COMPETITION COMMISSION

Review of undertakings given by IMS Health Inc following its acquisition of Pharmaceutical Marketing Services Inc in 1999

Final decision

26 March 2014

Website: www.competition-commission.org.uk

Members of the Competition Commission who conducted this inquiry

Martin Cave *(Chairman of the Group)*

Katherine Holmes

Jon Stern

Chief Executive and Secretary of the Competition Commission

David Saunders

The Competition Commission has excluded from this published version of its final decision information which the inquiry group considers should be excluded having regard to the three considerations set out in section 244 of the Enterprise Act 2002 (specified information: considerations relevant to disclosure). The omissions are indicated by [✂]. Some numbers have been replaced by a range. These are shown in square brackets. Non-sensitive wording is also indicated in square brackets.

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1. Summary

1.1 On 25 February 1999, the Monopolies and Mergers Commission (MMC) published its final report on the acquisition by IMS Health Incorporated (IMS) of Pharmaceutical Marketing Services Incorporated (PMSI) (the 1999 report).[1]

1.2 The MMC found that the merger may be expected to operate against the public interest with the following adverse effects:

(a) reducing competition in the supply of specialized pharmaceutical data services;

(b) higher prices to pharmaceutical companies, weaker incentives to improve quality of data and service, and less innovation and customer choice in the supply of specialized pharmaceutical data services than would otherwise be the case, and lower rewards to data providers, adversely affecting the incentives to provide data and the quality of the data provided; and

(c) greater costs to the NHS for the supply of medicines, higher prices for over-the-counter (OTC) medicines in the UK, and less choice of pharmaceutical products in the UK.[2]

1.3 Pursuant to the 1999 report, the Secretary of State for Trade and Industry accepted undertakings given on 29 October 1999 by IMS (the Undertakings). In summary, the Undertakings comprised:

(a) the divestiture of the former PMSI wholesale data business, Source Dispenser;

(b) a requirement on IMS to license all its prescription data on reasonable terms to other parties;

(c) a requirement on IMS to price all its specialized data services according to a transparent price list and discounts;

(d) a prohibition on bundling and tying its products with other IMS goods or services; and

(e) a requirement not to enter into or enforce any exclusive contract with a pharmacist (which comprised both pharmacies and doctors providing pharmaceutical services).

1.4 In October 2000, IMS divested PMSI's Source Dispenser business to NDC Health Corporation (NDC Health). In October 2002, NDC Health contributed the Source Dispenser business to a newly created 50:50 joint venture with Cegedim SA (Cegedim), called Infopharm Limited. In October 2004, Cegedim acquired NDC Health's UK business and thus took full ownership of the Source Dispenser business. Infopharm subsequently exited the market in 2009.

1.5 The Office of Fair Trading (OFT) reviewed the licensing prescription data remedy in 2005 and found that in the five years since the Undertakings had been accepted, the licensing obligation had not been used by any business for the intended purpose.

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[1] *IMS Health Inc and Pharmaceutical Marketing Services Inc: A report on the merger situation*, 25 February 1999. Cm 4261.
[2] The 1999 report, paragraph 2.81.

The OFT decided that this undertaking should be allowed to expire on 28 February 2005. It also decided against recommending that IMS be released from any of the other undertakings due to third party concerns at the time that removing the Undertakings might jeopardize the current degree of competition in the market.

1.6 There are therefore only three undertakings remaining in force—paragraph 1.3*(c)* to *(e)* above.

Change of circumstances

1.7 Under section 88 of the Enterprise Act 2002 (the Act), the OFT has a general duty to keep under review undertakings given under the Act and to consider whether, by reason of any change of circumstances, an undertaking is no longer appropriate and needs to be varied or superseded, or parties to undertakings need to be released from them. The OFT shall give such advice to the Competition Commission (CC) as it considers appropriate in relation to any possible variation or release from such undertakings.

1.8 On 14 November 2012, IMS submitted to the OFT that there had been a change of circumstances that meant the Undertakings were no longer appropriate and that IMS should be released from them in full.

1.9 On 12 August 2013, the OFT published its advice to the CC (the OFT's advice) that there had been a change of circumstances because the UK Government had started publishing free of charge on a monthly basis GP prescription data (the NHS prescription data) for England. It said that IMS had submitted that new entry had been facilitated by the free NHS prescription data but that the effect of the change of circumstances was unclear because the OFT had been unable to verify the extent of this new entry or its effect. The OFT's advice to the CC was that, on the basis of its findings regarding a change of circumstances and the mixed evidence, the CC should consider whether it was appropriate to release IMS from the Undertakings.

Findings

Change of circumstances

1.10 We found that there has been a change of circumstances since the 1999 report as a result of the release of NHS prescription data. However, because of the limited frequency and coverage of data across some of the UK, the effects of this change of circumstances are not as yet as significant as they might be. The new entrants that have emerged have to date been providing services that are largely complementary to IMS and only a few customers have switched to self-supplying data services using the NHS prescription data instead of using IMS specialized pharmaceutical data (which is based upon wholesale data and/or prescription data). Although this trend may increase over time, at present there remains insufficient countervailing power in the market. In addition, in the absence of the Undertakings, barriers to entry would remain due to IMS being the only current provider of wholesale data and near census-level prescription data on a frequent basis, its ability to offer a range of services (and in particular, hospital-based data services) which it could bundle with its prescription-based products, and its advantage of being the incumbent.

Implications of the change of circumstances for the Undertakings

1.11 We considered whether IMS could be released from some or all of the Undertakings in light of our findings.

1.12 We found that IMS has both the incentive and ability to bundle and tie. Even though some customers might benefit from having access to bundled products and services (and thus in the short term possibly paying a lower price overall), the effect of permitting bundling or tying would be to raise barriers to entry. This is because it would be open to IMS to create bundled or tied products by integrating services where IMS is the only provider or faces limited competition, creating offers which competitors would be unable to match. Emerging competition would therefore be unlikely to develop. Over the longer term we consider that this increase in barriers to entry would be detrimental to customers. We therefore concluded that the prohibition on bundling and tying should be retained.

1.13 We found that the price transparency remedy works in combination with the prohibition on bundling and tying and it supports the effective monitoring of the prohibition on bundling. We did not consider that the ability for IMS to discount was removed by the remedy—IMS is only required to be transparent in its pricing. The remedy has longer-term benefits because it prevents IMS from selectively reducing prices to customers who are more likely to, or have expressed a propensity to switch to a new entrant, such that entry is then foreclosed. The longer-term effects of this strategy would be detrimental to customers. We noted that the remedy also has benefits in preventing IMS from selectively increasing prices to those customers who have less countervailing power. We concluded that the obligation to publish prices in a transparent manner should therefore be retained.

1.14 We have found that NHS prescription data is not yet substitutable for IMS specialized pharmaceutical data for enough customers to provide a competitive constraint on IMS. IMS data is the most complete and up-to-date source of prescription data. A new entrant wishing to replicate IMS's offer would need to obtain data from pharmacies. This option would be unavailable for any competitor if IMS could engage in exclusive contracts with pharmacies. For these entrants, the effect of this remedy is clear as it lowers a potentially significant barrier to entry. Any costs arising from this remedy seemed low. We concluded that the non-exclusivity remedy should be retained.

Our final decision

1.15 For the reasons above, we concluded that the Undertakings should be retained in their present form.

1.16 At present it is uncertain to what extent or when further NHS prescription data might be published in the future or whether other possible changes of circumstances might make the Undertakings inappropriate. We recognize that the need for the Undertakings may be reduced or eliminated in the event that the coverage and timeliness of the NHS prescription data becomes more consistent across the four UK nations such that it provides a viable alternative for customers or a viable basis for competitors to compete with IMS's products. These or any such developments in the market, or any unanticipated effects of the change of circumstances assessed in this review, would need to be considered by the Competition and Markets Authority (CMA) through a subsequent review of the Undertakings. It would be for the CMA to consider the need for any such review consistent with its review guidelines published in January 2014.[3]

[3] *Remedies: Guidance on the CMA's approach to the variation and termination of merger, monopoly and market undertakings and orders*, January 2014, CMA11.

2. Introduction

2.1 Under section 88 of the Act, the OFT has a general duty to keep under review undertakings given under the Act and to consider whether, by reason of any change of circumstances, an undertaking is no longer appropriate and needs to be varied or superseded, or parties to undertakings need to be released from them. The OFT shall give such advice to the CC as it considers appropriate in relation to any possible variation or release from such undertakings.

2.2 On 29 October 1999, pursuant to the 1999 report, the Secretary of State for Trade and Industry accepted the Undertakings from IMS. Responsibility for the Undertakings was transferred to the CC on 10 March 2006 by Statutory Instrument.[4]

2.3 On 6 August 2013, the OFT gave advice to the CC that on the basis of its findings regarding a change of circumstances and the mixed evidence it had found, the CC should consider whether it would be appropriate to vary the Undertakings or release IMS from them.[5]

2.4 This report sets out our final decision regarding our review of the Undertakings in light of the change of circumstances identified by the OFT. In this report we set out:

(a) the background to our review, including the findings in the 1999 report, a summary of the Undertakings and a summary of the OFT's advice (Section 3);

(b) our approach to assessing the change of circumstances, including setting out the way in which the harm identified in the 1999 report might still arise (the 'theory of harm') (Section 4);

(c) our assessment of the change of circumstances by considering changes in the market against the theory of harm (Section 5);

(d) our assessment of the implications of the change of circumstances on each remedy in the Undertakings (Section 6); and

(e) our final decision (Section 7).

3. Background

Industry background

3.1 IMS is a provider of market information to pharmaceutical manufacturers and health-care companies. IMS collects data from different sources to develop data services that it sells to pharmaceutical companies. Pharmaceutical business information (ie information on sales of pharmaceutical products in the UK) is used by pharma-ceutical companies to monitor their competitive position on a product-by-product basis, to identify areas of product development, to focus their sales and marketing programmes, and to provide a basis on which to remunerate their sales team.[6]

3.2 Figure 1 shows how IMS collects data and then sells this data to pharmaceutical companies.

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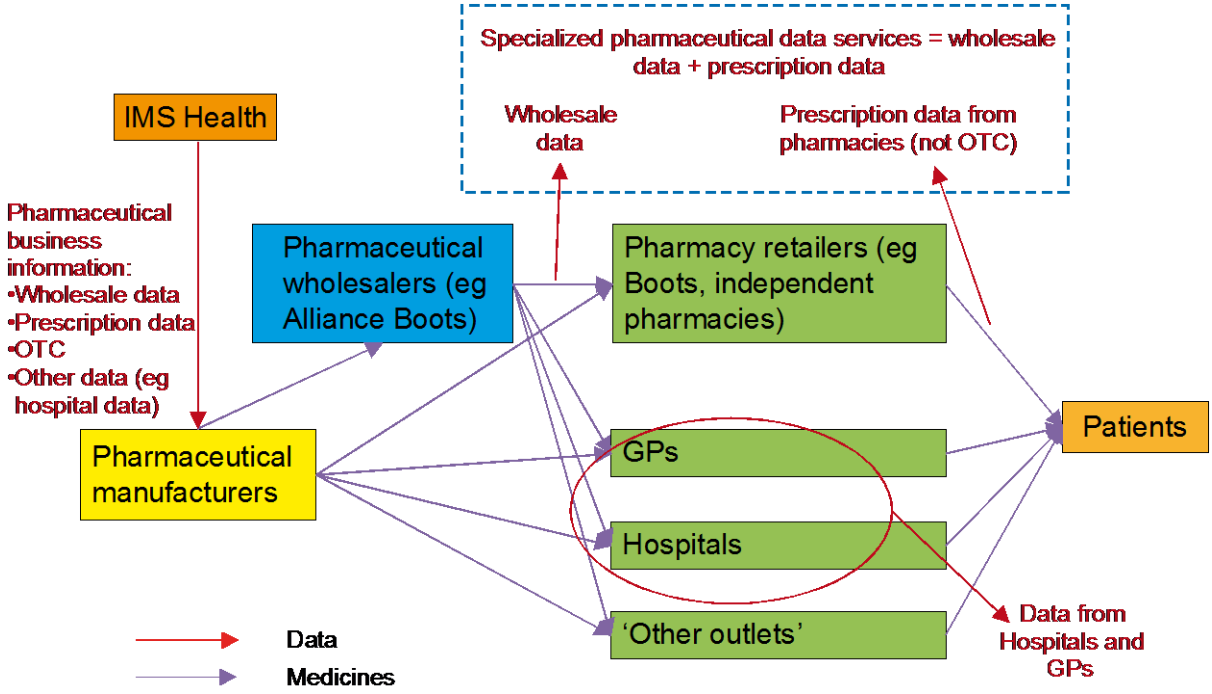
[4] SI No.355/2006—The Enterprise Act 2002 (Enforcement Undertakings and Orders) Order 2006.
[5] The full text of the advice was published on 12 August 2013.
[6] The 1999 report, paragraph 2.14.

FIGURE 1

Sources of IMS pharmaceutical business information



Source: CC analysis.

3.3 Figure 1 shows that pharmaceutical business information comes from three main sources:

(a) Wholesale data—data collected from pharmaceutical wholesalers on pharmaceutical products purchased by pharmacies. This allows IMS to create products of national sales audits (wholesale data of all sales) and sales territory reports (full sales coverage, analysed territorially for monitoring sales force and setting remuneration).

(b) Prescription data—data collected from pharmacies on prescriptions dispensed to patients. This allows IMS to create data showing products prescribed and dispensed by pharmacy and by geographic areas, known as 'bricks', allowing targeted marketing.

(c) Hospital data—data collected from hospitals on sales to hospitals. This allows IMS to create data services showing the value and volumes of medicines dispensed from NHS hospital pharmacies, including specialty detail level information. This is used by pharmaceutical companies to monitor the success of sale campaigns and assess sales representatives' performance in the UK.

3.4 In the 1999 report, the MMC found that pharmaceutical business information based on wholesale data from a census of prescribed pharmaceuticals generated revenues in 1997 of £16 million (all of which related to IMS and PMSI) and that pharmaceutical business information based on prescription data from potential census and samples generated £2.1 million (of which IMS and PMSI accounted for £0.8 million)—a total of

£18.1 million. Information from other data sources (including wholesale data on OTC and veterinary medicines) accounted for £46.7 million.[7]

3.5 IMS told us that, in 2012, it generated £[✂] million from its prescription data services and £[✂] million from its wholesale data services—a total of £[✂] million (up [✂] per cent from 1997). Hospital-based data services accounted for £[✂] million in 2012. Due to [✂] (see paragraph 5.3), IMS's revenue forecast for 2013 was £[✂] million from its prescription-based data services and £[✂] million from its wholesaler-based data services—a total of £[✂] million (down [20–30] per cent on 2012).

The 1999 report

3.6 In the 1999 report, the MMC identified the relevant market as that of 'specialized pharmaceutical data services' which comprised services based on wholesale data (national sales audits and sales territory reports) and prescription data (prescription audits, micromarketing services and GP-level prescription data services). The MMC found that IMS had an 85 per cent share of this market and PMSI 8 per cent, giving a combined post-acquisition market share of 93 per cent.[8] In wholesale data services, which accounted for 88 per cent of the relevant market in revenue terms, the MMC found that the merger gave IMS a 100 per cent share of such services (previously IMS had a 95 per cent share and PMSI had had a 5 per cent share—they were the only two competitors prior to the merger).[9]

3.7 The MMC also noted that 'arguably, hospital audits and medical audits could also be regarded as part of a specialized pharmaceutical data market—but it would make little difference to the size of the market or to the combined market share of IMS and PMSI if they were included'.[10] However, the MMC did not include these products in the relevant market.

3.8 The MMC found that IMS had considerable market power in the UK, derived from its strong position internationally as a supplier of data on a global basis to pharmaceutical companies.[11] The MMC said that the potential effects of the merger may go wider than the specialized pharmaceutical data services market because of the links with more general market research that IMS had created in its sales strategy and the links with related products that were involved in data supply.[12]

3.9 The MMC found that the prospects of effective entry into the UK market were limited[13] and countervailing power of purchasers was insufficient to offset the loss of competition resulting from the merger.[14]

3.10 The MMC found that the merger may be expected to operate against the public interest with the following adverse effects:

(a) reducing competition in the supply of specialized pharmaceutical data services;

(b) higher prices to pharmaceutical companies, weaker incentives to improve quality of data and service, and less innovation and customer choice in the supply of specialized pharmaceutical data services than would otherwise be the case, and

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[7] The 1999 report, Table 2.1.
[8] ibid, paragraph 2.40.
[9] ibid, paragraph 2.47.
[10] ibid, paragraph 2.39.
[11] ibid, paragraph 2.26.
[12] ibid, paragraph 2.40.
[13] See paragraph 5.43 below for a discussion of the barriers to entry identified in the 1999 report.
[14] The 1999 report, paragraph 2.74.

lower rewards to data providers, adversely affecting the incentives to provide data and the quality of the data provided. The MMC said that the merger may therefore be expected to have adverse effects on the efficiency and effectiveness and costs of the management and marketing of pharmaceutical companies; and

(c) greater costs to the NHS for the supply of medicines, higher prices for OTC medicines in the UK, and less choice of pharmaceutical products in the UK.[15]

3.11 The MMC considered a range of remedies. It found that divestment of the whole of PMSI would not be effective because events since the merger had led to the worsening financial situation of the business.[16] The MMC therefore recommended to the Secretary of State for Trade and Industry a package of remedies aimed at lowering barriers to entry and encouraging one or more new or expanded competitors into the market.[17] This package comprised requirements *(a)* to divest PMSI's former activities based on wholesale data (Source Dispenser); *(b)* to license prescription data; *(c)* to publish price lists and discounts; *(d)* not to bundle or tie products; and *(e)* not to enter into exclusive contracts for the supply of data (see paragraph 3.12).[18]

The Undertakings

3.12 On 29 October 1999, the Secretary of State for Trade and Industry accepted final undertakings from IMS which were in accordance with the MMC's recommendations:

(a) Divestiture of Source Dispenser business. The divestment of the former PMSI wholesale data business, Source Dispenser, was completed on 2 October 2000 to NDC Health.

(b) Licensing prescription data. IMS was required to license all its prescription data on reasonable terms to other parties. This undertaking was time-limited until 31 August 2004, but was subsequently extended by the OFT to 28 February 2005.

(c) Transparent pricing. IMS was required to publish on its website[19] prices and discounts of 'specialized pharmaceutical data'.

(d) Not to bundle or tie. IMS was required not to supply or offer to supply in the UK 'specialized pharmaceutical data' (i) subject to a condition that the purchaser will acquire or agree to acquire other goods or services from IMS, or (ii) with a discount if the purchaser acquires or agrees to acquire other goods or services from IMS.

(e) Non-exclusive acquisition of data. IMS was required not to enter into or enforce any contract with a pharmacist in the UK which contains a provision preventing or restricting the pharmacist from supplying 'specialized pharmaceutical data' to any other person in the UK. IMS also undertook not to take any action in relation to computer hardware or software in any pharmacy which might inhibit the extraction of 'specialized pharmaceutical data' by any other person.

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[15] ibid, paragraph 2.81.
[16] ibid, paragraph 2.87.
[17] ibid, paragraph 2.89.
[18] ibid, paragraph 2.90.
[19] And make available in hard-copy form if required.

3.13 The Undertakings defined 'specialized pharmaceutical data' in *(c)*, *(d)* and *(e)* as 'census-level wholesale data (excluding over-the-counter data and veterinary data) and prescription data produced in the UK', where 'prescription data' meant information contained in any prescription dispensed by a pharmacist[20] (in practice, pharmacies and doctors) providing pharmaceutical services.

3.14 IMS said that the primary objective of remedies *(c)*, *(d)* and *(e)* was to facilitate the implementation of the structural remedy in respect of wholesale data and the licensing remedy. In our view, whilst it is clear from the 1999 report that these three remedies were expected to work in combination with the structural remedies,[21] it is also clear that these remedies 'were necessary ... for *any new entrant* or business divested from IMS to compete in the market' (emphasis added). These remedies were thus enabling measures aimed at lowering barriers to entry in general, as well as being aimed at supporting remedies *(a)* and *(b)*.

Developments in the Undertakings since 2000 and before this review

Source Dispenser business

3.15 In October 2002, NDC Health contributed the Source Dispenser business to a newly created 50:50 joint venture with Cegedim, called Infopharm Limited. In October 2004 Cegedim acquired NDC Health's UK business and thus took full ownership of the Source Dispenser business.

3.16 Cegedim said that its Infopharm business (see paragraph 5.45) was definitively closed in 2009. Cegedim told us that the closure of Infopharm was due to the increased cost of purchasing wholesale data from Alliance Boots.

Licensing of prescription data

3.17 When the OFT reviewed the licensing prescription data remedy in 2005, the OFT found that in the five years since the Undertakings had been accepted, the licensing obligation had not been used by any business for the intended purpose. The OFT decided that this undertaking should be allowed to expire on 28 February 2005.[22]

Other remedies

3.18 In its 2005 review, the OFT decided against recommending that IMS be released from any of the other undertakings due to third party concerns at the time that removing the Undertakings might jeopardize the current degree of competition in the market.

3.19 There are therefore only three undertakings remaining in force—see *(c)* to *(e)* in paragraph 3.12.

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[20] A 'pharmacist' was defined as a person included by a health authority in a pharmaceutical list in accordance with the National Health Service (Pharmaceutical Services) Regulations 1992 reg 4(1), and a doctor who is able to provide pharmaceutical services to a patient in accordance with arrangements made by a health authority in accordance with National Health Service (Pharmaceutical Services) Regulations 1992 reg 20(3) and (4).
[21] The 1999 report, paragraphs 2.89 and 2.95.
[22] OFT press release 32/05 of 18 February 2005, OFT completes review of IMS Health merger undertakings—The Office of Fair Trading.

IMS's submission to the OFT

3.20 On 14 November 2012, IMS submitted to the OFT that there had been a change of circumstances resulting from the publication of NHS prescription data free of charge that meant the Undertakings were no longer appropriate and that IMS should be released from them in full.

3.21 IMS argued that the NHS prescription data was directly comparable to the prescription data purchased and provided by IMS and therefore, a new entrant could source the data free of charge, thus reducing barriers to entry. IMS said that since the NHS prescription data had become available there had been considerable new entry, and that numerous other companies were already using NHS prescription data, thus affecting IMS's business directly and appreciably.

3.22 We consider the effect of the publication of NHS prescription data in Sections 5 and 6.

The OFT's advice

3.23 On 12 August 2013, the OFT published its advice to the CC that there had been a change of circumstances because the UK Government had started publishing free of charge on a monthly basis NHS prescription data that were three months in arrears for England. It said that IMS had submitted that new entry had been facilitated by the free NHS prescription data but that the effect of the change of circumstances was unclear because the OFT had been unable to verify the extent of this new entry or its effect. The OFT's advice to the CC was that, on the basis of its findings regarding a change of circumstances and the mixed evidence, the CC should consider whether it was appropriate to release IMS from the Undertakings.[23]

CC consultation

3.24 On 16 August 2013, we invited comments on the OFT's advice regarding the change of circumstances and its effect on the Undertakings. We received submissions from IMS, one competitor and two customers. We subsequently received many responses from customers and competitors to questionnaires we sent to them.

3.25 On 23 December 2013, we published our provisional decision for consultation. We received responses from IMS and one competitor.

3.26 We summarize submissions and responses in further detail in Sections 5 and 6 as relevant.

4. Our approach to assessing the change of circumstances

4.1 In assessing whether by reason of a change of circumstances it is now appropriate to release IMS from the Undertakings or to vary or supersede the Undertakings, we have considered the extent to which the adverse effects on competition identified in the 1999 report are likely to emerge in the absence of the Undertakings.

4.2 Based on the MMC's findings set out in paragraphs 3.8 to 3.10 and the aim of the remedies set out in paragraph 3.11, we have considered how the adverse effects identified in the 1999 report might still arise. Our 'theory of harm' is based on the

[23] The OFT's advice, paragraphs 18–20.

findings of the 1999 report and is testing whether these concerns still apply. The theory of harm is designed to test whether actual and potential competition in the supply of specialized pharmaceutical data services remains insufficient to constrain IMS due to *(a)* the continued existence of barriers to entry and expansion in the absence of the Undertakings and *(b)* a lack of countervailing buyer power. In the absence of the Undertakings, this would lead to higher prices, lower quality and/or reduced innovation than would otherwise be the case.

4.3 In making our assessment, we used as our starting point the OFT's advice on the change of circumstances, and reviewed the submissions made and responses to our questions from IMS, IMS's competitors in the market of specialized pharmaceutical data services, IMS's customers and NHS bodies from the UK.

5. Assessment of change of circumstances

5.1 In this section we set out our assessment of the change of circumstances. We cover:

(a) the market environment before the release of NHS prescription data;

(b) publication of NHS prescription data;

(c) new entry into specialized pharmaceutical data services that has occurred;

(d) a comparison between NHS prescription data and the data used by IMS in its products;

(e) the impact of the publication of NHS prescription data on IMS;

(f) changes in barriers to entry and expansion since 1999;

(g) changes in countervailing power since 1999;

(h) other issues raised by IMS; and

(i) our conclusions on the change of circumstances.

Market environment before the release of NHS prescription data

Specialized pharmaceutical products

Wholesale data

5.2 Since 2009 IMS has been the only provider of specialized pharmaceutical data services based on wholesaler data in the UK. We were told that the only other provider, Taylor Nelson Sofres (TNS), exited the market in around 2008 for similar reasons to Infopharm.

5.3 IMS recently [✂] for the reasons explained below.

5.4 IMS identified two main advantages of prescription-based data products over wholesale data products. First, wholesale data is affected by changes in stock levels. Second, products supplied by wholesalers to pharmacies are increasingly exported to other EU countries. Prescription data is therefore seen as a more accurate measure than wholesale data for tracking sales and marketing performance in the UK.

Prescription-based data

5.5 Before they merged, IMS and PMSI were the only providers of micro-marketing and GP-level prescription-based data services, with shares of 34 and 66 per cent in 1997 respectively. TNS was a competitor of IMS and PMSI on the provision of prescription audits, with a share of 76 per cent in 1997, although it expressed to the MMC that it had no intention of competing with IMS and PMSI more widely.[24] As noted above, TNS exited the market in around 2008.

5.6 IMS continued providing its prescription-based service (Xtrend). IMS developed and improved its prescription products, rebranding them as Xponent. IMS has recently [✂].

Prices

5.7 IMS submitted its prices for prescription and wholesaler data services from 2005 to 2014. In general, prices show an upward trend. Prices of all products increased by 3.5 per cent in 2009, 2011 and 2012, with the exception of the Early Insight product, which increased by 7 per cent in 2012.[25] The prices of Supply Chain Manager and Early Insight for 2014 increased by an additional 3.5 per cent. The price of Prescribing Indicator decreased by almost 50 per cent in 2007, and increased by 12 per cent in 2008. IMS prices are shown in Table 1 (see paragraph 5.41 and Table 4 for our assessment of prices since 2012).

TABLE 1 **Prices of IMS's pharmaceutical business information services based on wholesale and prescription data**

*£'000 per line of data**

Product	*Data source*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*	*2013*	*2014*
National Prescription Audit (NPA)	Prescription	[✂]	[✂]	[✂]	[✂]	[✂]	[✂]	[✂]	[✂]		
PCO micromarketer (sub-national NPA)—price dependent on Rx count	Prescription				[✂]	[✂]	[✂]	[✂]	[✂]		
Xponent Trawling Report (Monthly report with 2 years' history)	Prescription	[✂]	[✂]	[✂]	[✂]	[✂]	[✂]	[✂]	[✂]	[✂]	[✂]
Xponent RxA	Prescription									[✂]	[✂]
Wholesaler Retail Sales Audit (RSA)	Wholesale	[✂]	[✂]	[✂]	[✂]	[✂]	[✂]	[✂]	[✂]		
Prescribing Indicator	Wholesale	[✂]	[✂]	[✂]	[✂]	[✂]	[✂]	[✂]	[✂]	[✂]	[✂]
Supply Chain Manager	Wholesale	[✂]	[✂]	[✂]	[✂]	[✂]	[✂]	[✂]	[✂]	[✂]	[✂]
Early Insight	Wholesale	No data	No data	No data	No data	No data	No data	[✂]	[✂]	[✂]	[✂]

Source: IMS.

*A line of data is a set of information for a specified time period, according to specified measures (e.g. value or number of units), relating to:

- A single product, pack, molecule or therapy area; or
- A summation of multiple products, packs, molecules or therapy areas.

5.8 IMS told us that its prices over the period from 2005 to 2012 had increased well below the rate of inflation over that period (which was approximately 26.5 per cent). It

[24] See the 1999 report, paragraph 2.46.
[25] We were not provided with data on this product for prior years.

also said that one of largest costs faced by IMS was the cost of employing staff. That cost had increased even more significantly over the period in question.

Quality

5.9 In 1999 the MMC found almost unanimous complaints about IMS's performance from pharmaceutical companies.[26] IMS believed that weaknesses in its performance were being addressed and some customers acknowledged that IMS had to some extent become more customer-focused.[27]

5.10 IMS provided the CC with results from its 2010, 2012 and 2013 customer satisfaction surveys of customers in North Europe and Africa, and detailed results from its UK customers for 2012 and 2013 only. The results from these surveys showed an overall satisfaction index of [50–60] per cent in 2013,[28] decreasing since 2010.[29] For UK customers, the satisfaction results were [50–60] per cent in 2013 and [50–60] per cent in 2012. The surveys also showed that [20–30] per cent of UK customers rated IMS's information and data services as very good or excellent in 2013 (compared with [20–30] per cent of customers in 2012) and [10–20] per cent of UK customers rated the accuracy of data as very good or excellent ([10–20] per cent in 2012). [30–40] per cent of UK customers rated IMS's client support services as very good or excellent in 2013 ([40–50] per cent in 2012).[30] The results for 2013 are shown in Figure 2.

FIGURE 2

Results from Customer Satisfaction Survey (2013)—UK customers

[✂]

Source: IMS.

5.11 We received comments from several customers expressing concerns about the quality of IMS's services, either in terms of prices, data accuracy, or customer service. One customer ([✂]) rated IMS's service as satisfactory. Seven customers ([✂]) mentioned concerns about IMS's products based on prescription data compared with the wholesaler-based data services, such as the reduced coverage of these services and accuracy of the data. These customers told us: [✂].

Publication of NHS prescription data

5.12 The NHS Health and Social Care Information Centre (HSCIC) started publishing monthly GP prescription data for England in December 2011.[31] This move was followed in Wales by NHS Wales (GIG Cymru) in April 2013 and in Northern Ireland by Health and Social Care Northern Ireland in September 2013 (quarterly data only). Currently, there is no monthly or quarterly GP-level prescription data published in Scotland by the Information Services Division (ISD) (but see Table 2 for details of the

[26] See the 1999 report, paragraph 2.64.
[27] ibid, paragraph 2.28.
[28] Percentage of customers very satisfied or satisfied.
[29] [60–70] per cent of customers were satisfied or very satisfied with IMS in 2010, [50–60] per cent in 2012 and [50–60] per cent in 2013.
[30] All percentages are calculated excluding answers left blank.
[31] Chemical-level data was released in December 2011. More granular presentation-level data was released in September 2012.

ISD's Prescription Cost Analysis annual publication).[32] We understand that England accounts for 80 per cent of total prescriptions, Scotland 10 per cent, Wales 5 per cent and Northern Ireland 4 per cent.

5.13 NHS prescription data available for England, Wales and Northern Ireland covers prescriptions by GPs or non-medical prescribers attached to GP practices in England, Wales and Northern Ireland respectively, and that are subsequently dispensed in the community (eg by pharmacies); it does not record prescriptions that have not been dispensed. NHS data also does not include private prescriptions (which IMS said amounted to 0.3 per cent of total prescriptions). The data is available for download free of charge from the NHS bodies' websites.[33] We compare the NHS data with IMS's prescription data in paragraphs 5.24 to 5.33.

5.14 Table 2 shows the current status of publication in each country.

TABLE 2 **Publication of NHS prescription data in each country**

	England	*Wales*	*Scotland*	*Northern Ireland*
First released	September 2012	April 2013	N/A	September 2013
Historical data	Backdated to August 2010	Backdated to April 2010	Backdated to 2000/2001	Backdated to April 2013
Frequency	Monthly	Monthly	Annual	Quarterly
Time lag	3 months in arrears	2 months in arrears	3 months in arrears	3 months in arrears
Granularity	By GP practice	By GP practice	At Scotland level	By GP practice
Data	Presentation level *	Presentation level*	Presentation level*	Presentation level*

Source: NHS.

*Presentation level means the individual drug name, form and strength or size.
N/A = not available.

5.15 Both HSCIC (England) and NHS Wales said that they had no plans to change their existing data publications. The ISD for Scotland told us that release of prescription data at a greater granularity and/or frequency was a key business objective for 2014/15 but that the timeline for this was still being worked on as part of its planning process. In Northern Ireland, there are no plans to publish GP prescribing data for products dispensed prior to April 2013[34] and Health and Social Care Northern Ireland told us that there are no plans to provide additional information to that currently provided.

5.16 In response to our provisional decision, IMS said that the NHS had recently announced its intention to publish patient-level care data for use by, among others, pharmaceutical companies and insurers (although the date of publication and uses of care data have since been reviewed by the Department of Health). IMS said that this came alongside the publication of NHS prescription data, which had been freely available since 2012 and was already used by pharmaceutical and consultancy companies. IMS said that this further demonstrated the speed of change in the sector.

5.17 We noted that this database is not yet available (in February it was announced by NHS England that the publication of patient data would be delayed by six months[35]

[32] The ISD said that requests for GP-level data were dealt with via its Information Request service. It said that the costs and time involved would depend on what was requested and the format the customer required the data in.
[33] England data available at www.nhsbsa.nhs.uk/PrescriptionServices/3516.aspx. Wales data available at www.wales.nhs.uk/sites3/page.cfm?orgid=428&pid=65866, Northern Ireland data available at www.hscbusiness.hscni.net/services/2471.htm, Scotland data available at www.isdscotland.org/Health-Topics/Prescribing-and-Medicines/Community-Dispensing/Prescription-Cost-Analysis/.
[34] www.hscbusiness.hscni.net/pdf/NI_GP_Prescribing_FAQs.pdf.
[35] www.england.nhs.uk/2014/02/19/response-info-share/.

and HSCIC will not begin collecting data until autumn 2014[36]) and that it has not yet been decided whether or under which conditions it will be made available to private companies. We also noted that this database is currently only proposed for England and will include only prescribed medicines. Whilst this database could potentially provide a source of information for some pharmaceutical companies, we found that it is too early to say how effective this database would be as a constraint on IMS's specialized pharmaceutical data products and services.

New entry into specialized pharmaceutical data services

5.18 The Undertakings were intended to encourage entry into the UK specialized pharmaceutical data market. However, entry was not observed until NHS prescription data became available. No company requested access to IMS's prescription data during the period that the licence requirement was in place, and there was no entry from competitors with a wholesaler-based data service. Moreover, Cegedim, which acquired the Source Dispenser business, closed that business in 2009, and TNS, a competitor in the prescription data sector, stopped providing data services in around 2008. This suggests that in the past the Undertakings have not been particularly successful in achieving their purpose. However, in considering the relevance of the Undertakings, we need to consider how important they will be in the future in facilitating new entry, particularly given the publication of NHS prescription data.

5.19 The publication of NHS prescription data influenced entry from several companies. IMS provided a list of eight competitors that it said had launched data services based on the NHS prescription data over the last two years. Neither customers nor pharmaceutical data providers have mentioned additional competitors to these eight.[37]

5.20 The competitors identified by IMS were:

(a) Cegedim—Cegedim provides products based on patient-level data, retail pharmacy dispensing data and NHS data. Cegedim currently provides the following products to customers:

(i) *Patient Data*—based on GP prescribing data gathered from 470 practices. Data from a subset of 150 practices (around 2 per cent of all practices) is taken and projected up to UK level. This product provides information on patient demographics, prescribing, symptoms, diagnosis and referrals. Cegedim has provided this service since the early 1990s. Cegedim told us that this product, which generated £[✂] in revenue in the last 12 months, competes primarily with IMS Disease Analyser. It does not therefore seem to be a part of the specialized pharmaceutical data market.

(ii) *Retail Pharmacy Data*—provides information on dispensed data from 1,500 small chain and independent pharmacies. Data is not suitable to project up to national level due to small sample size. Information is used by clients to conduct ad hoc analysis. Cegedim has offered this service since August 2009.

(iii) *NHS Data*—provides information based on NHS data, such as NHS practice level prescribing data, Quality of Outcomes audit results, practice demographics (list sizes, numbers of health care professionals). Cegedim has provided this service since 1 January 2012.

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[36] www.hscic.gov.uk/article/3915/What-we-will-collect-from-GP-records-under-caredata.
[37] We received responses from seven out of eight listed competitors and held further discussions with two of them.

(iv) *Multiview*—a multi-dimensional viewing software system. It is not sold on a stand-alone basis. In April 2012, Cegedim announced the integration of NHS prescription data for England with its Multiview software.[38]

(b) Wilmington Group—Wilmington has two brands: NHiS and Binley's.

(i) *NHiS's* products are primarily aimed at pharmaceutical, biotech and medical devices companies. NHiS has been publishing these products for approximately five years. In response to the release of NHS prescription data in November 2011, NHiS launched its GPRx service.

(ii) *Binley's*[39] BI division was merged into NHiS in early 2013. NHiS uses a variety of datasets, including prescription data, to provide services that range from database management to market intelligence. Its business intelligence products use the NHS prescription data.[40]

(c) Harvey Walsh[41]—Harvey Walsh, owned by Chime plc, is a health information specialist that has traditionally focused on Hospital Episodes Statistics (HES) data licensed from the NHS. Its AXON database holds over 1 billion HES patient records as well as information from additional data sources, including monthly prescribing data.[42] Harvey Walsh said that it had only begun providing specialized pharmaceutical prescription data services in 2013.

(d) WaveData[43]—WaveData launched Scriptmap in January 2012. Scriptmap uses NHS prescription data and additional data to flag dispensing doctors, identify patient numbers and provide geographic maps of surgeries, Clinical Commissioning Groups (CCGs) and districts.

(e) CSL[44]—CSL provides data warehousing and analytics solutions using any data requested by the client. For some of its clients CSL downloads and processes NHS GP prescribing data, which it said was used as a complement to the IMS data.

(f) I4Health—Datapharm is a not-for-profit company, funded by more than 200 pharmaceuticals companies that provides a range of medicines information services for healthcare professionals, medicine users, carers, the general public and the pharmaceutical industry. In July 2013, Datapharm announced the creation of a new company, i4Health Limited. We were told that I4Health is looking to offer access to NHS prescription data and also tailored enquiries based on the NHS prescription data available for England.

(g) GPrX Data[45]—GPrX Data provides a data service based on NHS prescription data as well as other NHS prescription databases. GPRx has been in the market since 2012.

5.21 Table 3 summarizes the products offered by each of these companies and their revenues derived from services based on NHS prescription data in 2012. Total annual revenues for 2012 and 2013 from specialized pharmaceutical data services

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[38] www.cegedimstrategicdata.com/Corporate/Pages/default.aspx.
[39] www.binleys.com/.
[40] www.binleys.com/Product/Prescribing_Intelligence/.
[41] www.harveywalsh.co.uk/pharma_services.
[42] http://chimeplc.com/our-companies/harvey-walsh.
[43] www.wavedata.co.uk/newscript.asp.
[44] www.csl-uk.com/csl_RealWorldData.php.
[45] www.gprxdata.com.

offered by IMS's competitors amount to around £[✂] million. These revenues compare with £[✂] million obtained by IMS from its prescription data services in 2012 (£[✂] million forecast in 2013) and £[✂] million from its wholesale data services (£[✂] million forecast in 2013)—a total of £[✂] million in 2013. In other words, competitors' revenues amount to approximately 5 per cent of IMS's revenues. This percentage would be even smaller if we were to examine only the impact of competitors' products launched in the last two years.

TABLE 3 **Products offered by IMS competitors and revenues obtained**

Company	*Products based on prescription data*	*Revenues from prescription-data-based products*
Cegedim	Retail Pharmacy Data NHS Data Integration of NHS prescription data for England to its MultiView software	Revenues in the last 12 months: • £[✂] from Retail Pharmacy Data • £[✂] from NHS data
Wilmington Group: NHiS and Binley's	GPRx and Prescribing intelligence: monthly practice prescribing data for England	Less than £[✂] in 2012 and expects similar revenues in 2013
Harvey Walsh	AXON	£[✂]
WaveData	Scriptmap: maps presenting information based on NHS prescription data and other data sources	2012: £[✂] 2013: £[✂]
CSL	Data warehousing and analytics using any data requested by the client, including NHS prescription data	No data provided
I4Health	No information on specific products	No data provided
GPrX Data	Reports based on NHS prescription data and other NHS databases	2012: £[✂] 2013: £[✂]

Source: Information submitted by these companies to the CC.

5.22 In response to our provisional decision, IMS said that this was evidence of eight vibrant competitors and that there was now more competition in the market than there was pre-merger. It added that the estimate of 5 per cent of IMS's revenues was a conservative estimate because it did not include data from two competitors or self-supply by customers.

5.23 We did not agree with this interpretation of the evidence. First, these new competitors remained small, fringe competitors in this market. Second, the estimate of 5 per cent combined market share for these competitors was not evidently more competitive than the pre-merger situation in which IMS had 85 per cent and PMSI 8 per cent. IMS's market share today (about 95 per cent) was higher than its combined market share post-merger (see paragraph 3.6). Third, only one of the two competitors for which we did not have estimates of revenues was mentioned by one customer as a potential future alternative and no customers referred to either of these two competitors as an actual alternative source of supply at present. Fourth, to the extent these new competitors' products and services or self-supply were being used by customers, they were mainly being used as complements to IMS's products (see paragraphs 5.35 to 5.42).

Comparison between IMS data and NHS prescription data

5.24 IMS submitted that NHS prescription data was directly comparable with its specialized pharmaceutical data services (in particular its Xponent products) because:

(a) both provide monthly data;

(b) the NHS prescription data is broken down to the level of individual GP practices (including the name and address of the practice and details of the Health Boards

and Localities). By contrast, IMS's data reflects 'bricks' (ie groupings of retail pharmacies), which are less granular than the NHS prescription data;

(c) the NHS prescription data includes all prescribed medicines, dressings and appliances that are dispensed from an NHS reimbursable prescription each month. This compares directly with IMS's data, which also excludes prescriptions that are not dispensed; therefore recording accurately only the products that are in fact consumed;

(d) the NHS prescription data and IMS's data both include: (i) value measures; and (ii) volumetric measures;

(e) as with IMS's data, the NHS prescription data shows individual transactions, categorized according to therapy area classification codes; and

(f) both the NHS prescription data and IMS's data identify product, form, and strength level.

5.25 Competitors argued that the NHS prescription data could not be considered a substitute for IMS's data services. Harvey Walsh told us:

> There are a number of important features that any UK government published data must have if it is to be considered a substitute for the IMS data. The first is that it must be geographically comprehensive. This is still not the case. …On the other hand, …government data … is published three months in arrears. …The third reason why IMS data is unique … is its historical depth. …Whereas the historical data in England and Wales goes back 28 months … IMS data goes back five years.

5.26 Similarly, Wilmington Group told us:

> At the moment we are unable to compete with the IMS Xponent product. We do not have access to individual doctor level prescribing data, and in addition, we do not have access to prescribing data for Scotland and Northern Ireland. …In order to compete … we would need data from all four nations at individual GP prescribing level, which is published monthly within a reasonable timeframe.

5.27 And CSL told us:

> The 3 main advantages IMS have with regards to pharmaceutical sales data are: (i) the NHS data is released three months in arrears (IMS is one month); (ii) Scotland do not release their data currently (IMS has all four nations); and (iii) hospital prescription data is not published (only available from IMS at present).

5.28 In response to these comments, IMS said that the submissions of competitors must be treated with extreme scepticism, given their powerful incentives to damage a rival. IMS added that there were two factual inaccuracies in these responses. First, IMS told us that it did not offer more than three years of prescription data—IMS told us that its prescription products available today (Xponent BPI and Xponent RxA) offered a more accurate analysis than its previous prescription-based products, and that IMS had access to data of sufficient quality to support the Xponent products only from

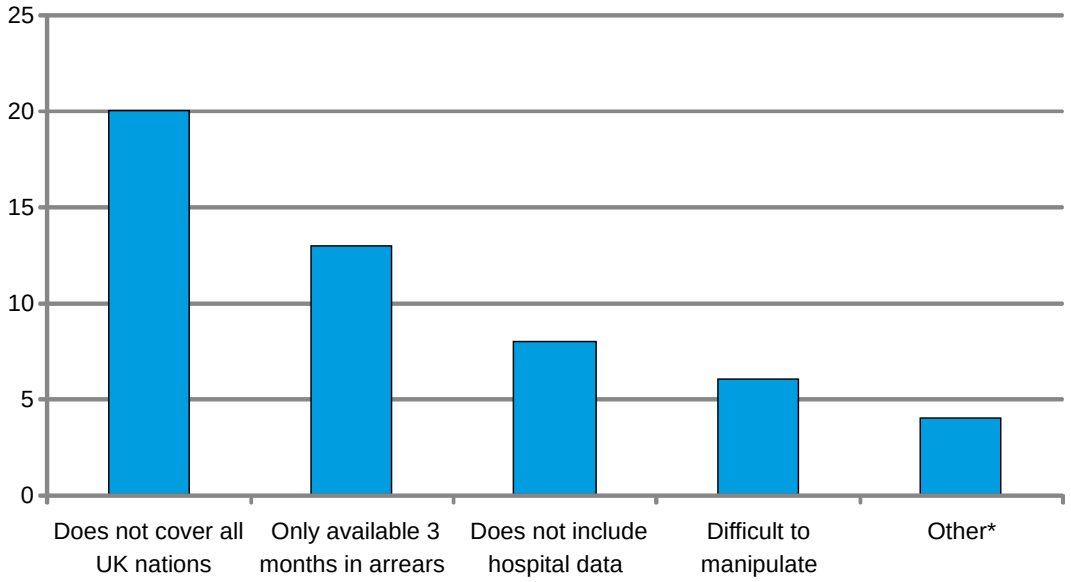
January 2011.[46] Second, IMS said that it did not acquire GP-level data and as a result, it was unable to publish GP-level data in any audit.

5.29 We noted IMS's concerns regarding the possible incentives of competitors. For these reasons, we did not place much weight on these responses on their own, but instead examined whether these concerns were corroborated by customers.

5.30 We sent questionnaires to 54 IMS customers and received 27 responses, accounting for 57 per cent of IMS's revenues in 2012. We found that IMS's customers identified similar limitations to competitors in terms of the NHS prescription data. Twenty respondents (74 per cent) said that there were few or no alternative providers that they considered were viable alternatives for their business: 20 out of 27 respondents (74 per cent) said the limited coverage of NHS prescription data (not yet covering Scotland), 13 respondents (48 per cent) referred to the timeliness of the data, 8 (28 per cent) said that they would also need hospital data and 6 (22 per cent) said that the data was difficult to manipulate.[47] We present a summary of the responses received in Figure 3.

FIGURE 3

Limitations of NHS prescription data
(number of respondents to our questionnaire)



Source: Responses to our questionnaire. Total responses: 27.
*Other include: only include what is prescribed, not dispensed; no information on product pack; need to update internal systems.

5.31 Internal documents from IMS suggest that it recognizes these differences. Figure 4 shows a comparison of the data offered by IMS and NHS prescription data. The areas where IMS identified a strong ability to compete are the areas where there is a higher degree of differentiation between the NHS prescription data and IMS's data.

[46] We note that IMS offered until 2012 products based on wholesaler and prescription data with up to five years of back data.
[47] Responses to the question: 'Is using the recently released NHS prescription data yourself (ie self-supply) a feasible alternative to using IMS's product? Why/why not?' (responses not prompted).

FIGURE 4

Differences between data provided by IMS's prescription data services and NHS prescription data

[✂]

Source: IMS [✂].

5.32 The responses we received from customers indicate that the limitations of NHS prescription data restrict their ability to substitute IMS products with NHS prescription data (or competitors' products based on NHS prescription data): NHS prescription data does not yet allow a UK-wide assessment of sales performance on a monthly basis or even a quarterly basis. The delay in releasing NHS prescription data (released three months in arrears) compared with IMS data limits the ability of customers to use NHS prescription data for tracking the performance of recently launched products. The absence of monthly data for Scotland (which is presented on an annual basis) and Northern Ireland (which is presented on a quarterly basis) prevents pharmaceutical company customers from using the NHS prescription data on the same basis across the whole of the UK (for example, when calculating remuneration for sales staff).

5.33 The information we have received from the NHS bodies across the UK does not indicate that the data will be published with a higher frequency or more uniformity in the near future, although there are aspirations to publish further data in Scotland (see paragraph 5.15).

Impact on IMS

5.34 IMS said that the effect of the publication of NHS prescription data on its business had been significant. It said that:

(a) IMS had lost a significant number of customers and customer contracts. It said that the impact of customers switching to other suppliers or processing the NHS prescription data themselves ('self supply') was that revenues from its prescription-based data services declined by £[✂] million as a result of customers cancelling their contracts. IMS said that the rate of cancellation in 2013/14 was [✂] the number that it would expect based on previous years' experience. It said that profitability had also declined;

(b) it had frozen its prices from 2012 to 2013, and introduced only minor price increases in relation to two of its products from 2013 to 2014 (see Table 1);

(c) it had been forced to restructure its business, with a reduction in UK headcount of around [✂] per cent; and

(d) in response to the publication of NHS prescription data, IMS had allowed its customers of sub-national data services to view the NHS prescription data using its existing software tool at no additional cost. IMS had been also working towards [changing its products in a number of other ways].

5.35 We sought to understand the extent to which these effects were caused by the publication of NHS prescription data and potentially increased competitive constraints on IMS. To do this, we investigated the extent to which IMS customers (or former IMS customers) had switched to a new provider of prescription-based data or were replacing some of the products offered by IMS with self-supply.

5.36 First, we noted the relatively small revenues that competitors have been able to generate (see Table 3) in contrast with the revenues IMS said it had lost. This suggested that IMS's lost revenues were not being fully gained by competitors. However, we noted that to some extent this may be due to competitors offering products at a lower price or due to an increase in self-supply.

5.37 Second, and in order to understand the reasons for the reduction in IMS's revenues, we examined the responses of those customers which IMS said had cancelled their contracts following the publication of NHS prescription data. In total, IMS submitted that [10–20] customers cancelled their contracts with IMS in 2012/13 or 2013/14 for either prescription or wholesale data services.

5.38 We asked customers whether they had reduced their expenditure on IMS products in 2012 or were intending to do so next year. We focused on the largest customers. We received responses from [around half] out of the [✂] customers who cancelled their contracts with IMS. Only one of them ([✂]) stated that it had reduced its purchase of IMS products and replaced this expenditure with NHS prescription data and another ([✂]) referred to NHS prescription data as one of several factors influencing expenditure for next year. Six customers said that they had reduced their data requirements or intended to reduce them next year as a result of changes in their business needs (eg end of product patents) or to reduce costs. One customer ([✂]) stated that it had not switched in the last 12 months and had no intention of cutting expenditure; and another customer ([✂]) said that its expenditure had been largely static as NHS prescription data was not available within the same time frame as IMS's.

[✂] 'Intend to cut spend by £[✂] in 2014 due to a number of factors:

- NHS prescription data for England is now available through other channels at less cost
- IMS have increased prices year on year to an unaffordable level
- IMS have historically had poor after sales support which has gotten worse in the last 3 months'

[✂] 'Some individual service costs were reduced due to redefined data needs. We decided to stop purchasing the IMS data sets due to the cost and business value.'

[✂] [✂] said that it had cancelled two contracts with IMS—one to switch to a competitor and one because the data source was not considered necessary anymore for its business.

[✂] 'Have reduced expenditure in IMS products as product portfolio mix has changed.'

[✂] 'We have significantly reduced our IMS spend this year [✂] by replacing IMS data services with Government Open Data available—specifically Practice level Prescribing Data. We will continue to reduce costs in 2014 by further reducing the number of lines of data we buy from IMS and will put our IMS services on a short notice contract to give us flexibility to transition to more NHS prescription data as it becomes available, and cancel our IMS subscription to equivalent services when we think this is appropriate.'

[✂] 'Spend on IMS was reduced in 2013 as a result of two products losing exclusivity and therefore various product and market competitor sales were not required … [✂] has sourced these products from IMS for a number of years and not switched providers. The only change made on annual basis is the definition of the markets that are purchased.'

[✂] 'Reduced spend from 2012 in 2013 by approx. £[✂]—change in services by IMS'

5.39 We also investigated whether customers who are currently using NHS prescription data had substituted IMS's products for NHS prescription data or were considering doing so. We focused on IMS's largest customers and those it said [✂]. Six out of 27 customers who responded to our questionnaire ([✂][48]) mentioned that they were using NHS prescription data, either through the products offered by IMS's competitors or by 'self-supply'. We found that most of these customers had not replaced IMS's products with NHS prescription data, but were using both in parallel, either because the NHS prescription data currently has limited geographic coverage on a timely basis or because of its format, which is not consistent across England, Wales and Northern Ireland. In particular, these customers told us:

[✂] 'We have not switched provider in the past 12 months. We have acquired some data from the NHS prescription source via another provider … This is in addition to the IMS data as it is an incomplete UK data set. ...

'Whilst there are new possible prescription data providers using the NHS England data, we would require full UK data access all in the same format to make this truly useful.'

[✂] 'The data is of sufficient quality for us to utilise for England but it is not yet available for all UK countries or not available in a consistent format. It is also three months in arrears … but it is something we could get used to. We do 'self supply' this data … but we operate across the whole UK and NI and therefore still revert to IMS data as a key measure.'

[✂] 'For a number of internal reporting activities and analysis we are using NHS prescription data rather than IMS data. When we have more stability in the NHS prescription data supply, a complete picture with all 4 nations and are comfortable with the quality and validity of the data we can then make an informed decision as to when we will consider transitioning.'

[✂] 'The recently released NHS prescription data is not a viable option for measuring UK-wide performance because it is only available for England and Wales. …

'We use the NHS prescription data for England and Wales for targeting and segmentation work as well as supporting business planning. However, we continue to use IMS for measuring sales performance to allow the whole sales team to be measured and rewarded using the same dataset'

[✂] 'Investigated alternative sources of information but found that these do not meet the need of business, as well as the accuracy of data. ...

'Market access team using the NHS prescription data for ad hoc reports. Not delivered in a user friendly way so we do use other services but this isn't always what is required.'

[✂] Uses a third party agency ([✂]) to produce some ad-hoc reports, but does not consider that NHS prescription data is equivalent to IMS data.

5.40 Some other customers (for example, [✂]) said that they might consider switching expenditure away from IMS if NHS prescription data were to become more comparable with IMS's products.

5.41 We also examined IMS's prices. IMS's current prescription-based and wholesaler-based products are presented in Table 4 below. We observed that prices had remained stable for prescription-based products since 2012, but had increased by

[48] These customers are among the top 25 customers in terms of IMS revenues and accounted for [15–20] per cent of IMS's revenues in 2012.

3.5 per cent for the Supply Chain Management and Early Insight products, based on wholesale data, in 2014.

TABLE 4 **Prices of current IMS prescription-based and wholesaler-based products**

£ per line of data

Product	*Data source*	*2011*	*2012*	*2013*	*2014*
Xponent BPI—Trawling (monthly, two years history)	Prescription	131,070	135,657	135,657	135,657
Xponent RxA	Prescription	3,468	3,589	3,589	3,589
Supply Chain Management	Wholesale	2,570	2,660	2,660	2,753
Early insight	Wholesale	9,792	10,490	10,490	10,857
Prescribing indicator	Wholesale	4,161	4,307	4,307	4,307

Source: IMS.

5.42 The evidence above suggests to us that, whilst there is potential for customers to switch to using NHS prescription data once the coverage and frequency becomes consistent across the UK nations, the reasons for reductions in expenditure on IMS's products seem to be primarily to do with factors other than increased competition. In particular, customers referred to changing business needs (for example, not producing certain products anymore) or wider cost-cutting measures. Where NHS prescription data is used, it is mainly as a complement to IMS's products rather than as a substitute.

Changes in barriers to entry and expansion

5.43 We have assessed the extent to which the barriers to entry identified in the 1999 report remain today, and in particular, how the publication of NHS prescription data has removed or mitigated these barriers. The barriers identified in the 1999 report were *(a)* exclusivity of wholesale data; *(b)* exclusivity of pharmacy data; *(c)* the advantage for IMS of offering a range of services in a range of countries; *(d)* the cost, time and skills necessary to compete; and *(e)* the advantage of IMS being the incumbent. We consider each of these potential barriers to entry in turn.

Exclusivity of wholesale data

5.44 At the time of the merger with PMSI, IMS had an exclusive arrangement with the British Association of Pharmaceutical Wholesalers (BAPW) by which the BAPW could not provide data to any other company to compete with IMS. Although this contract was due to expire by the end of 1999, and the BAPW said that any future arrangement with IMS would not be exclusive, the MMC found that the uncertainty over potential future exclusive contracts was likely to deter entry. The divestiture of PMSI's Source Dispenser business was recommended by the MMC to address this concern.

5.45 Cegedim operated the Infopharm business (the previous Source Dispenser business from PMSI) in competition with IMS until it exited the market in 2009 (see paragraph 3.16). We were told that Cegedim's (and TNS's) exit from wholesaler data services was driven by the price charged by Alliance Boots to access its wholesale data increasing from £[✂] million to £[✂] million a year.

5.46 IMS told us that it did not have any exclusive contracts for the acquisition of wholesale data. IMS said that its costs of acquiring wholesale data in 2012 amounted to £[✂]. As a result of its more general move away from the use of wholesaler data, IMS told us that it was able to negotiate lower prices with its largest wholesaler data

suppliers in 2013. IMS forecast a cost of £[✂] for the acquisition of wholesale data in 2013.[49]

5.47 Cegedim told us that the cost of wholesaler data meant it remained a barrier to entry.

5.48 Based on the evidence above, IMS is currently the only buyer of data from wholesalers after the exit of TNS and Cegedim from their wholesaler data businesses. IMS is therefore the only provider of specialized data services based on wholesaler data. However, as IMS no longer has any exclusive contracts for the acquisition of wholesale data (and it is not prohibited from doing so by the Undertakings), exclusivity of wholesale data is no longer a barrier to entry. It nevertheless seems to us that the costs of acquiring wholesaler data have in the past led to exit from the market and the costs of acquiring such data today appear high in comparison with the revenues currently obtained by IMS's competitors. It is therefore still difficult for new entrants to grow their business and compete with IMS by using wholesaler data.

Exclusivity of pharmacy data

5.49 One of the undertakings given by IMS in 1999 prevents IMS from engaging in exclusive contracts with pharmacies. With the Undertakings in place, there is no barrier relating to exclusivity per se.

5.50 We considered whether, regardless of the absence of exclusive contracts with pharmacies, IMS remains the only company with access to pharmacy data for the provision of prescription-based services.

5.51 IMS's panel of pharmacies covers around 78 per cent of UK pharmacies. Cegedim, which is to our knowledge IMS's only competitor on prescription data services that has its own panel of pharmacies, has a smaller panel of small chains and independent pharmacies (approximately one-fifth the size of IMS's panel), which does not allow customers to obtain information at the same level of detail as with IMS products.

5.52 Cegedim told us that IMS's panel contained the main pharmacy chains, most importantly Boots and Lloyds, but that the cost of data supply had increased to such a level that it was no longer commercially viable to acquire it. Cegedim also told us that it was a key requirement of pharmaceutical companies that pharmacy data included these chains, and, without it, it was extremely difficult to compete with IMS. Cegedim's strategy is therefore not to compete on a like-for-like basis, but to provide complementary analysis.

5.53 Given the current limitations of NHS prescription data (see paragraphs 5.24 to 5.33), and IMS's access to a UK-wide panel of pharmacies, IMS is currently the only company with access to prescription data across the four UK nations that is capable of being provided on a monthly basis. Until the NHS prescription data provides a viable alternative, the cost of acquiring data from the pharmacies remains a barrier to potential entrants.

[49] These figures show the sums recorded by IMS Health for accounting purposes. In the case of multi-year contracts, the figures recorded represent the average annual fee paid across the term of the contract.

The advantage for IMS of offering a range of services in a range of countries

5.54 The 1999 report identified that IMS offering a range of services in a range of countries, reinforced by the perceived bundling of products and lack of transparency in pricing, would deter competitors from competing in particular niches.[50]

Range of services in the UK

5.55 IMS is currently the only provider of pharmaceutical data services in the UK with a large portfolio of services, based on both wholesaler and prescription data (including private prescriptions and prescriptions dispensed in hospitals). The products that IMS customers mentioned most frequently in their responses to our questionnaire were the British Pharmaceutical Index (BPI) and RSA, historically based on wholesaler data, but recently [✂]; Supply Chain Management, based on data from wholesalers, and Hospital Pharmacy Audits (HPA, HPAI).

5.56 Several responses to our questionnaires, both from customers and competitors, highlighted in particular the importance of hospital prescription data. We have therefore considered the role of hospital data in more detail.

5.57 In its 1999 report, the MMC stated that hospital audits and medical audits could potentially be part of the relevant market, but they were excluded as they would make little difference to the market size or to the combined market share of IMS and PMSI (as IMS had 100 per cent of the market).

5.58 In recent years, hospital audit data has become increasingly important for some pharmaceutical companies:

(a) 19 of the customers who responded to our questionnaire (70 per cent of respondents, representing 46 per cent of IMS revenues in 2012), acquire hospital data in addition to specialized pharmaceutical data services based on wholesaler or prescription data.

(b) The proportion of the total cost of medicines in the UK accounted for by hospitals has increased from 33 per cent in 2010 to 40 per cent in 2013, as shown in Table 5.

TABLE 5 **Proportion of the total cost of medicines in the UK accounted for by hospitals and pharmacies**

per cent

	2010	*2011*	*2012*	*2013 (January–September)*
Prescriptions dispensed	66.9	64.5	61.7	59.8
Hospital usage	33.1	35.5	38.3	40.2

Source: IMS.

(c) Harvey Walsh told us that the hospital market was as important as the prescription market to pharmaceutical companies. Cegedim told us that in order to compete on level terms with IMS in the specialized pharmaceutical data market, a company would require access to drug use data within secondary care,

[50] The 1999 report, paragraph 2.54*(d)*.

as new product development was now largely focused on specialist use in secondary care. It also told us that it would prefer to have access to hospital data to increased coverage and timeliness of NHS prescription data.

5.59 IMS told us that hospital data was collected separately from pharmacy data and was offered by IMS as a separate service. It collects the data on a monthly basis from hospitals' pharmacy stock control systems. IMS generates £[✂] million in revenue from hospital-data-based services.

5.60 IMS said that there were no contractual restrictions on NHS Trusts or the UK Government from publishing hospital own data or selling such data to others. IMS has non-exclusive annual agreements with NHS Trusts for this data. HSCIC is contractually restrained from publishing IMS's own HPA datasets for a period of six months after the period to which the dataset refers. That restriction has been published on HSCIC's website.[51] IMS added that a competitor could either acquire hospital-level data from NHS Trusts (as IMS Health does) or it could purchase such data directly from IMS. IMS said that another company, RX Info, was paid by NHS Trusts to collect the same data as IMS obtained from hospital pharmacy systems.

5.61 RX Info told us that it did not purchase hospital data but provided software on a licence basis to NHS Trusts so that it could analyse their data. This is a different proposition from that offered by IMS because it means RX Info cannot use the data to sell on to other potential customers, for example pharmaceutical companies.

5.62 The evidence above indicates that IMS is the only company able to offer a range of products that provide a comprehensive view of the market, which customers need in order to monitor their market position and to remunerate their sales force in a timely manner. No other company has been able to develop a comparable range of products, either based on wholesale or prescription data since the merger with PMSI. This evidence is relevant to our consideration of the prohibition on bundling and tying (see Section 6).

Range of services in a range of countries

5.63 IMS told us that it collected prescription data in a number of other countries (China, France, Germany, Greece, Indonesia, Netherlands, Spain and Sweden).

5.64 Cegedim was concerned with the possibility, absent the Undertakings, of IMS bundling UK data at an EU or global level, as, it said, many companies purchased IMS products as part of a multi-country agreement.

5.65 IMS clearly has a significant international presence and this sets it apart from some of its competitors. To the extent that such multi-country agreements could be used by IMS, this would act as a barrier to entry. However, few customers mentioned this to us as a concern and it was not clear to us that many customers generally purchased data products in this way, particularly given the country-specific nature of the data products.

The cost, time and skills necessary to compete

5.66 The availability of NHS prescription data has reduced the costs of developing a database based on data collected from pharmacies. Companies draw on their

[51] www.hscic.gov.uk/catalogue/PUB12651/hosp-pres-eng-2012-rep.pdf.

experience in providing data and business intelligence services to add the freely available NHS prescription data to their product portfolio. IMS estimated that the cost of hardware and software necessary for a new provider of NHS prescription data based services could be as low as £1,000, and the complete NHS database could be downloaded in two days.[52]

5.67 Although the costs to access CCG-level prescription data have been reduced substantially, NHS prescription data alone does not necessarily allow competitors to provide products capable of competing with IMS's. As we discussed above, NHS prescription data still has limitations that prevents it being considered a viable alternative to IMS data for customers who need data for the whole of the UK and published more frequently. Also, as secondary care data is becoming increasingly important for pharmaceutical companies, competitors would need access to hospital data in addition to GP prescription data if they wanted to offer a service able to provide information on sales to the secondary care market. Harvey Walsh said that it could only obtain hospital data pursuant to Freedom of Information requests, which took usually one month to process.

The advantage of IMS being the incumbent

5.68 In its 1999 report, the MMC found that IMS had a 'first mover advantage' from having developed pharmaceutical business information services which were now embedded in the fabric of the pharmaceutical business.

5.69 Entry observed in the market since 2012 suggests that the availability of NHS prescription data has reduced to some extent IMS's first mover advantage in the market for specialized pharmaceutical data services. Competitors have been able to develop new products based on NHS prescription data, which are now potential alternatives or complements to IMS products for some customers, and could become viable alternatives in the future if NHS prescription data across the four nations was published on similar terms.

5.70 However, new entrants need time to establish themselves in the market, especially smaller competitors. GPRx told us that clients perceived risk from signing up with a small supplier, which is one of the challenges it faced in positioning its offering against large established companies like IMS.

5.71 In our view, IMS has developed over the years a product portfolio and client base which would be difficult for a new entrant to match such that its incumbency advantages remain a barrier to entry.

Changes in countervailing power

5.72 In the 1999 report, the MMC found that IMS's customers had little alternative to IMS and the extent of complaint about IMS's policies confirmed that they had very limited countervailing power.[53]

5.73 The publication of NHS prescription data has increased countervailing power for customers whose data requirements can be covered, at least partially, by self-supply or alternative providers.

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[52] These figures were calculated as the costs incurred by an IMS [✂].
[53] The 1999 report, paragraph 2.61.

5.74 One of IMS's customers which responded to our questionnaire ([✂]) said that it had replaced IMS prescription data services with NHS prescription data, and that it would continue to reduce the number of lines purchased from IMS, as well as putting IMS on short-notice contract to give it flexibility to transition to more NHS prescription data as it becomes available, and to cancel its IMS subscription to equivalent services when it thinks it is appropriate.

5.75 For most customers, however, the publication of NHS prescription data has not increased their ability to choose an alternative provider: 74 per cent of customers who responded to our questionnaire mentioned that there were few or no alternative providers that they considered were viable alternatives for their business.

5.76 Some customers expressed their concerns with IMS's decision to [change the way it provided some services]. Comments received from IMS customers suggest that despite customers' concerns with the accuracy of IMS's prescription data, [✂] (see paragraph 5.11).

5.77 Customers' responses suggest that, had there been an alternative to being supplied by IMS, they would have switched. Although NHS prescription data has increased countervailing power to some extent, NHS prescription data is not yet equivalent to IMS data services (for the reasons discussed in paragraphs 5.24 to 5.33), and therefore, the lack of viable alternatives makes countervailing power still limited for most customers.

5.78 In response to our provisional decision, IMS said that it faced a significant competitive constraint because it was unable to identify customers that did not view its services as comparable to using NHS prescription data and noted that, according to the CC's questionnaire, a quarter of respondents had stated that they were ready to switch to NHS prescription data.

5.79 We did not agree with IMS's argument. We were concerned that, even if IMS could not identify the price sensitivity of each of its customers, there were no countervailing forces to keep prices or quality at the competitive level.

Other issues raised by IMS

5.80 IMS submitted that:

(a) behavioural remedies, such as those in the Undertakings, were used only rarely by competition authorities;

(b) behavioural remedies of indefinite duration risked distorting a market, hence competition authorities tended to prefer them to be time-limited. In particular, IMS argued that the principal effects of the Undertakings were to require it to maintain an overly rigid pricing structure and to prevent it from offering lower prices over a range of services; and

(c) merger control should not intervene in transactions to impose ex ante regulation against possible future abuses of dominance, which would be deterred by, and could be enforced under, Article 102 TFEU or the Chapter 2 Prohibition.

5.81 We considered each of these submissions carefully but did not consider that any of these amounted to a change of circumstances. We noted in addition that:

(a) Although the CC has a policy of only adopting behavioural measures in unusual circumstances, one of these circumstances was precisely relevant when the

MMC recommended the behavioural measures contained within the Undertakings—namely, that divestiture and/or prohibition was unfeasible.[54] In any event, the MMC made a decision on the basis of the facts before it and any subsequent changes in remedy approach would not render the remedy inappropriate because the potential for taking alternative remedial action has long since passed.

(b) Behavioural remedies can have distorting effects over time. However, the MMC was silent on the expected duration of its remedies in the 1999 report. In addition, IMS has not clearly set out how the Undertakings are creating costs that are outweighing the benefit of lowering barriers to entry. We consider the duration of the remedies further in paragraph 7.2.

(c) The main purpose of the remedies put in place by the MMC was to lower barriers to entry in order to address the lessening of competition that the MMC found. The purpose of the remedies was not to address any potential future abuses of dominance by IMS.

Conclusion on the change of circumstances

5.82 We find that there has been a change of circumstances since the 1999 report as a result of the release of NHS prescription data. However, the effects of this change of circumstances are not yet as significant as they might be because of the limited coverage and frequency of data across some of the UK. Further publication of NHS prescription data to improve this deficiency at this stage remains uncertain. As a result, new entrants that have emerged are at an early stage and have to date been providing services that are largely complementary to IMS and only a few pharmaceutical companies have switched to self-supplying prescription data instead of using IMS's products. Although this pattern may increase over time there presently remains insufficient countervailing power and the combined market share of competitors remains less than PMSI had in 1999. In addition, in the absence of the Undertakings, barriers to entry would remain due to IMS being the only current provider of wholesale data and prescription data on a frequent basis across the four UK nations, its ability to offer a range of services (and in particular, hospital-based data services) which it could bundle with its prescription-based products, and its advantage of being the incumbent. Based on our theory of harm in paragraph 4.2, we therefore find that adverse effects would continue to arise absent any remedies.

6. Implications of the change of circumstances on Undertakings

6.1 We found in paragraph 5.82 that adverse effects would continue to arise absent any remedies, which suggested to us that remedies are still required. We have considered in this section the potential effects if IMS were to be released from some or all of the remedies in the Undertakings.

Undertaking not to bundle or tie

6.2 In the 1999 report, the MMC found that:

> IMS should not sell specialized pharmaceutical data service products only as a package or discount to the same effect; nor should it make sale of any UK specialized pharmaceutical data service products or

[54] The 1999 report, paragraph 2.88.

terms on which they are sold dependent on the sale of any other UK data service or product. The prospect of such bundling or discounts is in our view a main deterrent to entry and the means by which IMS can abuse its position to the detriment of users.[55]

6.3 The Undertakings require IMS not to 'supply or offer to supply in the UK specialized pharmaceutical data (a) subject to a condition that the purchaser will acquire or agree to acquire other goods or services from IMS, or (b) with a discount if the purchaser acquires or agrees to acquire other goods or services from IMS'. This prevents both tying (where two or more products are sold only in a unique package at a single price) and mixed bundling (where two or more products are available separately but can also be bought together at a price which is lower than the sum of the products sold separately).

Views of parties

6.4 Competitors to IMS were concerned about the potential removal of this remedy. [✂] said that it would be unable to compete in the prescription segment of the market if IMS were allowed to bundle its products. [✂] was concerned that IMS could reduce prices for prescription data on the condition that the customer agreed to stick with IMS for hospital data. This would mean that the prescription market would be closed to [✂] or anyone else offering competitive services in the hospital data market. It said that, should hospital data be available to all suppliers, this would not be an issue. Similarly, Cegedim said that its main concern was IMS bundling primary and secondary care data.

6.5 We also received comments from customers suggesting that the possibility of IMS bundling its products, in particular with hospital data, is a concern. For example, [✂] said that its biggest concern would be on bundling and allowing IMS the ability to bundle products as well as pricing variability and therefore lack of pricing transparency; and [✂] said that it would not want to have to purchase other IMS products when purchasing specialized pharmaceutical products.

6.6 IMS said that there was no reason why it should remain subject to this restriction because:

(a) mixed bundling of the kind prohibited by the Undertakings was not per se illegal and might be in the consumer interest and would raise competition concerns only in exceptional circumstances;

(b) IMS was not dominant in any relevant market (including in relation to hospital data);

(c) there was no evidence that, even if IMS did bundle specialized pharmaceutical data services with other services, competitors would be foreclosed. It said that provided competitors were reasonably efficient, they could match IMS's specialized pharmaceutical data services prices and still compete effectively;

(d) hospital data formed part of a separate product which was sold separately by IMS and did not form part of the market for specialized pharmaceutical data products. It also said that any customer or competitor could either acquire hospital-level data from NHS Trusts (as IMS Health did) or it could purchase such data directly from IMS and combine it with NHS prescription data (see paragraph 5.60);

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[55] The 1999 report, paragraph 2.90*(b)*.

(e) even if IMS were to have market power in a market other than specialized pharmaceutical data services, the Undertakings only prevented it from making the supply of specialized pharmaceutical data services conditional on a customer purchasing other services (which could include hospital data) or discounting in such a way to encourage customers of specialized pharmaceutical data services to purchase other services. It said that, as far as it could discern, the Undertakings could not be read as preventing IMS making the supply of hospital data services conditional on the customer buying other services (or discounting to the same effect); and

(f) IMS said that, in any event, it had never required customers that purchased hospital data also to purchase specialized pharmaceutical data services, nor did it have any plans to develop an integrated service that would replace services currently supplied separately. It said that it would not act in a way that might alienate customers because it faced competition from other suppliers of specialized pharmaceutical data services.

6.7 In response to our provisional decision, IMS said that any concerns were limited to the possibility of tying and not mixed bundling. It said that the Undertakings could be varied to prevent IMS from tying other services to the supply of specialized pharmaceutical data services, while allowing it to offer discounts on mixed bundles.

Our assessment

6.8 We considered IMS's arguments carefully. We are not assessing the illegality or otherwise of mixed bundling, nor are we making an assessment of dominance. We are assessing the remedy in the context of its original purpose, which was to remedy a lessening of competition arising from a merger. The remedies were designed to lower barriers to entry to address the adverse effects identified by the MMC. They were specifically put in place to avoid competitors being foreclosed in the event of IMS bundling or tying its products. We therefore considered whether the possibility of this behaviour acting as a barrier to entry remained a concern. To do so, we considered whether IMS has both the incentive and ability to bundle or tie its products and we considered both the short-term and longer-term effects of bundling and tying.

6.9 With regard to IMS's incentive to bundle or tie, we found that IMS had experienced a decline in revenues from its data services, and it expected that this decline would continue in the coming years. The release of NHS prescription data had caused IMS to [✂]. IMS's internal documents suggested that, [✂]. We considered that IMS would seek to profit maximize when selling its products and that it had a clear incentive to either bundle or tie specialized pharmaceutical data services in order to give itself a competitive advantage.

6.10 We next considered IMS's ability to bundle or tie. Entry and subsequent expansion of competitors depends on their ability to make profits based on NHS prescription data (or prescription data procured from other sources as per Cegedim). At this point in time, competitors are not on a level playing field against IMS because they cannot offer bundles or ties in the same way IMS can. Without the prohibition on bundling and tying, it would be open to IMS to create bundled or tied products by integrating services where IMS is the only provider or faces limited competition, creating offers which competitors would be unable to match. This would raise barriers to entry. Competition would therefore be unlikely to develop if the prohibition on bundling and tying remains.

6.11 We noted that, even though some customers might benefit from having access to bundled products and services (and thus in the short term possibly paying a lower

price overall), the effect of permitting bundling or tying would be to raise barriers to entry, as described above. Over the longer term we consider that this increase in barriers to entry would be detrimental to customers.

6.12 We noted competitors' concerns regarding bundling and tying of hospital data and specifically considered further the role of hospital data in terms of the no bundling and tying remedy. We noted that no competitor had yet acquired such data from IMS and any such sale to a competitor would erode a significant competitive advantage that IMS holds. Harvey Walsh told us that it had tried to access hospital data using Freedom of Information requests, with limited success.

6.13 Whilst the Undertakings prevent IMS from making the sale of specialized pharmaceutical data service products dependent on the sale of other UK data services or products (and not vice versa), we did not agree with IMS's argument that hospital data was not relevant. The possibility of bundling with other products in IMS's portfolio was a relevant factor in the MMC's considerations in the 1999 report (see paragraph 6.2). As set out in paragraph 6.11, we found that such bundling and tying remained a concern.

6.14 We concluded that both tying and bundling remained a concern in raising barriers to entry and that overall the benefits of keeping barriers to entry lower outweighed any detriment to some customers not being able to receive particular bundles of products at possibly lower prices in the short term. We therefore concluded that the prohibition on bundling and tying should be retained.

Undertaking to publish prices

6.15 The requirement on IMS to publish prices in a transparent fashion was aimed at addressing the risk of IMS exercising its discretion in pricing to deter new entry.[56]

6.16 As a result of the remedy, details of IMS's pricing structure are available on its Customer Portal. Larger discounts are available for those customers taking more lines of data and for those taking a two-year contract (as opposed to an annual subscription).

Views of parties

6.17 IMS said that:

(a) there was no basis for retaining the no bundling remedy and, if we were to vary the no bundling remedy to refer only to tying, the price transparency remedy would not be necessary to monitor tying;

(b) no-bundling commitments had been accepted in other cases without the need for published prices; and

(c) the pricing transparency remedy had a chilling effect on IMS's readiness to offer varied, lower prices. IMS said that, because of the Undertakings, its customers had been charged standard prices regardless of their relative size and importance. It said that this prevented IMS from offering lower prices to certain customers and was inefficient. It said that the incentive to offer discounts was

[56] The 1999 report, paragraph 2.90.

likely to be extremely strong because specialized pharmaceutical data was characterized by high fixed costs and low marginal costs.

Our assessment

6.18 As noted in paragraph 6.15, the MMC described the aim of this remedy as preventing IMS from using its discretion in pricing to deter new entry. It works in combination with the prohibition on bundling and tying and it supports the effective monitoring of the prohibition on bundling.

6.19 We considered IMS's arguments on the price transparency remedy, as set out in paragraph 6.17. In relation to *(a)* we found above that the prohibition on bundling and tying remained necessary, hence IMS's argument fell away.

6.20 We noted IMS's argument in *(b)* that other no-bundling cases have been implemented without price transparency remedies. In our view, the need for a price transparency remedy for monitoring will vary depending on the facts of a particular case. In cases where prices are already transparent, there may be no need for a requirement to publish prices. In other cases where there already exists a significant regulatory framework, a no-bundling remedy can be monitored by an existing regulator. In this case, the price transparency remedy makes the remedy capable of being monitored by customers and significantly reduces costs of monitoring on the part of the competition authority.

6.21 In our view, the transparent pricing remedy is not unduly restrictive. We did not consider that the ability to discount was removed by the remedy. The remedy only requires IMS to be transparent in its pricing; it does not require IMS to charge standard prices regardless of size. As noted in paragraph 6.16, IMS does in fact offer different prices to those acquiring different volumes of data or taking different lengths of contracts. It is open to IMS to offer other structures of discounts provided they are published on its website and not in breach of the other requirements of the Undertakings (notably the prohibition on bundling and tying).

6.22 Any potential chilling effects on competition from the remedy need to be examined in the context of both short-term and longer-term effects. The remedy has longer-term benefits because it prevents IMS from selectively reducing prices to customers who are more likely to, or have expressed a propensity to switch to a new entrant, such that entry is then foreclosed. The longer-term effects of this strategy would be detrimental to customers (see also paragraph 6.11). We noted that the remedy also has benefits in preventing IMS from selectively increasing prices to those customers who have less countervailing power.

6.23 Having considered the issues in paragraphs 6.18 to 6.22, we concluded that the price transparency remedy should be retained.

Undertaking preventing exclusive agreements with pharmacists

6.24 The undertaking preventing exclusive agreements with pharmacists was intended to remove the widespread perception among potential entrants of exclusive contracts between IMS and pharmacies, which, according to the MMC, were a main barrier to entry.[57] IMS also undertook not to take any action in relation to computer hardware or

[57] The 1999 report, paragraph 2.90.

software in any pharmacy which might inhibit the extraction of 'specialized pharmaceutical data' by any other person.

Views of parties

6.25 We were not told by any existing competitors of any intentions to expand prescription data services beyond what they could offer based on NHS prescription data. Cegedim, to our knowledge the only competitor in the market with a product based on its own panel of pharmacies, told us that expanding its current pharmacy panel would be too costly. However, in relation to the undertakings regarding computer software, Cegedim told us that if IMS were allowed to enter into exclusive arrangements with software providers, it would potentially prevent Cegedim and other potential competitors from building and maintaining patient databases with full geographic coverage and therefore reduce its ability to compete effectively.

6.26 IMS said that it had no exclusive contracts in place and had no intention of entering into any. It added that, because of the availability of NHS prescription data, there was no realistic possibility that any company would seek to acquire pharmaceutical data in the way IMS did. In response to our provisional decision, IMS said that there was no valid justification for maintaining this remedy. It added that this undertaking would create costs of ensuring existing processes were in place for compliance.

Our assessment

6.27 In our view, in a scenario where the data released by the NHS were equivalent to the data provided by IMS's products, a requirement not to enter into exclusive contracts with pharmacies for the acquisition of specialized pharmaceutical data would be irrelevant, as any market participant would have access to data that would allow it to compete. We have found, however, that NHS prescription data is not yet substitutable for IMS data for enough customers and that IMS data is the most complete and up-to-date source of prescription data. IMS's panel of pharmacies covers around 78 per cent of UK pharmacies. At present, a new entrant wishing to compete effectively with IMS's offering would need to obtain data from pharmacies. This option would be unavailable for any competitor if IMS could engage in exclusive contracts with pharmacies.

6.28 We noted that one strategy to augment the NHS prescription data would be to acquire data in those areas where NHS prescription data is not comparable to IMS's data. Although existing competitors have not yet sought to adopt such a business model, new entrants might have different approaches to competing with IMS. For these entrants, the effect of this remedy is clear as it lowers a potentially significant barrier to entry.

6.29 We did not consider that the costs of compliance claimed by IMS would be at all significant—to the extent they exist, they comprise monitoring contracts for exclusivity clauses. Further, any distortion costs also seemed minimal given IMS's stated intention that it did not wish to enter into exclusive contracts.

6.30 On balance, we therefore concluded that the non-exclusivity requirements should be retained.

Conclusion on the effect of the change of circumstances on the Undertakings

6.31 Based on the assessment above, we conclude that the Undertakings should be retained in their present form.

7. Our final decision

7.1 Our findings in Sections 5 and 6 can be summarized as follows:

(a) The publication of NHS prescription data has facilitated small-scale entry into the market for specialized pharmaceutical data services.

(b) NHS prescription data does not have the same level of coverage and timeliness as IMS data. Customers do not consider NHS prescription data as a substitute for IMS data, and use both data sources in parallel. NHS prescription data does not therefore allow new providers to compete on a like-for-like basis with IMS products. This is reinforced by the advantage that IMS maintains as a provider of a wide range of services, which competitors are not able to match.

(c) The development of new entrants as a result of the publication of NHS prescription data is at an early stage and it is important that it is not stifled such that the adverse effects about which the MMC was concerned in the 1999 report are allowed to emerge. Removal of the Undertakings at this stage would place that entry in jeopardy, particularly as publication of NHS prescription data is expanded further.

7.2 Based on our findings in Sections 5 and 6 we conclude that the Undertakings should be retained in their present form. At present it is uncertain to what extent or when further NHS prescription data might be published in the future or whether other possible changes of circumstances might make the Undertakings inappropriate. We recognize that the need for the Undertakings may be reduced or eliminated in the event that the coverage and timeliness of the NHS prescription data becomes more consistent across the four UK nations such that it provides a viable alternative for customers or a viable basis for competitors to compete with IMS's products. These or any such developments in the market, or any unanticipated effects of the change of circumstances assessed in this review, would need to be considered by the CMA through a subsequent review of the Undertakings. It would be for the CMA to consider the need for any such review consistent with its guidelines published in January 2014.[58]

[58] *Remedies: Guidance on the CMA's approach to the variation and termination of merger, monopoly and market undertakings and orders*, January 2014, CMA11.