Completed acquisition by Atos Medical AB of Countrywide Supplies Limited

ME/6536/15

The CMA's decision on reference under section 33(1) of the Enterprise Act 2002 given on 7 August 2015. Full text of the decision published on 14 September 2015.

Please note that [✂] indicates figures or text which have been deleted or replaced in ranges at the request of the parties for reasons of commercial confidentiality.

SUMMARY

1. On 31 January 2015, Atos Medical AB (**Atos**), a Swedish manufacturer of medical appliances, acquired Countrywide Medical Supplies Limited (**Countrywide**) a UK dispenser of medical appliances (the **Merger**). Atos and Countrywide are together referred to as the **Parties**.

2. The Competition and Markets Authority (**CMA**) considers that the Parties have ceased to be distinct and that the share of supply test is met. The four-month period for a decision, as extended, has not yet expired. The CMA therefore considers that a relevant merger situation has been created.

3. The Parties overlap in the supply of laryngectomy and tracheostomy appliances to end users (patients) in the UK. The CMA has considered whether the Merger raises a realistic prospect of a significant lessening of competition (**SLC**) through horizontal or vertical effects.

Horizontal unilateral effects

4. Based on the evidence it received during its merger investigation, the CMA considers that there is a negligible increment at the dispensing level of the supply chain and that, absent the Merger, standalone entry by Atos in the dispensing of laryngectomy and tracheostomy medical appliances to patients would not have been likely. Accordingly, the CMA believes that the Merger does not give rise to a realistic prospect of a SLC as a result of horizontal unilateral effects in relation to the dispensing of laryngectomy and

tracheostomy medical appliances in the community channel to patients in the UK.

Vertical effects

5. Based on the evidence it received during its merger investigation, the CMA considers that the merged entity:

   - has the ability and incentive to engage in input foreclosure (ie the foreclosure of competing dispensing alliance contractors (**DACs**)). However, the CMA considers that based on the evidence it has received that the effect of any such action would not be sufficient to give rise to a realistic prospect of an SLC;

   - would not have the ability or incentive to engage in customer foreclosure of competing manufacturers of laryngectomy and tracheostomy medical appliances.

6. Furthermore, the CMA believes that the Merger would not allow the merged entity to gain access to commercially sensitive information to non-vertically integrated competing manufacturers and, as such, would not give rise to a realistic prospect of an SLC.

7. Accordingly, the CMA believes that the Merger does not give rise to a realistic prospect of an SLC as a result of vertical effects in relation to either:

   - the manufacture and supply of laryngectomy and tracheostomy medical appliances in the community channel in the UK;

   - the dispensing of laryngectomy and tracheostomy medical appliances in the community channel to patients through retail pharmacies and DACs in the UK.

8. The Merger will therefore **not be referred** under section 22(1) of the Enterprise Act 2002 (the **Act**).

ASSESSMENT

Parties

9. **Atos Medical MB** (**Atos**) is a global company based in Sweden. Atos manufacturers a wide range of medical appliances with a focus on voice and pulmonary rehabilitation appliances for use by patients undergoing, or

rehabilitating from laryngectomy,[1] tracheostomy,[2] jaw mobility or otology[3] procedures. Atos is owned by EQT Holdings AB, a Swedish private equity group. All Atos products supplied in the UK are manufactured in Sweden.

10. **Platon Medical Limited** (**Platon**) is a wholly owned subsidiary of Atos. All Atos activities in the UK are carried out by Platon. Platon supplies Atos products to counterparties (predominantly hospitals and wholesalers) across the UK. Platon's turnover in the financial year ending 31 December 2014 was £[✂], all of which was generated in the UK.

11. **Countrywide Services Limited** (**Countrywide**) is a dispenser of medical appliances. Countrywide dispenses a range of products for laryngectomy, tracheostomy, ostomy, urology and renal patients.

12. Countrywide's turnover in the financial year ending 31 December 2014 was £[✂], all of which was generated in the UK.

Transaction

13. On 31 January 2015, Atos acquired the entire issued share capital of Countrywide.

Jurisdiction

14. As a result of the Merger, the enterprises of Atos and Countrywide have ceased to be distinct.

15. The Parties overlap in the supply of laryngectomy and tracheostomy medical appliances to all end users (ie patients with or without a prescription). Atos estimates that the merged entity will have a combined share of supply of [70–80]%,[4] almost entirely derived from the activities of Countrywide. Atos has a small level of direct sales to private patients of laryngectomy and tracheostomy medical appliances.[5] The CMA therefore considers that the share of supply test in section 23 of the Act is met.[6]

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[1] A laryngectomy procedure is a surgical procedure removing the voice box (see paragraph 21).
[2] A tracheotomy procedure is a medical procedure where an incision has been made in the trachea to create a direct airway.
[3] Otology procedures are medical procedures relating to the treatment of the ear.
[4] Merger Notice, paragraph 171.
[5] In 2014 this amounted to approximately [0–5]% of the supply of laryngectomy and tracheostomy medical appliances to all end users.
[6] The share of supply test is satisfied 'where an enterprise already supplies or acquires 25% of any particular goods or services …. so long as its share is increased as a result of the merger, regardless of the size of the increment'. See *Mergers: Guidance on the CMA's jurisdiction and procedure* (CMA2), January 2014, paragraph 4.54.

16. The Merger completed on 31 January 2015. However, the CMA considers that it was first informed about it on 2 April 2015. Atos submitted that details of the transaction were published on the website of Countrywide's financial advisor, Clearwater, on 24 February 2015.[7] Further, communications were also sent to Countrywide Supplies (by Atos) and various Ear, Nose and Throat nurses by Countrywide following completion.[8] The CMA does not consider that either of these events amounts to the material facts about the Merger being 'made public', that is when they are 'so publicised as to be generally known or readily ascertainable'.[9] The CMA therefore considers that it became aware of the Merger when it was first informed about it on receipt of a third-party complaint, received on 2 April 2015.

17. The four month deadline for a decision under section 24 of the Act is 9 August 2015, following an extension under section 25(2) of the Act.

18. The CMA therefore believes that it is or may be the case that a relevant merger situation has been created.

19. The CMA opened an own-initiative investigation into the Merger by sending an Enquiry Letter to Platon Medical Limited on 8 May 2015.[10]

Counterfactual

20. The CMA assesses a merger's impact relative to the situation that would prevail absent the merger (ie the counterfactual). For completed mergers the CMA generally adopts the pre-merger conditions of competition as the counterfactual against which to assess the impact of the merger.[11] In this case, the CMA received no evidence supporting an alternative counterfactual. Therefore, the CMA considers the pre-Merger conditions of competition to be the relevant counterfactual.

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[7] Merger Notice, paragraph 17, and Clearwater International press release (February 2015): Countrywide supplies sold to Atos Medical.
[8] Merger Notice, paragraph 18.
[9] OFT Decision: Completed acquisition by Genius plc of Local Breeders Limited (14 May 2008). See also *Mergers: Guidance on the CMA's jurisdiction and procedure* (CMA2), January 2014, paragraph 4.44.
[10] See *Mergers: Guidance on the CMA's jurisdiction and procedure* (CMA2), January 2014, paragraphs 6.9-6.19 and 6.59-60.
[11] However, the CMA will assess the merger against an alternative counterfactual where, based on the evidence available to it, it considers that, in the absence of the merger, the prospect of the pre-merger conditions continuing is not realistic, or there is a realistic prospect of a counterfactual that is more competitive than these conditions. See *Merger Assessment Guidelines* (OFT1254/CC2), September 2010, from paragraph 4.3.5. The *Merger Assessment Guidelines* have been adopted by the CMA (see *Mergers: Guidance on the CMA's jurisdiction and procedure* (CMA2), January 2014, Annex D).

Background

Laryngectomy and tracheostomy medical appliances

21. A range of medical appliances have been developed to assist patients who have undergone laryngectomy[12] or tracheostomy[13] procedures. These are generally broken down into three product areas:

- **Breathing aids** – these are appliances that help the patient to breathe following the medical procedure. One of the most common types of breathing aid is a heat and moisture exchange (**HME**). HMEs help to prevent complications in laryngectomy and tracheostomy patients caused by drying of the respiratory mucosa.[14] HMEs are usually attached to the stoma[15] by use of an adhesive (base plates and adhesive glues).[16]

- **Speaking aids** – patients can use these appliances[17] to help regain speech following a laryngectomy.

- **Related accessories** – these are used in conjunction with a breathing or speaking aid which include tube cleaning brushes and swabs, dressings and adhesive remover.

Dispensing of laryngectomy and tracheostomy medical appliances

22. Atos submitted that almost all laryngectomy and tracheostomy medical appliances in the UK are dispensed on prescriptions issued by the National Health Service (**NHS**).

23. In addition, Atos told the CMA that, in England, under the National Health Service (Pharmaceutical Services) Regulations 2009, only medical appliances listed under Part IX of the Drug Tariff can be prescribed and dispensed. This was confirmed by a number of third parties who responded to the CMA's market testing. The dispenser is reimbursed by the NHS for a fee listed in Part IX of the Drug Tariff.[18] Patients do not pay for these medical appliances as the nature of their treatment exempts them from prescription charges. A patient may order any medical appliance, including those not listed on the

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[12] Laryngectomy is the removal of the larynx and the separation of the airway from the mouth, nose and oesophagus.
[13] Tracheostomy is a procedure to create an opening at the front of the neck so a tube can be inserted into the trachea to help the patient breathe.
[14] A HME works by trapping the water vapour during exhalation and returning it during inhalation.
[15] A stoma is a surgically created opening which connects, in this case, the trachea to the outside environment.
[16] Usually an adhesive base plate on the neck to which the HME can be attached.
[17] Usually either a voice prosthesis or an electrolarynx.
[18] These fees are set on a national basis when the appliance is first placed on the Drug Tariff and are able to be re-negotiated, on application, annually.

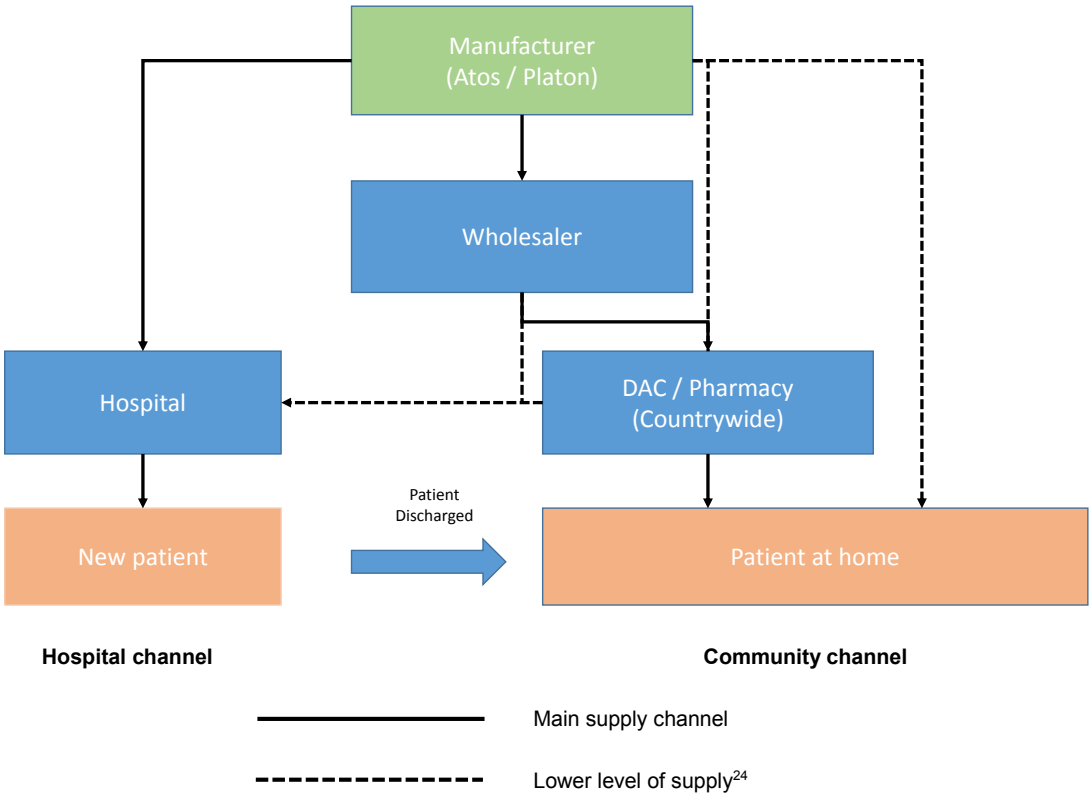
Drug Tariff, directly from a supplier. However, such private purchases are not reimbursed by the NHS and represent an insignificant portion of the market.[19]

24. Dispensers of NHS prescriptions hold licences allowing them to fulfil prescriptions for laryngectomy and tracheostomy products. There are four types of NHS contractors licenced to dispense products under prescription (broadly drugs or medical appliances), namely:

- hospital pharmacies;[20]
- community pharmacies;[21]
- dispensing doctors;[22]
- DACs.[23]

[19] Similar regimes exist in: Scotland under the National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009; Wales under the National Health Service (Pharmaceutical Services) Regulations 1992 and in Northern Ireland under the Health and Personal Social Services (Northern Ireland) Order 1972.
[20] These are pharmacies based in hospitals. Hospital pharmacies are licenced to dispense both drugs and medical appliances and focus on dispensing to the hospital channel, though they dispense to patients in the community channel who present with a prescription.
[21] These are retail pharmacies based in the community. Community pharmacies can dispense both drugs and medical appliances and dispense to patients in the community channel with a prescription.
[22] Dispensing doctors tend to be active in areas where the provision of community pharmacies is low. These are doctors who have been licensed to dispense drugs and medical appliances to their patients.
[23] DACs are businesses who are licenced to dispense medical appliances to patients in the community channel. DACs can only dispense medical appliances listed in Part IX of the Drug Tariff.

Figure 1: Supply channels for laryngectomy and tracheostomy medical appliances to patients (illustrative)



Frame of reference

25. The CMA considers that market definition provides a framework for assessing the competitive effects of a merger and involves an element of judgement. The boundaries of the market do not determine the outcome of the analysis of the competitive effects of the merger, as it is recognised that there can be constraints on merger parties from outside the relevant market, segmentation within the relevant market, or other ways in which some constraints are more important than others. The CMA will take these factors into account in its competitive assessment.[25]

Product scope

26. Atos is active in the manufacture and supply of laryngectomy and tracheostomy medical appliances including breathing aids, speaking aids and related accessories. Countrywide dispenses breathing aids and related accessories to patients with a prescription.

[24] That is, sales channels that account for a minimal proportion of sales in the market.
[25] *Merger Assessment Guidelines*, paragraph 5.2.2.

Distinction by type of medical appliance

27. Atos submitted that the product frame of reference should be assessed on the basis of distinct product markets comprising each of the main laryngectomy and tracheostomy medical appliances supplied by Atos and dispensed by Countrywide.[26]

28. In *APW/APSA/Nordic Capital/Capio*, the European Commission noted that its market investigation confirmed that sub-markets could exist for the different categories of medical appliances (ie voice prostheses and HMEs), although it left the definition of the relevant product market open.[27]

29. **HME and adhesives**: Atos submitted that HMEs and adhesives are complementary products.[28] Responses from third parties to the CMA's merger investigation confirmed this. Therefore, the CMA has considered these product categories together.

30. **Voice prostheses and HMEs/adhesives**: Atos submitted that voice prostheses should be considered as distinct products from HMEs and adhesives, as they meet different patient needs and are only available through the hospital channel following surgery. Atos further submitted that voice prostheses are not dispensed by DACs and that there is therefore no overlap between Atos and Countrywide in the supply of these products.[29] Responses from third parties to the CMA's merger investigation indicated that demand-side switching is not possible given that each appliance category meets specific patient needs. Furthermore, on the supply-side, the CMA notes that whilst there is commonality in suppliers across the different categories of appliances, competitive conditions (as indicated by market shares supplied by Atos) vary between these suppliers.

31. Therefore, on a cautious basis, the CMA has considered the manufacture and supply of voice prostheses separately from that of HMEs/adhesives.[30]

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[26] Merger Notice, paragraphs 116-118.
[27] COMP/M.4367: *APW/APSA/Nordic Capital/Capio,* 16 March 2007.
[28] For example HMEs and adhesives are included on the same prescription and patients require the same combination of HME and adhesives to be supplied.
[29] Merger Notice, paragraph 116.
[30] Given that Atos supplies speaking aids through the hospital channel and Countrywide does not supply speaking aids to the community channel, no horizontal or vertical overlaps arise in relation to speaking aids and these products are not considered further in the decision.

Distinction by brand of medical appliance

32. Atos submitted that it is not necessary to differentiate between different types of HMEs or adhesives as manufacturers generally supply a full range of products or could otherwise extend their product range relatively easily. In addition, patients are able to switch between different types of HMEs and adhesive.[31]

33. Hospital based Speech and Language Therapists (**SLTs**) who responded to the CMA's merger investigation said that there was some variation between brands and that SLTs will often try a variety of appliances across all suppliers with the patient (balancing clinical effectiveness, ease of use, patient comfort and confidence and any other factors resulting from the patient's medical conditions) in order to find the most appropriate product for a patient.[32]

34. SLTs also said that patients tend to rely on the advice of their medical adviser and that once patients have made their choice and are discharged into the community, they will generally request the previously chosen appliance(s). Most third party respondents to the CMA's merger investigation submitted that patients have a strong preference for the appliance(s) they are currently using. However, patients will change that product if, for example, it becomes uncomfortable, or if the patient develops a reaction to it.[33] If a patient needs to change appliance for any reason at a later stage, SLTs said that patients again generally make the choice on the basis of the above factors and on the advice of their SLT or GP.[34]

35. The CMA considers that the evidence above indicates that it is not appropriate to differentiate between different brands of medical appliance.

Distinction by distribution channel

36. Atos submitted that it was not necessary to distinguish between the distribution channels in relation to the manufacture and supply of laryngectomy and tracheostomy medical appliances. From a supplier perspective there was little difference between the hospital and community channel. Although pricing for laryngectomy and tracheostomy medical appliances is established individually with hospitals (rather than via the Drug

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[31] Merger Notice, paragraph 118.
[32] This was also supported by other third parties who responded to the CMA's merger investigation.
[33] Third parties who responded to the CMA's merger investigation indicated that patients tend to be in recuperation over many years and have regular repeat prescriptions.
[34] SLTs who responded to the CMA's merger investigation said that GPs are not generally very experienced with dealing with laryngectomy and tracheotomy patients and will tend to refer back to the SLT for advice when patients consider changing products.

Tariff), the pricing of appliances listed on the Drug Tariff typically matches the Tariff price.

37. In *Coloplast/SSL*[35] the Competition Commission (CC) found that the market for the supply of medical appliances under Part IX of the Drug Tariff was divided into two sectors – hospitals and the community.

38. Third parties who responded to the CMA's merger investigation told the CMA that the primary supply route for most laryngectomy and tracheostomy medical appliances for both the hospital and community channel was through wholesalers. Furthermore, manufacturers do not adopt different approaches to supply these end users.

39. The CMA has, on a cautious basis, considered the supply to the community channel separately from the supply to the hospital channel.[36]

Dispensing of laryngectomy and tracheostomy medical appliances

Distinction by distribution channel

40. Atos submitted that the relevant market definition should only encompass the community channel. DACs, such as Countrywide, are primarily involved in supplying medical appliances and related services to patients in the home. Countrywide does not supply laryngectomy and tracheostomy medical appliances to patients in hospitals.

41. In *Coloplast/SSL*,[37] the CC found that the market for dispensing medical appliances under Part IX of the Drug Tariff is divided into two sectors – hospitals and the community. Further in *Amcare/Surecalm*,[38] the OFT did not consider competition from the hospital channel as part of the product scope for these two dispensers who overlapped only in the community channel.

42. A number of third party respondents to the CMA's merger investigation stated that although patients in the community channel can go to hospital pharmacies to fulfil their prescriptions, very few consider this as a reasonable option as retail pharmacies and DACs (and dispensing doctors where appropriate) are more convenient.

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[35] Competition Commission Report: *Coloplast/SSL* (June 2002).
[36] Countrywide is not active in distribution to the hospital channel and as such any potential competitive effects of this Merger would primarily relate to the community segment.
[37] Competition Commission Report: *Coloplast/SSL* (June 2002).
[38] OFT Decision: ME/5422/12 *Amcare/Surecalm*, 27 June 2012.

43. On the basis of the evidence available to it, the CMA therefore does not consider it appropriate to aggregate dispensing via the hospital and community channels.[39]

Distinction between DACs, pharmacies and dispensing doctors

44. Atos submitted[40] that the CMA should consider both DACs and pharmacies as being in the product frame of reference as competing distribution paths within the community channel. Atos submitted that this would be in line with the OFT's previous decision in *Amcare/Surecalm.*[41]

45. Retail pharmacists who responded to the CMA's merger investigation in this case said that whilst there may be some storage restrictions, they can obtain products very quickly for patients, and in particular, patients now tend to send their prescription to the retail pharmacist in advance via electronic means, so that the appliance can be available when the patient is ready to pick it up. They also told the CMA that they can and do provide a home delivery service. Retail pharmacists and manufacturers who responded to the CMA's merger investigation told the CMA that the amount of related services that DACs offer in the laryngectomy and tracheostomy area is not significant. Retail pharmacists confirmed that they would have no difficulty in providing these services.

46. On the basis of the evidence available to it, the CMA therefore considers that it is appropriate to consider retail pharmacies and DACs as operating in the same market for the purposes of dispensing of laryngectomy and tracheostomy medical appliances.

Dispensing by product types

47. Atos submitted that the CMA should assess the Merger on the basis of a frame of reference consisting of the dispensing of all medical appliances listed in Part IX of the Drug Tariff.[42]

48. In *Amcare/Surecalm*,[43] the OFT considered the scope of the appropriate product market in the dispensing of ostomy, urology and wound care medical products.[44] Atos submitted that a similar approach in this case would be to

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[39] There is no horizontal or vertical overlap in the supply of laryngectomy and tracheotomy medical appliances to the hospital channel. As a result, the CMA does not consider the hospital channel further in this decision.
[40] Merger Notice, paragraph 123.
[41] OFT Decision: ME/5422/12 *Amcare/Surecalm*, 27 June 2012.
[42] Merger Notice, paragraph 126.
[43] OFT Decision: ME/5422/12 *Amcare/Surecalm*, 27 June 2012.
[44] Although it did not find it necessary to conclude on the product market, the OFT did differentiate between these three products when assessing the merger.

consider the dispensing of laryngectomy and tracheostomy medical appliances and related services.[45] The CMA did not receive any contrary views from third parties.

49. Many third parties who responded to the CMA's merger investigation mentioned that patients have a wide range of needs and may present a wide range of drugs and medical appliances on a single prescription. In the laryngectomy and tracheostomy area the CMA was told that that it is common practice for several prescriptions to be written so that the laryngectomy and tracheostomy medical appliances can be dispensed from one prescription irrespective of the other prescribed needs of the patient.[46]

50. DACs and retail pharmacists who responded to the CMA's market investigation said that market shares in the laryngectomy and tracheostomy dispensing market, and the number and nature of companies who are active in the market, are very different from other DAC markets.

51. On the basis of the evidence available to it, the CMA therefore considers that it is not appropriate to broaden the scope of the dispensing market beyond the market for dispensing laryngectomy and tracheostomy medical appliances.

Geographic scope

52. Atos submitted that the appropriate geographic frame of reference should be at least UK wide. Atos submitted that all manufacturers supply laryngectomy and tracheostomy medical appliances on a UK-wide basis.[47] On the dispensing side, whilst DAC licences are location specific, DACs supply the UK as a whole from these locations.[48]

53. In *Coloplast/Mentor*,[49] the CC concluded that the geographic scope for the supply of certain urology products was in the UK. In *Amcare/Surecalm*[50] the OFT did not find it necessary to conclude on the geographic market. However, it did assess the transaction using a cautious geographic frame of Great Britain. All third parties who responded to the CMA's merger investigation in relation to this point confirmed that manufacturers supply the UK as a whole, and that DACs can, and do, supply on a UK-wide basis from their base(s). NHS England confirmed that there are reciprocal arrangements in place for patients in Scotland, Wales and Northern Ireland to be able to order

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[45] Merger Notice, paragraph 125.
[46] If a DAC was presented with a prescription that included both prescription drugs and medical appliances, they would not be able to dispense the products as they are not licenced to dispense drugs.
[47] Merger Notice, paragraph 143.
[48] Merger Notice, paragraph 150.
[49] Competition Commission Report: *Coloplast/SSL* (June 2002).
[50] OFT Decision: ME/5422/12 *Amcare/Surecalm*, 27 June 2012.

laryngectomy and tracheostomy medical appliances from DACs based in England for home delivery.[51]

54. For the reasons set out above, the CMA has considered the impact of the Merger on the basis of a UK-wide geographic frame of reference. However, it was not necessary for the CMA to reach a definitive conclusion on the geographic frame of reference, since, as set out below, no competition concerns arise on any plausible basis.

Conclusion on frame of reference

55. For the reasons set out above, the CMA has considered the impact of the Merger on the basis of the following frames of reference:

- the manufacture and supply of laryngectomy and tracheostomy medical appliances, in the community channel in the UK; and
- the dispensing of laryngectomy and tracheostomy medical appliances in the community channel to patients through retail pharmacies and DACs, in the UK.

Competitive assessment

56. This Merger raises both horizontal and vertical issues. In relation to horizontal issues, the CMA has considered whether the Merger raises a realistic prospect of an SLC through:

- the loss of existing competition in the dispensing of laryngectomy and tracheostomy medical appliances to patients in the community channel in the UK; and
- the loss of potential competition in the dispensing of laryngectomy and tracheostomy medical appliances to patients in the community channel in the UK.

Horizontal unilateral effects

Loss of existing competition

57. Atos submitted that there was no material horizontal overlap between the Parties' activities, since they operate at different levels of the supply chain for

[51] Arrangements are in place between England, Wales, Scotland and Northern Ireland where payments for medical appliances which are ordered from a provider in another nation are processed by that nation and reimbursed on a national level.

laryngectomy and tracheostomy medical appliances (see Figure 2 below). Atos submitted that it had made total direct sales to patients of less than £[✂] in the last year. By comparison, Countrywide generated a turnover of around £[✂] in 2014 from these activities.

58. No third parties who responded to the CMA's merger investigation raised concerns in relation to this horizontal aspect.

Loss of potential competition

59. Atos submitted that prior to the Merger, it had acquired three DAC licences.[52] Atos explained that whilst it could have used these DAC licences to enter the dispensing level of the supply chain for laryngectomy and tracheostomy medical appliances, it had not done so. Therefore, absent the Merger, Atos would have been able to begin dispensing medical appliances to patients as a competitor to Countrywide. Internal documents suggest that it was [✂].[53]

60. A merger involving a potential entrant could lessen competition by weakening the competitive constraint on the incumbent (or its prospects).[54] In assessing whether a merger leads to unilateral effects from the loss of actual potential competition, the CMA will consider whether:[55]

- the potential entrant is likely to enter in the absence of the merger; and
- such entry would lead to greater competition.

61. The CMA also considers whether there would have been other potential competitors before concluding on the SLC test.

62. The CMA notes that Atos had held the DAC licences for a number of years, but had not used them to dispense laryngectomy and tracheostomy medical appliances to patients. Furthermore, Atos' internal documents[56] indicate that Atos [✂]. In this arrangement, Atos would not have been directly involved at the downstream level.[57]

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[52] Atos acquired the following licenses: (i) DAC licence for premises in Upton, West Yorkshire acquired [✂] from Rapidcare; (ii) DAC licence for premises in Beeston, Nottingham acquired [✂] from Amcare; and (iii) DAC licence for premises in Manchester acquired [✂] from Amcare.
[53] Merger Notice, appendix 32.
[54] The CMA refers to such situations as 'actual potential competition'.
[55] *Merger Assessment Guidelines*, paragraph 5.4.15.
[56] Merger Notice, appendix 37.
[57] Specifically, this would have involved Atos selling its dispensing licences to the DAC and entering into a distribution agreement which would see Atos products through the DAC's existing network.

63. Atos submitted that there are currently 128 DAC licences[58] held by a total of 46 businesses[59] which could be used for the dispensing of laryngectomy and tracheostomy medical appliances. However, only a small subset of these businesses are active in dispensing laryngectomy and tracheostomy medical appliances, suggesting that other factors impact on the commercial decision to enter the dispensing level of the supply chain.

64. The CMA believes that these factors indicate that stand-alone entry by Atos (ie otherwise than through a joint venture) into the dispensing of laryngectomy and tracheostomy medical appliances would not have been likely absent the Merger.

Conclusion on horizontal unilateral effects

65. For the reasons above, the CMA considers that the Merger does not give rise to a realistic prospect of a substantial lessening of competition as a result of a loss of existing or potential competition arising through horizontal unilateral effects in the dispensing of laryngectomy and tracheostomy medical appliances in the community channel to patients through retail pharmacies and DACs, in the UK.

Vertical effects

66. Vertical effects may arise when a merger involves firms at different levels of the supply chain. Vertical mergers are largely competitively benign and can even be efficiency-enhancing, but in certain circumstances can weaken rivalry, for example when they result in foreclosure of the merged firm's competitors. The CMA only regards such foreclosure to be anticompetitive where it gives rise to a realistic prospect of a substantial lessening of competition in the foreclosed market(s), not merely where it disadvantages one or more competitors.[60]

67. In this case, the Parties submitted that there is a vertical relationship between the Parties whereby Atos supplies laryngectomy and tracheostomy medical appliances to Countrywide for dispensing in the community channel.[61] Figure 2 below shows Atos' sales in the community channel in the UK.[62]

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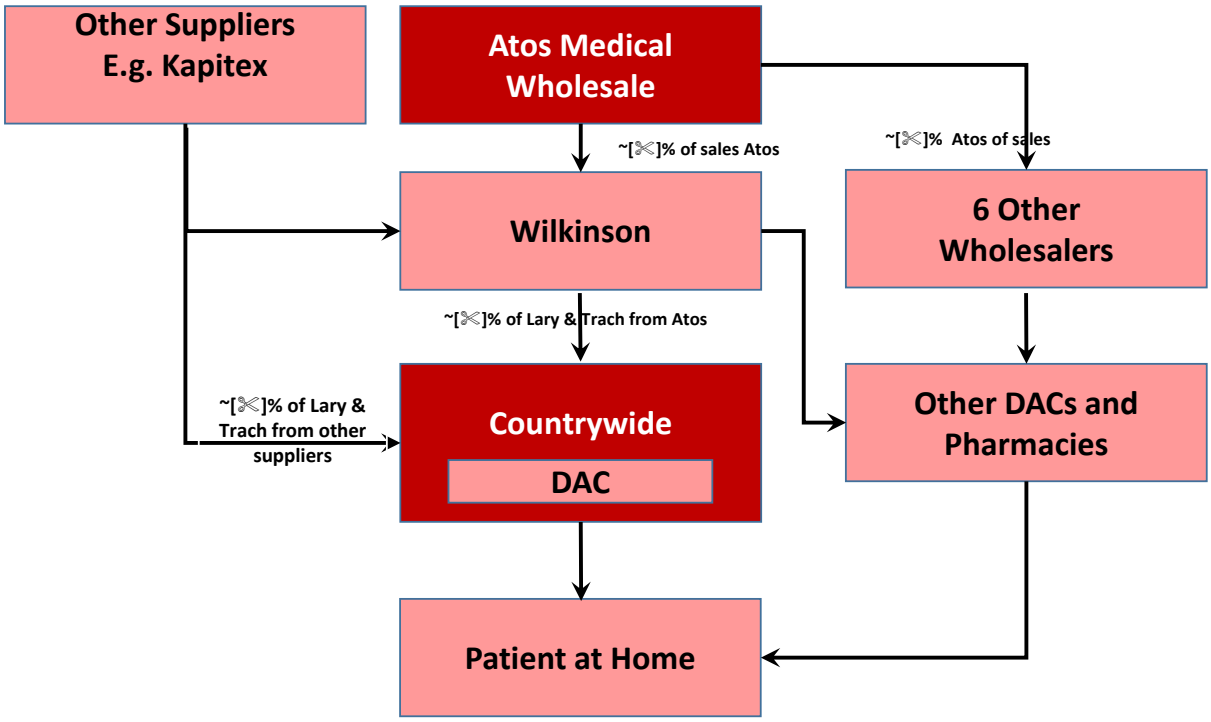
[58] 110 England; 13 Scotland; 4 Wales; 1 Northern Ireland.
[59] 41 England; 7 Scotland; 4 Wales; 1 Northern Ireland (6 businesses hold at least one DAC license in two or more nations).
[60] In relation to this theory of harm 'foreclosure' means either foreclosure of a rival or to substantially competitively weaken a rival.
[61] Countrywide has no activities relating to the hospital channel and this area is not considered further.
[62] The community channel accounts for around [✂]% of total Atos sales, with the remainder derived from sales to the hospital channel.

Figure 2: Atos' sales to the community channel



Source: Parties' submission.

68. The CMA has considered the following vertical theories of harm:[63]

- **Input foreclosure** – the merged entity could stop supplying laryngectomy and tracheostomy medical appliances, reduce discounts (ie increasing the input prices it charges to wholesalers and ultimately DACs) or otherwise worsen the service offered to competing DACs. This could in turn lead to these DACs competing less effectively with the merged entity at the dispensing level, potentially thereby leading to a lessening of competition in the dispensing of laryngectomy and tracheostomy medical appliances to patients.

- **Customer foreclosure** – the merged entity could stop dispensing laryngectomy and tracheostomy medical appliances from competing manufacturers, require higher discounts (ie reducing the input prices it pays to competing manufacturers) or otherwise worsen the service in dispensing laryngectomy and tracheostomy medical appliances from competing manufacturers. This could in turn lead to these manufacturers competing less effectively at the manufacturing level, potentially leading to a lessening of competition in the manufacturing of laryngectomy and tracheostomy medical appliances.

[63] *Merger Assessment Guidelines*, paragraphs 5.6.5-5.6.13.

- **Access to commercially sensitive information**: The merged entity could gain access to commercially sensitive information about the activities of non-vertically integrated competing manufacturers. This could lead to a lessening of competition in the manufacturing of laryngectomy and tracheostomy medical appliances.[64]

69. A number of features of the market for the supply of laryngectomy and tracheostomy medical appliances (as discussed above) are relevant to the assessment of vertical effects.

70. The CMA has taken account of these market features in its assessment of the potential for the merger to give rise to vertical effects in the supply of laryngectomy and tracheostomy medical appliances.

Input foreclosure

71. A number of third parties who responded to the CMA's merger investigation had concerns that the merged entity would be able to use its strong position at the manufacturing level to disadvantage competitors at the dispensing level of the supply chain for laryngectomy and tracheostomy medical appliances (partial input foreclosure). Key concerns were that the merged entity could:[65]

    - reduce the discounts offered to competing DACs via the wholesalers (see Figure 2), thus making it more difficult for these DACs to compete with Countrywide and that this could induce competing DACs to exit the supply of laryngectomy and tracheostomy medical appliances, leading to reduced competition at the dispensing level of the supply chain; and

    - the merged entity could stop its supply of laryngectomy and tracheostomy medical appliances to competing DACs which could lead to the exit of competing DACs and reduced competition at the dispensing level of the supply chain (total input foreclosure).

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[64] Through Countrywide's supply relationship with competing manufacturers, the merged entity could gain access to information about competing manufacturers' discounts to competing DACs, allowing it to compete less aggressively. Through Countrywide's dispensing relationship with patients, the merged entity could gain access to patient-level information which would allow it to target its own laryngectomy and tracheostomy medical appliances to these patients, thereby putting rival manufacturers at a competitive disadvantage. In both cases, the merger could lead to a lessening of competition in the manufacturing of laryngectomy and tracheostomy medical appliances.

[65] Under both scenarios *(a)* and *(b)*, the merged entity would reduce supply of its own manufactured laryngectomy and tracheostomy medical appliances to competing DACs at the dispensing level of the supply chain. In turn, the reduced availability of Atos manufactured products at competing DACs could lead patients to switch to the merged entity's own dispensing arm (ie Countrywide). If switching is significant, competing DACs would become weaker competitors over time and might exit the supply of laryngectomy and tracheostomy medical appliances to patients altogether. Competition between DACs would be reduced leading to a reduction in the quality and range of dispensing services provided by DACs.

72. Atos submitted that partial or total input foreclosure was not possible for a number of reasons, and in particular:

- Rival DACs can obtain laryngectomy and tracheostomy medical appliances from competing manufacturers. Whilst prescriptions fulfilled by DACs specify the brand of laryngectomy or tracheostomy medical appliances, in certain circumstances (such as where a particular brand is out of stock), DACs may offer an alternative and request the prescribing clinician to alter the prescription.

- Countrywide did not supply the entire patient base for laryngectomy and tracheostomy medical appliances. Furthermore, [Atos supplied a statement to the CMA in relation to efficiencies]. By supplying its products to wholesalers, Atos' products remain available to other dispensers. Therefore, the Merger would not alter the supply chain for competing DACs.

- Any attempt to restrict supply would risk losing manufacturing sales and would require significant switching at the dispensing level to make it worthwhile. Manufacturing margins are significantly higher than at the dispensing level of the supply chain. Atos told us that average gross margins on HMEs and adhesives are around [✂]% of the wholesale price. By contrast, margins on a single unit prescription of Atos' best-selling HME and adhesive product through Countrywide would generate an approximate gross margin of around [✂]%.[66] Furthermore, the merged entity would risk reputational damage, both in the community and hospital segments.

73. The CMA assessed the merged entity's (i) ability and (ii) incentive to engage in input foreclosure and (iii) the potential effect of such foreclosure on competitive conditions in the supply of laryngectomy and tracheostomy medical appliances.

[66] Atos' best-selling HME and adhesive product through Countrywide in the year to date April 2015 were [✂] and [✂]. These were sold to Countrywide at a price of £[✂] and the Drug Tariff price was £[✂], meaning Countrywide received a discount of around £[✂]. Countrywide also received a dispensing fee of £[✂] and an infrastructure fee of £[✂]. Countrywide's total gross margin on a single unit prescription was therefore around £[✂] on an input price of around £[✂], or around a [✂]% gross margin.

Ability

74. In assessing the ability of the merged firm to engage in input foreclosure, the CMA may consider:[67]

- the cost of the input relative to the output. All else being equal, if the input represents only a small proportion of the total cost of the output, then foreclosure is less likely; and
- the extent to which rivals can avoid a price increase by switching away from the input. If rivals can turn to many good substitutes for the input, then foreclosure is less likely.

75. In this case, the CMA believes on the basis of the evidence available to it that in relation to point *(a)* above, laryngectomy and tracheostomy medical appliances are an important input for dispensers. The CMA understands that DACs are obliged under NHS regulations to fulfil the prescriptions issued by clinicians.[68] Therefore their offering to patients depends to a significant extent on their ability to fulfil these patient and clinician requirements. Furthermore, manufacturers are required by the NHS Drug Tariff Unit to make their products readily available to the market. Therefore, the CMA does not consider that the merged entity would have the ability to engage in total input foreclosure. However, the CMA notes in relation to partial input foreclosure that terms of supply are not regulated or specified, such that manufacturers could feasibly reduce discounts or otherwise worsen the terms of supply to specific wholesalers or DACs.

76. The CMA has therefore considered whether rivals could switch away from Atos' products to avoid a price increase.

77. Atos submitted that it considers it is obliged, as a minimum, to supply a major wholesaler in order to meet the requirement to ensure products are readily available. Atos also submitted that patients could choose between a number of DACs and pharmacies from which to obtain their laryngectomy and tracheostomy medical appliances. Atos also noted that there were a number of alternative manufacturers of laryngectomy and tracheostomy medical appliances available in the UK, which rival DACs will be able to dispense. The Parties submitted analysis of 2014 monthly Countrywide sales data to patients who were prescribed [a competitor brand][69] HMEs and adhesives in Q4 of 2014. Atos submitted that this data shows that these patients had previously

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[67] *Merger Assessment Guidelines*, paragraph 5.6.10.
[68] These obligations are set out in the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, Schedule 6, Section 7(1).
[69] [A competitor brand] products are manufactured by [✂], a competing manufacturer to Atos. See: [✂]

received other appliances and gradually switched to [a competitor brand] products.

78. Furthermore, Atos submitted that although it had control over the level of discounts offered to wholesalers, the discount offered to DACs was a result of negotiations between wholesalers and DACs. It said that DACs and pharmacies receive a significant proportion of their revenues from the NHS in compensation for their dispensing activities. Finally, it submitted that laryngectomy and tracheostomy medical appliances are niche products and represent a relatively small segment in comparison to other medical appliance segments supplied by pharmacies and DACs (such as urology and ostomy products). Therefore, it submitted that DACs and pharmacies are not reliant on revenues from laryngectomy and tracheostomy medical appliances.

79. A number of third parties who responded to the CMA's merger investigation noted that manufacturers (and in particular Atos) had a significant position in the market for the supply of laryngectomy and tracheostomy medical appliances. However, prescriptions were brand-specific and dispensers were under an obligation to fulfil the prescription. Competing DACs and pharmacies told the CMA that the market was small by comparison to other healthcare products and that there were few internationally significant manufacturers of these products (they mentioned InHealth and Atos in particular).

80. Third party DACs who responded to the CMA's merger investigation noted that Atos had reduced the discounts offered to wholesalers prior to the merger, which had an effect on their own discounts. They argued that in relation to the existing reduction and potential future reductions in discounts, wholesalers and dispensers would have to absorb the reductions because of the obligation to fulfil prescriptions from patients and the inability to alter these prescriptions.

81. The CMA believes, on the basis of the evidence it has found, that DACs have limited ability to switch in response to a worsening in the supply terms by the merged entity. This is because DACs are reliant on access to the prescribed products and cannot generally fulfil prescriptions with alternative products or brands. Furthermore, the evidence available to the CMA indicates that [✂]. Third parties reported discounts from other manufacturers of up to 17.5%, and these significantly higher discounts do not appear to have encouraged DACs to increase the use of alternative HME suppliers.

82. The CMA further notes that the merged entity's share of supply in the manufacture of laryngectomy and tracheostomy medical appliances – which the CMA considers to be a reasonable proxy for the market power that the merged entity has at this level of the supply chain – is significantly higher, at

above [80–90]%, than the 30% threshold, below which the CMA considers vertical mergers would be unlikely to raise vertical concerns.[70]

83. The CMA therefore considers that the merged entity would have the *ability* to engage in partial foreclosure of competing DACs.

Incentive

84. In assessing whether a merger provides a merged firm with the incentive to engage in input foreclose, the CMA may consider:[71]

- the loss of profit in the upstream market. This will be greater if competition upstream is intense, reducing the incentive to foreclose;
- the gain in profit in the downstream market. This will be less if:
  - customers do not react strongly to changes in price downstream; and
  - the diversion ratio from downstream rivals to the merged firm is low, reducing the incentive to foreclose.
- relative variable profit margins upstream and downstream. If these are higher upstream than downstream, then the negative impact on profit upstream may exceed the positive impact on profit downstream, reducing the incentive to foreclose.

85. Atos submitted that even if the merged entity had the *ability* to foreclose competing DACs, it would not have the commercial *incentive* to do so. It also submitted that, given that prices paid by the NHS are fixed, manufacturers have an incentive to encourage prescriptions of their appliances. Whilst the Merger incentivises the merged entity to encourage the use of Countrywide's dispensing activities, Atos argued this could not be at the cost of lost prescriptions for its appliances sold through competing DACs (for example refusing to supply competing DACs). Atos noted that manufacturing margins were [✂] than dispensing margins, such that [✂].

86. The CMA believes that total foreclosure of competing DACs is unlikely to be successful. Competing DACs told the CMA in response to its merger investigation that they could offer alternative products to patients under certain circumstances, such as when the product is out of stock. Therefore, competing DACs could encourage the use of alternative products, which would have a significant impact on the upstream profits of the merged entity.

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[70] *Merger Assessment Guidelines*, paragraph 5.3.5, first bullet.
[71] *Merger Assessment Guidelines*, paragraph 5.6.11.

Furthermore, if the merged entity were to stop supplying or otherwise worsen its terms of supply to wholesalers, it would risk losing product sales to patients who do not currently use Countrywide.[72]

87. However, the CMA believes that the merged entity may have the incentive to engage in partial input foreclosure - that is, reductions in the discounts offered to competing DACs or other forms of worsening in the supply terms. This is because, under such a strategy, the likelihood of patients switching to competing products would be minimal. As noted in paragraph 23, prices for laryngectomy and tracheostomy medical appliances are regulated through Part IX of the NHS Drug Tariff and these appliances are NHS-funded for patients. Furthermore, prescriptions for laryngectomy and tracheostomy are brand-specific and on the basis of the evidence it found, the CMA believes there are very limited circumstances under which patients might be provided with alternative products by their DACs (see paragraph 81).

88. In addition, SLTs who responded to the CMA's merger investigation, and internal documents submitted by Atos, suggest that patients are unlikely to switch away from a preferred brand/product which they have tested at the hospital. Furthermore, they indicated that any switching would require patients to change their prescription, which in turn requires a GP and/or hospital clinician's advice (see paragraph 75) and demand for appliances is primarily driven by patient needs.

89. The CMA believes that this indicates that switching to alternative laryngectomy and tracheostomy medical appliances is likely to be very limited in response to partial or total input foreclosure. It therefore believes that the lack of switching away from Atos' appliances indicates that the impact on upstream profits would be minimal, despite the significantly higher relative margins at this level of the supply chain. This would particularly be the case in relation to partial input foreclosure.

90. Accordingly, the CMA believes that even small gains at the dispensing level of the supply chain would be profitable overall. Therefore, on the basis of the evidence available to it, the CMA believes that there is a realistic prospect that the merged entity would have the *incentive* to engage in partial input foreclosure of competing DACs.

[72] This could for example be patients who require other services not offered by Countrywide, such as the dispensing of medicines which are typically met by pharmacies.

Effect

91. In assessing the competitive effects of a merger, the CMA compares the prospects for competition with the merger against the competitive situation without it.[73] When the increment to any existing market share is minimal, it is unlikely that the change to any existing market power is substantial (in the absence of any other external factors).

92. Atos submitted that any possible effects on competition would be negligible. Atos submitted that were the merged entity to foreclose competing DACs, these DACs would encourage the use of competing laryngectomy and tracheostomy medical appliances, resulting in greater competition at the manufacturing level of the supply chain.

93. Atos submitted that Countrywide had a share of supply of laryngectomy and tracheostomy medical appliances supplied in the community by DACs (ie excluding pharmacies) of between [90–100]% and [90–100]%. The CMA believes that this indicates that the competitive constraints exerted by competing DACs on Countrywide are limited pre-Merger. When pharmacies are included, Atos indicated that Countrywide still has a [70–80]% share of supply, while pharmacies account for [20–30]% of the dispensing market.

94. Further, third parties who responded to the CMA's investigation indicated that some pharmacies may not be offering the same level of services as DACs. The CMA considers that they may therefore only impose limited constraints on DACs. Although some retail pharmacies informed the CMA that they offer several service elements offered by DACs (dispensing of the laryngectomy and tracheostomy medical appliances, home delivery, electronic prescription service etc), the CMA was informed by other DACs in response to the CMA's merger investigation that a large number of retail pharmacies will recommend that the patient use a DAC service when presented with a prescription for a laryngectomy and tracheostomy medical appliance.[74]

95. Given the above, the CMA considers that pre-merger constraints by competing DACs on Countrywide were limited. This suggests that any input foreclosure would have negligible effects on the quality and services offered by the merged entity due to the limited constraints exerted by pharmacies and Countrywide's strong position pre-merger. In addition, the CMA considers that there would be no effect on the prices of the appliances in question as these are regulated under the NHS Drug Tariff (Part IX).

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[73] *Merger Assessment Guidelines*, paragraph 4.3.1.
[74] Retail pharmacists told the CMA that they are under an obligation to offer the patient at least two alternative dispensing options if they are unwilling or unable to fulfil the prescription.

96. The CMA therefore believes on the basis of the evidence available to it that any further potential increases in the share of supply at the dispensing level and, by implication, any effect on competition following potential input foreclosure of competing DACs (in the form of reductions in quality and range of services provided to patients) would be small.

97. The CMA therefore believes, on the basis of the evidence it has found, that whilst the merged entity has the ability and incentive to engage in the partial foreclosure of competing DACs, the *effect* of any such action would not be sufficient to give rise to a realistic prospect of an SLC.

Customer foreclosure

98. The CMA's approach to assessing customer foreclosure is analogous to the assessment of input foreclosure. More specifically, the CMA considers whether the merged entity would have (i) the ability and (ii) the incentive to engage in customer foreclosure, and if so, the effect of such customer foreclosure on competitive conditions in the relevant market.

99. In the present case, the CMA has considered whether the Merger raises a realistic prospect of an SLC through customer foreclosure in the supply of laryngectomy and tracheostomy medical appliances in the community channel.

100. Third parties told the CMA in response to the CMA's merger investigation that following the Merger, the merged entity could use its strong position at both the manufacturing and dispensing level of the supply chain to disadvantage competing manufacturers' products. This could be achieved by reducing or ceasing the distribution of competing products, requiring higher discounts (reducing input prices) or otherwise worsening the service or terms for laryngectomy and tracheostomy medical appliances supplied from competing manufacturers.

101. Atos submitted that the Merger did not raise a realistic prospect of a SLC through customer foreclosure primarily because:

- Competition between manufacturers of laryngectomy and tracheostomy medical appliances was aimed at persuading relevant clinicians to prescribe their appliances. DACs had little ability to influence this decision and were obliged to fulfil the brand-specific prescriptions issued by clinicians.

- A key element of the DAC offering to patients was the ability to source a range of appliances from different manufacturers. Restrictions on their

range of appliances would significantly undermine a key element of their offering to patients. Furthermore, such restrictions would be harmful to the DACs' reputation with patients and prescribing clinicians.

- Patients can and do switch between alternative supply routes. Aside from this, were Countrywide to refuse to stock competing manufacturers' appliances, this could result in these manufacturers setting up agreements with other DACs, including those not active in the prescription of laryngectomy and tracheostomy medical appliances. Manufacturers could also develop their own direct supply to patients by, for example, purchasing an existing DAC licence, as Atos had done.

- A significant proportion of Countrywide's fulfilled prescriptions contain mixed orders of Atos and competing manufacturers' products. Attempts to restrict the supply of competing products would risk losing the revenues on the competing products (the discount), the infrastructure and the dispensing fees.

102. Third party DACs explained that Countrywide's strong position at the dispensing level of the supply chain meant that it was an important route to market for manufacturers of laryngectomy and tracheostomy medical appliances. They said that, as a result of the Merger, Atos as the dominant manufacturer of laryngectomy and tracheostomy medical appliances would be able to influence the promotional and sales activity of the most important DAC, in order to maximise the sales of its own products. The CMA considers that this practice, if successfully carried out, could in turn lead to other manufacturers competing less effectively at the manufacturing level, potentially leading to a lessening of competition in the manufacturing of laryngectomy and tracheostomy medical appliances. Third party DACs also submitted that these effects would become more prevalent over time and might impact on long term competitive outcomes such as innovation and investment into new products.

Ability

103. The CMA considered whether the merged entity would have the ability to engage in customer foreclosure, in particular by stopping dispensing competing manufacturers' products or increasing the discounts negotiated with competing manufacturers or otherwise worsening the service it provides at the dispensing level in relation to competing products. The CMA considered the extent to which:

(a) Countrywide was an important route to market for manufacturers of laryngectomy and tracheostomy medical appliances; and

(b) competing manufacturers could react to customer foreclosure in order to protect sales of their products by, for example, supplying through alternative routes to patients.

104. All third parties who responded to the CMA's merger investigation and expressed an opinion considered that Countrywide had a strong position at the dispensing level of the supply chain, and by implication was an important route to the community market for manufacturers of laryngectomy and tracheostomy medical appliances. Third parties further stated that Countrywide had established itself as the strongest DAC in this segment and that other competing DACs were significantly weaker alternatives to Countrywide in this area.

105. In particular, SLTs and a patient group who responded to the CMA's merger investigation told the CMA that Countrywide was the only realistic alternative for patients in this area and that it had by far the most significant market share at the dispensing level of the supply chain.[75] One SLT told the CMA of an instance following the Merger, where Countrywide had sought to change a patient's prescription from a competing brand to an Atos branded product. However, the CMA notes that DACs are obliged under the terms of their licences to fulfil prescriptions issued by clinicians.[76]

106. In relation to paragraph 101, point *(b)* above, the CMA believes that in the event that the merged entity were to stop dispensing competing manufacturers' products or increase the discounts negotiated with competing manufacturers or otherwise worsen the service it provides at the dispensing level in relation to competing products, competing manufacturers could find alternative routes to market. One third party told the CMA that in the event of customer foreclosure by the merged entity, competing manufacturers would look at alternative supply routes and closer cooperation with other dispensing organisations in the dispensing of laryngectomy and tracheostomy medical appliances.

107. Third party DACs who responded to the CMA's merger investigation told the CMA that barriers to entry/expansion into the dispensing level of the supply chain are low for existing dispensers in other medical appliances or other levels of the supply chain. One wholesaler [✂].

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[75] Atos estimates Countrywide has a share of supply in the DAC sector of the community segment of between [90–100]% and [90–100]% (excluding pharmacies).
[76] These obligations are set out in the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, Schedule 6, Section 7(1). As noted above, these prescriptions are brand-specific and are made by the prescribing clinician in discussion with the patient.

108. The CMA therefore considers that the merged entity would not have the *ability* to engage in customer foreclosure.

Incentive

109. The CMA believes that (as discussed above) given patients using competing products/brands are not likely to switch to Atos' products, Atos/Countrywide would lose customers to competing DACs or pharmacies if it attempted to foreclose competing manufacturers. The CMA notes that where third parties noted issues with insufficient stock (see paragraph 86 above), patients were able to obtain the desired brand through an alternative dispenser/pharmacy. Given that [✂]% of Countrywide's sales are accounted for by competing manufacturers' products, the CMA believes that the incentives to foreclose are limited.

110. Finally, third party responses to the CMA's merger investigation also suggested that reputational effects are particularly important for DACs. Third parties suggested that if a dispenser was considered to be favouring a particular manufacturer over others contrary to the patient's interests, prescribing clinicians and ultimately patients would become aware and respond. They noted that the neutrality of DACs was an important element of their service offering to patients. The example of a stock-out given by third parties and described above suggests that prescribing clinicians are aware and would be able to respond to attempts to move patients onto alternative products.

111. The CMA therefore believes on the basis of the evidence it has found that the merged entity would not have the ability to engage in customer foreclosure of competing manufacturers of laryngectomy and tracheostomy medical appliances. Notwithstanding this conclusion, the CMA also considers that the merged entity would not have the incentive to engage in customer foreclosure.

Access to commercially sensitive information

112. Some third parties told the CMA in response to its merger investigation that the merged entity had access to commercially sensitive information through:

(a) Countrywide's supply relationship with competing manufacturers – the Merger would potentially allow Atos to gain access to information about competing manufacturers' discounts to competing DACs, allowing it to compete less aggressively; and

(b) Countrywide's dispensing relationship with patients – the Merger would potentially allow the merged entity access to patient-level information which would in turn allow it to target its own laryngectomy and tracheostomy medical appliances to these patients, thereby putting rival manufacturers at a competitive disadvantage.

113. The CMA therefore considered whether the Merger could raise a realistic prospect of a SLC in the manufacturing of laryngectomy and tracheostomy medical appliances by allowing the merged entity to gain access to commercially sensitive information.

114. In relation to the first of these concerns *(a)*, the CMA notes that pre-Merger, Atos already held a substantial position in the supply of laryngectomy and tracheostomy medical appliances. Data submitted by the Parties indicates that discounts may be [✂], and that Atos' discounts [✂]. The CMA therefore believes therefore that access to such discount data would not lead to the merged entity competing less aggressively.

115. In relation to the second of the concerns, *(b)*, the CMA notes that improved customisation and targeting of appliances may be beneficial for patients. As noted above, third parties have strongly suggested that choices of laryngectomy and tracheostomy medical appliances are predominantly driven by considerations of clinical appropriateness and the relative qualities of appliances. The CMA therefore believes that access to patient level data is unlikely to substantially alter these considerations, except in cases where the merged entity might encourage the use of alternative appliances which better meet clinical and quality needs.

116. The CMA therefore believes on the basis of the evidence it has found that the Merger does not give rise to a realistic prospect of a SLC by allowing the merged entity to gain access to commercially sensitive information for non-vertically integrated competitors.

Conclusion on vertical effects

117. As set out above, the CMA believes that:

- whilst the merged entity has the ability and incentive to engage in the foreclosure of competing DACs, the effect of any such action would not be sufficient to give rise to a realistic prospect of an SLC;
- the merged entity would not have the ability to engage in customer foreclosure of competing manufacturers of laryngectomy and

tracheostomy medical appliances, and that the merged entity's incentives to engage in customer foreclosure are limited; and

- allowing the merged entity to gain access to commercially sensitive information in relation to non-vertically integrated competitors does not give rise to a realistic prospect of a SLC.

118. Accordingly, the CMA believes that the Merger does not give rise to a realistic prospect of a SLC as a result of vertical effects in relation to either: (i) the manufacture and supply of laryngectomy and tracheostomy medical appliances, through the community channel in the UK, or (ii) the dispensing of laryngectomy and tracheostomy medical appliances in the community channel to patients through retail pharmacies and DACs, in the UK.

Third party views

119. The CMA contacted customers, competitors, wholesalers and specialist clinicians (such as SLTs) who are involved in the laryngectomy and tracheostomy marker as well as other government departments with responsibility in this area such as the Department of Health and the NHS.

120. Third party comments have been taken into account where appropriate in the competitive assessment above.

Decision

121. Consequently, the CMA does not believe that it is or may be the case that the Merger has resulted, or may be expected to result, in a substantial lessening of competition within a market or markets in the United Kingdom.

122. The Merger will therefore **not be referred** under section 22(1) of the Act.

Jonathan Parker
Director, Mergers
Competition and Markets Authority
7 August 2015