Neutral citation [2015] CAT 8

IN THE COMPETITION APPEAL TRIBUNAL

Case No.: 1230/6/12/14

29 April 2015

Before:

THE RIGHT HONOURABLE LORD JUSTICE SALES
(Chairman)
CLARE POTTER
DERMOT GLYNN

Sitting as a Tribunal in England and Wales

BETWEEN:

FEDERATION OF INDEPENDENT PRACTITIONER ORGANISATIONS

Applicant

-v-

COMPETITION AND MARKETS AUTHORITY

Respondent

Heard at Victoria House on 26 and 27 January 2015

JUDGMENT

A P P E A R A N C E S

Mr Brian Kennelly and Ms Emily Neill (instructed by Watson Farley & Williams LLP) appeared on behalf of the Applicant.

Ms Kassie Smith QC and Mr Brendan McGurk (instructed by the Treasury Solicitor) appeared on behalf of the Respondent.

Note: Excisions in this judgment (marked "[…][✂]") relate to commercially confidential information: Schedule 4, paragraph 1 to the Enterprise Act 2002.

I. INTRODUCTION

1. This is the majority judgment of Sales LJ and Clare Potter on an application made by the Federation of Independent Practitioner Organisations ("FIPO") under section 179 of the Enterprise Act 2002 ("the 2002 Act") to challenge parts of the report produced by the Competition and Markets Authority into the provision of private healthcare, *Private Healthcare Market Investigation: Final Report*, 2 April 2014 ("the Report"). Dermot Glynn has prepared a dissenting judgment, which follows this judgment. The market investigation was conducted by the Competition Commission, whose role was then taken over by the Competition and Markets Authority: in this judgment we refer to them compendiously as "the CMA". The market investigation was carried out pursuant to a reference to the CMA made by the Office of Fair Trading ("OFT") on 4 April 2012.

2. FIPO is an organisation which represents the interests of medical organisations with private practice committees and the medical consultants who are members of such organisations. It made representations to the CMA in the course of the market investigation.

3. The Report covered a wide range of different aspects of the private healthcare market. The parts of the Report which are in issue on this application are as follows:

   (a) In the Report, the CMA considered whether there were adverse effects on competition ("AECs") for the purposes of section 134 of the 2002 Act arising from the buyer power in the healthcare market of private medical insurers ("PMIs") in relation to consultants. The CMA concluded that although in some cases PMIs had significant power in the market to constrain consultants' fees and control consumer choices regarding which consultants to use, this did not give rise to an AEC ("the PMI Decision"); and

(b) The Report included the finding that there was an AEC arising from the lack of independent publicly available performance and fee information on consultants which gave rise to the distortion of competition between consultants by preventing patients from exercising effective choice. This reduced competition between consultants on the basis of quality and price. To address this AEC the Report proposed the implementation of an Order requiring healthcare facility operators and consultants to publish information about consultants' fees and other aspects of their practice ("the Information Remedy"). The CMA subsequently made an order giving effect to the Information Remedy.

4. FIPO put forward six grounds of challenge to the PMI Decision, which are reviewed in turn below. For the most part, these grounds of challenge allege that the CMA made irrational findings in various respects. There is also a procedural ground of challenge, under which FIPO alleges that the CMA did not consult with it properly, as required by section 169 of the 2002 Act, and did not give it a fair opportunity to deal with the suggestion (later, a finding) that, notwithstanding the fee caps widely imposed on consultants by PMIs, consultants could compete with each other on price below the fee caps.

5. FIPO also challenges the decision to impose the Information Remedy, on the grounds that it is not an effective remedy, such as to be permissible under section 138 of the 2002 Act. FIPO contends that it is not an effective remedy because the CMA should have found that consultant fees were so constrained by price limits imposed by the PMIs that consultants have no meaningful room to compete with each other on price. This challenge is therefore closely linked with the challenge to the PMI Decision and, indeed, FIPO conceded at the hearing that its challenge to the Information Remedy cannot succeed unless it also persuades the Tribunal that the PMI Decision is unlawful.

II. THE LEGISLATIVE FRAMEWORK

6. Section 134 of the 2002 Act provides in relevant part as follows:

> "**134 Questions to be decided on market investigation references**
>
> (1) The CMA shall, on an ordinary reference, decide whether any feature, or combination of features, of each relevant market prevents, restricts or distorts competition in connection with the supply or acquisition of any goods or services in the United Kingdom or a part of the United Kingdom.
>
> …
>
> (2) For the purposes of this Part, in relation to an ordinary reference, there is an adverse effect on competition if any feature, or combination of features, of a relevant market prevents, restricts or distorts competition in connection with the supply or acquisition of any goods or services in the United Kingdom or a part of the United Kingdom.
>
> …
>
> (3) In subsections (1) and (2) "relevant market" means—
>
> (a) in the case of subsection (2) so far as it applies in connection with a possible reference, a market in the United Kingdom—
>
> (i) for goods or services of a description to be specified in the reference; and
>
> (ii) which would not be excluded from investigation by virtue of section 133(2); and
>
> (b) in any other case, a market in the United Kingdom—
>
> (i) for goods or services of a description specified in the reference concerned; and
>
> (ii) which is not excluded from investigation by virtue of section 133(2).
>
> (4) The CMA shall, if it has decided on a market investigation reference that there is an adverse effect on competition, decide the following additional questions—
>
> (a) whether action should be taken by it under section 138 for the purpose of remedying, mitigating or preventing the adverse effect on competition concerned or any detrimental effect on customers so far as it has resulted from, or may be expected to result from, the adverse effect on competition;
>
> (b) whether it should recommend the taking of action by others for the purpose of remedying, mitigating or preventing the adverse effect on competition concerned or any detrimental effect on customers so far as it has resulted from, or may be expected to result from, the adverse effect on competition; and

(c) in either case, if action should be taken, what action should be taken and what is to be remedied, mitigated or prevented.

(5) For the purposes of this Part, in relation to a market investigation reference, there is a detrimental effect on customers if there is a detrimental effect on customers or future customers in the form of—

(a) higher prices, lower quality or less choice of goods or services in any market in the United Kingdom (whether or not the market or markets to which the feature or features concerned relate); or

(b) less innovation in relation to such goods or services.

(6) In deciding the questions mentioned in subsection (4), the CMA shall, in particular, have regard to the need to achieve as comprehensive a solution as is reasonable and practicable to the adverse effect on competition and any detrimental effects on customers so far as resulting from the adverse effect on competition.

(7) In deciding the questions mentioned in subsection (4), the CMA may, in particular, have regard to the effect of any action on any relevant customer benefits of the feature or features of the market or markets concerned.

(8) For the purposes of this Part a benefit is a relevant customer benefit of a feature or features of a market if—

(a) it is a benefit to customers or future customers in the form of—

(i) lower prices, higher quality or greater choice of goods or services in any market in the United Kingdom (whether or not the market or markets to which the feature or features concerned relate); or

(ii) greater innovation in relation to such goods or services; and

(b) the CMA or (as the case may be) the Secretary of State believes that—

(i) the benefit has accrued as a result (whether wholly or partly) of the feature or features concerned or may be expected to accrue within a reasonable period as a result (whether wholly or partly) of that feature or those features; and

(ii) the benefit was, or is, unlikely to accrue without the feature or features concerned."

7. Section 138 of the 2002 Act provides that, where a decision is made that there is an AEC, the CMA "shall … in relation to each [AEC], take such action under section 159 or 161 as it considers to be reasonable and practicable" to remedy, mitigate or prevent the AEC or any detrimental effects for customers which result from, or may be expected to result from, the AEC. If a decision is taken to impose a remedy pursuant to

section 138 which is ineffective to achieve its aim, it will be outwith the statutory purpose, disproportionate and unlawful: see *Tesco plc v Competition Commission* [2009] CAT 6, at [137].

8. Section 169 of the 2002 Act imposes a duty of consultation on the CMA with respect to decisions taken by it in relation to, amongst other things, the questions mentioned in section 134 (including whether there is an AEC). Section 169 provides in relevant part as follows:

> "**169 Certain duties of relevant authorities to consult: Part 4**
>
> (1) Subsection (2) applies where the relevant authority is proposing to make a relevant decision in a way which the relevant authority considers is likely to have a substantial impact on the interests of any person.
>
> (2) The relevant authority shall, so far as practicable, consult that person about what is proposed before making that decision.
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> (3) In consulting the person concerned, the relevant authority shall, so far as practicable, give the reasons of the relevant authority for the proposed decision.
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> (4) In considering what is practicable for the purposes of this section the relevant authority shall, in particular, have regard to—
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> (a) any restrictions imposed by any timetable for making the decision; and
>
> (b) any need to keep what is proposed, or the reasons for it, confidential.
>
> (5) The duty under this section shall not apply in relation to the making of any decision so far as particular provision is made elsewhere by virtue of this Part for consultation before the making of that decision. …"

9. Section 179 of the 2002 Act provides in relevant part as follows:

> "**179 Review of decisions under Part 4**
>
> (1) Any person aggrieved by a decision of the CMA … in connection with a reference or possible reference under this Part may apply to the Competition Appeal Tribunal for a review of that decision.
>
> (2) For this purpose "decision"—
>
> …

(b) includes a failure to take a decision permitted or required by this Part in connection with a reference or possible reference.

…

(4) In determining such an application the Competition Appeal Tribunal shall apply the same principles as would be applied by a court on an application for judicial review.

(5) The Competition Appeal Tribunal may—

(a) dismiss the application or quash the whole or part of the decision to which it relates; and

(b) where it quashes the whole or part of that decision, refer the matter back to the original decision maker with a direction to reconsider and make a new decision in accordance with the ruling of the Competition Appeal Tribunal.

…"

10. It was common ground on this application that the statement of the law by the Tribunal in *BAA Ltd v Competition Commission* [2012] CAT 3 ("*BAA*") at [20] provides relevant guidance. (The case went on appeal - see [2012] EWCA 1077 - but the relevant statement of the law to be applied was not called into question). The Tribunal said this:

"20. Section 179(4) of the Act provides that on an application to it for review of a decision of the CC [the Competition Commission] the Tribunal "shall apply the same principles as would be applied by a court on an application for judicial review." There were no major differences between the parties as regards the approach that these principles require on the part of the Tribunal, but there were potentially significant differences of emphasis. In our judgment, the principles to be applied are as follows:

(1) Sections 134(4) and (6) and 138(2) and (4) of the Act …, read together, require that any remedies that the CC recommends or adopts must be reasonable, practicable and – subject to those parameters – comprehensive;

(2) In light of the relevance of the Convention right in Article 1P1 in this context, section 3(1) of the HRA requires that sections 134 and 138 should be read and given effect in a way compatible with that Convention right, which means that any such remedies must satisfy proportionality principles. Also, the CC accepts in its published guidance that any such remedies must satisfy proportionality principles (paragraph 4.9 of the Competition Commission Guidelines on Market Investigation References, June 2003). There was common ground as to the formulation of the proportionality test to be applied by the CC in taking measures under the Act (and by the Tribunal in reviewing its actions):

> "… the measure: (1) must be effective to achieve the legitimate aim in question (appropriate), (2) must be no more onerous than is required to achieve that aim (necessary), (3) must be the least onerous, if there is a choice of equally effective measures, and (4) in any event must not produce adverse effects which are disproportionate to the aim pursued" (*Tesco plc v Competition Commission* [2009] CAT 6 at [137], drawing on the formulation by the Court of Justice in Case C-331/88 *R v Ministry of Agriculture, Fisheries and Food, ex p. Fedesa* [1990] ECR I-4023, para. 13)

In addressing proportionality, the following observation of the Tribunal at para. [135] of its judgment in *Tesco* should particularly be borne in mind:

> "[C]onsideration of the proportionality of a remedy cannot be divorced from the statutory context and framework under which that remedy is being imposed. The governing legislation must be the starting point. Thus the Commission will consider the proportionality of a particular remedy as part and parcel of answering the statutory questions of whether to recommend (or itself take) a measure to remedy, mitigate or prevent the AEC and its detrimental effects on customers, and if so what measure, having regard to the need to achieve as comprehensive a solution to the AEC and its effects as is reasonable and practicable."

(3) The CC, as decision-maker, must take reasonable steps to acquaint itself with the relevant information to enable it to answer each statutory question posed for it (in this case, most prominently, whether it remained proportionate to require BAA to divest itself of Stansted airport notwithstanding the MCC the CC had identified, consisting in the change in government policy which was likely to preclude the construction of additional runway capacity in the south east in the foreseeable future): see e.g. *Secretary of State for Education and Science v Tameside Metropolitan Borough Council* [1977] AC 1014, 1065B per Lord Diplock; *Barclays Bank plc v Competition Commission* [2009] CAT 27 at [24]. The CC "must do what is necessary to put itself into a position properly to decide the statutory questions": *Tesco plc v Competition Commission* [2009] CAT 6 at [139]. The extent to which it is necessary to carry out investigations to achieve this objective will require evaluative assessments to be made by the CC, as to which it has a wide margin of appreciation as it does in relation to other assessments to be made by it: compare, e.g., *Tesco plc v Competition Commission* at [138]-[139]. In the present context, we accept Mr Beard's primary submission that the standard to be applied in judging the steps taken by the CC in carrying forward its investigations to put itself into a position properly to decide the statutory questions is a rationality test: see *R (Khatun) v Newham London Borough Council* [2004] EWCA Civ 55; [2005] QB 37 at [34]-[35] and the following statement by Neill LJ in *R v Royal Borough of Kensington and Chelsea, ex p. Bayani* (1990) 22 HLR 406, 415, quoted with approval in *Khatun*:

> "The court should not intervene merely because it considers that further inquiries would have been desirable or sensible. It should intervene only if no reasonable [relevant public authority – in that case, it was a housing authority] could have been satisfied on the basis of the inquiries made."

(4) Similarly, it is a rationality test which is properly to be applied in judging whether the CC had a sufficient basis in light of the totality of the evidence available to it for

making the assessments and in reaching the decisions it did. There must be evidence available to the CC of some probative value on the basis of which the CC could rationally reach the conclusion it did: see e.g. *Ashbridge Investments Ltd v Minister of Housing and Local Government* [1965] 1 WLR 1320, 1325; *Mahon v Air New Zealand* [1984] AC 808; *Office of Fair Trading v IBA Health Ltd* [2004] EWCA Civ 142; [2004] ICR 1364 at [93]; *Stagecoach v Competition Commission* [2010] CAT 14 at [42]-[45];

(5) In some contexts where Convention rights are in issue and the obligation on a public authority is to act in a manner which does not involve disproportionate interference with such rights, the requirements of investigation and regarding the evidential basis for action by the public authority may be more demanding. Review by the court may not be limited to ascertaining whether the public authority exercised its discretion "reasonably, carefully and in good faith", but will include examination "whether the reasons adduced by the national authorities to justify [the interference] are 'relevant and sufficient'" (see, e.g., *Vogt v Germany* (1996) 21 EHRR 205 at para. 52(iii); also *Smith and Grady v United Kingdom* (1999) 29 EHRR 493, paras. 135-138). However, exactly what standard of evidence is required so that the reasons adduced qualify as "relevant and sufficient" depends on the particular context: compare *R (Daly) v Secretary of State for the Home Department* [2001] UKHL 26; [2001] 2 AC 532 at [26]-[28] per Lord Steyn. Where social and economic judgments regarding "the existence of a problem of public concern warranting measures of deprivation of property and of the remedial action to be taken" are called for, a wide margin of appreciation will apply, and – subject to any significant countervailing factors, which are not a feature of the present case – the standard of review to be applied will be to ask whether the judgment in question is "manifestly without reasonable foundation": *James v United Kingdom* (1986) 8 EHRR 123, para. 46 (see also para. 51). Where, as here, a divestment order is made so as to further the public interest in securing effective competition in a relevant market, a judgment turning on the evaluative assessments by an expert body of the character of the CC whether a relevant AEC exists and regarding the measures required to provide an effective remedy, it is the "manifestly without reasonable foundation" standard which applies. One may compare, in this regard, the similar standard of review of assessments of expert bodies in proportionality analysis under EU law, where a court will only check to see that an act taken by such a body "is not vitiated by a manifest error or a misuse of powers and that it did not clearly exceed the bounds of its discretion": Case C-120/97 *Upjohn Ltd v Licensing Authority* [1999] ECR I-223; [1999] 1 WLR 927, paras. 33-37. Accordingly, in the present context, the standard of review appropriate under Article 1P1 and section 6(1) of the HRA is essentially equivalent to that given by the ordinary domestic standard of rationality. However, we also accept Mr Beard's submission that even if the standards required of the CC by application of Article 1P1 regarding its investigations and the evidential basis for its decisions were more stringent than under the usual test of rationality, the CC would plainly have met those more stringent standards as well;

(6) It is well-established that, despite the specialist composition of the Tribunal, it must act in accordance with the ordinary principles of judicial review: see *IBA Health v Office of Fair Trading* [2004] EWCA Civ. 142 per Carnwarth LJ at [88]–[101]; *British Sky Broadcasting Group plc v Competition Commission* [2008] CAT 25, [56]; *Barclays Bank plc v Competition Commission* [2009] CAT 27, [27]. Accordingly, the Tribunal, like any court exercising judicial review functions, should show particular

restraint in "second guessing" the educated predictions for the future that have been made by an expert and experienced decision-maker such as the CC: compare *R v Director General of Telecommunications, ex p. Cellcom Ltd* [1999] ECC 314; [1999] COD 105, at [26]. (No doubt, the degree of restraint will itself vary with the extent to which competitive harm is normally to be anticipated in a particular context, in line with the proportionality approach set out by the ECJ in Case C-12/03P *Commission v Tetra Laval* [2005] ECR I-987 at para. 39, but that is not something which is materially at issue in this case). This is of particular significance in the present case where the CC had to assess the extent and impact of the AEC constituted by BAA's common ownership of Heathrow, Gatwick and Stansted (and latterly, in its judgment, Heathrow and Stansted) and the benefits likely to accrue to the public from requiring BAA to end that common ownership. The absence of a clearly operating and effective competitive market for airport services around London so long as those situations of common ownership persisted meant that the CC had to base its judgments to a considerable degree on its expertise in economic theory and its practical experience of airport services markets and other markets and derived from other contexts;

(7) In applying both the ordinary domestic rationality test and the relevant proportionality test under Article 1P1, where the CC has taken such a seriously intrusive step as to order a company to divest itself of a major business asset like Stansted airport, the Tribunal will naturally expect the CC to have exercised particular care in its analysis of the problem affecting the public interest and of the remedy it assesses is required. The ordinary rationality test is flexible and falls to be adjusted to a degree to take account of this factor (cf *R v Ministry of Defence, ex p. Smith* [1996] QB 517, 537-538), as does the proportionality test (see *Tesco plc v Competition Commission* at [139]). But the adjustment required is not as far-reaching as suggested by Mr Green at some points in his submissions. It is a factor which is to be taken into account alongside and weighed against other very powerful factors referred to above which underwrite the width of the margin of appreciation or degree of evaluative discretion to be accorded to the CC, and which modifies such width to some limited extent. It is not a factor which wholly transforms the proper approach to review of the CC's decision which the Tribunal should adopt;

(8) Where the CC gives reasons for its decisions, it will be required to do so in accordance with the familiar standards set out by Lord Brown in *South Buckinghamshire District Council v Porter (No. 2)* [2004] UKHL 33; [2004] 1 WLR 1953 (a case concerned with planning decisions) at [36]:

> "The reasons for a decision must be intelligible and they must be adequate. They must enable the reader to understand why the matter was decided as it was and what conclusions were reached on the 'principal important controversial issues', disclosing how any issue of law or fact was resolved. Reasons can be briefly stated, the degree of particularity required depending entirely on the nature of the issues falling for decision. The reasoning must not give rise to a substantial doubt as to whether the decision-maker erred in law, for example by misunderstanding some relevant policy or some other important matter or by failing to reach a rational decision on relevant grounds. But such adverse inference will not readily be drawn. The reasons need refer only to the main issues in the dispute, not to every material consideration. They should enable disappointed developers to

> assess their prospects of obtaining some alternative development permission, or, as the case may be, their unsuccessful opponents to understand how the policy or approach underlying the grant of permission may impact upon future such applications. Decision letters must be read in a straightforward manner, recognising that they are addressed to parties well aware of the issues involved and the arguments advanced. A reasons challenge will only succeed if the party aggrieved can satisfy the court that he has genuinely been substantially prejudiced by the failure to provide an adequately reasoned decision."
>
> In applying these standards, it is not the function of the Tribunal to trawl through the long and detailed reports of the CC with a fine-tooth comb to identify arguable errors. Such reports are to be read in a generous, not a restrictive way: see *R v Monopolies and Mergers Commission, ex p. National House Building Council* [1993] ECC 388; (1994) 6 Admin LR 161 at [23]. Something seriously awry with the expression of the reasoning set out by the CC must be shown before a report would be quashed on the grounds of the inadequacy of the reasons given in it."

III. THE REPORT

11. The CMA reviewed the market power of PMIs with respect to consultants in Section 7 of the Report, at paras. 7.48 et seq. The CMA outlined the issues and the case for finding an AEC based on PMI market power, as put forward by FIPO and other organisations, at paras. 7.48 to 7.56 as follows (omitting footnotes):

> "7.48 This section considers whether insurers have buyer power in relation to consultants which may be used to suppress consultant fees to a level below those which would prevail in a competitive market. If this were the case, this could lead to a shortage of consultants in private practice and/or a reduction in the quality of service provided by consultants to patients and incentives to innovate. Insurers could also distort competition between consultants if caps on the reimbursement of fees were applied to some consultants but not others.
>
> 7.49 The role of the insurers, and in particular their relationship with consultants, has prompted a significant number of submissions from consultants, their trade associations and members of the public. The majority of these have been published on our website and the views of consultants are summarized in Appendix 7.3.
>
> 7.50 In terms of the views expressed by the profession, FIPO submitted that there was clear evidence that fee capping to uneconomical levels affected patient choice. The fact that AXA PPP and Bupa were directing patients to the newly-qualified consultants (who were subject to inflexible retail price maintenance clauses) in preference to the established consultants directly affected patients.
>
> 7.51 FIPO referred to an NAO report which reported that there were, in 2012, 15,754 consultants in private practice, equating to 39 per cent of the total consultant population of 40,394. It submitted that as the NAO indicated in 2006 that the number of

> consultants undertaking private practice was 55 per cent, then the number of consultants undertaking private practice work in 2011/12 had reduced by one-third. Similarly, the Private Patient Forum (PPF) noted reductions in the number of consultants working in the private sector on the basis of the same NAO figures and questioned whether the 'directed care model' of insurers contributed to this apparent reduction in consultants entering private practice.
>
> 7.52 The Independent Doctors Federation (IDF) considered that decreasing reimbursement fees from insurers, particularly from Bupa and AXA PPP, combined with increasing expenses involved with running a private medical practice, were such that newly-appointed consultants were reluctant to enter private medical practice. Similarly, the London Consultants' Association was of the view that newly-appointed consultants could not be kept on grossly reduced fees in the long term, in the face of rising costs.
>
> 7.53 The AAGBI was of the view that the supply of consultants to the private sector was reducing, particularly anaesthetists. It said that whilst in theory insurers, as the purchasers of 80 per cent of private healthcare, would be expected to function as advocates for the consumer, by driving down the cost and improving the quality of care, this only held true in practice if the surplus generated by the insurers' collective buyer power was passed on to the consumer, whilst maintaining or improving choice of hospital and consultants. The evidence of insurers' premiums consistently going up while the cost per case went down suggested that savings were being diverted into the PMIs' profits, according to AAGBI.
>
> 7.54 In this section we focus on the ways in which insurers have sought to constrain consultant fees and whether this has an AEC in the provision of consultant services. Finally, we also describe other concerns raised by consultants and their trade associations in relation to the behaviour of insurers."

12. BUPA has the largest market share of the private healthcare insurance market, at 39.5% (by revenue in 2012). AXA PPP also has a large market share, at 25.5%. Third equal come Aviva and PruHealth, each with 13%, so that the largest four PMIs accounted for some 91% of the market (Report, Figure 3.15, page 3-24). There are a number of other PMIs with lesser market shares. At paras. 7.55 to 7.67 of the Report, the CMA reviewed the evidence regarding the introduction of fee schedules by PMIs. All the PMIs publish fee schedules or guidance setting out the level of consultant fees they reimburse under their policies. BUPA's fee schedule is regarded as the industry standard (para. 7.57; and see para. 7.61). PMIs, in particular BUPA and AXA PPP, have introduced initiatives to seek to control their costs in relation to consultant fees, whilst also seeking to reduce the need for policyholders to pay additional top-up fees to

consultants (para. 7.59). The CMA reviewed the PMI fee schedules at paras. 7.61 to 7.67 of the Report.

13. In the following section of the Report, the CMA reviewed consultant fee capping by the PMIs in paras. 7.68 to 7.81, as follows (reflecting excisions on grounds of commercial confidentiality and omitting footnotes):

> "7.68 As noted in paragraph 7.14, Bupa and AXA PPP have introduced new recognition criteria for new consultants. Bupa and AXA PPP said that these new criteria were aimed at addressing what they termed shortfalls. Where a consultant's fees were in excess of an insurer's reimbursement rate, a consultant generally may charge the patient the difference, assuming the insurer did not meet the difference. This difference between the insurer's reimbursement rate and the consultant's fee was termed a top-up fee if the patient was aware of and agreed to pay the difference in advance of treatment. However, if the consultant for whatever reason had not made the patient aware of this potential difference in advance of treatment, the difference was termed by the insurer as a shortfall.
>
> 7.69 According to the insurers, shortfalls are identified by policyholders as a key concern. Bupa stated that in 2013, for [✂] per cent of surgical procedures and [✂] per cent of anaesthetic procedures, the consultant's fees were higher than Bupa's Benefit Maxima. Aviva stated that in 2013, approximately [✂] per cent of its recognized consultants invoiced for fees exceeding its fee schedule, and that as a result, approximately [✂] per cent of its policyholders might have an additional fee to pay to consultants as a result of Aviva not reimbursing in full the consultant's invoiced fees. PruHealth indicated that between August 2012 and August 2013, [✂] per cent of its consultants charged [✂] its benchmarked rates, while [✂] per cent charged [✂] per cent [✂] those rates. Several insurers explained that they frequently reimbursed consultant fees in full over and above their fee schedules, in particular where the patient was not aware of the likelihood of a differential. Insurers therefore sought ways to guarantee that their policyholders did not experience any shortfalls in relation to consultant fees as well as reducing their claim costs in covering such differentials.
>
> 7.70 Under the AXA PPP scheme introduced in 2008, AXA PPP required all newly-recognized consultants, who were also largely newly qualified, to sign up to an agreement whereby in order to be recognized by AXA PPP they must charge AXA PPP insured patients only fees set within its fee schedule and agree not to charge AXA PPP insured patients any top-up fees. We refer to such consultants as 'fee-capped' consultants. For such consultants, AXA PPP's reimbursement rate therefore is the maximum fee that the consultant can charge for their services. AXA PPP told us that as at 31 December 2013, around [✂] per cent of its 24,000 recognized consultants were subject to this contract, compared with [✂] per cent in July 2012. AXA PPP also told us that between 2011 and 2013, it had signed up on average each year [✂] previously recognized consultants (ie those recognized prior to 2008) to the new contract. It had not seen any change in the number of new consultants applying for recognition since the introduction of the new contract.

7.71 In addition to the [✂] per cent of consultants who are fee-capped in 2013, approximately [✂] per cent of AXA PPP's recognized consultants are fee-assured based on a 'usual and customary approach'. There is no contract in place between AXA PPP and these consultants but they have historically charged within reimbursement levels deemed acceptable by AXA PPP. However, if such a consultant were to routinely charge AXA PPP policyholders significantly higher fees than they previously had, AXA PPP would review its charges and practice. If, after discussion with AXA PPP, this charging practice were to continue, the consultant would then be told that they were no longer on AXA PPP's list of fee-assured consultants, and their fees would be capped and limited to the published schedule. This meant that AXA PPP did not recommend such consultants to policyholders, and when a policyholder sought pre-authorization to see a non-fee-assured consultant, AXA PPP informed the policyholder that they might be liable for additional fees. However, AXA PPP policyholders could use their benefits to see such consultants and were free to pay top-up fees.

7.72 Although newly-recognized consultants from 2008 must adhere to AXA PPP's fee schedule, AXA PPP told us that it monitored the number of fee-capped and fee-assured consultants that it recognized to ensure that its policyholders had adequate choice. AXA PPP also confirmed that it would keep under review the level at which fees were capped as those fee-capped consultants became more experienced in order to keep the proportion of fee-assured and fee-capped consultants at over [✂] per cent of its recognized consultants. This meant that after a number of years, some consultants who were contractually obliged to charge within AXA PPP's fee schedule might be able to increase their fees. [✂]

7.73 As at December 2013, Bupa had approximately 19,000 active recognized consultants and a total of 25,883 recognized consultants. Bupa had a number of different categories of recognized consultants depending on when the consultant became a recognized Bupa consultant and whether the consultant had agreed to charge only within agreed fee levels.

7.74 Prior to 2010, Bupa ran a voluntary scheme under which, if a consultant agreed to charge within Bupa's reimbursement rates for all treatments covered by the Benefit Maxima, Bupa would pay a retrospective annual bonus of [✂] per cent of the consultants' charges (excluding consultation fees). Consultants on the scheme, some [✂] as at June 2010, were advised to policyholders as 'fee assured'. In June 2010, Bupa closed the voluntary scheme to new members and introduced a new mandatory consultant contract, which sets out the terms of recognition between Bupa and consultants who are newly recognized as of June 2010. Like AXA PPP, as a condition of recognition under the terms of Bupa's new contract, consultants are required, among other things, to charge Bupa policyholders in accordance with the fees set by Bupa. They are not permitted to charge Bupa-insured patients any amount over and above the Bupa agreed fees including for consultations, even if this has been discussed with the patient in advance of treatment. Such consultants are referred to by Bupa as 'Contract Consultants'.

7.75 If a consultant was already recognized by Bupa in June 2010, they were not required to sign up to the new contract capping their fees. However, Bupa has encouraged pre-2010-recognized consultants to sign up voluntarily to a new contract. Between 2011 and 2013, it has signed up around [✂] pre-2010-recognized

consultants to its contract and refers to such consultants as 'Premier Partners'. In return for agreeing to have their fees capped, such consultants are given additional benefits by Bupa such as enhanced promotion by Bupa to GPs, Bupa policyholders and the public on the Bupa consultant finder facility on its website. Such Premier Partners also receive a higher scoring and are, all else equal (see paragraph 7.85 below), listed higher in Bupa's consultant search engines.

7.76 As at December 2013, a total of approximately [✂] consultants were therefore fee capped (ie either Contract Consultants or Premier Partners). Bupa also has informal agreements with some consultants that they will bill within its Benefit Maxima (referred to as 'Consultant Partners') and a number of recognized consultants who habitually bill within its Benefit Maxima (referred to by Bupa as 'Guarantee Consultants'). Approximately [✂] consultants fall into these two further categories.

7.77 In addition, since August 2011 Bupa has undertaken a program to negotiate with consultants whose charges are higher than 90 per cent of their 'peers', adjusting for specialty, sub-specialty interests, geography and, in some cases, experience. Bupa approaches all such consultants and seeks to negotiate a lower fee rate which it regards as reasonable. Since August 2011, over [1000] Bupa-recognized consultants have been asked to provide a clinically valid reason for their high fees or to lower their fees when billing to Bupa customers. Twenty-seven consultants have been derecognized as a result of this process since August 2011, the remaining consultants having agreed to lower their fees or are still in discussions with Bupa over whether to do so.

7.78 Bupa said that none of its policies limited policyholders to using only fee-capped consultants and all policyholders, including those on open referral policies, could access non-fee-capped consultants under its policies. However, unlike other insurers, as explained above, Bupa derecognizes consultants whose fees it regards as too high, meaning that policyholders irrespective of their policy type can no longer access such consultants under the terms of their policies. As noted above, this has affected 27 consultants since 2011, less than 0.2 per cent of consultants in private practice. In addition, where there is an opportunity to guide a patient, Bupa guides all policy-holders (irrespective of their policy type) towards consultants who have agreed to charge within their Benefit Maxima, whether fee-capped (Contract Consultants and Premier Partners) or otherwise fee-assured (Consultant Partners and Guarantee Consultants). It does this *(a)* through open referral, *(b)* by prioritizing in its consultant rankings those consultants who are fee-assured so that patients are more likely to select such consultants when seeking authorization from Bupa whether on an open referral policy or not; and *(c)* by advising policyholders at pre-authorization that should they select a consultant who was not fee-assured they risked being charged top-up fees and would recommend other fee-assured consultants.

7.79 Policyholders on open referral policies, approximately [✂] per cent of Bupa policyholders ([✂] per cent of which are corporate members), can only be treated by 'plan-approved' consultants. These are Bupa-recognized consultants whom Bupa has 'deemed do not exhibit any unexplained treatment variations in their practice', based on the consultants' clinical practice and the overall cost of care provided by the consultant. An individual consultant's status as a 'plan-approved' consultant is not fixed but may vary over time depending on the consultant's practice and those of peers. Bupa stated that 'plan-approved' consultants comprised approximately 90 per

> cent of Bupa's recognized consultants and, as noted previously, Bupa recognized over 25,000 consultants compared with approximately 22,000 estimated active consultants in 2011/12 in private practice.
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> 7.80 During 2013, Aviva made a number of changes to its specialist registration terms and conditions, including that new consultants seeking to obtain 'approved status' must agree to charge in accordance with its fee schedule and may not ask Aviva policyholders to pay a top-up fee. However, the registration process allows new consultants to opt out of obtaining approved status. Such consultants remain recognized but Aviva advises its policyholders that a top-up fee may be payable.
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> 7.81 PruHealth is not proposing to introduce similar consultant fee-capping contracts. WPA and Simplyhealth told us that they did not cap the level of fees at which their consultants may charge. While both publish a schedule of customary and reasonable fees reimbursement maxima for their consultants, consultants are permitted to charge patients above published fee levels, on the basis that the patient is aware of and is willing to contribute any shortfall. In WPA's case, the consultant must also make their fees clear to the patient in advance in writing. As far as we are aware, WPA does not have plans to introduce fee-capping contracts for its consultants. [✂]"

14. At paras. 7.82 to 7.92 of the Report, the CMA reviewed the position in relation to open referral terms introduced by BUPA, AXA PPP, Aviva and PruHealth into insurance policies provided in the corporate sector. While each PMI's terms are slightly different, in essence, the insured patient is required to obtain an open referral from their referring clinician to the relevant speciality or sub-specialty, rather than to a particular consultant or hospital. This is an initiative to constrain the costs to be met by PMIs, although the PMIs claim that the quality of clinicians on their panels is maintained at a high level. Patients under open referral policies do not have the option of paying top-up fees to secure any recognised consultant of their choice.

15. Next, the CMA moved to make its assessment of PMI buyer power in the market at paras. 7.93 et seq., making these introductory observations at paras. 7.93 and 7.94:

> "7.93 In light of the above, we focused our investigation on two key issues relating to consultants fees: first insurer reimbursement rates and secondly insurer restrictions on top-up fees including the impact of open referral policies. In doing so, we make two general observations. First, in the context of consultant fees, the consultant is the supplier of a service and the insurer is the payor and can therefore be characterized as the buyer of services. Strong buyers can generally lead to increased competition and lower prices for consumers.

> 7.94 In the absence of the insurers constraining consultants' fees, it is unclear how such fees would be constrained for insured patients—given that the insurer is responsible for funding the treatment rather than the insured patient. Consultants are critical to the insurers' business. The key perceived benefits of privately-funded healthcare are treatment by a consultant of choice and treatment at a time and place convenient to the patient. Moreover, patients' experience of privately-funded healthcare is, in the main, driven by the consultant. Insurers therefore depend for their business on a supply of high quality widely located and available consultants across most specialties for their policyholders."

16. Para. 7.94 is relevant to one of FIPO's Grounds of challenge, in that it sets out a basis for the CMA's assessment later in the Report at para. 7.100, criticised by FIPO, that PMIs have an interest to maintain access to high-quality consultants and hence an incentive not to constrain consultant fees to such an extent that they are driven out of business or to offer a poor quality service. Para. 7.94 included a footnote reference to a patient survey conducted on behalf of the CMA, as follows:

> "76 per cent of respondents to our patient survey stated that the main reason for going private was reduced waiting times, 52 per cent availability of appointment times, 39 per cent ability to chose a specific consultant, 38 per cent better quality of care, 25 per cent better after care, 25 per cent better clinical care, 23 per cent ability to [spend more time with consultant] in the top highest ranking reasons for selecting PMI (CC patient survey, Table B1)"

17. Mr Kennelly, for FIPO, was critical of the survey, having regard to what he said was a low rate of response. However, in our view the CMA could reasonably rely upon the survey, taking account of its response rate, as relevant evidence for the purposes of its market investigation.

18. At paras. 7.95 to 7.100, the CMA reviewed the issues in relation to PMI reimbursement rates as follows (omitting footnotes):

> "7.95 Bupa told us that its Benefit Maxima was key in constraining consultants' charges. Without the insurers, in Bupa's view, consultants would not have any constraints on their fees. It provided analysis comparing consultant reimbursement per member by Bupa between 2007 to 2011 for outpatient consultations which were not subject to the Benefit Maxima and for surgical procedures which were subject to the Benefit Maxima. Bupa's analysis showed that spend per member for consultant consultations grew at a significantly faster rate than for surgical procedure spend per member and general inflation (RPI).

7.96 Bupa did not consider that its Benefit Maxima should be automatically increased each year. In its view, the size of the PMI market was similar to that in the mid-1990s but the number of consultants available for private work had increased over the period. Moreover, in its view, improvements in technology had reduced the complexity of, and the skill and time required for, a number of treatments.

7.97 AXA PPP made similar observations regarding the lack of constraints on consultants' fees. In particular, AXA PPP stated that newly-qualified consultants charged less than the average consultant per procedure and had lower episode costs. Like Bupa, AXA PPP also said that it had no evidence that consultants who charged above its reimbursement levels were of higher quality. AXA PPP also compared its reimbursement rates with those available in the NHS. For example, according to AXA PPP, NHS Trusts paid approximately £120 per hour for additional work by a consultant compared with an hourly rate in excess of £450 in the private sector.

7.98 As set out in Appendix 7.2, our preliminary analysis and the evidence submitted by parties on consultants' fees did not suggest that consultants' fees were either increasing or decreasing significantly. The extremely wide variation in the levels of consultant earnings and costs depending on specialty, locality and size of practice would have made any profitability analysis extremely difficult, resource intensive and likely to be inconclusive. Appendix 7.2 contains further analysis by Stanbridge Associated Limited, which suggests that net average incomes for ten key specialties between 2005 and 2010 have been relatively stable over time. A number of factors have impacted on consultant fee income in recent years independent of the insurers, including a decline in demand both from insured and self-pay patients, decreased NHS waiting times, improved NHS consultant remuneration, greater NHS commitment requirements, and an increase in the number of consultants.

7.99 In addition, on the basis of the information we received, we are not able to ascertain whether the level of PMI reimbursement rates mean that consultants' charges are being constrained by the insurers at a level which is more or less appropriate compared with the charges previously made. It is evident that the insurers' strategies in relation to consultants' fees over the last few years are tending to constrain consultants' fees. This has combined with the insurers' increasing role in determining the choice of consultant for particular treatments/referral journeys through the use of open referral and other specialist referral schemes, increasing the impact of the insurers' steps to lower their reimbursement rates for many procedures.

7.100 However, we have not seen evidence to indicate that the insurers' reimbursement rates are leading to lower quality of services, to lower incentives to innovate or dissuading consultants from entering or remaining in private practice in sufficient numbers to affect consumer choice or cause long-term detriment. Further, it is in the insurers' own commercial interests [the CMA included a footnote reference here to comments made by the PMIs to this effect and to para. 7.94 of the Report] to balance carefully their desire to constrain consultant fees (the benefits of which can be passed on to their policyholders in the form of lower premiums) and their need to ensure that their policyholders have access to high-quality, appropriately located and available consultants—such access is fundamental to their business as insurers. Thus, it would not be in the insurers' own interest to drive consultant charges so low that quality and innovation is negatively affected—and insurers are, therefore, unlikely to do so. We make a few observations in paragraphs 7.124 and 7.125 in relation to

> information provided to policyholders and consultants themselves in particular with regard to these matters."

19. Appendix 7.2 to the Report, referred to in para. 7.98, contained a detailed review of consultant remuneration over a number of years, based on a wide range of different sources. Mr Kennelly was critical of the CMA's reliance on the analysis by Stanbridge Associates, referred to in para. 7.98 and Appendix 7.2, on the basis that it only covered the years 2005 to 2010, whereas there had been significant changes in consultant numbers and the market for consultant services since then.

20. However, two points should be made. First, we see nothing untoward, let alone irrational, in the CMA's decision to attribute some weight to that analysis. The CMA was very well informed about changes in the market and was well placed to assess the significance of that analysis, notwithstanding such changes as may have occurred since 2010. Secondly, the analysis was but one part of the thorough review of consultant remuneration set out in Appendix 7.2 by reference to a range of sources, several of which related to the period up to 2012.

21. In Appendix 7.2, the CMA referred to the fact that the percentage of consultants in the NHS also in private practice had declined in recent years, albeit the number of consultants active in private practice had remained more or less steady (the total number of consultants had grown steadily over the period 2002 to 2012: see Figure 4 in Appendix 7.2). At paras. 21 to 23 of Appendix 7.2, the CMA made this assessment (footnotes omitted):

> "21. The vast majority of consultants who undertake private practice also work within the NHS: very few doctors who work in the private sector do so exclusively. There are a number of reasons why the percentage of consultants in the NHS also in private practice may have declined in recent years. Higher NHS starting salaries, more progressive pay structures and a longer working week introduced in 2006 with the aim of limiting private practice work by NHS consultants might be expected to lessen consultants' incentives to seek private work. Furthermore, the rising costs of professional indemnity insurance may also have been a factor depressing the numbers of consultants undertaking private practice as a proportion of the total number of NHS consultants. A BASS survey, for example, indicated that indemnity charges for spinal surgeons was the most commonly given reason for leaving or deciding not to enter private practice. As described in paragraph 2.8, there has also been a decline in

demand for private work, at least outside London and the South-East, and an increased number of consultants competing for work.

22. Most of the PMIs commented that they had not seen a decrease in the number of new consultants seeking recognition.

23. These factors might signal that the pool of NHS consultants available to the private sector might shrink in the future. However, drivers in the other direction include the fact that basic pay in the NHS has been frozen for the past two years and, as indicated by responses to our survey of consultants, even with a longer working week, 47 per cent of consultants who responded said that they had time available and would like to undertake more private work."

22. This was a lawful and rational assessment, properly founded on evidence available to the CMA. It is relevant to FIPO's Grounds of challenge which seek to suggest that PMI reimbursement rates were set so low as to jeopardise the quality of consultant services which would be available for private patients in the future and to preclude the possibility of competition on price between private consultants. The CMA's assessment was that the fall in the percentage of NHS consultants doing private work was explicable by other factors, and that there remained an appetite among consultants to do more private work.

23. In the next part of the Report, at paras. 7.101 to 7.112, the CMA reviewed the issue of PMI buyer power in relation to top-up fees as follows (with excisions reflecting commercial confidentiality and omitting footnotes):

"7.101 Bupa and AXA PPP argued that their fee-capping of consultants enabled them to offer their policyholders the assurance that consultants' fees would be fully covered, with 'no surprises'. They also argued that price was not necessarily an indicator of quality.

7.102 Consultants and some of their trade associations [including FIPO] argued that:

(a) Bupa and AXA PPP represented a significant proportion of the market for consultants and through requiring consultants only to charge up to their reimbursement rates were determining the maximum fees a consultant may charge.

(b) Consultants could no longer set their fees based on their experience, their specialist knowledge, the local market in which they operated and the quality of the service they provided but purely by reference to the standard rates that AXA PPP and BUPA were willing to reimburse. In addition, consultants' fees varied

depending on the patients' insurer rather than the consultants' own costs or the treatment provided.

(c) The codes were relatively rigid and did not take into account the level of variation within different procedures, co-morbidities and associated factors.

(d) A policyholder might wish to pay a top-up fee in order to secure the services of a consultant with particular expertise, which enhanced patient choice and transparency. This would provide an incentive on consultants to develop expertise and compete on quality and did not affect insurers' claims costs.

(e) Bupa and AXA PPP's restriction on top-up fees led to a reduced choice for patients, and by capping fees, insurers were able to engage in price fixing for all consultants in private practice.

7.103 Nuffield said that it saw no reason why top-up fees should not be permitted by insurers. Consultants should be able to charge fees that reflected their experience and expertise, provided that any anticipated excess was made known to the patient at the first available opportunity.

7.104 There is clear disparity in organizational size between an individual consultant (and indeed most consultant groups) and an insurer. In addition, we find the argument that Bupa recognition and AXA PPP is critical to many consultants persuasive, given Bupa and AXA PPP's share of private patients. Furthermore, a consultant who is not recognized by Bupa and/or AXA PPP or who loses a significant proportion of Bupa referrals because they refuse to agree to be fee-capped could well find it uneconomic to run a private practice. See paragraph 7.75 above in relation to Bupa's ranking of consultants and its promotion of Premier Partner consultants versus other consultants and the criteria it applies for a consultant to be 'plan approved' under open referral policies.

7.105 The two largest insurers have been able to agree standard fees without negotiation with a significant number of consultants (and in relation to all new consultants impose a standard fee in order to be recognized). We note that the BMA's recent survey of consultants found that the number of consultants threatened with de-recognition by insurers has risen from 11 per cent in 2011 to 34 per cent in 2012. We also refer to paragraph 7.77 above and the fact that since August 2011 Bupa has asked approximately 10 per cent of its active non-fee-capped consultants to lower their fees, failing which they will be derecognized, almost all of whom have agreed to lower their fees. We consider, therefore that at the very least Bupa and AXA PPP have buyer power in relation to consultants. Consequently, Bupa and AXA PPP's actions in relation, in particular, to capping some consultant fees and the recognition of consultants has the potential to distort competition between consultants.

7.106 If extensively and rigidly applied, fee-capping consultants could lead to distortions in competition between consultants and to reduced consumer choice. Fee-capping (and derecognition of consultants who do not agree to abide by the insurer's fee schedule) has the potential to increase the disincentives on consultants from setting fees to reflect their costs, experience, expertise and the local market conditions. This distortion may potentially be increased, the greater the number of insured patients on policies that require open referrals from GPs as policyholders are channelled to lower

cost consultants. Moreover, assuming that Bupa continues with its policy of de-recognizing consultants who charge prices which are higher than 90 per cent of their peers (see paragraph 7.77 above) and not recognizing new consultants unless they agree to be fee-capped, this is likely to lead to the majority of consultants being required to charge Bupa's standard national reimbursement fees and the ability of policyholders to pay top-up fees to have a greater choice of consultant significantly limited irrespective of the terms of their policy.

7.107 However, we have not received evidence that Bupa's and AXA PPP's contracts with new consultants are leading to the number of new consultants being recognized reducing annually since their introduction. Over the period from 2011 to 2013, we observed no material reductions in the total number of consultants recognized by Bupa, with the number of actively billing consultants remaining constant at about 19,000 each year, compared with, according to NAO estimates, approximately 15,750 consultants active in private practice work in 2011/12. Bupa confirmed that it continued to recognize around [✂] new consultants annually. The number of consultants recognized by AXA PPP over the period also remained constant, at around 24,000. As discussed in more detail in paragraph 7.116 below, Bupa and AXA PPP have only derecognized 27 and 21 consultants respectively for charging in excess of contracted fee levels since 2011.

7.108 We also do not have evidence that the number of consultants in private practice as a whole is being adversely affected by the actions of the insurers, nor that, as a result of the fee-capping of some consultants, consultant fees are being constrained to such a level that this is adversely impacting on consumer choice or quality, discouraging innovation or otherwise causing long-term consumer detriment. We note that FIPO submitted concerns that based on an NAO report, the number of consultants undertaking private practice work has reduced by a third from 2006 to 2012 (see paragraph 7.51). However, the NAO report indicates that in 2003, the NHS introduced a new contract for its consultants with a view to improving value for money for taxpayers, including by preventing an increase in private practice work undertaken. Although the proportion of NHS consultants undertaking private work had declined from around two-thirds in 2000 to 39 per cent in 2013, the NAO observed that the absolute number of consultants in private practice had not declined significantly—from 16,349 in 2000 to 15,754 in 2012.

7.109 There are clear benefits to policyholders, which should be passed on to consumers, resulting from insurers promoting lower-cost consultants. Moreover, we would anticipate that competition in the insurance market would ensure that the insurers' strategies to contain costs in particular by Bupa and AXA PPP are passed though to policyholders in the form of lower premiums and do not lead to a reduction in innovation or quality. However, FIPO expressed concerns that it should not be presumed that if insurers have buyer power, any gains would be passed on to consumers. Whilst the PMI sector is highly concentrated (see paragraph 3.80), we note that patients insured under corporate trust arrangements benefit directly from reduced consultant costs achieved by the insurers. Similarly, the large corporate sector is highly transparent and competitive, with pricing based on costs incurred by insurers in the previous period which would result in a significant proportion of reduced fees being passed through to such customers. Finally, we note that even a monopolist would pass through a proportion of a reduction in costs achieved.

> 7.110 Moreover, corporate policyholders can relatively easily switch providers if this were to become an issue for their members, in particular as a result of open referral policies and insurance recognition policies. In relation to personal policyholders, we note that at present open referral policies are not generally available. It can be extremely difficult for a personal policyholder to switch insurer and on taking out a policy or at renewal a personal policyholder may not be able readily to understand the implications in terms of consultant choice of an open referral policy or the likely impact of the insurers' consultant fee and recognition policies on choice of consultant at the time of claim. This can be contrasted to the position in relation to hospitals where a policyholder is generally able to identify which hospitals they would most likely want to access and therefore be included in their policies.
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> 7.111 We also recognize that whilst the insurers encourage policyholders to see fee-capped or fee-assured consultants, policyholders—with the exception of those that hold open referral policies—can pay top-up fees under the terms of their policies if they wish to see any recognized consultant. Whilst policies that require open referral are a standard option for Bupa corporate policies (although not all corporate policies have open referral) and Bupa is considering whether to offer such policies to personal customers more widely, policyholders will continue to be able to choose between policies offered by Bupa and other insurers where open referral is not mandatory and under which policyholders are able to pay, and are not prevented from paying, top-up fees if they so choose. In relation to Bupa, the majority of policyholders and almost all personal policyholders are not required to obtain pre-authorization before seeing a consultant and are able to see any recognized consultant under the terms of their policies. It is only policyholders on open referral policies whose choice of consultant is more limited and who are required to obtain pre-authorization before seeing a consultant. However, as noted previously, such policyholders currently have access to over 90 per cent of recognized consultants.
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> 7.112 We therefore do not find that insurer buyer power in relation to consultants has an adverse effect on the provision of consultant services in the UK. However, see our comments below in paragraph 7.135 with regard to the nature of information provided to policyholders and to consultants and the potential this may have to distort competition between consultants and limit patient choice causing long-term detriment."

24. The CMA then proceeded to address certain other issues which had been raised with it. At paras. 7.116 and 7.117, the CMA reviewed evidence regarding the numbers of consultants who had been de-recognised by PMIs as authorised to provide services which would be paid for under their policies, for failing to charge within the PMI fee schedules. As the CMA observed at para. 7.121, the de-recognition levels are low. Mr Kennelly emphasised that this might simply indicate that most consultants were afraid to charge higher rates, for fear of losing PMI funded work. However, the significance of the rate of de-recognition was a matter for the CMA, which was well placed to make

that assessment as a result of the extensive work it had done to inform itself about the market.

25. The CMA said this at paras. 7.121 and 7.122 of the Report:

> "7.121 We have not received persuasive evidence that these issues indicate a competition problem in the provision of consultant services. As described above, derecognition levels are low. All the major insurers recognize the vast majority of consultants in private practice and the vast majority of policyholders have access to all such recognized consultants. Even policyholders on Bupa's open referral policy have access to over 90 per cent of its recognized consultants. Similarly, the evidence we have received regarding treatment authorizations does not suggest that the insurers are restricting access to consultants or treatments so as to give rise to an AEC.
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> 7.122 However, we recognize the level of concerns expressed by consultants and their trade associations and we consider that this raises important issues with regard to effective communication by the insurers of their strategies to consultants given the critical role consultants play in facilitating choice and quality and innovation in the sector. Insurers increasingly determine not only fee levels but also which consultants a patient may see. Depending on how rigidly and extensively they implement standard national fees, direct policyholders and fee-cap consultants, this could lead to a shortage of consultants and/or a reduction in quality and innovation."

26. At para. 7.125, the CMA stated:

> "7.125 To the extent to which initiatives such as open referral achieve the insurers' objectives of lowering costs and these are passed on to policyholders in the form of lower premiums, this will be beneficial to consumers. If they are unsuccessful in reducing premiums, we have no evidence to suggest that in particular the corporate sector, where many of these initiatives have been launched, will not respond accordingly."

27. At paras. 7.127 to 7.135, the CMA set out the summary of its findings, of which those at paras. 7.130 to 7.135 are relevant in these proceedings:

> "7.130 The two largest insurers at least, Bupa and AXA PPP, have significant buyer power, but we have found insufficient evidence that currently it is being exercised in such a way as to harm competition by suppressing fees to uneconomic levels resulting in a shortage of consultants in private practice or to a reduction in innovation or quality of consultant services. Indeed, the incentive is on insurers to promote competition among consultants on price and quality and maintain innovation and quality to protect and indeed improve demand for PMI.
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> 7.131 In relation to fee-capping specifically, we consider that, on balance, the evidence we have received does not demonstrate that, at present, Bupa—or indeed any other insurer—is distorting competition between consultants by imposing fee-capping,

in particular on newly-recognized consultants, as a condition for recognition. Evidence we obtained from the major insurers did not reveal any material changes in the total number of consultants recognized, or new consultants recognized each year since 2011. We also observed that only a small number of Bupa and AXA PPP recognized consultants had been derecognized for failing to charge within contracted rates (whether fee-capped or not). Similarly, evidence regarding de-recognition of consultants more generally from the insurers does not suggest that quality or innovation is being adversely affected at present by these initiatives.

7.132 There are clear benefits to policyholders in insurers promoting lower-cost consultants which should be passed on to their policyholders in the form of lower premiums. We have some concerns that if fee-capping is rigidly and extensively applied, competition between consultants could be distorted as the fee levels adopted by Bupa and AXA PPP, whilst maximum fees are in practice actual fee levels and are uniform fees and therefore do not take into account a consultant's degree of specialism, patient mix, experience or geographic location. There is also the risk that without transparent and fair review mechanisms and flexibility in application, uniform fees could lead to a distortion of competition between consultants and an adverse effect on quality and innovation.

7.133 Whilst all policyholders are able to pay top-up fees under the terms of their policies and all insurers including Bupa and AXA PPP offer policies to both corporate and personal policyholders that do not require open referral, the ability to pay top-up fees and the choice this provides policyholders is dependent upon the insurers' consultant recognition policy. Moreover, the more patients are directed to fee-capped consultants by the insurers irrespective of the terms of a policyholder's policy, this could impact on the viability of private practice for some consultants.

7.134 As noted above, it is not in the insurers' interests to exercise their buyer power in such a way as to harm competition in the provision of consultant services. Whilst we have not received persuasive evidence that the other issues raised by consultants and trade associations in relation to insurers indicate a current competition problem in the provision of consultant services, we consider that insurers, and in particular Bupa, as they increase their role in directing patients to consultants, need to ensure that their policyholders are provided with clear and accurate information about the terms of their policies. Similarly, they need to ensure that their interaction with consultants is fair and transparent to enable consultants to manage effectively their practices and effectively treat patients.

7.135 The availability of information on consultant performance and fees is considered further in Section 9. As set out in Section 9, we consider that with greater availability of information on consultant performance and fees, this will increase competition between consultants and lead to patients being able to make more effective choices. This may address some of the issues that have led to insurers adopting the type of strategies considered in this section and may ensure that these strategies are not rigidly and extensively applied with the consequent risks to, in particular, quality or innovation."

28. At para. 10.9 of the Report, the CMA set out its finding of an AEC in relation to the lack of publicly available performance and fee information on consultants in private practice, noting that this prevents patients from exercising effective choice in selecting consultants and "reduces competition between consultants on the basis of quality and price."

29. Section 11 of the Report set out the measures that the CMA had decided to implement to remedy the AECs which it had found to exist. At paras. 11.626 to 11.630, the CMA explained its reasons for concluding that - contrary to FIPO's representations that unless consultants were left free from interference from PMIs to set their own fees "there could not be effective competition on price among consultants" (para. 11.628) - there could be competition between consultants on price under current market circumstances and its assessment that the Information Remedy would be effective, as follows (footnotes omitted):

> "11.626 The majority of respondents to both the Remedies Notice and the provisional decision on remedies did not question the effectiveness of providing additional information to patients on consultant fees in terms of helping patients to 'shop around' or in preventing the occurrence of unexpected shortfalls and therefore remedying the AEC arising from a lack of information on consultant fees.
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> 11.627 As discussed in paragraph 11.619, we thought that the requirement to publish consultant fees, both for outpatient consultations and for the procedures undertaken by the consultant in private practice, on the IO's website would address AXA PPP's concerns regarding the completeness of the information available to patients and the extent that it could be used to 'shop around'. We recognize that by delaying the publication of information, this reduces the immediate effectiveness of the remedy. However, we considered that this delay was justified by the need to ensure that consultant performance information (being collected by the information organization) was made available at the same time as price information, which should avoid a potential race to the top in which price is seen to be a proxy for quality and consultants therefore push up their fees.
>
> 11.628 We considered FIPO's argument that without the ability of consultants to set their fees without interference from the insurers and for patients to freely choose a consultant, there could not be effective competition on price among consultants. We did not agree with this argument. We did not find that the price caps imposed by the insurers were forcing consultants out of private practice at the aggregate level, which would have reduced the choices available to patients, nor did we see any reason that insurers should not sell restricted policies provided it was made clear to patients what they were purchasing. Patients who preferred to have a free choice of consultants

could choose a different insurer or different policy to give themselves this option. For those patients who had chosen restricted policies, we thought that even in a context where insurers set an upper limit to the fees charged to their policyholders, consultants could still compete below this level on price, making the remedy effective.

11.629 We recognize that many patients, particularly those with medical insurance, may choose not to 'shop around' even if given the information with which to do so. However, we consider that for this remedy to be effective, it is only necessary for a relatively small but significant proportion of private patients to do so as switching on the part of these patients would provide consultants with an incentive to compete on fees. The survey undertaken by GfK for the CC indicated that 29 per cent of patients cited whether or not their PMI would cover a consultant's fees to be an important reason for choosing a particular consultant. In addition, 10 per cent of patients surveyed indicated that they would be prepared to travel further for a lower-cost consultant or a lower-cost hospital. Finally, insured patients subject to a policy excess may need to pay some or all of the consultant's fee for a first appointment themselves, thus increasing the incentive to shop-around. This suggests that a small but significant proportion of patients are price sensitive, at least to the extent that they may be required to make co-payments and hence are likely to use this information to shop around. Furthermore, insured patients, if provided with the consultant fee information suggested, would be better placed to determine the extent of their policy coverage as early as possible in the process and make choices in terms of whether to claim on their policy and/or pay any additional fees not reimbursed by their insurer.

11.630 We concluded, therefore, that this remedy was likely to be effective in ensuring that patients had sufficient information on the prices charged by consultants. In conjunction with our remedy on providing consultant quality information, we reasoned that this remedy would be effective in allowing patients to make meaningful choices between consultants based on value (ie both quality and price) of the healthcare services provided by consultants."

IV. THE CHALLENGE TO THE PMI DECISION

A. Ground 1 – Top Up Fees and Consumer Choice

30. We have re-numbered FIPO's Grounds of challenge to reflect the order in which they were presented by Mr Kennelly. Ground 1 was helpfully summarised by Mr Kennelly in the Notice of Application as follows:

> "the PMI Decision was reached on the basis of a finding that consumer choice was not restricted by the practice of PMIs to direct policyholders to consultants whose fees were within the caps set by the PMIs because consumers could select consultants whose fees were above the caps and pay the top-up fees. That finding was factually erroneous and/or irrational in that it was reached in spite of the CMA's finding that the threat of derecognition by PMIs meant that the vast majority of consultants charged within the caps and did not offer services requiring top-up fees to be paid."

31. As Mr Kennelly explained in his submissions, the crux of this Ground is a challenge to the finding in para. 7.111 of the Report (set out above) that "policyholders – with the exception of those that hold open referral policies – can pay top-up fees under the terms of their policies if they wish to see any recognised consultant". Mr Kennelly says that other parts of the Report dealing with the issue of top-up fees show that, even though in theory patients might be free from legal restraints so as to be able to agree to pay top-up fees, in practical terms most consultants will not offer that option, by reason of contractual or policy restrictions imposed on them by the PMIs. Therefore, Mr Kennelly submits, the CMA's finding in para. 7.111 was irrational, because as a matter of practical reality in many cases policyholders cannot pay top-up fees to see a consultant of their choice.

32. We would dismiss this challenge. In our view, it rests on a mis-reading of the Report. In fact, the CMA had very well in mind that the practical availability for policyholders (who did not hold open referral policies) of payment of top-up fees could be substantially constrained by reason of the restrictions on the freedom of action of consultants, since it had made precisely that point a few paragraphs before para. 7.111, in paras. 7.104 to 7.106 (set out above). The CMA expressly referred to this practical constraint again at para. 7.133 of the Report.

33. On no fair reading of the Report could it be said that the CMA had forgotten or overlooked this matter in making its findings at para. 7.111. Rather, at para. 7.111, the CMA was making an accurate, albeit supplementary point, about the *legal* freedom of choice for policyholders, which also had a degree of practical force since not all PMIs forbade consultants from charging top-up fees (see e.g. paras. 7.80, 7.81 and 7.103, set out above) and, as counsel for the CMA showed us by reference to confidential sections of the Report, by no means all BUPA and AXA PPP recognised consultants were subject to a restriction on charging top-up fees. In our view, the CMA's findings and assessment in para. 7.111 cannot be said to be irrational.

34. In the context of his submissions under this Ground, Mr Kennelly also argued that the CMA had said that an AEC would arise if BUPA's and AXA PPP's actions in fee-capping consultants were "extensively and rigidly applied" (see paras. 7.106 and 7.122), and that in the light of its findings about how fee-capping was applied it ought rationally to have held that the fee-capping measures *were* extensively and rigidly applied. Consequently, so Mr Kennelly said, the CMA acted irrationally in failing to find that there was an AEC.

35. We do not accept this contention. Again, it involves a mis-reading of the Report. It is clear that the CMA considered that the findings it made in the Report did *not* show that the fee-capping arrangements were "extensively and rigidly applied", according to the standard that it had in mind. The point of the CMA referring to such a standard was in order to say that the practices of the PMIs did not satisfy that standard under current market circumstances: see, in particular, paras. 7.68 to 7.81, 7.106 to 7.112 and 7.121 to 7.122, set out above. Therefore, on a fair reading of the Report, the CMA found that the fee-capping arrangements were not extensively and rigidly applied to a degree that would warrant the conclusion that there was an AEC. This finding was based on an extensive consideration of the available evidence about the operation of the market and cannot be said to be irrational.

36. We respectfully disagree with the views of Mr Glynn on this Ground in his dissenting judgment. We do not think his judgment on this Ground reflects the arguments of FIPO on the present application, which were focused on the terms of the Report, and the CMA had no fair opportunity to meet the points he makes. We also respectfully consider that Mr Glynn's judgment involves a departure from the rationality approach which is appropriate for the Tribunal to adopt on a challenge under section 179 of the 2002 Act: it seems to us to be a merits-based review approach, contrary to the guidance summarised in *BAA* at para. [20(6)]; see also *AXA PPP Healthcare Ltd v CMA* [2015] CAT 5 at [42].

B. Ground 2 – Competition Below Fee Caps

37. Mr Kennelly summarised Ground 2 thus:

> "the PMI Decision was reached based on the finding that, notwithstanding the fee caps widely imposed on consultants by PMIs, consultants could compete below the fee caps. That finding was irrational insofar as it was based on no probative evidence whatsoever and/or amounted to a fundamental error of fact. Further, the PMI Decision was procedurally unfair in that that finding had at no point been put to FIPO (or any other representative medical organisation). Had it been put to FIPO, FIPO would have been able to present substantial evidence that such a finding was unrealistic."

38. Under this Ground, therefore, there is both a rationality challenge and a procedural challenge. We deal with them in turn.

39. For the rationality challenge, Mr Kennelly focused on the CMA's finding at para. 11.628 of the Report, set out above, that even where the PMIs applied fee capping there could still be effective competition on price among consultants. This was also the main foundation for FIPO's challenge to the Information Remedy, since if in truth the fee caps were so low that no consultant could realistically charge lower fees and remain in business, then there could be no effective competition between consultants on price and the remedy should be regarded as ineffective and hence unlawful.

40. We do not accept the rationality challenge to the CMA's finding in para. 11.628. The CMA had made a detailed study of the relevant market and was well placed to assess what scope there could be for competition between consultants on price and quality. Price capping was not an inflexible rule (see the discussion under Ground 1, above), and to the extent that it was not rigidly applied consultants could clearly compete on price and quality. Even where price capping was applied, the CMA had carried out a careful investigation of consultant remuneration and had a proper evidential foundation for its view that consultants had not been 'screwed down' on price by the PMIs to such an extent that they would be unable to compete on price against each other. The CMA made a number of rational and legally defensible findings in the Report which supported that view. See, in particular, paras. 7.100, 7.108 and 7.121 of the Report (set out above) and Annex 7.2, in particular at paras. 21-23 (set out above): capped prices

remained at a level which had not detrimentally affected the quality of services, the ability to innovate, or the availability and flow of consultants willing to provide private healthcare services. This was not a picture of consultants operating at 'rock bottom', in financial terms, and unable to compete on quality and price. The evidence reviewed by the CMA in Appendix 7.2 provided further reasonable grounds for thinking that consultant remuneration and profitability appeared to be reasonably stable over the period when fee-capping practices had been extended by the PMIs, which again supported the conclusion that a degree of competition on price was possible.

41. Mr Kennelly placed great weight in his submissions on the judgment of the Tribunal in *Skyscanner Ltd v Competition and Markets Authority* [2014] CAT 16, in order to suggest that the CMA was obliged to carry out a fuller review of consultant profitability before making its finding in para. 11.628 that there was scope for consultants subject to the fee-capping regime to compete with each other on price below the cap.

42. We do not agree. The CMA had a good deal of evidence available to it on the basis of which it was entitled to conclude that there was a real prospect of consultants being able to compete on price even below the cap: see above. As the CMA explained at para. 7.98 of the Report, "The extremely wide variation in the levels of consultant earnings and costs depending on specialty, locality and size of practice would have made any profitability analysis extremely difficult, resource intensive and likely to be inconclusive." We were not shown anything in the background circumstances which called in question that assessment. On the basis of the investigation the CMA had carried out, it could lawfully decide that it was not necessary or appropriate to try to undertake some such further inquiry before reaching the conclusions it did: cf *BAA* at [20(3)]. The CMA has a discretion to decide how far it needs to take its investigations before it makes relevant findings, the importance and width of which is underwritten by the fact that, where it is required to conduct a market investigation where a reference is made to it, it has to produce its final report within a set time: see section 137 of the 2002 Act (for the market investigation in issue in these proceedings, the time

limit was two years from the date of the reference on 4 April 2012): see also *AXA PPP Healthcare Ltd v Competition and Markets Authority* [2015] CAT 5, paras. [9]-[10].

43. *Skyscanner* was a very different case, in which the OFT (which by the time of the proceedings had become the CMA) refused to consider at all (see [86]-[87]) a plausible, indeed (on the face of it) compelling, argument from a party opposed to the OFT's proposal to accept certain commitments pursuant to section 31A(2) of the Competition Act 1998 with a view to addressing its competition concerns in the relevant market, who maintained that the commitments would not be sufficient to achieve that result. The argument that the commitments might generate their own economic effects in the market, including potentially anti-competitive effects, was clearly a strong one (the complainant had raised "an important and obvious point of principle": [90]); the complainant was not able to provide detailed information itself, beyond pointing to the problem ([91]); and "To the extent that the OFT could reasonably have felt the need for additional material, this could relatively easily be obtained and verified by the OFT itself" ([93]), so further investigation would not have involved any significant additional burden for the OFT (a point emphasised by the Tribunal's observation at [92] that it would not wish to add to the CMA's burdens in cases of this kind).

44. By contrast, in the present case the CMA had carried out an extensive investigation of the market, including in relation to FIPO's contentions during the market investigation regarding the supposed impossibility for consultants to compete on price; it had acquired and carefully considered evidence directed to that issue; to carry out an extensive further profitability analysis such as that which FIPO now contends it should have conducted would have been difficult, time-consuming, burdensome and probably inconclusive (para. 7.98); and FIPO was itself representing the very people who maintained that they could not be profitable if competing on price below the cap, so the CMA could reasonably expect them to have put forward as compelling a case as could readily be put together on that issue (and the CMA clearly did consider the arguments and evidence put forward by FIPO with care). In our view, there is nothing in the

Skyscanner decision which takes the present case outside the general guidance given in *BAA* at [20(3) and (4)] or which indicates that the CMA acted unlawfully or irrationally in the circumstances of the private healthcare market investigation in deciding to draw conclusions without seeking yet further evidence on the questions it had to address.

45. Mr Glynn has given a dissenting judgment on the rationality aspect of FIPO's challenge under Ground 2. He agrees with us that the work done by the CMA rationally supports the view that consultants could make a living while charging below the fee caps: see para. 84 below (he refers only to the profitability analysis; we refer to other aspects of its work as well, which supported its assessment on this). However, he says that the price caps act as minima as well as maxima, and in that way reduce or eliminate competition. He refers to para. 7.132 of the Report and says that, in finding that there was no AEC because consultants could compete below the fee caps, the CMA "did not have regard to the economic realities, and was therefore irrational" (para. 87 below).

46. We respectfully disagree. Again, we do not consider that the point made by him reflects the way in which Mr Kennelly presented FIPO's case. As we understood it, Mr Kennelly's argument for FIPO was that the only finding rationally available to the CMA was that consultants simply could not compete below the price caps. This is an argument which Mr Glynn rejects, as we do. The CMA did not have a fair opportunity to address the distinct point made by Mr Glynn.

47. In fact, it seems to us that if consultants are able to compete on price below the cap, but choose not to do so, it is well arguable that the AEC relates to the characteristics of the market which tend to foster lack of price competition. The CMA found that the lack of independent publicly available information on performance and fees gives rise to an AEC in the provision of consultant services due to patients being prevented from exercising effective choice. They concluded that this AEC is most appropriately addressed by a remedy to require transparency in relation to fees and performance as

between consultants. This AEC finding was not challenged directly in FIPO's application for review.

48. On our reading of paras. 7.132 and 7.135 of the Report, set out above, the CMA recognises that fee-capping could lead to distortion of competition between consultants if rigidly and extensively applied, so that the fee caps operate as uniform actual fee levels with the result that charging does not take into account factors such as specialism, experience and location. The CMA also notes that without transparent and fair review mechanisms and flexibility in application, uniform fees could lead to a distortion of competition between consultants and an adverse effect on quality and innovation. But the CMA considered that the Information Remedy would lead to patients being able to make more effective choices and would address that potential distortion. In our opinion, if FIPO had tried to present its case in a way that followed the analysis proposed by Mr Glynn, that would have been an answer rationally and lawfully available to the CMA.

49. In addition, we again respectfully think that Mr Glynn's analysis goes into the merits of the case beyond what is appropriate for the Tribunal on a challenge under section 179 of the 2002 Act: see para. 36 above.

50. As regards the procedural challenge under this Ground, we consider that this falls to be rejected. In our view, the complaint has an air of unreality about it and is unmeritorious. We respectfully disagree with Mr Glynn's assessment at para. 88 below.

51. The CMA's Statement of Issues promulgated at the outset of its market investigation for the purposes of consultation included, as Theory of Harm 4, the possibility that PMIs enjoyed buyer power in relation to consultants through measures to cap consultant fees, which might result "in consultant fees being too low," and that this might lead to a reduction in the quality of service provided by consultants to patients and affect the incentives to innovate and might in addition result in distortions of competition between consultants. All parties were therefore aware that the question of

anti-competitive effects arising from control of reimbursement rates and fee-capping by PMIs were under investigation, and it was obvious that if FIPO wished to present a case that reimbursement rates were so low as to preclude any competition between consultants below those rates it should do so. Similarly, Theory of Harm 6 identified by the CMA related to limited information availability, including in relation to the price and quality of treatments offered by consultants, which could distort competition by limiting a patient's ability to make informed choices about treatment options. So, again, it was obvious that if consultants wished to contend that there was no point in their being required to make such information available because there would be no question of competition on price below PMI price-capped reimbursement rates, they should do so.

52. In response, at every stage of the market investigation, FIPO vigorously pressed its case that the PMIs had substantial market power to impose fee caps and that consultants were subject to very low returns, which restricted competition, innovation and technical development: see e.g. paras. A.2 to A.7 in the Executive Summary of FIPO's Reply to Statement of Issues, July 2012 (detail was given in the body of the document, in particular in paras. B.47 to B.67, discussing Theory of Harm 4, and paras. B.84 to B.96, discussing Theory of Harm 6) and the Executive Summary of FIPO's reply to Annotated Market Investigation, April 2013 (and, in particular, paras. 2.1 to 2.6 on top-up fees, 4.1 to 4.4 on detrimental consumer effects and 5.15 to 5.34 on consultants' incomes and costs).

53. Having regard to these representations, among others, the CMA produced a Provisional Findings Report and a Provisional Decision on Remedies, to allow a yet further opportunity for comments and presentation of evidence. It is noticeable that para. 7.68 of the Provisional Findings Report is closely similar to para. 7.102 of the Report, set out above, in which the CMA noted the case presented by FIPO and others that consultants could not set fees by reference to experience, local market conditions and quality of service, "but purely by reference to the standard rates that AXA PPP and BUPA were willing to reimburse" – i.e. that consultants could not compete on price,

but had to charge the approved reimbursement rates. It was not suggested that the CMA had misunderstood or mischaracterised the representations received in that regard. The nature of the representations made by FIPO and consultants shows that they appreciated very well that this was an issue which was live and should be addressed in the course of the consultation in the market investigation.

54. Further, in the Provisional Findings Report and the Provisional Decision on Remedies, the relevant parts corresponding to the review of PMI buyer power in section 7 of the Report (including Appendix 7.2) and to a proposed information remedy were very similar to the final version of the Report, and it was obvious that the CMA's provisional view was that consultants could compete on price notwithstanding the PMI standard reimbursement rates and that the Information Remedy would be relevant and effective in the circumstances (see, e.g., para. 10.6 of the Provisional Findings Report: "… lack of sufficient publicly available performance and fee information on consultants … reduces competition between consultants on the basis of quality and price"). Again, therefore, FIPO was presented with a yet further informed opportunity to make representations and present evidence on that issue.

55. Once more, FIPO took up that opportunity, in its Reply to the Provisional Findings Report and Notice on Remedies, September 2013: see, e.g., the Executive Summary ("… it is implicit in Remedy 6 [information about consultants' fees] that consultants must be able to set their fees; fixed fees, set by an insurer, would prevent Remedy 6 from working": para. 1.4; also para. 1.5), Section 4 (discussing Remedy 6) and paras. A1.28 to A1.63 (discussing issues of profitability of consultants' practices, consumer detriment and so forth).

56. The Report, as eventually issued in final form, took account of these and previous representations by FIPO. It did not introduce any new ideas which had not been notified to participants in the market investigation previously, to allow them to comment on them.

57. In our judgment, it is clear from this background that the CMA satisfied the obligation upon it to consult fairly, pursuant to section 169 of the 2002 Act and the general requirements of fairness in public law.

C. Grounds 3 and 4 – Consultant Numbers

58. Mr Kennelly addressed these Grounds together. In the Notice of Application, he summarised them in this way:

> "the PMI Decision was reached on the basis of the factually erroneous finding that the buyer power of the PMIs had not resulted in a reduction in the overall number of consultants. In fact, the number of consultants in private practice has reduced and there was cogent and accurate evidence before the CMA to support this. The PMI Decision was therefore unreasonable and/or irrational in that it was premised on an error of fact"; and
>
> "the PMI Decision was reached on the basis of this (mistaken) finding that the number of consultants had not fallen alone. The CMA failed to take into account the relevant consideration and/or irrationally failed to conduct any investigation into the issue of whether or not the number of consultants was likely to fall significantly in future."

59. In the unanimous judgment of all members of the Tribunal, these Grounds fall to be rejected. The CMA conducted a careful analysis of what had been happening in relation to consultant numbers generally and in private practice in particular, the detail of which was set out in Appendix 7.2 to the Report. On the evidence available to the CMA, it was well entitled to make the assessment that, although the proportion of NHS consultants available for private work had fallen, in fact the number of consultants available for private practice had remained broadly constant (in part because the numbers of NHS consultants had been rising). That finding was supported by evidence from the National Audit Office: see para. 7.108 of the Report, set out above.

60. The CMA also addressed what was likely to happen in future, in particular in paras. 21 to 23 of Appendix 7.2. Its assessment was rational and lawful. It was not obliged to extend further its investigation into these matters: see para. 7.98 of the Report and the discussion under Ground 2 above.

D. Ground 5 - Fee Caps and Lower Premiums

61. Mr Kennelly summarised Ground 5 as follows:

> "the PMI Decision was reached on the basis of the finding that the fee constraints imposed by PMIs would result in a benefit to customers insofar as premiums would be reduced for policyholders. That finding was irrational and/or unreasonable in that it was not only based on no probative evidence whatsoever but also reached in spite of contrary evidence submitted by parties to the CMA's investigation that premium levels had increased while consultants' fees had been driven down."

62. Mr Kennelly explained that the challenge focused on paras. 7.109 and 7.110 of the Report, set out above. However, in the unanimous view of all members of the Tribunal, the reasoning in those paragraphs, albeit thin, is clearly rational.

63. In particular, the CMA identified that "the large corporate sector is highly transparent and competitive" (para. 7.109) and that corporate policyholders "can relatively easily switch providers" (para. 7.110); see also para. 7.125, set out above. Mr Kennelly did not suggest that this is inaccurate, as a characterisation of that part of the market. Under those conditions it would have been very difficult for the CMA to reach any other conclusion than the one it did, at least in relation to that sector of the market. The corporate sector of the healthcare insurance market is the largest part of that market: approximately 5.3 million people are covered under an employer's scheme compared with about 1.5 million who subscribed individually (para. 3.75 of the Report).

64. Further, for the other parts of the market, the CMA was entitled to draw on its knowledge of economic theory and general experience of the operation of markets to make an evaluative assessment of whether consumers would be likely to benefit in the manner identified by it.

65. The CMA had identified a rise in premium levels (see, e.g., para. 3.78 of the Report), while reimbursement rates for consultants had fallen, remained stable or not risen as quickly. However, contrary to the suggestion by FIPO, this did not show that benefits from limiting consultants' fees as the PMIs sought to do would fail to reach policyholders. Figure 2.4 in the Report showed that private hospital charges had risen

strongly in the period 2004-2013, and it was rationally open to the CMA to conclude that this accounted for a significant part of the rise in premium levels. This picture of underlying market costs and the rise in premium rates is consistent with, and does not disprove, the reasoning of the CMA in paras. 7.109, 7.110 and 7.125 of the Report.

E. Ground 6 – Insurers' Interest in Maintaining Consultants in Private Practice

66. Mr Kennelly's summary of Ground 6 is as follows:

> "the PMI Decision was reached on the basis of the assumption that it was in the interests of the PMIs to ensure that there were high-quality consultants in private practice (since that would ensure that private healthcare insurance remained attractive to customers). That assumption was based on no probative evidence whatsoever and further made notwithstanding evidence to the contrary submitted by the PMIs themselves."

67. We reject this Ground of challenge as well. In our view, the CMA was entitled to make the assessment it did, at para. 7.100 of the Report, set out above, that "it is in the [PMIs'] own commercial interests to balance carefully their desire to constrain consultant fees … and their need to ensure that their policyholders have access to high-quality, appropriately located and available consultants – such access is fundamental to their business as insurers"; see also para. 7.130 of the Report. This evaluation was supported by the CMA's reasoning at, in particular, para. 7.94 of the Report, set out above. The reasoning is straightforward and we do not think it could begin to be said to be irrational: if the PMIs are to have a viable product to sell, they need to offer consumers something more attractive than what would be available under the NHS.

68. In making the assessment that it did, against its general understanding of the background of the private healthcare market, the CMA was entitled (as noted under Ground 5 above) to rely on its knowledge of economic theory and its general experience regarding the operation of markets. In addition, in relation to its assessment here, the CMA had more specific evidence to which it was entitled to give weight. This included representations by PMIs regarding the importance of maintaining a vibrant source of good quality consultant services (i.e. that it was in their interests not to kill 'the goose that laid the golden eggs', as it were) and evidence regarding consumer

priorities, as drawn from the patient survey referred to in footnote 667 to para. 7.94 of the Report, set out above. The CMA's assessment was also supported by its findings (in particular, at para. 7.108 of the Report) that it could not discern, on the evidence before it, an adverse impact on consumer choice or quality as a result of the actions of the PMIs, even though the PMIs had been taking relevant initiatives to constrain consultants' fees for some years.

69. We respectfully disagree with Mr Glynn's dissenting judgment on this Ground of challenge. As he acknowledges, the CMA was well aware of the competing considerations which could be expected to be taken into account by PMIs in deciding how to set fee rates. In our view, the assessment to be made as to how those competing considerations could be expected to work through to decisions in practice was pre-eminently one for the CMA, and the CMA's assessment could not be said to be irrational. Again, we respectfully think that Mr Glynn, in his judgment, has gone beyond the proper function of the Tribunal on a challenge under section 179 of the 2002 Act: see para. 36 above.

F. Ground 7 – the Information Remedy

70. Ground 7 relates to the Information Remedy, rather than the PMI Decision. Mr Kennelly summarised it in this way:

> "in granting the [Information Remedy], the CMA acted in contravention of its duty under s. 138 of the 2002 Act to remedy adverse effects on competition. That is because the [Information Remedy] is no remedy at all to insufficient competition between consultants. The further provision of information on fees (and performance) by consultants will do nothing to improve competition because the substantial buyer power of the PMIs constrains consultant fees and consumer choice to the extent that competition between consultants is constricted. For the same reason, the [Information Remedy], insofar as it is ineffective to achieve its aim, is disproportionate according to the first limb of the test laid out in Tesco Plc v Competition Commission [2009] CAT 6 at para. [137]."

71. In opening FIPO's application, Mr Kennelly accepted that if FIPO failed in its challenge to the PMI Decision (as in our judgment it has done: see above), then it could not succeed in its challenge to the Information Remedy under Ground 7. We agree. In

substance, this Ground overlaps most especially with Ground 2, discussed and rejected above. Accordingly, this Ground of challenge is dismissed as well.

V. CONCLUSION

72. For the reasons set out above, in the judgment of the majority of the Tribunal all FIPO's Grounds of challenge to the PMI Decision and to the Information Remedy should be dismissed.

DERMOT GLYNN: REASONS FOR DISSENT FROM MAJORITY OPINION[1]

73. For the reasons set out below, I respectfully disagree with the judgment of the majority to dismiss FIPO's challenge to the CMA's PMI Decision and Information Remedy. I make these points with great diffidence, as the non-lawyer member of the Tribunal hearing an application for review (for judicial review, not review on the merits), and do so only because the issues are very important for the development of healthcare in the UK. The CMA reports that there is significant spare capacity in the private healthcare sector. If the sector operates fairly and efficiently, this may therefore help to alleviate pressures on the NHS, to the benefit not only of patients currently using the private sector but of all concerned. Although serving wider public policy objectives is not an explicit goal of the market investigation regime, awareness of the broader background should surely affect the depth of analysis to be expected from the CMA.

74. FIPO's Application for Review has underlined the importance of the role of PMIs in the private healthcare market. Indeed, approximately 75 percent of privately funded patients have a PMI policy[2], making PMIs the most important source of revenue for the private sector. Moreover, the four largest PMIs have over 85 percent of the PMI market by revenue, and the largest two, Bupa and AXA PPP, have 65 per cent (see figure

[1] The abbreviations and terminology used by the Tribunal in the majority judgment are adopted in this judgment.

[2] First Witness Statement of Geoffrey Glazer, para. 14

3.15). The CMA confirmed that the two largest PMIs have buyer power in relation to consultants (see e.g. para. 7.105), so that there is at least the possibility of an AEC.

75. The CMA's decision not to find an AEC in the purchasing power of the PMIs is therefore a major matter, not only for consultants but also for policyholders who use consultant services, and for the system as a whole.

76. The CMA did not explain what it would regard as the competitive operation of private healthcare, so that the counterfactual against which it thought that possible adverse effects have to be assessed has to be inferred from the discussion in the Report. I take it as axiomatic (and consistent with the CMA guidelines) that in applying competition law through a market investigation such as this the CMA should always analyse issues primarily with regard to underlying economic substance rather than legal form. I also assume that where a market does not operate in the best interests of consumers or denies them reasonable choices or tends to reduce innovation by suppliers then the CMA should either identify the features of the market which "prevent, restrict or distort" competition, and so identify an AEC, or explain why this cannot be done. In the present case, the consumers are patients, not intermediaries such as PMIs or employers.[3]

77. I am also advised that although the principles of judicial review rightly allow a very wide margin of discretion to the CMA, it is not impossible for an application for review on grounds of lack of Wednesbury rationality to succeed.[4]

A. Ground 1 – Top Up Fees and Consumer Choice

78. It is clear from the Report that in 2013 (the latest year for which the CMA had data) the majority of consultants respected the PMIs' fee schedules or caps and therefore did not

[3] It may also be valid to see employers as consumers of private health products, which they use as part of the remuneration packages offered.

[4] A decision will be Wednesbury irrational (or unreasonable) if no reasonable decision maker acting reasonably could have reached that decision (Associated Provincial Picture Houses Ltd v Wednesbury Corporation (1948) 1 KB 223). This standard is referred to in the authorities cited in the majority opinion as the rationality test (see para. 10 above).

offer services requiring top-up fees to be paid, and that this proportion was likely to increase.[5] This reduces consumer choice in at least two ways. It means that a majority of PMI patients are: (a) unlikely to have a choice between a consultant recommended by the PMI and another offering better service but requiring a top-up fee, and (b) unlikely to have a choice between different levels of service offered by the same consultant. There is therefore a significant reduction in choice currently affecting the majority of PMI patients. The CMA failed to consider either of these aspects of consumer choice.

79. If this were a market for homogenous products then a minority of suppliers being able to charge outside set fee caps could provide reasonable choice to consumers; but not here. Patients need particular specialists.

80. If the proportion of consultants operating within the PMI schedules increases, as the CMA expects, or if the fee limits discourage some consultants from trying to improve their services, as they very well may, then there would be further adverse effects in the future. The 2002 Act requires the CMA to take account of adverse effects on innovation when considering whether action should be taken to remedy, mitigate or prevent any detrimental effect on consumers resulting from the AEC (see section 134(4) – (5)).

81. In considering the present situation, CMA's Report says at para. 7.108 that it did not have evidence that "as a result of the fee-capping of some consultants, consultant fees are being constrained to such a level that this is adversely impacting on consumer choice or quality, discouraging investment or otherwise causing long-term consumer detriment." However, it is not clear from the Report that the CMA sought evidence in relation to these potential outcomes. Rather, the CMA appears to have based its

[5] In 2013, [✂] BUPA consultants out of 19,000 were contractually required not to charge above the fee caps and a proportion of those had voluntarily entered into Premier Partner contract. A further [✂] either had informal agreements or habitually billed below maxima [✂]. This means that the great majority of policyholders do not in practice have the choice of a consultant whose fees will be entirely covered by their PMI and another who they think would be better but who charges more. The proportions were less for other PMIs but still substantial and set to rise further (see paras. 7.68 to 7.81).

conclusion chiefly on its finding no evidence of a reduction in the number of consultants since the introduction of BUPA and AXA PPP's more restrictive consultant terms. This was a mistake, because a significant reduction in the choice offered to individual consumers clearly indicates an AEC, irrespective of whether it comes about from a reduction in the numbers of consultants or in a reduction in the options offered by consultants operating in the market. The CMA knew that the PMIs' policies are substantially reducing the option of paying top-up fees for preferred consultants.[6] Its view about aggregate numbers of consultants is not relevant to this point.

82. Clearly, there are potential advantages from the present arrangements for policyholders in general, whose premiums may be held down as a result. Present arrangements might be justified if they were the only way of containing PMI costs. However, I can see no competition law or other justification for effectively preventing top up fees being sought by many individual consultants whose expertise or popularity would allow this, and whose patients would be willing to pay. The policies of the PMIs, which have substantial market power, prevent agreements that would otherwise be reached between patients and consultants.

83. It was therefore in my opinion irrational for the CMA to find that the prevalence of fee-capping practices and top-up fee restrictions did not unnecessarily restrict patients' choice and so constitute an AEC.

B. Ground 2 – Competition Below Fee Caps

84. The main evidence the CMA used in addressing this question was the profitability analysis. I have no criticisms to make of that work, and agree that it is relevant to the question whether consultants "could" compete below the fee caps. This analysis did not indicate such low levels of income that it is inconceivable that some consultants could make a living while charging below the fee caps. It is also correct that there is no legal barrier to charging below the caps (although in applying competition law, the CMA

[6] In principle, there might indeed be an AEC affecting only a small number of consumers. In the present case, however, the AEC affects the clear majority of private patients, who are not given a choice between services covered by the PMI fee schedules and services that would also involve a top-up fee.

should analyse issues with regard to underlying economic substance rather than legal form).

85. However, the profitability analysis addressed only one among a number of possible reasons why consultants might in practice not try to compete by undercutting the fee caps. These are not discussed in the Report, but might obviously include a fear that undercutting might indicate poor professional reputation (why else would patients suppose that particular consultants would offer to charge below the approved schedules?), or it might lead to sanctions of some sort from peers who might see undercutting as unhelpful in their negotiations with the PMIs. It might not lead to much if any more business, if patients are insured for fees up to the cap.[7]

86. The reality appears to be that – unsurprisingly – the caps act as minima as well as maxima, and so obviously have the effect of reducing or eliminating competition on the basis of price.

87. The absence of competition on price is in my opinion inescapably an AEC by comparison with a normally competitive market. In such a market, characterised as in healthcare by suppliers offering a highly differentiated service, one would expect to see a range of different fee rates, reflecting different levels of expertise and cost, and changing over time as supply and demand for particular services changes, and as individual consultants gain or lose reputations. In contrast, here the CMA notes in para. 7.132 that "… maximum fees are in practice actual fees and are uniform fees and do not take into account a consultant's degree of specialisation, patient mix, experience or geographic location." For the CMA to find no AEC on the ground that consultants "could" compete below the fee caps did not have regard to the economic realities, and was therefore irrational.

88. In my view, the procedural challenge under this Ground should also succeed. The CMA did not put to FIPO its view that consultants could compete below the fee cap at

[7] It is possible that PMIs might move undercutting consultants up their lists of recommended consultants, contrary to such concerns.

the administrative stage. Had it done so, FIPO would have had the opportunity to present evidence as to the likely reality of this supposition. As I understand the CMA's duty pursuant to section 169(2) of the 2002 Act, it was required to consult with interested persons. By not mentioning that it thought consultants were able to compete on price below the caps in any of the documents circulated to FIPO, the CMA failed to do so.

C. Ground 6 – Insurers' Interest in Maintaining Consultants in Private Practice

89. This Ground goes to the heart of the reasons why the bargaining power and policies of the largest PMIs may create an AEC.

90. On the one hand it is obvious, as the CMA found, that the PMIs have a strong incentive to recruit and retain consultants and to be able to offer a high quality service to employers and policyholders. The CMA was in my opinion quite right to emphasise this.

91. However, it is equally obvious that PMIs also have other incentives, and that these may sometimes conflict. This is why, as the Report notes, PMIs sometimes steer patients towards fee-assured or fee-capped consultants (see paras. 7.82 – 7.92) and sometimes threaten to de-list consultants on purely financial grounds (see para. 7.116). It is also why they sometimes steer patients towards low-cost medical solutions (as reported by consultants to the CMA - see Appendix 7.3, especially "Interference in clinical pathway"). In concluding that "[i]nsurers increasingly determine not only fee levels but also which consultants a patient may see" (para. 7.122), the CMA suggests that it expects this trend to continue.

92. The CMA was not blind to the issue - see for example paras. 7.100, 7.121ff, 9.34ff and 9.78 - 9.79, and 11.580 – but it reached the conclusion in paras. 7.134 – 7.135 that any problems would be best managed by addressing information asymmetries so that patients can see whether an insurer recommendation is based on price or quality.

93. However, in my view the CMA as an expert body could not rationally have concluded that the conflict of interest affecting PMIs would be solved by its proposed Information Remedy. Patients are indeed generally far less well-informed than the medical experts to whom they turn for advice and treatment, but this lack of information is essentially about what is wrong with them, and what if any treatment would be best. The proposed Information Remedy, publishing fee rates and summary performance statistics, has nothing to do with this fundamental information asymmetry. Moreover, the majority of policyholders receive their private health cover as an employee benefit. They are therefore in a very different position to the much smaller number who subscribe individually and are more likely to consider the terms of their insurance cover for their individual needs before purchase. For all these reasons, patients are generally in no position to act as well-informed consumers might be expected to act in other markets.

94. In a well-functioning healthcare market patients would be entitled to assume that the advice they receive is based on their medical needs. PMIs have significant buying power in relation to consultants and are also in a strong position in relation to individual policy-holders. It was not reasonable of the CMA to expect that the fundamental conflicts of interest affecting PMIs would not give rise to an AEC, irrespective of the publication of the proposed additional information.

D. Ground 7 – the Information Remedy

95. I also disagree with the majority's decision at para. 71 above that the challenge to the Information Remedy fails.

96. Unlike the majority, in my view, FIPO's Ground 2 succeeds. As set out above, I was persuaded that the CMA's finding that consultants could compete below the PMIs' fee caps was flawed. There is only limited competition through top-up fees. There is thus no real price competition between consultants so far as policyholders are concerned. On that basis, providing information about fees to policyholders will do nothing to improve the competitive outcome because there is no competition on those fees in the

first place. Providing information about distorted fees cannot be expected to improve the competitive outcome.

97. It is clear that PMIs, as the main purchasers in the market, are price sensitive to consultant fee levels and have taken various measures to control those fees. However, the pricing pressure exerted by PMIs is very different to the sort of pricing pressure that would exist in a competitive market because PMIs are only the intermediary between the service provider and the service user, and as explained above are subject to conflicting objectives. The CMA will also have been aware of the economics literature to the effect that in a market with few players, providing additional information may facilitate tacit collusion – here, by encouraging smaller PMIs to follow the Bupa or AXA PPP fee schedules.

98. Therefore, the Information Remedy cannot constitute an effective remedy.[8]

99. For those reasons, in my opinion, the Information Remedy should also be quashed.

E. Conclusion

100. I would therefore allow FIPO's Grounds 1, 2, 6 and 7 and quash both the PMI Decision and Information Remedy and refer the matter back to the CMA.

[8] I also doubt the wisdom of having different information disclosure systems of non-price information for the private sector and for the NHS, but this is not a point raised in the appeal.

SALES LJ

101. Accordingly, by a majority, all FIPO's Grounds of challenge to the PMI Decision and to the Information Remedy are dismissed.

The Rt Hon Lord Justice Sales (Chairman) | Dermot Glynn | Clare Potter

Charles Dhanowa OBE, QC (*Hon*) (Registrar) | Date: 29 April 2015