

## 6 Conclusions

6.1. On 3 November 1991 Medicopharma Ltd and Medicopharma (UK) BV, which are (unless the context otherwise requires) jointly referred to as Medicopharma UK, resolved to cease trading. They were separate legal entities, but were effectively run as one business, with the same senior management. They were subsidiaries of Medicopharma NV, a Dutch pharmaceutical company, now in bankruptcy. On the same day all the stock of Medicopharma UK together with its three largest depots and certain assets were sold to another subsidiary of Medicopharma NV, Pharmaceuticals International (UK) Ltd (PIUK). PIUK was then purchased by AAH Subsidiaries Ltd (AAH Subsidiaries), a subsidiary of AAH Holdings plc (AAH), one of the two largest United Kingdom pharmaceutical wholesalers. Under a reference dated 21 November 1991 (see Appendix 1.1) we are required to investigate and report whether a merger situation qualifying for investigation has been created in that enterprises carried on by or under the control of Medicopharma NV have within six months preceding the date of the reference ceased to be distinct from enterprises carried on by or under the control of AAH and, if so, whether the creation of that situation operates or may be expected to operate against the public interest.

### **The companies involved**

#### **Medicopharma NV**

6.2. Medicopharma NV is a Dutch pharmaceutical company which was founded in 1952. Originally it sold its products exclusively to dispensing physicians, most of whom were also company shareholders. In 1962, the first speciality products from other manufacturers were added to the range, marking the start of the wholesale operations. From the mid-1970s Medicopharma NV expanded through acquisitions, business associations and the formation of new subsidiaries. Before the company went into bankruptcy, it had 17 affiliated companies and divisions in the Netherlands and other countries employing, prior to the closure of the United Kingdom business, about 2,500 people world-wide.

6.3. It entered the United Kingdom wholesale pharmaceutical market in 1990 with the purchase of E H Butler & Sons Ltd (Butler), a small regional wholesaler serving the Midlands. In the same year it bought the wholesaling division of Macarthy PLC (Macarthy) with the objective, it said, of becoming a national pharmaceutical wholesaler. Macarthy's wholesale distribution network covered Scotland, the Borders and Southern England. With the acquisition of these two businesses Medicopharma UK became the third largest United Kingdom pharmaceutical wholesaler, with eight depots and a market share of sales by wholesalers of about 8 per cent. Under the agreement with Macarthy, a supply agreement was entered into for Macarthy's retail pharmacy chain, Savory & Moore Ltd (Savory & Moore), under which Macarthy was committed to purchasing not less than 90 per cent of its ethical products (that is pharmaceuticals which are supplied only on prescription) from Medicopharma UK for a period of five years 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. Medicopharma UK's management told us that sales to Macarthy accounted for between 15 and 20 per cent of its total sales.

6.4. Medicopharma UK 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 over-the-counter (OTC) products (including a Numark own-label range) and on some ethical drugs and also undertakes marketing initiatives.

6.5. Medicopharma NV had a turnover in 1990 of Dfl 933 million, roughly equivalent to £300 million. Of this about £89 million related to its United Kingdom business including four months' trading of the pharmaceutical wholesaling business acquired from Macarthy in August 1990. In a full year of trading, it is likely that the United Kingdom operation would have had sales of about £270 million, which would have accounted for just over half of Medicopharma NV's world-wide turnover.

## **AAH Holdings plc**

6.6. AAH is the holding company of a group of companies, which, through its Healthcare Services Division, carries on the business of pharmaceutical wholesaling and retailing, specialist medical supplies and packaging of generic drugs and agency distribution services as well as contract manufacture of soaps and toiletry products. The other business activities of AAH concern builders' supplies, environmental services, consumer products and transport services.

6.7. Formed originally in the 1920s as a coal-mining company, AAH developed over the following 50 years into a company with distribution businesses, initially relating to solid fuel and fuel oil distribution and later including the supply of building materials and road haulage services. Other trading activities were developed in 1973 with the acquisition of a land maintenance company, R B Tyler, and in 1976 when AAH acquired Chemists Holdings Ltd which had two trading subsidiaries, Hills Pharmaceuticals Ltd, a pharmaceuticals wholesaling business, and Hill-Smith (Warrington) Ltd, the owner of a small chain of retail pharmacies. This was the start of the development of what became AAH's Healthcare Services Division.

6.8. AAH subsequently purchased further pharmaceutical businesses including Vestric Ltd, a company providing wholesale supply services to retail pharmacies, dispensing doctors and hospitals throughout the United Kingdom, which it acquired from the Glaxo group. In 1985/86 AAH formed Statim Finance Ltd to offer loan guarantees to pharmacists. In 1987 it launched a pharmacy franchising programme.

6.9. AAH is now a specialist distribution and service group with five divisions, all of which are wholly owned: Healthcare Services; Builders' Supplies; Consumer Products; Transport Services; and Environmental Services. Healthcare Services, through a combination of acquisitions and internal growth, has expanded to become AAH's largest trading division, with a turnover in the year ending March 1991 of £922 million, 82 per cent of the group's turnover in that year of £1,122 million, and reporting trading profits of £22 million, 68 per cent of the group's total trading profits of £33 million.

6.10. AAH has 27 pharmaceutical distribution warehouses throughout the United Kingdom (including the three it acquired from Medicopharma NV) with the most highly automated being at Warrington. AAH estimated that approximately 85 to 90 per cent of its wholesaling business was in National Health Service (NHS) business (20 per cent of which was sales to hospitals), and about 10 to 15 per cent was in OTC products. AAH's Healthcare Services division comprised 139 retail pharmacies as at the end of December 1991, of which 60 are wholly-owned and 79 are operated by independent pharmacists under franchise agreements.

## **The pharmaceutical market**

6.11. We have recently completed inquiries on two references concerning proposed mergers which would affect the wholesale pharmaceutical market. These concerned an offer by UniChem PLC (UniChem) for Macarthy (which, after the sale of its wholesaling business, consisted mainly of a retail pharmacy chain and a pharmaceutical exclusive distribution agency business) and an offer by Lloyds Chemists plc (Lloyds), also for Macarthy. Our report on these references<sup>1</sup> was submitted to the Secretary

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<sup>1</sup>UniChem PLC/Macarthy PLC and Lloyds Chemists plc/Macarthy PLC, Cm 1845, February 1992.

of State on 17 January 1992 and published in February 1992. For the purposes of those inquiries we analysed the pharmaceutical market and our analysis of the market in this report is in many respects similar.

6.12. 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 remaining 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 older people.

### **Wholesalers and direct supply by manufacturers**

6.13. 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 The Chemists Ltd (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 are supplied direct by manufacturers. There are currently some 30 full-line pharmaceutical wholesalers, which stock the full range of ethical pharmaceuticals. Two of these, AAH and UniChem, 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. Some pharmaceutical manufacturers supply branded ethical products only to full-line wholesalers which take their complete range. In addition, not all full-line wholesalers prepared to meet this condition will necessarily be able to secure direct supply from all manufacturers. Some, indeed, in order to offer the full range, have to obtain the products of some prominent manufacturers from other wholesalers. 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 fallen from 39 in 1978 to 22 in February 1992.

6.14. As shown in Table 3.7, 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 dispensing doctors and AAH being slightly the larger supplier when sales to hospitals are also included. AAH's own estimates of the total value of the market were higher than the figures shown in Table 3.7, and its share of sales of ethicals would therefore be lower on those estimates, as explained in the footnote to the table. The third largest supplier, until it withdrew from the market, was Medicopharma UK.

6.15. We were told that national wholesalers have a number of advantages over regional wholesalers. All wholesalers purchase branded ethicals at the same price (as discussed in paragraph 6.41), but larger wholesalers are likely, because of the scale of their purchases, to obtain better terms on generics, parallel imports (that is, branded ethicals manufactured abroad), OTC medicines and other OTC products. 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 uses of computer technology.

6.16. The evidence we received suggested that there is currently active competition in the wholesale market but there was concern as to whether this would continue. The number of wholesalers has declined sharply in recent years. It may drop further or the smaller wholesalers' 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.

## Supply to retail pharmacies

6.17. Retail pharmacy chains tend to prefer to buy 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. Some 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.

6.18. There are other 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 and, as paragraph 6.13 explained, there are exceptions even to this. As we have noted in paragraph 6.15, the national wholesalers already have a number of significant advantages over the regional wholesalers, including economies of scale both in purchasing and wholesale operations. There is also an increasing degree of vertical integration, as discussed in paragraph 6.23. 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 the financial performance of regional wholesalers; some made a loss in 1990, while others earned profits as high as those achieved by the nationals. Overall, however, the profit margin earned was around half that of the two national wholesalers.

6.19. 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.

6.20. 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 retail pharmacies an incentive to buy as much as possible from one supplier. UniChem 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.

6.21. The increasing use of small packs of drugs has meant that individual pharmacies now tend to hold lower stocks and rely to a greater extent on 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.

6.22. 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 is undertaken by wholesalers acting as agents of Glaxo, in return for an agency fee. The terms on which retail pharmacies are supplied is determined directly between Glaxo and the retail pharmacies. It was suggested to us that other ethical manufacturers might consider adopting similar distribution arrangements in the future.

6.23. Vertical integration in the pharmaceutical market has been increasing. A number of pharmaceutical wholesalers now own retail pharmacies; AAH currently has 139 and UniChem 132. Some regional wholesalers also operate retail pharmacies, as shown in Table 3.15. In some cases, retailers have acquired pharmaceutical wholesalers or set up wholesaling businesses. 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, in particular by UniChem and AAH. Numark also operates a loan guarantee scheme but this does not impose any purchasing obligations. 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.

6.24. The two largest retail pharmacy chains, Boots and Lloyds, obtain a high proportion of their pharmaceutical requirements by direct supply from manufacturers, and a number of the smaller pharmacy chains also 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 3.6). This was partly because more generics and parallel imports were bought from wholesalers rather than direct from manufacturers or importers, and partly because there was a switch by some self-supply chains towards greater use of wholesalers. One such chain, Kingswood GK Ltd (Kingswood), was, however, subsequently acquired by Lloyds.

### **Supply to dispensing doctors**

6.25. As paragraph 3.42 explained, dispensing doctors generally prescribe a much narrower range of medicines than is supplied by a typical retail pharmacy and so require less frequent deliveries from wholesalers. Some of the services offered to pharmacies (such as loan guarantee scheme and supply of OTC goods) are also not required by dispensing doctors. Dispensing doctors generally buy ethical pharmaceuticals from the same sources and on similar terms to retail pharmacies.

### **Supply to hospitals**

6.26. AAH accounted for 70 per cent of sales by wholesalers of ethicals to hospitals in 1990, with UniChem accounting for 5 per cent, Medicopharma UK 3 per cent and other wholesalers 22 per cent. Hospitals have somewhat different arrangements and requirements from those of retail pharmacies, as described in paragraphs 3.43 to 3.50. They purchase a higher proportion-about half-of their ethical pharmaceuticals direct from manufacturers. We were told, however, that hospitals may, as a matter of policy, carry less stock in future and rely to a greater extent on wholesalers. Hospitals tend to buy high-turnover items (or products in frequent demand) direct from manufacturers and lower- turnover products from wholesalers. Manufacturers may offer hospitals substantial discounts on some ethical products in order to encourage hospitals to include them in the local 'formulary', that is a list of drugs from which hospital doctors will generally prescribe, as this can lead to continued use of those drugs once the patient leaves hospital. Where contracts are negotiated direct with a manufacturer (which may be for one or two years), the physical distribution of the products to individual District Health Authorities (DHAs) and hospitals may still be undertaken by a wholesaler in return for a fee. The products are sometimes purchased in bulk and held in short-line stores until required.

6.27. The fact that some pharmaceutical manufacturers of branded ethicals may not be prepared to deal with all wholesalers, as mentioned in paragraph 6.13, is also a barrier to entry to supply by wholesalers to hospitals. In addition, there is a range of specialised pharmaceutical products (such as anaesthetics) which are only used in hospitals, some of which are difficult to handle. Demand by hospitals for pharmaceuticals is also, we were told, less predictable than demand by retail pharmacies. These factors make it more difficult for smaller wholesalers to supply hospitals. In addition, the purchasing arrangements for NHS hospitals are largely undertaken by Regional Health Authorities (RHAs), which generally require a wholesaler to be able to supply the whole RHA area, which is in some cases quite large. We were told that AAH has a significant advantage in its computer system which provides manufacturers with information on product sales to hospitals. Regional wholesalers said that this would be very costly for them to match and that manufacturers would be unwilling to operate more than one such system. In addition a number of pharmaceutical manufacturers have exclusive distribution agreements-in particular with AAH-for the supply of some of their products to hospitals. These, it was argued by regional wholesalers, made it more difficult for them to compete for RHA contract business.

## **The retail pharmacy market**

6.28. There are just under 12,000 retail pharmacies in the United Kingdom with contracts to dispense 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.

6.29. The largest retail pharmacy chain is 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. As Table 3.13 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.

6.30. The NHS generally covers 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 dispense a prescription and opening hours). For OTC medicines-both 'P' products and those on the general sales list (GSL)-resale price maintenance is permitted pursuant to the Restrictive Trade Practices Act 1976 and is, we understand, generally enforced. Own-label OTC medicines or competing brands may, however, be available. GSL medicines may be sold in other types of outlet, in particular in drugstores, as may OTC products other than medicines, such as toiletries, baby foods and so on.

## **Market definitions**

6.31. We considered whether, as argued by AAH (see paragraphs 4.149 to 4.152), the supply of pharmaceuticals to retail pharmacies, dispensing doctors and hospitals is, essentially, one single market or whether there are a number of separate markets. In particular, we looked at:

- (a) whether the supply of ethicals is a separate market from the supply of OTC pharmaceuticals;
- (b) whether the supply of ethicals to retail pharmacies, to dispensing doctors and to hospitals are separate markets;
- (c) whether direct supply of ethical pharmaceuticals to retail pharmacies and dispensing doctors by manufacturers and self-supply by retail pharmacy chains should be regarded as a separate market from the supply of ethicals by wholesalers; and
- (d) whether direct supply of ethical pharmaceuticals to hospitals by manufacturers is a separate market from supply by wholesalers.

### ***Whether the supply of ethicals is a separate market from the supply of OTC pharmaceuticals***

6.32. We examined whether the supply of ethicals is a separate market from the supply of OTC pharmaceuticals in relation to retail pharmacies. (Neither dispensing doctors nor hospitals are significant purchasers of OTC pharmaceuticals.) The requirements of retail pharmacies, particularly with regard to the frequency of delivery (see paragraphs 3.26 and 3.27), are different from their requirements for the supply of OTC pharmaceuticals; this is reflected in the fact that wholesalers offer different terms on OTC and ethical products. Moreover, retail pharmacies have a wider range of sources from which to obtain OTC pharmaceuticals. Ethical pharmaceuticals can only be purchased direct from the manufacturer or from a wholesaler which holds a wholesaler dealer licence (see paragraph 3.8). Some OTC pharmaceuticals, on the other hand, may be obtained from wholesalers other than pharmaceutical wholesalers and from 'cash-and-carry' outlets.

6.33. The demand for ethicals by pharmacists is fixed by what is prescribed by the doctor. This is not true of the demand for OTC medicines by pharmacists. In addition, in the case of branded ethicals (although not generics or parallel imports) wholesale margins are controlled under the Pharmaceutical Price Regulation Scheme (PPRS) (see paragraphs 3.5 to 3.7); in particular, the terms on which wholesalers purchase branded ethicals are fixed (ie list price less 12.5 per cent) and manufacturers do not offer volume-related discounts whereas wholesalers can negotiate discounts (eg volume-related) on their purchases of OTC pharmaceuticals from manufacturers. Taking all these factors together, we concluded that the supply of ethicals is a separate market from the supply of OTC pharmaceuticals.

### ***Whether the supply of ethicals to retail pharmacies, to dispensing doctors and to hospitals are separate markets***

6.34. AAH suggested to us that retail pharmacies, dispensing doctors and hospitals all had similar requirements as to the type of service they required for the supply of ethical pharmaceuticals. We concluded that this was essentially true as regards retail pharmacies and dispensing doctors. The requirements of hospitals are, however, different from those of retail pharmacies in a number of respects:

- (a) hospitals need a range of specialised hospital products such as medical gases and drugs which can be administered to patients only in hospital;
- (b) hospitals do not require some of the support services which are offered to retail pharmacies (such as loan guarantee schemes and other financial support, ethical advice on drugs and the supply of OTCs);
- (c) the purchasing arrangements for hospitals are undertaken largely by RHAs which require service over fairly large geographical areas; and
- (d) for some heavily used products, hospitals do not need frequent delivery, unlike independent retail pharmacies and dispensing doctors, since health authorities generally operate their own 'short-line stores' (see paragraph 3.44) which enable them to make bulk purchases of pharmaceuticals.

6.35. There are a number of other factors which suggest that the supply of ethicals to hospitals is a separate market from the supply of ethicals to retail pharmacies and dispensing doctors. First, in many cases hospitals have different contractual arrangements. It is common for hospitals to purchase ethicals on the basis of long-term contracts awarded by competitive tender; such contractual arrangements are unusual for retail pharmacies and dispensing doctors. Secondly, pharmaceutical manufacturers offer special prices to hospitals for some ethical products (see paragraph 3.47) and this affects the purchasing arrangements made by hospitals.

6.36. We concluded, therefore, that the supply of ethicals to hospitals is a separate market from the supply of ethicals to retail pharmacies and dispensing doctors.

***Whether direct supply of ethical pharmaceuticals to retail pharmacies and dispensing doctors by manufacturers and self-supply by retail pharmacy chains should be regarded as a separate market from the supply of ethicals by wholesalers***

6.37. As discussed earlier (see paragraph 3.34), around 17 per cent of ethical pharmaceuticals sold to retail pharmacies are either sold direct by manufacturers or self-supplied by retail pharmacy chains. Some large retail pharmacy chains, such as Boots and Lloyds, self-supply the majority of their requirements. Other large chains, such as National Co-operative Chemists, Macarthy and Safeway plc, rely largely on supply by wholesalers. There have been examples where self-supply chains have turned to using wholesalers; Kingswood, for example, prior to its acquisition by Lloyds, decided to switch to UniChem as its main source for pharmaceuticals. AAH told us that it acted as a secondary supplier to both Boots and Lloyds and was actively competing to increase its business with these two companies.

6.38. Around three-quarters of all retail pharmacies are either single-outlet businesses or form part of a small chain (fewer than six outlets). Although most of these independent retail pharmacies obtain at least part of their ethical requirements direct from manufacturers or importers, this usually applies mainly to generics and parallel imports rather than branded ethicals. For the reasons discussed in paragraphs 3.25 and 3.26, these pharmacists rely on wholesalers to provide both a distribution and stockholding function. Although it is possible for small groups of independent pharmacies to combine and self-supply some pharmaceuticals on a co-operative basis, only a small number of such co-operatives currently exist. Self-supply on any significant scale by independent retail pharmacies is neither practical (because of physical storage space limitations) nor economic (because of the need to tie up working capital in stocks for long periods of time).

6.39. Taking account of all of these factors we concluded, on balance, that the supply of ethicals to retail pharmacies by wholesalers should be seen as a separate market. We recognise, however, that direct supply and self-supply by retail pharmacies should be taken into account in assessing the nature of the wholesale market.

***Whether direct supply of ethical pharmaceuticals to hospitals by manufacturers is a separate market from supply by wholesalers***

6.40. Direct supply by manufacturers currently accounts for around half of all ethicals supplied to hospitals (see Table 3.8). The health authorities would have the ability to obtain a higher proportion of their ethical requirements direct from manufacturers if they chose to do so; we were told that in fact hospitals (particularly NHS trusts) might if anything move the other way and make greater use of wholesalers. Nonetheless there are differences in the nature of the two different types of supply. Medicines supplied direct tend to be high-turnover items and products which are offered by manufacturers to hospitals at special prices; low-turnover ethicals are more often supplied by wholesalers. Most health authorities operate a 'short-line store' where ethicals purchased direct from manufacturers are held before distribution to individual DHAs or hospitals. The health authorities themselves told us that they did not regard supply by manufacturers as providing a strong competitive constraint on prices charged by wholesalers. Therefore although direct supply by manufacturers is a more feasible option for hospitals than for most retail pharmacies, on balance we consider that direct supply of pharmaceuticals to hospitals by manufacturers is not a direct substitute for supply by wholesalers and is a separate market.

**The regulatory framework**

6.41. 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 PPRS, as described in paragraphs 3.5 to 3.7. 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.

6.42. 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.

6.43. The current arrangements for remunerating pharmacists for their professional services 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.

6.44. 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 3.8. 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 so as to ensure a cost-effective system of distribution (see paragraph 6.43) and to discourage 'leapfrogging', that is, for example, moving a pharmacy so as to bring it closer than its competitor to a doctors' surgery. FHSAs are also responsible for taking disciplinary action against pharmacists for poor service. Similar functions to those of FHSAs are undertaken in Scotland by Health Boards and in Northern Ireland by Health and Social Services Boards.

6.45. There have therefore been two significant recent changes in the regulatory system affecting pharmacies—the controls on entry introduced in 1987 (paragraph 6.44) and the change to the remuneration system for pharmacists in 1989 (paragraphs 6.42 and 6.43). 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.

6.46. 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.

6.47. 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.

6.48. 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 as we stated in our previous report, it 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.

6.49. The possible merger situation which has been referred to us has to be considered against the background of regulatory intervention outlined above. We begin with a summary of developments in 1990 and 1991 which led up to the arrangements made on 3 November 1991.

## **The events leading up to the arrangements**

6.50. Medicopharma NV stated that the price it had paid for the wholesale operations of Macarthy in August 1990 was satisfactory and the company had potential. But, it told us, it wanted a partner to come into the Medicopharma NV group with the aim of strengthening shareholders' equity. In August 1990, with the knowledge of its bankers, ABN-AMRO Bank NV (ABN-AMRO Bank), it began negotiations with McKesson Inc (McKesson). This is the largest United States pharmaceutical wholesaling company. In 1990 McKesson had shown some interest in buying Macarthy's wholesale operations but had been forestalled by Medicopharma NV. The negotiations led to McKesson acquiring 10 per cent of the equity of Medicopharma NV and representation on its Board. In October 1990 there were further negotiations between them with a view to McKesson acquiring part of the Medicopharma UK business, either as an equal partner or as a majority shareholder, but as described in paragraphs 4.6 and 5.143 these were unsuccessful.

6.51. In 1990 Medicopharma NV made a net profit after tax of Dfl 12.3 million (approximately £3.8 million<sup>1</sup>), compared with Dfl 14.9 million (about £4.3 million<sup>1</sup>) in 1989. In the first half of 1991 it reported a loss on trading operations of Dfl 15.5 million (about £4.7 million<sup>1</sup>). This loss mainly reflected the results of its United States operation (manufacturing OTC pharmaceuticals and personal hygiene products) and the dental division in the Netherlands. The restructuring of these divisions involved an additional non-trading loss of Dfl 20 million so that the full losses sustained in the first half of 1991 were in excess of Dfl 30 million. Medicopharma NV told us that profits of the Dutch pharmaceutical wholesaling division were also under severe pressure and that the situation was exacerbated by the expansion of the United Kingdom wholesaling business and the substantial increase in its working capital requirements. ABN-AMRO Bank was unwilling to provide further finance so an alternative solution had to be found. Medicopharma NV said that by September 1991 it was clear that it had insufficient funding to continue as then structured and a reduction in its level of borrowing and/or an increase in shareholder funding was essential if the Medicopharma Group was to survive at all.

6.52. Negotiations took place during 1991 with a range of parties to find a partner to strengthen Medicopharma NV shareholders' equity. McKesson was again approached and there were discussions on the basis of McKesson acquiring the United Kingdom business for net asset value. These negotiations were unsuccessful, as described in paragraph 4.8. Detailed discussions also took place with the senior management of the United Kingdom business, Messrs Baseley and Stedman, for a management buy-out (MBO). The best offer put forward by the MBO would have realised about £23 million. Negotiations also took place during this period with the German pharmaceutical group Ratiopharm GmbH, through its subsidiary Ferd Schultze GmbH. In addition there were discussions with AAH, in conjunction with another Dutch company, Internatio-Müller NV (IM), involving the possibility of an acquisition of a majority share in Medicopharma NV. Subsequently, various other options were discussed including a reverse take-over proposal under which Medicopharma NV would acquire Interpharm BV, IM's wholesaling subsidiary, in exchange for IM obtaining not less than 51 per cent of Medicopharma NV's expanded equity. AAH would then acquire just over 25 per cent of Medicopharma NV's equity. Thus IM

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<sup>1</sup>Converted at the average rates of exchange for the periods in question.

and AAH would both provide finance for Medicopharma NV and, between them, obtain a majority shareholding.

6.53. In further discussions in mid-October AAH suggested that if Medicopharma NV were to close down its United Kingdom operations AAH would be willing to buy certain of the assets. Detailed discussions on terms began on 23 October and led to the arrangements made on 3 November. Medicopharma NV told us that it approached McKesson again in late October but that agreement could not be reached on an acceptable price for the United Kingdom business. Discussions also continued on the MBO up to 2 November, but Medicopharma NV told us that the sum under discussion (£23 million) would not have been sufficient at that time to prevent Medicopharma NV going into receivership, as explained in paragraph 4.9.

## **The arrangements giving rise to the reference**

6.54. As Chapter 2 described, the principal features of the arrangements on 3 November were as follows. Medicopharma (UK) BV, Medicopharma Ltd and PIUK (a company dealing in parallel imports and the registration of pharmaceutical products) each resolved to cease trading with effect from 3 November. Directors were authorised to dismiss employees and to announce the closure of the businesses. Under the Asset Transfer Agreement PIUK transferred all its assets-apart from its stock, motor vehicles and certain product licences-and all its liabilities to Medicopharma UK. The assets included the goodwill attaching to its previous business. Under the same agreement Medicopharma UK sold to PIUK the leases of depots at Harold Hill near Romford, Weedon in Northamptonshire and in Aberdeen, computer systems and plant at those three depots, certain vehicles and all the stock (including stock at Medicopharma UK's other United Kingdom depots) for a net consideration of just under £24 million, subject to an adjustment described in paragraph 6.55(a) and to the other features described in paragraph 6.55. Among the assets specifically excluded from the sale were goodwill, properties other than the three depots mentioned above, intangible assets, book debts and cash. Under the Share Purchase Agreement AAH Subsidiaries acquired from Medicopharma NV the whole of the issued share capital of PIUK for the sum of £1. At this time PIUK was indebted to ABN-AMRO Bank for almost £24 million as described in paragraph 2.46, and AAH therefore took on this debt. The debt was equivalent to the provisional book value of the stock and fixed assets of PIUK, as described in paragraph 6.55(a). Under the Share Purchase Agreement AAH also undertook to become Medicopharma NV's agent in recovering debts owing to Medicopharma UK and to take an assignment of up to £7 million of certain of these debts to the extent that they were not recovered by the date indicated in the agreement.

6.55. In substance, the consideration payable by AAH could be regarded as falling under three separate heads:

- (a) Just under £24 million was to cover stock and fixed assets, of which £2 million related to tangible fixed assets and the balance to stock, being the book value of these assets at 31 August 1991, subject to an adjustment to reflect their actual book value at completion on 3 November.
- (b) There was also an agreed shortfall provision under which AAH would compensate Medicopharma NV, up to a maximum of £7.6 million, for any shortfall in excess of £5.8 million arising from:
  - any shortage on the realisation of fixed assets against net book value, less any hire purchase and lease obligations taken over;
  - the costs for Medicopharma NV of terminating the employment of Medicopharma UK employees;
  - the costs of temporarily employing staff to facilitate the handover and to collect trade debts owing to Medicopharma UK;

- any amounts incurred by AAH as a consequence of the termination of the employment of employees of the Medicopharma Group and PIUK; and
  - certain other provisions and write-offs.
- (c) Up to £7 million was payable for the assignment of certain trade debts to the extent that they were not recovered by the date indicated in the agreement.

6.56. AAH told us that the figure for fixed assets and stock to be finally paid was likely to be about £22.3 million, less £0.8 million in respect of outstanding hire purchase and leasing obligations. It is not yet clear whether any payment will be made under the agreed shortfall provision. As regards trade debts, an assignment is likely to be made of not more than £3.5 million.

6.57. A separate letter, also on 3 November, from AAH to Medicopharma NV concerned certain pharmacy loan guarantee schemes. When Medicopharma NV had purchased Macarthy in 1990, it had undertaken to assume Macarthy's obligations under its pharmacy loan guarantee schemes. Lloyds Bank Plc had, however, refused to accept the Medicopharma UK covenant and the liability therefore rested with Macarthy, although Medicopharma UK remained under an obligation to assume the Macarthy loans. A similar position applied in relation to the Butler loan scheme. Under a letter to Medicopharma NV, also on 3 November, AAH undertook to use 'reasonable endeavours to assume the obligations and liabilities whether as guarantors or otherwise of the Medicopharma Group ... in respect of the Medicopharma Group's pharmacy loan guarantee schemes' and in particular the Medicopharma Group's obligations in respect of the Macarthy Pharmacy Finance Scheme and the Butler loan scheme.

## **The merger situation**

6.58. Section 65(1) of the Fair Trading Act 1973 (the Act) provides that any two enterprises shall be regarded as ceasing to be distinct enterprises if either (a) they are brought under common ownership or common control (whether or not the business to which either of them formerly belonged continues to be carried on under the same or different ownership or control), or (b) either of the enterprises ceases to be carried on at all and does so in consequence of any arrangements or transaction entered into to prevent competition between the enterprises. An enterprise is defined by section 63(2) of the Act as meaning the activities or part of the activities of a business. Both AAH and Medicopharma NV disputed that a merger situation had been created under either of the circumstances described in section 65(1) of the Act. We consider first section 65(1)(a).

### **Section 65(1)(a)**

6.59. AAH argued that Medicopharma NV's United Kingdom pharmaceutical wholesaling and importing activities ceased on 3 November and from that date none of the relevant companies (Medicopharma Ltd, Medicopharma (UK) BV and PIUK) constituted an enterprise within the meaning of the Act. AAH stated that its acquisition of PIUK did not amount to the acquisition of an enterprise, as PIUK was a company that was no longer trading, which had ownership of certain assets (which were not employed in any business activity), and had bank indebtedness. Following the closure of Medicopharma UK on 3 November 1991, AAH argued, all business transacted thereafter by AAH comprised AAH's own business and not a continuation or a revival of part of the activities of Medicopharma UK. The arrangements therefore, in AAH's view, did not meet the conditions in section 65(1)(a).

6.60. The key features of section 65(1)(a), AAH said, are that initially there are at least two distinct enterprises and that they are brought under common ownership or control and thus that the issue as to section 65(1)(a) before the MMC in this reference is what it was that AAH acquired. To discover the answer to that question, AAH argued, the MMC should examine and construe the Asset Transfer Agreement and the Share Purchase Agreement and only have regard thereto. These agreements, it was

asserted, constituted the whole of the relevant transaction for the purpose of answering the question as to what AAH acquired.

6.61. AAH accepted that in anticipation of, and subsequent to, the execution of the documentation comprising the Asset Transfer Agreement and the Share Purchase Agreement it took steps designed to secure commercial advantages to itself but argued that these steps and the arrangements, understandings or transactions concerning them were to be left out of account in ascertaining whether enterprises of Medicopharma NV and AAH had ceased to be distinct.

6.62. Medicopharma NV also submitted that no merger situation had been created, pointing out that its United Kingdom operation had ceased to trade prior to the acquisition and that AAH had acquired only stock, certain assets and three depots. We have considered carefully these arguments of AAH and Medicopharma NV, which are set out in more detail in paragraphs 4.113 to 4.148 and 4.16 respectively.

6.63. AAH further argued that it was for the MMC to demonstrate that what was acquired amounted to the activities or part of the activities of a business and not for AAH to demonstrate the converse. AAH said that in its view the burden of proof lay with the MMC. We do not accept this in respect of this question or generally. In our view, the MMC is an investigatory body and its duty to investigate and report does not involve it in an adversarial process. We regard our task as being to investigate to determine the facts on the basis of a balance of probabilities and to report in pursuance of the Act.

6.64. As already stated, an enterprise is defined by the Act as the activities or part of the activities of a business. We note that 'business' is defined in section 137(2) of the Act not exhaustively but 'includes a professional practice and includes any other undertaking which is carried on for gain or reward or which is an undertaking in the course of which goods or services are supplied otherwise than free of charge'. 'Activities' is not defined by the Act.

6.65. We have to consider whether the activities or part of the activities of the business of Medicopharma NV were brought under common ownership or common control with enterprises of AAH. We note that 'control' may include a 'controlling interest' which is not specifically defined and that the opening words in section 65(2), in specifying instances of 'common control' for the purpose of section 65(1), recognise that these are 'without prejudice to the generality of this expression in that subsection.

6.66. A starting point in the consideration of the issue posed in the last paragraph is to decide what we are entitled to take into account on the true construction of the Act and thus whether AAH's assertion that we should only have regard to the Asset Transfer Agreement and the Share Purchase Agreement is correct. In our view such an assertion is not correct.

6.67. The word 'brought' is not defined in the Act. The Act does not therefore expressly define or limit how the result of two enterprises being under common ownership or common control is to be, or can be, achieved. We are advised, and consider, that the phrase 'brought under common ownership or common control' is to be construed, and that the question whether it limits what can be taken into account is to be examined, having regard to its context and the purpose of the Act.

6.68. In our view, the phrase 'brought under common ownership or common control' looked at in isolation does not confine us to the legally enforceable agreements of transfer in deciding what was brought under the common ownership or common control of AAH or what was acquired by AAH by way of ownership or control. Further, if the phrase is considered in its context and having regard to the purpose of the Act, we believe that it is clear that it does not have this effect.

6.69. In our view, one of the intentions and purposes of the Act is to enable the MMC to consider commercial realities and results and not just the results of legally enforceable agreements and transfers or acquisitions resulting therefrom. In this respect, and with particular reference to what may be taken into account in deciding whether enterprises have been brought under common ownership or common control, we note, and have had regard to, the wide definition in section 137(2) of the Act of 'agreement' as meaning 'any agreement or arrangement, in whatever way and in whatever form it is made, and whether it is, or is intended to be, legally enforceable or not'. We also note the use in section 64(4)(b) of the term 'arrangements or transactions'. Parliament therefore expressly envisages enterprises being brought under

common ownership or common control by arrangements or transactions. In our view, Parliament must have envisaged that common ownership or common control would, or could, be brought about by agreement, and it would be odd if Parliament had intended that only legally enforceable agreements should be taken into account in this context. We consider that if Parliament had intended this to be the case it would have so provided in express terms.

6.70. We have concluded that in considering and deciding whether the activities or part of the activities of the business of Medicopharma NV were brought under common ownership or common control with enterprises of AAH, we are, on the true construction of the Act, entitled to, and should, consider and have regard to the effect of all and any agreements, arrangements and transactions in whatever way and in whatever form they were made, and whether they were or were intended to be legally enforceable or not, between on the one side Medicopharma NV and its subsidiaries and AAH and its subsidiaries on the other side which are connected to, and a part of, the commercial arrangements immediately leading up to, and subsequent to, the Share Purchase Agreement.

6.71. So that there can be no doubt about it, we record that in our view none of the relevant agreements, arrangements or transactions was ever intended to create rights and obligations other than those that they appear to create. AAH openly and with the benefit of advice took a course of action which, it asserted, did not create a merger situation qualifying for investigation but which, it accepted, gave it commercial advantages over its rivals.

6.72. In our view it is clear that the Share Purchase Agreement was part of a set of arrangements which also included the following agreements, arrangements or transactions:

- (a) the Board Resolutions of Medicopharma (UK) BV, Medicopharma Ltd and PIUK dated 3 November 1991 and of the combined meeting of the Supervisory Board and the Board of Management of Medicopharma NV, also on 3 November 1991 (see Appendix 2.6);
- (b) the Asset Transfer Agreement;
- (c) the letter of 3 November from AAH to Medicopharma NV undertaking to use reasonable endeavours to assume the obligations and liabilities of Medicopharma NV in respect of the pharmacy loan schemes;
- (d) the issuing of redundancy notices to employees of Medicopharma (UK) BV, Medicopharma Ltd and PIUK; and
- (e) the public announcements of the closure and sale.

We have taken into account the overall effect of these arrangements (together with the agreements and understandings between Medicopharma NV, AAH and their respective subsidiaries relating thereto) in deciding whether section 65(1)(a) of the Act applies.

6.73. We note in this context that a recital in the Asset Transfer Agreement stated: 'on the date hereof the Guarantor [ie Medicopharma NV] has announced its decision to close down the business with immediate effect and the vendors and the purchaser have given notices of redundancy to each of their employees'. It was a requirement of the Share Purchase Agreement that PIUK should deliver to AAH a duly executed copy of the Asset Transfer Agreement. While AAH pointed out that a recital was not a binding provision, we consider that some weight may be given to it.

6.74. Moreover, the evidence from the various parties confirmed that the clear understanding was that AAH would sign the agreement to purchase the various assets as soon as the redundancy letters were sent and would not do so unless this had happened. AAH accepted that it itself suggested that Medicopharma NV should close its United Kingdom operation. As stated in paragraph 4.112, in its evidence to us it described the principal features of 'the transaction' as including the various Board resolutions, the redundancy notices to employees, the Asset Transfer Agreement and the Share Purchase Agreement. We also note that the proposals for the letter of intent and the draft heads of agreement dated 24 October stated that following Medicopharma NV's announcement to discontinue its United Kingdom operations, AAH

would be willing to purchase the stock, certain assets, the three depots, and a shareholding in Pharmacy Systems Ltd (PSL-which was subsequently excluded from the arrangements). This announcement was not to be made without the prior authorisation of AAH. Clause 9.2 of the Share Purchase Agreement as finally concluded provided for there to be consultation on the timing and content of any announcement relating to the subject matter of the agreement. We also note that a report to AAH's Board on 30 October included the statement: 'The essential principle of the deal is that Medicopharma will close its business and that AAH will purchase the specified assets once closure has been effected.'

6.75. The resolutions by Medicopharma UK and PIUK to cease trading in the United Kingdom were decisions that they had to take before any of the envisaged arrangements, to which AAH was to be a party, would be entered into. In our view, however, it was the common understanding of all concerned, and an essential ingredient of the arrangements, that the redundancy letters would be sent out and the Share Purchase Agreement would be completed before any public announcement of such decisions to cease trading was made. The arrangements therefore provided that the only practical implementation or fulfilment of the decisions to cease to trade that was to take place on 3 November 1991 (apart from the transfer of certain assets and so on under the agreements) was the dispatch of the redundancy letters. In the event on the day the redundancy letters were not sent out until after the Asset Transfer Agreement and the Share Purchase Agreement had been entered into, but in our view nothing turns on this point of timing.

6.76. It was also part of the arrangements that there would not be any period after the public announcement that Medicopharma UK had ceased to trade during which Medicopharma UK owned and controlled the three depots and the stock transferred to PIUK. If such an interval had occurred we consider it likely that the results that flowed from the arrangements would have been different.

6.77. We accept that if a company has decided to cease to trade, this decision, and whether and to what extent it has been given effect, is a relevant factor in considering whether the activities or part of the activities of a business which the company previously carried on have been brought under common ownership or common control with enterprises of another. Another such factor is what the company in fact transferred. However, we consider that the mere fact that a company has made the decision to cease to trade, or even has ceased to trade, and is thus not actively carrying on its business as before does not mean that its business or part of it cannot be transferred as a going concern or that the activities or part of the activities of its business cannot be brought under common ownership or common control with enterprises of another.

6.78. Accordingly in our view the fact that Medicopharma UK and PIUK had resolved to cease to trade on Sunday 3 November 1991 before the Asset Transfer Agreement and the Share Purchase Agreement were entered into is not decisive. We consider that following such resolutions it would have been possible, and practical, for Medicopharma UK to have transferred all, or some, of the activities of its business to AAH. This can, we believe, be tested by asking what the position would be in a case where a decision to cease trading had been taken and in which existing contracts with customers and with suppliers were transferred. We consider that in such a case 'part of the activities of the business' might well be transferred notwithstanding the decision by the transferor to cease trading. In other words, a decision to cease trading cannot in itself determine whether activities or part of the activities of a business can be or are in fact transferred.

6.79. The business of Medicopharma UK was that of a pharmaceutical wholesaler, operating from eight depots in the United Kingdom. The business carried on from its Harold Hill, Weedon and Aberdeen depots accounted for almost two-thirds of its total turnover. As is apparent from paragraph 6.78, it seems to us that had the three depots been sold as going concerns, we would have been justified in concluding that 'the activities or part of the activities of a business' had been transferred. On the other hand, had AAH acquired only an amount of stock from these or other depots, no such conclusion would have been likely. In our view, the facts of this case lie between these two situations.

6.80. We next discuss these facts in more detail and assess whether or not the activities or part of the activities of a business were in fact brought under common ownership or common control as a result of the set of arrangements (and the agreements and understandings) referred to in paragraph 6.72. We consider that this question is one of fact and degree and that the vital consideration for us is whether, following the completion of the Share Purchase Agreement, part of the activities of the business of Medicopharma UK

continued to be carried on but under different ownership or control. This includes a consideration of whether part of the business carried on by AAH subsequent to the arrangements should, as a matter of commercial reality, be regarded and treated as only its own business (as AAH alleges) or, in whole or in part, as a continuation of the activities of the business of Medicopharma UK at the three depots acquired by AAH.

6.81. AAH did not take on any existing contracts either with suppliers or with customers. AAH drew our attention particularly to this point as supporting its argument that there was no *de facto* continuation of business. AAH already had a close and existing relationship with all relevant suppliers. As regards contracts with customers, we recognise that in many cases it is the assignment and fulfilment of such contracts that preserves, or plays an important part in preserving, the customer base and thus transfers goodwill and provides for the continuation of the activities of an existing business in new hands as a distinct entity or as part of the business of the acquirer. A transfer of existing contracts with customers and their fulfilment would have provided a contact with the customers of Medicopharma UK. Most business between retail pharmacies and wholesalers is, however, not on the basis of formal or long-term contracts, the Savory & Moore contract with Medicopharma UK being very much an exception. A transfer of the existing contracts of supply would therefore not have created any long-term relationship with customers. It is true that outstanding customer orders had not been assigned to AAH and stock already picked was returned to the shelves but we note that as orders are placed and deliveries are made twice daily, the value of the outstanding orders will have amounted only to a small fraction of Medicopharma UK's annual turnover. What is most important in the preservation of the customer base of a pharmaceutical wholesaling business such as that of Medicopharma UK is to create a contact and connection with the customer. We have therefore considered whether such a connection with customers and a continuation of the business of Medicopharma UK after 3 November 1991 was provided by other means.

6.82. In the pharmaceutical wholesaling business, the general location of a depot has importance. Deliveries of ethical pharmaceuticals are usually made twice daily to customers and service is particularly important in this industry. In addition to the normal delivery service there will usually be an emergency service to meet urgent demands that fall outside the general demand pattern. Thus closeness (in terms of driving time rather than distance) to customers is important. We were told that 'trunking and fanning', that is the use of a large vehicle to deliver to smaller vehicles which then service the pharmacies, can to some extent be used. AAH advised us, however, that the way this was done had to reflect the special handling needs of pharmaceuticals and could not always substitute for the service provided by a local depot. We were also told that retail pharmacies in the Grampian and Highland region, for example, could not easily be served on a twice-daily basis from a depot in the central belt of Scotland, although we note that UniChem has a 19 per cent share of sales of ethicals in the Grampian and Highland region supplied from its depot in the central belt and, more generally, provides a national service from far fewer depots than AAH.

6.83. Moreover, contact between a retail pharmacy and a particular depot from which it is supplied is important. Many retail pharmacies will have dealt with a particular depot for a considerable time using both computer links and telephone contact, which we discuss further in the following paragraph. In the case of the Aberdeen depot, we were told that many customers still regarded the depot as 'Davidsons' notwithstanding changes of ownership. Although there are other elements of goodwill, some would attach to the depot, and by its ownership of the leases of the three depots AAH would thus obtain some elements of the goodwill of Medicopharma UK's business.

6.84. We also note that most customers have a computer terminal which is used to place orders, and that AAH took on the computer equipment in the depots it acquired which were accessed by such terminals. We do not consider that the fact that AAH initially switched off this equipment means that it has no relevance to our consideration. AAH also took on the telephone and fax numbers within the depots. The practice of most customers of Medicopharma UK was to place orders electronically twice a day. On the morning of 4 November this electronic ordering system at the three depots AAH acquired was switched off so that orders could not be registered. We were told that this was done for the reasons given in paragraph 6.87, but it had the obvious effect that pharmacists were likely to telephone the depots. Customers also did not receive deliveries due from Medicopharma UK that morning. We were told that not surprisingly-most of Medicopharma UK's previous customers at the three depots telephoned their depot that morning (if they had not already been contacted as is discussed below). We were further told

that customers were informed that AAH had acquired the depot, which would be operating fully as soon as possible, and meanwhile orders could be placed at another AAH depot. AAH stated that oral instructions were given by managers as to the form of words to be used by sales staff to customers.

6.85. The arrangements involved exclusive prior knowledge for AAH and the other parties directly involved of the fact and timing of the closure of Medicopharma UK. The Share Purchase Agreement provided for there to be consultation on the timing and content of any announcement relating to the subject matter of the agreement. Although AAH argued that Medicopharma NV's financial difficulties had been widely reported in the press, it is clear that the actual closure of the Medicopharma UK operation took other companies in the industry very much by surprise, and they were quite unprepared. The stock which AAH purchased for £22 million as part of the arrangements represented over one month's supply for Medicopharma UK (or sufficient for all AAH's existing customers for seven working days). Even if AAH could not use this stock initially because of the need to establish clean title, it was in a position to run down its existing inventories in the knowledge that it had this additional stock. It also told us that it had ordered an extra £5 million of stock in anticipation of Medicopharma UK's closure. Other wholesalers were not in a position to take on a large number of new customers, as manufacturers only supply fortnightly to wholesalers, whereas wholesalers deliver to customers twice daily. Indeed we understand that some regional wholesalers did run short of stock in the days following 4 November. Therefore by its knowledge of the arrangements AAH was likely to secure a large proportion of Medicopharma UK's business at least in the short term. The way that discounts in this industry operate provides a disincentive for customers to switch to another wholesaler at a time other than at the beginning of the month. Thus AAH was not only likely to take on a high proportion of Medicopharma UK's customers in the short term, but those customers would then have had a strong incentive to stay with AAH, at least for the time being. Moreover, pharmacies would, we were told, also be less likely to switch in December, a very busy trading month. Thus the commercial effect was that AAH would be likely to take on and, at least temporarily, retain and control much of Medicopharma UK's business at the three depots that AAH acquired.

6.86. We note that under clause 6(4) of the Share Purchase Agreement AAH undertook to withhold supplies to any debtor of Medicopharma UK (as defined by the Asset Transfer Agreement) which refused to pay its debt to Medicopharma UK. In our view this carries the implication that AAH expected, following the arrangements, to be supplying such customers, as a result of the arrangements and not simply because Medicopharma UK had ceased to carry on business.

6.87. AAH told us that the three depots began operating fully again on 7 and 8 November. It said that it would have offered a full service on Monday 4 November if it could have done so, but a number of problems were encountered, in particular in establishing clean title to the stock, checking the stocktaking, obtaining wholesale dealers' licences for the depots, recruiting employees and obtaining a licence to use the computer software for stock dispatch and control purposes.

6.88. While the Asset Transfer Agreement stated that goodwill of the Medicopharma UK business was not included in the sale to PIUK, the evidence we have received leads us to conclude that, in this industry, a key element of goodwill is the knowledge which employees have of customers and their relationship with them. Knowledge of customers would include not just their names and addresses, but their terms of trading and sales product mix. Moreover, as already described, service is a very important aspect of competition, and there is regular contact with customers. We were told that in many cases there were personal relationships between employees and customers forged over a number of years. All Medicopharma UK staff were told in a letter dated 3 November that they had been made redundant. At AAH's request, the letter to be sent to staff at the depots it acquired asked staff, notwithstanding the fact of their redundancy, to report to their place of work on Monday 4 November. It seems to us reasonable to infer that AAH must have expected in these circumstances that overwhelmingly such staff would in fact do so and indeed they did. They were at least temporarily taken on by AAH, initially at the pay rates and conditions previously provided by Medicopharma UK (other than holiday entitlement and sick pay). Previously booked holidays which Medicopharma UK employees had planned to take were honoured by AAH. AAH told us that it would not have offered such terms unless it had been able to ascertain what they were. It was able to do so because on 4 and 5 November it requested and was given information on Medicopharma UK pay rates at each of the acquired warehouses. Some staff received pay from both Medicopharma UK and AAH on the same pay-slip, as AAH paid some outstanding holiday pay and overtime on behalf of Medicopharma UK, for which it was then reimbursed by Medicopharma NV, under

an arrangement entered into after 4 November. The same bureau was used to prepare the payroll for Weedon and Harold Hill as Medicopharma UK had used. Thus although the employees of Medicopharma UK were issued with redundancy letters, the arrangements in effect provided AAH with the opportunity to take on all the employees at the three depots it acquired, and overwhelmingly (apart from senior staff) they were in fact taken on by AAH.

6.89. A report to AAH's Board on 30 October (see Appendix 2.7) shows that AAH considered the risk of an argument succeeding that the use of the depots by AAH for trading purposes constituted a transfer of business in the context of the Transfer of Undertakings legislation. The papers stated:

It is possible that employees made redundant by Medicopharma UK could claim that the use of the designed warehouse by AAH for trading purposes constituted a transfer of the business in the context of the Transfer of Undertakings legislation. A successful claim would result in AAH being sued for unfair dismissal. It is intended that a very high number of the Romford, Weedon and Aberdeen employees will be offered employment by AAH, so it is difficult to see how a successful claim could result in damage, other than in respect of differences in terms and conditions of employment. This is a commercial risk that, in relation to the wider value of the deal, is considered acceptable to take.

6.90. We also note that following the closure of Medicopharma UK, AAH recruited certain Medicopharma UK staff from depots other than the three it acquired. AAH told us that it received many enquiries from former Medicopharma UK employees and some such employees were subsequently taken on by AAH. The ex-Medicopharma sales manager at Weedon was asked, on 4 November, to arrange for his field sales representatives to attend a meeting on 5 November and these were then offered at least temporary employment by AAH. We received evidence from one of these sales representatives who covered an area not served by the depots acquired by AAH. AAH told us, however, that its information was that only employees of Weedon were invited to attend. An AAH manager also visited the Leicester depot on the morning of 4 November (to make arrangements for the security and movement of stock) and in response to questions from former Medicopharma UK employees he said that there would be vacancies for telesales staff and drivers at AAH's Nottingham branch. A small number of the ex-Medicopharma UK Leicester drivers were subsequently taken on by AAH. Thus by its prior knowledge of the fact and timing of Medicopharma UK's closure and by the arrangements made with respect to employees at the three depots acquired, as described above, AAH was also able to take on employees from other parts of Medicopharma UK. In the result, the ability to make use of the knowledge and experience, noted in paragraph 6.88, of previous employees of Medicopharma UK came under the control of AAH.

6.91. We note that AAH undertook to compensate Medicopharma NV for some of the costs of the redundancy payments made, by agreeing to pay Medicopharma NV up to £7.6 million as described in paragraph 6.55(b). The agreed shortfall provision also referred to any amounts incurred by and paid by AAH as a consequence of the termination of the employment of the employees of the Medicopharma Group and PIUK. AAH told us that it did not yet know if the compensation would be triggered in practice. The amount in any event was unlikely to be material. This provision nonetheless tends to reinforce our view that the redundancy arrangements, as discussed in paragraph 6.88, were not simply a matter for Medicopharma NV.

6.92. Customer lists were not included in the agreement. AAH told us that it would have known who Medicopharma UK's customers were from its own market information, and it was already the second supplier to a number of them. However, customer information was on the computers acquired by AAH. Although AAH had not acquired the rights to such information, some ex-Medicopharma UK sales staff taken on by AAH, we were told, accessed the computers on Monday 4 November to obtain the telephone numbers of ex-Medicopharma UK customers and then rang them up to inform them of the position. This had, in some cases, been done with the consent of local AAH management, although not, we were told, on the instructions of senior AAH management. Other ex-Medicopharma UK staff taken on by AAH, we were told, used their own written lists of customers (prepared under their previous employment) for this purpose, where customers had not already rung in, as described in paragraph 6.84. Use by AAH employees of information acquired under their previous employment could, we consider, have been expected if instructions had not been given to staff not to make use of such information. Instructions not to access computer information were not given by AAH. Thus by arranging, as described in paragraph 6.88,

to take on the employees at the three depots it acquired, AAH in practice obtained the benefit of information concerning Medicopharma UK's customers. Although it already had its own information, in practice and in effect it made use of that of Medicopharma UK.

6.93. Under the Share Purchase Agreement, AAH also agreed to become Medicopharma NV's agent in recovering trade debts owing to Medicopharma UK. For this purpose Medicopharma NV undertook to provide a list of all the trade debtors within 14 days, with an age analysis within 21 days, and to produce *on demand* 'such information as the purchaser may reasonably require for the purposes of establishing the existence and validity of any of the debts'. AAH told us that in practice this would not have been relevant until after the list of trade debtors had been provided, which it did not receive until 18 November, but we note that under the agreement AAH was entitled to ask for it. AAH told us that at very early stages of the negotiations it was perceived that there could be a benefit to AAH in getting the debtor information quickly because, quite clearly, having acquired that debtor information, it would have effectively given AAH the customer list and, if AAH obtained that very quickly, it would have been an advantage to AAH. AAH also told us that the debtor list would have been of considerable commercial value, as it would have shown not merely the identity of a customer but also details concerning the volume of business done. AAH said, however, that as it did not receive the debtor list until two weeks after Medicopharma UK had closed, this advantage was not in practice obtained. AAH also agreed to take an assignment of up to £7 million of certain of these debts if not recovered by the date indicated in the agreement. AAH placed £7 million as an interest-bearing deposit with ABN-AMRO Bank on the Thursday prior to the transaction. We were told that this was to be maintained until all Medicopharma UK debts were collected or AAH's underwriting of £7 million of debt was triggered.

6.94. We note that subsequent to the arrangements Medicopharma NV did not instruct Cork Gully to sell the customer lists in relation to the three depots AAH acquired (although it did for the other depots). AAH told us that it had not been consulted about this. Medicopharma NV said that it considered that such lists would not have a significant value unless sold together with the depots.

6.95. Following the arrangements AAH told manufacturers to cancel deliveries of stock previously ordered by Medicopharma UK, not only to the depots it had acquired, but also to those it had not acquired. It advised us that this was to prevent disputes regarding title to the stock. The effect of doing this was, in our view, to assist Medicopharma NV in cancelling its delivery contracts.

6.96. As mentioned in paragraph 6.57, under a letter on 3 November AAH had undertaken to use reasonable endeavours to assume the obligations and liabilities of Medicopharma NV in respect of the pharmacy loan guarantee schemes. In this connection, AAH had written to Macarthy on 25 October 1991. AAH's report to its Board on 30 October stated that the transfer of the loan scheme guarantees was 'part of this deal' and we consider that it is clear that it was. Such loan guarantees carried with them a purchasing obligation. By its undertaking AAH was in our view in effect removing from Medicopharma NV an obligation in relation to certain of its customers. This reinforces the view that AAH was hoping and expecting to take on Medicopharma UK's customers by standing in its shoes, as a result of the arrangements (and the agreements and understandings) identified in paragraph 6.72 and not simply because Medicopharma UK had ceased to carry on business.

6.97. In purchasing PIUK, AAH acquired a company which held leases of three depots, computer equipment, fixtures and fittings in those depots, a number of vans, and the stock at all of what had been Medicopharma UK's depots. In the circumstances of this case we consider that PIUK should be regarded essentially as a vehicle for the transaction between Medicopharma NV and AAH. At the time of the Share Purchase Agreement, PIUK had a Board of Directors consisting of directors or employees of Medicopharma NV concerned with the pharmaceutical business. It had bank indebtedness outstanding of just under £24 million, share capital of 100,000 ordinary shares of £1 each, and it was itself a party to the Asset Transfer Agreement. It had title to certain non-transferable product licences. It also had a trading record as an importer of pharmaceutical products although it had resolved at 5 pm on 3 November to cease trading.

6.98. AAH told us that it was very conscious of the possibility of investigation by the competition authorities and tried to structure the arrangements so that they would not constitute a merger situation

qualifying for investigation. Had it not been for these constraints, it would have wished to have acquired Medicopharma UK as a going concern.

6.99. In its paper to its Board of 30 October concerning the proposed transaction, AAH said that Macarthy-which, as explained in paragraph 6.3, had a long-term contract with Medicopharma UK for the supply of its Savory & Moore chain-might be expected to transfer its purchases to other wholesalers. Of the remaining business, the papers estimated a 'retention' of £130 million of Medicopharma UK's sales (excluding those to Savory & Moore) of £220 million. This figure of £130 million was calculated as 'a good proportion' of the business of £120 million at the three depots AAH was to acquire and at least 40 per cent, ie at least £40 million, of the remaining £100 million. In our view, this indicates that AAH's rough estimate was that it expected to obtain something approaching £90 million, that is, say, 65 to 75 per cent, of the business at the three depots it was to acquire.

6.100. The three depots AAH took over were Medicopharma UK's three largest depots which accounted for almost two-thirds of its sales to retail pharmacies and dispensing doctors. The depots acquired (and in particular the Harold Hill depot) also accounted for almost all of Medicopharma UK's sales to hospitals. Of the depots not acquired by AAH, the Cambridge and Leicester depots were the two most sizeable and profitable. The Dundee depot was a small transshipment depot, operated as a branch of the Aberdeen depot. The Glasgow depot was heavily dependent on sales to the Savory & Moore chain, as shown in Table 2.6. The Carlisle depot was small and not profitable. AAH told us that it had subsequently revised downwards its estimate of Medicopharma UK's total turnover but its initial results were broadly in line with the forecasts referred to in the previous paragraph. As discussed in paragraphs 3.55 to 3.57, we estimate that overall AAH initially gained about 50 per cent of Medicopharma UK's sales to retail pharmacies and dispensing doctors, or 60 per cent if sales to Savory & Moore are excluded, and more than this in the areas of the three depots acquired. AAH considered that, taking into account seasonable demand in December, its extra sales represented about 45 per cent of Medicopharma UK's former sales to retail pharmacies and dispensing doctors. On either basis, the proportion AAH gained was significantly above its national market share of around 30 per cent. AAH also gained, we estimate, 85 per cent of the hospital business. We discuss in more detail in paragraphs 6.116 to 6.120 what would have occurred had the arrangements not been made. We consider it likely that in this event the Medicopharma UK business would have been placed in receivership not later than 4 November. AAH would then have been likely to achieve some increase in sales, but in our view it is clear that that increase would have been much less significant than was achieved by AAH by virtue of the arrangements (and the agreements and understandings) described in paragraph 6.72.

6.101. We have considered carefully AAH's argument that it acquired only assets and in this respect we have noted that Medicopharma UK had resolved to cease trading, the depots did not operate fully until 7 or 8 November, Medicopharma UK's wholesaler dealer licences lapsed, no contracts were transferred, outstanding orders were not delivered, customers had to make new arrangements, the supply contracts to the warehouses were terminated and AAH installed its own branch managers at the depots. All of these matters are factors which favour the argument of AAH that it acquired only assets.

6.102. In our view, however, although AAH did not in terms acquire the depots as going concerns, in reality it obtained much of the benefit of so acquiring them and it clearly acquired more than bare assets, as described in greater detail above. It obtained three depots complete with stock and fixtures and fittings, which for reasons given in paragraphs 6.82 and 6.83 would have carried with them a certain degree of goodwill. It acquired the computers in those depots to which the computers or terminals of Medicopharma UK's customers had access, and the telephone and fax numbers of those depots. In this industry orders are placed and deliveries are made twice daily and retail pharmacies would need to find an immediate source of supply. The arrangements involved exclusive prior knowledge for AAH (and the other parties directly involved) of the fact and timing of the closure of Medicopharma UK. It was part of the Share Purchase Agreement that there had to be consultation on the timing and content of any announcement relating to the subject matter of the agreement. Other wholesalers were very much taken by surprise by the closure of Medicopharma UK and as a result were not in a position to recruit a large number of new customers. The way the arrangements were structured also ensured that AAH could take on the employees at the depots it acquired almost as surely as if it had acquired those depots as going concerns. By these means it gained the benefit of those employees' knowledge of Medicopharma UK's customers as well as the benefit of their relationship with those customers. Under the Share Purchase Agreement, AAH undertook to become

Medicopharma NV's agent in recovering trade debts and acquired access to certain information relating to Medicopharma UK's trade debtors, which were the customers of Medicopharma UK. AAH also undertook to use reasonable endeavours to assume the obligations of Medicopharma NV in respect of the loan scheme guarantees as described in paragraph 6.96. All the above matters (dealt with in more detail in paragraphs 6.82 to 6.100) affect the three depots acquired by AAH and the continuation of business therefrom although some do not relate exclusively thereto.

6.103. AAH asserted, and we accept, that it is not possible to be precise as to the amount of the business of retail pharmacy customers of Medicopharma UK which was taken on by AAH. It is also difficult to assess this just in relation to the three depots acquired. It is, however, clear that, as AAH estimated would be the case, the percentage of the retail pharmacy business of Medicopharma UK that AAH acquired was much higher in respect of these three depots than it was in respect of the remainder of the business. As appears from paragraphs 6.99 and 6.100, we consider that the rough estimate made by AAH that it might acquire some 65 to 75 per cent of the business carried on from the three depots and at least 40 per cent of the remainder (in both cases excluding sales to Savory & Moore) was a fair one and one that was broadly realised in practice. As is discussed in more detail below, had Medicopharma UK been placed in receivership, AAH would have been likely to secure some of Medicopharma UK's sales but in our view the amount of the retail pharmacy business of Medicopharma UK acquired by AAH in relation to the three depots is much greater than would have occurred in that event and is to a considerable extent attributable to the set of arrangements (and the agreements and understandings) identified in paragraph 6.72 and the matters summarised in paragraph 6.102 which flowed therefrom.

6.104. In respect of the three depots (at Harold Hill, Weedon and Aberdeen) we have concluded that the set of arrangements (and the agreements and understandings) described in paragraph 6.72 and the matters summarised in paragraph 6.102 provided a strong contact and connection between AAH and AAH Subsidiaries and both the retail pharmacy customers and hospital customers of the business of Medicopharma UK carried on from the three depots. In our view, the overall effect of such arrangements, agreements and understandings was that the business carried on by AAH after 3 November 1991 was in part a continuation of a significant proportion of the business previously carried on from the three depots by Medicopharma UK.

6.105. We have examined with care the activities of Medicopharma UK, and particularly those concerned with the three depots acquired by AAH, before the arrangements made on 3 November and against this background considered what was acquired by AAH.

6.106. On the basis of the evidence we have received and summarised in this report and having particular regard to what was acquired by AAH and AAH Subsidiaries as summarised in paragraph 6.102 and dealt with in more detail in paragraphs 6.81 to 6.101, we conclude that the overall effect of the set of arrangements (and the agreements and understandings) mentioned in paragraph 6.72 was that AAH and AAH Subsidiaries acquired control of part of the activities of the businesses of Medicopharma UK at the three depots (at Harold Hill, Weedon and Aberdeen) and continued to carry them on.

6.107. We thus conclude that enterprises of Medicopharma NV and of AAH have ceased to be distinct in the manner described in section 65(1)(a).

### ***The assets test***

6.108. Among the matters recited in the reference was that it appeared to the Secretary of State that the value of the assets taken over exceeded £30 million, and we therefore investigated this. The assets taken over by AAH, and their book value at the time of the acquisition, were discussed in paragraphs 6.54 to 6.56. It appears to us that the value of the assets taken over did not exceed £30 million and we conclude that the assets test in section 64(1)(b) of the Act is not satisfied.

### ***The market share test***

6.109. The reference, however, does not exclude us from considering the alternative test, prescribed by section 64(1)(a) of the Act—the market share test—and it is clearly consistent with the intention of the Act that, the assets test not having been satisfied, we should do so. We also note that, under section 68(4) of the Act, as amended, it is open to us to decide the criteria which are most suitable for determining when goods are to be treated as being of a separate description for the purposes of section 64, and we have given effect to this in considering the market share test.

6.110. We now examine whether the market share test is met. We have already concluded (see paragraphs 6.31 to 6.40) that supply of ethicals is a separate market from supply of OTC pharmaceuticals, and that supply of ethicals to hospitals is a separate market from the supply of ethicals to retail pharmacies and dispensing doctors. We have also concluded that supply of ethicals by wholesalers is a separate market from direct supply by manufacturers both in the case of supply to hospitals and supply to retail pharmacies and dispensing doctors.

6.111. We first consider sales of ethicals by wholesalers to retail pharmacies and dispensing doctors. On the basis of AAH's own estimates, it had a 24 per cent market share before the arrangements. On our estimates, as shown in Table 3.7, AAH had a 27 per cent market share. AAH suggested that it had acquired about 45 per cent of Medicopharma UK's sales to retail pharmacies and dispensing doctors following Medicopharma UK's withdrawal, that is an additional market share of about four percentage points, but that almost all of this increase was attributable to Medicopharma UK's closure rather than to the merger situation. Our own estimates (as discussed in paragraph 6.100) suggest that AAH gained a higher share of Medicopharma UK's sales. In our view the increase in AAH's market share was to a considerable extent attributable to the acquisition by AAH, as described above, of Medicopharma UK's three largest depots which accounted for almost two-thirds of its sales in this market. We thus conclude that the condition specified in section 64(2) of the Act—namely a market share of at least one-quarter in the United Kingdom—prevailed to a greater extent with respect to the supply of goods of this description by AAH as a result of the enterprises having ceased to be distinct. Had we accepted AAH's market estimates, we would also have found that the market share test was met—as we would have concluded that the condition specified in section 64(2) prevailed as a result of the enterprises having ceased to be distinct.

6.112. We now consider sales of ethicals by wholesalers to hospitals. Table 3.8 shows that in 1990 AAH accounted for 70 per cent of such sales. Medicopharma UK accounted in 1990 for 3 per cent of sales of ethicals to hospitals, of which almost all was supplied from the depots (and in particular the Harold Hill depot) which AAH acquired. We estimate that AAH acquired 85 per cent of Medicopharma UK's hospital sales following the arrangements. AAH would, in our view, have been likely to achieve a significant proportion of Medicopharma UK's business had a receiver been appointed, but in our view it would not have been as high as was achieved as a result of the arrangements (and the agreements and understandings) described in paragraph 6.72, under which AAH acquired in particular the Harold Hill depot. We therefore consider that these resulted in an increase in AAH's market share with respect to sales of ethicals to hospitals, and we conclude that the condition specified in section 64(2) of the Act, namely a market share for AAH of at least one-quarter in the United Kingdom, prevailed to a greater extent as a result of the enterprises having ceased to be distinct. Had we concluded that supply to hospitals by wholesalers was not a separate market from direct supply by manufacturers we would also have reached the same conclusion in relation to section 64(2); we note in this context that AAH accounted for 33 per cent of total sales of ethicals to hospitals and Medicopharma UK for 1.5 per cent of such sales, in particular from its Harold Hill depot.

## ***Conclusion***

6.113. We have concluded that enterprises of Medicopharma NV and of AAH have ceased to be distinct in the manner described in section 65(1)(a). We have also concluded that the market share test specified in section 64(1)(a) and (2) is met. Both Medicopharma UK and AAH carried on business in the United Kingdom. We thus conclude that a merger situation qualifying for investigation has been created.

## **Section 65(1)(b)**

6.114. As already discussed, AAH told us that it acquired no part of the activities of a business, and that enterprises of Medicopharma UK ceased to be carried on at all. It therefore argued that whether a merger situation had been created should be considered under section 65(1)(b), but that the requirements of these provisions were not in fact met, as the closure of Medicopharma UK's business was not in consequence of any arrangements or transactions entered into between Medicopharma NV and AAH and that such arrangements were not 'entered into to prevent competition ...'. We have already concluded that a merger situation qualifying for investigation has been created, as we regard the arrangements as falling within section 65(1)(a) of the Act. We therefore do not consider it necessary to reach a conclusion as regards section 65(1)(b).

## **The public interest**

6.115. We now consider whether the merger situation which we have identified operates, or may be expected to operate, against the public interest. We first discuss what is likely to have happened had the arrangements not been made.

6.116. AAH argued that had the arrangements not been made, Medicopharma NV would have closed its United Kingdom operation on 3 November. A paper to the AAH Board on 30 October asking for approval for the deal stated 'The emergence of Medicopharma has not been helpful' and 'The benefit to AAH from the demise of Medicopharma in the United Kingdom cannot be overstated'. AAH said, nonetheless, that by late October it understood that the decision had been taken by Medicopharma NV to close its United Kingdom business and no other options were under serious consideration by ABN-AMRO Bank. It was AAH's impression that McKesson was no longer interested in acquiring Medicopharma UK. AAH said it did not know that an MBO proposal was under consideration by ABN-AMRO Bank or Medicopharma NV.

6.117. Medicopharma NV stated that by late October some major United Kingdom suppliers had required a tightening of credit terms or restricted some supplies to Medicopharma UK to a 'cash with order' basis (because of the publicly known financial difficulties of Medicopharma NV). It said that ABN-AMRO Bank was actively considering receivership for the parent company and a meeting had been arranged for 3 November with receivers. Medicopharma NV told us, however, that in its view it was by no means certain that a receiver for either the parent company or the United Kingdom operation would have been appointed on that day had the deal with AAH not been concluded. It said that the alternatives of the MBO and the McKesson bid were still open to Medicopharma NV and were actively pursued until shortly before the agreement with AAH was signed. Medicopharma NV was in touch with McKesson as late as 1 November. McKesson had already done considerable 'due diligence' work. Medicopharma NV said that the main obstacle was the price which McKesson was prepared to pay, which by late October was some £23 million. Discussions were also held with Messrs Baseley and Stedman on the MBO on 2 November. Their offer at that stage was £22 million, which was about 70 per cent of net asset value. Medicopharma NV stated that it was reluctant to accept either the McKesson or the MBO bid because neither would have been sufficient to prevent Medicopharma NV going into receivership. According to Medicopharma NV, the bids were, however, probably in excess of what would have been secured in a liquidation of the United Kingdom operation and had the AAH deal not gone through, the McKesson offer or the MBO might well have succeeded. Medicopharma NV said that it was difficult to estimate exactly what would have been

received in a liquidation but thought it was likely to have been in excess of the Medicopharma UK management estimate of some £16 million. The main assets were stock (which might have realised 70 per cent of book value) and debtors.

6.118. McKesson confirmed to us that when it was approached by Medicopharma NV in late October it responded that it was willing to reopen negotiations for the acquisition of Medicopharma UK's business, but only on the basis of a price of some £23 million.

6.119. ABN-AMRO Bank told us that, as described in paragraph 6.52, negotiations had taken place with a range of parties during 1991. By the end of October the options open for the United Kingdom business were effectively receivership (which would have placed Medicopharma NV itself into receivership); closure and liquidation; sale of the business as a going concern (McKesson or the MBO being the only buyers with whom discussions were under way) or the AAH deal. The AAH deal was chosen because it offered the highest price. McKesson had expressed serious interest in acquiring Medicopharma UK in February 1991 and again in August 1991 and a letter of intent had, the Bank was told, been received by Medicopharma NV from McKesson on the basis of full net asset value. Negotiations had, however, broken down without, as far as the Bank was aware, McKesson undertaking 'due diligence' investigations. In response to a further approach by Medicopharma NV in late October, McKesson said that any resumption of negotiations would have to be based on an offer of £22 million or £23 million. Any deal with McKesson would, in the Bank's view, have taken a few weeks to finalise. The MBO team had also offered £22 million, but a deal with it would have taken at least four weeks to bring to fruition (as 'due diligence' would need to be carried out by its financial backers). ABN-AMRO Bank told us that major payments were due by Medicopharma UK at the end of October and a further injection of some £20 million would have been needed. It said that it was not prepared further to increase the Bank's exposure. Given this, and as the alternative options would have taken some weeks to finalise, it would have appointed receivers for Medicopharma UK, which for the reasons given in paragraphs 4.7 and 5.156 would have led to receivership for Medicopharma NV, not later than 4 November, had the AAH deal not been concluded. In the Bank's view, the receiver would have stopped trading immediately and would have sold the various assets. The Bank said that the receiver would not have had to meet redundancy costs or other liabilities of the company. The Bank would, in its view, have realised significantly more from receivership than it would have obtained from the McKesson or MBO deals.

6.120. Our conclusion from this evidence is that the AAH deal was accepted because the price obtained for the arrangements was more favourable than bids for the whole United Kingdom business as a going concern or the proceeds which ABN-AMRO Bank expected to have realised from receivership for Medicopharma UK. The arrangements also had the important advantage of not involving immediate receivership for Medicopharma NV. Had such a deal not been available, we consider it probable that the Medicopharma UK business would have been placed in receivership not later than 4 November, leading in turn to receivership for Medicopharma NV. We consider it unlikely in the circumstances of this case that the receiver would have carried on the business either in whole or in part with a view to a sale as a going concern, because of the difficulties of obtaining working capital for continuing purchases of stock. Nonetheless, the receiver, in our view, could have, and is likely to have, sold at least some of the individual depots complete with fixtures, fittings, customer lists and possibly also stock, which could have allowed them to be reopened and brought into operation quite quickly.

6.121. It is against this background that we now consider the effect on competition of the merger situation. We first consider the effects on competition in wholesale supply to retail pharmacies and dispensing doctors at a national level and then in particular regions and, finally, the consequences for the hospital market.

### **Wholesale supply to retail pharmacies and dispensing doctors**

6.122. The two largest wholesale suppliers before the arrangements were UniChem and AAH, with a share of sales by wholesalers of ethicals to retail pharmacies and dispensing doctors of 33 per cent and 27 per cent respectively. Medicopharma UK was the third largest wholesaler, operating almost on a national scale with a market share of sales of pharmaceuticals by wholesalers of 8 per cent. The three depots

acquired by AAH, at Harold Hill, Weedon and Aberdeen, accounted for almost two-thirds of Medicopharma UK's sales to retail pharmacies and dispensing doctors.

6.123. In 1990, apart from UniChem, AAH and Medicopharma UK, ten wholesalers had a market share of 1 to 2 per cent each and the remainder had a share of under 1 per cent each. Thus Medicopharma UK was significantly larger than the next largest competitor.

6.124. About 17 per cent of Medicopharma's sales were to Macarthy's Savory & Moore chain. As explained in paragraph 6.3, under the 1990 agreement Macarthy was committed to purchasing not less than 90 per cent of its ethical products from Medicopharma UK for a period of five years, subject to the discount terms offered by Medicopharma UK being not less favourable by more than 0.5 per cent than those offered to Savory & Moore by other wholesalers. Savory & Moore's chain of pharmacies was located mainly in Central Scotland, South Wales and the South-West and South-East of England. They were chiefly served by Medicopharma UK's depots in Glasgow (where they represented almost half of the depot's sales), Weedon (22 per cent) and Harold Hill (12 per cent), as shown in Table 2.6. We would expect the discounts offered by a wholesaler to be highest if it could quote for the whole chain; in practice we would thus expect either AAH or UniChem, the only wholesalers supplying all the areas, to obtain this business in the absence of Medicopharma UK, provided Macarthy remained independent. On 4 November AAH initially became the main supplier of ethicals to Savory & Moore. UniChem shortly afterwards replaced AAH in this role.

### ***Effects of closure of Medicopharma UK***

6.125. A number of those who gave us evidence argued that there was likely to be a reduction in competition as a result of the closure of Medicopharma UK and the arrangements made by AAH with Medicopharma NV. As we consider it likely, as discussed in paragraph 6.120, that in the absence of the arrangements Medicopharma UK would have been placed in receivership and ceased trading, the loss of Medicopharma UK as a competitive force cannot in itself be attributed to the merger situation. It is only the effect for the public interest of the merger situation that we have to assess. We cannot, however, ignore the fact that the closure of Medicopharma UK is likely to have an impact on competition and we therefore consider this before turning to the consequences of the merger situation itself.

6.126. Medicopharma UK had been an active competitor, offering keen credit terms and discounts. Its management told us that it had been gaining some market share, principally at the expense of AAH and UniChem. Medicopharma NV stated that it considered that a high level of discounts could have been maintained by Medicopharma UK by achieving greater economies of scale. Several wholesalers, however, said that they thought that discounting on the scale practised by Medicopharma UK was not consistent with a viable business. Had the Medicopharma UK business remained in existence, whether as such or owned by some other company, it would, in our view, have continued to exert competitive pressure on the two national wholesalers. This pressure could have taken the form either of keen discounts or competition on service or both. In the absence of a third force in the market we would expect the two national wholesalers to exercise greater price leadership, which the much smaller wholesalers may well follow, and there is likely to be some reduction in competition.

6.127. The position of regional wholesalers will have been affected by the closure of Medicopharma UK. Medicopharma UK was the largest member of Numark, which undertakes central negotiation for independent full-line wholesalers with manufacturers on OTC products (including a Numark own-label range) and on some ethical drugs and also carries out marketing initiatives. Numark told us that it had suffered an immediate and substantial reduction in its overall volume of business as a result of Medicopharma UK's closure, which had serious implications for its ability to provide its members with the support they needed. By weakening Numark, the withdrawal of Medicopharma UK may thus also have weakened regional wholesalers. On the other hand, it is clear that regional wholesalers have increased sales following the closure, at least in the short term. This is discussed further in paragraph 6.129. If Medicopharma UK's business had remained an active competitor, regional wholesalers would have to compete more aggressively for business, with adverse consequences for their financial position, which in some cases was not strong.

6.128. Against this background, we now consider the effects of the merger situation.

### ***Effects on competition at a national level***

6.129. AAH's national share of sales of ethicals to retail pharmacies and dispensing doctors increased, we estimate, by about four percentage points after 4 November. AAH argued that had Medicopharma UK been closed, it would have gained a significant increase in sales. It claimed that the sales it acquired over and above the closure scenario, ie as a result of the arrangements with Medicopharma NV, were relatively small. Thus it said that in December, when its total turnover was £95.5 million, it achieved some £10.4 million extra sales of which £9.7 million were to retail pharmacies and dispensing doctors other than Savory & Moore, £0.2 million to Savory & Moore and £0.5 million to hospitals. It estimated that only about £0.5 million to £0.75 million of these would not have been gained in the absence of the arrangements. In order to assess whether this was the case, we considered what increase in sales had been achieved by other wholesalers in November and December 1991. UniChem told us that it had achieved extra sales in December of some £5 million (ie an increase in its share of about two percentage points), to a large extent due to its becoming the main supplier to the Savory & Moore chain. A number of regional wholesalers said that subsequent to 4 November they had acquired additional business and they expected to retain much of this in the longer term. In the light of figures provided by full-line wholesalers, we estimate that overall the combined market share of regional wholesalers may have increased by between one and two percentage points to around 24 per cent, as a result of picking up former customers of Medicopharma UK. On this basis, AAH acquired about 50 per cent of Medicopharma UK's former sales, or 60 per cent if sales to Savory & Moore are excluded. AAH's own view was that it had acquired 45 per cent of Medicopharma UK's sales (including sales to Savory & Moore). AAH expected to gain a particularly high proportion of Medicopharma UK's customers in the areas served by the three depots it acquired and the evidence suggests that it did indeed do so. In our view AAH would not have achieved nearly as high a proportion of Medicopharma UK's sales in the absence of the merger situation. Nonetheless it clearly would have achieved some increase in market share, and we now consider the size and significance of the difference between that and what it actually acquired.

6.130. If wholesalers had taken on Medicopharma UK's customers in proportion to their market shares, following receivership for Medicopharma UK, UniChem and AAH would, broadly speaking, each have achieved an additional 2 per cent market share (excluding the Savory & Moore business), and other wholesalers would have gained 2 per cent combined. (As explained in paragraph 6.124, we would have expected either AAH or UniChem to have gained the Savory & Moore business, if Macarthy remained independent.) The actual outcome might have been different from the national market shares, for example depending on who had acquired Medicopharma UK's depots, but these figures suggest that in broad terms the increase in AAH's market share at a national level as a result of the merger situation is likely to have been two percentage points or a little more above what would otherwise have occurred. We do not consider that this increase, even if sustained, is likely in itself to have any significant effect on competition.

6.131. Some regional wholesalers and others expressed concern that by strengthening the position of AAH, the merger situation would have a detrimental effect on regional wholesalers. AAH and UniChem were, it was argued, already eroding the customer base available to regional wholesalers by the acquisition of retail pharmacies, by offering loan guarantees to pharmacies and by franchise arrangements. The transaction would give AAH an even bigger customer base. In addition it was argued that AAH would now be more likely to adopt predatory tactics towards particular wholesalers and drive them out of business. The evidence did not show that AAH had yet pursued such tactics. We accept that with a high market share in particular regions, such actions by AAH would be more likely to be successful than before ownership and control of the relevant depots had passed to AAH, and this may in itself deter new entry by wholesalers. We do not, however, consider that the increase in AAH's market share at a national level is sufficient to have a marked effect in this regard.

6.132. Concern was expressed as to whether AAH would, as a result of its acquisition of the three depots, obtain more favourable terms from manufacturers. We see no reason for concluding that ethical manufacturers will change their present practice of offering the same discount terms on branded ethicals to wholesalers whatever the size of their purchases. There are likely to be differences in purchasing power on

generics (the use of which, as we have noted in paragraph 6.15, is increasing), parallel imports, OTC medicines and other OTC products, but as AAH's national market share has only increased by 4 per cent (of which part would, as already discussed, have been likely to occur in the absence of the arrangements), we do not consider that any material increase in purchasing power is likely to result.

6.133. It was put to us that, by acquiring the stock at all of Medicopharma UK's depots, AAH in effect prevented the depots being sold until the stock was removed from those depots: the agreement provided for this to be done by AAH within 30 days. By that time all the former customers would have had to make alternative supply arrangements. AAH told us that this had not been part of its plans. It did not think that it would have been practical for the stock to have been divided between a number of purchasers, in view of the difficulties over claims to retention of title. Moreover, it had cleared the stock from all the depots not acquired by 18 November (apart from damaged or obsolete stock that AAH had not purchased). Had it been asked to clear the stock from particular depots more quickly it could have done so. The merger situation we have identified relates to the three depots acquired by AAH, as discussed in paragraphs 6.102 to 6.106. With this in mind, we do not consider that adverse effects for the public interest arise in this respect as a result of the merger situation.

6.134. We therefore consider that by acquiring the three largest depots of Medicopharma UK, AAH strengthened its position and ensured that it obtained a considerable benefit from the withdrawal of Medicopharma UK. As already discussed, we believe that the closure of Medicopharma UK reduced competition, but we do not consider that the additional effect of the arrangements made between AAH and Medicopharma NV had a material effect, at a national level, on competition between pharmaceutical wholesalers supplying retail pharmacies and dispensing doctors. We now consider the position in particular regions.

### ***Effects in particular regions***

#### ***Grampian and Highland region***

6.135. A number of those who gave us evidence suggested that as a result of AAH acquiring Medicopharma UK's depot in Aberdeen there had been a marked reduction in competition in the Grampian and Highland region. In Scotland AAH and Medicopharma UK together had accounted for over half of all sales of ethicals by full-line wholesalers; in the Grampian and Highland region they each accounted for about 40 per cent of sales, with UniChem being the only other significant supplier. Figure 3.1 shows that no other wholesaler apart from AAH and Medicopharma UK had a depot in the Grampian and Highland region. Medicopharma UK had a small transshipment depot in Dundee and a depot in Glasgow, which were closed following the deal with AAH. Short of opening a new depot in the North of Scotland, other wholesalers (such as UniChem and John Hamilton (Pharmaceuticals) Ltd) could supply the Grampian and Highland region only in so far as this could be done from their depots in the central belt of Scotland. We were advised that, because of the terrain and the long distances involved, it was difficult to offer an adequate level of service to parts of Scotland from depots in this area. UniChem told us that it used trunking and fanning to provide, from its depot in the central belt, a twice-daily service to the area south of Aberdeen but only a once-daily service north of Aberdeen. In March 1992 it extended its twice-daily service to the Aberdeen area and north towards Fraserburgh and Peterhead.

6.136. UniChem estimated that its extra turnover in the Grampian and Highland region in December was about £0.2 million (just under 20 per cent of Medicopharma UK's sales in that region). No other wholesaler reported a significant increase in sales in Grampian and Highland. This evidence suggests that AAH gained the vast majority of Medicopharma UK's sales in this region. AAH accepted that, following its acquisition of Medicopharma UK's Aberdeen depot, it had increased its share and it estimated that it now supplied some 65 to 70 per cent of the market in the Grampian and Highland region. It considered, however, that competition was not foreclosed. It noted that UniChem provided a service and Medicopharma UK's Dundee depot was still available if a wholesaler wished to take it over. We nonetheless consider that by acquiring the Aberdeen depot competition between wholesalers especially in the Grampian and Highland region was reduced.

6.137. We asked ourselves whether any reduction in competition was attributable to the merger situation or whether it would have arisen had Medicopharma UK been placed in receivership. We note that Medicopharma UK's Aberdeen depot was its most profitable and had a strong customer base, only a small percentage of which was represented by sales to the Savory & Moore pharmacies. As already noted, no other wholesaler apart from AAH had a depot in the region. We said earlier (paragraphs 6.82 and 6.83) that the location of a depot has importance, as has contact between a retail pharmacy and a particular depot from which it is supplied. Many retail pharmacies will have dealt with a particular depot for a considerable time by both computer links and telephone contact, as discussed in paragraph 6.83. In the case of the Aberdeen depot, many customers regarded the depot as 'Davidsons' notwithstanding changes of ownership. Given these considerations, we consider it probable that the Aberdeen depot would have been acquired by a wholesaler had Medicopharma UK been placed in receivership. Although the receiver would have tried to sell the depot as rapidly as possible, AAH is likely to have raised its market share in Grampian and Highland even in the event of receivership for the Medicopharma UK business, but there is little doubt in our minds that in this event AAH's share would have increased by a lot less. Any purchaser other than AAH would have provided greater competition in the region.

6.138. As we have stated in paragraph 6.18, there are some difficulties in setting up and becoming established as a wholesale supplier of ethicals to retail pharmacies and dispensing doctors. There are economies of scale both in purchasing and wholesale operations. In particular the need for twice-daily deliveries means that, to be economic, a considerable volume of business is needed in an area. Given the long distances and terrain in the North of Scotland, this is a particularly important factor. The expense of carrying a complete range of stock in a depot is also high. To incur these outlays while a customer base is gradually built up from scratch is, we were told, a costly strategy. The growing degree of vertical links between wholesalers and retail pharmacies has reduced the number of 'free' retail pharmacies which are in principle available for 'capture' by a new wholesaler. When taken together with the economies of scale already mentioned, these factors make new entry in a particular region by an existing or a new full-line wholesaler difficult. AAH did not consider that there were significant barriers to entry to the pharmaceutical wholesale market, other than low margins and low returns on capital. However, it did not think it likely that new companies would become full-line wholesalers, with the obligation to carry a long tail of slow-moving and unprofitable products, when they could establish a satisfactory business as short-line wholesalers with much less investment. It pointed out, however, that a new company had very recently been formed, Norscot Pharmaceuticals Ltd (Norscot), to operate from Aberdeen. (We discuss this further in the next paragraph.) There were also regional wholesalers based in Glasgow and Kilmarnock servicing at least part of the Scottish market as well as UniChem, which covered Scotland from its branch in Livingston.

6.139. The new company, Norscot, has been established by some former managers of Medicopharma UK's Aberdeen depot. It intends, we were told, to start operations in Aberdeen as a pharmaceutical wholesaler in April, with a target turnover of about half that of Medicopharma UK's Aberdeen and Dundee depots. This development occurred, we understand, only at a very late stage in our deliberations. It is evidently too early to assess how successful this venture is likely to be. We understand that one of the key people involved is the former manager of 'Davidsons' who, we were told, was widely known and well regarded among pharmacists and this may well help the new business to gain a foothold. We were also told that, as stated in paragraph 5.66, Norscot has support from a number of retail pharmacies. It may, therefore, overcome some of the difficulties of new entry described above. Nonetheless, in our view, Norscot's entry is not likely to mitigate to a significant extent the effects of the reduction in competition we believe has occurred.

6.140. Retail pharmacies tend to prefer to source from one main supplier and in practice do not frequently switch suppliers; if they switch at all, they tend to do so at the beginning of the month, because of the discount structures offered by wholesalers. On the other hand, Medicopharma NV told us that, provided sufficiently attractive terms were offered, pharmacies could be persuaded to move to a new main supplier and that Medicopharma UK had succeeded in increasing its market share by this means.

6.141. AAH argued that short-line wholesalers also operated in the North of Scotland. We do not, however, consider that increased competition from short-line wholesalers is likely to provide a significant competitive force. The range carried by such wholesalers is very much more limited and is not a direct substitute for the service offered by a full-line wholesaler.

6.142. We considered whether the opportunity for retail pharmacies to purchase direct from manufacturers would ensure continued competition between wholesalers in the Grampian and Highland region. As discussed in paragraph 6.24, some large retail pharmacy chains obtain the majority of their requirements direct from manufacturers and some small groups of independent pharmacies also combine to self-supply their pharmacy requirements on a co-operative basis. For most independent retail pharmacies, however, direct supply on any significant scale is neither practical (because of physical storage limitations) nor economic (because of stockholding costs). Even though some small retailers may buy some products direct from suppliers which are prepared to sell in that way, they all still need wholesalers for most of their purchases. For these reasons, we do not consider that direct supply is a sufficiently close alternative to ensure that competitive conditions are maintained in pharmaceutical wholesaling generally or in the Grampian and Highland region in particular.

6.143. AAH argued that the regulatory procedures for the reimbursement of pharmacists' drug costs fully protected retail pharmacies from any material reductions in the levels of discounts given by wholesalers. Therefore there had not been, and would not be, any threat to the stability of the retail pharmacy sector from further concentration of the wholesale supply service. AAH also argued that regulatory powers were adequate to ensure that wholesalers did not generate excessively high profits even if, contrary to AAH's belief, the changed circumstances had alleviated the competitive pressure on wholesalers to any material extent. This view was not shared by the DH or the Scottish Office which were concerned to ensure that competition in the wholesaling sector was maintained in order to ensure value for money for the NHS. We have already stated in paragraph 6.48 that this is a highly regulated market and that we consider that close attention ought to be paid to the possible effects on competition of the regulations. Where, however, there are opportunities for competition, we consider that the maintenance of competitive conditions is likely to be a more effective way of ensuring value for money for the NHS than a complex regulatory scheme which attempted to mimic the benefits of competition.

6.144. In the light of all these factors, we consider that the merger situation has resulted in a reduction in competition in the Grampian and Highland region, significantly greater than would have occurred in the absence of the merger situation. As a result of AAH's very high market share, notwithstanding AAH's arguments regarding possible competition from short-line wholesalers or direct supply from manufacturers and the influence of the regulatory procedures, there will be less pressure on AAH to give keen discounts and to offer high levels of service (particularly where this is costly to provide). In the light of the proposed entry of Norscot, we asked ourselves whether adverse effects for competition were still likely to arise. It is unclear how high a market share this company will achieve. In our view while it may mitigate in part the reduction in competition, it is not likely to do so to a significant extent. We expect that the effects of the reduction in competition we have identified will be that prices to retail pharmacies and dispensing doctors will over time be higher and service standards lower than would otherwise have been the case. We believe that these consequences will be adverse to the public interest.

### *South-East England*

6.145. We now consider whether adverse effects on competition may be expected to arise in the South-East of England. Before the arrangements UniChem and AAH accounted for 53 and 28 per cent respectively of sales by full-line wholesalers in that region; Medicopharma UK had 8 per cent. There were six other full-line wholesalers but with only small shares, serving parts of the area. By acquiring, in particular, the Harold Hill depot and to a lesser extent the Weedon depot, AAH put itself in a position to secure a high proportion of Medicopharma UK's sales in the South-East. Had Medicopharma UK been placed in receivership it is possible that another wholesaler would have taken over either or both these depots, which could have provided greater competition in this region, although we note that both are large depots. Even had the depots been so acquired, AAH might have been expected to increase its sales at least to some extent in the South-East.

6.146. Numark emphasised to us that UniChem and AAH now had a combined market share in the South-East of well over 80 per cent, and that this amounted to a duopoly. There are six other full-line wholesalers, but with only small shares, serving parts of the region. Graham Tatford & Co Ltd, for example, had a 4 per cent share of sales by wholesalers in the South-East before Medicopharma UK's

withdrawal, but essentially only served the South coast, from its depot in Portsmouth. Most of the others had a share of 1 per cent or less. Nonetheless it would be possible for some at least of these wholesalers to expand sales in the areas within range of their depots, and thus act as a potential restraint on attempts by UniChem and AAH to raise prices or reduce service, particularly as there is a relatively high density of retail pharmacies in the South-East reflecting the concentration of population. AAH argued that it competed hard with UniChem. It also said that the combined market share of UniChem and AAH greatly exaggerated their market strength. Competition in the South-East was intense. Short-line wholesalers, parallel importers and direct supply manufacturers were particularly active in the South-East, and retail pharmacies used them to a greater extent than elsewhere.

6.147. We consider that, had Medicopharma UK been placed in receivership, some reduction in competition in the South-East would be likely to have occurred. We consider on balance that any additional effect on competition in the South-East as a result of the merger situation is likely to be small.

### ***The Midlands and South-West***

6.148. Medicopharma UK's depots at Weedon and Harold Hill also supplied retail pharmacies outside the South-East and in particular in the Midlands. As shown in Figure 3.1 there are, however, a number of other full-line wholesalers serving this region, and they had a share before Medicopharma UK's closure of some 20 per cent. We do not consider that the merger situation may be expected to give rise to adverse effects for competition in this region, over and above the reduction in competition that would otherwise have occurred as a result of receivership for Medicopharma UK.

6.149. Medicopharma UK also had significant sales to part of the South-West from its Weedon depot, but these were largely to the Savory & Moore chain, and we expect no material effect on competition to arise as a result of the merger situation.

### **Wholesale supply to hospitals**

6.150. We now consider the effects of the merger situation on competition between wholesalers in the supply of ethicals to hospitals.

6.151. Overall, Medicopharma UK had a 3 per cent share of wholesalers' sales of ethicals to hospitals. Its share was, however, higher in certain RHA regions, namely North East Thames (11 per cent), South East Thames (9 per cent) and South West Thames (7 per cent).

6.152. The North East Thames and South West Thames RHAs expressed concern that the acquisition by AAH of Medicopharma UK's depots at Weedon and Harold Hill would lead to a reduction in competition. Overall, hospitals buy a much higher proportion (about half their ethical requirements) direct from manufacturers. Such products tend to be high-turnover items (often supplied under one- or two-year contracts) and products which are offered by manufacturers to hospitals at special prices. (Manufacturers see an advantage in encouraging hospitals to use particular products as this can lead to continued use of the drugs once the patient leaves hospital.) The RHAs did not, however, see direct supply from manufacturers as providing sufficient competitive pressure to offset a reduction in competition between wholesalers. Deliveries to hospitals by wholesalers are available more than once a day, whereas manufacturers make deliveries only when orders are of sufficient size. RHAs are large buyers, but this does not enable them to secure sufficiently frequent deliveries from manufacturers to reduce significantly their reliance on wholesalers.

6.153. Supply to hospitals is different in a number of respects from supply to pharmacies. As we discussed in paragraph 6.27, there are a number of barriers to entry to this market, including the decision of some manufacturers to distribute their products through one wholesaler by means of exclusive distribution agency agreements, in particular with AAH. Taking these factors into account, we would not expect regional wholesalers to become significant suppliers to the hospital market, although we note that East Anglian Pharmaceuticals Ltd is a sizeable supplier in the East Anglia region. UniChem is not as yet a

significant wholesaler to hospitals, having approximately a 5 per cent share, although, given its major role in supplying pharmacies and dispensing doctors, it clearly has the potential to become so.

6.154. AAH is the major supplier to hospitals, and regional wholesalers, we were told, find it difficult to compete with it, particularly on price. In the RHA areas where Medicopharma UK had a reasonable presence (as mentioned in paragraph 6.151), AAH accounted for over half of the sales by wholesalers. By acquiring the three largest depots of Medicopharma UK, and in particular the Harold Hill depot which was a significant supplier to hospitals in the region it covered, we consider that AAH further strengthened its own position in supply to hospitals. Had Medicopharma UK been placed in receivership, AAH would not have improved its position to such an extent, but it is likely, as it already accounted for some 70 per cent of sales by wholesalers to hospitals, that it would have picked up a significant proportion of this business even had some of the depots been sold as going concerns. We also note that while UniChem is not yet a significant supplier, it has the potential to become so. Moreover, in the area served by the Harold Hill depot, the market share held by other wholesalers is somewhat higher than elsewhere. We therefore do not consider that the merger situation is likely to cause a reduction in competition in supply of ethicals to hospitals to a material extent.

## **Benefits of the merger situation**

6.155. We considered whether benefits for the public interest would arise as a result of the merger situation which might offset the adverse effects we have identified. AAH argued that a benefit of the arrangements was that AAH would be strengthened *vis-à-vis* UniChem. We do not, however, consider that this is likely to result in greater competition between these two suppliers. We note that although one or the other is the stronger in certain regions, nationally their shares are similar. Although individual deals are negotiated, there are not, we were told, significant differences in the terms offered by the two wholesalers to pharmacies in different regions.

6.156. AAH also said that the function of pharmaceutical wholesalers represented an important public service as well as a commercial activity. It suggested that it was in the public interest that it should not be prevented from improving its efficiency, by concentrating its volume into a smaller number of larger warehouses like that acquired at Harold Hill, in order to match the cost base of UniChem. The Romford depot would progressively be used to replace the three small depots at Ipswich, Foots Cray and Enfield. The Weedon depot would provide capacity for distribution into Central and Eastern England. These two depots were required for AAH's rationalisation plans. As regards Aberdeen, AAH's own papers showed that it envisaged that the Aberdeen operations would be merged as soon as practicable. We note that AAH already had a rationalisation programme planned, which it would have pursued had the merger situation not taken place. We do not consider it likely that the merger situation will result in significant cost savings which could not otherwise have been achieved.

6.157. AAH also suggested that the arrangements made had minimised the disruption and breakdown of supply occasioned by Medicopharma UK's closure, and had safeguarded employment to a greater extent than would otherwise have occurred.

6.158. Taking all the factors into account, we consider that while there may have been some benefits for the public interest arising from the merger situation, these are not in our view significant and they do not outweigh the adverse effects of the merger situation which we have identified.

## Conclusions

6.159. We have concluded that a merger situation qualifying for investigation has been created (paragraph 6.113). We have further concluded that it has led to a reduction in competition between wholesalers supplying retail pharmacies and dispensing doctors in the Grampian and Highland region significantly greater than would have occurred in the absence of the merger situation (paragraph 6.144). We have identified no significant benefits for the public interest from the merger situation (paragraph 6.158). We conclude that the merger situation may be expected to operate against the public interest with the particular effects adverse to the public interest that prices may be expected over time to be higher and service standards to be lower than would otherwise have been the case.

## Recommendations

6.160. Where we have found that a merger situation operates, or may be expected to operate, against the public interest, we are required by section 72(2) of the Act to consider what action (if any) should be taken for the purpose of remedying or preventing the adverse effects which we have identified and, if we think fit, to include recommendations as to such action.

6.161. In the course of our investigation we discussed with AAH the possibility that we might put forward certain remedies to the adverse effects which we have identified. Its views are included in Chapter 4.

6.162. The adverse effects which we have identified arise from AAH's acquisition of Medicopharma UK's Aberdeen depot. A possible remedy would be to require that this be sold, either on its own or as a going concern, with a customer list approximating as closely as possible to that of Medicopharma UK. AAH argued that, while divestment of the depot as such would be quite feasible, it would be impracticable and potentially damaging to the public interest to require divestment as a going concern. Prior to the arrangements AAH had already been at least the secondary supplier to most of the retail pharmacies served by Medicopharma UK. It would be both inequitable and anti-competitive for these customers to be deprived of their choice of supplier and access to the best available terms of supply. AAH also argued that UniChem and other wholesalers were already offering an alternative service in the area; if customers became dissatisfied with AAH, they could transfer their accounts. In our view, if the Aberdeen depot were sold as a going concern, with a customer list, it would not prevent those customers from choosing to deal with AAH if they preferred to do so, but it would encourage new entry into the market.

6.163. We considered whether divestment was appropriate given the proposed operations of Norscot, as discussed in paragraph 6.139. As already noted, this company has not as yet commenced operations and it is unclear how substantial a competitor it will become. We do not think it alters our view as to the appropriate remedy.

6.164. AAH argued that if its costs were increased by a requirement to dispose of part of its business, it would be obliged to review the viability of its service to the North of Scotland and the Islands; this might result in concentration on the more profitable urban areas. We do not regard the risk of AAH withdrawing in this way from the North of Scotland as a serious one, noting that before the merger it found it profitable to operate there, notwithstanding Medicopharma UK's presence.

6.165. AAH argued that it could not be required to sell Medicopharma UK's customer lists, as it had not purchased these. AAH told us, however, that it did know who these customers were, from its own information.

6.166. It also told us that since the merger it had concentrated sales of ethicals into one Aberdeen depot and sales of OTCs into the other. There would thus need to be at least some movement of stock and possibly other adjustments for the depot to be sold on a going concern basis. We do not, however, regard this as an insurmountable problem.

6.167. We considered whether it would be sufficient to require AAH to sell the depot itself, without stock or other assets or a customer list. We consider, however, that it would be preferable for the business to be sold, as this would be more likely to remedy the adverse effects identified.

6.168. AAH argued that if its position in the area gave rise to any concern, a more equitable solution might be to require an undertaking that its trading terms in the Grampian region and the North of Scotland should be no less favourable than those in the central belt of Scotland. We note, however, that trading terms include not just discount rates and levels of service, but also credit and other terms. We consider that such a remedy would be less likely to be effective than divestment in encouraging new entry and thus continued competition in the region.

6.169. We considered whether restrictions should be placed on the manner and extent of supply by AAH in the region, with the purpose of encouraging and facilitating new entry. We considered that this might help to offset the reduction in competition, but on balance the preferable remedy was divestment.

6.170. We recommend that AAH should be required to divest a business approximating as closely as practicable to the business operated from Aberdeen by Medicopharma UK just before the arrangements, that is complete with stock and other assets necessary to operate as a full-line pharmaceutical supplier to retail pharmacies and dispensing doctors, and a list of customers previously served by Medicopharma UK. If it were not practicable to draw up a list of Medicopharma UK's former customers, we consider that AAH should be required to supply a list of the customers served from both of its Aberdeen depots.

H H LIESNER (*Chairman*)

R O DAVIES

J EVANS

A FERRY

J F PICKERING

S N BURBRIDGE (*Secretary*)

20 March 1992