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InHealth – Alliance/IBA merger
Response to the CMA Issues Statement ("IS") issued 28 April 2014
NON-CONFIDENTIAL VERSION

1 Executive summary

1.1 This confidential submission to the Competition and Markets Authority ("CMA") is made by InHealth Group Limited[1] ("InHealth") in relation to the completed acquisition by Alliance Medical Imaging Limited ("Alliance Medical") of the assets of IBA Molecular UK Limited ("IBA") (Alliance Medical and IBA collectively referred to as "the parties") which InHealth understands was completed on or around September 2013 ("the merger").[2]

1.2 In this submission, InHealth:

1.2.1 broadly agrees with the proposed framework;

1.2.2 broadly supports the approach in the IS to market definition;

1.2.3 considers that:

1.2.3.1 NHS self-supply is not in the same market as the market in which the parties supply FDG, essentially because that supply could not be diverted in response to a SSNIP in FDG;

1.2.3.2 third-party maintenance of a cyclotron will be in the same market if that arrangement enables commercial supply (i.e. under a Market Authorisation) but not in a simple outsourced provision of a cyclotron with no MA in place;

[1] Company number 04620480
[2] This submission has been prepared based on the information available to InHealth and the market as InHealth understands it to be. The expression of any view by InHealth in this submission is a provisional view, based on current information and may change as further market information becomes available. In particular, InHealth has not seen the OFT's Phase 1 decision. InHealth's position on all issues is subject to re-statement or further submissions in light of the OFT's decision.

1.2.3.3 back-up can be characterised in different ways in different configurations; and

1.2.3.4 Alliance's self-supply of FDG is in the relevant market, since it could be diverted in response to a SSNIP in FDG;

1.2.4 responds to the CMA's comments on geographic definition, and the PET-CT market, with an emphasis on a forward-looking analysis of the market as it will be shaped by the current re-commissioning process initiated by NHS England;

1.2.5 does not consider that there is evidence that would sustain a finding that exit by IBA was inevitable (and, in particular, there seems to have been little if any effort to explore other, less-harmful outcomes to competition than the merger); and

1.2.6 comments briefly on each of the CMA's theories of harm, each of which InHealth considers ought to be considered in the CMA's analysis.

1.3 [REDACTED]

1.4 [REDACTED]

1.5 [REDACTED]

1.6 Since the OFT's decision, NHS England has announced the pre-qualifying phase of the commissioning of PET-CT in the majority of England (covering both the North and South regions).[3] Contracts will be offered in relation to 4 lots, for a period of 10 years.[4]

1.7 This is likely to affect the CMA's analysis as set out in the IS, particularly in relation to the counterfactual scenario and the assessment of the competitive effects of the merger. In summary, issues that were raised as possible concerns under some scenarios are now being realised.

1.8 InHealth expects NHS England to require bids to be lodged around early September (essentially, simultaneously with the CMA's decision under the administrative timetable). As a result, PET-CT market outcomes may be established (in the form of

[3] See Appendix **[IS/1]**

[4] The lot structure may also change at the ITT stage – for example, lots may be combined (this occurred in 2007/8 during that last procurement process).

committed decisions by bidders for PET-CT contracts) for a period of 10 years by the time the CMA reaches a conclusion on the merger.

2 Background (Competition in the NHS)

2.1 This submission refers throughout to issues relevant to competition between different providers of health care services as part of the National Health Service ("NHS").

2.2 To an even greater extent than in other sectors of the wider economy, it is important to emphasise that competition and patient choice in the NHS are a means to an end – that end being to ensure that health care services are provided in ways that are economic, efficient and effective and that maintains or improves the quality of the services.[5]

2.3 InHealth strongly supports this emphasis. We recognise that although different providers, whether NHS organisations or independent sector providers, may have from time to time opposing commercial objectives (and may compete fiercely to, for example, secure a contract available from a commissioner), all such providers have in common a shared strategic objective, which is to improve the quality, efficiency and safety of the NHS in the interests of patients.

2.4 This shared strategic objective will sometimes be served by cooperation between providers (or between providers and commissioners), particularly in relation to the development of clinical standards, care pathways or service delivery. Given that competition law is also applicable to the conduct of undertakings in the health sector, providers are obliged to adopt approaches and structures that enable them to achieve compliance with competition law at all times, whilst sustaining collaborative and cooperative activities in parallel, in the best interests of patients. References by InHealth in this response to 'competition' need to be read in that light.

2.5 InHealth therefore urges the CMA to keep in mind the particular characteristics of the NHS - and above all the need to give primacy to the interests of patients above all other concerns – in mind as it conducts its review of the merger.

2.6 The rest of this document sets out InHealth's response to the various sections of the IS.

2.7 InHealth broadly agrees with the facts as set out in the 'Background' section of the IS.

[5] This objective also comprises Monitor's main duty (see Health and Social Care Act 2012 ("HSCA2012"), section 62(1).

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3 Market definition

3.1 InHealth agrees that the parties overlap in the supply of FDG at sites in England. Prior to the merger, InHealth was able to secure competing bids to supply it with FDG from both parties. When InHealth sought to appoint an FDG supplier in 2007/8, it had a choice of Alliance/Erigal, IBA and Siemens PETNET.[6] The degree of competitive pressure each party provides to the other is likely to vary between sites, but there is a significant portion of the South region that can be served by both the parties.

3.2 The market for FDG is distinct from the market for other tracers. InHealth is concerned about the market for FDG (and the impact on the market for PET-CT) and about the market for other tracers (such as the Alzheimer's tracers) and, ultimately, the market for imaging services using those other tracers. Most of this submission deals with the FDG market, but in relation to the other tracers:

3.2.1 Development of those tracers requires significant investment and may initially be developed by only one party/a single cyclotron. It is important for providers in the PET-CT market to have unfettered access to these developmental tracers for the benefit of patients. It is therefore important for the CMA not to focus solely on FDG, but also to take access to non-FDG tracers into account.

3.2.2 The position of the other NHS Trusts in relation to other tracers is different to the position with respect to FDG. InHealth considers that market entry by NHS Trusts in other tracer markets is more plausible (in part because, for example, some of the other tracers only require local radiopharmacy equipment to support a radiopharmaceutical production unit, rather than the cyclotrons necessary to support the production of FDG). [REDACTED]

Should hospitals that own and operate cyclotrons for their own needs but that do not currently supply to other parties be included in the same market?

3.3 The UK *Merger Assessment Guidelines* ("UK Merger Guidelines") provide that:

> *The Authorities will generally follow the principle that captive production by the firms will be included in the relevant market only if it can be demonstrated that it would be profitable for the supplier to forgo its use and sell into the merchant market in response to a SSNIP. The Authorities will also consider whether self-supply by potential customers of the merger firms should be included in the relevant market. The Authorities*

[6] [REDACTED]

will generally include self-supply if the ability of customers to choose this option affects the profitability of a price rise by the hypothetical monopolist.[7]

3.4 It is not possible for the NHS hospitals to divert supply to the commercial market in response to a SSNIP in the price of FDG. To do so, they would need to obtain a Market Authorisation ("MA") from the MHRA which require time and effort to establish.

3.5 Would, in practice, the response of hospitals to a higher price for FDG be to seek to obtain an MA and sell into that market? This is obviously a matter that the CMA can test directly with the NHS providers. However, as an experienced purchaser and user of FDG, InHealth is sceptical that it would be a simple matter for NHS Trusts to enter the market to supply FDG, since:

3.5.1 There is a need to meet the standards of Good Manufacturing Practice (that are considerably more stringent than the conditions for production of FDG on a non-commercial basis under a 'Specials' licence;

3.5.2 Many of the NHS cyclotrons and production facilities are older and may not be suitable for commercial use without upgrading;

3.5.3 There is a need for capital to be available to invest in these activities, and many NHS Trusts are capital-constrained; and

3.5.4 Although Alliance state that "a full commercial licence could be granted by the MHRA in around three months", this seems to understate the position, as the MHRA performance data suggests that it can take 100 days to *start* the assessment and that completing the assessment of a new MA can take, in some cases, years to complete.[8]

[7] UK Merger Guidelines, at paragraph 5.2.20, page 35.

[8] See Appendix **[IS/2]**. The notes to this presentation state that: 'These 12 charts measure the times taken for work carried out in the MHRA Licensing and VRMM assessment teams. For UK MA only applications we show the time taken (from receipt of a valid application) for the first assessor to start the assessment, for all allocated assessors to complete their assessment, and for determination (grant or refusal) of the application. Completion of assessment and determination times are also shown for a range of other work types where the UK acts as an [sic] Reference Member State (RMS) in Decentralised or Mutual Recognition procedures or as Concerned Member State (CMS) for new MA determinations.' Chart 10 shows the total time taken to determine applications, in terms of 50% and 90% completion of applications. Throughout 2013-14, the periods for determination range widely with a long-run average between 18 months and 2 years (around 500 days). Although performance appears better in March 2014, past performance suggests that a further increase in the time taken

3.6 InHealth is not suggesting that these obstacles are necessarily insurmountable, but as a matter of fact, the CMA should seek to understand whether, in practice, there are any NHS Trusts who would be likely to undertake that project in the event of a 5-10% increase in the price of commercially produced FDG (as opposed to doing, say, in order to address their relative isolation from commercial laboratories – likely to be a factor in, for example, Cardiff).

3.7 In any event, indirect evidence that NHS hospitals are not focused on developing the production of FDG on a commercial basis is the fact that none have done so in the lead-up to the commissioning of PET-CT by NHS England. Under current arrangements, the most significant opportunity to sell FDG commercially in England arises periodically as the NHS England regional contracts are commissioned. If NHS hospital were so attuned to such opportunities, and market entry were a simple matter of re-configuring work processes, then InHealth might find itself in the position of having a number of NHS hospitals offering to bid to supply FDG to it and compete with IBA, Erigal and Siemens PETNET. In fact, InHealth knows of no such interest and it would be surprised to receive any.

3.8 An unknown factor at this point is the level of certainty/robustness required by NHS England in the supply of FDG on the part of bidders for PET-CT contracts. In the last round of tendering, NHS England strongly favoured bids that had at least two independent suppliers of FDG (and it appeared not to regard the practice that Alliance now characterises as 'self-back-up' as being sufficient - see the discussion of back-up services below). While at this point InHealth does not know what level of certainty NHS England is likely to require of bidders (in terms of numbers of suppliers of FDG), InHealth does not expect that, based on its understanding of the current market position, there is any prospect of any NHS Trust being in a position to meet the requisite standard so as to be a suitably-qualified commercial FDG supplier for the purpose of supporting a major (and plausibly winning) bid for one of the four lots on offer. There is simply insufficient time, prior to the tender deadline, to obtain an MA and develop the relevant reputational stability in the eyes of customers to be a credible competitive alternative to the existing FDG suppliers.

3.9 Therefore the self-supply of FDG by NHS hospitals should not be considered to be in the same market as Alliance, since NHS self-supply of FDG does not provide a competitive constraint on Alliance/IBA's ability to set prices for FDG.

(e.g. to levels similar to that seen in 2013 could not be ruled out as a possibility). This may be a point the CMA wishes to test with the MHRA directly.

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Should arrangements whereby a third party builds and operates a cyclotron at its customer's sites (typically a hospital) in return for a long-term exclusive supply contract be treated as being in the same market as other types of commercial arrangements?

3.10 If the arrangement involves the commercial supply of FDG, even on an exclusive basis, under an MA, then the diversion of supply is likely to be straightforward and that supplier is likely to be in the same market as the parties (where there is geographic overlap).

3.11 For example, in relation to the cyclotron at Nottingham, that facility is owned and operated by Siemens PETNET (which has an MA). Siemens PETNET could easily divert supply from the scanner at Nottingham to other fixed or mobile sites reachable from Nottingham and does so, for example regularly providing FDG supply across the Midlands and North-East of England. Accordingly, this cyclotron's supply of FDG is considered to be in the same market as the parties.

3.12 Where the arrangement is one where a hospital purchases an installation and upkeep of a cyclotron as an outsourced arrangement, but there is no commercial supply of FDG necessitating the securing of an MA, then the situation would seem to be the same as the position of in-house NHS supply noted above. InHealth is not aware of any such arrangements but they would not necessarily be in the public domain.

Should the primary supply of FDG be considered in the same market as all or some of the back-up arrangements that currently exist, namely: self-back-up, where a supplier uses another of its own cyclotrons for back-up; formal back-up arrangements; and spot back-up arrangements?

3.13 A supplier of FDG needs some back-up arrangement. Securing suitable back-up is one of a number of elements necessary to deliver a fully resilient FDG supply that contributes to a sufficiently reliable PET-CT service to meet the needs of customer providers (hospitals). In the last round of procurement, 'self-back-up' was not considered by the Department of Health as being a suitable basis for robust supply; InHealth was expected (and required, given the need for major sub-contracts to be approved by the Department) to contract with two suppliers of FDG in order to procure a robust supply.

3.14 Does the FDG supplier have to provide the back-up, or could InHealth contract separately for this back-up? In practice, there are two configurations for back-up supply:

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3.14.1 Back-up is purchased solely by the primary contractor and offered as an element adding to the quality and reliability of the primary service. In this configuration, back-up is an essential part of the service specification of the primary supply. In other words, back-up is not part of the same market, but an input to the primary market. There is perhaps a secondary market for back-up supply, and this may be internal (self-supply) or external. The precise configuration of these backup arrangements then forms part of the primary supply service specification. In this configuration, back-up supply is not a substitute for primary supply; or

3.14.2 The customer multi-sources their primary FDG supply contract, and expects their two suppliers each to back-up the other, essentially on the same terms as described above. The customer contracts 'in the normal course of business' with both suppliers, and then uses the fact that it is a primary customer to provide additional confidence that back-up supplies will be available when needed, since the risk to a supplier who fails to supply back-up when called on is not limited to the back-up supply contract, but also extends to harming the relationship with the primary customer.

3.15 Reflecting the then-expressed requirements of the Department of Health, InHealth's present FDG strategy in the PET-CT South Contract adopts this second configuration. InHealth contracts with both Siemens PETNET and IBA as a primary customer for FDG, and relies on these two suppliers to back up each other. This arrangement has been sufficiently robust to enable InHealth to win contracts for the supply of PET-CT, including the South Contract.

3.16 As far as InHealth is aware, NHS customers do not have a view that this type of back-up arrangement is inferior to a 'self-back-up' model. What matters to customers is that there is back-up, sufficient to ensure a reliable and dependable source of FDG.

3.17 Given that FDG is undifferentiated, the issue when obtaining an alternative is convenience and certainty of supply. The position of the PET-CT provider who faces failure of FDG supply is like a driver who needs to refuel, who finds that their nearest petrol station has run dry. They do not seek the next closest petrol station in the same corporate chain; they simply try to find the next closest station. Restricting their choice to a single supplier from multiple sites might be helpful in some specific circumstances but most of the time, it brings the risk of having them miss out on a closer, easier alternative. Therefore the preferred approach of PET-CT suppliers (given the option) is likely to be better and more effective cooperation between all FDG

suppliers to provide resilience in the system, not a narrowing of the relevant networks.

3.18 InHealth has no experience that would suggest that 'back-up FDG supply' is ever purchased directly by PET-CT service providers, separate from a primary contract for the supply of FDG (and InHealth has not done so, nor sought to do so). If it were, then back-up might be thought of as a closely linked product for which demand is derived from the primary supply.

Should the supply of FDG by Alliance to its own downstream PET-CT scanning services operation be included in the same market as the supply of FDG to other providers of PET-CT scanning services or hospitals carrying out the scans themselves?

3.19 Applying the same test as self-supply in relation to NHS hospitals, Alliance (Erigal) operates in the same market as IBA. Given that Erigal is established and operating as a commercial supplier (it holds an MA), it is able to divert supply as between its own operations and sales to third parties.

3.20 Indeed, not only could Erigal divert supplies as between the provision of FDG to Alliance and the provision of FDG to other PET-CT suppliers, InHealth understands that both prior and after its acquisition by Alliance, it does, in fact, do so. InHealth understands that Erigal supplies a number of other PET-CT providers (as set out in the Alliance submission) such as NHS Trusts that do not have their own cyclotrons. The fact of its change of ownership subsequently makes no difference to the question of its capability to substitute supplies of FDG between these types of sales.

The geographic scope of the market(s)

3.21 It seems necessary to consider the geographic scope of the market at different levels – for example, across England, in various sub-national/regional zones and perhaps in relation to particular cities or local areas. Relevant factors include that:

3.21.1 The radioactive decay of FDG sets a limit on the economic viability of the distance between cyclotron sites and scanner sites;

3.21.2 For a particular scanner location, this determines the degree to which cyclotron sites can act as credible competitors to supply FDG;

3.21.3 Cyclotron sites in close proximity will generally be rivals, whereas those located further apart are unlikely to compete to fulfil the same demands;

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3.21.4 In the short to medium term, the location of both the scanner sites and cyclotron sites is set and cannot be altered easily.[9] Therefore, the boundaries of the supply catchment areas of cyclotron sites will remain largely stable with respect to the price of the FDG supply service. (Consider an extreme example: the price of FDG could be much higher in Scotland, and this situation would be sustained even if supply south of the border were very competitive. i.e. it is in a different geographic market); and

3.21.5 Given the points made earlier about back-up supply, this must also be taken into account when considering the geographic scope of the primary supply market(s).

3.22 In light of the details now available about NHS England's plans for PET-CT commissioning, the '4 lot' structure is a more relevant set of geographic markets to consider than to assume that the split between the North and South regions remains relevant. This underscores the importance of the CMA's analysis being robust across a range of different views about geographic market definition.

The PET-CT market

3.23 InHealth agrees that it is necessary to take account of the different models of delivery of PET-CT (NHS in-house supply; contracting with individual hospitals or groups of hospitals; and commissioning by NHS England to a number of hospitals).

3.24 The North and South contracts provide context, but the forward-looking assessment should be focused on the next wave of commissioning contracts. The 4 lots that are being offered by NHS England should be taken into account individually, to understand the effect of the merger on each of them.

3.25 [REDACTED]

3.26 InHealth expects that final bids will need to be lodged perhaps in early September – essentially, at the same time as the CMA reaches a final decision on the merger.

3.27 [REDACTED]

3.28 [REDACTED]

[9] Both 'fixed' and 'mobile' scanner sites are intended to be covered by this statement, although there is obviously some degree of flexibility about the re-establishment of a mobile scanning location, compared to a fixed scanner.

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Northern Ireland

3.29 InHealth understands that in relation to Northern Ireland and Eire, there is only one commercial provider serving that market (M2i, served from its cyclotron in Dublin). [REDACTED]

4 Counterfactual

4.1 The IS raises the question of whether IBA meets the necessary criteria for a 'failing firm defence'.

4.2 The elements of such an argument are that:

4.2.1 IBA's exit is inevitable; and

4.2.2 There is no alternative buyer or other less harmful alternative way of disposing of IBA's assets or sales.

Is exit inevitable?

4.3 InHealth does not have direct access to financial information about the position of IBA. However, InHealth's view of the situation (pre-merger) was as follows:

4.3.1 As a customer of IBA, InHealth did not consider that IBA was close to financial failure (although InHealth recognises that this may not be unusual, given that IBA might have sought to avoid any difficulties being visible to customers);

4.3.2 IBA was a division of a large, well-established and publicly listed parent company that had a track-record of installing and operating 400 particle accelerators (in this context, cyclotrons) with a total revenue from operating its particle accelerator division of €45m and a commitment to that service line as one of its three strategic core priorities[10];

4.3.3 There had been short-term quality issues around the time of the acquisition by Alliance [REDACTED].[11]

4.3.4 The uncertainty created by the forthcoming commissioning for PET-CT also creates opportunities for material changes in the FDG supply market. On this basis alone, it seems hard to believe that exit prior to establishing the outcome

[10] Please see http://group.iba-worldwide.com/?page=investor-relations
[11] Please see InHealth's response to Question 12 of the Phase 1 submission.

of that process was inevitable. Provided it was not bankrupt prior to that sales process, then under any scenario (i.e. even in the event that the current investors regarded an exit as likely at some point), it would be preferable to remain in business during the 2014 tenders and see what business might be captured by IBA.

4.3.5 There are a number of factors that might have caused InHealth to reverse the shift of supply as between IBA and Siemens PETNET – including, as noted above, in the event that IBA demonstrated some progress on addressing quality issues. Had InHealth been appraised that it was possible that IBA would exit the market unless sales improved, it might well have been willing to enter into a strategic support arrangement, at least in the short term, to see if IBA could restore its position in the market. If quality could be improved, volume could have been increased relatively quickly. Given the high fixed cost nature of the business, this would have improved margins.

4.3.6 InHealth took it as given that IBA would be available as a competitive tenderer for FDG supplies in the lead-up to any new PET-CT contracts. InHealth anticipated discussing issues of quality and price with IBA ahead of the commissioning of PET-CT (when InHealth and IBA would both have a much clearer sense of the likely shape and scale of the market for the period from 1 April 2015).

4.4 IBA has now exited the market. Therefore, the relevant test is not whether IBA will exit the market at some point in the future – it is that it is inevitable that IBA would have exited the market in September 2013. The loss of IBA as a competitive supplier of FDG in the period from September 2013 to September 2014 (i.e. during the period of the NHS England commissioning process) is itself an SLC, in the sense that the competitive effect of having IBA operate as an independent supplier has been lost.

4.5 In deciding that IBA's exit is inevitable, it is necessary to consider whether absent a bid by Alliance, IBA's management might consider the case to await the outcome of the FDG sales cycle (expected to occur in the course of 2014) offering FDG to the bidders for the re-commissioned PET-CT services. Even on the most pessimistic account of IBA's position[12], it appears that IBA have clung on almost until the moment when competition might have provided a new opportunity to re-energize their business. Is it inevitable that IBA would exit mere months or weeks before this possible lifeline, or

[12] Alliance's initial submission to the CMA at paragraph 122.

would the owners – absent a bid by Alliance – put their efforts into securing new sales in this opportunity?

Is it the case that there is no alternative outcome that is less likely to lead to an SLC?

4.6 IBA's owners do not appear to have engaged in any good-faith efforts to explore alternative arrangements by offering the company or its assets to the market in an orderly way. [REDACTED]

4.7 In cases where the competition authorities have accepted a 'failing firm' defence, this has been in the context of such efforts having been made. For example:

4.7.1 In *HMV/Zavvi*[13], the view that there was no obvious credible competitive trade interest in a purchase of the failing business was the view of the administrator, not the acquiring business (para 38) and occurred only after the publication of notices seeking expressions of interest (para 42);

4.7.2 In *Optimax*[14], the outcome that the bidder was the only credible buyer emerged from an administration process and based on views of an accounting firm appointed to establish whether there were options available (para 9 and 5.30); and

4.7.3 In *Stagecoach*[15], Preston Bus Limited had asked a consultant to approach seven bus operators (including Stagecoach) to ask if they would be interested in purchasing the business. However the CC still ordered the divestiture of the business as an SLC was found.

4.7.4 Even Dairy Crest (rejected by the OFT but ultimately accepted as an 'exiting firm' by the CC) approached three companies about the possible sale of Millway Stilton (para 53).[16]

4.8 Nor is InHealth aware of any other wider efforts to offer IBA or its assets (for example, to NHS Trusts who might be interested in entering the market to supply FDG on a

[13] Anticipated acquisition by HMV of 15 Zavvi stores: ME/4036/09
[14] Completed acquisition by Optimax Clinics (Unlimited) of Ultralase Limited: ME/5989/13
[15] Completed acquisition by Stagecoach Group PLC of Preston Bus Limited: ME/4032/09, Stagecoach Group PLC v Competition Commission case reference: 1145/4/8/09, [2010] CAT 14.
[16] Completed acquisition by Long Clawson Dairy Limited of Millway Limited: ME/3794/08, Competition Commission, 14 January 2009.

commercial basis).[17] InHealth notes the view of the parties that "*the main barrier to entry is that they would need to obtain a variation to the licences issued by the MHRA to permit commercial supplies. So far as AM can judge, there is no reason why MHRA would refuse to grant such a consent given that third parties are authorised to supply FDG*"[18]. If that were the case, it suggests that such Trusts might be plausible bidders for IBA's assets, since it may be cheaper and easier to take over the existing assets of IBA (including its MA) than to establish a new cyclotron or improve an existing one to the point where a new MA could be secured.

4.9 [REDACTED]

4.10 [REDACTED]

4.11 If IBA were allowed to fail, it seems likely that its sales to its existing customers would be split between Alliance and PETNET. This seems to be a better outcome in terms of competition that these sales being exclusively captured by Alliance.

4.11.1 In Optimax, the CC cleared the merger only on the basis that the alternative of letting the company fail would not be preferable because the sales of the failing company would have flowed to the purchaser anyway. (para 6.34 et seq)

4.12 If exit as a stand-alone entity were found to be inevitable, the counterfactual scenario should not exclude other scenarios that might occur that would distribute IBA's assets (possibly as part of wider reforms of the FDG supply chain) in a way that led to greater efficiencies without an anti-competitive effect or the risks of foreclosure – for example, by establishing an ownership structure or set of binding constraints that mean the business engaged in FDG supply has an incentive to maximise sales across all PET-CT suppliers, rather than to act in ways that favour only its own downstream division.

4.13 In an orderly disposal of the assets of IBA, it is likely that the Dinnington assets would be of particular interest to parties interested in competing for PET-CT contracts in the North. Absent a bid from Alliance, those assets would find their way back to market and would form the basis of any competitive pressure on Alliance in those areas. This is considered under the third theory of harm ("TOH3") below.

5 Theory of harm 1: Loss of actual competition

[17] Further InHealth was not aware of the sale of IBA's assets as set out at questions 21 and 22 (paragraphs 128-133) of InHealth's response to the CMA's questionnaire.
[18] Alliance's Initial Submission to the CMA, paragraph 135.

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5.1 Prior to the merger, IBA was an independent competitor that provided a competitive alternative to Alliance/Erigal and PETNET. The parties do not appear to dispute that this third competitor will be removed from the market.[19]

5.2 As set out in the Phase 1 submission, there are currently two major contracts for the supply of PET-CT services. Alliance is the contracted provider for PET-CT services in the North of England, whilst InHealth is the contracted provider for PET-CT services in the South of England. Both contracts expire in April 2015. Both Alliance and InHealth are credible bidders in the upcoming contracts commissioning process being run by NHS England and are direct competitors in this market.

5.3 [REDACTED]

5.4 The loss of a competitor, even a weak competitor, is likely to substantially lessen competition. In *NGW/Arqiva*[20], which involved a merger between two businesses that each engaged in bidding for long-term contracts, and a situation where the undertaking being acquired had no prospect of immediate opportunities to bid for additional contracts, the Competition Commission noted that:

> *7.12 We noted that the examples provided by the parties related only to costs that are split between the multiplexes. We noted as well that the incentives, as described, depend upon the effective operation of contractual provisions regarding the distribution of any savings. We observed that, even in situations where long-term contracts exist, and even if contracts have been drafted to cover most foreseeable eventualities, the presence of a competitor provides some degree of constraint on the incumbent provider when changes to the terms or scope of the service are required. Measures which offer transparency to customers, and even the opportunity to audit the provider's costs, give some comfort to customers, but we did not believe that they replace the constraining effect of a potential competitor. Even though a long-term contract may create a strong incumbency advantage, the threat of losing the customer to a competitor under a similar long-term contract in the future, or the threat of losing other business to the competitor, possibly in an adjacent market, typically does constrain the incumbent provider's behaviour. Therefore, we remained concerned that the loss of rivalry*

[19] See, for example, the Alliance submission at Table 2 (page 48) and at paragraph 157, where Alliance notes the three closest cyclotrons to each site and notes that in each case, IBA is not one of the first two – but does not dispute that IBA is the third competitor in each site and, tacitly, that this third competitor will be lost from the market as a result of the merger.

[20] Macquarie UK Broadcast Ventures Limited/ National Grid Wireless Group Completed Acquisition Final Report, 11 March 2008.

between Arqiva and NGW may lead to higher charges or lower service quality under existing contracts.

5.5 In that case, 'long-term' meant through to the 2030s. In the current matter, long-term contracts will be available for bidding in the next few months.

5.6 It is also necessary to consider the impact of back-up requirements: the primary supply of FDG and the back-up supply are effectively tied services – you cannot have one without the other. Even if you could contract to buy them separately, they are not independent of each other. The result is that competition must take place between pairs of cyclotron sites – a primary and a backup. In the case of two suppliers who back up each other, these two roles might be played on a reciprocal basis, so that competition is between Cyclotron A (backed up by B) and Cyclotron B (backed up by A).

5.7 This necessarily exacerbates the reduction in competition in moving from 3 to 2 suppliers. [REDACTED]

5.8 [REDACTED]

5.9 Table 1 annexed to this submission shows the closest cyclotron sites to each of the InHealth scanner locations. The table shows that for 10 of the 16 scanner locations run by InHealth, these three cyclotron sites are the closest three. For all except one of these, the next nearest (i.e. the 4th nearest) is PETNET in Nottingham and is over 2 hours away.

5.10 **Switching.** InHealth considers that switching behaviour in the FDG market tends to be clustered around the periods when longer-term, higher volume contracts become available. The next few months are such a period (in the lead-up to the PET-CT commissioning). Therefore, it is not clear that the evidence of the past few years is truly evidence that switching in the market is low in a general sense.

5.11 Nor is there any evidence that switching between FDG providers is particularly difficult. Deliveries can arrive from a different point of origin without changing business processes or incurring additional costs at the scanning site. FDG itself is undifferentiated, both by virtue of compliance with the relevant clinical standard and by virtue of the regulatory requirements under an MA that are common to all FDG suppliers.

5.12 Switching between FDG suppliers by PET-CT providers who contract with more than one supply of FDG can also occur in whole or in part – that is, there is periodic bidding to establish supply agreements, and then decisions taken about the balance of trade

with different suppliers. Being able to shift the mix between established suppliers is only possible where there is sufficient geographic overlap between the suppliers.

5.13 In relation to the CMA's consideration of "rivalry-enhancing efficiencies and Alliance's argument that the merger will 'create a stronger competitor to InHealth and PETNET'", InHealth notes that:

5.13.1 InHealth does not compete in the market for FDG, and so:

5.13.1.1 To the extent that Alliance competes with Siemens PETNET to offer FDG to PET-CT providers, the effect on competition of removing a third competitive force is likely to outweigh the efficiency benefits, if any, associated with a reduction in the number of suppliers; and

5.13.1.2 [REDACTED]

5.13.2 Siemens PETNET does not compete in the market for PET-CT services, and so:

5.13.2.1 To the extent that Alliance competes with InHealth to bid for contracts to provide PET-CT, [REDACTED];

5.13.3 To the extent that the implication is that InHealth and Siemens PETNET can respond to the competitive threat in a coordinated way, this outcome is unlikely to be plausible given the different incentives and strategies of the two organisations (as per InHealth's response to the CMA's questionnaire at Question 19 (paragraphs 114-119]).

6 Theory of harm 2: Loss of potential competition

6.1 As a geographic analysis of the scanner sites illustrates, the strategic value of the Dinnington site to any player who seeks to bid for contracts to provide PET-CT in the North is very high – particularly if [REDACTED].

6.2 [REDACTED]

7 Theory of harm 3: Vertical effects

7.1 The EC Guidelines on Non-Horizontal Mergers note that:

> *34. Input foreclosure may raise competition problems only if it concerns an important input for the downstream product (6). This is the case, for example, when the input concerned represents a significant cost factor relative to the price of the downstream product.* ***Irrespective of its cost,***

> ***an input may also be sufficiently important for other reasons. For instance, the input may be a critical component without which the downstream product could not be manufactured or effectively sold on the market*** *(7), or it may represent a significant source of product differentiation for the downstream product (8). It may also be that the cost of switching to alternative inputs is relatively high.*

7.2 The supply of FDG clearly fits this criterion; it is essential to the supply of PET-CT and the securing of FDG is strategically vital to competition in PET-CT services irrespective of the proportion of the total cost of supply it represents.

7.3 The EC Guidelines provide that:

> *36. The merged entity would only have the ability to foreclose downstream competitors if, by reducing access to its own upstream products or services, it could negatively affect the overall availability of inputs for the downstream market in terms of price or quality. This may be the case where the remaining upstream suppliers are less efficient, offer less preferred alternatives, or lack the ability to expand output in response to the supply restriction, for example because they face capacity constraints or, more generally, face decreasing returns to scale (9). Also, the presence of exclusive contracts between the merged entity and independent input providers may limit the ability of downstream rivals to have adequate access to inputs.*

7.4 In this matter, there is an additional factor, which is the need to provide resilience of supply via back-up arrangements. By removing the third independent supplier in the South, Alliance/Erigal makes itself an essential supplier of back-up to InHealth or to PETNET.

7.5 [REDACTED]

7.6 [REDACTED]

7.7 Alliance makes a number of points in its submission to the CMA in relation to foreclosure. InHealth highlights a few key points and responds to them below:

[REDACTED]

8 Theory of harm 4: Coordinated effects

8.1 InHealth's reading of the IS is that this theory of harm constitutes an additional hurdle – that is, if there is no concern in relation theories 1, 2 and 3, then the risk that the merger would have coordinated effects would come to the fore.

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8.2 [REDACTED]

8.3 [REDACTED]

9 Countervailing factors

CMA question: Will entry and expansion be timely, likely and sufficient so as to mitigate the effects that might otherwise arise? In particular, would the 12 owners of cyclotrons who do not currently supply FDG to third parties do so following the merger?

9.1 This question is dealt with in relation to the question of market definition in relation to FDG.

CMA question: Any off-setting efficiencies?

9.2 InHealth does not believe that operating multiple cyclotrons brings great efficiencies of scale.

CMA question: Buyer power?

9.3 [REDACTED].

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Table 1

[REDACTED]