Neutral Citation Number: [2016] EWCA Civ 777

Case No: C3/2015/2066

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE COMPETITION APPEAL TRIBUNAL

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 25th July 2016

Before :

THE CHANCELLOR OF THE HIGH COURT
LORD JUSTICE PATTEN
and
MR JUSTICE BARLING

- -

Between :

FEDERATION OF INDEPENDENT PRACTITIONER ORGANISATIONS	**Appellant**
- and –	
COMPETITION AND MARKETS AUTHORITY	**Respondent**

- -
- -

Brian Kennelly QC, Emily Neill and Suzanne Rab (instructed by **Watson Farley & Williams LLP**) for the **Appellants**
Kassie Smith QC and Brendan McGurk (instructed by **CMA Legal**) for the **Respondents**

Hearing dates : 29 June 2016

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Approved Judgment

The judge has given permission for this judgment to be published in the following redacted form only. The judge has not given permission for any other format of this judgment to be published. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

The Chancellor of the High Court (Sir Terence Etherton) :

1. Pursuant to a reference by the Office of Fair Trading on 4 April 2012 under sections 131 and 132 of the Enterprise Act 2002 ("the 2002 Act") the Competition Commission and its successor the Competition and Markets Authority ("the CMA") carried out an investigation into the supply or acquisition of privately funded healthcare services in the UK. The final report of the CMA is dated 2 April 2014 ("the Report").

2. This is an appeal by the Federation of Independent Practitioner Organisations ("FIPO") from the decision of the Competition Appeal Tribunal ("the CAT") dated 29 April 2015 dismissing the application by FIPO under section 179 of the 2002 Act challenging parts of the Report. The CAT's decision was by a majority (Sales LJ and Clare Potter), with Dermot Glynn, an economist member, dissenting.

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

The legal objectives of the investigation

4. Section 134 of the 2002 Act specifies the questions to be decided on a market investigation reference. The provisions relevant to this appeal are as follows:

> "134 Questions to be decided on market investigation references
>
> (1) The CMA shall, on an ordinary reference, decide whether any feature, or combination of features, of each relevant market prevents, restricts or distorts competition in connection with the supply or acquisition of any goods or services in the United Kingdom or a part of the United Kingdom.
>
> …..
>
> (2) For the purposes of this Part, in relation to an ordinary reference, there is an adverse effect on competition if any feature, or combination of features, or 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.
>
> ….
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> (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-
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> (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. Section 138(2) of the 2002 Act provides as follows:

> "(2) The CMA shall, within the period permitted by section 138A, in relation to each adverse effect on competition, take such action under section 159 or 161 as it considers to be reasonable and practicable-
>
> (a) to remedy, mitigate or prevent the adverse effect on competition concerned; and
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> (b) to remedy, mitigate or prevent any detrimental effects on customers so far as they have resulted from, or may be expected to result from, the adverse effect on competition."

The Report

6. Section 7 of the Report, headed "Consultants", is the part of the Report with which this appeal is concerned. Section 7 sets out the CMA's assessment of whether there are features relating to the provision of consultant services which give rise to an adverse effect on competition ("AEC").

7. The CMA considered whether private medical insurers ("PMIs") have buyer power in relation to consultants which might be used to suppress consultant fees to a level below that which would prevail in a competitive market. The CMA acknowledged that, if that were the case, it could lead to a shortage of consultants in private practice or a reduction in the quality of service provided by consultants to patients and incentives to innovate or all of those things.

8. The Report described the ways in which PMIs, in particular Bupa and AXA PPP, which are the largest and between them have a 65% share of the PMI market, have embarked on a number of initiatives to seek to control their costs in relation to consultant fees. The principal aspects of such control mentioned in the Report are as follows.

9. All PMIs publish fee schedules or guidance setting out the level of consultant fees they reimburse under their policies (7.56). Bupa's fee schedule, also known as Bupa Benefit Maxima, is regarded as the industry standard. Over time it has become the benchmark for consultant fees, acting effectively as a minimum fee schedule for consultants in the private healthcare sector (7.57).

10. Where a consultant's fees are in excess of an insurer's reimbursement rate a consultant generally may charge the patient the difference, assuming the PMI does not meet the difference. The difference between the PMI's reimbursement rate and the consultant's fee is called a "top-up fee" if the patient is aware of and agrees to pay the difference in advance of treatment. If, however, the consultant did not make the patient aware of this potential difference in advance of treatment, the difference is called a "shortfall" (7.68).

11. Since 2008 AXA PPP has required all newly-recognised consultants, who are also largely newly qualified, and who wish to be recognised by AXA PPP, to sign an agreement that they will only charge AXA PPP insured patients fees set within its fee schedule and will not charge any top-up fees. The Report called such consultants "fee-capped consultants". For such consultants, therefore, AXA PPP's reimbursement rate is the maximum that they can charge for their services (7.70).

12. In addition to the […%] of consultants who were fee-capped in 2013, approximately […%] of AXA PPP's recognised consultants were "fee-assured". There is no contract in place between AXA PPP and such consultants but they have historically charged within reimbursement levels deemed acceptable by AXA PPP. If, however, such a consultant were routinely to charge AXA PPP policyholders significantly higher fees than previously and persisted in doing so after discussions with AXA PPP, the consultant would be removed from the list of fee-assured consultants and their fees would be capped and limited to the published schedule. Such consultants would not be recommended by AXA PPP to its policyholders. The policyholders could, nevertheless, use their benefits to see such consultants and were free to pay top-up fees (7.71).

13. Bupa's new contract similarly requires consultants to charge Bupa policy holders in accordance with the fees set by Bupa. They are not permitted to charge Bupa insured patients any amount over and above the Bupa agreed fees, even if this has been discussed with the patient in advance of treatment. Bupa calls such consultants "Contract Consultants".

14. Consultants already recognised by Bupa during 2010 were not required to sign up to the new contract capping their fees. Bupa has, however, encouraged such consultants voluntarily to enter into a new contract. It refers to such consultants, who have voluntarily signed up, as "Premier Partners" (7.75).

15. Bupa also has informal agreements with some consultants (called "Consultant Partners") to charge within its Benefit Maxima, and with a number of other consultants (called "Guarantee Consultants") who habitually charge within its Benefit Maxima (7.76).

16. Since August 2011 Bupa has also sought to negotiate with consultants, whose charges are higher than 90% of their peers, adjusting for speciality, sub-speciality, interests, geography and, in some cases, experience, to reach agreement on a lower fee rate which it regards as reasonable. Between August 2011 and the publication of the Report, 27 consultants had been derecognised as a result of that process. The remaining consultants had agreed to lower their fees or were still in discussion with Bupa as to whether to do so at the time of the Report (7.77).

17. Unlike other PMIs, Bupa derecognises consultants whose fees it regards as too high. Policyholders, irrespective of their policy type, no longer have access to such consultants under the terms of their policies. In addition, where it has the opportunity to do so, Bupa guides all policy holders (irrespective of their policy type) towards consultants who have agreed to charge within their Benefit Maxima, whether fee-capped or otherwise fee-assured (7.78).

18. Bupa, AXA PPP, Aviva and PruHealth have introduced in the corporate sector "open referral" policies, under which the policyholder is required to obtain an open referral from their GP or other referring clinician. Under such a referral the referring clinician does not name the consultant (or hospital) but specifies the speciality or sub-speciality. The policyholder then contacts their PMI and the insurer advises the patient on the appropriate consultant. (7.79, 7.82). Evidence was given to the CMA that open referral policies were a growing trend and that insurers used them to steer patients to hospitals at which they had secured the best price, but not necessarily the best quality (7.91).

19. Consultants and some of their trade associations contended to the CMA that those practices of the PMIs were anti-competitive because (a) Bupa and AXA were determining the maximum fees a consultant may charge, (b) consultants could no longer set their fees based on their experience, their specialist knowledge, the local market in which they operated and the quality of the service they provided but purely by reference to the standard rates that AXA PPP and Bupa were willing to reimburse, and consultants' fees varied depending on the patients' PMI rather than the consultants' own costs or the treatment provided, (c) the codes were relatively rigid and did not take into account the level of variation within different procedures, co-morbidities and associated factors, (d) a policyholder might wish to pay a top-up fee in order to secure the services of a consultant with particular expertise, which enhanced patient choice and transparency, and that would provide an incentive on consultants to develop expertise and compete on quality and did not affect insurers' claims costs, and (e) Bupa's and AXA PPP's restriction on top-up fees led to a reduced choice for patients, and by capping fees, insurers were able to engage in price fixing for all consultants in private practice (7.102).

20. In discussing its conclusions on the constraints on consultants' fees, the CMA described the consultant as the supplier of a service and the insurer as the buyer (7.93).

21. The CMA observed that consultants are critical to the PMIs' business and that the key perceived benefits of privately-funded healthcare are treatment by a consultant of choice and treatment at a time and place convenient to the patient (7.94).

22. The CMA acknowledged that, nevertheless, if extensively and rigidly applied, fee-capping consultants could lead to distortions in competition between consultants and to reduced consumer choice since fee-capping and derecognition of consultants who do not agree to abide by the PMIs' fee schedule have the potential to increase the disincentives on consultants from setting fees to reflect their costs, experience, expertise and the local market conditions (7.106).

23. The CMA said, however, that it had not received evidence that Bupa's and AXA PPP's contracts with new consultants were leading to the number of new consultants being recognised reducing annually since their introduction (7.107).

24. The CMA also said that it did not have evidence that the number of consultants in private practice as a whole was being adversely affected by the actions of the PMIs, nor that, as a result of the fee-capping of some consultants, consultant fees were being constrained to a level that was having an adverse impact on consumer choice or quality, discouraging innovation or otherwise causing long-term consumer detriment (7.108).

25. The CMA noted that patients insured under corporate trust arrangements benefitted directly from reduced consultant costs achieved by the PMIs. It also observed that the large corporate sector was highly transparent and competitive, with pricing based on costs incurred by PMIs in the previous period, and that would result in a significant proportion of reduced fees being passed through to such customers (7.109). It also said that, unlike personal policyholders, corporate policyholders could relatively easily switch providers (7.110). The CMA said as follows at paragraph 7.111:

> "We also recognize that whilst the insurers encourage policyholders to see fee-capped or fee-assured consultants, policyholders—with the exception of those that hold open referral policies—can pay top-up fees under the terms of their policies if they wish to see any recognized consultant. Whilst policies that require open referral are a standard option for Bupa corporate policies (although not all corporate policies have open referral) and Bupa is considering whether to offer such policies to personal customers more widely, policyholders will continue to be able to choose between policies offered by Bupa and other insurers where open referral is not mandatory and under which policyholders are able to pay, and are not prevented from paying, top-up fees if they so choose. In relation to Bupa, the majority of policyholders and almost all personal policyholders are not required to obtain pre-authorization before seeing a consultant and are able to see any recognized consultant under the terms of their policies. It is only policyholders on open referral policies whose choice of consultant is more limited and who are required to obtain pre-authorization before seeing a consultant. However, as noted

> previously, such policyholders currently have access to over 90 per cent of recognized consultants."

26. Subject to one qualification, the CMA concluded that PMI insurer buyer power in relation to consultants had not had an adverse effect on the provision of consultant services in the UK. The qualification was with regard to the nature of information provided to policyholders and to consultants and the potential this might have to distort competition between consultants and limit patient choice causing long-term detriment (7.112) (7.135).

27. Paragraphs 7.127 to 7.135 of the Report contained the following summary, so far as relevant to this appeal, of the CMA's findings on consultants:

> "(7.130) The two largest insurers at least, Bupa and AXA PPP, have significant buyer power, but we have found insufficient evidence that currently it is being exercised in such a way as to harm competition by suppressing fees to uneconomic levels resulting in a shortage of consultants in private practice or to a reduction in innovation or quality of consultant services. Indeed, the incentive is on insurers to promote competition among consultants on price and quality and maintain innovation and quality to protect and indeed improve demand for PMI. "

> "(7.131) In relation to fee-capping specifically, we consider that, on balance, the evidence we have received does not demonstrate that, at present, Bupa—or indeed any other insurer—is distorting competition between consultants by imposing fee-capping, in particular on newly-recognized consultants, as a condition for recognition. Evidence we obtained from the major insurers did not reveal any material changes in the total number of consultants recognized, or new consultants recognized each year since 2011. We also observed that only a small number of Bupa and AXA PPP recognized consultants had been derecognized for failing to charge within contracted rates (whether fee-capped or not). Similarly, evidence regarding de-recognition of consultants more generally from the insurers does not suggest that quality or innovation is being adversely affected at present by these initiatives. "

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

> mechanisms and flexibility in application, uniform fees could lead to a distortion of competition between consultants and an adverse effect on quality and innovation. ”
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> “(7.133) Whilst all policyholders are able to pay top-up fees under the terms of their policies and all insurers including Bupa and AXA PPP offer policies to both corporate and personal policyholders that do not require open referral, the ability to pay top-up fees and the choice this provides policyholders is dependent upon the insurers’ consultant recognition policy. Moreover, the more patients are directed to fee-capped consultants by the insurers irrespective of the terms of a policyholder’s policy, this could impact on the viability of private practice for some consultants. ”
>
> “(7.134) As noted above, it is not in the insurers’ interests to exercise their buyer power in such a way as to harm competition in the provision of consultant services. Whilst we have not received persuasive evidence that the other issues raised by consultants and trade associations in relation to insurers indicate a current competition problem in the provision of consultant services, we consider that insurers, and in particular Bupa, as they increase their role in directing patients to consultants, need to ensure that their policyholders are provided with clear and accurate information about the terms of their policies. Similarly, they need to ensure that their interaction with consultants is fair and transparent to enable consultants to manage effectively their practices and effectively treat patients. ”
>
> “(7.135) The availability of information on consultant performance and fees is considered further in Section 9. As set out in Section 9, we consider that with greater availability of information on consultant performance and fees, this will increase competition between consultants and lead to patients being able to make more effective choices. This may address some of the issues that have led to insurers adopting the type of strategies considered in this section and may ensure that these strategies are not rigidly and extensively applied with the consequent risks to, in particular, quality or innovation. ”

28. Accordingly, the CMA found that the power of the PMIs to constrain consultants’ fees and to control consumer choice did not give rise to any AEC (“the PMI Decision”).

29. The CMA did find that there was an AEC arising from the lack of independent publicly available performance and fee information on consultants, and that caused the distortion of competition between consultants by preventing patients from exercising effective choice. In order to address that AEC the Report proposed the implementation of an order requiring healthcare facility operators and consultants to

publish information about consultants' fees and other aspects of their practice ("the Information Remedy"). The CMA subsequently made an order giving effect to the Information Remedy.

The application to the CAT

30. By notice of application dated 2 June 2014 FIPO applied to the CAT, pursuant to section 179 of the 2002 Act, for an order quashing the PMI Decision and the Information Remedy on the grounds that they were unlawful and for an order remitting them to the CMA for reconsideration. FIPO relied upon seven grounds, which the CAT described as follows:

> (1) "The PMI Decision was reached on the basis of a finding that consumer choice was not restricted by the practice of PMIs to direct policyholders to consultants whose fees were within the caps set by the PMIs because consumers could select consultants whose fees were above the caps and pay the top-up fees. That finding was factually erroneous and/or irrational in that it was reached in spite of the CMA's finding that the threat of derecognition by PMIs meant that the vast majority of consultants charged within the caps and did not offer services requiring top-up fees to be paid."
>
> (2) "The PMI Decision was reached based on the finding that, notwithstanding the fee caps widely imposed on consultants by PMIs, consultants could compete below the fee caps. That finding was irrational insofar as it was based on no probative evidence whatsoever and/or amounted to a fundamental error of fact. Further the PMI Decision was procedurally unfair in that that finding had at no point been put to FIPO (or any other representative medical organisation). Had it been put to FIPO, FIPO would have been able to present substantial evidence that such a finding was unrealistic."
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> (3) "The PMI Decision was reached on the basis of the factually erroneous finding that the buyer power of the PMIs had not resulted in a reduction in the overall number of consultants. In fact, the number of consultants in private practice has reduced and there was cogent and accurate evidence before the CMA to support this. The PMI Decision was therefore unreasonable and/or irrational in that it was premised on an error of fact."
>
> (4) "The PMI Decision was reached on the basis of this (mistaken) finding that the number of consultants had not fallen alone. The CMA failed to take into account the relevant consideration and/or irrationally failed to conduct any investigation into the issue of whether or not the number of consultants was likely to fall significantly in future."

> (5) "the PMI Decision was reached on the basis of the finding that the fee constraints imposed by PMIs would result in a benefit to customers insofar as premiums would be reduced for policyholders. That finding was irrational and/or unreasonable in that it was not only based on no probative evidence whatsoever but also reached in spite of contrary evidence submitted by parties to the CMA's investigation that premium levels had increased while consultants' fees had been driven down."
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> (6) "The PMI Decision was reached on the basis of the assumption that it was in the interests of the PMIs to ensure that there were high-quality consultants in private practice (since that would ensure that private healthcare insurance remained attractive to customers). That assumption was based on no probative evidence whatsoever and further made notwithstanding evidence to the contrary submitted by the PMIs themselves."
>
> (7) "In granting the [Information Remedy], the CMA acted in contravention of its duty under s.138 of the 2002 Act to remedy adverse effects on competition. That is because the [Information Remedy] is no remedy at all to insufficient competition between consultants. The further provision of information on fees (and performance) by consultants will do nothing to improve competition because the substantial buyer power of the PMIs constrains consultant fees and consumer choice to the extent that competition between consultants is constricted. For the same reasons, the [Information Remedy], insofar as it is ineffective to achieve its aim, is disproportionate according to the first limb of the test laid out in *Tesco Plc v Competition Commission* [2009] CAT 6 at para. [137]."

31. In determining that application the CAT had to apply the same principles as would be applied by a court on an application for judicial review: 2002 Act section 179(4). It was common ground before the CAT and before us that judicial review principles required the CAT to apply a test of rationality in determining whether the CMA was entitled to reach the conclusion which it did.

32. The CAT rejected all the grounds of challenge.

33. Mr Glynn gave a dissenting judgment on grounds (1), (2), (6) and (7)

The appeal

34. FIPO appeals to the Court of Appeal with the permission of the CAT. An appeal lies on a point of law only: 2002 Act section 179(6).

35. The grounds of appeal are as follows:

(1) The majority of the CAT misdirected themselves as to FIPO's argument in relation to top up fees and consumer choice and wrongly failed to consider consumer choice when determining FIPO's Application Grounds 1 and 7.

(2) The majority of the CAT misdirected themselves as to FIPO's argument in relation to fee caps, wrongly failed to consider the operation of fee caps as minima as well as maxima when determining FIPO's Application Grounds 2 and 7 and adopted in relation to fee caps an incorrect approach to the statutory questions in section 134 of the 2002 Act.

(3) The majority of the CAT erred in concluding that Mr Glynn's approach involved a departure from the proper approach on a challenge under section 179 of the 2002 Act.

(4) The majority of the CAT gave no or insufficient reasons for its view that Mr Glynn's approach to Application Grounds 1, 2 and 6 went beyond the appropriate standard on a challenge under section 179 of the 2002 Act.

(5) The CAT erred in the conclusion that there was no breach of procedural fairness. Procedural fairness in this context requires that the CMA "give the reasons … for the proposed decision" when consulting in advance of the Report (2002 Act section 169(3)). Since the CMA had not mentioned prior to the publication of the Report that it thought consultants were able to compete on price below the cap, the CMA failed to comply with this requirement.

Discussion

Ground 1

36. In FIPO's skeleton argument for this appeal the thrust of its submissions on Ground 1 was that the CAT had wrongly focused on whether the reasoning in the Report was internally inconsistent and did not address the substance of FIPO's arguments relating to top-up fees and consumer choice.

37. Somewhat confusingly, Mr Brian Kennelly QC, for FIPO, did not appear to address that issue at all in his opening oral submissions. Instead he addressed the point of substance as to whether, as FIPO contends, the restriction on consumer choice as a result of the inability of many consultants to charge top up fees, even where policyholders were willing to pay them, constituted an AEC. He submitted that it was no answer to find, as did the CMA, that currently there is no lack of availability of suitable consultant services in terms of price, quality and expertise. He said that the restrictions imposed by the PMIs, in particular by AXA PPP and Bupa, precluded competition on price between consultants and restricted the ability of patients to make informed choices between consultants. That is sufficient, he submitted, to constitute a restriction on competition within section 134(1) and (2) of the 2002 Act and so an AEC.

38. Mr Kennelly reinforced that submission by emphasising the word "or" in section 134(4)(a), that is to say the distinction made there between "the adverse effect on competition", on the one hand, and "any detrimental effect on customers so far as it has resulted from, or may be expected to result from, the adverse effect on competition", on the other hand.

39. I do not accept FIPO's case that, on the evidence and findings of fact recorded in the Report, the CMA was bound to conclude as a matter of law that there was a restriction of competition between consultants for the purposes of section 134 or, to put it in judicial review terms, to decide otherwise was irrational. No doubt in principle competition may be prevented, restricted or distorted within section 134 without any detrimental effects having yet become apparent. The existence or absence of such detrimental effects, however, is plainly a material indication of whether or not competition has in fact been prevented, restricted or distorted.

40. It is important to bear in mind in this context that, as emphasised by Ms Kassie Smith QC, for the CMA, the PMIs who are said by FIPO to have restricted or distorted competition are the buyers of the services of the consultants and who, as such buyers, and proxies for their policy holder patients, have a legitimate interest in constraining any unrestricted power of the consultants to charge whatever they wish. This is relevant to Mr Kennelly's over-arching point, which he particularly highlighted in his oral submissions in reply, that patients should be able to pay top-up fees if they wish to do so. On the other hand, there are limits to the proper imposition of such constraints. Whether or not those limits have been exceeded so as to give rise to an AEC in the relevant market was the task of the CMA to determine.

41. The CMA acknowledged in the Report that Bupa's and AXA PPP's actions in relation, in particular, to capping some consultant fees and to restricting recognition of consultants on fee grounds had the potential to distort competition (7.105); that, if extensively and rigidly applied, fee-capping consultants could lead to distortions in competition between consultants and to reduced consumer choice (7.106); and that fee-capping and derecognition of consultants who do not agree to abide by the PMIs' fee schedule had the potential to increase the disincentives on consultants from setting fees to reflect their costs, experience and the local market conditions.

42. In assessing whether that "potential" was a reality (which involved an assessment of whether fee-capping was extensively and rigidly applied as warned in paragraph 7.106 of the Report) the CMA took into account, and was entitled to take into account, its findings that there was no evidence that Bupa's and AXA PPP's practices had led to any diminution in the number of consultants being recognised by them (7.107), or that the number of consultants in private practice as a whole was adversely affected by the actions of PMIs, or that consultant fees were being constrained to such a level as to impact adversely on consumer choice or quality or to discourage innovation or otherwise to cause long-term consumer detriment (7.108). The CMA also took into account, and was entitled to take into account, that not all PMIs followed the same practices as Bupa and AXA PPP (7.79-7.81, 7.87 and 7.88); that it was not in the interests of PMIs to exercise their buying power in such a way as to harm competition in the provision of consultant services (7.100); and that it should be anticipated that the actions of PMIs, as buyers of the consultants' services, in promoting lower-cost consultants would benefit policyholders in the form of lower

premiums (7.109). I can see no proper basis for any contention, insofar as any such contention is made, that those findings of fact were themselves irrational.

43. In short, the CMA's overall conclusion, at which it was entitled to arrive, was that, despite its potential to do so, the buyer power of PMIs, and in particular Bupa and AXA PPP, had not in fact prevented, restricted or distorted competition between consultants or reduced consumer choice.

44. Ms Smith said in her oral submissions that Ground 1 of FIPO's application to the CAT, or at least a central element of that Ground of Application to the CAT, had been a quite different point to that which I have just discussed. It was that the statement in paragraph 7.111 of the Report that, with the exception of those who held open referral policies, policyholders could pay top-up fees under the terms of their policies if they wished to see any recognised consultant was inconsistent with other parts of the Report. The statement was indeed incorrect insofar as it failed to mention the various other practices of Bupa and AXA PPP described in the Report which constrained the ability of consultants to charge, and policyholders to pay, top-up fees. The majority of the CAT dismissed that ground of complaint because they considered that on no fair reading of the Report could it be said that the CMA had forgotten or overlooked those other constraints: see paras 32 and 33 of the CAT's decision. The majority of the CAT were both entitled, and indeed right, to take that view for the reasons they gave.

45. Mr Kennelly submitted in his oral reply that paragraph 7.111 is "internally inconsistent" but I cannot see any basis for that contention.

46. For the sake of completeness – even though, as I have said, the point was not taken up in Mr Kennelly's oral submissions (save in relation to paragraph 7.111 of the Report in his reply) – I do not accept that the majority of the CAT focused solely on the question whether the wording of the Report was internally contradictory. It seems to me perfectly plain that they properly considered the issue of substance as to whether, in the light of the facts recorded in the Report, the CMA's conclusions on top-up fees and consumer choice were irrational.

Ground 2

47. Mr Kennelly's opening oral submissions on Ground 2 of the appeal were to the effect that the majority of the CAT had failed to take account or sufficient account of the fact that the capped-fees were in reality standardised fees and consultants did not charge lesser fees. He referred to several paragraphs in the Report in that connection, including, in particular, paragraphs 7.57, 7.61 and 7.63 and 7.132. The consequence of that, he submitted, is that the Information Remedy would not serve the purpose of remedying, mitigating or preventing the adverse effect on competition or any detrimental effect on customers as required by section 134(4) of the 2002 Act.

48. I would reject that ground of appeal. In the first place, it is far from clear that the point on standardised fees was clearly put to the CAT in the way that it has been argued before us. Ms Smith submitted that it had not, and she pointed to the fact that there is no explicit reference to "standardised fees" anywhere in FIPO's skeleton argument on its application to the CAT. Mr Kennelly referred to a very brief oral statement made by him before the CAT that consultants were "constrained in practice to price at the cap" in answer to a question by Mr Glynn but I do not think that could

possibly be said to be a clear presentation of an oral argument on standardised fees. That is further supported by the absence in the decision of the majority of the CAT of any reference to such an argument despite their careful recitation of the submissions made on behalf of FIPO.

49. Secondly, and in any event, the CMA made findings that the PMIs' insurance rates were not set at uneconomic levels, such as to dissuade consultants from entering or remaining in private practice in sufficient numbers to affect consumer choice or cause long term detriment (7.100, 7.107, 7.108, 7.130) or to prevent consultants from competing on price below those levels (11.628). There is nothing to prevent consultants from charging below those levels if they wish to do so. Mr Kennelly accepted that it might be possible for consultants to make a living if they charged less than those levels, as was expressly acknowledged by Mr Glynn in paragraph 84 of his dissenting decision in the CAT. None of those findings is undermined by the standardised fee argument.

50. The majority of the CAT rejected the complaint of FIPO in its second ground of application that the finding of the CMA that consultants could compete below the fee caps was irrational since it was based on no probative evidence whatsoever and amounted to a fundamental error of fact. The majority of the CAT set out their reasons for rejecting this criticism in paragraphs 39 to 44. Mr Kennelly did not seek in his oral submissions to challenge their detailed reasoning. I consider that, for the reasons the majority gave in the CAT, they were entitled to, and indeed right to, reject that part of the application of FIPO.

51. I have found the submissions of FIPO on the Information Remedy under Ground 2 difficult to follow. As I understand FIPO's skeleton argument, FIPO's contention is that the majority of the CAT (at para. 48) wrongly held that the CMA was entitled to find there was no AEC caused by the fee caps operating as uniform actual fee levels because the Information Remedy would enable patients to make more effective choices and would address the potential distortion of competition between consultants. It is said that such an approach is inconsistent with section 134(4) of the 2002 Act because it is only following the determination of whether there is an AEC that the CMA can proceed to consider whether, and if so what, action should be taken to remedy the AEC.

52. There are two answers to that argument. Firstly, in paragraph 48 of their decision the majority of the CAT are addressing an analysis put forward by Mr Glynn but which, they said (at para. 46) was not in fact advanced by Mr Kennelly for FIPO.

53. Secondly, as stated by the majority of the CAT (at para. 47), the Information Remedy was the remedy which the CMA considered would most appropriately address the AEC arising from the lack of publicly available information on consultants' performance and fees and which prevented patients from exercising effective choice. In that connection, it must be remembered that the Information Remedy applied to the whole of the private healthcare market, which is not restricted to PMIs (which comprise only 55% of the market).

Grounds 3 and 4

54. Without any disrespect to Mr Glynn, who is a highly valued and respected economist member of the CAT, Grounds 3 and 4 of the present appeal proceed on a plainly mistaken basis. There was no obligation at all on the majority of the CAT to explain why they disagreed with Mr Glynn, any more than there is an obligation in the Court of Appeal or the Supreme Court for the majority to examine and address directly the views of the dissenting minority. For the purposes of this appeal, it is sufficient to determine whether or not the challenges to the decision of the majority in the CAT are justified. Insofar as they wish to adopt the reasoning of Mr Glynn, FIPO have done so through the medium of the skeleton argument served on their behalf and Mr Kennelly's oral submissions. I have addressed those in this judgment.

Ground 5

55. Ground 5 of the appeal is a criticism that the CMA adopted an unfair procedure by not mentioning prior to the publication of the Report that it thought that consultants were able to compete on price below the cap. This criticism formed part of Ground 2 of the application to the CAT. The challenge was rejected for the detailed reasons set out in paragraphs 50-57 of the majority decision of the CAT.

56. Mr Kennelly did not make any oral submissions on this ground of appeal. Nor did the skeleton argument for FIPO address the detailed reasoning of the majority of the CAT. Accordingly, no basis has been advanced for the submission that the reasoning was wrong. On the material and arguments before us, I consider that the majority of the CAT were both entitled, and right, to reach the conclusion they did on this aspect.

Conclusion

57. For the reasons I have given above, I would dismiss the appeal.

Lord Justice Patten.

58. I agree.

Mr Justice Barling

59. I also agree.