

Excess Pricing in the Napp Chapter II Case – how much is too much?

In any standard economics textbook the description of monopoly shows a supplier who has the power to raise price above costs in order to earn profits in excess of the normal or competitive level. The textbook monopolist restricts output in order to create an artificial scarcity for its product, and this causes the welfare losses arising from monopoly abuse.

Most economists would readily agree that public policy ought to be capable of dealing with excess pricing. This is most starkly seen in the regulation of privatised natural monopoly suppliers such as water supply companies, where price cap controls are required to ensure a fair deal for consumers. However, in markets where profits perform a dynamic function of rewarding success and providing incentives for investment and innovation, the connection between the simple static model of monopoly abuse and the law on abuse of dominance is not straightforward.

This Brief discusses the UK competition authorities' approach to excess pricing in the Napp Pharmaceuticals case.¹ This was the first abuse of dominance decision under the UK's new Competition Act to attract a fine.²

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Economists now working at RBB acted as economic experts to Napp in connection with this case.

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OFT Decision dated 30 March 2001, and CCAT Judgment dated 15 January 2002. The case was brought under the Chapter II prohibition which mirrors EC Article 82. Napp was originally fined £3.2m following an OFT Decision, but this was reduced after appeal to the CCAT to £2.3m.

The Napp case

Napp was found to enjoy a dominant position by virtue of its ownership of MST, a brand of slow release morphine sulphate tablet used to treat severe chronic pain in patients such as those suffering from cancer. MST had been launched in 1980 and promoted successfully as a breakthrough pain relief product. Napp had no patent in the active molecule but it did own a formulation patent in the slow release technology used in MST. However, even that limited protection had expired in 1992, leaving Napp open to competition from a number of rival brands that, whilst not strictly generic copies of MST, had similar clinical properties.

Despite this market entry, MST continued to hold a very high brand share in excess of 95% and the prices it charged for sales via general practitioners (GPs) in the so-called "community market" had hardly changed since the product was launched. Three main factors explain this situation.

First, Napp had established a clear first mover advantage in this market. When MST was launched, it was actively promoted by Napp to health care professionals as a breakthrough in the treatment of severe chronic pain. Through active marketing and education, the MST brand had become firmly established in the minds of the main users, and Napp has continued to develop new products in this field, thus preserving its reputation for innovation and expertise in palliative care.

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The OFT defined the market as slow release morphine sulphate. There are other medicines aimed at treatment of chronic severe pain, including the Durogesic patch marketed by Janssen, but these were excluded from the market analysis.

Second, there is a high degree of inertia in the UK health care market that blunts normal competitive dynamics. As is typical in prescription pharmaceutical markets, product choices are made by clinicians whose primary motivation is medical rather than economic. MST is used comparatively rarely by GPs and it forms only a tiny element in the typical medical practice budget. It is also used in cases of severe pain in which busy, risk-averse doctors have little incentive or inclination to experiment with new formulations unless they are shown to offer something new.³

Third, the OFT argued (and, on appeal, the UK appeals tribunal, the CCAT, concurred) that Napp's pricing to the hospital sector had anticompetitive exclusionary effects in the market as a whole. Although hospital sales accounted for just 10% of MST sales, purchasing behaviour of hospital buyers was much more price-sensitive than the behaviour of GPs in the community market, and hospital sales held a wider strategic importance. Napp's competitors recognised this and had instigated a series of aggressive price reductions in their bids for hospital contracts. Napp responded by consistently matching its rivals' price reductions in order to retain the business, even to the point where all suppliers' hospital bids fell to levels below the costs incurred in manufacturing the product.

The OFT and CCAT found that the impact of Napp's below-cost hospital pricing extended beyond the hospital segment because a brand's sales in the hospital market were linked to outcomes in the community market. By denying competing brands access to hospital sales they argued that Napp also prevented competition in the community market. Napp, meanwhile, contended that these same hospital-community linkages were the very factor that justified the apparently sub-economic hospital prices, and that its policy of loss leading in hospital bids represented a normal competitive response to the fact that loss-making hospital sales generated profitable sales in the community market.

The exclusionary pricing aspects of the case raise some interesting and novel issues in their own right, but in this Brief we focus on the OFT's separate finding that Napp had committed an abuse by virtue of excessively high community market prices.⁴ Specifically, we ask what lessons can be drawn from this decision for other firms who fear that they might be investigated for a similar abuse.

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Napp's fine was intended to cover both aspects of the abuse, but the CCAT did not specify how much of the penalty was due to the excess pricing abuse. Napp was also obliged to make a one-off reduction in its community price to remedy the excess pricing abuse.

The flawed analysis of excess pricing in the Napp case

The OFT relied on a range of measures to justify its conclusion that Napp's community price for MST was excessive, mostly based on various comparisons of Napp's price-cost margins. It found that the price charged for MST in the community market was more than four times the cost of production, and an eye-catching 2000% higher than Napp's lowest (and below-cost) price in the problematic hospital contract bids. The MST selling price was also some 30 to 50% higher than the prices charged by Napp's rivals.

Aside from the price-cost comparisons, the OFT was also critical of the fact that Napp continued to charge virtually the same price for MST as it had when the brand was introduced over 20 years ago, despite the entry of cheaper competing products.⁵

There are, however, two fundamental flaws with the OFT's approach to measuring excess pricing.

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Though in real, inflation-adjusted terms, this represented a decline of more than 60% since launch.

The first stems from the OFT's reliance on price-cost margins. In any industry where the ability to offer a product for sale is dependent on incurring up-front costs (e.g. in R&D) it is simply impossible to measure the true profitability of a product by reference to price-cost margins on on-going sales. At a minimum, it is necessary also to know how big was the initial investment in up-front sunk costs that needs to be remunerated by the flow of attractive high price-cost margins on sales. And it is essential to know the total value of such sales – a product with a sales value of £ 10m at a "low" price-cost margin of 10% would generate a higher return on any given up-front investment than a product with a "high" price-cost margin of 90% but sales of just £ 1m.

The second flaw arises from the difficulty of distinguishing *ex ante* from *ex post* profitability in cases where, as in the pharmaceutical industry, investments are made under conditions of uncertainty. High returns on the products that turn out to be winners are of course necessary in order to compensate firms for low or negative returns on those projects that fail to find their way to market. It is inevitable that an inquiry into alleged dominance in the pharmaceutical industry (or other industries with similar characteristics) will deal

with a biased sample of successful projects, but it is equally clear that *ex post* investigation of these successful products, and regulatory intervention designed to reduce their returns to “normal” levels would undermine the balance of risk and rewards that underpins the dynamic competitive process in such industries.

In the CCAT Judgment on the Napp case, these criticisms of the OFT’s approach were noted but rejected. The first criticism was dismissed on the grounds that, had the OFT done a thorough *ex post* appraisal of MST, it would indeed have found that the successful product had earned high profits over its lifetime. This does not, however, explain why the OFT did not carry out the necessary analysis, and by implication it also confirms that the price-cost margins on which the OFT’s analysis relied were not, after all, a reliable basis for its conclusions.

Napp’s second criticism, relating to the need for a “portfolio” approach to profit assessment, was rejected by the CCAT as follows:

“it is not appropriate, when deciding whether an undertaking has abused a dominant position by charging excessive prices in a particular market, to take into account the reasonableness or otherwise of its profits in other, unspecified, markets comprised in some wider but undefined “portfolio” unrelated to the market in which dominance exists”.⁶

This rather evades the issue of how to assess profits under uncertainty. One possible solution would be to apply an extremely high cost of capital to the investment funds that were originally committed to the development of MST to reflect the fact that those funds were committed in a situation of *ex ante* uncertainty. But neither the OFT nor the CCAT attempted to make or acknowledge the need for this kind of adjustment.

Ultimately, the conclusion that Napp’s prices for MST amounted to an excess pricing abuse is highly dependent on the observation that Napp had not felt the need to reduce the product’s price despite patent expiry and market entry.⁷ The OFT’s own definition, endorsed by the CCAT, states that a price is excessive:

“if it is above that which would exist in a competitive market, and where it is clear that high profits will not stimulate successful new entry within a reasonable period.”⁸

The fact that MST’s community price had remained virtually fixed for over 20 years in nominal terms indicates an absence of the kind of price dynamics that we expect in conventional markets. But that merely reflects the imperfect quasi-regulated environment in which Napp operates. After all, most true monopoly suppliers operating in conventional markets would have taken steps to increase prices in line with costs at some point in this 20 year period. Moreover, no rational firm in this or any other industry would rush to cut prices in response to market entry if the entrant was failing to make any headway into the market despite its price advantage. Yet it was Napp’s failure to take such pre-emptive action that constituted the abuse in this case.

Napp argued that the explanation for this unusual competitive environment lay in the peculiarities of the health sector, but contended that regulation of the sector by the Department of Health, acting on behalf of the virtual monopsony buyer the National Health Service, could be relied upon to secure reasonable results. The OFT, however, laid the blame for this lack of competition at Napp’s market-foreclosing behaviour in the hospital sector.

Lessons for other firms

Following the CCAT Judgment, Napp was obliged to pay the OFT fine and reduce the community price of MST.⁹ The more interesting question going forward is how other dominant firms should react to the way in which excess pricing was addressed in the

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CCAT Judgment, para 413. Napp argued that the PPRS, the price regulation scheme operated by the UK Department of Health, regulates pharmaceutical company profitability on the basis of the return on capital of each firm that falls within the Scheme, thus taking such a portfolio approach to regulation.

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At para 417 of the Judgment, the CCAT states “We do not accept that, after such a long period, the price of MST can credibly be defended on a “portfolio pricing” theory”.

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See paras 390 and 391 of the Napp Judgment.

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Interestingly, this price reduction will make life harder for Napp’s competitors since it has reduced the competitive advantage they enjoy on price. In this sense the remedy for the excess pricing ruling conflicts with the remedy against Napp’s alleged exclusionary behaviour.

Napp case. Specifically, should dominant firms who are enjoying a steady stream of profit contributions from mature products suddenly volunteer price reductions to their customers in order to secure compliance with the Chapter II prohibition? Or, to turn the proposition around, should customers who believe they are currently paying prices that contribute to such profit streams react by lodging complaints with the OFT and/or initiating a claim for damages through the courts?

There are a number of special features of the Napp case that would argue against the need for other firms to take pre-emptive action to reduce prices. There is a strong suspicion that the exclusionary hospital pricing found in the Napp case was the real target of the enforcement action. If there had never been a price war in the hospital market for slow release morphine sulphate, and if Napp had continued to enjoy a steady stream of revenues from its first mover advantage in MST whilst suffering only minor irritation from smaller fringe brands, it is extremely unlikely that the OFT would have initiated and sustained a truly stand-alone case of excess pricing on MST.

But that in turn begs the question of why the OFT chose to pursue excess pricing as a distinct abuse. Under EC law, there have been very few serious attempts to deal with excess pricing as an abuse since the United Brands case, in which the Court rejected the Commission's finding that UB had charged abusively high prices, but kept open the possibility that Article 82 could in principle be used for such purposes.¹⁰ The old UK Fair Trading Act regime has taken a consistent interest in measuring the profitability of scale monopoly suppliers. In industries such as white salt, condoms and business telephone directories it has applied price cap regulation on the market leaders.¹¹ Each of these cases raises its own controversies, but they all involve regulation after the event to ease a perceived consumer detriment. This is sharply distinct from an abuse of dominance case in which firms can be fined for the unlawful act of not taking the initiative to reduce prices when they perceive that "normal competitive pressures" are not working.

In taking this approach on the Napp case, rather than concentrating on concerns with exclusionary hospital pricing, the UK authorities have opened up a Pandora's box of excess pricing issues for no particularly compelling reason. By basing their analysis on economic reasoning that provides no operational basis for evaluating when prices can be considered excessive, they have added yet another layer of uncertainty to the kind of compliance advice that can be given to firms who fear they might be considered dominant.

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Case 27/76 United Brands v Commission (1978).

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In the recent SME banking inquiry, the Competition Commission even recommended price cap controls in a market with four main suppliers and no clear market leader.

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