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IN THE COMPETITION APPEAL TRIBUNAL

Case No. 1228/6/12/14

Victoria House,
Bloomsbury Place,
London WC1A 2EB

26 January2015

Before:
THE RT. HON. LORD JUSTICE SALES
(Chairman)
DERMOT GLYNN
CLARE POTTER

Sitting as a Tribunal in England and Wales

BETWEEN:

AXA PPP HEALTHCARE LIMITED

Applicant

- and -

COMPETITION AND MARKETS AUTHORITY

Respondent

- and -

BRITISH MEDICAL ASSOCIATION
BUPA INSURANCE LIMITED
ASSOCIATION OF ANAESTHETISTS OF GREAT BRITAIN AND IRELAND

Interveners

_____

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HEARING DAY TWO

APPEARANCES

Ms.Kelyn Bacon QCand Ms. Sarah Love(instructed by Linklaters) appeared forAXA PPP Healthcare Limited.

Ms.Kassie Smith QC and Mr. Brendan McGurk(instructed by the Treasury Solicitor) appeared for the CMA.

Mr. Aidan Robertson QC (instructed by the Legal Department) appeared for the BMA.

Ms. Anneli Howard (instructed by Hogan Lovells) appeared for AAGBI.

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THE CHAIRMAN: Yes, Ms. Smith?

MS. SMITH: On Friday we were in the middle of Ground 4 and we were looking at the results of the pricing analysis. Over the weekend AXA's solicitors have produced a further table, I think it is in front of you in A4, a corrected, refined version of the table which I have only just seen, but I think I can make some general submissions on that.

Sir, there was also a question that Mr. Glynn raised on Friday about the average versus individual pricing that was looked at. I can give some response to those questions. First, when we conducted the pricing analysis rather than looking at a price agreed by the group we looked at the actual average price charged by members of the group and that is apparent from para. 9 of Appendix 7.1 – I will not take you to that, but just for your note. We were not looking at the agreed price, we were looking at the actual average price charged by members of the group.

The second question was: looking at the average price charged by the group, did we also look at the pricing of individual members within the group? Although it does not feature heavily in the Report we did look at variations within the group, and I have been able to find a reference to that which is para. 21(b) of Appendix 7.1, which refers to variation within the group for case study A. So those analyses were also carried out.

Sir, we had looked at case studies D to F and, given the time available, I am not going to go back to those. We are now looking at case studies A to C and you had open on Friday the Final Report and Appendix 7.1. If I could ask you again to have both of those documents open.

The Final Report, which is vol.1 of 2 at p.204, and vol. 2 where we find Appendix 7.1, p.1031. So we are looking now at case studies A to C, where the CMA had the data to carry out what we have called in summary "pre- and post- event analysis".

If I could ask you to look first at the Final Report at para. 7.31(c) on p. 205. The summary there is for the other three case studies where we could conduct the pre and post- event price analysis.

> ". . . the evidence that the presence of the anaesthetist groups, and especially their collective price-setting, may have led to higher prices was, to some extent, mixed for two of the case studies."

So it is just saying that it is mixed for case studies A and B. And that summary of conclusions is detailed a little more in Appendix 7.1 paras. 19(a) and (b).

19:

"(a) Results on two case studies (namely A and B below) were mixed. It is worth noting that the most significant result for the two groups is the pre- and post- event analysis.

(b) Results on one case study (namely C below) were broadly consistent in showing that the anaesthetist groups seemed to have an impact on price."

So clear recognition of the different results by the CMA.

Then, if we could look at each of the case studies and the details. If you look at the Final Report, para. 7.32 for case study A. This group had a market share of over 80 per cent by volume. The pre- and post- event analysis, which is the one to which we afforded the most weight, showed that relatively higher average prices for five out of six and lower prices for one treatment, so five out of six higher. But importantly we then went on to look at the extent of the difference in prices. Three out of those five higher prices were very small differences in price – what I would call minimal differences in price – of four, two and one per cent. So we are not just looking at the fact there were differences, we are looking at the extent of those differences as well. For two out of the five where there were higher prices there were more significant differences in price. Then for the sixth treatment the lower price was minus two percentage points.

THE CHAIRMAN: Can I just ask, in relation to each of the case studies that we are looking at here, is there evidence discussed in the Report about what proportion of anaesthetists in that group set their fees by reference to the group standards?

MS. SMITH: Not that I am aware of, no. The evidence we have in that respect I think is only at the average level that we have in the Report, which is at 7.18, which is an average of 60 per cent of anaesthetists in a group set fees at the level determined by the group. What we then have in the case studies is an analysis of actual impact of the group by reference to the actual average prices charged by members of the group versus actual average prices charged by people who are not in a group. I do not understand, at least on the face of the Report, that we have, say, an analysis of those actual prices, three per cent, ten per cent or 20 per cent or 50 per cent accorded with the suggested price or not. I have not seen that analysis. So case study A, more details are given in Appendix 7.1, page 1033, paragraphs 20 and 21. In paragraph 20 over 80 per cent by volume is the market share and then the findings for the case study are set out in a bit more detail in paragraph 21. I have mentioned earlier sub paragraph B talks about variation within the group. Sub paragraph C talks about the pre- and post-event analysis. Then importantly we also look at the other analyses that were carried out for that group.

THE CHAIRMAN: Just looking at paragraph 20 some group members did charge below the fee set by the group.

MS. SMITH: Yes. So we have general statements to that effect; what we do not have, as I said, if any, is specific figures. The point is simply that there you have set out at paragraph 21 a very detailed analysis of all the data that was in front of the CMA for case study A.

For case study B, if we could go back to the Final Report, page 205, paragraph 7.33, we have the summary. The anaesthetists' group in that area had a market share of about 60 per cent by volume. The pre- and post-event analysis showed relatively higher average price rises for five out of the five treatments that we have data to analyse – so four out of five higher. But again we then look at the extent of those differences. For two of those four higher prices the difference was minimal – one percentage point. So for two out of four there were very minimal differences; for only two out of four was there any significant difference. For the fifth treatment the price was three percentage points lower. That analysis of case study B is developed in Appendix 7.1, paragraphs 22 to 23 and we have relatively data for that group; we were only able to carry out the analysis for average fees and the pre- and post-event analysis for case study B.

For case study C, back in the Final Report, page 205, paragraph 7.34 we are told that this anaesthetists' group has a market share of above 50 per cent. The pre- and post-event analysis showed relatively higher average prices for four of the four treatments we have data to analyse. So we did not have data to analyse two of the treatments; but for four of them they were higher prices and those price differences are relatively significant, but again different extents of price difference – eight percentage points, ten and 14.

That analysis is developed in more detail at Appendix 7.1, paragraphs 24 and 25 and you will see there the market shares in paragraph 24; in 25 the analysis that were carried out, average fees at A, pre- and post-event analysis at sub paragraph B and the comparison at sub paragraph C between hospitals. You see in the comparison between hospitals there were higher fees for two of the four treatments and broadly the same fees for the other treatment. It looks like we only have data for the hospital and a comparison for three of the treatments.

The point is there is a very detailed analysis of all the data available set out in these paragraphs.

In the Final Report, back on page 205 at paragraphs 7.35 and 7.36 the CMA records the submissions made on these results by Bupa and AXA; so the results of these analyses were produced in the Provisional Findings and put out to consultation. So not only the analysis

was carried out but it was also put out to consultation; comments were made by the insurers that were taken into account by the CMA in reaching its conclusions; and I have already taken you to paragraph 7.36 for AXA who make submissions which are in essence the same as those which it is now making in this appeal. Those were considered by the CMA in reaching its conclusion.

The conclusion on the pricing matters is then set out in paragraphs 7.37 and 7.38. 7.37: "Although the national and regional analyses generally suggest a price effect... we have placed less weight on these analyses as they do not control for geographical differences. In relation to the individual case studies, our view remains..." – having taken into account these consultation responses – "...that the evidence of a price effect of anaesthetist groups was mixed. In three of the six case studies undertaken..." – and I insert here case studies D, E and F – "...the evidence does not suggest the presence of anaesthetist groups leads to higher prices. For the other case studies, there was evidence of some price effect; however, this was not consistent across all treatments analysed for two of the case studies (A and B) but it was for one of the case studies (C). Whilst the anaesthetist groups in these three case studies have high market shares, the anaesthetist group in case study C has a lower share (about 50 per cent) than those in case studies A and B (over 80 per cent and about 60 per cent respectively). Finally, we note that, due to data limitations, we could not carry out all the analyses set out in our methodology for all treatments for all case studies."

They then go on to address the question of barriers to entry and I will come back to that point.

What I say is that the conclusion that was reached by the CMA on these prices analyses was a fair conclusion which took into account and carried out a very detailed analysis of all the evidence that was before it; took into account consultation responses and, in my submission, was not irrational. So of course one could say that on a high level analysis there were a larger number of results showing higher prices than not and that has been illustrated or attempted to be illustrated by the table that has been put in by AXA. We say that that table misses a number of fundamental points and if I can make some submissions briefly on the detail of the table and then some submissions about what it does not show and cannot show.

My submission by way of introduction is that by reducing these results summarised in the Final Report on the Appendix to a table you cannot do justice to the analysis of the data that was carried out by the CMA. It fails to reflect accurately the nuanced analysis that was carried out by the CMA and in some respects it is – I will not say misleading but it provides a picture that is over simplistic. If you look at the table – and I will take some examples of

where, in our submission, it is over simplistic – the first table produced on Friday did not include market shares and the table produced this morning now does. If you look at some of the results that are recorded in this table, for example, under case study C, row 2, groups versus independents in the same hospital, we have a red triangle, but that red triangle is interpreting data which showed that the group had higher prices for two out of six of the treatments, broadly the same for one, and no data for three out of six, but nevertheless there is a red triangle.

Similarly, if you look at case study E in that second row, we have a red triangle, but the group is only higher for two of the six, although the gap is decreasing over time, lower for one out of six, and not done for three out of six.

If you look at case study B, row 4B, the regional analysis 2, we have a red triangle but the group is higher for only two out of six, close for two out of six, and lower for two out of six. So for four out of six it is not higher, but again we have a red triangle.

So trying, as I said on Friday, to reduce these results just to red or green triangles, in our submission, does not really assist.

A further point on this table is that if you look at row 4A, regional analysis 1, we have disaggregated results when, in fact, that does not reflect what was done in the Report. To explain this, you have here six red triangles, but, in fact, all you have from this analysis are two averages, an average for group 1 and an average for group 2. That is why it says region 1 and region 2, I am now told. We have six triangles, and really you should only have two. Can I show you that by looking at para.17 of Appendix 7.1, you see it is reflected. I am not saying this is not reflected, I am just saying how problematic putting it into red triangles can be. If you look at para.7 of Appendix 7.1, which is on p.1031, this the first type of regional analysis, which, as you can see, looks at average annual fees charged by group members in region 1, compared with those charged by non-group members, and average annual fees for group members in region 2, compared with non-members. So we have two averages, two averaged figures, which show, as is said in the table, that for region 1 the average was higher for six out six of the treatments; and for region 2 it was higher for five out of six. It is just two results, and it has been disaggregated into six triangles.

All I am saying is that there are dangers in presenting the evidence in this form. You need to look, in my submission, at the much more detailed and nuanced approach that was carried out by the CMA and summarised in Appendix 7.1 and the Final Report.

This table also cannot reflect the following important factors that were taken into account by the CMA in analysing and interpreting this material. I stress the word “interpreting”.

First of all, there are four ways in which this table cannot reflect the interpretation that was carried out by the CMA. The CMA took into account the lack of consistency between market shares and the extent of price differences. For example, case study C, which showed the most consistent and material price differences, had a lower market share than all the other case studies. In the table handed up today, you are shown the market share as recorded in the CMA's Final Report, also the market share recorded in Bupa's analysis, you will see on the top row, but the point holds good.

Case study C, the area for case study C, anaesthetist groups have the lowest market share. The question then is that there is a lack of consistency between the market shares, the fact that there is a higher market share, and the fact of price differences. Something may be going on in some local markets, but drawing the conclusion from this data that is due to problems with competition, it is due to the higher market shares, particularly when you know there is geographical variation in prices, it gives rise to questions.

We are not, contrary to what AXA says, arguing for "perfect consistency or empirical perfection" in this matter, it is just that this is an aspect of the figures that the CMA properly took into account in analysing and interpreting the data.

That is the first point. The second point, and I think I have made this point already, is that one needs to look not just at the fact of price difference, but the magnitude of those price differences, and I have made the point that in a number of cases, including for case studies A and B, the magnitude of the price differences was small.

The third point is that the individual case studies that were carried out, the six case studies, related to areas that had been identified by insurers as being of particular concern. The insurers made the submission that high market shares, collective price setting is leading to higher prices in the areas where these anaesthetist groups are engaged in these practices. The CMA said, "Can you show us this?" and they presented this evidence of these 11 groups where they said this was the worst effects of these practices. So they should have been those which were most likely to show material price differences.

The fourth point is the limitations of the data and the reliability of the results. For example, there is a small number of data points, a very small number of data points, for some of the case studies. We know that the national and regional analyses were unlikely control for geographical differences in price, and we know that there was a lack of data for some of the various tests carried out on the individual case studies.

All of these problems with the data, which were accepted fairly by Ms. Bacon for AXA, in my submission, lead to this result: the level of judgment to be applied by the CMA is

increased. It is the CMA who is aware of the problems and limitations in the data, and, in my submission, is the best position to interpret the results in the light of those problems.

In conclusion, in my submission, of course it is perfectly possible that a different decision maker may have come to a different conclusion on these results, but as you are aware that is not the test to be applied. In all the circumstances, we say that the CMA's conclusion on the results of these pricing analyses cannot be said to be irrational.

In her submissions on Friday, Ms. Bacon made the point about case study C, and said that you certainly cannot say that the CMA's conclusions on case study C itself, just focusing in on that one case study, even if their conclusions were rational or their decision to stop the investigation for other areas was rational for other areas, it could not be rational for the area covered by case study C given the results in that case study.

My submissions in response to that submission are as follows. It is true that the area covered by case study C showed four out four higher prices for pre- and post-event analysis. It was not just the pre- and post-event analysis that was in front of the CMA. If you look even at the table produced by AXA, you can see that there are on the other analyses carried out the results were not so clear cut.

But, in any event and, perhaps more importantly, although the data showed price increases after the formation of the group it is not enough, in my submission, just to say that there were price increases. The CMA has to be satisfied that those were caused by the collective price setting of anaesthetist groups with a high market share, which is what was said to it by the insurers. You have to look at the reasons for the price increases. The problem with the case study C results was that the anaesthetists group in this area had lower market shares than any of the other areas where consistent price increases were not found.

Also, if the CMA was going to find an AEC just as regards case study C, then it has made it clear that it would have to look at other factors and go on from simply stopping at the evidence of the price increases.

If you look at the Final Report on p.207, the CMA addresses this point generally in the response to the submission or the representation made that you should have carried on your investigation area by area.

In para. 7.40:

> "We did not undertake an area by area competitive assessment . . ."

So we did not look at every local area:

> ". . . to identify whether a particular anaesthetist groups in any local area may have market power giving rise to competition problems... In some local areas, some

anaesthetist groups may have market power. However, to identify such local areas and whether such market power adversely affects competition would require a detailed area-by-area competitive assessment. For the reasons set out in paragraph 7.21, we do not consider that a finding of an AEC can be made on the basis of collective price setting and high market share alone. Such an area-by-area competitive assessment would require not only consideration of shares of supply and price analysis . . ."

- which was carried out for case study C:

" . . . and potentially other market outcomes) over an appropriate period of time but also consideration of any countervailing factors, including barriers to entry, the level of constraint provided by individual consultants, the likelihood of any local entry and of any countervailing buyer power of the insurers."

Then the focus goes into the six case study areas. Para. 7.41:

"Those anaesthetist groups which insurers had indicated were a particular concern and for whom we were able to undertake a price analysis showed mixed results and in particular only showed consistent evidence of price effects in one case."

- insert "case study C".

"Given the difficulties in obtaining data on anaesthetist groups as described in Appendix 7.1, the results of the pricing analysis and the constraints on time and resources available for investigation overall, we considered that pursuing this line of inquiry was not justified. In particular, we did not consider that further work to determine whether in any local market . . ."

- including, by implication, case study C:

". . . an anaesthetists group has local market power which adversely affects competition would be beneficial."

So this issue was considered by the CMA, but they fairly said if we are going to go on and make an AEC finding we would have to go further than just looking at the price data, we would also have to look at these countervailing factors, and given the difficulties in obtaining data – and I say that the CMA did keep asking for further data from the insurers for their problem areas, but the only data that they were able to provide is that considered in the Report. Given those difficulties in obtaining data and the restraints on time and resources available the CMA considered that pursuing the question of whether there was an AEC in any local market, including case study C, was not justified.

In my submission, that was a wholly rational conclusion to reach in these circumstances.

The second point made by AXA under Ground 2 was whether the CMA properly took into account other relevant evidence, and these, I outlined, were the high market shares, barriers to entry, Bupa's shortfall analysis, and the countervailing buyer power of PMIs.

I think I can deal with those four points relatively briefly. As to high market shares, those were clearly taken into account by the CMA, and you will see in its assessment of the local case studies it looked at the market shares.

As to barriers to entry, I am not going to take you back to those paragraphs because I have read them out, but they were considered by the CMA at para. 7.38 of the Final Report, and para. 32 of Appendix 7.1. They were also considered in Annex A to Appendix 7.1, which I have not taken you to, and it might be worthwhile for completeness just to show you what this.

If I could take those in turn, just to take you to Annex A to Appendix 7.1, which is at p.1037 of the second volume. This sets out an analysis, a summary of the consultation responses put forward by various parties on the pricing analysis and the effect of groups of anaesthetists.

In para. 2 we see AXA's submissions. In para. 3 we see Bupa's submissions, and specifically I will deal with this point now, there the CMA specifically considers Bupa's shortfall analysis, as it has been summarised in this case, which is an analysis presented by Bupa in the consultation process of the frequency of shortfall, that is the difference between the fees that Bupa is prepared to pay and the fees that the anaesthetists charge and have to recover from the patient, so a different analysis, and that was expressly considered there by the CMA.

Paragraph 4, Aviva's concerns, and para. 5 PruHealth. Paragraph 6, WPA, then the submissions made by the anaesthetist groups and the reasons given there, which comes back to a point I think we were covering on Friday as to why the anaesthetist groups said they were a good thing.

Then the submissions from para. 9 onwards of the AAGBI. From para. 13 onwards the hospitals' viewpoint. So all those submissions are considered in detail by the CMA.

As to barriers to entry we can go back, if you want, to the Final Report – I have been asked by Ms. Bacon to do so – p.206 of the Final Report, para. 7.38, and this is where barriers to entry is considered by the CMA. The background to this, as Ms. Bacon said in her submissions, in the Provisional Findings, the preliminary view of the CMA was that barriers to entry were low, the point of that being that, even if prices were higher in the presence

where there were anaesthetist groups the barriers to entry are low, and therefore independent anaesthetists can come into those areas to compete on price.

Paragraph 7.38 is the question about whether the CMA have to carry out further analysis on barriers to entry and in light of submissions made by Bupa and AXA the CMA said there that:

> ". . . in order to determine whether barriers to entry are low, it is necessary to consider the level of constraint imposed on an anaesthetist groups by individual consultants in the relevant local area."

So we would need to look at barriers to entry in each local area. Yes, we accept that, but given that we have found mixed price effects in relation to the formation of anaesthetist groups we have decided not to prioritise our resources in carrying out a detailed assessment of barriers to entry.

So on the basis of prioritisation of resources we have not taken the step of carrying out a barriers to entry analysis for each of the local areas, and we say that in the circumstances that was a wholly reasonable conclusion to reach.

A third piece of evidence which AXA said we did not take into account was Bupa's shortfall analysis, I have taken you to Annex A to show that we did take that into account. For your note the reasons why the CMA preferred its analysis to that of Bupa is found in para. 143 (c) of the Defence.

THE CHAIRMAN: Of the Defence – there is not a reference in the Report?

MS. SMITH: No, this is an explanation given in the Defence.

THE CHAIRMAN: Which paragraph in the Defence?

MS. SMITH: It is para. 149(c) on p.49, behind tab 7 of the core bundle. I apologise for having a third bundle open. I will probably start at (b), Bupa's analysis was summarised at Appendix 7.1, Annex A, paragraph 3 as you have seen.

"The CMA took account of Aviva's shortfall analysis by including some of the eight areas covered in Bupa's analysis in its individual case studies. Case studies A to C were areas included in Bupa's analysis, as was case study C. Case studies E and F were not included in Bupa's analysis. The other areas included in Bupa's analysis were not used as case studies as there were insufficient observations.

The CMA preferred its own analysis on the basis that it used (i) fees (as opposed to the difference between fees and benefit maxima), ii the same treatments (as opposed to averages), and (iii) control groups where possible." Footnote 61where it says that Bupa's analysis is summarised at the reference I have already given you:

"The CMA indicated it would use control groups at Final Report, paragraph 7.26 (see also Appendix 7.9 paragraph 10)."

Then a submission is made that:

"Moreover, even on Bupa's analysis there was no consistent relationship between market share and shortfall, although one would have expected higher shares to lead to higher shortfalls, all else being equal."

Then the final point, the fourth point relied on that we are said not to have taken into account is account availing by a power of the insurers. Yes, that was not considered specifically in detail in the context of anaesthetist groups; it is referred to in paragraphs 7.21 and 7.40 to which I have already referred you as being one of the countervailing factors that would have had to be included and considered if we were to proceed to a positive AEC finding for any local market area, but it was one of the factors that the CMA in our submission entirely reasonably decided not to proceed to carry out.

Finally, Ground 5 insofar as there is anything different---

THE CHAIRMAN: In the evidence you received were there any advantages of price fixing by the anaesthetist groups to the advantage of the anaesthetist group?

MS. SMITH: The only point I could take you to in that regard – I will check with those sitting behind me – there is a point in Annex A to Appendix 7.1 on page 1039 paragraph 7(c). I am not sure if this is exactly on point but it is the closest I can find. The top of that page (c) finances:

"Having a single billing system led to higher efficiency financial dealings, including estimates, invoicing, banking and accountancy. In addition, it allowed the group to provide estimates efficiently to all patients pre-operatively."

I am not sure it is entirely on the point. But then there are some other points on fees set out in paragraph 8. I am sure the Interveners can make some points on more detailed submissions that were made to the CMA, but that addresses that point I think, or at least is relevant to that point.

So Ground 5, AXA's argument under Ground 5 is that the CMA failed to discharge its statutory obligation under Section 134(1) to reach a final decision on whether or not there was an AEC. Their alternative and perhaps second order argument is that CMA failed to discharge its *Thameside* duty to undertake sufficient enquiries to enable it to reach a decision.

As to the first argument it is our case, as set out in the Pleadings, that we dispute that the CMA made a non finding or failed to reach a final decision or failed to discharge its

statutory obligation under Section 134(1). You have seen, but it may be useful to have it open again in front of you, paragraph 7.47 of the Final Report on page 208 of volume 1. We say that that was a clear finding that on the evidence before it the CMA did not find an AEC. The second sentence:

"In addition we do not find that the formation of any individual anaesthetist group... adversely affects competition in any local market."

We do not find an AEC an adverse effect on competition.

THE CHAIRMAN: It is put in a negative way. They do not say "Positively we find that there is no AEC."

MS. SMITH: No. In the circumstances perhaps that was the fair way to conclude.

THE CHAIR: I can see that because in 7.40 for example they say "Some of us may have markets but we are not going to investigate further because they are saying it is disproportionate in effect to do so."

MS. SMITH: Yes.

THE CHAIRMAN: That seems to live with reading 7.47 in a negative sense – we cannot find an AEC.

MS. SMITH: Yes.

THE CHAIRMAN: You seem to be saying that the CMA is positively saying there is no AEC.

MS. SMITH: I am not sure what the importance of that distinction is.

THE CHAIRMAN: Nor am I but you made the submissions.

MS. SMITH: Yes. Our submission is that there is a clear finding that---

THE CHAIRMAN: Of what?

MS. SMITH: We find that there is no AEC; we do not find there is an AEC. The latter is the finding – insofar as anything turns on that the latter is the finding. That is clearly, we say, acceptable under Section 134(1) which provides that the CMA shall decide whether any feature or combination of features restricts or distorts competition. The CMA says "We do not find that these features adversely affect competition."

THE CHAIRMAN: Perhaps putting it another way, the trigger for the CMA to take any further action is that they have positively to find that there is an AEC and they were unable to do that.

MS. SMITH: Yes, I would accept that characterisation of what is done. For your note, however, the conclusion is also set out in pretty much the same terms in paragraph 7.129 on page 227 of the Report, but it is made more explicit that this conclusion held good for any individual anaesthetist group and that is the fourth line of the paragraph, "in any local market".

THE CHAIRMAN: Again, I think it is put negatively; "It does not lead us to conclude that there is an AEC."

MS. SMITH: Yes, absolutely; a fair and accurate observation Sir.

MS. POTTER: While you have taken us to that paragraph can you just explain the last sentence of that paragraph, 7.129 because I did struggle with that.

MS. SMITH: "We also note that, having regard to the relevant provisions on anti-trust enforcement, and depending on the particular circumstances of the individual arrangements in point, certain practices may be contrary to such competition provisions."

I am sure I will be stopped if I am saying the wrong thing but as I understood that the OFT decision in 2003 held that certain arrangements, in particular partnership formats, did not fall foul of the Chapter 1 prohibition and Article 101, but we cannot anticipate whether or not there may be arrangements in other areas, depending on particular circumstances of the individual arrangements in point that may be contrary to the Article. I think that is simply the point that is being made.

THE CHAIRMAN: I rather read it in conjunction with the preceding sentence. They say, "formation of groups may give rise to competition benefits", but I read that last sentence as indicating, "but we do not want this to be taken as, if you like, our *imprimatur* in relation to future objections based on chapter 1. On that previous sentence, "As stated above, the formation of groups may give rise to competition benefits", where is the "as stated above" - can you help us with that?

MS. SMITH: I think that is probably 7.21, let me just double-check.

THE CHAIRMAN: Or is it the glancing reference at 7.19?

MS. SMITH: It is 7.19. That is simply the formation of the group, rather than ----

THE CHAIRMAN: Is that a cross-reference to Annex A of Appendix 7.1, p.1038?

MS. SMITH: I think it must be a cross-reference to the evidence summarised there, yes.

THE CHAIRMAN: Is that an implicit acceptance by the CMA that there are competitive benefits associated with the groups? How does it fit together?

MS. SMITH: There are three different issues: the formation of a group, with nothing more; a group collectively setting prices, a second and distinct issue; a group collectively setting prices where it has a high local market shares, the third an distinct issue. What we are dealing with here is simply the first, which is the formation of a group with nothing more.

THE CHAIRMAN: So am I right to read these three bits as fitting together, 7.19, where they say there may be a number of benefits to consumers and that does not seem to be contested from the formation of groups, leaving aside setting, and so on, and that, in itself, does not

seem to be contested by Bupa and AXA. 7.129 is a reference back to 7.19 in the Final Report, but that bit in 7.19 reflects an acceptance of the anaesthetist groups' viewpoint at p.1038 of the rationale behind group formation - is that how it fits together?

MS. SMITH: I think so. That seems to be correct from my reading of the Report. From my reading of the Report, that seems to be the case, obviously with the caveat that Annex A is only a summary of the representations that were made, and all the detailed representations that were made on behalf of anaesthetist groups that were published on the CMA's website were open to public inspection. It may be that the summary does not cover all of the detail of what was put in by way of representations, but all of that information was available as part of the consultation process.

THE CHAIRMAN: Yes, thank you.

MS. SMITH: Really, in our submission, the point at Ground 5 is, was the CMA entitled to stop its enquiry where it did? Here the question for the Tribunal is, did the CMA undertake reasonable steps to equate itself with relevant evidence to enable itself to answer the statutory question posed for it? I do not take you to the authorities, but it is para.23 of the *BAA* judgment in the Tribunal, but the question of whether the CMA has taken reasonable steps is a question of irrationality. In our submission, obviously it is not irrational for the CMA to have decided not to carry out further investigations, and I have taken you to it, and I do not need to take you back to it, paras.7.40 and 7.41 of the Final Report, and 7.28 and 7.129.

In summary, the reasons given are the mixed results of the price analysis, the difficulties of obtaining data, and in para.85 of our Skeleton Argument we give you some cross-references to other points at which we have explained in the Final Report the difficulties of explaining the data, and finally the constraints on time and resources.

I have just been handed a note, and I think it is right that I should make the point. The CMA accepted that there may be benefits, and I underline "may be benefits", resulting from the formation of consultant groups. We did not find a price effect, so we did not need to investigate and come to a final conclusion on the existence or extent of those benefits. It is reflected in the damage of para.7.19, "There may be a number of benefits to consumers resulting from the formation of consultant groups…".

THE CHAIRMAN: Is that then one of the issues that is, if you like, parked in 7.40 and 7.41?

MS. SMITH: Yes.

THE CHAIRMAN: Even though they do not mention that?

MS. SMITH: Yes. It may be included in the countervailing factors.

THE CHAIRMAN: Perhaps it is the last sentence of 7.41:

> "… whether in any local market an anaesthetist group has local market power which adversely affects competition would be beneficial."

MS. SMITH: The "beneficial" I think refers to the desirability of carrying out further investigations, but it would be whether they adversely affects competition. It may be that where there are countervailing factors, benefits, etc, you come to the conclusion that overall there is no adverse effect.

THE CHAIRMAN: So was the first way I put it accurate so far as your reading of this is concerned?

MS. SMITH: Subject to the "may be", yes.

THE CHAIRMAN: There are a number of "may be's" explicitly referred to in 7.14 and 7.41, but you are saying there is another "may be" that is there as well.

MS. SMITH: Yes. I have made the point that the reasons given in summary as to why no further steps were taken were wholly rational. AXA accepts that the CMA can focus its resources and that it is not obliged to undertake an unlimited investigation - that is its Skeleton, para.88. AXA argues that the existence of anaesthetist groups was an important issue on which the CMA should have focused its resources, and in particular it should have focused on particular local problem areas. I think I have already addressed that point. When it comes to the issue before the Tribunal it is one of rationality, and we say that the approach was not irrational.

THE CHAIRMAN: Would this be a relevant consideration on that question, that the markets are local, so in so far as the work was going to be done it would have to be local market by local market by local market? Is it legitimate to have some sort of trade-off between the amount of work that would need to be done and the extent of possible corrections to the market that might be achieved?

MS. SMITH: I think that is right, Sir, and that does relate to the very last point I was going to make under Ground 5, which is this aggregation point that is made explicitly for the first time in AXA's Reply, and developed in paras.100 to 106, if I recall, of AXA's Skeleton Argument. This is the argument that having found markets were local the CMA could not logically aggregate its findings on different local markets to find that there was no AEC overall. What I say is that we did not actually do that. What the CMA actually did, if you look at para.7.25 as a starting point in the Final Report, which is on p.203, it is made explicit there:

> "We did not have enough information on the anaesthetist groups' presence and membership across UK hospitals to test systematically their possible impact on average fees charged by anaesthetists. Therefore, our analysis covered those local geographic areas, and anaesthetist groups active in those areas, which insurers highlighted as potentially raising competition concerns, or mentioned specifically…, as these were likely to be more indicative of raising competition problems."

I would also draw your attention in that regard to footnote 598 which sets out some detail on the information that was provided to the CMA, and the information which the CMA sought, but which was unable to be provided.

So we were seeking to get the data, but we could not test across the UK as a whole, because we did not have the data. So we took a market by market approach, and in that regard we looked at the groups which the insurers had said had caused particular problems - that is where prices had increased, they said, as a result of collective price setting by groups with high market shares, and those were the case studies.

Evidence on those, as I have said, was mixed. We decided to take the analysis no further, either as regards particular local markets which had already been the subject of the case studies, but also as regards looking at further local markets, and that takes us back to paras. 7.40 and 7.41. 7.40, sets out – and we have been through it – what would be required by an area by area competitive assessment. Then, in 7.41, we explicitly say that those anaesthetist groups which the insurers had indicated were a particular concern gave the following results and we considered that pursuing this line of inquiry is not justified.

> "We did not consider that further work to determine whether in any local market an anaesthetist group has local market power which adversely affects competition will be beneficial."

Also, for your note, 7.128 and 7.129 make similar points, but the point is that we have concluded that it would not be worthwhile to carry out further investigations into the local markets.

When the CMA referred to no ebbing, no evidence of widespread harm to competition, it clearly meant harm to competition in those local markets. We were not suggesting that there was any sort of national market definition. So there was no unlawful or irrational aggregation of results, it all just comes back to the question of whether it was reasonable for the CMA to stop where it did. We say for the reasons I have developed and the reasons set out in 7.40, 7.41, 7.128, and 7.129 that was a rational conclusion.

Sir, unless I can help you or your colleagues further those are our submissions.

THE CHAIRMAN: Thank you very much. It is AAGBI?

MS. HOWARD: That is right, the Association representing the anaesthetists. I am conscious I have a very short time, and so I really wanted to cut straight to the chase and to give you some signposts I just want to lay out what I was going to address you on this morning. I have some very brief comments on the AEC test which you may not want to hear me on. I was then going to come back on some brief points on Ground 3 and address the Tribunal's questions on the reasons behind the formation of groups and the reasons for collective price setting. And then finally Grounds 4 and 5, again brief points because I do not want to duplicate those already made.

Turning to the AEC test, this has been covered by my learned friend, Ms. Smith, I just wanted to take the Tribunal briefly to some relevant parts of CC3, which is at Authorities Bundle 2, tab 31. If you could turn to p.24, and just keep a finger in that tab, as I am also going to refer you to some later parts.

This is Part 3 of CC3 which sets out the AEC test. Ms. Bacon submitted on behalf of AXA that really the AEC test is a straight forward test which produces a yes or no answer – you are either pregnant or you are not. She said that the CMA only had to look at features of the market and could stop there and look no further. We would say that the assessment is much more involved than that, and if you look at para. 94 you will see that there are three stages, but these are not distinct chronological stages, and they often overlap on a continuous piece of work, see para. 95.

The first stage in para. 94(a) is looking at the main characteristics of the market and the market outcomes. If you flick a few more pages down you will see that section 1 on the following pages sets out the approach for that first step.

There is then stage 2, which is covered by para. 94(b) which is the market definition and composition. Again, that is tracked in section 2, which starts at p.30.

Finally, we have in para. 94(c) the competitive assessment, and for your reference that is tracked in section 3, from page 35 onwards.

For the competitive assessment, you look at the theories of harm, and have to test those theories against the outcomes of the market. In 94(c), importantly, considering also "*possible countervailing factors such as efficiencies which may remove or mitigate the competitive harm features*".

Ms. Smith took you to para. 163, which is over on p.37, about the theories of harm, saying how this was just a hypothesis, it is just a working methodology to test if there is any harm.

It does not imply any pre-judgment. There is one other paragraph, para.156 at the top of p.36, which says: "*It has been emphasised that the CMA (as it now is) makes no presumption that there are market features that harm competition.*"

THE CHAIRMAN: I am so sorry, I missed the reference.

MS. HOWARD: It is para. 156, Sir, at the top of p.36.

THE CHAIRMAN: Thank you.

MS. HOWARD: So there is no presumption that there are market features that harm competition and, indeed, the CMA may go on to find there are no such features at all, despite the reference that is made to it.

So the theory of harm may be revisited and, importantly, has to take account of countervailing factors. And those are addressed over the page at p.39. There is a whole section there from paras. 173 to 176 setting out the countervailing factors which members of the Tribunal were not taken to on Friday. Now, those paragraphs set out three particular types of countervailing benefit. There may be efficiencies (they are dealt with in para. 174) that outweigh any harmful effects. There may be entry or expansion and there may be countervailing buyer power.

So the fact that at market feature may give rise to benefits may actually totally remove any idea of harm. And this is actually envisaged by the Act itself – just for your pen, it is s.134(8) of the Enterprise Act. So the feature may give rise to benefits in the form of lower prices, higher quality, greater choice or greater innovation and there is explicit recognition of that in the Act.

We would submit that it follows that the AEC test is actually a very sophisticated inquiry. Importantly, it is context specific and involves expert evaluation, not just of the facts and features, but also the economic conditions in the market. In particular, the AAGBI submits that the AEC test requires proof of an adverse effect. You cannot rely purely on a presumption based on some abstract market features and no more; there has to be some further analysis to ascertain whether there is some effect in reality, not purely in abstract theory.

Secondly, the actual effect on the process of competition must be significant in order to be "adverse"; it cannot be merely nominal. It must have economic significance, and be shown by statistical evidence. Lastly, the effect must be unjustifiable in the sense that it is disproportionate to some countervailing pro-competitive benefit.

Moving from the test to Ground 3, we say, first, as a matter of law there is no reviewable error of law here; AXA's interpretation of how the test should be applied is simply wrong

and I would like to make four points here. First, AXA contends that you can rely purely on formalistic indicia. I hope that by taking you through the test I have shown that actually you cannot rely on market features alone and no more.

Secondly, AXA introduces this prima facie test that once these indicators or features are in place, the onus then shifts, on to the CMA to come up with evidence to the contrary.Yet that approach is completely unsupported by authority. It is not even provided for in Article 101 or the Chapter I prohibition. You would expect that this sort of positive duty on the CMA to come up with further evidence to prove a negative would be covered by the Act explicitly, there would be explicit wording imposing that sort of duty and it is not there.

My third point is that AXA now starts to shift position and says that it is not relying on the Article 101 and Chapter 1 object infringement. The extent of AXA's reliance on this is unclear. Ms. Bacon was still saying that there were "echoes" and it must be looked at "in parallel", yet her prima facie test relies on similar concepts to those in Article 101and we say that this is purely wrong as a matter of legal interpretation. It risks confusing the very different policy objectives behind each regime.

There is standard case law from the European Court of Justice that the competition authorities are allowed to rely on evidential presumptions in cartel cases and hardcore infringements. That is because that is a *quasi penal* deterrence regime. This is not that type of regime; it is an inquisitorial market-led assessment. And really AXA's approach of borrowing from European case law and seeking to import it into a national regime which has come from a very different background and has very different aims really risks undermining the whole scope and purpose of the market investigation regime.

For my fourth point I would like to say that AXA's assessment of the features in the first instance is wrong in any event, and there are two points to this. One is there is no high "market share"; secondly, there is no collective price setting or price fixing here. On market share, it is important in the Final Report that the CMA did not define the local market in any detail. If you look at paragraph 7.2. They looked at the local market but did not carry out any detailed market assessment.

AXA’s assessment of the market is wrong. First, it is based on its own data, it gathered data about consultants that it has recognised under its scheme, but that does not include data from other consultants that may be operating in the local area.

Secondly, the members of the AG may actually be competing between themselves. You will remember that 40 per cent figure that 40 per cent of AGs do not follow a pricing schedule.

Sir, you took Ms. Smith this morning to paragraph 20 of Appendix 7.1 where in Case Study A the members do compete between themselves. It is also instructive to look at paragraphs 22 and 24 of Appendix 7.1. At paragraph 22, dealing with Case Study B, the anaesthetist groups "*told us that some members had difficulty in charging at the level agreed by the group due to contractual arrangements with some insurers*". What that means is that for the individual members to be recognised by the PMIs, they had to sign up to their maxima and therefore had to price lower than the group.

Over the page at paragraph 24 in relation to Case Study C, it also mentions that "*some group members charge fees below those set by the group*". So in assessing the level of competitive constraints AXA ignores the fact that the members of the AG themselves may be competing with each other.

Most importantly there may be other AGs or independent anaesthetists competing at the very same hospital. AXA's data is based on earnings by the group at their base hospital; but the evidence before the CMA was that there are a number of hospitals that have more than one AG. I think 92 per cent of other hospitals have groups and 80 per cent of members have access to work in other hospitals. This is all in Annex A of AAGBI's response to the Annotated Issues Statement. That is at CB2 tab 14, page 13; there are some Figures 18, 20, 21 and 22. Under figure 18 it says:

"*Eighteen of the groups (58%) indicated that there was at least one other local hospital at which one of their partners has privileges...*"; where they compete.

A quarter of groups indicated that at least one of their partners could practise at one or two private hospitals if they wished, with 62 per cent having access to three or more.

So this shows that although you may have a group at one base hospital they do face competition from other groups at other hospitals in the locality.

Similarly, over the page at the top of page 14, 74 per cent had at least one independent anaesthetist working in the same base hospital and 49 per cent had six or more.

So in assessing the competitive constraints, you do need to look at the constraint posed by independent anaesthetists and other groups operating at other hospitals in the locality.

The other aspect is that in the Provisional Report, the CMA recognised that there is a drive time isochrone catchment area for the hospital of 30 minutes. It did not go on to finalise the market definition in the Final Report, but patients will travel up to 30 minutes or more for their surgery and consultants also travel. So you will often have consultants who will come into London to do an all day clinic. So there is a wider competitive constraint than just the base hospital itself.

So these purported "market shares" – I am not going into percentages if they are confidential – actually in reality translate into much lower market shares of five per cent rather than these super high numbers that we are seeing. That was my point on market share.

THE CHAIRMAN: Just on that, the CMA in relation to case studies A, B and C did seem positively to find the market shares.

MS. HOWARD: I think because it was relying on the data from the insurers and that was the data that had been posited by the insurers, so this was a hypothesis.

MS. POTTER: What about the table you have just taken us to, figure 22, where obviously there are some groups which are saying there are no independent anaesthetists working in their base hospitals.

MS. HOWARD: I am sorry; I was trying to be quick and did not mean not to take you to a specific point.

MS. POTTER: There is a very high market share there.

MS. HOWARD: 26 per cent have no independent in their hospital but they would still face competition from independents and groups outside that hospital.

THE CHAIRMAN: In relation to the market share given in the Report certainly looking at the table the CMA has not simply adopted the market shares that Bupa and AXA are putting forward – they have taken slightly lower ones. I am not sure what the source for those figures is.

MS. HOWARD: The Bupafigures are taken from a slightly different assessment. Their figures are based on benefit maxima; a quite different analysis based on shortfalls.

My understanding is – and I will be corrected if I am wrong – that the actual percentages that have been shown for A, B, C and D are the same as those recorded in the Appendix 7.1 from AXA's data.

THE CHAIRMAN: If you look at the Report, 7.32 to 7.34 it certainly reads as though the CMA have possibly said things which amount to findings by them. So 7.32, page 205, "...the anaesthetist group in this area has a high share of all anaesthetist treatments – over 80 per cent by volume."

MS. HOWARD: I should have made this clear, Appendix 7.1, if you look at paragraphs 22, 23, 26 and 28, is talking about "shares" of anaesthetists' treatments in one hospital not "market shares"; so it is not a finding of market definition. It is talking about just treatments in one hospital. So there is no positive finding that hospital equals the relevant market, it is simply looking at the percentage in a particular hospital.

THE CHAIRMAN: It is that caveat, I think I am right Ms. Smith, in reading the Report that positive findings have been made by the CMA, not about market share in a defined market.

MS. SMITH: Not in a defined market but in a particular hospital, yes.

MS. HOWARD: This is where I pointed out that the Final Report has not made.

THE CHAIRMAN: You also made the point that the CMA adopted, more or less accepted figures that had been put forward without examining them and they did not do that.

MS. HOWARD: I am sorry, I did not mean to imply criticism. I was saying this was their working hypothesis. Obviously they have taken the data that has been taken by AXA but it is not the same---

THE CHAIRMAN: I am sorry, you say it is a working hypothesis. It is not, they have made findings for those hospitals, not for defined local markets, because you have shown us they did not do that, but for those hospitals they have actually found what the market share was.

MS. HOWARD: They have found what the "share" was in a particular hospital. That is not the same as a "market share" in competition law terms, because there has been no formal market definition ----

THE CHAIRMAN: I follow that, but I understood you to be making another point, that they had not even made findings about the share of treatments in a particular hospital. Are you saying that?

MS. HOWARD: No. Sorry, they made findings about particular hospitals, but AXA, in their arguments, is elevating this to being a finding of high market share as if it was based on a proper market definition, which has not been carried out.

THE CHAIRMAN: Thank you, yes, I understand.

MS. HOWARD: In terms of the feature of the market, this is not a valid feature in the first place. There has been no formal finding of market definition or precise market share in competition law terms.

My second point is that there is no collective price fixing element here, because competition law prohibits price fixing between *undertakings* - that is between different economic groups. Here, pricing within an anaesthetist group is no different to, for example, charges set by law firms. You may have litigation partners competing between themselves on quality and expertise, but the law firm will set the charge rate for the firm as a whole. That is internal price setting within a corporate group, and that is exactly the same as is happening for the anaesthetist groups.

The flaws in AXA's arguments can be demonstrated by a simple question, which we say is very similar to that raised by the Tribunal on Friday: would AXA have any objection if the

AGs priced to AXA's maxima, for example, or Bupa's maxima, which is even lower? Surely that would be the same *prima facie* restriction of competition because you have got a group with a high market share, as they call it. Presumably the PMIs would have no objection to the AGs pricing at their maxima. What is more, the PMIs would like, and are trying to force, all AGs and independent anaesthetists to price at that price point. We say that is an outcome which is even more harmful to competition.

Sir, what I wanted to move on to now is to address your questions on the reasons for consultants groups and for joint price setting, which you asked on Friday. Ms. Bacon took you to the guidance issued by the AAGBI to suggest that the spike in the number of consultant groups suggested that they were merely setting up these groups to avoid prosecution under the Competition Act. That selective snippet from the guidance is very far from the truth. Can I, please, take you to the Guidance, which is at core bundle 3. I do not have time to take the Tribunal to the whole of this document, but I would, if you do have time ----

THE CHAIRMAN: Give us the paragraph numbers and we will read them ourselves.

MS. HOWARD: If you do have time to read it, I think it would be instructive as a whole. Could I take you to page 3 ----

THE CHAIRMAN: Do you want to give us the paragraph numbers first?

MS. HOWARD: It is not paragraph numbered unfortunately. It has not been written by lawyers. At the bottom of page 3, there is a paragraph advising members whether to go into independent private practice. It sets out the advantages of additional income over working in the NHS and clinical freedom. Then it carries on:

> "The disadvantages include the additional time spent in practice, out-of-hours and antisocial working, and the need for flexibility. Consultants may also need to be on call for their private patients and will work more often on their own. Anyone doing private practice will be required to pay a higher medical indemnity subscription, have more complicated accounts and must make sure that the private work does not conflict with their NHS contract."

Those disadvantages of having to provide on-call care are very much limited by working within a group. Anaesthetists are different to other medical consultants because their responsibility does not stop at the end of the surgical intervention. They have to remain on call during the post-operative period, which may be between 24 and 48 hours. The reference for that is pp.6 to 7 of this Guidance. That may involve emergency resuscitation and transfer to an intensive care unit where the anaesthetist has to go with the patient.

If you are an independent anaesthetist, that may clash with your NHS contractual duties; or vice versa, you may be with your private patient and you have suddenly got to go and do an emergency on-call in the NHS.

So the main advantages for working in a group are that the consultants can provide 24 hour on-call care for emergencies, which are often life threatening, and they provide that 365 days a year.

The group formation gives them the flexibility to work and schedule rotas in advance, so there is always a member of the group on call to cover, and it shares the burden of out of hours and antisocial hours between the members.

The AAGBI submitted quite a lot of evidence to the CMA which is summarised in Annex A to Appendix 7.1 of the Final Report. Can I just give you some little nuggets for your notes.

Appendix A to the AAGBI response to the Annotated Issues Statement which is the AAGBI survey at, CB2, tab 14, p.20; 78 per cent of groups provide 24/7 call services 365 days a year at no extra charge.

Independents often do not provide these services at all, or if they do they impose an additional charge for them, and in London that can be up to £2,000 a day. Again, in Appendix B to that response at CB2 tab 15, p.2, there is a reference to 84 per cent of groups can get to patients within 15 minutes.

THE CHAIRMAN: Sorry, what was that reference?

MS. HOWARD: Core bundle 2, tab 15, p.2.

THE CHAIRMAN: The Provisional Findings - is that right?

MS. HOWARD: No, this is a summary that the AAGBI submitted as part of its evidence.

THE CHAIRMAN: I do not have that as tab 5 of my bundle.

MS. HOWARD: Sorry, it is right at the back of tab 14.

THE CHAIRMAN: Is that in the survey document again?

MS. HOWARD: It follows on from the survey and is the AAGBI Submission in Defence of Independent Departments of Anaesthesia.

THE CHAIRMAN: Appendix B to the survey.

MS. HOWARD: There is a heading half way down, "Emergency post-operative care, emergency surgery and emergency transfer", and it carries on:

> "Life threatening complications are not uncommon and can occur even after relatively minor surgery … It is standard practice for patients … in NHS hospitals to be attended to rapidly by the anaesthetists … IDAs …"

that is AAGBI's terminology meaning the same as AGs -

"… usually provide reliable and highly experienced emergency care …
78 per cent of IDAs have an 'on-call' rota that is wholly separate … [they] do not customarily charge separate, additional fees for this service."

Then at the last paragraph at the bottom of p.2:

"… [an] average response time of less than 15 minutes for 84 per cent of IDA partners …"

THE CHAIRMAN: Sorry, an IDA is?

MS. HOWARD: It is the AAGBI's terminology for an anaesthetist group. It is an Independent Department of Anaesthesia, but it is the same as an AG. So their response time is less than 15 minutes. 84 per cent of groups can make that target compared to 43 per cent of independent anaesthetists.

MR. GLYNN: It is very clear from this that there are a great many advantages in having these groups, but quite a few of them do not set fees and some of them do. Nothing you have said shows any advantage of setting the fees. Could I press you on that?

MS. HOWARD: That was my next point, which I am coming to. Can I just mention one other benefit and then I can move on to the pricing. The other reason is that anaesthetists will often have specialist fields, so if you have a particular type of intervention you might want a cardiac anaesthetist, or a paediatric anaesthetist, and by working in a group you can tailor the specific skill to the type of operation. Independent anaesthetists are only allowed to work within their clinical portfolio, so they may not be able to offer the full range of services.

Why do AGs need to have a common fee? That is because it creates team cohesiveness. By having a set fee you will also have a common fee sharing arrangement between the members, and that eradicates conflicts about who has done more on-call shifts, who has greater speciality and expertise, and it makes the team work as a corporate cohesive body. It also creates transparency for patients and insurers as it enables them to have a single point of contact and the Group is able to set out single quotations for insurers and patients.

If I could take you back to that guidance ----

THE CHAIRMAN: Well, you have had 13 minutes of your 15, so, no, you can give us the page reference.

MS. HOWARD: That is fine. At p.26 of the AAGBI guidance, core bundle 3, tab 25. That sets out a series of bullet points explaining why it helps patient safety and welfare. There are efficiencies in terms of lower insurance and administration costs, increased transparency by having one fee and "strength in numbers in negotiating with PMIs and hospitals".

We submit that those benefits must be taken into account when assessing the market features and market outcomes, and those were referred to in the decision as we discussed this morning.

THE CHAIRMAN: Yes, thank you.

MS. HOWARD: Could I just mention, they are also recognised by both Nuffield and PruHealth. PruHealth's submissions are summarised in Annex A to Appendix 7.1, and Nuffield also said that these benefits counteracted any possible harm through the increase in fees.

MR. GLYNN: Am I right in thinking about 40 per cent of the groups do not set fees?

MS. HOWARD: That is correct, yes. You will see it in the guidance, they operate more like chambers of barristers where each member will take the work they have done and then contribute to expenses, but then there can be conflicts over how much individual members should be paying.

I am conscious of over-running time, I have very brief points to make on Ground 4 and Ms. Smith has dealt with Ground 5.

On Ground 4 we say that this is really an irrationality challenge, that the AEC test is an evaluative specialist judgment. That has been recognised by the court in the *Barclays* judgment at para. 20(5).

The fact that AXA prefers another conclusion which it says is more reasonable is not sufficient to overturn these findings on judicial review.

THE CHAIRMAN: I think we have had that point made to us.

MS. HOWARD: That is fine.

THE CHAIRMAN: What is your second point?

MS. HOWARD: My second point is that AXA's 'colouring in' exercise is over-simplistic and should not be preferred ----

THE CHAIRMAN: Yes, we have had that point made to us as well.

MS. HOWARD: -- and I just want to make one point which is ----

THE CHAIRMAN: Is this your third point?

MS. HOWARD: No, this is my first point on Ground 4, which is AXA ignores the significance of the price increases which we say for the main part are less than 5 per cent, where total anaesthesia costs represent approximately 2.6 per cent of the total surgery cost. So if you are looking at a hip replacement, or a knee replacement, that increase actually translates between 0.2 per cent and 0.5 per cent of the total surgery cost. We say that is a nominal amount which is not significant in competition law terms and is fully offset by these benefits.

MR. GLYNN: Would you agree that there is, however small, there is a general tendency for prices to be higher in cases where the groups have set the fees?

MS. HOWARD: I think the CMA has said that on the regional assessment there has been a tendency. We cannot deny that there have been some price increases, but it is not clear that each treatment in the table that AXA has submitted is the same. There may be some types of treatment, for example heart surgery, which carry a much greater, heavier risk, and more post-operative care afterwards, so it is hard to unpick and analyse whether these treatments were justified by the degree of risk entailed by the surgery.

THE CHAIRMAN: Yes. You are now using Mr. Robertson's time, so we must stop you.

MR. ROBERTSON: That is fine by me.

THE CHAIRMAN: All right, Mr. Robertson is sacrificing his time to you.

MS. HOWARD: My second point that I wanted to make on Ground 4 is this failure to take account of countervailing buyer power. We say that AXA's arguments that it has a lack of countervailing power are preposterous, first, given their market share compared to that of Anaesthetists Groups; then the ability for patients to shop around and the insurers to use their Open Referral procedures to move patients to another hospital; AXA's and Bupa's position is much more powerful when they have the threat of de-recognition hanging over the doctors. They say: "We have hardly ever de-recognised" but 24% have been threatened ----

THE CHAIRMAN: But if we make a finding that the conclusion reached for the reasons given is irrational, it is clear that the CMA has put various other points which would be relevant to a finding of AEC to one side, so it seems to me that other than on Ms. Bacon's case at its absolute highest as to a presumption, the outcome would be a remission rather than us saying that the only possible conclusion was that there was an AEC, would it not?

MS. HOWARD: It would be a remission, yes. These matters are going to be dealt with in this afternoon's appeal.

THE CHAIRMAN: As I understand the Report, the CMA have put the buyer power issue to one side because they say that they do not need to get into that for the purposes of their Report. If they are wrong about that then there is no determination as to AEC taking into account the buyer power issue, and it seems to me it would have to be a remission rather than us saying buyer power has no role to play.

MS. BACON: That is all we have asked for.

MS. HOWARD: Well on the basis of that we would say we support the CMA, we think there is no irrationality here, and the Final Report should be upheld. I am grateful.

THE CHAIRMAN: Yes, thank you. Yes, Mr. Robertson?

MR. ROBERTSON: Sir, members of the Tribunal. I will be very brief indeed and I will attempt to finish by quarter past 12 in accordance with the timetable.

I have three points to make. The first is as to the intensity of the review to be applied by this Tribunal. You have had submissions on the standard of review, but just to complete the picture, on intensity of review can I take you to the *BskyB* case, authorities bundle 1, tab 15. This was an unsuccessful for review under s. 120 of the Enterprise Act. Section 120 is the equivalent to s. 179 for mergers. This was a challenge to a merger decision. To paraphrase Barack Obama "I know it was unsuccessful, I made it", being led by Mr. Flynn QC and Mr.Beloff QC – Mr.Beloff on this particular point.

The intensity of review is addressed in the judgment of the Court of Appeal starting at para. 28. Unfortunately this report is not paginated, but the key point can be picked up at para.32. The Tribunal rejected Mr.Beloff's argument for a greater intensity of review by this Tribunal and so do we. The Tribunal's reasoning can be picked up at the very bottom of the quoted passage:

> "It is one thing to allege irrationality or perversity; it is another to seek to persuade the Tribunal to reassess the weight of the evidence and, in effect, to substitute its views for those of the Commission."

BskyB was submitting that the expert nature of the Tribunal meant that the Tribunal should be in a position to substitute its inferences for that of the Commission and that was rejected by the Appeal Tribunal and that was followed by the Court of Appeal – you can see that at para. 37.

> "They show that the Tribunal is to apply the normal principles of judicial review in dealing with a question which is not different from that which would face a court dealing with the same subject matter. It will apply its own specialised knowledge and experience, which enables it to perform its task with a better understanding, and more efficiently. The possession of that knowledge and experience does not in any way alter the nature of the task."

And turning the page, the final paragraph 40:

> "Mr.Beloff's argument that the Tribunal, as a hyper-competent specialised tribunal, is bound to apply a greater intensity of review than the court itself would apply in a comparable situation seems to us to fly in the face of the words of s.120(4)."

And the wording of 120(4) is the same as 179(4). So that is my first point.

The second point is to emphasise that the reason why the BMA has intervened in these proceedings is to express our concern that the private medical insurers, AXA and Bupa, are trying to prevent consultants exercising their freedom to practise in partnership or indeed any other form of business enterprise. This is a freedom which all other professionals enjoy; even barristers now have the right to set up as partnerships, LLPs and limited companies through Alternative Business Structures regulated by the Bar Standards Board. So to characterise this as somehow collective price fixing in our submission just does not stand muster. This is just consultants exercising their freedom to practise in partnership. When a partnership sets prices it is not engaging in any anti-competitive price fixing, otherwise it would be price fixing any time a barrister in a previously independent practice joined a law firm and then had his or her fees set by the firm.

THE CHAIRMAN: Would it be any different if the law firm in question had a dominant position in a particular work, do you think?

MR. ROBERTSON: It is still difficult to see how an individual barrister joining that law firm could somehow, by joining a dominant firm, thereby be entering into some anti-competitive agreement.

THE CHAIRMAN: The practice of setting the fee---

MR. ROBERTSON: It would be a separate issue of abuse of dominance but it would not be an Article 101 issue. That comes to our point that the Article 101 analogy simply goes nowhere, and this is the third of the three points that I wanted to make. Ms. Bacon still is attempting to keep this suggestion in play by referring to Article 101 as a parallel or as an echo or something. Section 134 needs to be interpreted in accordance with its own terms. It refers to effect; it does not refer to object. The term "object" does not appear anywhere in the 2002 Act. If you were to look at this under Article 101 the answer is the answer that the OFT gave in 2003 – they are acting in partnership, they are a single undertaking, it does not engage Article 101. We say that that analogy must be rejected.

We have drawn your attention to the previous legislation that the 2002 Act replaced. I am not going to give the Tribunal a tutorial now on the definition of a complex monopoly situation under the 1973 Fair Trading Act; but the point for your note is that when you go back and compare the predecessor to Section 134 it is Section 11 of the Fair Trading Act, the authorities' bundle Volume 2 at tab 27. You will see that that defines complex monopoly situation by reference to Sections 6(2) and 7(2). You will see there that the test was whether goods or services were supplied by a number of unconnected persons who, whether voluntarily or not, and whether by agreement or not so conduct their respective

affairs as in any way to prevent restriction to restore competition in connection with the production of supply of goods or services. That language was complex and it raised an issue about what was meant by conducting respective affairs in any way. The 2002 wording was intended to sweep away that uncertainty and that is why you have the use of the term "features". That was intended to simplify the previous test but it is an effects based test. So as well as the 1973 Act it was effects based going back to the first legislation we had post-war, the Monopolies and Restrictive Practices and Control Act 1948. It has always been effects.

The concept of "object" relied upon by my learned friend Ms. Bacon was unknown to domestic competition law until it was imported from what was then Article 81 EC and is now Article 101 TFEU by the 1998 Act. So it can be seen that there always were two separate and self-standing regimes. There is no basis for importing the object concept into Section 134.

My Lord, those are my submissions.

THE CHAIRMAN: Yes, Ms. Bacon.

MS. BACON: My Lord, can I have three minutes before I start my submissions?

THE CHAIRMAN: Yes.

(Short break)

THE CHAIRMAN: Yes, Ms. Bacon?

MS. BACON: I have handed up hard copies of my reply notes. Accordingly, I will go through my reply submissions a bit faster and give you references where appropriate.

THE CHAIRMAN: Thank you very much.

MS. BACON: I should also mention that on Friday afternoon we did hand up a copy of the Annotated IssuesStatement and I am not going to refer to that, but I wanted to make sure that you were aware or that.

THE CHAIRMAN: I am being told I am aware of that. I will locate it later.

MS. BACON: I take no point on it. The Tribunal asked for it during the course of the morning, and we provided it.

THE CHAIRMAN: Thank you very much.

MS. BACON: I would like to make a few submissions on Ground 3 and Ground 4. Right at the end I think I will need about four minutes in closed session.

THE CHAIRMAN: All right.

MS. BACON: Starting with Ground 3, terminology: you have seen in our Notice of Application a footnote which referred to the fact that we have used various expressions in the course of

our correspondence. In this appeal we have used the term "*prima facie* AEC". We have done that deliberately in order to make clear that we are not saying that there is a legal presumption. Actually, Sir, your suggestion of "evidential expectation" is exactly what we had in mind and what we were expressing with that term, and we would be happy to have our Ground 3 couched in those terms. In all cases, whether one calls it a *prima facie* AEC or an evidential expectation, the point is as we have put it in the Notice of Application. It is the starting point and then one looks to see if there is anything contrary to that starting point. Also, importantly, it is not necessary for the CMA to develop detailed price evidence, and I will come back to that point in a minute. That is the point as we have always put it in the Notice of Application and we are happy to have that couched as an evidential expectation.

I have put it in my notes as to the way that you put it in the afternoon on Friday. Just to take you to the relevant transcript - you do not need to turn up to it, I can give you the reference, it is at the bottom of p.77. My note is perhaps a little bit of an elision because the starting point was actually Ms. Smith's term, and you responded:

> "In other words, distortion of the market and then you look to see whether there is anything contrary to your expectations?"

That is the bottom of p.77 of the uncorrected transcript. We just got that this morning. Regarding the alleged change of emphasis, Ms. Smith fairly accepted in her submissions on Friday afternoon that that is of no relevance, but in any event we maintain the position that we have set out since the Notice of Application and indeed since our letters to the CC, which I showed you on Friday morning.

What is the consequence of adopting that starting point or evidential expectation? The interveners still seem to labour under the false assumption that we are saying that one looks at features and goes no further - in other words, you look at the fact that there are high market shares and collective pricing and stop there. We are not saying that. What we are saying is that by adopting that starting point, or *prima facie* expectation, it focuses, and should have focused, the CMA's assessment on testing whether that expectation was displaced by the other evidence, rather than starting with a blank slate and saying, "We do not know anything, we have to use the pricing evidence to see whether there is a problem here." That is entirely consistent with para.164 of the guidelines, and I have set the relevant point out here, which requires focusing the competitive assessment on testing of theories of harm. While we completely ----

THE CHAIRMAN: Just on that though, if you are looking at CC3, there is the provision that says that the theory of harm does not create a presumption, whereas what you seem to be saying, the force of what you seem to be saying, is that it does.

MS. BACON: We are not saying that there is a legal presumption. We are saying that you take this as your starting point and you test to see whether that is borne out by the evidence or not. Crucially, if you are looking at market outcomes, the question there is the evidence that you may have of market outcomes, such as price, displaces the evidence from your theory of harm in relation to the market features, because it is the market features that are the core part of your analysis. The market outcomes are merely part of the background assessment of the market. This is where we differ from the CMA and the interveners, because they set up evidence of market outcomes as being a prerequisite. Our position is that you take it into account as part of your overall assessment of the market, but that is not dispositive. You do not have to find positive evidence of price effects in order to conclude that there is an AEC.

You, Sir, quite properly, asked me on Friday morning when might then the *prima facie* evidential expectation be rebutted? As I have explained to you, we accept that in some cases the CMA might legitimately conclude that there is no AEC following analysis of market outcomes and everything else - for example, if further analysis showed that there were no barriers to entry in a dynamic market.

THE CHAIRMAN: Is it not a short answer to my question to you that it is the countervailing factors rehearsed at para173 and following in the CC3?

MS. BACON: Also, yes, one can take them into account. If those displace the evidential expectation of *prima facie* AEC then we would accept that the CMA could conclude that there was ultimately no AEC. That is why we use the term "*prima facie*", and that is why we are not saying there is a presumption or an object case.

That raises AAGBI's point about benefits, and I want to just make four submissions on that. Firstly, we accept that there may be benefits from group formation, not only to the anaesthetists themselves but more generally, and we have not disputed that. It is a "may be benefits".

Number two, in our correspondence with the CC we emphatically rebutted the suggestion that those benefits justified collective pricing. I can give you the reference to that. It is our letter of 23rd September 2013, which I took you to on Friday morning. It is in volume 3, tab 17, pp.2 and 3. We made the points there, and you can read those. I do not want to take up time doing that. We made the point there that whatever the claimed deficiencies, these did

not mean that one had to set a collective price. One can see it in relation to barristers' chambers. We have many of the same efficiencies, but there is not a collective schedule of fees, and there does not have to be.

The third point is that, in any event, the CMA did not make any findings of benefits in this regard, let alone make a finding that those benefits outweighed or trumped the other considerations, such as to displace the AEC finding. In particular, there is nothing at all in the Report about team cohesiveness - for example, justifying a collective schedule of fees. In any event, that point about team cohesiveness is undermined by Ms. Howard's own point about some anaesthetists not always adhering to the fee schedules, which is a point we accept.

The fourth point is the point about legal structure requiring analysis of benefits, or not, as in fact the case is. Ms. Howard just gave you the reference in passing to s. 134(8) of the Enterprise Act, but actually this makes my point for me, because what this says is that the relevant benefit goes to deciding the question in sub-section (4), which is the remedies question. If you wanted to look at it, it is tab 29 of authorities bundle 2, p.179 in the top right corner. So the discussion of relevant customer benefits as far as the Enterprise Act is concerned comes in relation to the question which is logically subsequent to the question of whether there is an AEC, which is whether action should be taken.

The Enterprise Act itself envisages that the question about relevant customer benefits should be taken into account at the remedy stage and not at the AEC stage. In any event, my primary point is that none of this was in the Report.

Sir, that was all I wanted to say in relation to rebuttal of the *prima facie* AEC and the relevance of benefit.

Can I now come to the CMA's main arguments contrary to Ground 3, and there were a few points that were made on Friday afternoon. The first is that there is a distinction between a market feature and a market feature that prevents, restricts and distorts competition.

Ms. Smith made the somewhat surprising, I thought, suggestion that high market shares and collective pricing were market features, but they were not market features that distorted competition. I say "surprising" because one would have thought that on the basis of standard principles of competition law, *prima facie*, at the very least one would think that a high market share and collective pricing within that high market share did distort competition, because it means that there is no competition within a group that occupies a very large part of the market, so across a large part of the market there is no price competition when there would otherwise have been.

Indeed, the position that a high market share of its own cannot distort competition contradicts the CMA's own guidance in the paragraphs that I have set out on p.3 of my note, and I do not need to take you to them. At numerous points in the CC's own guidance, the point is made clear: on its own a highly concentrated market may distort competition. I am not saying it always will, but that that is the evidential expectation: if you have a high market share and collective pricing within that, normal principles of competition law and particularly the echo or parallel with the way that one looks at this under Article 101, would suggest that there was a distortion of competition.

The second argument from the CMA, and this is point 6 in my reply note, is related, and what they say is that, because you cannot presume that the high market share and collective price distorts competition, you look for the harm to competition in the price effect. In my submission, that makes the very confusion that we identified in our Skeleton Argument, and I identified in my opening submissions, between indicators and features. A price effect, according to the guidelines themselves, is an indicator of an AEC, not the AEC itself. So, effectively, what the CMA is doing is setting up evidence of market outcomes, as I have said, as a prerequisite for a finding of an AEC, and that, we say, is a manifest misdirection as a matter of law.

The third argument which came towards the end of the submissions on Friday afternoon is the claim that nothing in the structure of the analysis of s. 134 requires that the market features giving rise to a theory of harm are given any sort of weight. My response is, that is contradicted by s. 134 itself, which refers to the decision of whether a feature or features of a relevant market give rise to an AEC. We know that from the start it is all about market features. Then the guidelines make clear, and this is a passage I have cited at the top of p.4 of my note, that the core task of the CC, given the statutory questions, is to assess the effects of possible features on competition. So they are already described there as the centrality of the assessment of the adverse effect on competition.

So in this case the theory of harm was not simply a blank slate, but the CMA started with evidence as to the functioning of the market, indeed mostly evidence that came from AAGBI itself, and that is the evidence that we have set out in our Notice of Application at paras.59 to 67. That was the starting point that created the evidential expectation and formed the background to the evidential expectation, or *prima facie* AEC that we said arose in this case.

There is one more point on Ground 3, which is Mr. Glynn's question, and I must confess that when initially asked I was not quite sure what it meant, but I think we have worked it

out, and this is my error. You asked me whether the CMA was or should be concerned with only the intra-group loss of competition, or also the group versus the outside world, if you like. There are two kinds of restriction of competition going on. Ms. Smith has explained to you that although the CMA was concerned to look at the loss of competition intra-group, they did not actually measure it. My response is that that is right, they focused on the group versus outside world, and that is what they did when comparing their average price rises. We totally accept that if such evidence is available that is relevant to an AEC finding, but it is not a pre-requisite. But, even if, and I think this is the crux of your question, which I failed to appreciate on Friday morning, even if the evidence did indicate that there was no rise in average prices, in principle that would still be a problem, that the CMA should be interested in. The CMA should not say: "We are not going to do anything about this, it is still something that they would be concerned about because it would affect the pattern of prices."

So, your question actually recognises the point that we are making under Ground 3, which is that competition is not just about the level of prices – group versus outside world – but it is also about the process of rivalry in setting the level and the structure of prices within the group and so group price setting interferes with both of those competitive dynamics, and that is one of the economic reasons that underlines our argument on Ground 3.

Can I turn then to Ground 4. The first question, and I think a very important question is what did the CMA decide? There are two possible answers to this. One is that on the available evidence the CMA decided that there was no AEC, and I accept, following the interchange between you, Sir, and Ms. Smith, that a slight variant of this could be a finding that we do not find that there is an AEC, but that is still a positive decision. It is a decision that answers the statutory question of whether there is an AEC, the answer is that, no, we have not found that there is an AEC or, as the CMA put it quite clearly in its Defence, in the paragraph I have cited there, a positive finding that there was no AEC.

The other type of decision is a decision that we have decided not to investigate this further, which is a non-finding, and in my submission one cannot elide the two questions. One is an answer to the statutory question in relation to the relevant theory of harm taken on the balance of the evidence. It is saying we have looked at all of the evidence available, and this is our conclusion. The other is saying we have not looked at all of the evidence available and we do not reach a positive conclusion.

THE CHAIRMAN: No, they say it is not available, and we are not going to devote the resources to get the additional evidence.

MS. BACON: In my submission, they did not say the evidence was not available. They quite clearly said there was evidence available and we are not looking at it. But if I can just develop the point.

THE CHAIRMAN: I have to say I do not see how you can get that out of 7.40 and 7.41 in the Final Report.

MS. BACON: I do not get it out of 7.41. I get it out of para. 7.38, where they say we have evidence on barriers to entry. But the pleaded case is a positive finding, they looked at all of the evidence and they say, having considered all of the evidence, and this is in the Skeleton Argument, and again in the Defence: taking account of all the evidence, we decided that there is no AEC. That is what they say and that is what they maintain in this hearing.

If you look at the passages of the Report, what they actually say is we did not look at all of the evidence. We had evidence on barriers to entry but we did not look at them, we did not prioritise our resources, and that is clearly set out in para. 7.38.

THE CHAIRMAN: 7.38 just says: "Bupa and AXA PPP commented on barriers to entry". That does not say: "We have all the evidence that would be required for us to make the conclusion."

MS. BACON: I am not saying that. I am saying that they did not look at the evidence available to them. I have taken you to our letter of December 2013, where we set out quite a lot of detailed evidence on barriers to entry at the request of the CMA. What the CMA is saying here is AXA provided that[in response to our request] but we have decided not to look at it. The point is made very clear in ----

THE CHAIRMAN: Decided not to look at what?

MS. BACON: The evidence that AXA provided.

THE CHAIRMAN: No, they do look at it, and they say, actually we have been moved off our preliminary view that there were no barriers to entry. We accept in the light of what AXA said there may be barriers to entry, but then they go on and park that issue because they say for other reasons we do not need to investigate that further.

MS. BACON: Actually, they do not say that. They have, in fact, abandoned their provisional view, but all they say is we have decided not to prioritise our resources in carrying out a detailed assessment. That is all they say. They do not make any conclusions one way or the other, and the Defence makes that even clearer, because in para. 147 of the Defence, the CMA says this is its pleaded case. The CMA did not consider PMI buyer power, for the same reason that it did not consider barriers, namely, the inconsistent picture relating to

price and the relationship between market share and price; that is its pleaded case. It is saying we did not consider two things which we have already said are relevant to consider if we are going to form a view as to whether or not there is an AEC.

The Report says, at para. 7.21, and this is the rejection of our Ground 3 point, they say when rejecting the ground point that you cannot presume an AEC, and then they say:

> "In assessing whether there is market power, we will consider market share changing over time, market outcomes … as well as the structure of the relevant market including the nature of any barriers to entry and countervailing buyer power."

So they say there quite clearly we reject your argument on Ground 3 because in deciding the statutory question, i.e. whether there is market power, we have to consider all these things. Then they go on to say we did not consider barriers to entry, and they say it again, and emphatically so in the Defence. We did not consider barriers to entry, we did not consider buyer power, and the reason because we reached conclusions on price adjusting and mixed picture.

So all I get out of this is in the Report itself is it is stated clearly that the CMA did not consider the things which, earlier on, they say they have to consider in order to reach a final decision, and that is why we read the Report as actually being a finding that they are not going to make a decisive finding one way or the other.

The point comes actually quite clearly from 7.40 when they say: "However, to identify such local areas and whether such market power adversely affects competition" [i.e. the statutory question] "would require a detailed area-by-area competitive assessment."

So that is why we say this was a non-finding, but actually even if you accept the CMA's case that actually they were trying to reach the decision that there was no AEC, these passages of the Report make very clear that that finding was untenable, because they have already said that in order to find out whether there was an AEC – they said it twice in para. 7.40 and 7.41 – in order to find out whether there was an AEC we have to do X, Y, Z. Then they said: we did not do X, Y, Z. We did not do any of those things. So if they are saying that the material in front of them supports a decisive finding, taken on all of the evidence, and that is what they say in their Defence, a decisive finding on all of the evidence, looking at it on the balance of probabilities as to whether there is AEC, their own Report admits that they did not take into account relevant considerations.

Quite apart from that, even if you set that to one side and ignore for the time being the fact that they did not take into account barriers to entry and buyer power, we say that on the

price evidence before them their decision was untenable, because it is clear that the centrality of their decision, however you couch it, whether it is a decision as to no AEC, or a decision that they are not going to take this further, the crux of their assessment on this was focused on the price evidence, and that is the reason that they give both in the Report and in the Defence for not looking at buyer power and barriers to entry.

But if a decision does rest on the price evidence, we say it cannot remotely support a decision that there is no AEC in respect of any of the 11 local markets examined by the CMA. Today Ms. Smith has accepted my point that this is about looking at local markets, not totting up across the aggregate of the different markets. I must confess, we read the Defence differently, and there are passages in the Defence which make it quite clear that the CMA is relying on mixed, or less compelling evidence in some markets – they say D, E and F – to justify not taking matters further in A,B and C. But, let us suppose I take Ms. Smith's submissions today at face value. She is not totting up, you do therefore need to look at a column by column analysis and in our submission the diagram, the table which is the best presentation that we have of all of the available evidence, clearly demonstrates that they could not say on the price effects that there was no AEC.

I take Ms. Smith's point that, of course, when you are presenting things in tabular form one may miss nuances, but in my submission, we have gone away, we have included the expanded information that you wanted, which is where there was a case when one data point pointed the other way, what was the reason for that, was it actually that it was lower, or was it that there was no data. We have included that in the expanded table and, in my submission, the picture is still a very compelling one.

Ms. Smith says the table does not take into account the nuance in the analysis of the CMA. With respect we have encapsulated on the table the information that is given in the Report. As far as I am aware Ms. Smith did not dispute it today. We have got all the evidence in the Report on this table accurately, in that we have accurately stated whether the price point went up or down and by how much where we know what that is. The advantage of presenting something in visual form is the same for doing any kind of diagram; if you do not do so you risk not being able to see the wood for the trees. The reason why, for example, you have scatter diagrams with a trend line drawn between them is if you look at individual data points without looking at the aggregate you do not see what the trend is. So the reason for doing this table was to show you the directional trend, and to make sure that one sees overall, okay, there may be some data points that go the other way but where we

put a red triangle that indicates that the preponderance of this price analysis set indicates one direction or another.

Ms. Smith drew attention to the fact that, for example, in relation to cell 4(b) in case study B we put a red triangle where we say that the group had higher prices for two out of six, close for two out of six and low for two out of six. We have done the red triangle because the weighted average is plus two; and we have done the same against ourselves in relation to case study D where if you just looked at the narrative, group higher for three out of six and lower for three out of six, you might say that on balance that is showing consistency of prices rather than one direction or another; but actually the weighted average is minus nine so we put a green triangle.

So what the red and the green shows you is the direction of the preponderance of the data in each set that they looked at and as far as I am aware Ms. Smith has not disputed it and that is accurate, and what it shows is that for all of these, save for one, the preponderance of the data on every piece of analysis carried out by the CMA showed overall a price effect. There may be a few that went the other way in terms of individual data conscripts, for example the minus two in relation to case study A on one of the treatments, but those are few and far between. The preponderance of the data is red and that is what we see from this table in the same way as you can see a trend from a scatter diagram with the tramline drawn through it.

In any event you will recall the points that I made on Friday and the points that I have made just now about the statutory test and what CC3 requires in terms of price evidence, and it is that the price evidence can indicate an AEC that is not decisive; it is not a prerequisite for an AEC finding.

Ms. Smith also says what this table does not do is it does not address the lack of consistency between the market players and the results. The point about non-linearity is a point that I addressed in opening and we have given the reasons why one cannot expect as clear linearity an absolute consistency in paragraph 68 of our Skeleton Argument, and I do not need to repeat the points here. But one point I should make is that if Ms. Smith is looking for causation between formation of the group and the price effect, one case study analysis that tested causation is the pre- and post-event analysis. I described it as the DNA of the price evidence on Friday. That, by looking at the differences in differences, did test the effect of group formation and when one sees that the CMA was able to do that for the six sample treatments – and this was the case studies A to C – the data pointed overwhelmingly in favour of a price effect. Only two individual treatments in the entirety of its analysis come out green – that is one treatment in case study A and one treatment in case study B; all

of the rest show a price effect. So that is the litmus test; this is the one piece of analysis that really did test as far as the CMA was able to for causation.

I accept – and we had an exchange on Friday – it may not be completely untainted; it may be tainted to some extent by the problems about shadow pricing and the blended price comparator, but the best we have.

To say that the figures are not significant suggests that there is something in the guidelines or in the Report which indicates that the CMA is only going to find an AEC if the data points come out as being over a particular level, and there is nothing there. Indeed, if that were the test one would strike out the two green data points because they are tiny.

So if that is the CMA's litmus test one leaves this with actually only red data points because you have to strike out all of the triangles that are representing only a very small price difference. What you are left with in relation to A, you have two very significant price effects; in relation to B the same; in relation to C they are all significant. Overall, as I have said, if you take an un-weighted average for each of those cells you come out with un-weighted average of more than five per cent which, on any view, has to be regarded as significant.

Ms. Smith's third point in relation to this is that these were the worst examples. These are the worst examples, we accept that, although I did say that we have identified we think two of our worst example groups which were not tested in the 11. Leaving that aside it is not surprising then if these were the worst examples that you get such consistent results.

That links the fourth point which is she said there were problems with the data. Yes, there were problems with the data but as I have explained if anything that resulted in a bias against showing a price effect; so given that there was an inherent bias against showing a price effect it is all the more remarkable that this set of data is so consistent in showing price effects.

So in relation to the claim that there was a decision that there was no AEC on the balance of the evidence, which is a claim that the CMA repeats today, that can only be tenable if two things are true – and this is the proposition I have set out at the top of my page 8. Firstly, the price evidence was genuinely inconclusive for every area under investigation. Number two, evidence of price effects, as a matter of law, is a prerequisite of an AEC finding such that it trumps all other factors and means that if you find that there is no price effect you can then stop there and not look at barriers to entry and buyer power.

Neither of those is correct. Number one, the Report did not say the price evidence was genuinely inconclusive in every area. Even in relation to the CMA's own assessment the

CMA said there were consistent effects for area C and we say to say that there were mixed effects for some of the areas simply cannot be reconciled by the CMA had before it; they were not mixed. Or to say, for example, that D, E and F conclusively, all of them pointed in the direction of no price effects. It cannot be reconciled with the picture that you have before you of the evidence. In any event, the Report did not say that the price was inconclusive in every area under investigation. Number two: if it is suggested that evidence of price effects is a prerequisite of an AEC, which is what the CMA seems to be suggesting, that is a proposition that is absolutely and unambiguously wrong as a matter of law on the basis of the statutory test and the CMA's guidelines.

So if the CMA did adopt the decision that there was no AEC actually the Tribunal does not need to look at Ground 5. Ground 5 is only there if the Tribunal decides, contrary to the CMA's pleaded case and contrary to the position that they have maintained in this hearing, that there was a non-finding, it is only then that we say you were not entitled to adopt a non-finding.

So if the Tribunal accepts the CMA's characterisation then you do not need to decide Ground 5, you only need to decide the rationality on the basis of the points I have just made to you. If you do consider that actually reading the Report fairly the CMA did not reach a positive conclusion then the Ground 5 point about breaches of the statutory duty does arise but it arises in the alternative; so you equally do not have to decide it if you are with me on rationality. So it is the icing on the cake, indeed it is the fairy on the top of the icing on the cake.

The point is this: in relation to the non-finding case our starting point is that that still rests on the irrational assessment of the price evidence. So if you are with me on that you do not have to go further. Even if you wanted to look at it and look at the statutory duty point we say that it is quite clear that the CMA was not entitled to stop there because one cannot accept these vague claims of time and resources constraints. The CMA did not just run out of time; it had carried out a detailed area-by-area assessment of price for six local areas and that detailed area-by-area assessment is set out in the Report and is reflected on this table. So it is nothing to the point to say we would have to look at it area by area; they did that and they did that in great detail and they had already done that right to the stage of the Annotated Issue Statement for some of the groups. So they had already started doing it then and they carried on doing it. They had been provided with evidence on barriers to entry and as I have shown you the position in relation to that is not that they ran out of time but they candidly admit and plead in their Defence that they did not consider barriers to entry

because of the relationship between market share and price and what they claim is an inconsistent picture related to price. So they are conceding actually that quite far from the suggestion of running out of time they did not consider their themes that they would have needed to do, and the reason why was their mixed picture on price as they assessed it. You will also recall that, in any event, they did not need price evidence on the basis of the statutory test and the guidance. Price evidence, if it had been available, was relevant, and could be taken into account, but it was not a prerequisite. So, again, there is no basis for saying, "We need all this further evidence and we did not have it", because actually, even if there were some data points missing from their price analysis that cannot justify a failure to take into account all the evidence before them on the balance of probabilities and say, "There are some data missing, but look, we have got this and actually on the preponderance the price evidence points one way or the other". That is something that they could have done, and they had very substantial price evidence for at least three areas where they were able to carry out their own best case analysis, which is the pre-and post-event analysis. They had significant price evidence also for groups E and F even if they could not do that DNA test on groups E and F. So even if price evidence had been a prerequisite, which it clearly was not, they could have proceeded on that basis and carried out a proper assessment of these and reached a decision one way or the other.

We have said in our Notice of Application that we accept in some cases it may be appropriate for the CMA not to explore a particular issue further. One example not given there, but I think it should be mentioned, is that, for example, if this point had been raised very late in the day during the market investigation. It was not. This was an issue that was, from the outset, recognised as a significant issue. There was no suggestion that because anaesthetists' fees were small in relation to the overall fees, this was a nominal or trivial issue. That was not accepted by the CMA. The OFT and the CC and the CMA all pursued this as an important issue in its investigation. In our submission, there was plainly enough evidence to take a decision one way or the other on the balance of probabilities. What you have here is a classic fudge that the CMA decided to adopt a decision that pursuing this line of enquiry was not justified, rather than setting out, in our view, a proper decision in the Report on a balance of probabilities on all of the available evidence before it. In our submission, if that is the correct interpretation of what the CMA did that was irrational and a breach of statutory duty, but you can decide for me on irrationality alone if you do not want to go down the route of setting out what the CMA can and cannot do in relation to prioritising its resources.

I have a few other pick-up points before I get to perhaps four minutes in closed session.

One is the point about market shares made by the AAGBI and the different market shares.

THE CHAIRMAN: Are you saying that you want to go into closed session for your last four minutes?

MS. BACON: I will, yes.

THE CHAIRMAN: All right.

MS. BACON: Before I go into closed session I had a few points I wanted to pick up.

THE CHAIRMAN: I think you are in your last four minutes.

MS. BACON: It is going to be even shorter than four minutes.

THE CHAIRMAN: You decide how you want to do it.

MS. BACON: The only point I wanted to make on market shares is that the CMA refers in its Defence at para.113(c) specifically to market shares. You may have characterised its finding as being market shares, but there is absolutely nothing at all in the Report that suggests that these groups have market shares in the region of 5 per cent as the AAGBI says.

The point that anaesthetists still face competition from outside, this is a point that if you are lying on the operating table you cannot at that point decide that you are going to go to another anaesthetist, because you rather prefer their fees somewhere else. As the CMA noted from the start and as the OFT noted from the start, the choice of anaesthetists is driven by the surgeon at a particular hospital.

That is all I wanted to say on AAGBI. My final point before I go into closed session: this is not a merits challenge. We have not brought a merits challenge, we are not simply disagreeing with the weight. We say this was a perverse, a manifestly and blatantly perverse, decision. We do, therefore, make an irrationality case, and we have also made a case under Grounds 3 and 5 on errors of law.

For closed session I have got two or three minutes.

THE CHAIRMAN: Very well. We will go into closed session now, and those not within either one or other confidentiality rings should leave the court room.

MS. BACON: I am sorry, I have been speaking very fast but I hope that it is captured on the transcript.

THE CHAIRMAN: You have given us your written note as well, thank you.

(For closed session, see separate transcript)

THE CHAIRMAN: We will obviously rise. We will obviously reserve our ruling on this case. It remains for me to thank all counsel involved in this appeal for their assistance. We will rise now.

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