Neutral citation [2015] CAT 5

IN THE COMPETITION APPEAL TRIBUNAL

Case No: 1228/6/12/14

13 March 2015

Before:

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

Sitting as a Tribunal in England and Wales

BETWEEN:

AXA PPP HEALTHCARE LIMITED

Applicant

-v-

COMPETITION AND MARKETS AUTHORITY

Respondent

-and-

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

Interveners

Heard at Victoria House on 23 and 26 January 2015

JUDGMENT

A P P E A R A N C E S

Ms Kelyn Bacon QC and Ms Sarah Love (instructed by Linklaters LLP) appeared for the Applicant.

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

Mr Aidan Robertson QC (instructed by the Legal Department) appeared for the British Medical Association.

Ms Anneli Howard (instructed by Hogan Lovells International LLP) appeared for the Association of Anaesthetists of Great Britain and Ireland.

I. INTRODUCTION

1. This is the judgment on an application made by AXA PPP Healthcare Limited ("AXA PPP"), one of the UK's leading private medical insurers ("PMIs"), under section 179 of the Enterprise Act 2002 ("the 2002 Act") to challenge parts of the report produced by the Competition and Markets Authority on its investigation of the provision of private healthcare, *Private Healthcare Market Investigation: Final Report* (2 April 2014) ("the Report"). The market investigation was conducted by the Competition Commission, whose role was then taken over by the Competition and Markets Authority: in this judgment we refer to them compendiously as "the CMA". The market investigation was carried out pursuant to a reference to the CMA made by the Office of Fair Trading ("OFT") on 4 April 2012.

2. The Report considered various aspects of the privately-funded healthcare market, including the provision of hospital services, consultant services and information availability. For the purposes of this application, we are concerned with the formation of consultant groups - specifically, anaesthetist groups. AXA PPP challenges the CMA's assessment of anaesthetist groups, as a result of which it found that the formation and operation of such groups did not give rise to an adverse effect on competition ("AEC") for the purposes of section 134 of the 2002 Act. AXA PPP contends that this conclusion was flawed. The CMA should not have terminated its investigation on the basis of the evidence it had obtained. On the evidence available, there was at least a *prima facie* appearance that there was an AEC, and the CMA should have continued to investigate the matter in order to see whether there were any countervailing factors which might justify it in finding that there was no AEC in any of the relevant local geographic markets despite that appearance. AXA PPP says that the CMA acted unlawfully in concluding that there was no AEC at the initial stage that its investigation had reached and acted irrationally in its approach to the price evidence on the basis of which it reached that decision. AXA PPP contends that the CMA had a legal obligation to carry out a further assessment before reaching any conclusion one way or the other on the question whether any AEC existed.

3. We should mention that AXA PPP's application under section 179 also extended to another part of the Report, regarding provision of private hospital services. Grounds 1 and 2 of AXA PPP's application related to this. However, the CMA has undertaken to reconsider relevant parts of the Report relating to that matter, so Grounds 1 and 2 have been stayed.[1] The Grounds of the application which were live before us at this hearing, in relation to anaesthetist groups, were Grounds 3 to 5. Although advanced as distinct Grounds, they also have a combined effect.

4. Grounds 3 to 5 are as follows:

   (a) By Ground 3, AXA PPP claims that the CMA failed properly to recognise that there was a *prima facie* AEC in relation to at least some local markets by reason of the formation and operation of anaesthetist groups in those markets, where a group has very high market share and there is evidence that it collectively sets prices, and the CMA had failed to identify any adequate reasons or evidence to displace the presumption that there was an AEC.

   (b) By Ground 4, AXA PPP claims that the CMA's assessment of the evidence on which it did rely as the basis for its conclusion that there was no AEC, namely its analysis of whether the formation of anaesthetist groups had led to higher prices, leading to the finding that the results of that analysis were "mixed" and were not such as to support a determination that there was an AEC, was irrational. AXA PPP submits that, in fact, the evidence assembled by the CMA demonstrated that the formation and operation of anaesthetist groups had led to an increase in prices in at least some local markets, so either this evidence did not displace the presumption for which it argued under Ground 3 or it positively tended to show that there was indeed an AEC in at least some local markets, and the CMA had not done any further analysis which would be capable of displacing such a conclusion.

[1] See the Tribunal's Ruling of 23 December 2014 ([2014] CAT 23) and Order of 12 January 2015.

(c) By Ground 5, taken alone or in conjunction with Ground 4, AXA PPP submits that the CMA breached its statutory obligation under section 134(1) of the 2002 Act to find whether there was an AEC; it failed to make a relevant finding, and was obliged to continue its investigation and to make further assessments in light of other evidence presented by the PMIs before it could conclude that there was no AEC in any relevant market.

5. At the hearing, Ms Bacon QC for AXA PPP explained that by the reference to a *prima facie* AEC or presumption of an AEC she simply meant that in the circumstances identified by the CMA in relation to at least some local areas, where there was a very high market share for a particular anaesthetist group (in certain areas, the share of anaesthetist services provided at particular hospitals was over 60% and even in a couple of cases at or over 80%) combined with collective price setting by the anaesthetists in that group, there was a clear evidential expectation, arising from ordinary application of economic theory, that an AEC exists. That is to say, in such circumstances there was an evidential presumption, though not a legal presumption, that an AEC exists; and no evidence obtained nor assessment made by the CMA was sufficient to displace that evidential expectation or presumption such as to allow it to conclude that, contrary to such expectation, there is no AEC.

6. Although AXA PPP's position is that an AEC exists in some local markets, Ms Bacon accepts that if the CMA had undertaken further analysis, it might have found that circumstances were such as to indicate that, contrary to the expectation that an AEC exists by reason of high market share and collective price setting, in fact none does. The CMA's Guidance document, *Guidelines for Market Investigations: their role, procedures, assessments and remedies*, CC3 (revised), April 2013 ("CC3"), to which all parties referred as containing lawful and relevant guidance regarding assessment whether an AEC exists and the procedures to be followed by the CMA in conducting a market investigation, makes it clear that there may be countervailing considerations which, upon analysis, may show there is no AEC even when an economic operator has unilateral market power: paras. 173 et seq. Ms Bacon's submission was not that the Tribunal should conclude that the CMA acted unlawfully and irrationally in failing positively to find that an AEC

exists, because only one conclusion was possible on the material available to it, but rather that the CMA had acted unlawfully and irrationally in failing to investigate further before coming to such conclusion (or, as Ms Bacon contended, non-finding) as it did. Accordingly, if AXA PPP succeeds on any of its Grounds of challenge, the remedy it seeks is for the matter to be remitted to the CMA for it to carry out further investigation and analysis of the position.

7. Against this, the CMA contends that it did carry out an appropriate investigation into whether an AEC existed in any local area; there is no presumption that an AEC does exist in any local area, even where there is a high market share for an anaesthetist group and evidence of collective price setting within that group; it could lawfully and rationally conclude that the results of its price analysis were "mixed" (in the sense of giving results which were so varied as not to support, or not to support in any very weighty manner, the hypothesis that there might in fact be an AEC in such areas); it was rationally entitled to conclude that the time, resources and effort which would be involved in investigating further in relation to local areas whether there might in fact be an AEC would be disproportionate and unjustified in light of the speculative and limited benefits which might flow from that in terms of clarifying the position; it did make a relevant finding sufficient to discharge its duty under section 134 (namely, that on the material available from its investigation it could not conclude that there was an AEC); and in these circumstances it had acted lawfully and there was no flaw in the analysis or conclusion reached in the Report.

II. THE LEGISLATIVE FRAMEWORK

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

> "**134 Questions to be decided on market investigation references**
>
> (1) The CMA shall, on an ordinary reference, decide whether any feature, or combination of features, of each relevant market prevents, restricts or distorts competition in connection with the supply or acquisition of any goods or services in the United Kingdom or a part of the United Kingdom.
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> …

(2) For the purposes of this Part, in relation to an ordinary reference, there is an adverse effect on competition if any feature, or combination of features, of a relevant market prevents, restricts or distorts competition in connection with the supply or acquisition of any goods or services in the United Kingdom or a part of the United Kingdom.

…

(3) In subsections (1) and (2) "relevant market" means—

(a) in the case of subsection (2) so far as it applies in connection with a possible reference, a market in the United Kingdom—

(i) for goods or services of a description to be specified in the reference; and

(ii) which would not be excluded from investigation by virtue of section 133(2); and

(b) in any other case, a market in the United Kingdom—

(i) for goods or services of a description specified in the reference concerned; and

(ii) which is not excluded from investigation by virtue of section 133(2).

(4) The CMA shall, if it has decided on a market investigation reference that there is an adverse effect on competition, decide the following additional questions—

(a) whether action should be taken by it under section 138 for the purpose of remedying, mitigating or preventing the adverse effect on competition concerned or any detrimental effect on customers so far as it has resulted from, or may be expected to result from, the adverse effect on competition;

(b) whether it should recommend the taking of action by others for the purpose of remedying, mitigating or preventing the adverse effect on competition concerned or any detrimental effect on customers so far as it has resulted from, or may be expected to result from, the adverse effect on competition; and

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

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

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

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

(6) In deciding the questions mentioned in subsection (4), the CMA shall, in particular, have regard to the need to achieve as comprehensive a solution as is

> reasonable and practicable to the adverse effect on competition and any detrimental effects on customers so far as resulting from the adverse effect on competition.
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> (7) In deciding the questions mentioned in subsection (4), the CMA may, in particular, have regard to the effect of any action on any relevant customer benefits of the feature or features of the market or markets concerned.
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> (8) For the purposes of this Part a benefit is a relevant customer benefit of a feature or features of a market if—
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> (a) it is a benefit to customers or future customers in the form of—
>
> (i) lower prices, higher quality or greater choice of goods or services in any market in the United Kingdom (whether or not the market or markets to which the feature or features concerned relate); or
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> (ii) greater innovation in relation to such goods or services; and
>
> (b) the CMA or (as the case may be) the Secretary of State believes that—
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> (i) the benefit has accrued as a result (whether wholly or partly) of the feature or features concerned or may be expected to accrue within a reasonable period as a result (whether wholly or partly) of that feature or those features; and
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> (ii) the benefit was, or is, unlikely to accrue without the feature or features concerned."

9. At the time of the private healthcare market investigation, section 137(1) of the 2002 Act required the CMA to prepare and publish its report within two years of the date of the reference to it by the OFT, on 4 April 2012. There was no power for the CMA to extend this time limit for publication: section 137(4). (The time limit has since been reduced to 18 months, although there is a power to extend the period by six months in special circumstances.)

10. This is relevant to the assessment made by the CMA of how far it ought to pursue any particular aspect of its market investigation. The requirement that it report within two years of the reference powerfully underlines in this context the position under general public law, that a public body such as the CMA has a degree of discretion in deciding how far to carry particular lines of inquiry before arriving at relevant findings to be set out in its published report. As is evident from the Report, the private healthcare market is a complex one with many disparate elements and various possibilities of AECs arising in several different contexts; the CMA's resources are limited and it had to take decisions as to how to prioritise

use of those resources as between those different elements in undertaking its market investigation of that market (as well as in relation to undertaking its other statutory tasks running alongside that investigation); and the decisions to be taken in that regard had to take account of the two year limit for reporting. The width of the discretion available to the CMA in making such decisions was confirmed by the complexity of the overall task which it had been set under the legislative framework and the limited time allowed for it to complete that task: difficult choices had to be made to ensure that the overall statutory obligation on the CMA was complied with.

11. The Guidance in CC3, the lawfulness of which was not challenged by Ms Bacon, confirms that the CMA has a discretion in deciding what tasks to prioritise and how to allocate its resources between those tasks. Para. 36 provides as follows:

> "36. The CC only carries out analysis that it considers necessary so as to reach a decision on the statutory questions. As the CC scrutinizes evidence, it will prioritize the uses of its resources to undertake as wide and as deep analyses as appropriate."

There is a footnote to that paragraph, which states:

> "The need for the CC to focus on the bigger issues in reaching a decision on the statutory questions has been underlined in Competition Appeal Tribunal (CAT) judgments: in *Barclays Bank plc v Competition Commission* (2009), CAT 27 (paragraph 21); citing *Tesco v Competition Commission* (2009), CAT 6 (paragraph 139), the CAT wrote: 'the depth and sophistication called for in relation to any particular relevant aspect of the inquiry needs to be tailored to the importance or gravity of the issue within the general context of the Commission's task.' This proposition was labelled 'double proportionality' in the CAT judgments."

12. CC3 explains how the CMA approaches the analysis to determine whether there is an AEC, including in particular by carrying out a competitive assessment of the relevant market (Part 3: Section 3, paras. 154 et seq.). It will assess "structural features" and "conduct features" separately and in combination (paras. 157-162). Potential sources of competitive harm include "unilateral market power (including market concentration)" (para. 170). However, even if a potential source of harm exists, there may be countervailing factors which indicate that no AEC exists. These include the positive effects of efficiencies associated with a particular market feature, which may outweigh the harmful effects of that feature; the

prospect of entry or expansion, if there are no significant barriers to entry; and countervailing buyer power (paras. 173-176).

13. Para. 319 of CC3 explains that "[h]aving considered evidence of all kinds, the [CMA] comes to a rounded judgement on what may be causing any adverse effects on competition"; and states:

> "In forming its judgement the [CMA] will apply a 'balance of probabilities' threshold to its analysis, ie it addresses the question: is it more likely than not that features or a combination of features lead to an AEC?"

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

> "**179 Review of decisions under Part 4**
>
> (1) Any person aggrieved by a decision of the CMA … in connection with a reference or possible reference under this Part may apply to the Competition Appeal Tribunal for a review of that decision.
>
> (2) For this purpose *"decision"*—
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> …
>
> (b) includes a failure to take a decision permitted or required by this Part in connection with a reference or possible reference.
>
> …
>
> (4) In determining such an application the Competition Appeal Tribunal shall apply the same principles as would be applied by a court on an application for judicial review.
>
> (5) The Competition Appeal Tribunal may—
>
> (a) dismiss the application or quash the whole or part of the decision to which it relates; and
>
> (b) where it quashes the whole or part of that decision, refer the matter back to the original decision maker with a direction to reconsider and make a new decision in accordance with the ruling of the Competition Appeal Tribunal.
>
> …"

15. The statement of the law by the Tribunal in *BAA Ltd v Competition Commission* [2012] CAT 3 ("*BAA*") at [20] provides relevant guidance. (The case went on appeal - see [2012] EWCA 1077 - but the relevant statement of the law to be

applied was not called into question.) So far as is relevant to the present case, the Tribunal said this:

> "20. Section 179(4) of the Act provides that on an application to it for review of a decision of the CC [the Competition Commission] the Tribunal "shall apply the same principles as would be applied by a court on an application for judicial review." There were no major differences between the parties as regards the approach that these principles require on the part of the Tribunal, but there were potentially significant differences of emphasis. In our judgment, the principles to be applied are as follows:
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> …
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> (3) The CC, as decision-maker, must take reasonable steps to acquaint itself with the relevant information to enable it to answer each statutory question posed for it (in this case, most prominently, whether it remained proportionate to require BAA to divest itself of Stansted airport notwithstanding the MCC the CC had identified, consisting in the change in government policy which was likely to preclude the construction of additional runway capacity in the south east in the foreseeable future): see e.g. *Secretary of State for Education and Science v Tameside Metropolitan Borough Council* [1977] AC 1014, 1065B per Lord Diplock; *Barclays Bank plc v Competition Commission* [2009] CAT 27 at [24]. The CC "must do what is necessary to put itself into a position properly to decide the statutory questions": *Tesco plc v Competition Commission* [2009] CAT 6 at [139]. The extent to which it is necessary to carry out investigations to achieve this objective will require evaluative assessments to be made by the CC, as to which it has a wide margin of appreciation as it does in relation to other assessments to be made by it: compare, e.g., *Tesco plc v Competition Commission* at [138]-[139]. In the present context, we accept Mr Beard's primary submission that the standard to be applied in judging the steps taken by the CC in carrying forward its investigations to put itself into a position properly to decide the statutory questions is a rationality test: see *R (Khatun) v Newham London Borough Council* [2004] EWCA Civ 55; [2005] QB 37 at [34]-[35] and the following statement by Neill LJ in *R v Royal Borough of Kensington and Chelsea, ex p. Bayani* (1990) 22 HLR 406, 415, quoted with approval in *Khatun*:
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> > "The court should not intervene merely because it considers that further inquiries would have been desirable or sensible. It should intervene only if no reasonable [relevant public authority – in that case, it was a housing authority] could have been satisfied on the basis of the inquiries made."
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> (4) Similarly, it is a rationality test which is properly to be applied in judging whether the CC had a sufficient basis in light of the totality of the evidence available to it for making the assessments and in reaching the decisions it did. There must be evidence available to the CC of some probative value on the basis of which the CC could rationally reach the conclusion it did: see e.g. *Ashbridge Investments Ltd v Minister of Housing and Local Government* [1965] 1 WLR 1320, 1325; *Mahon v Air New Zealand* [1984] AC 808; *Office of Fair Trading v IBA Health Ltd* [2004] EWCA Civ 142; [2004] ICR 1364 at [93]; *Stagecoach v Competition Commission* [2010] CAT 14 at [42]-[45];
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> (5) In some contexts where Convention rights are in issue and the obligation on a public authority is to act in a manner which does not involve disproportionate interference with such rights, the requirements of investigation and regarding the

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

(6) It is well-established that, despite the specialist composition of the Tribunal, it must act in accordance with the ordinary principles of judicial review: see *IBA Health v Office of Fair Trading* [2004] EWCA Civ. 142 per Carnwarth LJ at [88]–[101]; *British Sky Broadcasting Group plc v Competition Commission* [2008] CAT 25, [56]; *Barclays Bank plc v Competition Commission* [2009] CAT 27, [27]. Accordingly, the Tribunal, like any court exercising judicial review functions, should show particular restraint in "second guessing" the educated predictions for the future that have been made by an expert and experienced decision-maker such as the CC: compare *R v Director General of Telecommunications, ex p. Cellcom Ltd* [1999] ECC 314; [1999] COD 105, at [26]. (No doubt, the degree of restraint will itself vary with the extent to which competitive harm is normally to be anticipated in a particular context, in line with the proportionality approach set out by the ECJ in Case C-12/03P *Commission v Tetra Laval* [2005] ECR I-987 at para. 39, but that is not something which is materially at issue in this case). This is of particular significance in the present case where the CC had to assess the extent and impact of the AEC constituted by BAA's common ownership of Heathrow, Gatwick and Stansted (and latterly, in its judgment, Heathrow and Stansted) and the benefits likely to accrue to the public from requiring BAA to end that common ownership. The absence of a

> clearly operating and effective competitive market for airport services around London so long as those situations of common ownership persisted meant that the CC had to base its judgments to a considerable degree on its expertise in economic theory and its practical experience of airport services markets and other markets and derived from other contexts; …"

III. THE REPORT

16. As explained in CC3 (paras. 163 et seq.), in the course of a market investigation the CMA may set out theories of harm to provide focus and structure to its assessment of the way competition is working in a market. This is a preliminary assessment by the CMA, based on its understanding of the market and economic theory, of how a distortion of the market might be occurring. As set out in para. 163 of CC3, the statement of a theory of harm does not involve any prejudgment that a distortion is in fact occurring ("A theory of harm is a hypothesis of how harmful competitive effects might arise in a market and adversely affect customers. The use of the term does not imply any prejudgement of an AEC in a given market"). It represents a hypothesis which the CMA thinks calls for investigation and analysis in light of evidence obtained by it: the evidence may cause the CMA to assess that the hypothesis is not made out on the facts (see paras. 166-169 of CC3).

17. The question of the weight to be attached to a theory of harm and the strength of evidence needed to rebut the theory is relevant in this case, in view of the argument by AXA PPP under its Ground 3 that there was a presumption that the formation and operation of anaesthetist groups gave rise to an AEC in certain areas. In our view, the weight to be given to a theory of harm in a particular context is very much a matter for the CMA, as the expert investigating body. This is in line with paras. 163-169 of CC3.

18. In this case, the CMA did set out a theory of harm ("ToH2"), that "individual consultants or consultant groups in some local areas may have market power over their patients" (Report, para. 4.5(b)). It noted that there might be unilateral market power for such groups, including through market concentration, and observed:

> "Under ToH2, we identified that individual consultants and/or consultant groups in certain local areas may have market power over their patients, arising from

> three particular factors: (a) there may be a limited number of consultants in a particular area providing particular treatments or specialties; (b) the way in which patients are referred to consultants; and (c) joint setting of prices by some consultant groups. In relation to the last of these factors, we concentrated on anaesthetist groups, as patients generally have little input into the selection of their anaesthetist and because we received the highest number of complaints about this group of consultants. These issues are examined in Section 7" (Report, para. 4.10).

The CMA tested this hypothesis of harm by gathering evidence relevant to it.

19. The CMA concluded that it should treat the geographic scope of competition in the provision of private healthcare consultant services as local; but it did not find it necessary to identify precisely the local geographic markets, since it was sufficient to understand them as similar in scope to hospital services markets, which were defined on the basis of the location of suppliers (Report, para. 5.70; also para. 7.2). Beyond this explanation of its approach to identification of relevant local markets, the CMA considered it unnecessary to go further.

20. If the CMA had been minded to find that there is an AEC in relation to the formation and operation of anaesthetist groups in any particular market, it would have had to proceed to identify the relevant local markets in each case with more precision, in order to determine market shares in those markets and to assess matters such as barriers to entry for competitors in those markets and the possibility of countervailing buyer power in those markets (in the form of PMI buyer power exercised to keep costs down), as well as the efficiency and other advantages claimed for anaesthetist groups. On its assessment of the position, the CMA did not need to proceed to do this, because on the information available it decided that it could not find an AEC and also considered it would be disproportionate to investigate further. AXA PPP challenges the lawfulness of that assessment.

21. The CMA noted that BUPA and AXA PPP considered that anaesthetist groups exercise market power, which meant that the prices of services provided by anaesthetists within such groups rose faster, or were maintained at a higher level, than the prices charged by independent anaesthetists; AXA PPP emphasised that certain anaesthetist groups had very high market shares in certain local areas, with

something approaching a monopolistic position, and co-operative price-setting arrangements operated within such groups (see, e.g., paras. 7.8 and 7.10 of the Report). Against this, the CMA noted that anaesthetist groups, the Federation of Independent Practitioner Organisations and the Association of Anaesthetists of Great Britain and Ireland ("AAGBI") argued that there was no AEC, and that there were countervailing factors, including that anaesthetist groups helped in delivering a higher quality of service (including better emergency cover, cross-dissemination of best practice and improved patient administration) and faced substantial buyer power on the part of the PMIs (see, e.g., para. 7.9 of the Report).

22. AXA PPP's main contention in the course of the market investigation was that the high market share for certain anaesthetist groups in certain local areas combined with collective price-setting arrangements should be regarded as features of the market which, in the absence of countervailing factors being shown to exist, indicated that an AEC existed. They also argued that the evidence collected by the CMA confirmed that these price-setting arrangements were successful in increasing the level of anaesthetist charges. This main contention was addressed by the CMA at paras. 7.17 to 7.22 of the Report, as follows (omitting footnotes):

> "7.17 As described in paragraphs 7.6 to 7.10, a number of consultant groups were identified by parties, in particular insurers, as potentially raising competition concerns. In particular, anaesthetist groups were highlighted in the OFT's decision to refer as consultant groups whose formation may give rise to competitive harm. The referral patterns for anaesthetists are different from other consultants in that in the vast majority of cases the surgical consultant chooses the anaesthetist. In addition to anaesthetist groups, Bupa also identified an ophthalmology group, CESP, as giving rise to competition concerns.
>
> 7.18 A BMA survey of consultant members in 2011 indicated that the majority of respondents (79 per cent) operate as sole traders in the private healthcare sector. Of the remainder, roughly half said that they traded as a member of a limited liability company, one-quarter that they were a member of an equity partnership and one-quarter that they were a member of a limited liability partnership. Our survey of consultants showed that whilst 76 per cent of consultants stated that they did not belong to a consultant grouping, anaesthetists were twice as likely to belong to a group as non-anaesthetists, with 39 per cent saying that they belonged to a group compared with 22 per cent for non-anaesthetists. According to our survey, anaesthetists were also more likely than non-anaesthetists to set their fees in relation to the group's guidelines or at levels specified by the group: 60 per cent of anaesthetists in a group set fees at the level determined by the group or set them with reference to group guidelines compared with 51 per cent of non-anaesthetists in a consultant group.

7.19 We consider that there is no general presumption that the formation of consultant groups is anti-competitive. There may be a number of benefits to consumers resulting from the formation of consultant groups, as is the case in other professions. Bupa and AXA PPP agreed that the formation of consultant groups did not in itself give rise to competitive harm but that the collective setting of prices, in particular by anaesthetist groups with a large local market share, inherently had an AEC and that it was not necessary for the CC to demonstrate any pricing effects to find that this lack of rivalry constituted an AEC.

7.20 AXA PPP was of the view that when anaesthetist groups set a common price adhered to by all members, they by definition eliminated all price competition between members within the partnership. When members of a partnership accounted for a very high share of local supply in the relevant market, this lack of price competition conferred substantial market power. While AXA PPP did not suggest that collective pricing within anaesthetist groups was analogous to a price-fixing cartel, it said that a parallel should be drawn with the approach taken under Chapter I of the Competition Act and EU law, which prohibited arrangements whose object was the prevention, restriction or distortion of competition, and did not require authorities to adduce any detailed evidence about their effects on competition. Bupa similarly told us that consultant groups had a negative impact on choice and competition at the local level. The most direct impact for patients is that groups tend to set uniform fee rates across all members. This means that if a group becomes too large within a particular local market, patients may have little choice other than to pay the group fee rate.

7.21 An AEC cannot be presumed on the basis of collective fee setting even if combined with high market shares. A finding of market power giving rise to an AEC requires more than the presence of collective fee setting and the existence of high market shares. In assessing whether there is market power, we will consider market share changes over time, market outcomes such as prices and profitability, as well as the structure of the relevant market including the nature of any barriers to entry and countervailing buyer power.

7.22 For the reasons set out in paragraphs 7.17 and 7.18 above, we focused our analysis of consultant groups on anaesthetist groups and in particular anaesthetist groups which set fees. The purpose of our analysis was to identify whether the formation of anaesthetist groups in local areas, which set fees, gave rise to widespread competition harm giving rise to an AEC. We considered that a pricing analysis of the impact of anaesthetist groups on prices would be an appropriate starting point to ascertain whether there was such widespread competitive harm. As set out in our guidelines, prices can provide evidence of how a market is functioning and importantly the extent of and nature of competition in the market. The following section summarizes our analysis of the impact of anaesthetist groups on prices. We then set out our assessment of consultant groups."

23. It is these paragraphs of the Report which set out the main part of the CMA's response to AXA PPP's main case in respect of anaesthetist groups in the course of the market investigation, and which are now the principal target of AXA PPP's complaint under Ground 3.

24. In paras. 7.23 to 7.38 of the Report, the CMA summarised its findings from a price analysis it carried out for the purposes of its investigation. The price analysis was described in more detail in Appendix 7.1 to the Report. Paras. 7.25 to 7.38 of the Report state as follows (omitting footnotes):

> "7.25 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 these areas, which insurers highlighted as potentially raising competition concerns, or mentioned specifically (ie 11 groups in total), as these were likely to be more indicative of raising competition problems.
>
> 7.26 A key aspect of the analysis of each local area and anaesthetist group was to find an appropriate control group that allowed us to compare the fees for treatments administered by consultants that belong to anaesthetist group(s) with the fees of the control group (see Appendix 7.1, paragraph 10). The more similar the circumstances that affect the fee level of the treatment offered by the two groups, the more likely that any difference in prices can be attributed to the presence of the anaesthetist group. As our control groups will not in general capture all other factors, there is some uncertainty associated with the results from our analysis. We controlled for the mix effect of different treatments performed in the different local areas by looking at six of the ten most common treatments in the UK under general anaesthesia (see Appendix 7.1, paragraph 11).
>
> 7.27 Where data was available, we conducted the analysis for each of the six treatments, as follows:
>
> > (a) First, we conducted price analysis at the national level to give an overview on the UK anaesthetist market (see Appendix 7.1, paragraph 12(a)).
> >
> > (b) We then focused our price analysis on local geographic areas, where insurers identified anaesthetist groups which in their view raised competition concerns. Based on the 11 areas identified by insurers, we conducted regional analysis and individual case studies (see Appendix 7.1, paragraph 12(b) and (c)).
>
> 7.28 In relation to our national and regional analyses, we note that, even for each specific treatment, we observe substantial price variation in anaesthetist fees across areas of the UK. Therefore, any difference between the average fees set by members of group(s) and non-members of groups showed by our national and regional analyses could be explained by factors other than the presence of a group. We have taken this into consideration in interpreting the results of these analyses.
>
> 7.29 The individual case studies provide more detailed analyses that aim at better controlling for geographical variations. The analysis of price changes pre- and post-formation of the groups, or change of their legal status, is the most useful (in what follows we refer to this analysis as pre- and post-event). The difference between groups' prices pre- and post-event and those of non-groups, particularly in the same region, represents a good comparator as the only (observable) feature is the group formation. However, this could only be applied to three case studies

as for the other case studies the group was formed before our period of analysis (2006 to 2012, part year). The second best comparator is independent consultants working in the same hospitals as group members, which was applied to four case studies. In theory, comparing average fees between group members and independents in the same hospital is a good comparator as the only (observable) feature that differentiates them is that they are not part of a group. However, one possible disadvantage of this approach is that independents may choose to follow the prices set by the groups. The third best comparator is comparisons with group members operating in nearby hospitals, which was applied in three case studies. We had difficulty conducting this analysis because of lack of data and information about the presence and/or size of anaesthetist groups in nearby hospitals.

7.30 Our national and regional analyses generally suggest that anaesthetist groups may charge higher prices compared with independent anaesthetists (see Appendix 7.1, paragraphs 16 to 18). However, as noted in Appendix 7.1, paragraph 6, these analyses do not control for geographical differences in anaesthetist charges.

7.31 In relation to the individual case studies, the results can be summarized as follows:

(a) We did not have enough observations to conduct individual case studies for five out of the 11 anaesthetist groups.

(b) The evidence on half of the individual case studies undertaken (three out of six) does not suggest that the presence of the anaesthetist groups, and especially their collective price-setting, leads to higher prices. However, for these case studies we were unable to carry out what we regard as the strongest piece of analysis—the pre- and post-event price analysis.

(c) 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. The summary results of our analyses, as described in Appendix 7.1, paragraphs 19 to 31 for each of these case studies are set out below.

7.32 For case study A, the anaesthetist group in this area has a high share of all anaesthetic treatments—over 80 per cent by volume. The pre- and post-event analysis showed relatively higher average price rises, compared with the region as a whole, for five of the six treatments and lower prices for one treatment. For three out of the five treatments (with higher prices), the differences in price rises were four percentage points, two percentage points and one percentage point. For the other two treatments, the differences in price rises were 13 and 15 percentage points. For the sixth treatment, the lower price rise was minus two percentage points. The comparison with independents working in the same hospitals could only be carried out for two out of six treatments and the comparison with nearby hospitals for three out of six treatments (see Appendix 7.1, paragraph 21(d) and (e)).

7.33 For case study B, the anaesthetist group in this area has a high share of all anaesthetic treatments in one hospital—around 60 per cent by volume. The pre- and post-event analysis showed relatively higher average price rises, compared with the region as a whole, for four of the five treatments we had data to analyse and lower for one treatment. For two out of the four treatments with higher prices, the difference in price rises was one percentage point. For the other two

treatments, the differences in price rises were eight and 19 percentage points. For the fifth treatment, the price rise after the group changed from a loose association to a formal partnership was three percentage points lower than that for the region. For this case study, we could not carry out the comparison with independents working in the same hospitals, or the comparison with nearby hospitals.

7.34 For case study C, the anaesthetist group in this area has a high share of all anaesthetic treatments in one hospital—above 50 per cent by volume. The pre- and post-event analysis showed relatively higher average price rises, compared with the region as a whole, for four of the four treatments we had data to analyse. The differences in price rises for two treatments were eight percentage points. For the other two treatments the price differences were 10 and 14 percentage points. For this case study, we could only carry out the comparison with independents working in the same hospitals and this could only be carried out for three treatments (see Appendix 7.1, paragraph 25(c)).

7.35 Bupa submitted that the anaesthetist groups in the areas examined by the CC often had very high market shares—with groups in the 11 areas the CC investigated having at least 50 per cent of anaesthetic activity in their main hospital, two of those areas having over 70 per cent and a further two areas where their share was over 80 per cent. It contended that the formation of anaesthetist groups had led to significantly higher prices for consumers in the areas studied by the CC—in particular, the CC's comparison of prices pre- and post-formation of a group showed that the formation of the group increased prices in 13 of 15 treatments studied. Bupa's own analysis, presented in response to the issues statement, found anaesthetist group prices to be on average higher than individual anaesthetists, which it said had also been repeatedly found across the CC's own measure. Bupa also argued that in considering barriers to entry, the CC needed to determine whether individual anaesthetists provided an effective competitive constraint on groups. In its view, the CC's own evidence showed that anaesthetist groups charge over 5 per cent more on average than individual anaesthetists, consistent with them providing a limited competitive constraint. Bupa also raised some criticisms about the methodology undertaken by the CC in its pricing analysis, as there had been no reporting of annual price changes associated with anaesthetist groups or an average price change for each treatment, it did not detail a sample size or whether the price changes were statistically significant. It said that there had also been no interrogation by the CC of the alleged benefits claimed by anaesthetist groups.

7.36 AXA PPP submitted that the CC had incorrectly summarized the results of its pricing analysis, stating that it demonstrated an upward effect on prices from the presence of groups. It said that the three case studies presented in the provisional findings where the CC was able to develop the most probative evidence (ie pre- and post-event analysis) all yielded results that supported an AEC in that they all pointed to increased prices—in particular, relatively higher average prices were shown in case study A in five out of six treatments; case study B in four out of five treatments; and case study C in all four treatments. It said that it was of no significance that the precise measure of price effects was difficult and uncertain; it was the directional indication of price which was quite clear on the preponderance of the evidence.

7.37 Although the national and regional analyses generally suggest a price effect of anaesthetist groups, 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 that the evidence of a price effect of anaesthetist groups was

> mixed. In three of the six case studies undertaken, the evidence does not suggest that the presence of anaesthetist groups leads to higher prices. For the other three 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.
>
> 7.38 We agree with Bupa and AXA PPP that in order to determine whether barriers to entry are low, it is necessary to consider the level of constraint imposed on an anaesthetist group by individual consultants in the relevant local area. In response to our provisional findings, Bupa and AXA PPP commented on barriers to entry. As we have found mixed price effects in relation to the formation of anaesthetist groups, we decided not to prioritize our resources in carrying out a detailed assessment of barriers to entry."

25. Ms Bacon submitted that the preponderance of the upwards price movements for the six specimen treatments on each of the national, regional and local area analyses was higher where anaesthetist groups were operating. She showed the Tribunal a summary sheet prepared by AXA PPP's representatives, based on the results of the CMA's pricing evidence, which purported to illustrate how almost all the price comparisons indicated that the formation of anaesthetist groups led to higher prices. She maintained, in particular, that this was the pattern in relation to the three local areas for which the CMA had been able to obtain the strongest type of comparative evidence (case studies A, B and C), in the form of comparison of prices before and after the formation of anaesthetist groups.

26. Ms Smith QC, for the CMA, on the other hand, submitted that the overall picture in relation to relative price movements was indeed "mixed", as the CMA had assessed it to be. She submitted that the position was considerably more nuanced than AXA PPP sought to suggest and invited the Tribunal to focus more directly upon the detail of the findings set out in Appendix 7.1 to the Report. Ms Smith submitted that the CMA was lawfully entitled to make the overall assessment that it did about what could be taken from the price analysis it had conducted.

27. Having set out a summary of its findings from its price analysis, the CMA turned to make its assessment whether an AEC existed in relation to the formation and

operation of anaesthetist groups, at paras. 7.39 to 7.41 and 7.47 of the Report, as follows:

> "7.39 Our analysis of anaesthetist group prices showed mixed results. The pricing evidence did not therefore indicate that anaesthetist groups were leading to higher prices and therefore have a widespread AEC. As noted above, the price analysis carried out at the local level on six anaesthetist groups which set prices and which were identified as having high local shares of supply and of concern to insurers showed consistent evidence of price effects in one case, mixed evidence in two cases and no price effects in the other three.
>
> 7.40 We did not undertake an area by area competitive assessment to identify whether a particular anaesthetist group in any local area may have market power giving rise to competition problems in that local area. 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 (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 any countervailing buyer power of the insurers.
>
> 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. 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 an anaesthetist group has local market power which adversely affects competition would be beneficial. …
>
> 7.47 On balance, the assessment we have carried out does not lead us to find that the formation of anaesthetist groups or other consultant groups adversely affects competition. In addition, we do not find that the formation of any individual anaesthetist group or other consultant group adversely affects competition in any local market."

28. It should be noted that the CMA's reasoning in paras. 7.40 and 7.41 recognised the possibility that there might be distorting effects upon competition in some local areas associated with the operation of anaesthetist groups in those areas. However, the CMA gave reasons why it considered that it would be disproportionately onerous, as compared with the possible gains which might be achieved and the need to prioritise use of its resources for other purposes, for it to investigate that possibility any further. It therefore put to one side other matters which might arise if the investigation of the existence of an AEC had to be pursued in more detail,

including detailed investigation and assessment of whether there might be countervailing factors which might show that there was no AEC in fact.

29. The CMA's assessment that the price analysis showed "mixed results" (para. 7.39 of the Report) was criticised by Ms Bacon as irrational. She submitted that the information obtained only admitted of one assessment, namely that it tended to reinforce the impression that there was an AEC by reason of the operation of anaesthetist groups in relation to certain local markets. This is the main thrust of AXA PPP's case under Ground 4.

30. For the purposes of Ground 5, Ms Bacon submitted that in para. 7.47 of the Report the CMA had simply failed to make a proper finding whether there was an AEC or not, and thus had failed to comply with its duty under section 134(1) of the 2002 Act. She also said that the CMA had acted unlawfully in deciding not to pursue further its investigation into whether there was in fact an AEC in any of the local geographic markets in which anaesthetist groups were operating (particularly those in which any one group had a high market share and there was evidence of a collective approach to setting prices and of upward price movements, especially in the areas covered by case studies A, B and C).

IV. DISCUSSION

A. Ground 3

31. In oral argument both parties agreed that the assessment of whether or not an AEC existed in a market is a multi-faceted process involving consideration of market structure, market outcomes and market features. At one stage, it seemed that Ms Bacon was seeking to argue that the CMA erred in law in that it improperly referred to price detriment to consumers (a matter relevant to the question of remedy under section 134(4), after there has been a finding of an AEC) at the stage of carrying out its assessment at the prior stage, under section 134(1), of determining whether there is an AEC. However, she clarified her position in the course of the hearing, to acknowledge that the CMA could lawfully refer to evidence of detrimental effects (or the absence thereof) for consumers in a particular market as part of its analysis for the purposes of section 134(1) whether

an AEC exists at all. Therefore, the mere fact that, for the purposes of its consideration under section 134(1) whether any AEC exists, the CMA sought to analyse whether there were detrimental pricing effects caused by the formation and operation of anaesthetist groups in local areas, or regionally, or nationally, did not in itself indicate any error of approach on the part of the CMA.

32. In our view, this is plainly correct. The fact that sub-sections 134(4) and (5) refer to the issue of detriment for consumers in the context of determining the remedy to be imposed if there is an AEC does not indicate that this is an irrelevant and impermissible consideration to be taken into account when determining, under section 134(1), whether there is an AEC. On the contrary, it may often be difficult to determine whether or not an AEC exists and an assessment taking into account a wide range of factors may be required. In many contexts, the presence or absence of evidence of detriments for consumers may be a very weighty consideration to be taken into account in such an assessment. The guidance in CC3 correctly indicates that it is a relevant consideration at the section 134(1) stage of determining whether an AEC exists - see paras. 94-95, which provide:

> "94. In assessing whether or not an AEC has arisen the CC looks at three basic issues:
>
> (a) the main characteristics of the market and the outcomes of the competitive process;
>
> (b) the composition of the relevant market [The term 'relevant market' is used throughout these Guidelines in two contexts, see paragraph 26] within which competition may be harmed (market definition); and
>
> (c) the features, if any, which are harming competition in the relevant market (the competitive assessment – which the CC frames using 'theories of harm'), considering also possible countervailing factors, such as efficiencies, which may remove or mitigate the competitive harm of the features.
>
> 95. Analyses of these issues are not conducted as distinct chronological stages of the investigation but as overlapping and continuous pieces of work, which often feed into each other. For example, the CC may take an initial view about the scope of the relevant market but the competitive assessment may suggest that this initial view of the market was either too broad or too narrow. Evaluation of outcomes continues throughout the investigation."

33. Under Ground 3, Ms Bacon pressed on us an analogy with Article 101 of the Treaty on the Functioning of the European Union ("TFEU") and Chapter I of the

Competition Act 1998, both of which prohibit certain anti-competitive agreements, in particular the agreement by potentially competing suppliers to set prices in common. The obvious parallel between these provisions and section 134 of the 2002 Act is that they all use the concept of 'preventing, restricting or distorting competition'. Ms Bacon said that these provisions showed that the CMA should have taken as its starting point, based on the information it had about high market shares for particular anaesthetist groups combined with collective price-setting in some local areas, that there was a presumption (even if only an evidential presumption) that an AEC existed, unless there was some good reason shown why that was not the case. Ms Bacon submitted that since the CMA did not proceed to examine and reach conclusions on the possible countervailing factors (in particular, those regarding the market benefits which anaesthetist groups said were associated with their provision of services and the question whether there were significant barriers to entry in the particular local geographic markets), it could not rationally conclude that no AEC existed in any of those markets. The CMA should have found that there was a *prima facie* AEC, and then proceeded to examine the other factors urged upon it by the anaesthetist groups and the AAGBI.

34. We do not accept these submissions. The putative analogy with Article 101 TFEU and Chapter I of the Competition Act is not apt. The relevance of these provisions to the concept of collective price setting by anaesthetist groups needs to be considered with proper reference to the factual context. The CMA was entitled to assess (at paras. 7.19 to 7.22 of the Report, set out above) that it did not provide a relevant guide for assessment in this particular context of the markets for anaesthetist services.

35. We note that the OFT had previously determined, in its 2003 investigation into whether six anaesthetist groups had breached the Chapter I prohibition, that (save for one of the anaesthetist groups investigated) each such group operates as a single undertaking for the purposes of competition law.[2] Therefore, in the OFT's view, an agreement between the members of the group (within their respective

[2] While the remaining group did not constitute a single undertaking, the OFT found that the members had not agreed between themselves the prices that they would charge for their services. Thus the arrangement did not engage Chapter I.

groups) as to the level of fees to be charged did not amount to an agreement between undertakings. The OFT concluded that the mere fact that anaesthetists grouped together and adopted a collective approach to setting prices did not indicate that they were to be regarded as operating something equivalent to an impermissible cartel to fix prices (this conclusion appears to have led to a spike in the formation of anaesthetist groups after that date, to take advantage for competition law purposes of that determination). In accordance with this approach, Ms Bacon did not contend that the CMA should have found the existence of an AEC simply by reason of the fact that some economic operators (individual anaesthetists) in a given market had engaged in collective price-setting – which is the hall-mark of a cartel, no matter what its market share. Rather, she maintained that it was by reason of high market share for a particular anaesthetist group *combined with* a collective approach to price-setting that the alleged presumption of an AEC arose.

36. As was submitted by Mr Robertson QC, for the British Medical Association (one of the interveners who supported the CMA on the application), anaesthetist groups operate in a manner similar to partnerships of professionals (say, firms of accountants or solicitors), which set prices for all their members. Such firms can be characterised as engaging in collective price-setting practices (i.e. with fees of members of the firm being set by the firm), but they are not for that reason treated as illegitimate cartels or as anti-competitive organisations. We note that where individual professionals operate through a genuine partnership structure with full sharing of profits and losses, the question of unlawful common price-setting by professionals does not arise, because the partnership is regarded as a single economic entity for competition law purposes and competition law would address the question of possible anti-competitive behaviour as a possible abuse of a dominant position. It is in this context that AXA PPP's case, that the CMA should have found that professional partnerships which set charges collectively in a similar way while possessing a dominant share of a particular market should be regarded as *prima facie* creating an adverse effect on competition, needs to be considered.

37. For the purposes of Ground 3, the collective price-setting arrangements combined with high market shares in certain local areas were the building blocks on the basis of which AXA PPP sought to contend that there must be a presumption that an AEC existed by reason of the operation of the anaesthetist groups in those areas. However, in our view, the CMA was entitled to hold at para. 7.21 of the Report, set out above, that AXA PPP's bald case based on a combination of collective fee setting and high market share for particular groups was insufficient to create a presumption of an AEC. For example, high market share for a firm does not in itself give rise to a presumption that it might be distorting the market through abuse of its position. The CMA was entitled to consider whether additional evidence existed to indicate that the formation and operation of anaesthetist groups gave rise to widespread competitive harm.

38. On investigation, the CMA found that the operation of relevant markets was far from perspicuous and regarded the evidence available to it as very limited (see, e.g., para. 7.25 of the Report). In the circumstances, the CMA could not be criticised for focusing on the 11 anaesthetist groups about which the PMIs had complained (and AXA PPP did not make such a criticism). The CMA adopted a rational approach to weighting the different forms of evidence available to it, as between national, regional and local information. The significance of the evidence at every level, including in relation to case studies A, B and C, called for assessment and expert judgment.

39. The CMA properly recognised that the evidence from case studies A, B and C was the best material available to it, but it was not bound to find that the evidence from those studies rationally pointed to only one possible conclusion, namely that an AEC existed in those areas. Like the other available evidence, it too required expert assessment as to its significance. Although Ms Bacon described the evidence from those case studies as equivalent to "DNA evidence" – i.e. an effectively conclusive form of evidence – in the present context the CMA clearly thought that it did not show conclusive results. Although the evidence from those studies showed a strong upward movement in the prices of some treatments provided by anaesthetist groups with high market share, it also showed that at other times the prices for other treatments provided by such anaesthetist groups

had gone down, or that there was little difference. Also, there appeared to be no strong correlation between the price movements in question and the extent of the market shares of the relevant anaesthetist groups, such as one might expect if increased market share combined with collective price-setting was indicative of anti-competitive effects.

40. Ms Bacon was critical of the CMA for seeking to draw inferences about whether an AEC existed in a particular local area by comparing what happened to prices in other local areas. We could see no merit in this criticism. Given the obscurity regarding how each local market was operating and the limited nature of the evidence about it, it could not be said to be inappropriate for the CMA to test its assessment and any inferences to be drawn in relation to that area by making comparisons with other local areas, as well as by having regard to the picture at a regional and national level. For some parts of her submissions, Ms Bacon herself recognised that the latter categories of comparative material had some value, and it is difficult to see why any of the categories should necessarily be regarded as irrelevant. The thrust of at least one part of the argument she presented by reference to the forensic charts she placed before us was to say that there was a preponderance of indications across all the case studies and the regional and national analyses that prices had risen faster where anaesthetist groups were in operation, which should have informed the assessment by the CMA whether an AEC existed in local geographic markets.

41. In our view, this was a classic case in which there was evidence pointing in different directions, in relation to which an overall evaluative judgment had to be made and where more than one alternative conclusion was rationally possible. The CMA could rationally have found that the price analysis tended to support the finding of an AEC in some local markets; but it could also rationally find, as it did, that the picture presented by the price analysis it conducted was mixed to such an extent that it did not support the hypothesis presented in its ToH2. The CMA could rationally find that the price analysis did not point strongly towards there being a pattern of anti-competitive effects associated with anaesthetist groups (even those with high market shares), so as to give a clear indication of the existence of an

AEC in any local market. The picture remained murky and the PMIs' case that AECs existed remained unproven on the evidence available.

42. In this regard, we were forcefully reminded by counsel for the CMA and counsel for the interveners of the limits of the Tribunal's role on a challenge brought under section 179 of the 2002 Act. Even though the Tribunal has expertise of its own, by virtue of section 179(4) its proper function on such a challenge is to apply ordinary judicial review principles in the same way that a court would do: see *BAA*, para. [20(6)], above, and *British Sky Broadcasting Group plc v Competition Commission* [2010] EWCA Civ 2, [28]-[41] (a case concerned with the equivalent challenge provision in section 120 of the 2002 Act in relation to review of mergers; like section 179(4), section 120(4) provides that the Tribunal is to apply the same principles as would be applied by a court on an application for judicial review).

43. We are dealing with a challenge by way of a statutory form of judicial review, not with an appeal on the merits. A review court or tribunal will be slow to find that an evaluative judgment of the nature in issue here, made by an expert regulatory body after careful assessment of relevant evidence, as here, was irrational or unlawful. In our judgment, AXA PPP has failed to show that the assessment made by the CMA of the significance of its price analysis was irrational or unlawful.

44. Once the CMA had reached the point that it had tested the hypothesis set out in its theory of harm ToH2 by reference to its price analysis and had rationally concluded that this analysis had "showed mixed results" which did not, therefore, provide any clear indication (or sufficient evidence to verify the hypothesis) that an AEC existed in any local market, it had to make a choice whether to pursue its investigations further. That choice engaged the CMA's discretion as to how to prioritise the use of its resources, and was addressed in paras. 7.40 and 7.41 of the Report.

45. In our judgment, the reasons given by the CMA in those paragraphs for its decision not to enquire further into the possibility that AECs might exist in

particular local markets cannot be impugned as irrational or in any way unlawful, according to the relevant test explained in *BAA* at [20], set out above.

46. The CMA recognised that some anaesthetist groups "may have market power" (para. 7.40) but, since this was not firmly supported by the results of the price analysis (which, as noted above, it had lawfully found to be "mixed", even in relation to the 11 areas which the PMIs had put forward as their best examples of alleged anti-competitive effects), this remained a speculative possibility. It would require a good deal of additional work, in "a detailed area-by-area competitive assessment" (para. 7.40) before any clear conclusions could be drawn whether an AEC existed in any particular area. Even if an AEC were found in relation to a particular local market, that would not give the CMA power to effect significant changes in the overall private healthcare market which it was investigating. Any remedy would be likely to be of very limited effect, confined in practice to that local market. In summary, therefore, the CMA found itself in a position where further investigation would be likely to take a lot of effort and resources, offered only a very speculative possibility that some more determinate conclusion could be reached, and even if an AEC were found it was likely to affect only a small part of the overall market for private healthcare services.

47. In the circumstances, we consider that the CMA was lawfully entitled, in the exercise of its investigative discretion, to decide not to pursue this dimension of its market investigation any further. To have done so might have jeopardised its ability to comply with its legal duty to produce its report within the statutory timetable. The CMA was entitled to have regard, as it did, to "the constraints on time and resources available for investigation overall" (para. 7.41): see paras. [9]-[11] above.

48. In conclusion under Ground 3, therefore, we consider that the CMA was entitled to find that the results of the price analysis were "mixed" and were not such as to provide verification for the hypothesis set out in the CMA's ToH2; and the CMA was entitled to decide that the prospect of finding a significant AEC in any particular local market was sufficiently speculative and the potential benefits of doing so were so limited that pursuit of that line of inquiry further could not be

justified, having regard to the constraints on time and resources available for its investigation into the private healthcare market overall.

B. Ground 4

49. Under Ground 4, AXA PPP contended that the CMA had irrationally concluded that the results of its price analysis were "mixed". As appears from what we have said above, we reject this contention. The CMA cannot be said to have behaved irrationally in making the assessments it did regarding the findings in the price analysis and their significance in relation to determining whether any AEC existed in any local market.

C. Ground 5

50. Under Ground 5, AXA PPP submitted that the CMA did not properly comply with its obligation under section 134(1) of the 2002 Act, because it failed to make any determination whether there was an AEC. Further and in the alternative, AXA PPP submitted that the CMA acted unlawfully in deciding not to pursue its inquiries into this aspect of the private healthcare market.

51. We reject the first of these submissions. AXA PPP's argument focused on para. 7.47 of the Report (set out at para. [27] above). Ms Bacon submitted that in that paragraph the CMA had failed to make any finding as to whether there was or was not an AEC. However, we consider that the meaning of that paragraph, read in the context of the Report, is clear, and that it did express a proper and lawful conclusion on the question which the CMA was obliged to determine under section 134(1) of the 2002 Act.

52. Under that provision, the CMA had to decide whether an AEC existed. Such a finding would be the necessary precondition for the CMA to have power to make remedial orders. The question the CMA had to address, therefore, was whether it could positively find that an AEC existed.

53. In para. 7.47 of the Report, the CMA addressed that question and gave a proper answer to it. It said that on the material before it, it did not find that an AEC existed. That was an answer which the CMA was lawfully entitled to give. On the

basis of the inquiries it had made, it had reached the point where it considered that it was not established that an AEC existed. It had also made the lawful decision not to try to investigate further.

54. As regards the second of the submissions under this Ground, as again appears from the discussion under Ground 3, we reject that submission as well. The CMA was lawfully entitled to decide that it had taken its investigations far enough, and that it would be disproportionate and potentially prejudicial to the fulfilment of its overall statutory obligations to take it further.

V. CONCLUSION

55. For the reasons given above, we reject AXA PPP's challenge on the Grounds which were live before us, namely Grounds 3, 4 and 5.

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

Charles Dhanowa OBE, QC (*Hon*)
Registrar

Date: 13 March 2015