

8 Conclusions

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Background

8.1. Our terms of reference (Appendix 1.1) require us to report on the supply in the UK of contraceptive sheaths (also known as condoms). There have been two previous MMC reports on this subject, in 1974¹ and 1982.² The latter concluded that the prices charged for contraceptive sheaths by LRC Products Ltd (LRC), which then had 90 to 95 per cent of the UK market, might be expected to become excessive and hence contrary to the public interest. Following that report LRC undertook to limit the growth in its average realized price by observing a system of price control recommended by the MMC and overseen by the Office of Fair Trading (OFT).

¹ *Contraceptive Sheaths: a report on the Supply of Contraceptive Sheaths in the United Kingdom*, HC 135, 1974-75, February 1975. Although not published until 1975, the report was completed in July 1974.

² *Contraceptive Sheaths: a Report on the Supply in the United Kingdom of Contraceptive Sheaths*, Cmnd 8689, November 1982.

8.2. The OFT reviewed the operation of price control in 1989 but recommended to the Secretary of State for Trade and Industry, who agreed, that no change should be made at that time. Following a further review begun in 1991, the Director General of Fair Trading (DGFT) decided to refer the matter to the MMC for a fresh look.

8.3. In making the reference, the DGFT said he believed that the market had changed and that the price control arrangements needed to be reviewed. He would be particularly interested in the MMC's view on the way in which the price control mechanism had operated and whether this had damaged the prospect of successful competition from Mates and other suppliers.

The monopoly situation

8.4. Our terms of reference (Appendix 1.1) require us first to investigate and report whether a monopoly situation exists in relation to the supply in the UK of contraceptive sheaths, and if so:

- (a) by virtue of which provisions of sections 6 to 8 of the Fair Trading Act 1973 (the Act) the monopoly situation is taken to exist; and
- (b) in favour of what person or persons the situation exists.

Section 6 of the Act deals with monopoly situations in the supply of goods and is therefore the relevant section for our inquiry (section 7 deals with services and section 8 with exports). It envisages two different kinds of monopoly situations, usually referred to as 'scale' and 'complex'.

8.5. A scale monopoly situation under section 6(1)(a) or (b) of the Act is taken to exist when at least one-quarter of all the goods of a particular description which are supplied in the UK are supplied by or to the same person, or by or to members of the same group of interconnected bodies corporate.

8.6. Contraceptive sheaths are relatively homogeneous products and we consider that their supply is best measured by reference to the volume of sales rather than the value. The footnote to Table 3.9 in paragraph 3.57 shows that in the year to March 1993 LRC supplied an estimated 78 per cent of all contraceptive sheaths supplied in the UK. Although that figure is inflated by a high level of forward sales by LRC at the end of the year, it is clear from the adjusted figures in Table 3.9 itself that LRC's share has been 75 per cent or more in recent years. The next biggest supplier is Mates Healthcare Ltd (which together with its subsidiary, Mates Vending Ltd, we refer to as Mates) which accounted for an estimated 12 per cent of the total in 1992/93 (14 per cent on an adjusted basis).

8.7. The UK market for contraceptive sheaths has three distinct sectors: supply for over-the-counter (OTC) sale in shops, supply through vending machines, and supply to the National Health Service (NHS) which then distributes condoms free of charge through family planning clinics and other outlets (see paragraphs 3.67 to 3.79). Section 10(3) and (4) of the Act allow us to take different forms of supply separately, for the purpose of determining whether monopoly situations exist, if we think it appropriate. Although there are important differences between the three sectors we do not consider that it would assist our inquiry to treat any of them separately for this purpose. We have therefore addressed the question of the existence of monopoly situations in relation to the supply in all three sectors taken together. (We consider in paragraphs 8.48 to 8.52 whether there are separate markets for the purposes of economic analysis.)

8.8. In the light of the information set out in paragraph 8.6 and our decision recorded in paragraph 8.7, we conclude that a monopoly situation exists by virtue of section 6(1)(a) of the Act (a scale monopoly) in that LRC supplies at least one-quarter of the contraceptive sheaths which are supplied in the UK.

8.9. As to the category of persons to whom supplies are made (see paragraph 8.5), Table 3.10 shows that some 272,000 gross of contraceptive sheaths were sold to the NHS in 1992/93, representing some 22 per cent of total UK supply in that year. This is below the 25 per cent level at which the NHS might be considered a monopoly buyer. Paragraph 3.80 records that sales to Boots the Chemists (Boots), a division of The Boots Company PLC-the largest single purchaser-in 1992/93 accounted for 17 per cent of total UK supply in that year.

8.10. In the light of the information set out in paragraph 8.9 we conclude that there is no scale monopoly situation among persons to whom contraceptive sheaths are supplied.

8.11. We have also considered whether a scale monopoly situation exists at the level of supply direct to consumers. Here the figures largely mirror those for trade purchases of condoms from the manufacturers and importers. Table 3.15 in paragraph 3.81 shows that Boots' sales were 174,000 gross, some 16 per cent of the total, in 1992/93. Boots is the largest single supplier of condoms to consumers. We therefore conclude that there is no scale monopoly situation at this level of supply.

8.12. Our terms of reference require us next to report in whose favour the monopoly situation which we have identified exists. We put it to LRC and to its parent company, London International Group plc (LIG), that the situation existed in favour of both of them. They accepted this. We therefore conclude that the monopoly situation which we have identified (paragraph 8.8) exists in favour of LRC and LIG.

LRC

8.13. LRC is one of LIG's principal subsidiaries. It has three main areas of business: contraceptives, within which condoms are by far the most important product; health and beauty products; and industrial and surgical gloves. It has manufacturing facilities at Chingford in London, Llanelli and Dundee. Chingford is the only manufacturing site for contraceptive sheaths and is now, since the transfer of production of surgeons' gloves to Malaysia in early 1992, almost exclusively concerned with these products. In 1992/93 LRC sold 1,337,000 gross of condoms from Chingford, of which 447,000 gross (roughly one-third) were exported to other LIG companies abroad. LRC also imported 77,000 gross, mainly from an Italian sister company. LRC has long been the only significant manufacturer of male condoms in the UK.

8.14. LRC's total turnover in 1992/93 was £96.6 million on which it made an operating profit of £16.9 million. UK sales of condoms were £17.6 million on which LRC's operating profit was £3.2 million. Table 4.1 gives a full breakdown of LRC's results for the last six years.

8.15. LRC told us that its Durex brand of condoms dated back to the 1930s and by 1939 had around 50 per cent of the UK market. During the Second World War the Government designated LRC as the sole UK manufacturer of condoms. After the war Durex continued to dominate the UK market and at the time of the 1975 report accounted for roughly 90 per cent of total sales, a situation which broadly continued until 1987/88 when Mates entered the market.

8.16. LIG manufactures condoms in Italy, Spain, the USA and India (via a joint venture) as well as the UK, and is constructing a plant in Thailand. It sells condoms throughout Europe and North America and in a number of countries in the Caribbean and the Asia-Pacific region. The Durex brand is marketed in over 70 countries but LIG also has several other condom brands and claims to be the world's leading supplier of branded condoms.

The 1974 and 1982 reports and the operation of price control

8.17. The 1974 report concluded that LRC's pricing policy resulted in excessive profits and caused retail prices of condoms to be higher than they otherwise would be. LRC subsequently undertook to submit proposed changes in its UK prices to the DGFT for approval. In considering LRC's applications, the OFT took 35.5 per cent, expressed on a historical cost basis, as the maximum permissible rate of return. In May 1981 LRC applied for a price increase from July of that year which in the OFT's view would have led to an excessive rate of return. Approval was given for the price increase from December 1981 but only after the DGFT had decided to make a further reference to the MMC, which he did on 15 October 1981.

8.18. In their 1982 report the MMC commented that LRC's market share of at least 90 per cent was unlikely to be eroded. No importer had been able to achieve a significant position, and because of the strength of the Durex brand and the difficulty of advertising condoms, the MMC thought it unlikely that any would do so. Although purchasing had become more concentrated there was no evidence that this had resulted in pressure on LRC's prices. Most supermarkets were not interested in selling condoms. Retail price

competition was not, in the MMC's view, an important feature of the market. Retailers enjoyed exceptionally high margins in condoms and had little incentive to switch to imports. Since LRC's prices were not effectively constrained by market forces, and bearing in mind the history of very high profit levels recorded in the 1974 report, the MMC concluded that in the absence of control LRC's prices would again become excessive.

8.19. Because of the complexities of the profit-related system of control which had applied after the 1974 report, the MMC recommended that LRC's prices should instead be controlled by reference to an index which reflected the input costs of its condoms business (a special cost index or SCI). This would also restore an incentive to increase efficiency which, LRC had argued, the profit-based control had removed. The MMC had no doubt that LRC had scope for raising its efficiency and thought that some part of the benefits of higher efficiency should accrue to the public, as it would if LRC were forced to seek cost savings by the pressure of competition. The report therefore recommended that LRC's prices should not be allowed to increase at a greater annual rate than 1.5 percentage points less than the rise in the SCI.

8.20. The price control system regulates the growth in LRC's average realized price (ARP), that is its total revenue from condom sales to the UK market divided by the total volume of those sales. Since both the ARP and the growth in the SCI can only be calculated after the year end, the OFT has had to assess LRC's compliance with the regime retrospectively. When, as in the first year of the control (1982/83), the ARP overshot the allowed level, the OFT required LRC to undershoot the allowed level in the next period to compensate. But the OFT also allowed the reverse process to apply, so that when LRC undershot the permitted level, it was permitted to overshoot subsequently.

8.21. Paragraphs 3.135 to 3.151 describe in detail how the system has operated and how LRC's prices have moved. The main points to emerge are as follows:

- (a) The initial overshoot in 1982/83 was largely offset by undershooting in the following two years. There were then two years of small overshoots. But for the next four years beginning in 1987/88, the year of Mates' entry, LRC undershot the permitted level, quite substantially in 1988/89, thereby building up a store of 'under-recovery'. The latest two years have seen, by contrast, substantial overshooting, particularly in 1992/93, to the extent that the accumulated under-recovery has been wiped out and replaced by a significant over-recovery. In 1992/93 the ARP was 8.5 per cent above the nominally permitted level.
- (b) The ARP of LRC's sales to the NHS moved closely in line with the overall average until 1988/89. Between then and 1992/93, the ARP of sales to the NHS grew by 11.5 per cent compared with nearly 37 per cent for the overall average.
- (c) As a result of a reorganization of LRC's vending sales, involving the replacement of its own vending operation by a franchise arrangement, the ARP of LRC's sales to the vending sector fell by nearly half between 1989/90 and 1990/91. It then stayed at the same level in the two following years.
- (d) Because of the slow growth in ARP in the NHS sector, and the substantial fall in the vending sector, LRC was able rapidly to increase its prices to the OTC sector in the period after 1988/89. As a result its average price in this sector rose by 75 per cent between 1988/89 and 1992/93, a period in which the SCI rose by 25 per cent.

8.22. Over the whole period of the control, the ARP has risen almost as fast as the retail price index (RPI) (see Table 3.29). This is due to a combination of three factors:

- the permitted increase in LRC's prices year on year has been 1.5 percentage points less than the percentage rise in the SCI; but
- the SCI has risen 6 per cent more than the RPI; and
- LRC overshot the permitted level by 8.5 per cent in the final year.

The product

8.23. Condoms are used for protection both against conception and against infection from sexually-transmitted diseases (STDs). They are made by dipping glass moulds into compounded, liquid latex. There has been little fundamental change in the latex condom for many years but the amount of superficial variation has greatly increased in the past decade. Some of these developments-the introduction of thicker and flavoured condoms and the use of certain spermicides-are linked to the growing concern about AIDS. Others-variations in shape and colour-both reflect and promote the wider use and acceptability of condoms. Until very recently only male condoms were made but in 1992 a female condom, called Femidom, was launched on the UK market. In August 1993 LRC announced the successful development of a male condom made from a synthetic, non-latex material but the product is not yet on the market and LRC told us that it did not plan to launch the product in the UK for some time.

8.24. The male condom is the only form of contraceptive available to men apart from sterilization. For women there is a variety of alternatives, although none is without problems. The condom is the only contraceptive which can be bought as a consumer product, without the involvement of the medical profession. The popularity of the condom as a contraceptive method declined in the 1970s but has recovered somewhat in the 1980s. There is no alternative to the condom for prophylactic purposes.

8.25. Given the importance of the condom's functions, product quality and reliability are crucial. There is a British Standard (BS 3704) which specifies the physical characteristics which condoms should have and prescribes certain tests which should be carried out during manufacture. The British Standards Institution (BSI) operates a certification (Kitemark) scheme to give assurance that BS 3704 is consistently being met. Neither compliance with the standard nor adherence to the Kitemark scheme is compulsory but many buyers are reluctant to stock condoms which do not carry the Kitemark.

8.26. A European (CEN) Standard is in an advanced state of preparation. When this is introduced it will replace the British Standard. Compliance with the CEN standard, certified by an approved testing body, will enable manufacturers to meet the requirements of the EC's Medical Devices Directive which is due to enter into force in January 1995 subject to a transitional period lasting until 1998. Once the Directive is fully operational, manufacturers will not be allowed to market products anywhere in the EC unless they meet the requirements which it lays down.

The market

8.27. UK demand for condoms was flat during the mid-1980s but jumped by some 20 per cent in 1987/88 as alarm about AIDS spread. Demand then levelled off again but growth appears to have resumed in the last two years (see Table 3.5). Of total UK demand in 1992/93 amounting to some 1.1 million gross (160 million units), 60 per cent was in the OTC sector, 23 per cent in the NHS and 16 per cent in vending. The total value of condom suppliers' sales in 1992/93 at trade prices was around £21 million to £23 million, while the value of sales in the commercial sectors (OTC and vending) is estimated at £47.5 million at retail prices. Sales in the NHS and vending sectors have been growing fast, with the result that the OTC share of the total market has fallen from 73 per cent in 1987/88 to the current level of 60 per cent.

8.28. On the supply side, as noted in paragraph 8.6 LRC had 75 per cent of the UK market in 1992/93 on an adjusted basis and Mates 14 per cent. The only other supplier with a significant share was Healthline Products Ltd (Healthline) with 8 per cent, [*Details omitted. See note on page iv.*] Mates was established by The Healthcare Foundation, a charitable body, in 1987 but was sold to a UK subsidiary of Pacific Dunlop Ltd (Pacific Dunlop), an Australian company, in the following year. Pacific Dunlop owns Ansell International (Ansell), a large US condom manufacturer which already supplied the condoms which Mates marketed. Healthline has been 75 per cent owned by Kumpulan Guthrie Berhad (Guthrie), a large Malaysian company, since 1992.

8.29. LRC is strongest in the NHS, where it has over [*] per cent of total sales, and in the OTC sector where its share is [*] per cent. In vending it has about [*] of the total. By contrast Mates' biggest share is in vending ([*] per cent). It has [*] per cent of the OTC sector and [*] per cent of sales to the NHS. Healthline is the biggest supplier to the vending sector with [*] per cent of the total but its sales elsewhere are small. (See Tables 3.10 and 3.11.)

Distribution channels

8.30. The NHS buys condoms to be handed out, free of charge, by clinics, hospitals, general practitioners (GPs) and voluntary bodies. There appears to have been an increase in recent years in supplies going through NHS channels concerned with prophylaxis relative to those concerned with family planning.

8.31. NHS purchasing is fragmented among a large number of bodies but in England there is a trend to increased centralization as a result of the establishment in 1991 of the NHS Supplies Authority, which has six divisions covering the whole country. There is no single buying system. The distributing bodies may 'call off' their purchases at prices agreed between the suppliers and the purchasing authorities but they sometimes negotiate their own terms directly with suppliers. The local autonomy of the distributing bodies reduces the negotiating power of central purchasing authorities but there appears to be a growing tendency for the central negotiators to bargain keenly, to co-ordinate their efforts, and actively to encourage the individual buying units to go for products which they consider offer the best value for money (see paragraphs 2.14 to 2.17 and 3.74 to 3.79).

8.32. Since the 1982 report there has been a considerable increase in the variety of outlets in the OTC sector. Pharmacies remain the most important group with over half of the total but the share of groceries (principally supermarkets) has risen from 9 per cent in 1986/87 to 23 per cent in 1992/93, and the share of garages from 2 to 8 per cent (see Table 3.15).

8.33. This increase in range of outlets has paradoxically been accompanied by a growth in concentration. LRC's ten leading retail customers now account for over 40 per cent of its sales by value. Some 20 per cent of its sales to the OTC sector go through wholesalers: those such as AAH Pharmaceuticals Limited (AAH) and UniChem PLC (UniChem) which supply independent pharmacies, and others which supply smaller grocery and convenience stores and garages.

8.34. Most retailers selling male condoms appear to stock only Durex, or Durex and Mates, although there are specialist shops and mail order firms which sell a much wider range of brands. Suppliers other than LRC told us that it was difficult to obtain wide acceptance by retailers, particularly in the pharmacy sector which LRC has long dominated.

8.35. As to the vending sector, most condom machines are located in public houses, other leisure outlets and transport facilities such as railway stations, motorway service stations and airport terminals. The vending operator installs, maintains and stocks the machines and collects the revenues. The operator may own the machines or, as in the case of LRC's franchisees (see paragraph 8.36), may rent them from the condom supplier. The site owner is generally not charged for the installation of the machines and is paid a proportion of the revenues as commission. Multiple site owners such as breweries invite competitive bids for their business before entering into contracts for periods of two to three years but arrangements with smaller owners tend to be much less formal.

8.36. The three main suppliers to the vending sector operate in different ways. LRC used to have a team of in-house vending staff but in 1990 it switched to a franchise operation whereby 25 independent franchisees buy the condoms from LRC, look after the machines and canvass for new business. LRC sets the prices at which the condoms are sold to consumers and negotiates the terms on which machines are supplied to major customers, while the franchisees keep net-of-commission proceeds for themselves. The Mates vending operation is run by a majority-owned subsidiary, Mates Vending. Healthline is not itself a vending operator but sells condoms and machines either direct to local and regional vending operators or to intermediaries. The condoms may be supplied under a Healthline brand name or that of the vending operator. Healthline does not control the prices at which its condoms are sold to consumers.

*Details omitted. See note on page iv.

8.37. Mates and LRC compete vigorously for major contracts, eg with Bass and Allied-Lyons. These contracts may be divided between two or more suppliers covering different regions but it is rare for a single site to sell more than one brand.

Advertising and promotion

8.38. LRC told us that expenditure on marketing is essential for brand recognition and consequent acceptance by consumers and retailers. Such expenditures include not only advertising but also other forms of publicity such as consumer and trade promotions and public relations activity. Around the time of Mates' entry there was a burst of advertising expenditure by Mates, LRC and public sector bodies. Since then the Health Education Authority has continued to spend about £10 million a year on campaigns to promote 'safe sex' but suppliers' expenditure has been relatively low, particularly on advertising.

Pricing

8.39. In the OTC sector LRC supplies smaller customers according to a published structure of trade prices called Terms 1-4, differentiated by order size. Over 90 per cent of its sales, however, are made at lower prices than these. LRC negotiates individual terms with ten leading retailers, including Boots, Lloyds Chemists plc (Lloyds), Superdrug Stores PLC (Superdrug) and the five leading supermarket chains. In recent years LRC has increased its trade prices at six-monthly intervals. Mates told us that it tended to follow LRC's pricing lead although its prices are at a lower level.

8.40. Unusually, LRC has two sets of recommended retail prices (RRPs) for the same products. One list for 'standard' RRP-is published in *Chemist & Druggist* and is generally followed by small pharmacists. LRC also advises its larger customers of recommended 'high street' prices which for the larger pack sizes are some 9 to 15 per cent below the standard prices. For packs of three both sets of RRP are currently in the range of £1.41 to £1.86 (with one exception), depending on the sub-brand. As is customary, larger packs offer lower prices per unit: thus the price for Durex Extra Safe bought in a pack of three, at the high street RRP, is 51p per condom, but just under 40p if bought in a pack of 18. Mates' RRP are currently between 7 and 16 per cent below the high street RRP for the equivalent Durex product.

8.41. Until May 1993 most large retailers adhered to LRC's high street RRP. In that month Superdrug cut all its condom prices by one-third with much accompanying publicity. This move was broadly followed by other leading retailers but most of them restored previous prices after a few weeks. By November, however, Superdrug, Tesco, Asda and Lloyds' Supersave chain of drugstores were still selling at prices well below the previous levels. Boots, the biggest retailer, told us that it had enhanced its programme of condom promotions in order to remain competitive. Retailers which cut prices experienced a gain in sales volume but LRC told us that an initial surge in overall demand had been followed by a corresponding dip: it did not expect any increase in the size of the market as a result of the price war among retailers.

8.42. If selling at standard RRP even small retailers make gross margins on Durex of nearly [*] per cent. Large retailers' margins have been in the range [*] to [*] per cent, varying by product line, on the basis of their normal buying prices and selling at high street RRP. But LRC has engaged in 'forward selling', ie offering special discounts to persuade customers to purchase ahead of normal requirements just before the end of its financial year, on a substantial and growing scale. As a result the average gross margin of the biggest retailers has been [*] per cent or more as long as they stuck to the high street RRP. (See paragraphs 3.117 and 3.122.)

8.43. LRC supplies its vending franchisees at a contract price. The franchisees' margin is the difference between that and the price to the consumer, less the commissions paid to the site owner. The latter vary considerably, between zero and 50 per cent, depending on the attractiveness of the sites and the degree of competition, particularly between LRC and Mates. LRC told us that it had recently been reducing the commissions it paid to major site owners, which had been bid up to uneconomic levels, as contracts fell due for renewal. Prices to the consumer change in relatively big steps because the machines are usually set to accept only £1 coins. Over a period of years, however, these prices have moved broadly in parallel with OTC retail prices. Both LRC and Mates said that they aimed to charge a premium for products sold through

*Figures omitted. See note on page iv.

vending machines to cover the extra costs involved. Consumers accepted that a premium was worth paying for the convenience and anonymity of buying from machines. Mates said that it would not allow the premium to exceed a certain level, around 20 per cent, because that would put consumers off and harm Mates' reputation for fair dealing. Currently the basic vending price for Mates condoms is £1 for two, while LRC is in the process of moving its basic price up from £1 for two to £2 for three. A typical price for condoms supplied (via vending operators) by Healthline is £1 for three.

8.44. Most supplies to the NHS take place on the basis of contracted or tendered prices. Of LRC's total NHS sales about two-thirds are made direct at prices typically around a third below its prices to the OTC sector. The other one-third passes through two distributors to whom LRC sells at prices usually above those it charges to the NHS direct but still well below those at which it sells to OTC customers.

8.45. The impact of price control on LRC's pricing policies has been described in paragraphs 8.21 and 8.22.

Market entry

8.46. There have been a number of attempts to enter the market in the past but none succeeded on any significant scale until Mates in 1987. The principal attempts since then have been as follows:

- Healthline entered the vending sector after its formation in 1987. Healthline told us that its Malaysian supplier was applying for the Kitemark; when this was obtained Healthline planned to enter the OTC and NHS sectors.
- In 1989 Sime Darby Berhad, a large Malaysian company, acquired the Jiffi brand of condoms which had been targeted at the youth market, mainly via vending machines. In 1992 it set up a sales subsidiary, Sime Health (UK) Ltd (Sime Health), and subsequently obtained the Kitemark for Jiffi condoms. Sime Health is currently attacking the NHS and OTC sectors.
- In September 1991 a major Japanese supplier, Sagami Rubber Industries Co Ltd (Sagami), launched a non-Kitemarked product, Le Condom, into the OTC sector via a UK distributor. Although the product was stocked by a number of retailers, including Tesco PLC (Tesco), it did not sell well and was withdrawn in July 1992.
- RFSU, a Swedish organization which has captured much of the Scandinavian market from LRC with condoms manufactured by Sagami, is currently in the early stages of attempting to enter the OTC and NHS sectors.
- In 1992 Chartex International PLC, a small UK company, launched its Femidom female condom in the OTC sector. The product is widely stocked by retailers but it remains to be seen whether it will become more than a niche product. Suppliers of male condoms told us that they did not see Femidom as a threat to their products.

8.47. In contrast to many other consumer healthcare products, there are no retailer own-label condoms. Boots, the most obvious candidate for introducing its own brand, told us that it had no immediate plans for doing so although it kept the possibility under review. A product would need to have some distinctive appeal, compared with the branded condoms already on the market, before Boots would seriously consider selling it under the Boots label. Tesco said that the consequences of product failure, and subsequent unfavourable publicity, were a deterrent to its introducing an own-label condom. Tesco also commented that it was unusual for retailers to enjoy high margins on selling a branded product as dominant as Durex, as had been the case before the price war.

Market definition

8.48. There are important differences between the three market sectors, and more particularly between the NHS on the one hand and the commercial sectors (OTC and vending) on the other. Consumers obtaining free NHS supplies appear to be a distinct group (or groups). In principle people who buy condoms in the commercial sector could obtain them free from family planning clinics but in practice there are practical and psychological barriers which prevent them from doing so. Condoms supplied to the NHS are purchased by institutions, not by individuals for their personal use. They buy on a large scale and are much more concerned with specification and price than with brand appeal, though the latter cannot be ignored because it influences the attitudes of clients whom the NHS and voluntary bodies wish to encourage to use condoms. NHS buyers are therefore able to look to a wider range of products than commercial buyers in order to obtain best value for money. It is NHS policy not to sell on products to commercial buyers without the supplier's consent and we were told that it does not sell on condoms. It is therefore possible for low manufacturers' prices to the NHS to co-exist with much higher prices to the commercial sector.

8.49. As regards differences between the OTC and vending sectors, it appears to be easier to enter the vending market because of the absence of brand loyalty, the customer profile and the fact that many purchases from vending machines are of an impulse or 'distress' nature. Prices from machines tend to be higher than in shops, but because vending prices have to be changed in steps the relationship varies. Finally the mechanics of the vending business are quite different from OTC selling. On the other hand there is no clear division between OTC and vending customers. Suppliers told us that if prices between the two sectors were to get significantly out of line purchasers would start to migrate from the dearer to the cheaper sector.

8.50. There are also interactions between the NHS and commercial sectors. The principal suppliers, LRC and Mates, are active in all three and their overall performance is influenced by their relative success across the whole market. Mates told us that success in selling to the NHS was helpful in attempts to sell through pharmacies, as an indication of quality. At the same time achievement of brand strength in the OTC sector influences sales to the NHS because it creates user demands which the NHS bodies may find difficult to resist. Finally, the system of price control applying to LRC has created a direct interaction between prices in all three sectors, albeit that the levels of those prices are different (see paragraphs 8.20 and 8.21).

8.51. Despite these interactions we consider that the evidence points clearly to the NHS being a separate market from the two commercial sectors. The key factor is that prices to the NHS are not only at a much lower level but can also move without reference to price levels elsewhere. This is not true of prices in the OTC and vending sectors, which we consider are part of the same market albeit with some differences between them. We have taken account of the existence of separate markets wherever it is relevant to our analysis.

8.52. The UK is largely separate from world and European markets, partly because price control has led to UK prices being below those prevailing in the rest of Europe, partly because of the importance of brand strength in the OTC sector and partly because of the importance of the BSI Kitemark. The NHS and vending sectors are, however, more open to attack by new overseas suppliers than the OTC sector.

Public interest issues

8.53. Having concluded that a monopoly situation exists (see paragraph 8.8) and having answered the questions in sub-paragraphs (a) and (b) in our terms of reference (see paragraphs 8.8 and 8.12), we have to deal with the remaining questions, *viz*:

- (c) whether any steps (by way of uncompetitive practices or otherwise) are being taken by that person or those persons for the purpose of exploiting or maintaining the monopoly situation and, if so, by what uncompetitive practices or in what other way;

- (d) whether any action or omission on the part of that person or those persons is attributable to the existence of that monopoly situation and, if so, what action or omission and in what way it is so attributable; and
- (e) whether any facts found by the Commission in pursuance of their investigations under the preceding provisions of this paragraph operate or may be expected to operate against the public interest.

8.54. We consider first the central issue of LRC's pricing and then a number of individual aspects of LRC's commercial behaviour.

LRC's pricing

The views of LRC

8.55. LRC submitted that the question for the MMC was not whether price control should be lifted but whether, if the MMC were approaching the matter *de novo*, they would conclude that some form of price control should be introduced. LRC argued that the market had changed in important ways since the 1982 report.

8.56. The factor which had triggered these changes, in LRC's contention, was the advent of HIV/AIDS. Previously demand for condoms had been stagnant at best. When there was an upsurge in public concern about AIDS in the mid-1980s, the condom's value as the only means of avoiding the risk of infection resulting from sexual intercourse was widely recognized. This had brought a sharp increase in UK sales in 1987/88, although subsequent growth in demand had been slow. The condom had become a respectable, indeed socially responsible product. Advertising restrictions on suppliers had been eased and the Government had mounted extensive advertising campaigns of its own to promote the use of condoms. The products had begun to be sold in a much wider range of retail outlets. There had been a substantial increase in world capacity for the production of condoms as manufacturers prepared to meet the expected growth in demand. Since demand growth had turned out to be below expectations, this had led to substantial overcapacity.

8.57. A second important development had been the entry of Mates as a competitor to LRC in the UK market. Taking the opportunity presented by the AIDS alarm and the Government's promotion of condoms, The Healthcare Foundation had launched the Mates brand in 1987. It had been able quickly to achieve widespread recognition of the brand and a 20 per cent market share. Mates was now, LRC said, a strong and well-established competitor whose parent, Ansell, was a major international supplier of condoms. Mates condoms were marketed in the OTC sector by Johnson & Johnson Ltd (Johnson & Johnson), a leading distributor of healthcare products to the retail trade, and were prominent in the vending sector.

8.58. Third, although condoms were sold in a wider range of shops, purchasing had become more concentrated among a small number of powerful wholesalers and retailers and the NHS. The major supermarket chains had all begun to sell condoms. The NHS had greatly expanded its purchases and was far more price-conscious than before.

8.59. As regards the high level of retail margins, LRC said that these had originated when condoms were bought and sold furtively and retailers had to be persuaded to stock them. More recently the buying of condoms for the OTC sector had become more concentrated, and retailers and wholesalers had been able to use their purchasing power to secure still higher margins.

8.60. LRC argued that the extent of retail price competition was outside its control. Traditionally retailers had usually sold condoms at the recommended price but in May 1993, after the start of our inquiry, Superdrug had initiated the first major condom price war by cutting a third off its prices for all condom product lines. Most of the other large retailers had responded with price promotions of comparable magnitude covering Durex, Mates and Femidom. Some of these had proved short-lived, but the leading price-cutters, notably Superdrug and Tesco, had maintained the low levels for several months and some were continuing to do so.

8.61. LRC said that to the best of its knowledge the UK was the only market economy country in the world where condoms were subject to official price controls. This was particularly remarkable seeing that condoms were available free of charge via the NHS to anyone who asked for them. Price control had had a number of adverse effects.

8.62. In the first place price control had caused UK prices to become artificially low. LRC presented us with figures showing that in the pharmacy and drugstore sector in other European countries, trade prices were, on average, over 50 per cent above the UK level and retail prices 20 per cent above. (This comparison was made before the price war among UK retailers.) This was the reverse of the situation at the time of the first MMC report. As a result, competition to LRC in the UK market had been stifled. There were a number of major overseas suppliers whom LRC encountered elsewhere whose supply sources could produce condoms at much lower cost than LRC's Chingford plant and who could enter the UK market if they chose. LRC believed that the existence of price control had deterred their entry. Some competitors had entered the market but made little progress. Mates itself had been unable to build on the [*] per cent share which it had established at the outset. The reason, in LRC's view, was that advertising and other promotional activities were essential for an entrant to gain public recognition of its brand and persuade retailers to stock it, and subsequently to sustain and increase sales. The likely return on investment in even a successful advertising campaign was, however, too low to warrant the necessary expenditure because of the low level of trade prices.

8.63. A related point put by LRC was that the sort of commercial advertising which could be expected if competitors were actively vying for market share would increase the size of the market. This would benefit society at large in view of the condom's role both as contraceptive and prophylactic. Commercial advertising would aim particularly at the young, whose use of condoms was relatively low but who were potential long-term users. LRC maintained that Government advertising tended to miss the mark with this audience. If prices rose, LRC itself-which did virtually no advertising at present-would seek to tap this market more effectively. Price control, on the other hand, had not stimulated usage because demand was not price-sensitive.

8.64. In addition, LRC submitted, artificially low prices were a deterrent to investment both in manufacture and in product development. LRC had invested little over the years in the Chingford plant because it could not justify the returns to its parent company. LIG had embarked on a major long-term investment in developing a non-latex condom-the successful conclusion of the development phase of the product was announced during the inquiry-but this would be priced at a premium to its existing products. Even if the product were free of price control, the gap in price in the UK would be much larger than elsewhere. As a result LIG had decided to launch the product elsewhere and would not be introducing it in the UK market for the time being.

8.65. LRC noted that the previous MMC reports appeared to have taken the view that the Durex brand was so strong as to constitute a powerful deterrent to entry or serious limitation on the likely success of any other brand. LRC submitted that the history of Durex (see paragraph 8.15) did not point to an inherently powerful brand so much as an artificially empowered brand. The period of immunity from challenge which flowed originally from the abnormal conditions of war had been artificially prolonged by the 18 years of profit or price control from 1975 to the present day. There was no ground for believing that Durex was potentially any less vulnerable to successful attack from competing brands than any other strong brand. Indeed the evidence was to the contrary. Mates had achieved high levels of brand awareness very rapidly when it entered the UK market. In Scandinavia Durex's market share had fallen from 80 to 20 per cent in the period 1980 to 1990. Experience in France and Italy showed that powerful entrenched condom brands could be successfully challenged.

8.66. LRC said it expected that if price control were lifted a more competitive market would develop over a period of about five years. LRC's selling prices in the OTC and vending sectors would gradually rise to average European levels and this 'normalization' of prices would bring in new entrants as well as enhancing Mates' ability to compete. Usage of condoms would not decline because consumers were not price-sensitive. Rather, the size of the market could be expected to increase because of the higher level of advertising and other kinds of promotion. Commercial advertising was less susceptible to being cut back than government expenditure on this activity. If price control were not lifted, on the other hand, no evidence would be gained of how a free UK market in condoms would work. There was no reason in those

*Figure omitted. See note on page iv.

circumstances to expect any change in the structure of supply and the whole question would have to be re-examined for a fourth time in a few years.

The competitiveness of the market

8.67. We have carefully considered the various elements of LRC's case. It is undoubtedly true that concern over HIV/AIDS has transformed attitudes to the condom and that this has affected the market in important ways.

8.68. The spread of condom retailing to convenience stores, garage forecourts, record shops and above all supermarkets has opened up new opportunities for suppliers and diminished the relative importance of the traditional retail channels (chemists, barbers and mail order). Mates told us that on entering the market it had set out to develop new avenues of distribution, notably grocers and garages. Its share of sales through groceries (including supermarkets) was much higher than in independent chemists and drugstores where the commitment to Durex appeared strong. Tesco told us that condoms, like female hygiene products, were increasingly being bought in the same way as the many other products which were part of the normal weekly shopping trip.

8.69. Sales through vending machines have also grown strongly. This appears to be due partly to the embarrassment factor which still exists for many consumers, and partly because of the increased use of condoms by young people who tend to buy condoms in small packs when they may need them. Brand loyalty and recognition appear to be far less important in determining purchasing patterns in the vending sector than in shops. In consequence supply to vending outlets is much less concentrated than in the rest of the market and a number of small suppliers, many of whom appear to obtain condoms from Healthline (see paragraphs 8.28 and 8.36), have been able to find a niche there.

8.70. Although advertising restrictions have been eased, they have not been removed altogether, as described in paragraphs 2.18 to 2.26. LRC argued that the remaining restrictions were inconveniences but did not prevent the development of high-impact advertising which clearly communicated the intended message. Other suppliers also told us that they did not see these restrictions as preventing them from mounting effective campaigns.

8.71. As regards the actual development of competition to LRC to date, we cannot accept LRC's description of Mates as a strong and well-established competitor. Mates' initial success in gaining wide public awareness of the brand and a [*] to [*] per cent market share within a year of its entry represented a remarkable achievement. Subsequently, however, its share has fallen back to [*] per cent, it has lost-or been unable to obtain-listings with several major buyers, and until recently consistently traded at a loss. It suffered as a result of adverse publicity arising from a *Which?* report in 1989 which cast doubt on the quality of Mates condoms. Mates told us that its parent, Pacific Dunlop, was now anxious to see a return on the major investment which it had made in attempting to develop its UK sales and in bearing the losses.

8.72. Mates condoms sell at a lower retail price than Durex but Mates told us that this was an inheritance from the original marketing strategy of The Healthcare Foundation, which had positioned Mates condoms as a lower-priced brand aimed at the young. Mates had tried to narrow the price gap between equivalent products in the Durex and Mates ranges but had been largely unsuccessful. We are satisfied that Mates' pricing stems from a position of weakness, rather than an aggressive attempt to win share from LRC, and that Mates' activity in the market has not constrained LRC's pricing in the OTC and vending sectors. The position regarding sales to the NHS is rather different: see paragraphs 8.81 and 8.82.

8.73. No other supplier apart from LRC and Mates has a significant share of the OTC sector. Towards the end of our inquiry Sime Health mounted a promotional campaign for its Jiffi brand of Kitemarked condoms (see paragraph 8.46). Sime Health has achieved a number of listings by retailers, notably Tesco, which told us that its initial sales experience with the products was encouraging. Sime Health itself forecast that its share of the commercial market would rise to 5 per cent in 1993. It is nevertheless too early to tell whether Jiffi will have a significant impact on the market in the longer term.

*Figures omitted. See note on page iv.

8.74. LRC's brand strength and the difficulty of obtaining listings from retailers are barriers to suppliers seeking to enter the OTC sector. Both of these need to be overcome by advertising and other forms of promotion. LRC told us that a new supplier would have to spend over £1 million on such activity in order to make a worthwhile initial impact. Although such a sum could certainly be afforded by some of LRC's competitors in the supply of condoms around the world, it is substantial in relation to the size of the UK market and would represent a sizeable risk for a supplier wishing to attack the market on a big scale.

8.75. LRC, Mates and Sime Health are currently the only suppliers whose condoms qualify to carry the BSI Kitemark (see paragraph 8.25). The costs of belonging to the Kitemark scheme are not large-for a Far East-based manufacturer, typically around £8,000 in initial approval costs and thereafter £20,000 a year-but nor are they insignificant, particularly for suppliers with a small market share. It is the policy of many leading customers, including the NHS, normally to buy only Kitemarked condoms, although this factor appears to be much less important in the vending sector. Some suppliers whose condoms comply with comparable standards elsewhere appear to regard Kitemarking as a needless additional expense in attacking the UK market. As noted in paragraph 8.46, the Japanese supplier Sagami attempted to enter the market in 1991 with a non-Kitemarked product called Le Condom but the attempt failed quite quickly. RFSU, a Swedish organization whose condoms are manufactured by Sagami, is currently seeking to enter the market with condoms which it claims match the highest standards but which are not Kitemarked. It remains to be seen how RFSU will fare but we would expect the absence of the Kitemark to create difficulties for it. The Kitemark provides an assurance of quality which many customers and retailers value but it does represent a barrier to entry, albeit one which a supplier of any substance should not, in principle, have much difficulty in surmounting. The position in future is likely to be affected by the introduction of a European Standard (see paragraph 8.26).

8.76. Our 1982 report concluded that purchasers, who were already becoming more concentrated, had brought no effective pressure on LRC's prices. The picture has evolved since then in two major respects: the entry of supermarket chains to condom retailing, and the increasing centralization and aggressiveness of NHS purchasing. In addition the price war initiated by Superdrug in May 1993 appears likely to have a lasting effect on the nature of the market.

8.77. As regards the OTC sector, LRC told us that it encountered a robust response from retail buyers when it sought price increases. It has in practice, however, been able to push up prices frequently (twice a year since 1991) and substantially. LRC told us that it was able to persuade retailers to accept price increases by arguing that prices in this country were much lower than in the rest of Europe. Two large retailers stated that LRC's salesmen typically argued, in addition, that the price increases had been approved by the OFT under the price control regime. These retailers said that they had no option but to accept LRC's increases since Durex was a 'must stock' item for anyone wishing to sell condoms in the OTC sector.

8.78. We have noted LRC's explanation (paragraph 8.59) of what it recognized to be the unusually high gross margins which retailers made on condoms. Like our predecessors, however, we consider that the high margins between LRC's trade and RRP's are a means by which LRC 'looks after' retailers and discourages them from searching for other suppliers. Given LRC's dominance of the market, it could have taken action to narrow these margins but until recently it has been under no competitive pressure to do so.

8.79. This situation may be changing as a result of the outbreak of price competition among retailers themselves. Some of the leading retailers are continuing to sell at the lower price level-ie around a third below the RRP-as we report, six months after Superdrug made the first move. Clearly this represents more than the usual form of price promotion which typically lasts for only a few weeks. We expect that the effect will be to increase the market share of the price cutters, to reduce average retail margins, and to bring more pressure on LRC's trade prices. Tesco told us that prices would not return to previous levels in the short term because consumers were now used to the lower level and would not accept a 50 per cent rise-the effect of restoring pre-May prices-in one move. [

Details omitted. See note on page iv.] Tesco would resist strongly any move by LRC to raise its selling prices while the present low retail prices continued. Although Tesco had little direct leverage over LRC as regards condoms because of the strength of the Durex brand, it had indirect leverage in that LRC was keen to sell its range of other health and beauty products.

8.80. LRC itself told us that retailers had pressed for lower trade prices to help them fund the price war but it had largely succeeded in rebutting this pressure on the grounds that it already supplied the cheapest

condoms in Europe. It had not raised prices in October 1993 as it normally would, but this had not been directly linked with the price war. It agreed, however, that it would expect stronger resistance to price rises in future as a result of the price cutting.

8.81. As recorded in paragraph 8.21, LRC's prices to the NHS have risen much more slowly than its prices to the OTC sector. LRC said that until the entry of Mates it did not follow differentiated pricing policies in the different sectors of the market. Mates had targeted the NHS and quickly taken a quarter of that business. LRC had belatedly responded by reducing its prices and by making more sales direct rather than through distributors, thus cutting out the distributors' margins. As a result of these measures and Mates' difficulties (see paragraph 8.71) LRC has been able to win back most of the share which it lost to Mates, and that at a time when the NHS's purchases have been rising strongly. During our inquiry LRC sought a price increase when its contracts with three of the six supplies divisions of the NHS in England expired. This encountered resistance particularly from one of the divisions (the North West) which had enjoyed a specially low price before. Pending resolution of the dispute, which had been going on for three months, LRC said that it was losing one-third of its previous volume of sales to that division. The North West Division was actively promoting Mates condoms to the NHS bodies which distributed condoms within its area, and LRC was aware that both Jiffi and RFSU condoms were also being bought by two of the divisions.

8.82. We are satisfied that there is keen competition among suppliers to the NHS, which is much less concerned with brand image than the OTC sector and can look for suppliers meeting the necessary quality standards virtually on a world-wide basis.

LRC's profitability

8.83. LRC supported its contention that condom prices in the UK were artificially low largely by reference to comparisons with prices in other European countries (see paragraph 8.62). Another aspect of its case, however, is that its profitability is too low to support a normal level of competitive activity.

8.84. The relevant financial data are set out in Chapter 4. Table 4.1 shows that LRC's UK condom business made a return on capital employed (ROCE), in historical cost terms, of 24 per cent in the year to March 1993 (23 per cent in 1991/92) and a return on sales (ROS) of 18 per cent (16 per cent in 1991/92). The ROS figure was slightly higher than the average for LRC as a whole but the ROCE figure much lower because of the very high (135 per cent) ROCE earned on other products. LRC told us that it earned high returns on health and beauty products because it had a number of brands which were well established in niche markets, with low capital employed and low promotional expenditure. It also made high returns on gloves, which were manufactured by other group companies overseas and bought in at low transfer prices. LIG's overall ROCE in 1992/93 was 19 per cent and its ROS 10 per cent. These results were affected by the loss which it made in its ColourCare photoprocessing business.

8.85. LRC's rates of return (both ROCE and ROS) on condoms in 1992/93 were the highest achieved in the last five years. In the four years 1984/85 to 1987/88 its ROCE was consistently over 30 per cent, reaching 47 per cent in 1985/86. Profitability then fell sharply after 1987/88, a year which saw a big increase in sales as concern about AIDS mounted, with the downward trend continuing to 1989/90. This was partly because LRC lost sales to Mates and had to hold its prices for a time, and partly because its cost base increased. Since then both sales and profitability have increased each year. (See Table 4.3.)

8.86. We put it to LRC that a 23 to 24 per cent ROCE on a historical cost basis was not an unreasonable rate of return for a business whose risks appeared relatively low. LRC said that it regarded this rate of return as unsatisfactory: its parent, LIG, looked for at least 30 per cent. Moreover its return was only as high as 24 per cent because it was operating old plant which was heavily written down—indeed in some cases wholly written off—and because the capital employed in condoms manufacture could be allocated to its substantial export business as well as to UK sales. (LRC normally makes low returns on its exports because of LIG's policy that these sales are priced at full manufacturing cost plus a small percentage. This does not affect returns on UK condoms business because of the basis on which costs and capital employed are allocated between the two areas: see Appendix 4.5.)

8.87. We noted that the average capital employed allocated to LRC's UK condom business showed a sharp increase, from £9.8 million to £13.4 million, between 1991/92 and 1992/93. LRC said that this was due partly to the closure of the surgeons' glove manufacture at Chingford, which meant that the cost of some fixed assets at the site could no longer be spread over that business as well as condoms; and partly because of an increase in working capital associated with the high level of forward sales which LRC had made at the end of 1992/93. We regard both these factors-which serve to reduce the nominal ROCE-as exceptional, rather than reflecting the underlying reality of the condoms business.

8.88. Another factor influencing the calculation of capital employed is the inclusion of the cost of vending machines, the average value of which in LRC's balance sheet has risen from £0.3 million in 1988/89 to £2.7 million in 1992/93. LRC's recent investment in fixed assets in the condom business has in fact mainly been in vending machines. When the vending operation was converted to a franchise basis in 1990 LRC retained ownership of the machines. LRC told us that this was partly because the franchisees could not afford to buy them, and partly because LRC wished to ensure that they were used to sell only LRC condoms. The machines are rented to the franchisees and LRC takes the depreciation charge in its accounts.

8.89. On one view the vending machines are part of a retail business which is separate from LRC's business of manufacturing and wholesaling condoms. We therefore recalculated LRC's results excluding the income, costs and capital employed of the retail vending operation. The effect of this was to increase the ROCE on LRC's main business-although ROS was little changed-while showing a small loss on LRC's business of owning and renting out vending machines. LRC argued that the vending machines were part and parcel of its own business because if it did not own the machines they would no longer be used to sell Durex condoms. There would then be a sharp decline in overall volumes, with adverse consequences for profits and rates of return. We agree that the cost of vending machines should be seen as part of the capital which LRC has invested in its main UK condoms business and that its ROCE should be calculated accordingly.

8.90. In order to get a fuller insight into the profitability of LRC's condom business we asked the company to recalculate its results for the latest year on a current value basis, and also to prepare an appraisal of the investment that would be needed to bring the Chingford plant up to modern manufacturing standards.

8.91. The conversion of the 1992/93 results to a current value basis essentially involved recalculating the value of fixed assets, which had the effect of increasing the value of capital employed, and deducting an additional depreciation charge, which reduced the operating profit. The resulting ROCE was 15 per cent on year-end capital employed, compared with 21 per cent historical cost return (see Table 4.10). The current value ROCE in the years before 1991/92 is likely to have been a good deal lower than this, in line with the pattern of historical cost returns (Table 4.1). Again we put it to LRC that 15 per cent was not a low return when compared with Central Statistical Office estimates of current value returns in UK manufacturing as a whole of around 7 per cent in recent years, albeit those are calculated on a somewhat different basis (see Table 4.12). LRC argued that the conversion to a current value basis did not alter the fact that it operated with plant which was likely to be much older than the average for British industry.

8.92. LRC's appraisal of a project to upgrade Chingford to modern standards showed that capital employed would rise from £15.3 million at the end of 1992/93 to £23.2 million after the investment was complete and old equipment had been scrapped. Over a ten-year period the investment showed an internal rate of return of 9 per cent at present price levels and sales volumes. LIG told us that it looked for a minimum of 30 per cent before investment projects were considered for approval. LRC estimated that it would need an average price increase of 17 per cent, with no change in the volume of sales, before the project would meet this hurdle rate of return. This gives an indication of the extent to which LRC's current, apparently quite good, ROCE figures are due to its use of old and written-down equipment. (See paragraph 4.25.)

8.93. Taking account of the various factors just discussed, we believe that the returns which LRC has made on its UK condom business in the last two years have been neither unreasonably low nor unreasonably high. We note that the 1992/93 results were achieved only as a result of LRC exceeding its permitted price ceiling (see paragraph 8.21). On the other hand capital employed in that year could be seen as somewhat inflated by the exceptional factors referred to in paragraph 8.87. In the preceding years LRC's returns could clearly be judged unsatisfactory: as noted in paragraph 8.21, those were years in which LRC's average price was below the level permitted by price control. We accept that the existence of price control is likely to have depressed the level of investment in production equipment and of expenditure on market development, ie

advertising and promotion. (Product development is a separate matter because it relates to LIG's world-wide condom business rather than to the UK market.)

The apparent effects of price control

8.94. In our analysis of the market we have attempted to assess what the effects of price control have been and hence what would be the effect of removing it. This is necessary not only for a proper understanding of how the market works but also, and crucially, to enable us to judge whether LRC's pricing has been against the public interest or may be expected to become so. LRC's views on these matters are summarized in paragraphs 8.61 to 8.66.

8.95. The way in which LRC's prices have actually moved is summarized in paragraph 8.21. Two points are important in understanding how LRC has responded to price control:

- because the control applies to LRC's ARP across the whole of its sales, a reduction in price in one part of the market creates headroom for an increase in another; and
- since LRC cannot affect the maximum ARP which it is allowed to charge, its only means of increasing revenue and hence profits has been by increasing the volume of its sales.

8.96. Both these effects are amplified by the fact that LRC has been allowed to recover in later years the effects of any undershooting of the allowed price (see paragraph 8.20). Thus a price cut has created headroom for price increases which could be used at a later date, depending on market conditions. Equally the volume of sales in a given year has given LRC the right to earn a particular level of revenue which, if not achieved at the time, could be carried forward to future years.

8.97. LRC has adopted different strategies for the three sectors of the market. It has kept its prices to the NHS low in order to recover sales from Mates. This was clearly a response to market conditions, as LRC submitted. (We consider later whether LRC's pricing in the NHS sector has been anti-competitive: see paragraphs 8.136 to 8.142.) But we believe price control may have caused it to set its prices lower than they would otherwise have been because price cuts to the NHS could be made up elsewhere in the market. It has also been in LRC's interest to maximize its share of NHS purchases almost regardless of price for the reasons given in paragraphs 8.95 and 8.96.

8.98. LRC told us that the conversion of its vending operation to a franchise basis was motivated by considerations of efficiency (see paragraph 7.35). We have no reason to doubt that such considerations were important. But we believe that the effect in increasing LRC's headroom to raise prices in the OTC sector will also have played a part in the decision (LRC agreed that this was a factor, albeit a very minor one).

8.99. As to the OTC sector, LRC told us that it had increased prices to the maximum extent permitted by price control. As noted in paragraph 8.21, in recent years this has been much faster than the rate of general inflation.

8.100. LRC has clearly found ways of operating under price control in recent years which have enabled it to peg back Mates' market share and then to improve its rate of profit, although not to the levels seen in the mid-1980s (see paragraph 8.85). It has, overall, raised its prices to the full extent permitted, indeed significantly beyond in the latest year (an overshoot which LRC said was due to its over-estimation of the rate of inflation). Prices to the OTC sector have risen more than would have been expected when the control regime was established.

8.101. On the other hand price control has resulted in UK prices being low by European standards, a point on which LRC provided detailed evidence and which Mates stated in general terms. Information provided to us by Nielsen, the retail analysts, confirmed that retail prices in pharmacies and drugstores in other European countries were on average some 20 per cent above those in the UK. As regards trade prices, LRC at first submitted information covering France, Germany, Italy and Spain which suggested that average prices elsewhere were nearly double those in the UK. Further enquiries covering a wider range of European countries indicated that the average elsewhere is more like 50 per cent higher (again, the comparisons concern the pharmacy and drugstore sector). The main reason for the disparity being greater at the trade

level than the retail level is that retail gross margins in the UK are at the top end of the range for the countries surveyed. This in turn at least in part reflects differences in the structure of the markets. In France and Italy, for example, LRC told us that suppliers were more heavily involved in the distribution process than in the UK. Trade prices are therefore higher in those countries, and retail margins lower, than they would be if their market structures resembled the UK's.

8.102. We do not consider that LRC can reasonably be criticized for the way in which it has adapted its pricing policy to price control (as opposed to the individual aspects of its conduct which we examine from paragraph 8.125 onwards). It has been making the most of the opportunities which were available to it, under the regulatory regime to which it was subject, in order to maximize the return to LIG's shareholders. To the extent that price control has distorted LRC's behaviour, this must be laid at the door of the control regime, not LRC's.

8.103. We have also considered the impact of price control on LRC's efficiency. As noted in paragraph 8.19, the present form of price control was designed with a view to removing the disincentive to increased efficiency inherent in the previous regime, which effectively set a maximum ROCE. Table 4.7 shows that LRC's manufacturing costs per gross of condoms sold have risen on average by [*] per cent a year in the last five years, and its labour costs by [*] per cent. Both these rates of increase are well ahead of the rate of inflation or the growth in average labour costs in the UK.

8.104. LRC said it did not consider that its efficiency had been influenced by the price control regime, though compliance with the controls meant that it had extra costs. One factor which had greatly increased costs was the need to comply with higher quality standards, and these could not be recovered under the price control system. Product improvement was therefore penalized. Another factor was that the relocation of surgeons' glove manufacture had changed the structure of the workforce because more managerial grade staff were now allocated wholly to condoms. LRC said that although it always looked to increase efficiency, improvements at Chingford had been minor. This was because the unsatisfactory returns available, in LRC's eyes, meant that it had not been able to justify investments which would have improved efficiency. There were great opportunities for automation in testing and packing: the investment needed to take advantage of these was not economic for LRC under price control but it would be in a normal commercial market.

8.105. Under price control LRC has made a reasonable level of profits despite its continuing use of old and outdated equipment. The investment appraisal which LRC prepared for us (see paragraph 8.92) showed that substantial improvements in labour productivity could be achieved with new equipment, and tended to support its contention that such investment would have been commercially justified if prices had been at the levels seen in unregulated markets. Whether LRC would actually have made such an investment had its prices not been regulated is impossible to say, but the existence of price control has ensured that it did not.

8.106. We have noted LRC's argument (paragraph 8.64) that the existence of price control had led to its decision not to launch its new non-latex condom in the UK. LRC expects this product to widen the market for condoms by appealing to people who dislike using latex condoms. LRC said that it would make sense commercially for it to launch the product first in countries where its share in the market for latex condoms was not high. On this criterion the UK would not have been a candidate for an early launch, regardless of price control. But we accept that the control will have contributed to LRC's decision not to include the UK among the countries where it is likely to launch the product first.

8.107. There is also the wider point that LRC cannot recover additional costs which it incurs in improving the quality of its products and is inhibited in its ability to charge premium prices for premium products. This is a well-known danger of price control regimes based on the 'RPI minus X' principle. On the other hand it was open to LRC to ask the OFT that an allowance be made for the costs involved in achieving higher quality.

8.108. As regards the effects of price control on the market generally, we believe that competition has been weaker than it otherwise would have been, at least in the OTC sector. As we have explained (paragraph 8.81), the NHS is more open to competition from suppliers whose brands are little known in the UK and which do not necessarily have to make a major initial investment in promotion. A similar consideration arises in the vending sector where there is little brand loyalty and a proliferation of small operators.

*Figures omitted. See note on page iv.

Healthline has been able to find a substantial niche in this sector by supplying condoms bought in at very low prices from the Far East.

8.109. The OTC sector represents the bulk of the market, however, despite having declined from over 70 per cent to 60 per cent since 1988/89, and it is here that the stifling effect of price control on competition has had its main impact. Notwithstanding the sharp increase in prices over recent years, there has been no significant entry since Mates. Le Condom attempted to enter in 1991/92 and Sime Health and RFSU are trying to do so now but their backers have not so far been prepared to make any substantial initial investment in advertising and promotion (see paragraph 8.74). Mates made a highly effective entry, in terms of brand recognition and sales, at a time when circumstances were particularly favourable, but it has since struggled. There appear to be a number of reasons for Mates' difficulties but two are related to price control: first the level of trade prices and secondly the fact that price control has sharpened LRC's response to competitive challenge (see paragraphs 8.95 to 8.97). We have noted LRC's evidence that the UK has the greatest concentration of any major developed condom market. This is due partly to the history and strength of the Durex brand, but price control is likely to have helped preserve this situation.

8.110. A related factor is that price control appears to have depressed the level of commercial advertising. LRC has advertised little in recent years, partly, it said, because the prospective return did not justify the expense and partly because its position has not come under strong attack. Mates has not been able to afford much advertising, while Johnson & Johnson cut back on its advertising of the Mates brand because sales were below expectations.

8.111. Although Mates' ability to challenge LRC has been hampered, particularly by image problems, its arrival in the market caused major changes in LRC's behaviour and brought benefits to customers. It also helped cause a sharp decline in LRC's profitability, which fell from over 30 per cent in the four years up to 1987/88 to an average of 17 per cent in the five subsequent years. Even with the improvement seen in the two most recent years, LRC's profitability is still well below the levels reached in the mid-1980s.

The likely effects of removing price control

8.112. If price control were removed LRC would seek to increase its prices in the OTC sector. There would probably be no early change in its vending prices because they have only just been increased, but in the medium term LRC's prices in vending would be likely to continue moving in parallel with the OTC sector. The judgment to be made is whether there would be an effective constraint on LRC's ability to raise prices both in the short and the longer term.

8.113. In the OTC sector the response to LRC would depend chiefly on the attitude of retailers and on the existence and strength of competing brands. In the short term the competition is not strong. Mates is likely to be more interested in profitability than market share at present and we would therefore expect it to follow LRC in raising prices, though not necessarily to the same extent. Sime Health is seeking to build up sales with its Kitemarked Jiffi brand. It has achieved a foothold, notably its listing by Tesco, but its likely success cannot be judged at this stage. The prospects for RFSU and Healthline are also uncertain. All three have substantial backers, however, who could be expected to increase the priority given to attacking the UK market if price control were removed. Given the extent of world over-capacity which has developed in recent years, other suppliers would also be interested.

8.114. As we have noted, there has hitherto been little resistance from retailers to LRC's frequent price increases. In the absence of price control the situation would be different, however, in that retailers would no longer feel that LRC's prices were officially approved. Furthermore, the retailing of condoms is becoming a more competitive business not only because of the price war but also because of the growth in market share held by some of the supermarkets and Superdrug (see paragraphs 8.79 and 8.80). In these new circumstances we would expect retailers to be more resistant to price increases. The existence of Mates gives retailers some leverage over LRC even if Mates were also raising prices: for example, retailers not stocking Mates at present could threaten to do so, while others could display Mates products more prominently if they considered that LRC was acting unreasonably. Sime Health's current campaign with Jiffi gives them a further option. Moreover because of competition among retailers, increases in trade prices would not necessarily be reflected in retail prices.

8.115. Looking further ahead the extent of competition would depend on the establishment of alternative brands which the public wanted to buy. LRC said that an entrant would need to spend at least £1 million in advertising costs to establish a new brand and thereafter perhaps £0.5 million a year to sustain sales growth. Other witnesses made similar broad estimates. We have seen no sign that any competitor is contemplating expenditure on this scale. But the removal of price control would change the situation: as a regulated market with prices well below those in the rest of Europe the UK is not an attractive prospect for potential entrants at present.

8.116. The expected introduction of a European Standard, combined with the implementation of the EC Directive on Medical Devices (see paragraph 8.26), will substantially alter the position as regards quality and certification over the next few years. On the one hand the Directive will prohibit the marketing of products which do not meet its requirements. On the other hand national standards will be replaced by the European Standard and all products certified as meeting that standard will qualify for free circulation throughout the EC. It remains to be seen how these developments will affect buyers' behaviour but our expectation is that they will make it easier for a supplier which can meet the European Standard-which most sizeable manufacturers are likely to be able to do-to establish itself on the UK market.

8.117. LRC would also be earning higher profits and could afford to resume advertising in order to protect its position. LIG's Chairman described Durex as a powerful brand with enormous consumer loyalty. To attack LRC's position successfully would be a formidable challenge. As LRC itself argued, however, the very size of its market share would make it a tempting target. We have noted the evidence which LRC presented of how entrenched brands had lost their pre-eminent positions in Scandinavia, France and Italy (paragraph 8.65).

8.118. At the time of our previous report there were strong grounds for believing that LRC would not be successfully challenged and would be able to exploit its monopoly position (see paragraph 8.18). Our judgment is that conditions have now changed sufficiently to create an expectation that competitive forces-essentially the combination of competing suppliers and more aggressive retailers-would begin to work and to constrain LRC's pricing. The strength of the Durex brand and LRC's entrenched position in the market are-leaving aside price controls-the main deterrent to entry and if LRC were to raise its prices unreasonably it would make itself more vulnerable to attack. Competitors would be likely to come in with prices below those of Durex so that the general level of prices in the market would not increase *pari passu* with LRC's prices. In vending LRC's share is already only one-third and its sales have been falling, possibly as a result of the availability of lower-priced alternatives.

8.119. As regards the NHS, LRC told us that its prices to the NHS would be unlikely to rise significantly, if price control were removed, because of the strength of competition. While we believe that price control may at times have caused LRC's prices to the NHS to be lower than they otherwise would have been, we are satisfied that there is sufficient competition to protect the NHS's position as a purchaser if price control was removed.

8.120. There would also be offsetting benefits to LRC's price increases. Chief among these is that a more competitive market would involve a big increase in commercial advertising and other forms of promotion. It is impossible to assess what the effect on consumers would be but the expectation must be that usage would increase as a result (see paragraph 3.100). Since demand for condoms appears to be insensitive to price, we believe that a stimulus to usage resulting from increased promotion would outweigh any contrary effect resulting from higher prices. Promotional efforts would be likely, as LRC argued, to focus particularly on the young, whose behaviour has not yet assumed established patterns. The evidence we received from official health promotion bodies was that government and commercial advertising were both necessary in order to increase awareness of the importance of condoms in preventing unwanted teenage pregnancies and in slowing the spread of AIDS and other STDs. These are among the objectives specified in the Government's White Paper on *The Health of the Nation*.¹ To the extent that commercial promotion stimulates young people's use of condoms, therefore, there would be a benefit to public health and welfare, a factor to which we attach great importance particularly as regards AIDS.

¹*The Health of the Nation*, Cm 1986, July 1992: see Appendix D.

8.121. Removal of price control would also be likely to advance the timing of LRC's launch of its newly-developed non-latex condom in the UK (see paragraph 8.106). This too might help stimulate usage of condoms as well as adding to consumer choice. The uncertainties surrounding this factor are, however, too great for us to attach weight to it.

8.122. It follows, from our judgment that LRC would be able to increase prices to the OTC sector, that its profitability would also rise. It is not possible to estimate by how much since this would depend on a variety of factors, notably the size of the price increases, the extent to which LRC would lose sales volume as a result of raising prices, and the amount of its extra expenditure on advertising and promotion. We would note, however, that the entry of Mates appears to show that even a limited degree of competition had a big impact in reducing LRC's profitability: see paragraph 8.111.

8.123. The likely consequences of not lifting price controls are the other side of this coin. The disadvantages for LRC which we have described in paragraphs 8.103 to 8.107 would continue to a greater or lesser extent depending on the particular control system which applied. As regards the market generally, some of the developments towards a more competitive climate could be expected to continue, notably the increase in competition in retailing and the greater openness of the UK market as part of the move towards a single European market for condoms. These developments would, however, be hindered if UK prices continued to be a good deal lower than those elsewhere. Even if LRC's prices under a revised control regime were allowed to rise closer to levels prevailing in the rest of Europe, the continued existence of a regulated market would still act as a deterrent to market entry. The disadvantages for consumers and for society at large would remain.

Conclusion on LRC's pricing

8.124. To sum up, we consider that if price control were removed LRC's prices in the OTC sector (and, in due course, in vending) would rise but the extent and timing of the increase would be constrained by market forces. The competitiveness of the market, which is already increasing at retail level, would strengthen further as a result of other suppliers challenging LRC's dominance. Increases in trade prices would not necessarily be reflected in retail prices. Alternative brands would be available, probably at prices below LRC's. This increase in competitive activity would involve much more spending by suppliers (including LRC) on advertising and promotion. The net effect of these market changes on condom usage, particularly by the young, would be likely to be positive. A continuation of price control, on the other hand, even in a revised form, would hinder these developments as well as adversely affecting LRC. We believe the balance of argument now clearly favours the removal of price control. Accordingly we consider that the DGFT should arrange for LRC to be released from the undertakings which it gave following the 1982 report.

Other aspects of LRC's trading practices

Exclusive deals

8.125. As recorded more fully in paragraph 3.108, LRC told us that it had made payments to three major customers in return for their agreement to stock only Durex condoms:

- A single payment of £5,000 was made to Superdrug in 1988. A possible further payment of £30,000 was discussed in May 1992 but Superdrug did not take this up and resumed stocking Mates on a trial basis soon afterwards.
- In mid-1990 LRC began making quarterly payments of £2,500 to UniChem. This arrangement continued until August 1993 when LRC withdrew from it following a hearing with the MMC.
- LRC made a single payment of £10,000 to Lloyds in November 1991. No further payment was made but Lloyds still does not stock Mates.

Superdrug, UniChem and Lloyds were LRC's second, third and fourth largest condom customers in the commercial market in 1991/92, accounting together for 16 per cent of its total sales in that year.

8.126. LRC said that its senior managers had not been aware of these arrangements until they made enquiries in order to be able to answer our questions. They now thought it likely that LRC sales staff would have discussed the possibility of having exclusive deals with most major customers. LRC regarded this as normal behaviour for a supplier seeking to protect an established market share but appreciated that it could be viewed as anti-competitive. It did not see the one-off payments as having given it the right to exclusivity on a continuing basis: Lloyds was now not stocking Mates for its own reasons, not because of the single LRC payment. Moreover the payments were all small in relation to the value of LRC's sales to these customers, which indicated that the latter did not need much persuasion not to stock Mates condoms. LRC added that the existence of price control had influenced its actions because the control led to LRC having to maximize its sales volume given its lack of freedom on prices.

8.127. UniChem and Lloyds told us that they had decided to stop stocking Mates for their own reasons, viz that sales were too low to justify continuing, and Superdrug said that it would probably have done so. They therefore regarded LRC's payments as a bonus, for which they did not have to change their behaviour.

8.128. LRC told us that it had received a letter from the OFT in May 1989 asking about an allegation that LRC had made an exclusive supply agreement with Superdrug whereby enhanced margin was conceded in return for its delisting Mates condoms. LRC had replied that there had been no change in its terms of trade with Superdrug in order to encourage solus supply. This had been strictly accurate because a lump sum payment was not regarded as a form of enhanced margin. Moreover LRC viewed the agreement with Superdrug as having expired. But given the unclear status of the payment LRC now wished that its existence had been discovered and disclosed to the OFT at the time. In further correspondence LRC assured the OFT in February 1990 that it had no exclusive supply arrangements with customers. This pre-dated the agreement with UniChem, which began around the middle of 1990, and the single payment to Lloyds in 1991.

8.129. Regardless of the three customers' position these payments by LRC were clearly aimed at closing important areas of the OTC sector to Mates and indeed any other potential supplier. For a monopoly supplier with 80 per cent of the market these are unacceptable tactics. Mates told us that it had found Superdrug's decision to delist Mates condoms puzzling. Johnson & Johnson said that it had encountered difficulties in attempting to sell Mates products to Lloyds and UniChem which went beyond its normal expectations of commercial attitudes. Although none of the agreements is now current we believe the harm they are likely to have done to Mates' position affects its current financial and market situation. The agreements have also increased barriers to entry for other would-be suppliers to the OTC sector. We conclude that these exclusive deals are actions by LRC which are attributable to the monopoly situation. We further conclude that they are facts which operate against the public interest, with the particular adverse effects that they weaken competition and reduce consumer choice.

8.130. We also consider it unacceptable that LRC should have entered into an exclusive deal with UniChem in 1990 only a few months after assuring the OFT that it had no such arrangements. It should have been plain to LRC that the OFT would have seen the agreement as anti-competitive. The fact that the existence of the arrangements was not known to LRC's senior management until they came to light during our inquiry does not speak well of LRC's internal controls and reporting systems.

Segmentation of the market

8.131. As noted in paragraph 8.44, LRC's prices to the NHS are about a third below even its keenest prices to OTC. In an unrestricted market such a large difference would be unsustainable because it would pay customers benefiting from the lower prices to sell on to customers in the rest of the market, keeping a margin for themselves.

8.132. LRC told us that it was NHS policy not to engage in such reselling without the agreement of its suppliers because reselling could damage the NHS supplier base and lead to higher costs for the NHS itself. Two years ago LRC had received a formal letter from the NHS asking for authority to sell its industrial gloves to the retail sector. LRC had refused. It assumed that many other suppliers to the NHS were in the same position in that they charged lower prices to the NHS, because of its buying power, than to other customers and could not afford to see the benefit of the lower NHS prices leak across.

8.133. LRC said that the two intermediary distributors to the NHS which it dealt with were also not expected to resell LRC-supplied condoms to non-NHS customers, although an exception was made for their small mail order businesses.

8.134. Mates told us that, while there were no contractual provisions preventing the NHS from reselling Mates condoms, there was an understanding that it would not do so.

8.135. The argument against segmentation is that it allows a monopolist to differentiate its prices, charging lower prices where competition is strong and higher prices where it is weak. This is precisely what LRC has done. But we recognize that the NHS is a special case. If LRC could not rely on NHS sales being insulated from the rest of the market, it would have to narrow the price differential. Within the constraints set by competing suppliers it would no doubt try to do so principally by increasing prices to the NHS rather than reducing prices in the commercial market. The NHS clearly acts on this assumption and the situation is not particular to LRC. The taxpayer's interest in the ability of the NHS to buy at low prices is evidently a relevant consideration. We do not therefore regard LRC's refusal to allow the NHS to resell its condoms as a matter for concern.

Pricing to the NHS

8.136. There remains the question whether LRC's pricing to the NHS represents predatory action against Mates.

8.137. As noted in paragraph 8.21, the trend of LRC's prices to the NHS changed sharply, relative to its prices to the OTC sector, after 1988/89. LRC said that it had had to respond to Mates' success in rapidly winning a quarter of the NHS's business. Although it had cut prices it had also reduced costs, notably by introducing specially for the NHS a new bulk pack with lower packaging costs. It charged prices which it judged were necessary to secure a large volume of NHS sales. Nevertheless these sales were still remunerative, even in relation to LRC's high production costs, in that they made a contribution to fixed costs.

8.138. Our analysis of LRC's profitability on a selection of individual products showed that in 1992/93 it made a loss of around £[*] per gross, after deducting both variable costs and an appropriate allocation of fixed costs, on sales of the bulk packs which it had introduced specially for the NHS sector (see Table 4.6). The sales did cover all variable costs and made a contribution to fixed costs as LRC claimed. Sales of this product represented 30 per cent of LRC's total sales to the NHS in that year.

8.139. Ultimately the question of whether pricing is predatory depends on a judgment of all the relevant circumstances, however, not a mechanical calculation as to whether pricing has been below full or variable cost. LRC argued that for a charge of predatory pricing to be sustained it would have to be shown that LRC had set out to eliminate competitors so that it could raise prices subsequently. This was not possible because the NHS sector was open to competition from suppliers throughout the world.

8.140. We agree that LRC could not have hoped to create a situation in which it could sell at monopoly prices to the NHS. Moreover, as noted in paragraph 8.97, we consider that LRC's pricing behaviour towards the NHS is likely to have been distorted by price control, which gave it an incentive to maximize sales volume while allowing it to make up elsewhere in the market any revenue lost as a result of charging low prices to the NHS.

8.141. We do believe, on the other hand, that part of LRC's aim has been to damage Mates, which would then be a weakened competitor in the rest of the market. In this it might appear to have been successful, in that Mates' share of NHS business fell back sharply from [*] to [*] per cent between 1988/89 and 1990/91, since when it has remained at about that level. But Mates' sales to the NHS have also suffered as a result of the 1989 *Which?* report which cast doubts on the quality of its products. This is certainly part of the explanation for Mates' loss of share at that time and for its inability to recover previous levels subsequently. It would be impossible to disentangle the effect of LRC's low pricing from this factor.

8.142. We conclude that LRC's pricing to the NHS below full cost is a step taken by LRC by way of uncompetitive practice for the purpose of maintaining the monopoly situation, since the aim was to maximize its share of NHS business. For the reasons stated in paragraphs 8.140 and 8.141, however, we

*Figures omitted. See note on page iv.

further conclude that this is not a fact which operates or may be expected to operate against the public interest.

Terms to vending site owners

8.143. Mates told us that after its success in winning a large share of the vending market, LRC had responded by offering levels of commission to major site owners which were higher than could be justified commercially. It had also provided machines rent-free in circumstances where rent would normally be charged.

8.144. LRC said that commission rates had indeed risen after Mates' entry because of competition between the two suppliers. These rates had proved uneconomic and recent contract renewals had been negotiated at lower levels. It believed that all operators provided machines free of charge. LRC argued that it had not attempted to foreclose the vending sector. It had less than [*] of total sales in that sector. Vending was not highly concentrated and smaller suppliers had been increasing their share.

8.145. It is clear that Mates' entry injected a stronger measure of competition for major vending contracts than had previously existed and it is not surprising that commission rates were bid up as a result. Whatever LRC's intentions in offering high commission rates, it has been particularly vulnerable to attack in this sector. Entry appears easy and smaller operators have built up a combined share from 12 per cent in 1988/89 to 45 per cent in 1992/93. In these circumstances the implied charge that LRC tried to shut Mates out of the market cannot be sustained.

Forward sales

8.146. For at least eight years, but on an increasing scale, LRC has offered major customers special discounts to encourage them to buy ahead of immediate requirements just before the end of its financial year. These forward sales have recently been on a very large scale: Boots told us that in March 1993 it bought [*] weeks' supply of Durex condoms, while Superdrug said that in 1992/93 [*] per cent of its purchases from LRC were at the special forward-purchasing price. The size of discount offered has ranged up to 13 per cent.

8.147. LRC said that it regarded forward selling as a common commercial practice. It agreed, however, that its use of the practice was on an unusually large scale. It said that it would prefer not to have to resort to forward sales to such an extent because of the discounts which it had to concede but the sales were made at the behest of its parent company which wished to increase group profits for the year about to end.

8.148. LRC said that it did not, however, consider that forward sales were anti-competitive or damaging to other suppliers. They were not related to market share and it was open to other suppliers to propose similar agreements to their customers if they wished.

8.149. We consider that a supplier with a much smaller share of the market, such as Mates, would in fact be unable to achieve forward-selling agreements on anything like the scale practised by LRC. This is because buying forward represents a risk for the retailer, namely that the products will not sell, which has to be set against the value of the discount offered. The risk is small with Durex because of its very high market share and hence the predictability of sales, but it would be much greater for any other brand of condom.

8.150. There is the possibility that forward purchasing on this scale might lead retailers to promote Durex products in preference to others in order to be sure of shifting the huge stocks. The evidence from retailers has led us to the view that this is unlikely to happen to a significant extent. Forward sales can therefore be seen simply as a way in which LRC varies its prices to large customers. We have dealt with LRC's pricing policies under other headings.

*Details omitted. See note on page iv.

Recommending retail prices

8.151. We commented in paragraph 8.78 that LRC has encouraged retailers to make high gross margins on Durex products in order to discourage them from seeking out other suppliers. It does so by recommending retail prices which are high in relation to its trade prices. To the extent that its recommendations are followed they may lead to retail prices being higher than they would otherwise be. A second aspect is that retailers use their bargaining strength to obtain higher margins from weaker suppliers (or suppliers with weaker brands). It can be expected, and indeed is the case, that retailers make even higher margins on Mates condoms than on Durex.

8.152. LRC said that actual resale prices were determined not by its recommendations but by competition among retailers, a matter over which it had no influence.

8.153. The importance of RRPs depends largely on the extent to which they are observed in practice. Widespread observance of RRPs is often a feature of retail markets to which entry is restricted: that is not the case here. The evidence we collected showed that LRC's recommendations were followed by most retailers until the price war initiated by Superdrug in May. Our judgment is that the market will not quickly return to its previous pattern. As the share of total sales going through supermarkets and other non-traditional outlets increases, the likelihood of a return to the general observance of RRPs will be diminished. Moreover RRPs provide a bench-mark against which aggressive retailers can publicize their price cuts.

8.154. We conclude, for the reason given in paragraph 8.151, that the recommending of retail prices is a step taken by LRC by way of uncompetitive practice to maintain the monopoly situation. In view of the current evolution of the retail market, however, we further conclude that this is not a fact which operates or may be expected to operate against the public interest.

Conclusions

8.155. We have concluded that a scale monopoly situation, as defined in section 6(1)(a) of the Act, exists in that LRC supplies at least one-quarter of the contraceptive sheaths which are supplied in the UK (paragraph 8.8), and that this situation exists in favour of LRC and LIG (paragraph 8.12).

8.156. We have concluded that the following are steps taken by LRC by way of uncompetitive practices for the purpose of exploiting or maintaining the monopoly situation:

- selling to the NHS at prices below full cost (paragraph 8.142); and
- recommending retail prices (paragraph 8.154).

8.157. We have also concluded (paragraph 8.129) that LRC's entering into agreements with customers whereby they agree to stock only LRC condoms are actions on the part of LRC which are attributable to the existence of the monopoly situation and that these are facts which operate and may be expected to operate against the public interest.

8.158. As regards the general question of LRC's pricing (see paragraph 8.124), we believe that the balance of argument now clearly favours the removal of price control. We propose that the DGFT should take the necessary action for LRC to be released from the undertakings which it gave following the 1982 report. The OFT should thereafter keep the position under review.

Recommendations

8.159. With respect to the question of exclusive deals, the only facts which we have concluded operate and may be expected to operate against the public interest, we recommend that LRC be required not to enter into agreements with wholesalers or retailers under which LRC would give the other party a material benefit—whether in the form of special payments, bigger discounts or in any other way—in return for that party's

undertaking to stock only LRC condoms, or not to stock the condoms of any other, named, supplier. LRC should also put in place the arrangements necessary to ensure that its staff comply with this requirement.

H H LIESNER (*Chairman*)

P BRENAN

R HALSTEAD

D J JENKINS

G C S MATHER

A J NIEDUSZYNSKI (*Secretary*)

30 November 1993