

# 6 Views of IMS

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## Introduction

6.1. In this chapter we summarize the evidence put to us by IMS in its written submissions and at two hearings. To begin with we record its reasons for the acquisition of PMSI and its plans to integrate the businesses. We then summarize its views on the definition of the relevant market, competition in the market and the effects of the merger. We go on to record its comments on possible remedies in the event that we found the merger might be expected to operate against the public interest. The chapter concludes with a summary of the evidence given to us separately by the former management of PMSI.

## Reasons for the acquisition

6.2. IMS said that PMSI had initiated the acquisition, first approaching IMS in 1996 as a possible alternative bidder to NDC, which had made an offer to purchase PMSI worldwide. Talks with IMS had been discontinued during the course of protracted negotiations with NDC, to whom the US Source business had been sold in December 1997, NDC having declined to buy the non-US businesses. Talks with IMS about the sale of the rest of the business had been resumed in January 1998. The transaction was valuable to both parties. IMS viewed it as a global transaction through which it would gain a product and a management team from PMSI covering a number of countries. The main value of the transaction to IMS was that it would allow it to fill territorial gaps in its services: in France and

Germany, for instance, it would be able for the first time to develop and sell a micromarketing service, and it would be helped to enter markets in other countries, such as Japan and Spain. In the UK IMS would obtain three different businesses. Two of them (Mediphase and Medical Research Factors Ltd) offered only services which IMS did not offer. The third business, Source, offered two products with which IMS did not compete (*Dispenser* and *OTC Adviser*) and three with which it did compete (*Prescription Audit*, *Prescriber* and *Micromarketer*). IMS commented that the transaction would have a limited impact in the UK, especially in the micromarketing services, which, on 1997 figures, accounted for only about 2.5 per cent of the turnover acquired. In fact the UK businesses were only a small part of a global transaction.

6.3. From PMSI's point of view, the transaction was valuable because it resulted in an alliance with a company that could afford to develop its new product to the quality demanded by customers and in the time desired by those customers. IMS commented that the combination of the sources selling prescription data to itself and PMSI would allow it to provide a better service to customers more quickly than either of them could have done alone. Customers would benefit from the combination of two different business approaches: IMS's strengths in the processing of large quantities of data and PMSI's creative and innovative approach in providing services to meet specific needs and, in particular, marketing needs.

### **Integration of the businesses**

6.4. Following the closing of the transaction on 5 August 1998, IMS and PMSI in the UK had taken certain steps to integrate their businesses. A common management team for IMS and Source had been put in place and had been working towards a single prescription database service, combining the best elements of the two companies' prescription audits and micromarketing services. The combined service was unlikely to be fully developed until February 1999, although some pilot data might be available earlier. The new product would eventually be sold as *Xponent*, but at present IMS and PMSI were continuing to supply their own distinct services under different brand names. Although the two systems were being kept separate, some of the pharmacy data were effectively being shared in the interests of providing a better service to customers. There had been collaboration between statisticians on the development of a new projection methodology for the new service, but in the meantime both the IMS and the Source methodologies were continuing to run.

6.5. IMS had developed new extraction software for use with the PMSI Mediphase pharmacy software. The new extraction module worked in the same way as other data extraction software, downloading data from the pharmacy management software on the same computer system. It did not replace the Mediphase software.

6.6. Some former PMSI staff were now working for IMS. PMSI's prescription audits and micromarketing services were being produced with PMSI data and equipment, operated by IMS staff. A number of the PMSI staff responsible for these services had resigned after the merger and others had been notified of their redundancy.

6.7. IMS told us that on 17 December 1998 it had given interim undertakings to the DGFT to the effect that it would (except with the prior written consent of the DGFT) carry on the IMS and PMSI businesses separately and take no action to prevent PMSI from being carried on as a viable business.

### **Market definition**

6.8. IMS said that the data services supplied to pharmaceutical companies by itself and PMSI addressed three important needs. First, companies needed to identify which products to sell, how to price them and where to position them in the market. These questions were answered by market research departments, using data from audits. Secondly, companies needed to know how, and to whom, to sell their new products. These questions were answered by marketing departments using profiling and micromarketing services. Thirdly, they needed to remunerate their sales forces and assess how well their products were selling in relation to those of competitors at a sales territory level. Sales departments answered these questions using STRs.

6.9. Data for the various information and monitoring services sold by IMS and PMSI were collected from all levels of the pharmaceutical supply chain. In Western Europe and the UK, pharmaceutical products were principally distributed through wholesalers to retail pharmacies and, to some extent, to hospitals. Data were collected from wholesalers that could be used to identify 'bricks', from which pharmaceutical companies built sales territories into which pharmaceutical products (both OTC and prescription) had been sold. In addition, the distribution of products by retail pharmacy chains from their warehouses to individual retail pharmacies was also counted. Some pharmaceutical supplies were, however, bought direct from manufacturers, bypassing wholesalers. Data on those sales were therefore also needed in order to obtain a complete picture of the pharmaceutical products reaching the market place from the wholesale level. Supermarkets and larger grocery stores were additional sources of data on OTC sales. Prescription data were generally collected from pharmacies' prescription databases, which provided information on the product prescribed, the product dispensed and the prescribing physician. IMS told us that the accessibility of data from pharmacies would continue to increase as computerization progressed. (The majority of pharmacies in the UK already had computerized prescription management systems for keeping records of prescriptions dispensed, printing labels, controlling stock etc.) Prescription data represented no more than the data contained in the actual prescriptions written by physicians and the only criterion for a pharmacy's participation in a contributing panel was that it must be computerized and capable of providing good-quality data. Quantitative information linking prescriptions, some patient details and diagnosis was collected from GPs from their practice records, often stored in their practice computer systems. Qualitative information about prescribing practices was collected from doctors and other healthcare professionals by means of questionnaire surveys or interviews. IMS also collected prescription data from hospitals.

6.10. Data from each source could be used to provide services at national, regional, territory or local level, depending on the end-use. National data were either projected from samples of various sizes collected from representative panels of pharmacies, GPs or wholesalers throughout the UK or comprised aggregated data collected in local-level services. In fact IMS was able to provide wholesale data based on sales at near to census level. Regional and territory data were also projected from sample data, or comprised aggregations of local-level data. Local-level data were used for local-level OTC services, such as *OTC Adviser*, individual pharmacy-level services, such as *Source Dispenser*, and micromarketing and GP-level prescription services. Micromarketing data were projected from a sample of prescription data from a representative panel of pharmacies in the UK, and GP-level data provided prescription data on specific doctors collected from pharmacies on the representative panel. GP-level data were not currently extrapolated by IMS, so any data collected could be sold with comparatively little processing.

6.11. IMS maintained that each of its or PMSI's services addressed a particular customer need. This was reflected in the fact that different customers within each pharmaceutical company bought different products and that sales and prices of particular products had not been affected by the introduction of new ones. There was therefore no demand-side substitutability between the individual services, because different products were used for different purposes. Commenting on experience in other national markets, IMS acknowledged that in the US sales force analysis could be based on either prescription or wholesale data, but said that the two products were very different in terms of coverage, since the prescription data product contained only details of prescriptions by the equivalent of GPs and did not include sales of all OTC products or sales into hospitals and clinics. For that reason, customers used the two products for different applications, depending on the channels into which they sold their products. Furthermore, even where their end-use applications overlapped, the two data products were possible alternatives only because, unlike in the UK, the prescription services were based on a very large sample of prescriptions whilst wholesale data were available only at comparable sample level, as opposed to census level. Even in these circumstances, sales of wholesale data products in the USA had continued to grow even after the introduction of prescription services. In Canada, there had been no erosion of sales of wholesale data products following the development of prescription data products, and in fact sales of the former had increased. The fact that customers bought both types of product tended to confirm that they were not substitutable. Moreover, notwithstanding that virtually the same skills and technology were used in the production of the broad types of service, supply-side substitutability was limited because of the different input data required for each, requiring different collection and processing methods. (The fact that the same skills were used in the pharmaceutical field as in other market research areas was indicative of ease of entry rather than supply-side

substitutability.) IMS concluded that, in these circumstances, each service constituted a separate relevant market.

6.12. IMS also maintained that the geographic market for each of its and PMSI's services was, at most, national. It said that the pharmaceutical sector was fragmented along national lines throughout Western Europe, with different prices, trademarks and regulatory regimes in each country. Furthermore, there were differences in the pharmaceutical distribution chain in each country, even within the EU. Consequently, the same services might not necessarily be appropriate to every country, and the data needed for any given service might have to be developed differently in each country.

## **The future of prescription data services**

6.13. IMS told us that there were legal uncertainties surrounding prescription data services, in particular the future of micromarketing services. These uncertainties were to do with confidentiality issues in relation to patient information. IMS's understanding of the legal position was that the Data Protection Act 1984 (the 1984 Act) provided strict guidelines as to the circumstances in which personal data might be processed. Identifiable data might not be provided without the consent of the subject, except in certain specific cases. Any person or company holding or processing data had to be registered with the Data Protection Registrar. There were criminal and civil sanctions for breaches of the 1984 Act. In English common law, there were further confidentiality issues relating to the supply of medical and pharmacy data. IMS was of the opinion that consent was not needed for the disclosure of any information that was anonymous or anonymized. In the case of prescription data, the GP's consent was required under the 1984 Act for any information that would identify him or her, but was not required for the collection of data from which the GP could not be identified. IMS believed that the patient's consent was not required for the collection of prescription data because none of the information was identifiable as the patient's. IMS's view was that this position was not materially changed by the Data Protection Act 1998. IMS understood the DH's view to be that any information given in a relationship of confidence (or in circumstances implying confidentiality) had, and retained, the quality of confidentiality regardless of whether the information was anonymized. The DH maintained, therefore, that prescription data might be collected only with the consent of the patient. IMS added that the provision of personal data in the UK was also governed by the ethical rules of the pharmacy and medical professions. Members of both professions were prohibited by those rules from disclosing the identity of a patient without his or her consent, except in specific circumstances. IMS noted that both the Data Protection Registrar and the professional bodies had been consulted about the services in question and had apparently accepted, respectively, that the collection of prescription data would not in principle infringe the statutory requirements or the ethical rules.

6.14. IMS said that it was necessary for any enterprise active in the market for the collection of pharmaceutical sales data to comply rigorously with the legal and ethical requirements. This was particularly important given the need to retain a consistent source of data supply. If wholesalers, pharmacists or prescribers lacked confidence in the ability of the data marketer to abide by these rules, they would very probably stop supplying data immediately, rather than risk leaving themselves open to legal action, criminal penalties and/or professional disciplinary sanctions.

6.15. In 1995 IMS had begun to investigate the development of a service based on information gathered from retail pharmacy computer systems. This was to become the *Xtrend* micromarketing service and the intention was that it would be able to provide information about the prescribing of identified GPs. In accordance with the requirements of data protection and confidentiality and the views of the RPSGB and the BMA, IMS had decided to obtain such identified information only if the GP in question gave permission to the pharmacist for it to be released to IMS. In the summer of 1997 IMS had written to all GPs in the UK requesting such permission. Some GPs had referred the letter to their Health Authorities for guidance. In July 1997 the DH had written to Health Authorities in England stating, among other things, that 'Anonymisation (with or without aggregation) does not, in our view remove the duty of confidence towards the patients who are the subject of the data'. Health Authorities had circulated extracts from this letter to GPs and others. The circulation of these views had not unnaturally caused concern and a number of data suppliers to IMS had withdrawn their supply or, in the case of GPs, their permission to be identified. The DH's letter had come as a surprise

because Source had previously received clearance from the Data Protection Registrar and had reached agreement with the BMA and the RPSGB on the ethical issues surrounding release of the data.

6.16. IMS said that the doubts caused by the DH's comments represented a significant constraint on the development of micromarketing services. It, and PMSI, had made sustained efforts to reach a negotiated solution with the DH. When, by the end of 1997, these efforts had borne no fruit, Source had taken the decision to seek judicial review of the DH guidance. The outcome of the application for judicial review would have a profound effect upon the development of the market for prescription data services. IMS thought that if the application were successful, the growth of micromarketing services might be stimulated and the PPA might well be encouraged to become commercially active in this sphere. If the application were dismissed then the future of prescription services in general, and micromarketing services in particular, would be jeopardized. IMS was aware, however, that even if the application were successful, it would be open to the DH, on policy grounds, to take other steps to prevent the release of prescription data. This would effectively close down the market [ *Details omitted. See note on page iv.* ].

## **Competition in the relevant markets**

### ***IMS and PMSI***

6.17. IMS said that in the UK it had overlapped with PMSI only in the supply of prescription audits and micromarketing services. There was no overlap in the sale of STRs: although PMSI sold a service called *Source Dispenser* that showed sales by BAPW members of a specific manufacturer to a particular pharmacy, it did not have the same end-use applications as IMS's STRs because it did not permit comparison among competitors' sales nationwide or at a regional level. Neither could it provide a complete picture of the individual customer's own sales, since it provided only sample data compared with the census level data provided by IMS's STRs. Similarly, although both IMS and PMSI sold products based on OTC data, they were not substitutable. PMSI's product, *OTC Adviser*, provided weekly data, again collected from BAPW members, on sales out of one or more retail pharmacies of identified OTC products sold by the company buying the service. Unlike IMS's *Pharmatrend*, it provided no comparative data on sales of other OTC products. Nor was *OTC Adviser* a substitute for IMS's *OTC Retail* product, which was based on sales of OTC products into retail pharmacies and supermarkets.

6.18. With regard to competition between IMS and Source in the supply of micromarketing services, IMS said that Source had taken the first steps in every country to develop the service, but in the UK IMS had not been far behind and had in fact been slightly ahead of Source in writing to GPs asking for their permission to use identified prescribing data. However, competition had not been IMS's real concern in the development of micromarketing. The most important consideration for IMS had been to get the product on the market as quickly as possible.

6.19. Commenting on PMSI's development with the BAPW of *Source Dispenser*, IMS said that the BAPW had itself started the service and had invited PMSI to market it. *Source Dispenser* did not attempt to replicate or compete with IMS's product. It could supply a customer with details of sales of only its own products into pharmacies, down to the level of the individual pharmacy. It did not provide any comparative data. It had seemed to PMSI that this was a good match with the provision of GP-level data in a micromarketing package. IMS commented that no customer buying *Source Dispenser* had cancelled IMS's product.

### ***Competitors***

6.20. IMS said that it faced competition across nearly the whole range of available services. The wide range of competitors included some of the world's largest and most experienced market research and marketing companies such as NDC, Quintiles, IRI, TNS and Nielsen. In the areas where IMS and PMSI overlapped—prescription audits and micromarketing services—both parties sold a prescription audit. There were currently no suppliers of micromarketing services in the UK other than PMSI, although IMS had expected to have a skeleton micromarketing service available by the end of 1998.

6.21. As regards prescription audits, TNS was the largest supplier in the UK and would continue to be a significant competitor. Its *Scriptcount* service was an audit of prescriptions filled by participating pharmacies. Moreover, TNS was a well-known international information/sales-monitoring provider. In the UK it provided a number of services specific to the pharmaceutical market as well as its other more general information/sales monitoring services, and it had been active in the healthcare sector since the mid-1970s.

### ***Potential competitors***

6.22. In IMS's view, the PPA was by far its most important potential competitor in the market for prescription data services, because it alone held all prescriptions written in England, collected from pharmacies for the purpose of calculating pharmacists' reimbursement for dispensing NHS prescriptions. At present, IMS and PMSI were both reliant on sample prescription data, and could not therefore compete with the PPA's archives. That would be the case whether the PPA chose to market the data alone or allow customers or competitors access under licence. Pharmaceutical companies would value highly the opportunity to gain access to its comprehensive prescribing information. IMS told us that the PPA had argued for many years that it should be allowed to sell the prescription data it held. Were these data to become available, the PPA would likely become the leading supplier of prescription data.

6.23. In IMS's view, other suppliers of sales monitoring/information services active in analogous market areas within the FMCG sector could enter the prescription data services market quickly and easily. These suppliers had ready access to the technology and skills needed to develop services in competition to IMS, since exactly the same technologies and skills were used throughout the FMCG sector. Five companies—three already active in the UK and the other two leading US suppliers—were particularly well placed to switch quickly and easily among the various services. IMS drew our attention to recent developments that confirmed the absence of barriers to entry and indicated the fast-changing environment within which the merger should be assessed.

6.24. Nielsen, the world's leading market research company, had already acquired all the skills necessary to participate in pharmaceutical sales monitoring/information services, first, from its experience in the general retail sector and, secondly, from operating its OTC audit. Its entry into other pharmaceutical-based sales monitoring/information services would, therefore, be exceptionally easy. (Nielsen had been one of the first organizations to offer audits in the pharmaceutical field.)

6.25. IRI had initially collected, processed and sold data in the general retail sector, and, more specifically, in health and beauty services. In about 1992 it had concluded an exclusive deal with Boots to collect its OTC pharmaceutical data. Since then, its revenues in the UK had increased significantly and it was now the fourth largest of the UK market research companies. Its skills, technology and expertise could easily be extended to another service.

6.26. NDC was one of the leading providers of information and sales monitoring services in the USA, where it had acquired the successful Source business and was a formidable competitor to IMS. It had all the skills, technology and expertise needed to provide audits, micromarketing, profiling services or STRs in the UK. NDC's complaints to the European Commission and the Belgian Competition Council alleged that, among other things, IMS's conduct had prevented it from gaining entry to European markets. IMS told us that NDC had not gained entry to these markets because of a non-compete agreement that NDC had signed with Source Europe. IMS maintained that the merger would improve competition in the relevant markets because that non-compete agreement had ceased to have effect on its acquisition of PMSI. NDC had recently bought three pharmacy software companies in the UK that had facilitated its obtaining access to data held by a large number of pharmacies. IMS believed that NDC would have immediate access to prescription data in around 35 per cent of UK pharmacies as a result of the acquisitions, and commented that this pattern of entry acquisition mirrored NDC's successful entry strategy in the USA.

6.27. TNS, which was already a competitor in the supply of prescription audits, could easily extend its service to provide micromarketing or any other sales monitoring/information services. IMS said that this depended only on TNS increasing the number of pharmacies it dealt with in order to provide local-level data services: no extra skills or technology were required. In addition, TNS's

business in sales monitoring/information services for other consumer goods had given it extensive experience in delivering data-collection and processing services.

6.28. Quintiles must also be considered a potential competitor. It had recently bought both PMSI's US businesses and Envoy, a US-managed healthcare company, in the space of a week. IMS submitted to us, as evidence of Quintiles' intentions, a *New York Times* article of 17 December 1998 in which the Chief Executive of Quintiles said that, although the company did not then compete with IMS, the purchase of Envoy would enable it to deliver more real-time data than IMS currently delivered. IMS commented that these recent purchases by Quintiles were powerful indicators of its strategy of entering the pharmaceutical information industry.

6.29. Cégédim, the leading French supplier of pharmaceutical business information services, had acquired Reuters Health Information (Reuters) on 24 December 1998. Although Reuters was not in itself a competitive threat to IMS, the acquisition was, in IMS's view, an indication that Cégédim was attempting to establish a presence in the UK as an impetus for entry into IMS's markets. That view was based on the fact of Reuters' long history of involvement in the healthcare sector in the UK and in particular its ownership of VAMP, a leading supplier of GP practice management systems.

6.30. IMS told us that its customers in the pharmaceutical industry were also potential entrants. They had already participated in the sales monitoring/information services markets in three different ways and the same routes would be open to them in future. First, pharmaceutical companies had, in a number of EU countries, formed partnerships with wholesalers to collect and process all sales data. [

*Details omitted. See note on page iv.*

] Secondly, where the pharmaceutical industry wished to have an additional supplier, it might choose to fund the start-up costs of that business. For example, Scott-Levin, PMSI's former US subsidiary, which had recently been sold to Quintiles, was funded in advance by payments from customers. Thirdly, when pharmaceutical companies had chosen not to develop information/sales monitoring services themselves, they might instead have funded other companies to develop services for them, thus obtaining the services that they needed whilst also controlling new entry to the market. IMS told us that several new information/sales monitoring services introduced in the past ten years had received initial funding from a pharmaceutical company. For instance, the development of PMSI's *Micromarketer* was funded by 'partner clients' who received exclusive access to the funded services for a minimum period of two years and at considerable discounts in return for what were effectively advance payments. IMS believed that the pharmaceutical industry had advanced around £6 million towards the funding of PMSI's prescription data services generally, although those advance payments were intended to pay for services throughout Europe and not just in the UK.

6.31. Data suppliers were also strong potential competitors, particularly with increasing consolidation among pharmaceutical wholesalers and pharmacy chains, and IMS suggested that they were well aware of the value of the data they held. It drew our attention to the acquisition in December 1998 of two UK wholesalers by Phoenix Pharmahandel AG (Phoenix). As a result, AAH, Alliance UniChem, Boots and Phoenix together accounted for over 80 per cent of all UK wholesaler sales data and around 30 per cent of prescription data (through their own pharmacies and pharmacy software companies). This strength had raised data suppliers' bargaining power with IMS on the one hand and, on the other, allowed them to gather data to offer competing services. AAH supplied a service to measure all sales of an individual company through AAH outlets nationally. This service did not presently compete with IMS's NSAs or STRs, because it did not provide any national estimate of a manufacturer's total sales or any comparative sales data. IMS argued, however, that AAH's ability to develop and market such a service was indicative of the ease with which any information/sales monitoring service could be established. It commented that in Holland it had lost about [  $\approx$  ] of its business [  $\approx$  ] after wholesalers had decided to band together to provide services based on wholesale data. There was nothing to prevent wholesalers in the UK from doing the same.

6.32. IMS said that it supplied data to value-added consultancy companies in order that they could process those data for the pharmaceutical companies who were their clients. They interpreted the data collected and processed by IMS as well as data provided by the pharmaceutical companies. IMS maintained that it was now competing with many of these companies for business from the pharma-

ceutical companies. IBM had recently acquired one such consultancy company (the Wilkerson Group) and IMS believed that other IT companies were entering the markets in the same way.

### ***Barriers to entry***

6.33. IMS argued that there were almost no barriers to entry into any of the markets for its services, and particularly into the markets for prescription audits and micromarketing services. (It acknowledged, however, that entry to micromarketing services was implausible so long as the current uncertainty over the legal position continued.) With regard to access to data, it said that the raw materials needed to build a database such as uncompleted questionnaires, service coding details, diagnosis codes and doctor speciality details were publicly available. In micromarketing services, IMS also told us that it was to publish the details of the methods it employed to ensure patient confidentiality. Transaction records could be purchased from pharmacies, wholesalers, doctors and hospitals. Questionnaires could be sent to doctors using mailing lists, which were available from a wide range of suppliers. In respect of services based on prescription data, IMS currently collected information on every pharmaceutical product available on prescription, including each form and strength in which a product was available. It therefore attempted to cover all pharmaceutical sales and turnover in the UK. IMS told us that there were no intellectual property rights that prevented new entrants from obtaining access to raw data. Intellectual property rights in the data provided to IMS were considered to remain in the data provider and IMS paid for, or otherwise received, only the right to use those data within its reports.

6.34. IMS stated that it no longer had any exclusive contracts with retail pharmacies for the supply of prescription data. In the past it had had one such arrangement with TNS for the supply of pharmacy data, but that contract was no longer exclusive and in any event had accounted for only 15 per cent of pharmacies. Nor, to its knowledge, did any other company have exclusive contracts in relation to prescription data, so there were no contractual barriers to accessing data from pharmacies. As far as data from wholesalers were concerned, the BAPW had given a notice under its contract with IMS that would enable the BAPW to terminate the contract on 31 December 1999. Any further contract with the BAPW would not be on exclusive terms. IMS drew attention to an undertaking given by Nielsen to the European Commission in November 1996 following an investigation. Part of the undertaking was that Nielsen would not enter into any exclusive data arrangements. IMS had been a sister company of Nielsen in the D&B group until just before the date of the undertaking. Although technically not a party to the undertaking, it had decided to act as if it were and throughout Europe had been undoing its exclusive data arrangements to ensure that all its contracts complied with EC and national competition law. It would not seek to enter into any further exclusive arrangements.

6.35. IMS said that many types of computer hardware were available with the capacity needed to provide deliverable information/sales monitoring services. Entrants to the market might buy or lease such hardware or might instead outsource this function. The software required to process the input data could be obtained through either a dedicated system or one of the numerous off-the-shelf packages now available.

6.36. A new entrant would need staff with appropriate skills and expertise in statistics, data collection and marketing. Although staff in some fields, for example sales or customer service, would be likely to have previous experience of the pharmaceutical industry, such staff were not difficult to recruit and in any event such experience was not generally necessary for production, clerical and IT staff or for managers. As regards prescription audits and micromarketing services specifically, no additional skills were required to develop, produce and sell the services.

6.37. IMS suggested that with the technology now available a new entrant could establish a service in six to nine months. This had been PMSI's experience in setting up both *Source Dispenser* and its micromarketing service (although IMS noted that *Source Dispenser* was itself originally developed by the BAPW on behalf of its members). In the case of micromarketing services, there would be no need for an entrant to build up a database over time, since pharmacies' computer systems tended to store records of prescription data for periods of sometimes more than six months and these records could be made available to new players in the market. Again, PMSI had used this method to populate the database used in the production of its *Micromarketer* product. IMS estimated that initial set-up costs for a micromarketing service would be in the region of £2 million over a two-year period.

6.38. IMS commented that the ease of entry to the relevant markets was reflected in the fact that information/sales monitoring services were viewed as commodity businesses. As a result of this development, data providers were seeking larger payments for their data and customers were seeking more value from service providers since data could now be collected, processed and delivered so easily. The ability to integrate internal data from pharmaceutical customers with data provided by third parties, or the ability to provide new insights into solving business issues were now key factors for customers in selecting suppliers. In addition many of the core skills needed to provide the services, for example data management, could be subcontracted rather than obtained by new entrants themselves.

6.39. IMS acknowledged that it had had an advantage as the first mover in the market and had built up relationships and the reputation of its products over many years. Pharmaceutical companies might have been reluctant to trust the success of their businesses to a new entrant without the established credibility that IMS enjoyed. However, the competitive environment, the growing demand for information, and the ability of the pharmaceutical companies to pay for it, together with the development of an electronic infrastructure throughout the pharmaceutical distribution chain, meant that historical barriers to entry had largely been broken down. In addition, IMS had been a publicly quoted company since 1 July 1998 and for the first time was producing transparent financial results. IMS said that its results so far were regarded as encouraging, and believed that they were likely to help motivate potential competitors to enter the market. Finally, IMS believed that the comments made by customers to the MMC indicated a desire to encourage and support new suppliers.

### **Countervailing power of customers**

6.40. IMS said that its customers, the pharmaceutical manufacturing companies, had the purchasing power to resist any price increases that they did not consider justifiable. [

*Details omitted. See note on page iv.*

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6.41. Only an insignificant proportion of the pharmaceutical industry's annual sales and marketing expenditure went on the type of services sold by IMS and PMSI, as relative turnover figures illustrated. Merck's 1997 worldwide turnover was US\$16.4 billion; Novartis's was £15.8 billion; Glaxo's was £8.3 billion; SB's was £7.9 billion; and Zeneca's was £5.4 billion. IMS's 1997 worldwide turnover was £700 million and PMSI's was £38 million. In terms of purchasing value, they therefore accounted for only around 1 per cent of the industry's annual expenditure on market research, marketing and sales force management, whereas the pharmaceutical companies accounted for very nearly 100 per cent of their sales. IMS was therefore far more dependent on its customers than vice versa. Furthermore, the customer base was shrinking because of mergers between pharmaceutical companies, with the result that customer power was increasing. Some 50 per cent of IMS's revenue currently came from 20 customers. In fact IMS's customers had in the past sought to prevent IMS from widening its customer base.

6.42. [

*Details omitted. See note on page iv.*

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6.43. IMS said that some of its customers themselves provided or had the capacity to provide similar services to its own. It suggested that an example of this was Glaxo's reorganization of its distribution network, which gave it control over the wholesaler sales data relating to its products. Another example was Merck's ownership and operation of a sales monitoring/information services

provider in the USA. IMS also noted that several pharmaceutical companies, including [ ⌘ ], had tendered for the PPA's data collection and processing functions when these were market tested in 1994.

## Pricing policy

6.44. IMS said that its price increases over the past ten years had, in general, been limited to those necessitated by increases in its own costs and the rate of inflation, although in the earlier part of the period *RSA* costs had also reflected a substantial improvement in the *RSA* service. (Because wage costs represented a significant proportion of IMS's production costs, wage inflation provided a better indication than the RPI of its rising costs.) For 1999, IMS had notified its customers of its intention to apply a flat rate price increase of 5 per cent, effective from 1 January. The increase was intended to cover the rise in wage and data acquisition costs. (IMS had demonstrated that its data acquisition costs were increasing rapidly.)

6.45. IMS told us that its prices did not generate a significant rate of return and that its profit margin in the UK was increasingly being eroded. A number of factors had contributed to the erosion of profit margin. First, data suppliers were becoming more aware of the value of the data that they held and so were raising their prices to IMS. Price inflation over the period 1995 to 1998 had been between 2 and 4 per cent, but data costs in the same period had risen by between 33 and 40 per cent a year. Secondly, wage costs represented a disproportionate amount of IMS's annual expenditure. Its wage bill for 1998 was expected to account for around 33 per cent of its total service production costs. Although wage inflation over the period 1995 to 1998 had been between 2 and 5 per cent, IMS's wage bill had risen more quickly, with an increase of around 9 per cent between 1997 and 1998. That increase represented IMS's investment in its customer services staff. Thirdly, in the past IMS had benefited from higher than average margins resulting largely from cost efficiencies created through technological advances, such as in the mid-1980s when the availability of electronic data collection drastically reduced its labour costs. The spread of technology over the past five years had eliminated this costs advantage and the value that IMS could bring to customers had been steadily eroded. Fourthly, IMS's customers were powerful enough to restrict price increases, as could be seen from their ability to resist the implementation of the new pricing model described in paragraphs 6.47 to 6.49. [

*Details omitted. See note on page iv.*

] Fifthly, the development of the *Xtrend* service had necessitated the reinvestment of revenue that would otherwise have been profit, accordingly reducing margins.

6.46. IMS provided brief details of the types of discount currently received by customers in the UK:

- (a) *Charter discounts* were received by customers who had supported IMS when a data format was initially launched. (Source had established a similar charter client scheme that helped to fund the development of its micromarketing service.) The charter discount had originally applied to any new IMS product and had been offered indefinitely, but was now being phased out. There were only around 15 charter clients left.
- (b) The *growth package* was designed to allow smaller companies to grow into IMS data formats that they could not otherwise afford. Initially, the growth package had been offered over a three-year period, but that period had later been shortened to two years. Growth packages were also sometimes offered in conjunction with new data formats, for example *Mediplus*, *Xtrend*. This was particularly advantageous for existing, smaller clients who wanted to subscribe to the new data format but did not want to give up their other IMS data formats in order to do so. There were some five customers with growth packages.
- (c) *Microlink* was software used with the *MAXIMS* and *SALEStab* data formats to link the customer to the database. Customers subscribing to both *MAXIMS* and *SALEStab* received a discount in recognition of the duplicate software element in the data formats. Around 15 UK customers were receiving this discount.

- (d) *MDI* clients who purchased *Mediplus* obtained a 50 per cent discount on their *MDI* subscription. The discount reflected the duplication in data between the two reports and the minimal cost of producing a customer's *MDI* report from its *Mediplus* data. Some six UK customers were benefiting from this discount.
- (e) *Field force discounts* were offered to companies with multiple field forces, for reports that were duplicated for each field force. About 20 UK customers were receiving these discounts.
- (f) *Multi-country* discounts were granted to customers supporting IMS in new countries into which it was seeking to expand. They had been phased out over time and there were now only two UK customers receiving them. In both cases, the discount was less than 5 per cent.
- (g) *Additional discounts* had been offered in certain circumstances. First, when customers wanted a tailored data format from IMS, prices were negotiated to fit the unique format. [

*Details omitted. See note on page iv.*

] Thirdly, the data formats sought by customers sometimes overlapped. When this occurred, discounts were given to reflect the resulting cost savings.

6.47. IMS was currently attempting to implement the recommendations of an independent consultancy relating to its pricing and data format strategies. This new initiative, Sunrise pricing, was being introduced in response to customer requests and comments. Its objective was to tailor price precisely to the customer's needs. Thus, companies needing small quantities of data would be able to access only the data that they wanted to buy and be charged accordingly. Previously all customers had had to pay a subscription representing the processing cost of a standard service so that customers wishing to buy only small amounts of data had, in effect, subsidized those making larger purchases. The new pricing model, from which the subscription element had been removed, offered more flexibility to customers and introduced greater transparency into the pricing process.

6.48. In the new model each line of data, representing a particular pack size of a specific product, was valued. The price paid by the customer then depended on two factors: how many lines of data were sought; and how the service was to be delivered (hard copy, on-line database access, electronic disc or tape). Discounts were available for larger volumes of data purchased. IMS said that this pricing model ensured that customers paid for the precise service that they received. In the past, some companies had not informed IMS that they were purchasing STR data for more than one field force and, accordingly, were liable under the old IMS pricing scheme for an additional charge for data supplied to a second or third field force. Although such companies might see an increase in their annual STR prices under the new pricing model, this increase would be by no means as large as the charge that they should have paid previously. IMS maintained that, by introducing the new model, it was in effect waiving the additional charges that should have been paid. IMS also told us that Sunrise should put an end to misconceptions about the bundling of its services. In the new pricing model, the delivery and organization of services had been formulated in an attempt to ensure that no misunderstandings arose. If, for instance, a company wanted to buy data at the sales territory level only, it would no longer have to buy the national-level book report.

6.49. IMS acknowledged that Sunrise had been unpopular in some quarters. However, it believed that such a pricing model was a fair commercial practice. Moreover, it was by no means certain that larger data purchasers would automatically pay more for their data and smaller purchasers would pay less. In IMS's view, opposition to this pricing model was, therefore, unjustified. However, it was being phased in because customers would not pay prices calculated under the new model and also to ensure that no company suffered hardship as a result and clients had the opportunity to discover the advantages of the new model.

## Effects of the merger

### ***Competition***

6.50. IMS said that in the UK its activities overlapped with those of PMSI in only two relevant markets: the supply of prescription audits and of micromarketing services. These overlaps gave rise to no competition concerns. IMS would continue to be constrained by a powerful competitor (TNS) in the supply of prescription audits and it would be easy for a new entrant to acquire the necessary skills to develop such a service. In any event, one of the conditions on which a number of pharmaceutical manufacturers had provided funding for the development of Source's micromarketing products was that *Source Prescriber* would be made available to no more than 15 such companies for two years from the date of its launch. Source had also agreed that after the two years had elapsed it would, in perpetuity, charge the 15 favoured companies 10 per cent less for *Source Prescriber* than it charged other purchasers. There had been, therefore, a serious restriction on the extent to which, absent the merger, Source could have competed with IMS in the provision of micromarketing services to any companies other than the maximum of 15 that might have been prepared to invest in Source. IMS pointed out that only nine companies had invested in Source's services in the UK. IMS drew two conclusions. First, that in funding Source's micromarketing project the pharmaceutical manufacturers were seeking to achieve competitive advantage for themselves rather than to support a competitor to IMS. Secondly, in the absence of the merger Source would have been able to compete with IMS in the supply of micromarketing services only to a significantly limited extent. IMS commented that the use of exclusive contracts either in the production or supply of data services was entirely contrary to its business practice. Since the merger it had therefore approached all the companies with which Source had entered into such contracts to discuss the termination of the exclusivity clause. These discussions were continuing.

6.51. IMS noted that the development of micromarketing services was seriously constrained by current legal uncertainties. If Source's application for judicial review of DH's guidance were dismissed then the market would cease to exist. If, on the other hand, the application were successful, in IMS's view the way would be open for the PPA, its most powerful potential competitor, to enter the market. The pharmaceutical companies would welcome entry by the PPA. IMS commented that micromarketing services could be developed by virtually any information services provider or market research organization as no specific additional skills or technology were needed. No new entrant would face the same barriers to entry as IMS and PMSI had encountered because they had already invested time and resources in overcoming the legal, regulatory and institutional obstacles to the establishment of micromarketing services. IMS had also made a great deal of its technical research available in the public domain, allowing new entrants to benefit from this knowledge.

6.52. Responding to concerns raised with us about the merger, IMS said that much of the comment from customers was not directed against the merger but was a function of the industry's previous relationship with IMS and weaknesses in IMS's past performance. Pharmaceutical companies had in general been positive about the merger in their comments to IMS and PMSI and had recognized the benefits to themselves, in terms of the development of a broader-based micromarketing product, and to the healthcare industry as a whole. Negative comments had tended to focus on IMS's perceived previous attitude to its customers. IMS told us that now it was an independent company it had an entirely new management team in place and was determined to change customers' perceptions of it.

### ***Portfolio power***

6.53. IMS maintained that the concept of portfolio power, as considered in *Michelin*,<sup>1</sup> did not apply in the case of its acquisition of PMSI. (The concept derived from the breadth of product ranges offered by competing companies, and from the fact that these companies, when combined, might be able to provide products in several neighbouring markets.)

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<sup>1</sup>Case 322/81 *Michelin v Commission* [1983] ECR 3461.

6.54. In *Michelin*, the relative competitive strength of Michelin in the tyre market that led to a portfolio power analysis was based on three factors: (a) the purchase of tyres represented a considerable investment for a transport company; (b) Michelin led its competitors in investment and research; and (c) customers traditionally preferred Michelin. IMS said that these factors were not relevant to the markets in the present case. In the healthcare industry, information and sales marketing services accounted for only a trivial proportion of annual sales and marketing expenditure. Furthermore, IMS's customers were multinational companies with the power to resist any price increases or other commercial conduct that they did not consider justifiable. Investment and research were not decisive factors in the information and sales monitoring industry. The collection of healthcare sales data required no significant investment and the necessary computer software was generally available at low prices from a variety of competing providers. IMS said that customers had no traditional preferences in the market for information and sales monitoring services. If anything, customer choice was driven entirely by factors such as speed, reliability, accuracy and price.

6.55. IMS noted that, as identified in *Michelin*, portfolio power issues arose primarily in markets involving branded goods, where the product ranges being merged had a common (wholesaler or retail) customer base dependent on the availability of a wide range of products. It commented that the information and sales monitoring markets did not display any of those characteristics. Customer choice was not driven by brand loyalty and customers tended to purchase different products or services from different suppliers without compromising the quality of the data obtained from the other supplier. Customers did not therefore look to buy only from companies offering a range of products or services, but would use a range of suppliers in order to meet their needs most efficiently. Furthermore, because IMS and its competitors sold a wide variety of services to meet a range of customer needs, different services were sold to different customers within the same company, all of which made their own purchasing decisions without reference to other departments. Customers did not therefore need or expect a comprehensive service package.

6.56. IMS said that portfolio power implied that a competitive advantage might be gained from the ability to offer a product or service portfolio of greater size. EC rulings on portfolio power had stated that the products or services in question should be 'closely related' and form part of a uniform or homogeneous product and service programme. IMS maintained that this did not apply to information and sales monitoring services, which derived from different sources and satisfied different customer needs. Even customers within the same company would buy services from different companies according to their specific needs, so an information/sales monitoring services provider gained no advantage simply from selling a wider range of services than its competitors.

6.57. In light of the above considerations, IMS submitted that none of the criteria commonly associated with portfolio power were met in the present case and any reliance on portfolio power as a measure of dominance could not be sustained.

6.58. Among the specific concerns about the merger was whether IMS would be in a position to promote the use of Walsh's ETMS system in conjunction with its own and PMSI data. It told us that pharmaceutical companies bought such systems on their merits, and to use both their own data and those of data suppliers. IMS data could be used on the ETMS systems of all suppliers. Nor would there be any advantage as regards the *Mediphase* pharmacy software system. *Mediphase* was sold to completely different customers for a completely different end-use application. Moreover, any other data collector could use the *Mediphase* system to collect prescription data because IMS had no exclusive access to data from that system. If that were not the case then *Mediphase* systems would be less attractive to pharmacies, which could use other systems to generate more income by selling data to more than one collector.

### ***Benefits of the merger***

6.59. IMS believed that the merger would operate in the public interest by enabling it to improve the quality of its prescription data services to customers and deliver better healthcare tools to the DH, pharmaceutical companies and the medical field in general. In an environment of continually rising needs and finite resources, cost-effective solutions to healthcare issues had to be found. High-quality statistical data on the incidence and prevalence of disease and the use and outcomes of treatment could make a major contribution to informed debate on these issues. Both IMS and PMSI were committed to

the use of their information services for the advancement of health and the improvement of patient care. The services would offer a number of other benefits, including improved prescribing in primary care through the provision of continuous feedback on particular therapy areas to GPs who had consented to being identified. The development and review of public health strategies could be assisted by the use of IMS data, and specific and linked anonymous patient data could be studied to provide a long-term perspective on cost-effective prescribing. In addition, micromarketing services would help to combat inefficiency and waste in the promotion of drugs. For pharmaceutical companies that would mean more working capital freed for use in R&D and greater profits, or savings for customers. For GPs it would mean more efficient use of their time as pharmaceutical companies' marketing became more selective and relevant.

6.60. In IMS's view, concerns expressed by the DH that the NHS drugs bill would increase if micromarketing services were allowed to continue were misplaced. It was difficult either to prove or to refute the DH's claim, although an increase in drug costs was not synonymous with an increase in the overall cost of healthcare: as the Secretary of State had said, the judicious use of drug therapy could lead to substantially lower expenditure in other areas of the NHS. IMS said that its services could assist the DH in encouraging the prescription of lower-cost, lower promotional products. It told us that much targeted promotional activity was directed towards inter-brand competition for market share. This activity did not favour more expensive brands in particular; cost-effectiveness was one of the important product characteristics that were stressed. Market leaders, which might be the most expensive products in their class, in any case had a competitive advantage in their established position. IMS maintained that effective targeting benefited the lower-priced products in the market, by making even better use of their lower promotional budgets. This applied with especial force to branded equivalent and generic products that would otherwise have less chance of success. IMS's *Xtrend* and PMSI's *Micromarketer* and *Prescriber* could, therefore, work to reinforce the efforts of the DH towards the prescribing of these lower-cost, low promotion items.

6.61. IMS expected that the merging of its prescription data services with those of PMSI would result in a product better able to meet customers' demands for detailed analysis based on prescription data at national, regional and local levels because at all levels the collected data would be more accurate and reliable. It also expected that that product would be available to customers more quickly than would have been the case had the two companies continued to try to develop those services alone. In addition, the combination of data sources would result in synergies each year as collection costs fell with the elimination of overlaps between sources. It estimated that the overlap was in the region of 80 per cent. Prior to the merger, IMS and Source were each being supplied with data by about 5,000 pharmacies: following the merger, the combined panel was about 6,000—approximately 50 per cent of pharmacies in the UK.

6.62. IMS claimed that the merger would promote effective competition by encouraging new entry into the emerging prescription data services market. First, there were no barriers to entry, largely because new entrants would benefit from the efforts and investments of the first movers in this market. There were no restrictions on access to raw data and IMS understood that exclusive agreements for access to data were no longer viable. Secondly, NDC, which was already a leading provider in the USA, should prove a strong competitor given that it would be released from its non-compete restriction as a result of IMS acquiring PMSI. Thirdly, if the judicial review found in favour of Source then the PPA could emerge as such a powerful competitor, given the comprehensive nature of its data, that it might conceivably make the prescription data services market obsolete. Resolution of the judicial review in favour of Source would also clear the way for other potential entrants such as NDC, Quintiles and TNS that might be discouraged by the current legal uncertainty. IMS argued that it was in the public interest that it and PMSI should be allowed to share the risk inherent in developing services based on prescription data. If micromarketing services were allowed to proceed, many of IMS's and PMSI's customers might switch to the PPA if its data became available. PMSI, in particular, could not afford to continue generating losses on a service that remained under threat. The merger would, therefore, help to protect the considerable investment already made in prescription data services, maintain their viability in the face of competition and minimize the risk to jobs in the UK.

## Remedies

6.63. We asked IMS to consider, in the event of our concluding that the merger might be expected to operate against the public interest, what practical remedies might be available. IMS's view was that the merger would not operate against the public interest. If, however, the MMC were to arrive at a different conclusion, any remedies recommended would have to be effective to meet the public interest detriments identified, which in IMS's view would go no wider than a loss of choice in two very small product markets. On that understanding, IMS put forward a set of undertakings for consideration and also commented on other hypothetical remedies.

6.64. We invited IMS to consider the divestment of the whole of PMSI UK and, alternatively, of Source UK. IMS said that total divestment of PMSI UK would not be an appropriate or proportionate remedy for adverse effects limited to prescription data services (including micromarketing) where only the Source business was relevant. It argued that neither option for divestment would be a practical proposition, nor would divestment be effective in promoting competition. The financial data indicated that PMSI UK, and Source UK in particular, had made considerable losses and had acquired liabilities that raised questions about their future financial viability. In addition, further investment would be needed fully to develop Source's new products (*Micromarketer* and *Prescriber*). Moreover, it was highly unlikely that there would be any market for these products pending the outcome of the judicial review and any subsequent challenge. Even if the products were allowed following the judicial review, PMSI, under existing contracts, would be required for two years after their launch in the UK to supply only the companies that had partly financed their development, of which there were nine in the UK, although there could be a maximum of 15. Buying the divested business would not necessarily be an attractive proposition to a potential competitor, particularly as a number of key PMSI personnel with knowledge of the business had been lost since the acquisition. The technology and skills needed for the supply of pharmaceutical business information were more widely available than in the past: NDC, for example, already possessed them as a result of its acquisition of the Source US business and now had access to pharmacy data as a result of its recent acquisitions of software companies in the UK.

6.65. IMS commented that it would not be a straightforward matter operationally to divest either PMSI UK or Source UK as a stand-alone business. PMSI UK consisted of three separate businesses (Source UK, a profiling business which sold a number of services including *Scriptrac*, and *Mediphase*) but each was essentially a product unit rather than a company. The three businesses had limited separate management and financial structures, and in particular no separate tax structure and no treasury or billing functions. Any acquirer would itself have to provide these functions. IMS doubted whether a buyer could be found within a reasonable timescale.

6.66. Divestment would have serious implications for IMS. It would take time to accomplish and would give rise to further uncertainty and cost. IMS had acquired PMSI as a strong addition to its business, in particular in terms of the experience, knowledge and skills of the key people it had gained. It wanted to retain such people and their loss would be a severe blow. IMS would also lose momentum in developing and bringing to the market its new *Xponent* product, to whose development the combination of the IMS and Source offerings contributed significant benefits in terms of both speed to market and the quality of the product. In addition, IMS would lose some of the other PMSI activities, such as physician profiling, that it had planned to incorporate in its product range.

6.67. IMS put forward a number of proposals that it believed would address the best interests of UK customers and data suppliers and would promote the competitive process within the UK. The product markets to which its principal proposals related were those directly affected by the acquisition of PMSI's business engaged in the supply of prescription information. IMS submitted that there was no justification for seeking to control its business conducted in other sectors within the supply of pharmaceutical business information: first, the merger had no material effect on the competitive process within those sectors; secondly, the market was changing so fast that controls on IMS not also imposed on its principal competitors would distort the market to the detriment of the public interest. The proposed undertakings related to the geographic UK market: IMS saw no justification for seeking control over its business practices outside the UK.

6.68. IMS submitted a detailed proposal for the licensing of its prescription input database, which it was confident could be implemented within a period of three months. It believed that the effect would be to increase competition in the prescription data services market in the UK and accelerate its

growth, since a licensee would be able to enter the market more quickly and easily than would otherwise have been the case. More particularly, IMS believed that if NDC were to license the data it would have a full complement of UK prescription data given that it already had access to some 35 per cent through its acquisitions of pharmacy software businesses. IMS said that a licensee would benefit from a consistent supply of prescription data, thus avoiding the need to work with data sources to develop such a supply. A licensee would also benefit from IMS's knowledge and experience of the structure and operation of prescription data services and would gain the ability speedily to generate a range of products that could compete with IMS's offerings. IMS believed that its proposal would also benefit customers for prescription data services, who would have available to them the benefits of IMS's acquisition of PMSI plus a choice between IMS and any new supplier. IMS would ensure that data suppliers, who were vital to the future of prescription data services, would not be financially disadvantaged.

6.69. The essence of the licensing proposal was that IMS was offering to collect and process prescription data for competitors. It would undertake to install new data extraction software in the pharmacies from which it already collected data, entailing renegotiation of its data supply contracts and the development of new software. It believed that this could be achieved speedily, although it would be a significant undertaking. The new software would collect the same prescription data that IMS currently collected. IMS would then design further new software to build a central data repository of edited input data collected from the pharmacies. The software would integrate the various product codes and data formats used by different pharmacies into a consistent set of industry-recognized product codes. The GP data would be anonymized. The licensee would receive the processed, edited and anonymized data from IMS's UK prescription database. The separation of IMS's own data processing system from the data repository would leave a licensee free to develop its own service and add value to the collected data. In response to an alternative suggestion from the MMC concerning the licensing of raw prescription data, IMS stated that, subject to the agreement of its data suppliers, an undertaking to license the raw data would in fact be its preferred option. IMS believed that it would not have the resources to establish a system to license both raw data and processed data on request.

6.70. IMS told us that it had received legal advice that it would be unlawful for it to assign to a third party the consents it had obtained from GPs for their identification in data passed by pharmacies to IMS. However, in order to assist a licensee to obtain the express informed consent of GPs, IMS would undertake to transfer to a licensee its technological know-how about the setting up of a third party arrangement to ensure compliance with the data protection legislation. Having to obtain the GP consents individually would place the licensee in no worse position than any new entrant to the market.

6.71. There were three principles on which IMS would be prepared to license the prescription input data. First, it wished to protect the interests of its data suppliers. It would therefore license the data on the same financial terms as those on which it obtained the data. Secondly, IMS would neither profit, nor lose, from the licence but would seek to recover only its costs in licensing out the prescription input database. Thirdly, it would document those costs, which would include computer processing time and directly chargeable employee time in operating and maintaining the database. It was not, however, expecting to recover costs incurred in software R&D, installing new software in pharmacies and negotiating with data suppliers. In the light of the principles set out above, IMS did not envisage any disputes over the licensing fee, but in the event that such a dispute did arise, it would agree to the Office of Fair Trading or a similar agency reviewing the fee.

6.72. IMS believed the merger would have no effect on wholesale data and said that licensing of wholesale data, given IMS's current poor financial performance in the UK and other developments in the market, would be seriously detrimental to its UK business and put other services at risk.

6.73. In addition, IMS indicated that it would be prepared to give a number of behavioural undertakings. In doing so, IMS stressed that it was prepared to give those undertakings in order to resolve the specific concerns it felt the MMC may have in relation to the particular conditions of the UK market:

- (a) *Price controls.* IMS would undertake to guarantee the current cost points for *Xtrend* and PMSI's *Micromarketer* contracts during the period of those contracts currently in existence (the initial periods of which varied between one and four years). Moreover, IMS would

undertake not to set the price of its *Xponent* service before consultation with an appropriate government agency.

- (b) *Price lists and discounts.* IMS would undertake to price according to published transparent price lists and discounts. This undertaking would apply across the board to all IMS products in the UK.
- (c) *Exclusive contracts with data suppliers.* IMS would undertake not to enforce the exclusivity provisions of current data supply agreements with the BAPW. Further, IMS would be prepared not to enter into any new exclusivity contracts with data suppliers, its existing contracts no longer having any element of exclusivity. This undertaking would apply to all IMS's data services in the UK including, for example, the other services used in compiling the *BPI* and *RSA*.
- (d) *Sales of information services as a package.* IMS would be prepared to enter into an undertaking not to package or discount to the same effect any UK services where adverse effects might be identified, or those services and any other UK service.
- (e) IMS would also make no exclusivity provisions relating to *pharmacy software and hardware*. IMS would also be prepared to state that it would not install into pharmacies in the UK any software or hardware for the purpose of extracting prescription data that would inhibit the extraction of those data by third parties. (IMS stressed its concern that this requirement should apply equally to all companies installing such software or hardware.)
- (f) IMS would be prepared to undertake that it would make good faith efforts to deliver the improved *Xponent* service sought by its customers.

## **PMSI**

6.74. The former management of PMSI gave separate evidence in which it told us that it was disappointed at not being able to continue as an independent company, but that it could not go on losing money on the development of micromarketing. It had faced difficulties from industry and official bodies in many of the European countries where it planned to introduce the service and the level of support from pharmaceutical companies had been disappointing. Only 9 out of a possible 59 had provided financial backing and not all of these had actually bought the product from PMSI, although this was a product that the industry claimed it needed. The length of time it had taken to reach agreement with the BMA on the question of obtaining GPs' consent had also been very frustrating.

6.75. PMSI regarded IMS as a strong competitor offering good products at reasonable prices. It had, however, lost its way under the ownership of D&B, when it had been treated as a cash generator and the management had lost the incentive to focus on the development of new business and the needs of customers. One of the gains to IMS from the merger had been the acquisition of innovative and progressive people from PMSI.

6.76. PMSI had seen itself as an effective competitor to IMS, although financially more vulnerable. It had been the only provider of micromarketing services in the USA for two years, until IMS entered the market and took customers from it, and believed that it would have done well with these services in Europe. It considered that it had had the know-how to compete with IMS in the supply of RSAs or wholesaler-based services, but it had not been inclined to do so given that its total focus had been on developing and launching its micromarketing service in the UK and on which it had lost a substantial sum of money.

6.77. The pharmaceutical industry had said that it wanted the micromarketing product and that it also wanted a competitor to IMS. PMSI did not, therefore, rule out the possibility that the industry would be prepared to encourage and support another entrant to the market. It thought that there was at present room for more than one micromarketing product, although this might change if consolidation among pharmaceutical companies were to continue.

6.78. PMSI said it had seen no firm evidence that TNS or Nielsen was on the verge of entering the market. However, one would not necessarily be aware of a potential competitor until it had already decided to enter. PMSI believed, however, that NDC was going to enter the UK market, as evidenced by its purchase of software companies.

6.79. According to PMSI, the merger would have no effect on the public interest. It would have no bearing on the price of pharmaceuticals charged to the NHS and hence the level of taxes. Although the merger had reduced competition from the pharmaceutical companies' point of view, they spent only about 1 per cent of their turnover on market research, which was insignificant in comparison with expenditure on, for example, product R&D.

6.80. With regard to possible remedies in the event of an adverse finding, it was doubtful whether a divested PMSI in the UK would be successful as a stand-alone business unless it received an injection of cash from a new buyer. PMSI said that the people were the most important element in its business and that there was a risk of key staff leaving if uncertainty about the future continued. Any remedy that might be proposed should therefore be capable of being implemented quickly.

A FORSTER (*Chairman*)

H ALDOUS

P HODGSON

A STEELE

R PROSSER

P A BOYS (*Secretary*)

28 January 1999