# 6 Views of the main parties

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6.1. In this chapter we summarize the views of the parties to the proposed merger.

# Views of Caremark

## Jurisdiction

6.2. Caremark confirmed that it was the intention of MedPartners to sell the whole of Caremark Limited's share capital to Fresenius AG. It also confirmed that the gross value of Caremark Limited's assets was below £70 million and agreed that the question of jurisdiction turned, therefore, on the share of supply test in section 64 of the Act. Given that the two main areas of overlap between the existing supply of services by Fresenius and Caremark was in high-tech home EN and PN services and that Caremark's share of the supply of EN services was in sharp decline because of the termination of its arrangement with Nutricia, Caremark agreed that, for jurisdictional purposes, it would be appropriate to examine shares of supply of PN services only. It accepted that the MMC had jurisdiction to pursue the inquiry on the basis that, as a result of the merger, Caremark's existing share of supply in PN services of more than 25 per cent would be enhanced.

## Market definition

6.3. We asked for Caremark's views on whether there was a broad definition of high-tech home healthcare services or whether each treatment area, such as PN, should be regarded as a separate service. Caremark said that a supplier capable of providing one such service would find it relatively easy to supply any of the other services. In that sense there probably was a broader market. Caremark considered, however, that those services funded by a drug manufacturer constituted a different sector of the market from those funded by the NHS. Caremark described the first of these sectors as the supply of homecare products and the second as the supply of packaged care services (called, respectively, prescribed services and contracted services elsewhere in this report). The difference between the two was that homecare products were off-the-shelf items available on GP prescription, even though the patient might benefit from instruction and other help to use the product at home, whereas packaged care services involved a significant service element that often included the formulation and compounding of the preparation by or for the service provider.

6.4. Caremark told us that a GP prescription for a homecare product was reimbursed at the manufacturer's list price. There was no provision for separate reimbursement of the cost of the homecare service supplied to the patient. This cost was met by the drug manufacturer either by a discount on the price of the drugs supplied to the service provider (who also acted as the dispensing pharmacist and so was reimbursed for the cost of the product) or by a separate fee paid to the service provider on a contractual basis.

6.5. Until the end of March 1995 packaged care services had also been provided through GP prescription. However, with effect from 1 April 1995 a major change in funding procedure had been introduced by EL(95)5. Since that date, these services had been funded by the HA for the patient's area of residence or by the Trust that was treating the patient. The HA or Trust entered into a contractual arrangement with the service provider. The contract specified the components of the package and the price.

6.6. With regard to the homecare products sector, Caremark agreed that home healthcare providers were competing to be the distributors for drug or feed companies. Such companies had almost complete discretion over the choice of provider, although HAs in the North West Region of the NHS had recently told Schering that they wanted it to use Caremark as the homecare provider for MS patients (see paragraph 4.113. Caremark also agreed that where the service component included nursing input (for example, in relation to Ceredase), drug or feed companies looking for a home healthcare provider would tend to opt for a company with skill, experience and reputation in the packaged care services provided in accordance with EL(95)5. To that extent there was a link between the two sectors.

6.7. Caremark said that EN services differed to some extent from the rest of the homecare products sector, as well as the packaged care sector, in that they were characterized by vertical integration of product and service provision. The unknown factor, however, was the entry into the market of

Nestlé and Novartis, who were substantial product manufacturers without a service provision capability. Caremark was of the view that one way these companies might gain market share quickly would be by pressing for a structural change in the market. What Caremark had in mind was persuading individual HAs to go down the route of tendering for EN services, on the lines of the pilot tender carried out in Avon in the summer of 1997 (see paragraph 4.115).

## The market

### *The buying power of the NHS*

6.8. In Caremark's view, the high-tech home healthcare sector presented many different characteristics from those found in markets where both suppliers and customers were in the private sector. It suggested that use of the term 'market' could be misleading since it suggested an interaction between supply and demand and the potential for a supplier to develop market power characteristic of the private sector. In high-tech home healthcare, however, the power of the NHS as the sole purchaser prevented a private sector supplier from exercising the market power (and in particular the freedom to increase prices) normally associated with a high market share. The NHS was well able to protect its interests and those of its patients. It could adopt whatever purchasing procedures it pleased and buy homecare products and services either separately or as a package, as it thought best.

6.9. Commenting on the situation that arose with the issue of EL(95)5 in January 1995, Caremark said that its priority had been to make alternative arrangements for large numbers of patients in the short time before the new policy came into force on 1 April 1995. Its strategy had been to focus its attention on entering into contracts with HAs, persuading them of the advantages of retaining funds that were being transferred to them, rather than passing them over to Trusts. Caremark argued that HAs' interests would best be served by keeping control of the funds and buying home healthcare themselves. The HAs would then be able to assure themselves that they were getting value for money. Caremark's own concern had been that if the funds were passed to Trusts they would easily be able to replace Caremark's services with their own.

6.10. Caremark said that the 120 HAs/Health Boards and over 500 Trusts in Great Britain represented a single purchaser on whose business it was dependent. There was only one purchasing authority for any particular patient, and although the purchasing decision was decentralized HAs and Trusts exchanged pricing and other relevant information and assisted each other to procure services at the best possible prices. The NHS was becoming an even more proficient purchaser as a result of HAs' and Trusts' increasing use of the services of NHS Supplies to assist with procurement. Tendering exercises undertaken with the help of NHS Supplies provided a conduit for the exchange of information on price and on the nature and scope of the services to be provided. As a result, NHS bodies that had not been involved in the exercise would nevertheless seek to buy services on the terms specified in the tender. One example that demonstrated NHS buying power was the tender for PN services carried out jointly by Manchester Children's Hospital NHS Trust and Salford Royal Hospitals NHS Trust in conjunction with Salford and Trafford HA in the summer of 1997. The tender was to select *inter alia* the home healthcare contractor for Hope Hospital, one of the main centres for adult PN patients. Caremark had previously been the homecare provider for Hope and won the 1997 tender at a reduced price. It had been important for it to retain this business because of the number of patients involved, not only those included in the contract with Hope but also Hope patients served by Caremark under contracts with HAs. If Hope had switched to another provider, the HAs might well have decided to change as well. The bid price reflected the importance of the contract, but Caremark then ran the risk that the new lower price would be demanded by HAs when they heard of it.

6.11. We asked Caremark to comment on a view put to us that, for the great majority of HAs, the amount paid for high-tech healthcare services at home was a very small proportion of total budget and for that reason was not given much priority. It had been suggested that, in consequence, HAs still tended to be inefficient in their purchasing and monitoring and were not necessarily achieving value for money. Caremark said that although the expenditure involved was relatively small it was closely scrutinized by HAs and many of them undertook more monitoring than had been done in the past. Caremark was usually required to submit the results of patient satisfaction surveys and many HAs conducted their own reviews with patients. Caremark commented that price trend data suggested that HAs were getting better value for money.

6.12. We also put to Caremark data and comments we had received suggesting that there was considerable inertia in the system, with the great majority of contracts being rolled over and the same supplier continuing more or less indefinitely. Caremark did not accept that as a fair summary of the position. It agreed that many contracts were rolled over, but said that this was in respect of existing patients. These contracts were not exclusive: as new patients required services at home the HA or Trust concerned would undertake an informal tendering exercise, talking to a number of suppliers before making a decision, regardless of whether it already had a contract in place. There was no guarantee that new patients would be added to an existing contract and it was not unusual for an HA to have contracts with more than one supplier for the same type of service. Nor was there any guarantee that a supplier would keep a patient for the duration of his or her treatment. We asked Caremark to comment on a view that HAs and Trusts were reluctant to change the supplier for any given patient because of a perception that patients would be unhappy about it; therefore they tended to retain a supplier unless there was a major problem with the service. Caremark said that this tended to be true of Trusts but HAs were not so averse to change: it was not unknown for an HA to move patients from one supplier to another. Caremark gave us examples of where this had happened.

6.13. We asked whether an HA, which was likely to have only a few existing homecare patients, would be interested in negotiating with suppliers over one or two new patients and then starting to work with an entirely new supplier when it would be easier to add a new patient to an existing contract. Caremark said that the situation was inherently dynamic and HAs were interested in considering new suppliers. There was tension between HAs and Trusts because of a lack of clarity as to which of them had the power to decide on the homecare supplier. In some cases the Trust discharging a patient would seek to impose its preferred supplier on the HA, even if the HA had a contract with a different company, and vice versa in other cases.

6.14. Commenting on a view that there was a bias in favour of the status quo in PN services because of the importance of clinicians knowing the pharmaceutical properties of the PN solutions, Caremark said that stability data were a constraint in a minority of cases where it had invested in carrying out stability studies for particular customers to meet their precise requirements. The data then belonged to Caremark and that made it less likely that patients would be moved to another homecare supplier. However, most stability data were held by manufacturers of the fluids, who would usually make the information available to alternative compounding centres in the interests of ensuring that their products continued to be used.

## *The NHS as a competing supplier*

6.15. Caremark commented that the NHS was uniquely well informed as to the content of the services required, the products and equipment involved and the method and cost of delivery. Many Trust hospitals had the expertise and facilities to provide high-tech home healthcare services themselves and a number already did so. Caremark quoted examples of Trusts that provided these services for the patients of other Trusts, and suggested that many others could easily do the same. Caremark provided information showing the extent of NHS provision, which in some treatment areas exceeded that of private sector suppliers. In particular, it drew attention to Trusts that engaged, in competition with Caremark, in the provision of PN and antibiotics services to patients at home. It told us that PN homecare services were the most complex for hospitals to provide because of the volume of the product and the number of items of equipment needed. Trusts that provided PN services could easily provide services involving smaller-volume IV products, which in many cases could be carried home by the patient. Caremark further suggested that any Trust that provided these high-tech treatments to in-patients could also provide them on an outpatient basis. Approximately 40 Trust hospitals, including all Caremark's major customers, had sophisticated compounding facilities and all had the requisite nursing expertise. Caremark told us that certain Trust hospitals competed with private sector suppliers for high-tech home healthcare business from other NHS bodies and sometimes an HA would award a contract to a Trust without conducting a formal tender process.

6.16. Caremark considered itself to be significantly constrained by the presence and potential presence in the market of the Trusts themselves as providers of packaged care services in competition with private sector suppliers, which, it said, further increased the influence of HAs and Trusts as sole purchasers. It considered that the various Trusts providing these services should be regarded as supplying

the same market as Caremark and exerting competitive pressures that were very relevant to the MMC's assessment of the public interest.

6.17. With regard to PN, we questioned Caremark's view that the capability of Trusts to provide homecare services was a powerful counter to the ability of commercial suppliers to raise prices, given that direct NHS provision was likely to be on a very small scale. Caremark said that many Trust hospitals would be able to arrange for PN services at home. Hospitals with in-patients receiving PN would have the necessary dispensing and nursing expertise and could provide a homecare service without significant investment or dislocation of other services. This possibility did act as a constraint on commercial suppliers.

## *Entry to the market*

6.18. Caremark said that EL(95)5 had opened up the market to new suppliers of packaged care services. The barriers to entry were low. Little capital investment was needed since the components of the service (drugs, equipment, distribution, nursing expertise and pharmacy services) could be obtained as and when required or, where appropriate, subcontracted to third parties. It was possible to operate almost as a virtual company, buying in most components of the service, although it was necessary to have an office and someone to co-ordinate the activities. A supplier could enter the market at a local or regional level, delivering services to patients of a particular hospital, without the need for a national network or supporting infrastructure, and it was possible to enter for the supply of a single service rather than a range of services. Caremark commented that there was little difference between some of the IV services, so that once a company had established a reputation for capability in IV antibiotics, for example, it would find it relatively easy to extend into the supply of antiviral or chemotherapy services.

6.19. We asked Caremark to estimate the minimum number of patients needed to establish a viable homecare business. Caremark said that this would depend on the type of organization to be established and level of profitability desired. It suggested, for example, that it would be possible to compete in the market with only a garage-based operation, subcontracting delivery and hiring agency nurses, with significantly lower overheads than those of an operation with more sophisticated facilities, such as a compounding centre. As an indication of the numbers of patients required, Caremark said that the average annual cost per patient for the provision of PN services would be in the region of £36,000. Approximately two-thirds of this represented the product cost and one-third the gross profit element out of which service costs had to be paid (see Appendix 3.1). As a rough estimate, therefore, Caremark considered that between five and ten patients would support a viable business in the provision of PN services only.

6.20. Any Trust hospital that believed it could provide the relevant services more economically than the private sector could enter the market. Caremark said that a number had done so since 1995 for the provision of a single service: Birmingham Children's Hospital and the Royal Free Hospital for the provision of chelation services, Bristol Royal Infirmary for PN services and Chelsea and Westminster Hospital for antiviral services. In the private sector, the pharmaceutical or feed manufacturers Alpha, Bayer, Nutricia and Sandoz had all entered the market for the provision of one service only.

6.21. Caremark said that as the contractual arrangements between HAs or Trusts and the suppliers of high-tech home healthcare services were not exclusive they did not constitute barriers to entry. Furthermore, whilst it was important for a supplier to demonstrate reliability and/or reputation the number of new entrants in recent years had shown that this requirement was by no means insurmountable. Capability in a related area could be, and had been, readily transferred for these purposes.

6.22. Entrants to the market could be divided into two main categories. The first category comprised companies whose main focus was service provision rather than the supply of products or equipment. Caremark acknowledged that it was relatively difficult for such companies to enter the market, but pointed out that a number had done so successfully since 1995—for example, Central, HaH and Sunscript. The other category comprised those whose primary business was the manufacture of products or equipment. Abbott, for example, had an important EN service business based on its pump and nutritional feed products. Nutricia, a major manufacturer of enteral feeds, had substituted its own

homecare service for that previously supplied for it by Caremark. Pharmacia, a supplier of products and equipment for PN, was currently transferring its homecare service from Caremark to Sunscript. Baxter was a major supplier of PN solutions and had expanded its Unicare service (previously confined to renal dialysis) to PN patients at home. Baxter had also submitted tenders for other high-tech homecare services and had won one such tender for the provision of antibiotics services. Caremark said that these companies had been at some advantage in entering the market because NHS bodies were prepared to accept their experience in related sectors as evidence of capability to supply home healthcare services. Some Trusts had helped pharmaceutical companies to become established in the market. As for potential competition, Caremark told us of several major companies that it expected to develop a significant homecare business—AAH (see paragraph 4.139), Alpha (see paragraph 4.24), Bayer (see paragraph 4.105) and Omnicare (see paragraph 4.28).

## *Economies of scale and scope*

6.23. Caremark maintained that there were few economies of scale in the provision of high-tech home healthcare services. Some discounts were available on the PN feed components, in line with the conventional wholesale discounts, and on disposable ambulatory pumps. Some limited economies could be achieved through full use of the distribution network wherever practicable, but Caremark had found that there were no huge savings to be made because the demands in terms of timing of deliveries to patients were too specific to allow it to run an efficient distribution operation. It was not necessary to invest in a compounding unit since compounding could be subcontracted to the NHS. A company could achieve volume-related savings if it was able to achieve full utilization of its own compounding facility, but conversely there would be cost penalties if volumes were insufficient. Caremark estimated that in gross terms the cost advantage of full utilization of its compounding unit at Harlow, as compared with buying-in from NHS units, might be some £10 to £15 a bag, but this figure took no account of the depreciation charge and financing costs attributable to the compounding unit (see also paragraph 4.118).

6.24. With regard to economies of scope, Caremark said that there were no significant benefits in terms either of cost savings or improved quality of service to be gained by offering more than one of the categories of high-tech home healthcare services or by offering one or more of those services together with any other healthcare service. It recognized that a reputation for one kind of service was likely to be helpful to a company seeking to extend its activities into another, since the skills and some of the equipment required might be the same. However, there was little scope for economies in the service element of the operation because of the varying needs of patients.

## *Price competition*

6.25. Caremark said that the constraints on its commercial freedom in the market (one customer, actual and potential competition from that customer, more sophisticated purchasing procedures and actual and potential competition from other private sector providers) had brought about a progressive decrease in the prices it had been able to obtain for many services. Increasing awareness within the NHS of the actual costs involved had further influenced the trend.

6.26. Caremark acknowledged that the prices charged for its services varied considerably and explained that this was by reason of cost variations arising from different product and service requirements. Immediately after the issue of EL(95)5 it had tended to agree a single price for a given service, so that there had been, for example, a more or less standard average price for adult PN services irrespective of the patient's location and individual requirements. The disadvantage to Caremark was that HAs and Trusts had an incentive to find other means of supporting low-cost patients, leaving Caremark to supply the higher-cost patients. Caremark had therefore changed its pricing policy to one of matching the price more closely with the cost base of the individual patient. Changes in treatment, for example the addition of a drug to a PN package, could lead to variations in price.

6.27. We asked Caremark what had happened to prices since EL(95)5 in respect of services to patients whom it was supplying before 1 April 1995. Caremark said that it had tried to increase prices in line with the NHS inflation index. It had achieved this for some HA contracts but in most cases had been held to the existing price or had had to agree to drop the price because competitors had offered to

provide the service at a lower cost. Caremark provided price data for the year ended 31 March 1997 and the nine months to 31 December 1997. It considered that in the case of contracts with HAs the figures were indicative of a climate of increasingly competitive pricing and a tendency towards a fall in prices. The decrease in prices was greater if the impact of inflation was taken into account. The figures for Trusts showed a number of decreases in price and hardly any increases.

## The effects of the merger

### *Competition*

#### *Homecare products*

6.28. The effect of Nutricia's decision to end its partnership arrangement with Caremark had been to remove Caremark from the market for the supply of EN services to patients at home. In Caremark's view the merger would have no effect on these services given the way the market was currently structured.

6.29. We put to Caremark the argument that the merger was likely to work against any move to put EN services out to tender because there would be three fully vertically integrated companies and new suppliers would also have to come in on a fully integrated basis. This would make it difficult for them to win existing patients from established suppliers. They would, therefore, be limited to competing for new patients. If the merger did not take place, however, Caremark would be available as an independent service provider for any new feed manufacturer and this would open up the possibility of some separation of product and service. Caremark did not agree and considered that the merger would make no difference. Suppliers would remain free to enter the market providing the limited services required themselves or using a third party provider until they could self-supply. Caremark said that it did not have any future as an independent provider of EN services under the current arrangements. It believed that the pressure of increased numbers of patients and cost would persuade the NHS to move to a tendered system. This change in practice was already beginning to happen with the recent Avon HA contract (see paragraph 4.115), which had been a defining moment because one of the three manufacturers broke ranks in terms of its approach to the issue and signalled to the market place that alternative arrangements to reimbursement via the GP prescription route would be supported. The other manufacturers would now have no choice, if other tenders were framed in the same way, but to be realistic in their bids as opposed to quoting the prescription price. There was no central initiative, as there had been with EL(95)5, but the NHS Executive was concerned about rising costs of home EN and was encouraging HAs to consider new purchasing methods. Caremark was confident that there would be change, but pessimistic about the rate at which it would come about. It expected that the NHS Executive would encourage more pilot programmes and that there would also be pressure for change from individual HAs which recognized that this was a problem area.

6.30. Apart from EN, IG was the only prescribed homecare product for which Fresenius provided service. Caremark believed that Fresenius's sales, on behalf of Alpha, had declined because Alpha, as the manufacturer, had increasingly been providing the homecare element of the package itself. Fresenius did not currently supply services in relation to any of the other homecare products. Caremark considered that the merger was largely irrelevant to such services, as no competition issues would arise.

6.31. We suggested to Caremark that the merged company would be in such a strong position as to deter any smaller independent service provider from entering this sector of the market. Caremark said that Fresenius had not been successful in these areas and therefore would not significantly enhance Caremark's position.

6.32. Caremark said that the drugs used in these services were not supplied to it under any exclusive or restrictive arrangements. An exclusive arrangement with Biogen for the supply of beta interferon, used to treat MS, had been changed in November 1997 to allow Biogen to supply through other routes, specifically via conventional pharmaceutical wholesalers to community pharmacies. Caremark had no exclusive agreement with Genzyme for the supply of drugs for the treatment of Gaucher's disease. Although Caremark accepted that it was in effect the sole distributor, it had no reason to believe

that Genzyme had refused to supply to others. It commented that this would not be in Genzyme's interests.

## *Packaged care services*

6.33. Caremark said that the constraints that already applied to it as the largest private sector provider of high-tech home healthcare services would continue after the merger. There would be no scope for the merged company to increase prices or reduce its quality of service. Furthermore, given Fresenius's limited product range any effect of the merger would be confined to only some services. Fresenius had been active in PN services but was now one of seven companies providing this service. Fresenius's shares of the patient population for antibiotic, antiviral and chemotherapy services were insignificant and it did not provide any other services that would continue to be supplied by Caremark.

6.34. Caremark did not accept that the merger would result in a substantial reduction in competition for the supply of PN services even though it would mean the loss of Fresenius, at present one of the two other significant, although much smaller, suppliers, as a competitor. It told us that Baxter had already become more active in PN services since the announcement that Fresenius was the prospective buyer of Caremark. Baxter, a large healthcare company with substantial resources, could be regarded as effectively a replacement for Fresenius. In addition, Caremark had been under pressure from other competitors, most notably HaH, as well as Fresenius and had not been holding its market share. The strongest competition over recent times had come from HaH, not from Fresenius. Those companies that had demonstrated over a recent period of time that they could enter the market, win business and successfully provide services were more likely, in Caremark's view, to be taken seriously by potential customers than Fresenius, which had been in the market since 1985 but had not achieved substantial growth. Pharmacia (which had recently linked up with Sunscript) was also seen by Caremark as a significant threat and had the advantage of being the market leader in the supply of components for PN.

6.35. We asked Caremark whether HaH was able to provide services nationwide, it having been put to us that there were parts of the country in which only Caremark and Fresenius were able to provide a credible service. Caremark believed that HaH could provide an efficient service in any area. Any lack of patients in a given area would reflect HaH's relatively small number of patients nationally and its dispersed patient base. There was no reason, however, why it should not arrange for services to be provided in any part of the country.

6.36. We put to Caremark a suggestion made to us that PN services were now entering a critical period—it had taken a while for EL(95)5 to have an effect, but the market was now changing significantly—and that the merger of the largest supplier with another major player could make it very difficult for emerging new companies to establish themselves. The argument was that a company trying to enter the market might be prepared to do so at a loss initially in the expectation of making profits in a year or two, but the point at which it would become profitable would be delayed, perhaps unacceptably delayed, because the merged company would have such a large share of the market. Caremark believed that the critical stage had come earlier, when HaH gained its first four PN patients and demonstrated a capability. Caremark did not think the merger would have any significant effect on emerging competitors.

6.37. In Caremark's view, the merger would not materially enhance its credibility with the NHS or its ability to compete in the market. It was in a strong position because it had been in the business from the outset, the first supplier in these relatively new markets, and had a record of providing a good and cost-effective service. It did not believe that the addition of Fresenius's patient base would have any impact on its position. It told us that there would be no change in its pricing approach as a result of the merger. It would be no more able to exploit its position with the NHS than it had been able to before the merger. Any concerns about the merger were therefore misplaced, and the structure of the supply side in the private sector segment of this market was best determined by the market itself.

## *Vertical integration*

6.38. Commenting in general terms on issues of vertical integration, Caremark said that in what it had described as the homecare products sector of the market the provider of homecare services could be paid only by the supplier of the product, which was thus in a relatively strong position. It would, however, be something of a simplification to suggest that this amounted to vertical integration that was costing the NHS dear. The prices at which product suppliers were reimbursed were controlled through the PPRS, which imposed an overall limit on the profits that could be made through the supply of drugs to the NHS. Furthermore, there was no reason in principle why the product supplier should not subcontract the provision of the homecare service to a third party. The crucial point, Caremark suggested, was that the product supplier decided which services were to be provided and by whom. Whilst it seemed fair to assume that a move to EL(95)5 purchasing procedures would be likely to reduce the cost of homecare products, it was not possible to say by how much. The situation with packaged homecare services subject to EL(95)5 procedures was completely different since the HA or Trust concerned paid both for products and services. Caremark said that EL(95)5 permitted the un-bundling of product supply from service provision in respect of existing packaged homecare services. It would be possible, if HAs and Trusts so wished, for this unbundling to be applied to the supply of homecare products that were currently subject to the GP prescription regime, and this would remove completely any remaining concerns about the proposed merger.

6.39. Caremark told us that Fresenius was one of its current suppliers of products and equipment. The products concerned were an ambulatory pump and ingredients for PN; EN feeds; and disposables. Caremark currently bought pumps and feed products from other suppliers and the question arose whether after the merger any change in this purchasing pattern was likely to occur. Whilst it would be the management of the Caremark business after its acquisition by Fresenius who would determine these matters, Caremark thought there was every reason to believe that there would be no significant change in purchasing practices. The source of any particular equipment or feed was primarily determined by the clinician who was responsible for placing the contract for the packaged care service. The supplier would provide any product or equipment specified by the clinician. Even if no particular product or equipment was specified, products were not necessarily substitutable; the supplier had to take account of stability limitations in ensuring that the requisite care package was presented to the patient. The opportunity for substitution of product would arise only in the few cases where there was a generic prescription and no stability constraints. Purchasing decisions would be made entirely on the basis of product suitability and quality. A departure from this policy would endanger the supplier's reputation and its continuation in business.

6.40. We put to Caremark the concern that had been expressed to us that Fresenius would seek to increase the use of its own products in the homecare business. Caremark recognized this as a legitimate concern, but did not believe that substitution of products was likely to happen under the current management of Fresenius, who understood the UK market and the anxieties that there would be about product and service becoming inextricably linked. Fresenius would wish to avoid any suspicion that this was happening, in order to protect its investment in Caremark. As evidence of this attitude, Caremark said that after its loss of the Nutricia contract Fresenius had not been willing for Caremark to talk to customers about supplying Fresenius products as an alternative to Nutricia products on the assumption that the merger would take place.

6.41. Although Caremark had not had detailed discussions with Fresenius about the organization of the merged company, its understanding was that Fresenius intended to retain Caremark as a service provider discrete from the rest of its business. The homecare services currently provided by Fresenius would in future be provided under the Caremark brand name.

6.42. We also put to Caremark a concern that some manufacturers might be reluctant to supply it with products, or might only supply on less favourable terms, following its acquisition by one of their competitors, namely Fresenius. Caremark said that in such circumstances it would expect the NHS to bring pressure to bear on the suppliers concerned. These were likely to be substantial suppliers to the NHS, so there was a lot at stake for them and they would be unlikely to risk their overall NHS business. An NHS purchasing body could in any event secure the provision of whichever product it thought best for any particular homecare service by buying the product itself along with its requirements for in-patients, and at the same level of discount, and making it available to the homecare provider as a 'free issue' item.

### *Benefits*

6.43. Caremark said that the combination of its skills in service provision with Fresenius's product expertise would be beneficial to purchasers and would reinforce the quality of service provided. Fresenius had faced difficulties in the past because of confusion in the market about how serious it was as a service provider. The acquisition of Caremark would give it critical mass on the service side. Caremark hoped to be able to influence Fresenius in the development of products that would meet the needs of patients and prescribers. On the equipment side, Fresenius had the expertise to provide technical support and maintenance for the pumps owned by Caremark.

6.44. Caremark's compounding unit at Harlow had spare capacity. Caremark said that the current underutilization was due largely to a freeze on staff recruitment imposed pending the outcome of Fresenius's bid. As Fresenius also had a compounding unit, Caremark thought that there would be the option after the merger of either concentrating resources in a single unit with the aim of making efficiency savings or of running the two units at below optimal capacity in order to have a fallback in the event of technical problems.

### Caremark's future in the absence of the merger

6.45. Caremark considered that it would have a positive future even if the proposed merger did not take place. Although it had felt the effects of a long period of uncertainty before the intended sale to Fresenius was announced, its business was sound and it would be able to develop other opportunities to compensate for the loss of the Nutricia business. However, Caremark believed that MedPartners intended to leave the home healthcare market and would seek another buyer if the transaction with Fresenius did not proceed. MedPartners seemed likely to take the view that it would get a better price from an established company than from a management buyout. Caremark thought that several companies might be interested.

### Remedies

6.46. We asked Caremark to consider whether, in the event of our concluding that the merger might be expected to operate against the public interest in respect of the supply of PN services, there were any practical remedies available short of prohibiting the merger. Caremark said that it did not think that any remedy that involved switching existing patients to other suppliers would be a realistic option. It thought that an undertaking by Fresenius not to compete for any new PN patients for a specified period of time might be practicable (if Fresenius was prepared to submit to it) but NHS customers would be unhappy about this restriction on their freedom of choice.

6.47. We asked Caremark whether concerns about vertical integration in PN services might be addressed by undertakings from Fresenius not to direct Caremark's sourcing policy and not to adopt a pricing strategy that discriminated against any independent homecare supplier. Caremark said that this was ultimately a matter for Fresenius but thought that such undertakings might be feasible if they could be structured so as to inspire confidence. There could, however, be difficulties over policing the undertakings.

## Views of Fresenius

### Jurisdiction

6.48. Fresenius confirmed that it was still its intention to buy Caremark Limited if approval were given following the MMC inquiry. It also confirmed that the gross assets of Caremark Limited were below £70 million and agreed that the question of jurisdiction turned, therefore, on the share of supply test in section 64 of the Act. Given that the two main areas of overlap between the existing supply of services by Fresenius and Caremark were high-tech home EN and PN services and that Caremark's share of the supply of EN services was in sharp decline because of the termination of its arrangement with Nutricia, Fresenius agreed that it would be appropriate to examine shares of supply of PN

services only. On that basis, Fresenius agreed that the share of supply test was satisfied in the light of the fact that Caremark's existing share of more than 25 per cent in PN services in the UK would be enhanced as a result of the merger.

## The background to the proposed merger

6.49. Fresenius said that the proposed merger was between two companies that had, in different ways, helped to shape the development of the emerging homecare markets for artificial nutrition (that is, EN and PN) and IV therapies. The purchase of Caremark would further one of Fresenius's objectives, namely to expand its business in home healthcare, which it regarded as a key area and a business that was here to stay, in view of the cost of keeping patients in hospital. It foresaw potential growth in the home healthcare market with the emergence of new therapies that would be suitable for delivery at home. The market could also grow considerably if Europe were to follow the USA in terms of disease management—homecare would play an important part in that process.

6.50. Over the past few years Fresenius had been moving towards separate product and service strategies. It had intended, before Caremark was for sale, to set up a new homecare company. It had recently set up a separate business unit which had allowed it to focus its efforts more clearly on homecare. The intention had been to run an entirely separate and independent operation, to be called Freedom Homecare, which would supply any manufacturer's products to patients at home. Its previous experience with its home dialysis service, Fastnet, had convinced Fresenius that total independence from the product business was the only way to achieve success in the homecare business. The change to a new brand name was intended to signal the independence of the homecare service and enable it to compete on equal terms. One of the attractions of Caremark as an acquisition was that it already had a tradition in home healthcare and a good branding. Fresenius told us that it would combine its existing homecare operation with Caremark's.

6.51. In its acquisition of Caremark, Fresenius recognized that the market conditions governing the provision of artificial nutrition, IV therapies and other homecare services could easily change and that this presented a major commercial risk. Nevertheless, it believed that there was a future for commercial suppliers of home healthcare services. The proposed merger of companies with highly complementary assets would allow Fresenius to expand its activities into a number of IV and other services that it did not currently offer. It told us that, leaving aside the merger, it intended to expand its existing business in PN and IG services, where it had a small patient base, and to move into other IV services, where it was not currently a significant player. Its projected patient numbers for the end of 1998 were 42 for PN, compared with 32 in 1997; ten for IG, compared with four in 1997; and 40 in other IV services (antibiotics, antivirals and chelation), compared with one patient at the end of 1997.

6.52. Fresenius believed that its expansion plans and its entry into a range of new homecare services that might be developed (for example, [ * ]) would be accomplished faster and more effectively under the Caremark brand name than by using its existing infrastructure. Caremark was recognized as an independent supplier, it already had experience of services that were new to Fresenius and it had investigated the market. Fresenius did not disagree that in the absence of the merger it could run an effective homecare service in the UK but thought it would take longer to become established if the merger did not take place.

6.53. We raised with Fresenius the agreed purchase price for CIBG. It confirmed that this was now US$[ * ] million, as compared with the price of some US$[ * ] million which was specified in the purchase agreement (see paragraph 3.48). Fresenius Limited said that it had not been a party to the negotiations leading to the agreement on a reduced price or its apportionment between the UK company and the other three companies, although it had given advice to the Fresenius negotiators. There had been a number of issues specific to Caremark's UK business, namely a deterioration in service quality, the loss or potential loss of some key business partners and the departure of the Managing Director. Fresenius told us that the new price was allocated [ * ] between the UK company and the other three companies, [ *Details omitted. See note on page iv.* ].

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*Details omitted. See note on page iv.

The price for the companies in Canada, Germany and the Netherlands had already been paid on the completion of the purchase of those companies.

6.54. Fresenius agreed that the final price in relation to Caremark's 1997 profits, after deducting the profits from the business it derived from Nutricia, suggested a PE multiple of about [ * ]. We suggested that this appeared rather high for a business with a low asset base, especially as Fresenius had commented that Caremark's reputation in the market had been damaged in recent months by deteriorating service quality. We also referred to projections prepared by Caremark's UK management and supplied to Fresenius which estimated a much lower figure (£[ * ] million) as a sensible price for the company (see paragraph 3.44). In the light of this evidence, we asked how the purchase price could be justified. Fresenius said that, as a multiple of sales revenue, the price did not seem nearly so high. The £[ * ] million in the Caremark document was an estimate by the former Managing Director of Caremark, who Fresenius believed was considering a management buyout. It believed this took account of the impending loss of the Nutricia business.[1] More fundamentally, Fresenius said that it was essentially buying the opportunity to get into the homecare market quickly, which it would find considerably more difficult to do as a product company. It needed the separate service business to give it credibility in the market and the speed to enter new homecare environments. Fresenius acknowledged that, as a German company, it took a longer-term view than a typical UK company might adopt and was prepared to accept a long payback period for the sake of establishing a position in a business with the potential for long-term growth.

6.55. We asked Fresenius to comment on the disjuncture between its rationale for the purchase of Caremark and the rationale suggested in a submission to the board of Fresenius AG in summer 1997, namely that the acquisition would, through backward integration, afford a further opportunity to sell Fresenius products. Fresenius Limited said that it was not its policy to substitute Fresenius products for those of other suppliers because such a strategy would not work in the UK. Any gain from so doing would be short term and the longer-term result would be a damaging loss of credibility and eventually a loss of business. Product substitution would in any event be very difficult because in every case the NHS customer prescribed the product taking account of the patient's clinical needs and it could not be changed without a clinician's agreement. A further consideration was that other product suppliers would refuse to deal with Fresenius if there was a danger that it would substitute its products for theirs. The board of Fresenius AG now understood this. The board would allow the management of Fresenius Limited to pursue its own strategy and would judge it by results. Fresenius Limited was confident that it would be able to resist any pressure, should it occur, from its parent company to opt for the synergies available from backward integration and product substitution.

## Market definition

6.56. We asked Fresenius whether, in its view, there was a broad market for high-tech home healthcare services. Fresenius inclined to the view that there was instead a series of separate markets, corresponding to the separate home healthcare services. In support of that view it said that on the demand side there was no substitutability between the different services. Each patient's needs were medically determined; whilst there had been some shift within artificial nutrition away from PN and towards less invasive and cheaper EN therapy, this had resulted from advances in medical technology and changed attitudes among clinicians. On the supply side, some elements of service, for example the home delivery operation, were substitutable but other elements were not. Competition for contracts for EN and PN tended to be decided on the basis of specific capabilities and expertise in serving patients. In some services, a link with the product and the supplier of the product was crucial. That created an entry barrier and prevented supply-side substitution.

6.57. We put to Fresenius a view that, on the one hand, there was fairly ready scope for a company with skill, experience and reputation in one service to move into another, so that in principle all the services under consideration in our inquiry were part of a single market, linked by supply substitutability. On the other hand, those parts of the market that fell under the GP prescription regime were effectively foreclosed to competitors, to a greater or lesser extent, in the sense that the feed or

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[1]We note, however, that the document itself appears to indicate that the author was expecting the Nutricia business to continue.

*Figures omitted. See note on page iv.

drug supplier had more or less complete discretion to decide on the service provider. Fresenius did not quarrel with that view. It agreed that there were strong elements of supply substitutability if the supply of service was looked at separately from the supply of product. It maintained, however, that it was not easy to move into new services. A company needed to identify the right products and put effort into marketing its service. Fresenius also believed that there were highly relevant differences between the way competition worked in the prescribed services and the contracted services, although this did not mean that there were no links between the two groups. Fresenius also suggested that EN services were significantly different from the other services.

## The market

### *The role of the NHS*

6.58. Fresenius said that the development of high-tech home healthcare and the partnership between the NHS and commercial providers had helped to improve the treatment of patients by delivering medical services into the community. This had benefited patients who preferred to receive treatment at home, as well as offering cost savings to the NHS.

6.59. The central role of the NHS could not be overstated in the assessment of the proposed merger. The NHS was not only the sole purchaser of home healthcare services and selected the treatment for patients at home but also offered the only real alternative, namely keeping the patient in hospital. NHS hospitals were themselves also able to offer most elements of home healthcare services, even though in practice they might prefer to leave the provision of such services to specialized companies. In Fresenius's view Government policy and the NHS Executive governed the nature of competition between companies in this sector and the NHS was a considerable negotiator, well able to regulate its purchasing. It said that the issue of EL(95)5 had resulted in the introduction of a successful tendering system for some home healthcare services. This had further increased price competition, as well as promoting market entry into the provision of PN services. Moreover, the recent White Paper[1] had announced changes in the way GP budgets in England were to be controlled. Fresenius believed that this would inevitably have a major impact on the competitive process by which EN services were purchased, in that they would cease to be prescribed services and become subject to tendering arrangements. Changes in funding arrangements might also encourage the larger Trust hospitals to enter the homecare market in competition with commercial providers.

6.60. We put to Fresenius the proposition that the NHS, although a sole purchaser, was in fact highly fragmented, with the different purchasing bodies varying considerably in the degree of sophistication that they brought to bear. Fresenius did not agree: it said that clinical teams within centres of excellence had a clear idea of what they wanted in terms of services to patients and a good knowledge of the companies active in homecare. In addition, the supplies function within Trusts always looked for the best price. Fresenius was not aware of any areas in the UK where Trusts were not vigilant over quality of service and price.

6.61. We asked Fresenius to comment on a suggestion made to us that HAs might not give high priority to negotiating sophisticated purchasing agreements for home healthcare services because a typical HA would have very few patients requiring them, so the cost would represent a very small proportion of total budget. Fresenius did not agree with this analysis. It believed that EL(95)5 had influenced HAs' behaviour and that a tender for one patient would be as vigorously contested as one for a large number of patients. Fresenius's own experience, however, related to purchasing by Trusts rather than HAs.

6.62. We also put to Fresenius data and comments we had received suggesting that there was considerable inertia in the system, with the great majority of contracts being rolled over and little movement of patients from one homecare provider to another. Fresenius said that there was some reluctance to switch existing patients from one provider to another if the service was satisfactory, not least because of a perception that patients would be unhappy with a change of supplier. Nevertheless, movement did occur and suppliers needed to be competitive on price as well as quality if they were to retain contracts. Although Fresenius had some long-standing contracts for PN services, they were

[1]See footnote to paragraph 4.46.

subject to periodic price review. Customers would generally obtain quotations from a number of suppliers in order to ensure that they were getting a competitive price. If patients continued with Fresenius they would be unlikely to do so at the same price as before. Since EL(95)5 had taken effect every one of Fresenius's PN patients had been included in either a formal tender or a request for quotations, and every existing patient was tendered for at least once every two years. Fresenius believed that the tendering process had led to lower prices and had also encouraged movement of patients between suppliers. As evidence of this it provided information relating to business it had won from, and lost to, other suppliers in 1997.

6.63. In further support of its view of the NHS as a purchaser, Fresenius informed us of a number of recent developments that it believed were relevant to our assessment. It said that Caremark had lost 60 IV services patients at Seacroft Hospital, Leeds, to Baxter following a competitive tender. Fresenius had also been an unsuccessful bidder. Caremark had lost at least four patients at Hope Hospital to Pharmacia. HaH had won a contract with Southampton General Hospital. At Addenbrooke's, Caremark had retained the contract for 11 to 14 patients for 12 months. However, the next two patients would be given to HaH and the two after that to Pharmacia.

6.64. Fresenius suggested that there was an increasing tendency for NHS purchasing bodies to enter into sponsorship arrangements with homecare suppliers. For example, one Trust had sought a substantial sum of money in order to set up a new unit and in Fresenius's view this had influenced the award of the contract for homecare services. As a result, Fresenius had lost six patients. Fresenius was not in favour of this approach and preferred to bid solely on price. Its own sponsorship within the NHS was limited to a contribution to the employment costs of a nurse in one hospital.

## *Market entry*

6.65. Fresenius said that the total costs of entry to the market would depend on whether a regional or national operation was planned and whether the NHS purchaser required comprehensive support or would accept more limited back-up from the homecare company. Costs of fixed assets such as buildings, equipment and vehicles need not be high as all could be leased. Single-use items, such as drugs and some disposable equipment, could be bought as needed. It was, however, important to have high-quality staff and this represented a relatively high cost. Fresenius said that there were irrecoverable costs in homecare because products bought for one patient but unused would not generally be suitable for another patient.

6.66. Barriers to entry were relatively low in that expertise in the provision of one service was transferable to other services. Suppliers were able, to varying degrees, to extend their operations from one service to others.

6.67. In the provision of PN services, the tendering process introduced in 1995 had facilitated entry. Upstream suppliers of products could easily expand into home healthcare provision; Baxter and Pharmacia had done so recently and there were other major companies which had the relevant expertise to offer PN services. Fresenius suggested that one reason for entry to this relatively small market, which was not expected to grow substantially, was that PN was a complex and demanding treatment, both medically and operationally. As such it demonstrated the competence of the provider and provided a springboard for other activity.

6.68. Fresenius expected entry into EN services to occur as had happened in PN. All the companies active in the PN market were in principle capable of extending their business into EN. Fresenius believed that several of them would do so in the near future and that the NHS would be receptive to new entry of reputable companies from the PN sector. A major pharmaceutical company (Novartis) was considering entering the EN homecare market and Nestlé, the world's largest food company, was in the process of setting up its own clinical nutrition division.

## *Economies of scale and scope*

6.69. Fresenius said that if a service provider bought in products and equipment then buying power tended to increase with volume of purchases. The advantage of this was not so much over price, where there was generally little room to negotiate with major pharmaceutical companies, as

over other conditions of supply such as quality of service. Scale economies tended to be more relevant in distribution and warehousing. Economies were not, however, very significant and did not apply to all services. They had little effect on entry and competition. The NHS purchasers controlled access to the market: if a Trust wanted a new entrant to become established it could accept a bid even though it might not be the most competitively priced. Fresenius believed that this had happened on occasion, although there was increasing pressure on purchasers to accept the lowest bid. More importantly, an NHS purchaser could offer an entrant the use of in-house compounding facilities as well as assist in distribution, thereby effectively negating any cost advantage that a larger provider might have.

6.70. We asked Fresenius about the advantages derived from having an in-house compounding unit and whether this was an economy of scale. Fresenius claimed that the main benefit was the flexibility it offered. The facility could be used whenever needed whereas the NHS units tended to work a five-day week and charge a premium for orders fulfilled out of hours. It was not necessarily cheaper, however, to use the in-house facility for everything, because the NHS units tended to price at marginal cost.

6.71. There were economies of scope to the extent that the delivery infrastructure could be used to provide more than one homecare service. This was an advantage but did not constitute a barrier to entry because of the option to use NHS facilities. Fresenius said that economies of scope became more important once a service provider sought to operate more autonomously. Experience in one service facilitated entry to other services but Fresenius had not found that a high proportion of Trusts were looking for contracts for a range of services. There was, though, some recent evidence to suggest that multi-service contracts were becoming more common. Fresenius was unable to comment on HA contracts.

## The effects of the merger

### *Competition*

6.72. Fresenius said that the merger did not present competition problems, for a number of reasons. The overlap between the activities of Fresenius and Caremark was confined to PN, EN and two of the IV services, namely IG and antivirals, and the merger would have different effects in each of the markets.

6.73. We put to Fresenius the concern that the very high market shares that would result from the acquisition would lead to higher prices for homecare services than would otherwise be the case, especially given the need for a return on the high price which would have been paid for Caremark. Fresenius said that it was not possible, in a situation where there was only one purchaser, to raise prices excessively. The NHS would simply find another supplier or provide the service itself and the Caremark business would lose market share.

#### *PN services*

6.74. In respect of PN services, Fresenius estimated that the merged company would have a market share of some 74 per cent. It argued, however, that any competition concerns based on market share were groundless. Competition in PN services had become increasingly vigorous over time and the regular competitive tendering system for contracts introduced in response to EL(95)5 had facilitated entry to the market and led to frequently changing contracts. The combined share had in fact fallen from 83 to 74 per cent over the past five years, although Fresenius's share had risen slightly. Fresenius said that market share at a given time was an inadequate indicator of the effect of the merger on competition. It was more meaningful to analyse the number of contracts won and lost over a recent period and to evaluate the inherent volatility of contracts held.

6.75. We put to Fresenius a suggestion made to us that PN services were now entering a critical period—it had taken a while for EL(95)5 to have an effect, but the market was now changing significantly—and that the merger at this time of Caremark and one of the two other significant, although much smaller, providers could make it very difficult for emerging new companies to establish themselves. Fresenius did not agree. It said that the NHS was active in looking for new players in the

market in order to foster competition and that there was evidence even in the past few months of some of the smaller companies having gained business.

6.76. We suggested that competition between Fresenius and Caremark must have been an important element in the fall in price of PN services since 1995. Data provided by Fresenius on patient numbers and number of contracts won indicated that it had been the most effective competitor to Caremark. We needed, therefore, to give considerable weight to the loss of that competition as a result of the merger. Fresenius said that there would still be seven companies supplying PN services after the merger. In its view, the NHS should also be regarded as a competitor. There was the potential for entry by other companies. Furthermore, the combined market share of the companies other than Fresenius and Caremark was larger than Fresenius's share and was increasing. HaH, for example, had recently been awarded a contract for a number of patients by Northwick Park & St Mark's NHS Trust, which would increase its share significantly. Fresenius believed that Pharmacia had considerable potential to compete in the market: it had a 60 per cent share of the supply of PN products to hospitals and a similar proportion of PN patients at home used its products. Baxter was another likely competitor, with a 23 per cent share of supply to hospitals. It also had the advantage of extensive experience in homecare services for patients on CAPD, and from its previous ownership of what was now the Caremark business.

6.77. Although the extent of vertical integration within the PN services market had increased as a result of the entry of Pharmacia and Baxter, Fresenius believed that there was a future for independent homecare companies because the NHS would give them business in order to maintain competition. The removal of Caremark, an independent supplier, was not a matter for concern because Fresenius's intention was to run its homecare service as a separate business, independent from its product business. In addition, it believed that other independent companies would enter the market.

### *EN services*

6.78. In the EN market, the ending of the partnership between Caremark and Nutricia meant that effectively all Caremark's market share was likely to be lost. The merger would not augment Fresenius's market share. Fresenius commented that, if anything, the merged company would become a stronger competitor to the dominant suppliers of EN services, Abbott and Nutricia, as it would be seeking to regain the patient base lost by Caremark. It believed that Caremark, owned by Fresenius but run as a free-standing service provider, could win business with other product suppliers.

6.79. Fresenius showed us ten-year projections in which it had assumed that, after the loss of the Nutricia business, Caremark's market share would rise again to about [ * ] per cent by 2006 from contracts with manufacturers new to the market (see paragraph 6.68). Fresenius accepted that this was an optimistic view and that it might be difficult for Caremark to secure business from manufacturers who would regard Fresenius as a competitor. However, it believed that Caremark's reputation as an independent supplier would help it achieve the target. Fresenius also expected that the NHS would take action within the next ten years to separate the purchase of EN products and services.

### *IV services*

6.80. In IV services, which encompassed IG and antivirals, the effect would be negligible as Caremark's share would be increased by approximately 1 per cent. The NHS was by far the largest provider of antivirals. The market for IV antiviral services had declined considerably since 1995, and was expected to decline further, because of the development of oral preparations which had largely replaced the IV treatment.

### *Other services*

6.81. Fresenius said that there was no overlap between its activities and those of Caremark in the provision of other high-tech home healthcare services. These markets, with the exception of CAPD,

*Figure omitted. See note on page iv.

were generally underdeveloped but could grow if the NHS was prepared to collaborate with commercial companies.

### *Vertical integration*

6.82. We raised with Fresenius concerns that had been put to us about the opportunity that the merger would give it, in the provision of home healthcare services, to substitute its own products for those of its competitors. Fresenius said that its strategy of running the homecare business independently would help it to attract third party suppliers, especially in the provision of IV services, an area in which it was particularly interested in expanding. It would not succeed if it went down the route of product substitution because it would lose credibility as an independent business. It believed the NHS would not tolerate substitution and would be likely to respond by inviting separate bids for the supply of product and service.

6.83. As evidence of its policy, Fresenius told us that it had been approached by Caremark, when it was clear that the agreement with Nutricia would end, for the supply of EN products as an alternative to the Nutricia products. Caremark was exploring this possibility with a view to retaining at least some of the business: it believed that for about half of the Nutricia patients the service supplier was more important than the product. Fresenius told Caremark that it was unwilling to supply, unless Caremark could offer customers the choice between Fresenius products and those of another manufacturer, because of its concerns about the potential loss of credibility for its policy of running separate product and service businesses. Caremark did not pursue this further and instead came to a satisfactory arrangement with Nutricia for the transfer of patients.

6.84. Fresenius was by no means totally self-supplying: in January 1998, for example, only four out of its 33 current PN patients were receiving Fresenius products, and it told us that it had on occasion bought in products at a loss in order to meet clinicians' preferences for non-Fresenius products. In view of Fresenius's comments that the squeeze on prices in recent years had been largely on the service side, we asked it why it wanted to expand that part of its business without a link to the product side, where it could perhaps expect to make more money. Fresenius said that it believed the NHS would increasingly split the provision of products and service, with the result that products would come under greater price pressure whilst service would have to be paid for at a reasonable level. There was evidence from the Avon tender (see paragraph 4.115) that this was already starting to happen in EN services. There were also new product suppliers coming into the market (for example, Novartis and Nestlé in EN) who might be looking for an independent homecare supplier.

6.85. Fresenius recognized that the option of using its own products could give it a certain advantage in negotiating competitive prices as a buyer from third parties. We put to it, however, the possibility that after the merger other manufacturers would cease to regard Caremark as an independent business, despite the best efforts of Fresenius, and would either refuse to supply or charge a very high price to prevent Caremark from providing patients with the products specified by clinicians. Fresenius said that in those circumstances it would ask the appropriate HA or Trust to inform the manufacturer that Caremark was its preferred distributor. It believed it would then be difficult for the manufacturer to threaten Caremark's supply because it could not afford to alienate the NHS.

### *Benefits*

6.86. Fresenius believed that the merger would secure a future for Caremark, a company that in recent months had suffered from a lack of interest and direction from its parent company, uncertainty about the future and a high turnover of staff. Fresenius was aware from its extensive contacts in the industry that there were some concerns about a decline in Caremark's standard of service. Fresenius was confident that it had the experience, commitment and systems needed to overcome these problems.

6.87. Fresenius did not expect any significant economies of scale as a result of the merger although it thought that it would be able to use Caremark's existing resources more effectively.

Compounding was the main area where savings might be achieved either through greater utilization of Caremark's facility at Harlow or by some rationalization, but no decisions had been taken.

## Remedies

6.88. We asked Fresenius to consider whether, in the event of our concluding that the proposed merger might be expected to operate against the public interest in respect of the supply of PN services, there were any practical remedies available short of prohibiting the merger. Fresenius's view was that the merger would not be anti-competitive and accordingly no remedies were required. It was, however, prepared to give its views on a purely hypothetical basis.

6.89. Fresenius commented that any undertaking that required it not to bid for new PN business, either for a given period of time or after it had achieved a given number of patients, would in itself have the effect of removing competition from the market.

6.90. We invited Fresenius to consider a possible undertaking to the effect that its subsidiary Caremark would be given complete operational independence in its choice of products and supplies and could buy them from wherever it wished. Having confirmed with us that such an undertaking would not prevent Caremark from buying from Fresenius if it so wished, Fresenius said that it could not object in principle to the hypothetical undertaking since it accorded with its intention of running Caremark as a separate, autonomous company.

6.91. Commenting on a suggestion that it should be required to give an undertaking not to supply Caremark on preferential terms, Fresenius said that it did not see how this would benefit its competitors because it was not dominant in the supply of products. It confirmed that it intended Caremark to operate at arm's length from Fresenius but suggested that action by the NHS to separate the purchase of products and services would be the best safeguard against discriminatory pricing.

D J MORRIS *(Chairman)*

J BEATSON

P MACKAY

J A REES

A STEELE

P A BOYS *(Secretary)*

9 March 1998