6.77. If the merger were to proceed, Lloyds would have a market share of about 7 per cent by NHS sales and by the number of pharmacies. Boots is the largest retail chain, with shares of 11 per cent and 9 per cent respectively. Three-quarters of pharmacies are still single outlets or in chains of less than six outlets. In the light of this we do not consider that the increase in Lloyds' share would in itself be of concern.

6.78. A number of those who gave us evidence suggested that the acquisition could, however, reduce the ability of independent pharmacies to compete. It was argued that the discount recovery arrangements operated by the DH for reimbursing pharmacies for dispensing NHS pharmaceuticals reflected the average discounts achieved by pharmacies in particular size bands. The more outlets Lloyds acquired, the greater their weight in the DH's periodic survey of pharmacies. Lloyds achieved larger discounts from wholesalers than the average pharmacy because of the size of its chain. Its costs of distribution of branded ethicals direct from manufacturers were also lower than the cost to an average pharmacy of acquiring such products from a wholesaler. Lloyds secured more favourable terms than an average pharmacy on generics. It was thus argued that when another periodic survey was done, it would include a higher proportion of

pharmacies operating on these favourable terms. Over time, the discount recovery rates would therefore increase further, to the disadvantage of pharmacies in particular size bands achieving below-average discounts from wholesalers.

6.79. While this argument is in theory correct, the Savory & Moore chain would only represent 1.5 per cent of total outlets and therefore the statistical effect is likely to be small. Moreover any such effect implies a reduction in cost to the NHS, which is in the public interest. We also note that it would be open to the DH to change the discount recovery arrangements.

6.80. We considered whether any increase in Lloyds' purchasing power on generics would adversely affect the manufacturers of generics. We accept that there would be scope for Lloyds to obtain better terms as a result of higher-volume purchases. We see no reason, however, to believe that the effect would be sufficient to affect the viability or reduce the range of particular suppliers. Moreover, even if there was an effect, different varieties of the same generic product are directly substitutable.

6.81. A further argument put to us was that Lloyds' purchasing power for OTCs would increase and that this could also make it more difficult for independent pharmacies to compete. It could also, it was argued, put pressure on the manufacturers of such products, which might lead to reduction in the range of products supplied. Sales of OTCs represent about one-third of turnover for many community pharmacies and convenience is likely, in our view, to be as important as price in such sales. As regards pharmacies serving wider catchment areas, we note that such pharmacies are likely already to be in competition with other (pharmacy and non-pharmacy) outlets, including drugstores and (to some extent) supermarkets, and that some of these already have significant bargaining power. We also consider that if there was a downward effect on retail OTC prices, this would benefit consumers.

6.82. We considered whether there would be a reduction in the range of OTC goods supplied as a result of the merger. Lloyds said that it intended to increase this side of the business. It would introduce its own-label range of goods into the Savory & Moore pharmacies, which would give greater value for money for consumers. It saw its main competitor in terms of competition on OTCs as being the various chains, whether pharmacy or not (Boots, Superdrug Stores PLC, the supermarkets and some smaller grocery chains) rather than independent retailers which it considered were not price competitive. The range offered in the Savory & Moore pharmacies may well be different following a merger, but we see no reason to consider that there would be a detriment as a result to the public interest.

6.83. It was suggested to us that in certain respects Lloyds pharmacies offered a lower level of service than independent pharmacies. In particular, it was argued that they more frequently used locums rather than permanent staff as pharmacists, tended to recruit less experienced pharmacists and undertook insufficient staff training. It was also suggested that the general standard of advice given was lower, that fewer innovations were made, that waiting times for prescriptions were longer and that Lloyds shops were less likely to open late on a rota basis.

6.84. Lloyds strongly denied that its service levels were poor. It said that where it had acquired pharmacies it had maintained or increased the level of prescription business, and that the average number of prescriptions dispensed by the group had risen above the national average each year. Lloyds argued that this was due to an improvement in service, which together with the location of the pharmacy was the main factor affecting competition for prescription business. As regards the use of locums, Lloyds said that the extent of locums employed would be lower than under Macarthy's ownership. There was, however, a general shortage of pharmacists. Lloyds was the second largest employer of pre-registration students. It had trained 83 graduates (17 per cent of those who qualified) in 1990. Lloyds stated that it had invested in staff training.

6.85. As regards professional standards and innovation, Lloyds told us that it provided a much wider range of professional services than an average independent, although it recognised that some independents who ran their own business might give an even better service. Lloyds also said that it was at the forefront of innovation in such matters as patient medication records, computerisation and the provision of services to residential homes. As regards other aspects of service, Lloyds said that the opening hours of the shops as Lloyds Chemists would be substantially longer than Macarthy currently operated and in no case would

they be reduced. As regards waiting times for prescriptions to be dispensed, we asked Lloyds for information on how often prescriptions were dispensed on the day of the patient's visit. Lloyds reported that almost 99 per cent of customers in a sample of representative pharmacies (covering 28,000 prescriptions) received their prescribed medication on the same day. As regards rota services, Lloyds said that some FHSAs imposed a rota and others did not. Lloyds would always offer to be part of a rota.

6.86. The evidence before us does therefore not support the allegations made regarding service levels. We invited the RPSGB to comment and it told us that it did not wish to do so. We note that the RPSGB has powers it can use if professional standards are not met. The FHSAs acting on complaints can also take disciplinary action if a pharmacy falls below acceptable standards of service, although we understand that only a small number of such complaints are received, which may reflect a lack of awareness generally of the FHSAs' role. We thus see no reason to conclude that the merger would lead to adverse effects for the public interest in respect of the service standards of the chain as a whole. We consider in paragraphs 6.88 to 6.91 the position in respect of particular localities.

6.87. It was suggested to us that Lloyds' insurance cover against claims arising from errors on dispensing prescriptions was below that of other pharmacies. Lloyds told us that its cover of £3 million, now raised to £5 million, was well above any claim to date. (In the United Kingdom no claim against a pharmacy had yet exceeded £1 million.) Moreover, it had the financial strength to pay above that if such a circumstance occurred. No issue for the public interest appears to arise in this respect.

Local competition between retail pharmacies

6.88. We now consider whether there is reason for concern arising from increased concentration in particular localities. As discussed in paragraph 6.57, in the context of the UniChem bid, the nature of competition between retail pharmacies is to a large extent local. Although disciplinary action by the RPSGB or FHSAs is possible, such intervention is unlikely to be as effective as competition, or the threat of entry, in ensuring a high level of services but, as we noted, new entry is currently constrained.

6.89. As shown in Figure 3.1, the Savory & Moore pharmacies are located mainly in Central Scotland, South Wales and the South-West and South-East regions of England. Lloyds retail pharmacies are dispersed throughout England and Wales, with a relatively high concentration of outlets in the West Midlands region. We looked at areas in which there was both a Lloyds and a Savory & Moore outlet, which after a merger would come under common ownership. There were 22 such localities, as shown in Appendix 3.1, Table 1. The definition of catchment areas for pharmacies is not straightforward, for the reasons given in paragraph 3.31, and the catchment areas may change over time. In most of the localities there was at least one, and generally more than one, pharmacy under different ownership within the catchment area. We considered in more detail two areas in which there was both a Lloyds and a Savory & Moore outlet but no other pharmacy. Lloyds told us that to a certain extent these outlets were competing with each other, but 90 to 95 per cent of patients would go for their prescriptions to the nearest pharmacy, subject to there being an acceptable service. On OTC products, other outlets provided competition. Lloyds also suggested that in practice the two outlets under the same ownership would continue to compete not least because the level of business would affect the bonuses of the staff. Such a situation had arisen in other locations, such as Atherstone, and there was no evidence of lower levels of service in these outlets.

6.90. The two localities in which there are no other competing pharmacies are Warlingham, a village in Surrey, and Midsomer Norton, a small town in Somerset. In the case of Warlingham, the Savory & Moore pharmacy is one of about 20 shops ranged round the sides of a small village green in the centre of Warlingham, and is about 200 yards from the doctor's surgery. The Lloyds pharmacy is in a separate parade of some 30 shops at Hamsey Green, about 1 mile to the north, separated from Warlingham by housing. This pharmacy is about 200 yards from another doctor's surgery. In both locations there are other shops selling OTC products. The nearest independent pharmacies are at Whyteleafe (about 1½ miles from the centre of Warlingham) and Sanderstead (about 2 to 3 miles). Midsomer Norton is about 9 miles to the south-west of Bath. Both pharmacies are in the town centre and there is probably a greater overlap in the customer base of the two pharmacies. There is also another Lloyds outlet in Paulton, a village about 2 miles from Midsomer Norton. There are, however, several other shops in Midsomer Norton selling OTC

products and there are two independent pharmacies in Radstock, a small town about 1 mile from Midsomer Norton.

6.91. In both localities, we would expect at least part of the customer base to be sufficiently mobile to ensure that some competitive pressure is maintained on these pharmacies. We also note the protection afforded by the fact that a pharmacist has to be on the premises for dispensing prescriptions and 'P' medicines and that if there was concern regarding levels of service, bodies exist which could take action, though, as pointed out before, this may not be as effective as the threat of new entry. On balance for all these reasons we do not expect that significant adverse effects would arise from the merger in individual localities. However, as we noted in paragraph 6.14, there are already a number of areas in the country where there is only one pharmacy, or more than one pharmacy in a locality under common ownership and no others. It would be helpful in providing a safeguard for consumers if the FHSAs were to give greater publicity to their role.

The health food market

6.92. As described in paragraph 6.41, the merger would bring together the two largest chains of health food stores, Holland & Barrett and Lifecycle, which together account for some 10 per cent of health food sales by all retail outlets and 20 per cent of total sales by specialist health food stores. We considered whether this was likely to lead to a reduction in competition in the health food retail or wholesale market.

6.93. The nature of competition between health food stores is essentially local, though probably less so than in the case of pharmacies. Although the more popular health food products are sold in other outlets (such as supermarkets and other grocers), these outlets are unlikely to offer as wide a range of health foods. The National Association of Health Stores (NAHS) also argued that health food stores provided a service that other outlets did not, as their staff were trained to advise on the various products.

6.94. No one who gave us evidence suggested that the acquisition would distort competition at retail level. It was the case that the two chains were the only health food outlets in a few locations, but there are no significant barriers to new entrants. The NAHS did state, however, that since Holland & Barrett had been acquired by Lloyds there seemed to have been a reduction in the previous commitment to service and staff training. In our view the ease of entry to this market, together with the fact that many health food products are sold in other outlets, is likely to ensure that the market remains competitive, on service as well as price.

6.95. The NAHS also suggested that if Lloyds acquired Macarthy, an undue proportion of the health food market would be controlled by one group. Lloyds would have 223 shops, while the next largest company would have only 19. As already noted, with the combined wholesale and retail interests (that is including Nature's Store and SOT, as well as the retail interest) Lloyds would have a share of about 20 per cent at wholesale prices of health food sales or 10 per cent of sales of health food through all outlets. The NAHS considered that this would give it considerable buying power over suppliers. The Health Food Manufacturers' Association and St James's Teas Ltd expressed similar concerns. It was pointed out that health food manufacturers tended to be small companies and could not withstand the exercise of strong buyer power. Our view, however, is that if the exercise of buying strength by Lloyds led to lower prices at retail level, this would have benefits for consumers. Given that Lloyds would only account for 10 per cent of health food sales through all outlets, manufacturers would still have a considerable range of other customers. We therefore do not envisage adverse effects arising from the merger in respect of the health food wholesale market.

Farillon

6.96. We considered whether adverse effects would arise in respect of Lloyds' acquisition of Farillon. Farillon's role as an exclusive distribution agency for pharmaceutical products was described in paragraphs 6.60 to 6.63, in the context of the UniChem/Macarthy merger. Although Lloyds self-supplies a high proportion of its retail chain's requirements, it is not in direct competition with other wholesalers. For this

reason we see no reason for concern regarding any information concerning wholesalers that might be acquired by Lloyds by reason of owning Farillon. We also see no reason to conclude that Lloyds would favour supply to its own retail outlets against supply to other retail outlets or wholesalers, given the basis on which Farillon operates. We therefore do not consider that adverse effects are likely to arise from the acquisition by Lloyds of Farillon.

Benefits of the merger

6.97. Lloyds told us that it considered it could improve the management of the Macarthy business and improve the service to customers, the product range and price competitiveness of the retail outlets, as described in paragraphs 4.199 and 4.200. By self-supplying a high proportion of its ethical pharmaceuticals Lloyds would restrain the positions of UniChem and AAH in the wholesale market. Lloyds said that it would also widen the range and value for money of products in the health food stores. As we have not identified adverse consequences, it is not necessary for us to assess whether or to what extent any such benefits might arise.

Conclusion

6.98. We have therefore identified no adverse effects as likely to arise from the proposed merger and we conclude that it should be allowed to proceed.

H H LIESNER (*Chairman*)

R O DAVIES

J EVANS

A FERRY

J F PICKERING

S N BURBRIDGE (*Secretary*)

17 January 1992

