

ALLIANCE/IBA MERGER INQUIRY

Summary of a hearing with InHealth held on 29 May 2014

Background and supply of FDG

1. InHealth, a provider of PET-CT scans, saw its role as working in collaboration with the NHS and not as an outsource provider or as a substitute for the NHS. Most of InHealth's customers were NHS commissioners or NHS providers, and [X]% of its work was provided on the NHS's behalf. InHealth was focused on providing high-quality services and sought to do this by encouraging efficiency and innovation through open competitive tendering.
2. PET-CT scanning was an increasingly important service as the early detection of cancer supported the better treatments which were now available. PET-CT scanners required a reliable, stable and secure supply of FDG. Competition between FDG suppliers encouraged them to provide such a supply, but InHealth considered that all FDG providers had a shared responsibility to work together to provide an efficient back-up supply in order to minimise the chances of scans being cancelled. InHealth did not have a view about the structure of the FDG market or as to exactly how FDG providers should collaborate, but it did consider that these should be determined by what was in patients' best interests.
3. InHealth noted that the emphasis on self-back-up of FDG supply in some of the material thus far published during the CMA's inquiry was a new hypothesis to the market, and it was concerned that this focus might lead to a reduction in the efficacy of the current multisource back-up arrangements which it regarded as working well.
4. PET-CT scanning made up around £[X] million of InHealth's £[X] million turnover, the rest of which consisted of providing various types of radiological and other diagnostic services. InHealth employed around 1,000 staff, around [X] of whom provided various types of diagnostic services. It provided diagnostic services in the UK and the Republic of Ireland. [X]
5. [X]
6. The services that InHealth provided tended to be ones that the NHS was also capable of providing itself, at least in some areas, so InHealth had to demonstrate that it could provide more efficient and flexible service than the NHS

could on its own. InHealth did not bundle PET-CT scans into an overall package of services as the NHS trusts it supplied tendered for other radiology services separately to PET-CT services.

7. When InHealth was founded it had four distinct business activities: diagnostic services, sterile/decontamination services, theatre and procedure packs, and IT services. InHealth had divested the IT services, sterile/decontamination services, and theatre and procedure packs businesses by 2007 and had focused almost entirely on diagnostics since then. This had coincided with an increased emphasis on the provision of moving diagnostic services out of hospitals where possible, under the then government. InHealth had acquired other businesses to support its diagnostic services work, but these had not included suppliers of inputs, such as FDG.
8. InHealth had partnered with PETNET to provide scanning services at Nottingham City Hospital. Nottingham City Hospital had tendered for the provision of both a PET scanner and a cyclotron to produce FDG on the Nottingham City Hospital site, and InHealth had been interested in the opportunity. InHealth successfully bid for the provision of scanning services and built the facility at the hospital. It entered into an arrangement with PETNET, which leased one part of the facility and set up the cyclotron, while InHealth set up the scanning provision in the other part. This model had not been replicated elsewhere in the NHS as since then no other trusts had looked for a co-located cyclotron and PET scanning operation. [X]
9. InHealth noted that the competition regime, since its formalisation in legislation by the Health and Social Care Act 2012, now had greater prominence in the NHS, and that the NHS and organisations it worked with, such as NHS Commissioning organisations, were still working through how the new regime would operate in practice and how it would affect patient services. [X]
10. The reliability of FDG supply had changed since the introduction of the block contracts. At first, because the providers had just established new cyclotrons there were regular failures of supply, but as the operations settled down production became more reliable. More recently, supplies of FDG had become less reliable again, possibly because the providers had reached the capacity limits at some of their facilities, and because new tracers had come into use, and the cyclotrons which had previously been primarily focused on producing FDG were now also making other tracers.
11. The management of back-up supplies had also evolved during the period of the block contracts. In the early days, in the event of a production failure, the FDG producers would have delivered to their nearest customers in order to maximise the number of doses available. Now, having consulted with the

scanning providers, FDG suppliers would deliver some doses to all their customers and leave it up to the clinicians to decide how to prioritise their use, based on which patients most urgently needed scans.

12. InHealth considered that there were three aspects of this inquiry which were health industry specific: the importance of the industry to patients, the extent and overlapping nature of the industry's regulation, and the way in which the competitive process of procurement was operating, noting the fact that the tendering process for the next round of block contracts was operating in parallel with the CMA's merger process.
13. In order to ensure a reliable scanning service for patients, InHealth regarded it as essential that the FDG producers worked together to back each other up and ensure that the provision of back-up supplies was as fair and seamless as possible. Until now, FDG producers had understood the need to prioritise the needs of patients above their commercial needs. InHealth was concerned that if producers moved towards a self-back-up model, then they would be inclined to ensure that their own supply was backed up before assisting other providers.
14. [X]
15. InHealth did not consider that because FDG prices had fallen over the course of the block contract this meant that FDG suppliers were in a weak bargaining position. It noted that when the block contract had been extended in 2013, the NHS had asked it for a reduction of [X]% to the overall cost of scanning services. InHealth had approached its FDG suppliers to ask them to 'share the pain' of this price reduction, but the suppliers had responded that they were operating at capacity and there was little scope for them to reduce their FDG prices. [X]
16. [X] The amount of FDG it bought from its suppliers was based on the number of scans it needed to carry out, which was driven by volumes as set out in the South Contract or by patient referrals and was not something that InHealth could increase other than in support of patient demand. [X]
17. As it was not an FDG producer, InHealth was unable to comment on whether the current prices for FDG were sustainable in the long term. [X]
18. InHealth did not have a good view of the economic or commercial aspects of the FDG market. It was concerned that FDG prices remained competitively neutral and that they were not a source of vertical foreclosure.
19. The PET-CT scanning market had grown by around 10% over the last three years. InHealth expected the overall growth in radiology services to continue

at around 10% year on year in light of the population increase, the ageing of the population and the application of PET-CT scanning to conditions other than cancer, such as Alzheimer's diagnosis.

20. A 10% increase in the number of scans did not necessarily lead to a 10% increase in the number of FDG doses required. Improvements in technology and clinical developments in other European countries had led to dose reductions, but for these practices to be introduced here would require cooperation between equipment manufacturers and the clinical community. The Department of Health had looked into this in 2012 and had concluded that the UK was some years away from agreeing on a clinically accepted approach on FDG dose reduction. Dose reduction would have a number of benefits as it would reduce the exposure of both patients, who were now more likely to receive more than one scan during their treatment, and scanning staff to radiation. Early diagnosis and an increase in the numbers of diagnostic tests were an important part in the improved treatment of cancer, so InHealth expected that there would be an increased focus on dose reduction in future. Over the course of the next ten years, InHealth hoped that there would be significant headway would be made in dose reduction, but it could not say when this would be, so in the short term an increase in the number of scans was likely to lead to an increase in the amount of FDG doses required.
21. InHealth had experienced reliability problems with its FDG supply from IBA from September 2013, and PETNET had been required to back IBA a number of times over a six- to eight-week period. As IBA supplied three particular InHealth sites, repeated production failures could repeatedly affect the same patients, which would greatly concern NHS England. In order to ensure a reliable supply to these sites, InHealth had switched volumes for the Kent/Canterbury sites from IBA to PETNET. [X] InHealth had given IBA three months to improve its performance, which it did, so InHealth had reinstated IBA as the supplier to the three sites, but there had been further production problems recently. [X]

Market definition and the nature of competition

22. InHealth considered that for the FDG market, geographic market definition should be based on the customer (ie scanning provider) sites to which the FDG was delivered by the FDG suppliers. It also postulated that the configuration of the new regional block contracts would affect its ability to switch between suppliers. [X]
23. As noted above, InHealth preferred to source its FDG requirements [X], as it felt this gave it a better security of supply. At the time of the last regional block contract tender, InHealth believed that there was an NHS requirement that

scanning providers had to source at least 5% of their FDG requirements from an alternative source. This had aligned with InHealth's preference for multiple sourcing, [X].

24. [X]
25. [X]
26. [X]
27. [X]
28. Any incumbency advantage that FDG suppliers might have with their customers was based on the customers' confidence in the performance of their supplier and the quality of the customer–supplier relationship. [X]
29. [X]
30. InHealth considered that it would be possible for a vertically-integrated scanner and FDG supplier to enforce a margin squeeze on its scanning competitors, as FDG was an essential product, even though it made up a relatively small part of the total costs of providing scanning services. InHealth also noted that overall prices of scans had declined and were likely to decline further, so increases in the cost of FDG could have a greater effect in future.
31. The precise specification for the new regional block contracts had yet to be published, so InHealth did not know what approach to FDG supply the NHS would take. Indications so far have suggested that the NHS's focus would be on the overall provision of scanning services, and that it would be up to the scanning provider to manage how it sourced FDG.
32. During the last tendering process for the regional block contracts, [X].
33. InHealth's experience of the long-term NHS contracts it had been involved with was that there had some subsequent renegotiation of them, but that the fundamentals of the contracts had not changed. InHealth would certainly not assume that there would be no significant change to long-term contracts over their lifetime, but it did not have any anxiety about entering into such contracts.

Counterfactual

34. InHealth had been unaware that IBA's owners had been intending to sell its UK assets. [X]

35. InHealth had assumed that following the acquisition of IBA by SK Capital, it would be much more robust financially. Had InHealth been aware of IBA's difficult financial situation, it might have sought to assist it in some way short of acquiring the business. It also might have been willing to assist in other ways, potentially by taking a minority stake in the business. [X]
36. InHealth considered that the mothballed IBA Dinnington site would be of interests to providers looking to compete in the North. [X] At the time of its mothballing in 2010, InHealth had been told by IBA that the mothballing would be a short-term measure. InHealth had not been told that the site would be closed long term, or that mothballing was a way of closing the site which avoided the much greater costs of decommissioning. Reopening Dinnington now might be more difficult as it had been closed for some time.
37. Based on its interactions with the NHS, InHealth thought that it could be challenging for those NHS Trusts with cyclotrons to commercialise their FDG production and enter the general commercial market.
38. InHealth considered that if IBA had simply gone out of business, then its customers would have been split between the remaining FDG producers (Alliance/Erigal and PETNET). It could not say whether either Alliance or PETNET would have been able to win most of these customers.
39. InHealth was currently having to source FDG contracts as part of preparing its bid for the regional block scanning contracts. [X] InHealth did not know whether the held-separate IBA business would be seen by the NHS as a new entity when the NHS evaluated bids and what effect this might have on a bid's success.
40. [X]
41. InHealth did not know how much Alliance had paid for the IBA business so could not judge whether it would have been sensible for InHealth to have purchased it.
42. If InHealth had sourced all or the vast majority of its FDG supplies from IBA, this [X].
43. InHealth was of the view that maintaining relationships with a range of suppliers was important to InHealth for the variety of reasons noted above, as well as being able to assist in the development of future tracers.

Barriers to entry

44. InHealth recalled that getting the Nottingham site up and running – ie from becoming a preferred bidder to opening the facility – took around [X].
45. It was difficult for InHealth to predict how long it would take a new tracer to gain approval by the authorities. PET-CT scans were now being used for other diagnoses apart from cancer and the range of tracers had expanded, but InHealth could not say how widely these might be used as this was dependent on the NHS. InHealth was interested in using PET-CT scans in new ways and in the development of new tracers and would pursue these opportunities.