IN THE COMPETITION APPEAL TRIBUNAL

Case Nos. 1275/1/12/17
1276/1/12/17

Victoria House,
Bloomsbury Place,
London WC1A 2EB

7th November 2017

Before:

PETER FREEMAN CBE QC (Hon)
(Chairman)
PAUL LOMAS
PROFESSOR MICHAEL WATERSON

(Sitting as a Tribunal in England and Wales)

BETWEEN:

FLYNN PHARMA LTD AND FLYNN PHARMA (HOLDINGS) LTD Appellant

- and -

COMPETITION AND MARKETS AUTHORITY Respondent

- and -

PFIZER INC. AND PFIZER LIMITED Appellant

- and -

COMPETITION AND MARKETS AUTHORITY Respondent

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HEARING – Day 5

A P P E A R AN C E S

Kelyn Bacon QC, Ronit Kreisberger and Tom Pascoe (instructed by Macfarlanes LLP)

Mark Brealey QC, Robert O'Donoghue QC and Tim Johnston (instructed by Clifford Chance LLP)

Mark Hoskins QC, David Bailey, Hugo Leith and Jennifer MacLeod (instructed by CMA)

Tuesday, 7 November 2017

(10.00 am)

MR HOSKINS: Sir --

THE CHAIRMAN: Good morning.

MR HOSKINS: There are just a few things I wanted to mention before Ms Bacon calls Mr Beighton --

THE CHAIRMAN: I have got one thing to say but I am quite happy to hear what you have to say first.

MR HOSKINS: Three things. First of all, the homework, I think you have now received both sets of homework. So our note in relation to the decision and there is a new bundle to contain some of these things, bundle N, tab 8 is our note and then the Flynn graph, I believe is in bundle N, tab 9. So you know where to find it.

THE CHAIRMAN: Thank you, right.

MR HOSKINS: The second point I wanted to raise was Mr Lomas asked Mr Poulton on Friday if the prices that Pfizer achieved in other EU member states were profitable and Mr Poulton said he did not know. There is actually information from Pfizer in the documents. I just wanted to give you the reference.

So the decision at paragraph 5.541 records that:

"Pfizer's price levels in other jurisdictions except for one were profitable."

And it gives a document reference number and that

document reference number relates to a section 26 response from Pfizer that was dated 11 March 2016 and it's in bundle J2 at tab 39. And in particular it's question 2 that covers the ground that we are dealing with.

The third point relates to Mr Beighton because there are a number of relevant facts, we say, that the tribunal should be aware of, before you hear from Mr Beighton. The tribunal may or may not be aware, certainly, I think, the chairman will be from the CMCs and the interim measures application, that the CMA is currently investigating -- has a number of investigations into a company called Concordia and some of those investigations are more advanced than others and as the chairman knows, Concordia applied to intervene in these proceedings at a hearing on 8 March 2017.

THE CHAIRMAN: I remember it very well, Mr Hoskins.

MR HOSKINS: Concordia was represented by counsel, Ms Love. I just want to show you what she said about Mr Beighton. It's bundle K, tab 9, at page 30, so K9 --

THE CHAIRMAN: Did you say "K"?

MR HOSKINS: "K". Page 30. Perhaps if I could just invite the tribunal to read on page 30 lines 7 to 21, so it begins:

"Miss Love: Sir, I am instructed that ..."

K9, page 30, lines 7 to 21. (Pause)

You will see from that that the tribunal was told that Mr Beighton remains an officer of Concordia. And then Concordia's request to intervene is in this same bundle at tab 7. If I could ask you to look at page 3, if you see the title page, it's "Request for permission to intervene", Concordia. And then page 3, again if I could just ask you to read paragraphs 10 to 12, please. (Pause)

So you will see from that Concordia is saying:

"As a party to an investigation concerning the same form of alleged competition law infringement, in the same industry ... "

And you will see there is express reference in paragraph 12 to the issue of buyer power, which obviously we are going to be hearing about today.

The reason I show you that is that the interests of Concordia and the position of Mr Beighton within Concordia, are clearly factors that are relevant for the tribunal when considering the weight to be given to Mr Beighton's evidence. He is not simply a disinterested, third party.

MR BREALEY: I do object to this. This is submission as to Mr Beighton. We are supposed to be dealing with the

factual evidence. Mr Hoskins can make all these points in closing. It's just --

THE CHAIRMAN: Mr Hoskins --

MR BREALEY: It is prejudicial.

THE CHAIRMAN: Mr Hoskins may make the points. We may not take them on board.

Just going back to page 30 of this transcript, I'm sure at line 22 I did not say, "I have had enough." Although I can see I might have felt that. I think what I said was, "I have heard enough". Perhaps we could correct the transcript.

MR HOSKINS: Perhaps we could retrospectively.

THE CHAIRMAN: I think we have got the point. We understand --

MR HOSKINS: There is another point I need to make to you because that arose on Friday. The reason why I'm making this now is because I think it's important that you are aware of these matters -- all the tribunal members are aware of these matters before they hear Mr Beighton rather than having heard them and a week down the line --

THE CHAIRMAN: I think you can take it that my colleagues are fully briefed on what has gone on up to now.

MR HOSKINS: There is another factor, there is a new thing that happened on Friday that I would like to tell you.

It's very quick but I would like to tell you about it, which is on Friday MLex published a report of a legal challenge that was brought by Concordia in the High Court against the exercise of a search warrant on its premises by the CMA and that was in relation to hydrocortisone tablets and the MLex report -- we do not need to turn it up, it's in bundle G2 at tab 152A. The MLex report tells us that Concordia was represented by Mr Brealey. The tribunal is therefore in an odd situation. It's going to hear an officer of Concordia being cross-examined on behalf of Pfizer by counsel who has been retained by Concordia on a related matter. I do not say Mr Brealey cannot do it. I do not say Mr Brealey will not do it perfectly properly. We simply point out again it's another factor that may go to the weight you choose to give to Mr Beighton's evidence and that's simply the reason I want to draw this to your attention.

MR BREALEY: As far as I'm aware, I have never met Mr Beighton so ...

THE CHAIRMAN: Thank you.

MR HOSKINS: Sir, that's all I had. Thank you for your time.

THE CHAIRMAN: Thank you. Ms Bacon, you kindly -- could you -- you kindly provided some graphs to us, trend

lines.

MS BACON: Yes.

THE CHAIRMAN: I think the request was for trend lines for both Flynn and NRIM and I think we have only got trend lines for NRIM.

MS BACON: I do apologise. We thought it was NRIM that was being asked about but we can reproduce those with Flynn's as well if you like or we can do a separate one with Flynn. What would you prefer?

THE CHAIRMAN: Which would you prefer?

PROFESSOR WATERSON: I do not mind, whichever is more straightforward.

THE CHAIRMAN: The point about the starting date is the same for both.

MR LOMAS: I think it would be helpful to have both Flynn and NRIM on the same paper from May 2014, whatever else is produced.

MS BACON: Right, so we have already got NRIM from May 2014 so I would propose to use the time period in any event for comparability purposes. That's not a problem and we will ensure they are both on the same diagram.

THE CHAIRMAN: Thank you. Right, so, who is going to call Mr Beighton?

MS KREISBERGER: I call Mr Beighton on behalf of Flynn.

MR JOHN BEIGHTON (affirmed)

Examination-in-chief by MS KREISBERGER

THE CHAIRMAN: Thank you, Mr Beighton. Make yourself comfortable, do sit down and counsel will put some questions to you.

MS KREISBERGER: Mr Beighton, I hope you are about to be handed up bundle B of the hearing bundle. That's the one.

If I could ask you to turn to tab 1 of that bundle, it should say there, "Witness statement of Mr John Beighton." And if I could ask you to turn the page, and you will see there on page 3 there is a signature. Mr Beighton, is that your signature?

A. It is.

Q. And, Mr Beighton, does this witness statement represent your evidence in these proceedings to the best of your knowledge and belief?

A. Yes, it does.

Q. Thank you, Mr Beighton. Mr Brealey now has some questions for you.

Cross-examination by MR BREALEY

MR BREALEY: Good morning, Mr Beighton. Just to let you know, I am counsel for Pfizer and the tribunal has asked -- has allowed me to ask certain questions about your witness statement and after I have asked some

questions, Mr Hoskins of the CMA will ask some questions.

You've got your witness statement in front of you, have you, because -- can we go to paragraph 1. You say at paragraph 1 that you were managing director of Teva from October 2002 to January 2009. Could you just give the tribunal an idea of what that meant on a daily basis? What did the job entail as a managing director of Teva?

A. So I was running the UK based subsidiary of Teva, a big international drug corporation. I had the responsibility for running the factory that we had in Eastbourne, which was a packaging unit. I also had the responsibility of the commercial activities that were based in Leeds. My job was to just make sure that that company ran well and that we were able to achieve certain sales targets.

Q. You say that Teva was a big international corporation. What sort of pharmaceutical products did Teva place on the market at that time?

A. We would generally put on the market generic medicines, so these would usually be launched at patent expiry of a big blockbuster medicine and the strategy would be to significantly reduce prices in order to gain market share and, you know, ensure that we were able to sell

our products.

Q. You say generally, was it purely generics or did you have certain branded products?

A. Yes, Teva had a small number of branded medicines that it sold in the traditional way of sending medical representatives to see GPs to persuade them of the benefits, clinical benefits of those medicines, so less of a commercial argument, more a clinical argument.

Q. So was it a member of the PPRS at that point, Teva?

A. I believe it was, yes.

Q. Also at paragraph 1 you -- the last sentence -- I take you to the last sentence -- you give an idea of your experience in the pharmaceutical industry and Mr Hoskins has just referred to Scheme M. So you say in that regard:

"I was closely involved in working with the Department of Health to help create the current system of reimbursement for generic medicines in the UK."

Could you just give the tribunal a flavour of how closely involved you were and what you did?

A. Yes, I was very closely involved. I met officials from the Department of Health, on a regular basis, during the run-up to the launch of Scheme M, including the gentleman that we will refer to -- referred to later. I also met Lord Hunt, who was the junior minister in

charge of pricing pharmaceuticals at the time in the run-up to that; and my job, as well as being managing director of Teva UK, who were probably the biggest generics company at that time, was also to represent the interests of the rest of the generics industry in the discussions with the Department of Health.

Q. You say you are going to refer to a gentleman. We will come on to the meeting a bit later on but can you just identify who this gentlemen was. You just mentioned, I think, a gentleman. The name?

A. I can but I heard on Friday there was lots of fuss about mentioning civil servants.

THE CHAIRMAN: Yes, we are not mentioning Department of Health names other than very senior officials and we do not know who very senior officials are. So a prudential cautionary approach would be much appreciated.

MR BREALEY: Sure.

THE CHAIRMAN: We all know who the individual that you are referring to is. So ...

Mr Beighton knows and you know, Mr Brealey. So I think you can question on that basis.

MR BREALEY: You mention Scheme M and category M in paragraph 4 in your statement. Could you go to bundle H1. Can I take you to bundle H1. So this is tab 16, H1, tab 16. At tab 16 this is a Department of Health

Scheme M document. Is this the scheme that you were familiar with, that you helped create or --

A. It looks like it.

Q. Yes.

A. It looks like it.

Q. And if you flip over, for example, to paragraph 6, it says:

"Arrangements for membership of each scheme are covered by voluntary agreements under section 33 of the Health Act 1999. All companies supplying generic medicines are able to join the relevant scheme. Those that decide not to shall be subject to a statutory scheme under section 34 to 38."

What was your understanding at the time? Did you discuss this with the Department of Health, these powers?

A. I really do not remember whether I personally discussed them. The decision of Teva was always to join the voluntary scheme anyway, so maybe it was not an issue that was high on my agenda.

Q. So Teva did join the voluntary scheme, Scheme M?

A. Yes.

Q. And if you go over to page 7, to paragraph 28, it says:

"Wherever possible, the Department will allow changes in market prices to be influenced by existing

market mechanisms. This means that where there is effective competition in respect of any given generic medicine then the Department will not interfere in the operation of the market for that medicine. However, should the Department identify any significant events or trends in expenditure that indicate the normal market mechanisms have failed to protect the Department from significant increases in expenditure, then the Department may intervene to ensure that the NHS pays a fair price for the medicine(s) concerned."

Were you familiar with that paragraph?

A. I was very familiar with that paragraph because it included an issue that was very important to the generics industry but also very important to the Department of Health.

Q. And why was it important to the generics industry -- and then I'll ask you why it was important to the Department of Health. Why was it important to the generics industry?

A. It was important to the generics industry because the industry wanted to have a free pricing mechanism. In a market that's very commoditised, like the generics medicines market tends to be, that usually leads to significant falls in prices of medicines. But in order for generics businesses to survive, they also need to

take advantage of price increases where that becomes possible.

Q. And why was this paragraph 28 important to the Department of Health?

A. Because my belief of their position was that whilst they understood that a free market generally led to prices coming down, they wanted to protect themselves where prices were going up excessively and where that did happen -- and we have a great example here -- they were able to intervene and effectively either in the case of Teva and Phenytoin, come to an agreement, or if that agreement is not reached, to use the power that the Secretary of State has in order to set that price on a non-agreed basis.

Q. So that's Scheme M. You also refer to category M at paragraph 4. Could you just give the tribunal an idea what category M is?

A. This is paragraph 4 of my --

Q. Of your statement, sorry.

A. Sorry.

Q. You can put that Scheme M away for the time being. So you refer to category M. What was the purpose of category M?

A. Category M is a category of the drug tariff that holds within it widely available generics and commonly

available generics, and effectively what that does, it provides a list of prices that a pharmacist in England and Wales will be reimbursed when he or she dispenses the medicine.

Q. So you refer to -- it's the drug tariff. So what involvement does the Department of Health have as regards prices in category M?

A. Okay, so the Department of Health fixes the prices in category M but it uses information which is openly and regularly submitted to the Department of Health by the finance departments of all the big generics businesses. So effectively the Department of Health knows what price UK wholesalers and pharmacists have paid for a certain medicine.

What the Department of Health then does is applies -- it applies some sort of multiplier, which is unknown to the generics industry, in order to allow the forward supply chain, wholesalers and pharmacists to make a profit which is agreed between the department and the PSNC.

Q. So when you say -- you just said that the Department of Health -- I think you said fixes the price. To what extent, therefore, can the Department of Health change the price in category M? Can it change the price? You say it fixes --

A. Well, it can change the price anyway because the Secretary of State has the power to dictate the price of a medicine. What would happen on a normal basis is that the price -- the Department of Health takes into account the prices that the generics companies have made and adjusts the reimbursement price accordingly. There is not a strict relationship but generally if the price goes up, then -- of the generic manufacturers, then the reimbursement price goes up. If the price goes down, the reimbursement price goes down but clearly the reimbursement price is significantly higher. In those days two or three times higher than the prices that were being provided by the generics companies.

Q. Can I move now to paragraph 5 of your witness statement, so we are -- where you refer to the drug tariff price of the tablets and the price increase prompted the DH to intervene. You say you do not recall the precise date but to the best of your recollection, in or around October 2007. You say:

"Teva was contacted by an official from the Department of Health who requested a meeting with Teva. The meeting was called because the DH wanted to discuss the pricing of the tablets."

You say that Teva was contacted -- can you remember -- I know it's a long time ago but can you

remember whether it was by letter, by phone or --

A. I cannot remember that. I cannot.

Q. So -- at what stage did you get involved?

A. Oh, I think that the contact was made with me. I just cannot remember how it was made, email or phone.

Q. So you -- right. So you think that you were the direct contact as managing director?

A. Yes.

Q. And what did you understand the Department of Health wanted when they contacted you?

A. The -- it was clear that they wanted to talk about Phenytoin tablets and they wanted to discuss the price and we in Teva understood or guessed that probably it was as a result of the significant increase that we had seen over the last few quarters..

Q. So you -- if I can go to paragraph 6, you say:

"I attended that meeting ..."

And recall that you were told that:

"... the DH wanted the price of the tablets to be reduced. The DH also told us that if Teva did not cooperate they had the power to bring the price down itself but would prefer to do it with our cooperation. It was my understanding that the DH had a range of different powers to regulate prices of medicinal products supplied in the UK, including generic products

such as the tablets, which it could use to bring down the price -- and that is what I understood the DH to be referring to when it said it could use its powers to bring down the price of tablets."

So as I understand it then, after, whatever it was, a letter or telephone call, there was a meeting. Can you remember how soon after the meeting was?

A. No, but it was fairly quickly. We had a meeting fairly quickly after we had been asked to attend.

Q. And did you go alone or did you -- you say:

"I attended that meeting ..."?

A. I attended with a colleague.

Q. And what was his role?

A. He was, I think at that time, head of our generics portfolio. So kind of the commercial officer of the business.

Q. And you met with the DH. Please do not mention the names but can you remember how many people were there from the DH?

A. Yes, I have a very clear memory of that meeting. There were two gentlemen, who I had known professionally very well during the discussions about Scheme M, and I believe that both of them were very influential in implementing Scheme M and so there were two of them and my colleague and I.

Q. You say at paragraph 7:

"We identified a reduced price for the tablets. I do not recall the precise price that we tabled to the DH officials, but I do recall that they wanted us to implement a phased reduction for the prices of the tablets ultimately to a lower level."

What I would like to do is just take to you a passage in the CMA's decision. Mr Beighton will be taken to the decision. At page 187. While you are being given that, you say at paragraph 2 you have not seen the decision. Is that still the case?

A. It's still the case.

Q. You still have not seen the decision?

A. No.

Q. So at page 187, if you just look at that table 3.12, you have the date 1 October 2007, category M, £113.62. 1 January 2008, category M, £40. 1 April 2008, category M, £35. 1 October 2008, category M, £30.

A. Sorry, this is page 185?

Q. 187, sorry. Do you want to have a look at page 187 and we will go through that again.

MR HOSKINS: I think they may be slightly out on the pages.

A. The price of 113 --

MR BREALEY: If you go to paragraph.

A. -- is on my page 185.

Q. Oh, is it? Is that paragraph 3.484?
A. Yes.
Q. So you were looking at that table 3.12 with various prices. If you go back to your witness statement you say that:

"We identified a reduced price for the tablets. I do not recall the precise price that we tabled but I do recall him wanting us to implement."

So a couple of questions on this. You've told us that the DH said they wanted it reduced. What happened? Did they -- did you discuss it with the officials? Did you -- how did the meeting play out?

A. The officials greeted us politely, but then told us very quickly that they were having a real problem with the price of Phenytoin tablets and were receiving feedback from, I think at that time it was PCTs, the primary care trusts, the people who were responsible for budgets, and I remember one of the officials saying to us that they really wanted to do this cooperatively, together, but he also reminded me that the Secretary of State did have the power to reduce the price to whatever level he wanted to, should we -- were -- would not agree.

So there was then some debate about our justification for the price, for the price increase, there was some debate about how the system -- the

Scheme M system -- was escalating the price well above where the Teva price was, but in the end the official said, "We would like you to reduce your price." We agreed and I'm just trying to remember who asked for the break in the meeting, but they left us and I cannot remember whether we said, "Can we just sit and talk for a minute whilst we decide what to do", or whether they asked us to sit and talk for a minute. They left us for probably five or ten minutes. My colleague and I said, "What are we going to do?" We came up with a price, which it seems from here was £40 and when they came back in, we said, "We would be willing to reduce our price to below £40 so that you can then set the reimbursement price at £40."

There was discussion at that stage about the multiplier effect of category M because we wanted to make sure that whatever price we were -- we were agreeing to sell at was not going to be multiplied over and above that. And they agreed to that but they also said that the price was not good enough and then told us that they were going to reduce the price subsequently on a number of further quarters and I guess we can see here where that price went to.

Q. So can I just be absolutely clear on this. Your evidence is that -- and I'm looking at the first line of

paragraph 7, just to be clear. You tabled £40 --

A. Yes.

Q. -- and the government officials, the DH officials said they wanted a phased reduction. Who was it that suggested or who fixed on £30?

A. They told us it would go down to £30 in a phased reduction.

Q. So again to be clear, that is the price that the officials wanted?

A. Yes.

MR BREALEY: I've got no further questions, sir. Thank you very much.

THE CHAIRMAN: Thank you, Mr Brealey. Mr Hoskins?

MR HOSKINS: Thank you, sir.

Cross-examination by MR HOSKINS

MR HOSKINS: Good morning, Mr Beighton. Can I stick with the meeting, the DH meeting, you have just been talking about to Mr Brealey. Just to put this in a bit more context, the 2000 price control regulations had been repealed on 24 May 2007. Do you remember that?

A. No, I do not remember that.

Q. And between April 2005 and December 2007 there had been a series of significant increases in the drug tariff price of tablets. Indeed the price increased by 6,584 per cent. Do you remember that?

A. I do remember -- I do not remember the specifics of the percentages but I do remember the prices of the tablets going up significantly.
Q. And Teva received a lot of criticism for these price increases, did it not?
A. I do not remember -- I do remember this discussion with the Department of Health. We may have had some feedback from PCTs as well but I certainly do not recall that.
Q. You may have had some feedback from PCTs? You said the Department had referred to complaints they had had from PCTs. Are you saying you were not aware of any of that criticism?
A. No, I'm just trying to dredge my memory. But there is a very clear memory of the discussion with the Department of Health. It's possible that there were -- that -- that my sales force were getting feedback at the time about the price but I do not remember it.
Q. The price had increased 6,584 per cent. It would be surprising if you did not receive any criticism that you were aware of, would it not?
A. I think it would if -- if there was an understanding that Teva were solely responsible for that price increase. I cannot work out the percentages but the price that Teva was charging was significantly below this £113 that we see here.

Q. I'm still not quite clear whether you are accepting or not that Teva was aware of external criticism of the price increase?

A. I am thinking that we probably were but my overwhelming memory of this period was of the discussion with the Department of Health.

Q. Insofar as there was criticism that you may be able to remember, it was not just of Teva was it but senior managers at Teva were being criticised as well, were they not?

A. No, I do not remember that.

Q. You say in your statement:

"The DH also told us that if Teva did not cooperate, they had the power to bring the price down itself."

Did the DH specify what powers it would use or was it more along the line of a general indication that they would do something if Teva did not reduce its prices. Which was it?

A. No, it was not a general indication. I do not remember whether there was a specific reference. There was at that time a general view within the generics industry -- and maybe we were -- maybe we were using the wrong term, but there was a view in the generics industry that the Secretary of State had the power under the Medicines Act to intervene on price whenever he or she felt it was

necessary to do so.

Q. So that was, you say, your understanding of the generics industry but the question was did the DH specify what powers it would use?

A. I do not remember whether they used the term "Medicines Act". I do remember they used the term "Secretary of State" and "has powers to set your price".

Q. When you refer to the Medicines Act, are you talking about the power of the Secretary of State to adopt regulations to control the price of generic medicines?

A. No, I'm talking about our understanding that the Secretary of State, which is then passed on to his officials, has the power to set price immediately. That is what we were feeling when we were having discussions with these two officials about the price of Phenytoin tablets.

Q. Can we go back to Scheme M, which Mr Brealey showed you. That was at H1, tab 16. At page 7 of the document, please. Mr Brealey showed you paragraph 28, which said that:

"... the department may intervene..."

But if we can look at the following paragraphs, 29:

"To allow the consideration of prices and reimbursement, a Scheme member shall provide to the Department on reasonable request information such as the

following:

"An analysis of the direct and indirect manufacturing and/or supply costs of the product or products which have increased in price."

Why would the DH want or need that sort of costs information in order to intervene in price?

A. I guess that they would want to use that information in a way that would be -- would be helpful to decide whether the price increase was justified or not.

Q. And at paragraph 30:

"In its examination of the reasonableness of a company's costs and prices, the Department would have regard to factors such as the following ..."

Then if you can simply cast your eye over those. As one of the people who had input into the scheme, why would the department want to have regard to these sorts of factors? What's the purpose of this exercise?

A. Again, I can only assume -- and this is, I guess, speculation -- that they would want to make sure that any price increase could be justified ...

Q. But, of course, Teva never got to this stage because, as you say, you had one meeting and you agreed a price with the DH?

A. Yes, that's true.

Q. Our understanding is that Scheme M has never actually

been used to reduce an excessive price. Does that accord with your understanding?

A. I do not know. I know that -- I know that on this occasion there were -- given my history with the Department of Health, it was -- it was a very memorable occasion because they were, to my memory for the first time, using powers that we in the industry had always known that they had.

Q. It must have been very embarrassing for you. You had worked closely with these officials to draw up the scheme and here you are being carpeted by them. Was it embarrassing for you?

A. It was -- it was a difficult meeting. Was I embarrassed? Look, companies like Teva and companies like Concordia, the majority of pricing decisions that they are taking are to reduce prices, 99 out of 100 decisions are to reduce prices and I was thinking about this over the weekend. The decisions that I've made and my team have made have influenced tens of billions of savings over the last 20 years, both in Teva and in Concordia. Tens of billions. Was I embarrassed because one price had gone up? I did feel uncomfortable but I also felt that -- that I could come to a -- you know, I could accept what I was being asked to do.

Q. And a company like Teva, presumably, wants to have

a good relationship with the DH. It's an important part of your business, is it not?

A. Absolutely. In the UK they are the -- effectively the single customer.

Q. So you would not want to fall out with them. That goes without saying?

A. True.

Q. Could we go to bundle G2, please, tab 150A. Have you seen this newspaper article before?

A. Yes, yes, I have.

Q. And have you re-read it in the last few days?

A. No, I have not.

Q. Do you want to just quickly cast your eye over it now, to refresh your memory? You do not need to?

A. I do not need to.

Q. This article tells us that you spoke at a conference at the Waldorf Hotel in central London in November 2012. Is that correct? Did you speak at that conference?

A. Yes, I did, yes, the Jefferies healthcare conference.

Q. It was the what, sorry?

A. The Jefferies healthcare conference.

Q. Can you explain what that is, please?

A. It's a conference hosted by Jefferies bank to bring together pharmaceutical managers, to bring together with them investors and journalists to the same event so that

there could be an exchange of information about -- about the individual companies and what their strategies are and so on.

Q. Given it was a bank organising it, is it fair to say the focus of the conference was commercial rather than technical/pharmaceutical. Is that fair?

A. Yes, that is fair to say, yes, though, of course, there would be some technical input as executives explained how their businesses worked and many of them would talk about individual medicines and the benefits that those medicines would have.

Q. Can you turn back in this bundle to tab 98A, please. 98A?

A. Yes.

Q. That should be a title slide -- there is a set of slides and this one is:

"MercuryPharma Amdipharm.

"Jefferies Healthcare Conference Presentation."

Do you have that?

A. I do.

Q. If you turn to the second slide, we see you looking -- you have not changed at all over the years.

You are one of the -- today's presenters and you were employed by Mercury Pharma at the time, were you not?

A. Yes, what was the date, November ...?
Q. You see it on the cover, 13 November 2012?
A. Yes, I was, yes.
Q. Have you seen these slides recently?
A. Yes.
Q. When did you look at them?
A. I think you submitted them on Friday --
Q. So in the last few days?
A. Yes.
Q. Then if you go -- look at the third bullet -- sorry, the third page is titled "Merger Plan". The third bullet on the fourth page says:

"Mercury now plans to merge with Amdipharm, a combined operation run by Group CEO John Beighton."

What was the purpose of telling the conference about this merger?

A. I guess it was an explanation of what my colleagues and I intended to do. We had just begun on this path. We knew where that path was going to lead. It was going to lead to -- in the end the owners of that business, Cinven, selling the combined business on to somewhere else -- to somebody else. So this was our first opportunity to start to inform investors and potential acquirers of the business -- as I have said, many big pharmaceutical companies were there and we wanted to

take the opportunity to explain what it was that we did.

Q. If we go to page 5. It's entitled "Mercury Pharma snapshot."

It says:

"Company Overview.

"Mercury Pharma is a speciality pharmaceutical company focused on sale of niche prescription, off-patent products with limited competition from originators or generics manufacturers or licence holders."

So that's an overview of Mercury Pharma and if we go to slide 13, it says:

"Limited and stable competitive dynamics around key products."

I wanted to ask you some questions about the bullet points on the left-hand side. If you've read these over the weekend, perhaps you do not want to read them again. If you would like to --

A. Yes, because I have not read it in detail.

Q. Absolutely. Please take your time to do that.

THE CHAIRMAN: Mr Hoskins, it's not suggested that Phenytoin is one of these products --

MR HOSKINS: No.

THE CHAIRMAN: This is just peripheral.

MR HOSKINS: You will see where it's going --

THE CHAIRMAN: I think I can see where it's going.

MR HOSKINS: So as described here, Mercury's business model was to find old, niche, out of patent products that were of subject to limited competition. Is that correct?

A. That was one aspect of our business model, yes. There were many other aspects to it including selling generic products. This was something that we felt would be particularly helpful to focus on for this particular audience.

Q. And presumably, it would be helpful because it was a source of revenue for the company?

A. Yes.

Q. And why is it significant that these types of products were subject to limited competition?

A. Sorry, I'm not sure I understand what you mean.

Q. We saw at page 5 in the description you referred to the fact that these products were subject to limited competition. We see it referred to again at slide 13. So I am just wondering why, when you are trying to explain to the audience why this is an attractive revenue, what's the significance of limited competition?

A. The first question that a potential owner or investor will ask him or herself is how sustainable is this business and I guess by referring to the competitive situation, we were trying to reassure people that

these -- that this revenue was sustainable.

Q. And one of the factors of limited competition that's attractive is it means that the pricing is not constrained by competition, is it not?

A. Yes, I guess so.

Q. If we go to page 14:

"Favourable position in UK regulatory framework.

"UK is an attractive market for Mercury/Amdipharm.

"UK pharmaceutical reimbursement less at risk from austerity policies.

"Unlike many other areas of government expenditure, the DoH currently forecasts the NHS budget ... to continue to rise...

"Pharmaceutical reimbursement contributed c.10 per cent to the total NHS budget in 2012, so is not as material to overall healthcare spending as actual service provision, which is the primary focus of healthcare reform."

Is it fair to say that what you are telling the audience here is that the UK was an attractive market because the NHS budget was forecast to continue to rise on one hand and there was little focus on healthcare spending on the other? Is that what is being said in this slide --

A. No, my position on the UK pharmaceutical market,

particularly the off patent area of the pharmaceutical market, is that this system of free pricing generally allows huge savings to be made and I think it's still the case that this freedom of pricing allows much lower prices in the UK than many other countries in the developed world including Europe.

So the system works and where prices are increased, then it is easily notable that that will then lead to competition coming in and then prices subsequently falling.

Q. Mr Beighton, this slide is not about reducing prices; it says in the little subheading:

"UK pharmaceutical reimbursement less at risk from austerity policies --

A. Sorry, which slide?

Q. I am still on page 14.

A. Okay.

Q. In the first blue heading:

"UK pharmaceutical reimbursement less at risk from austerity policies."

What this slide is saying is that there will be NHS money available; indeed there will be more NHS money available. It's not dealing with price reductions, is it; it's dealing with there being a pool of money --

A. I'm sorry, yes, of course, yes, specifically that is

what that is referring to.

Q. So what you are saying here, in this slide is the UK is an attractive market from a revenue standpoint because the NHS budget was forecast to continue to rise on one hand and there was little focus on healthcare spending on the other. That is what this slide says, is it not?

A. But there is little focus on healthcare spending, I do not --

Q. It is the second bullet point:

"Pharmaceutical reimbursement contributed c.10 per cent to the total NHS budget ... so is not as material to overall healthcare spending as actual service provision..."

A. No, indeed and --

Q. So why could would you say that pharmaceutical reimbursement is not the primary focus. What's the significance of that?

A. No, indeed and my point about the generally much lower reimbursement prices in the UK and the generally much lower drugs bill in the UK compared to other geographies is really a benefit which allows government to focus on other areas, rather than drug spending and therefore, if you are in the drug spending sector, then that is a benefit to you as an investor.

Q. Go to slide 11, please. "Key Strategic Elements". The

second point on the page:

"Limited and stable competitive dynamics around key products.

"Strong barriers to entry due to relatively small size of individual product markets by country..."

Why is it relevant that there are strong barriers to entry?

A. Again, to make sure that a potential investor would be able to see sustainable revenues.

Q. So the reason why strong barriers to entry are relevant, as you say here, is because it helps to ensure limited competition; correct?

A. I guess so, yes.

Q. Then the third point:

"Favourable position in UK regulatory framework."

The first bullet says:

"Portfolio comprises low cost off patent products, which are not the main focus of healthcare cost reduction initiatives."

So this chimes with the previous slide that we saw?

A. Yes.

Q. And what you are saying here is the point I was putting to you. The reason why this commercial revenue stream is attractive is because nobody really notices it; there is little focus on it?

A. Because generally the products are smaller -- yes.
Q. So little regulatory focus on it. Is that fair?
A. Yes, and -- yes, that is right. That is what this presentation is saying.
Q. And then still in the third point but the second bullet:
"UK is an attractive market owing to unrestricted pricing on unbranded products."
So what you are saying here is that there is an attractive commercial opportunity in the UK for pharmaceutical companies that can find these drugs that are off patent and subject to limited competition. Is that correct?
A. Yes, definitely correct. My word there, "unrestricted pricing", is not one that I would usually use. I did not actually write the presentation but I did give it, you are absolutely right. My normal description of the system in the UK is one of free pricing, where prices freely fall but sometimes can be increased.
Q. Sorry, if you just bear with me a moment. And you used the phrase "unrestricted pricing". I mean, that is a clear indicator, is it not, that fear of regulatory intervention is actually very low in the UK, is it not?
A. There is a -- there is a freedom of pricing in the UK and generally overwhelmingly that is of benefit to the NHS.

Q. And in these sorts of products we are talking about, you repeatedly refer to the favourable position in the UK regulatory framework. You are saying that the attractiveness is that in these niche areas, where the focus is not on them, there is no real focus on your prices, is there?

A. I think that there is focus on price whenever the price reaches a certain level, as we saw with the Phenytoin tablets and Teva and then there is one of a number of different types of intervention. One is potentially from the Department of Health; the other, of course, is, as the product increases in size, whether it's through volume or through price, you see competition.

Q. To attract any sort of regulatory attention, the price has to be pretty eye watering, does it not?

A. I am not sure the price does but the overall cost does.

Q. Sorry, I did not catch the end of that answer.

A. The overall cost.

Q. To the NHS. But if one were, for example, to introduce a very dramatic price increase, like you did in relation to tablets, that's the sort of case that might attract attention; otherwise, carry on regardless; correct?

A. No, I do not think -- I do not think that we carried on regardless. Decisions over price both up and, as I have said before, the vast majority of them are down -- are

taken very seriously.

Q. At paragraph 8 of your statement you say:

"It was my understanding from my dealings with the DH at the time that the DH was satisfied and if it was not happy with the revised prices it could intervene again."

Did the DH ever actually tell you that they were satisfied with the price?

A. I cannot remember the words that we used as we left the meeting but my feeling was that whatever they were going to do with our agreement was acceptable to them.

Q. So you assumed they were satisfied because they did not take any further action against you. Is that a fair way to put it?

A. Not only did they not take any further action but they also implemented the prices. These were not Teva prices, remember, these were Department of Health prices and they publish them in subsequent drug tariffs.

Q. And it's on the basis of that that you assumed they were satisfied with the price?

A. On the basis of the meeting and whatever we discussed in the meeting actually happening.

Q. And are you aware that the DH complained to the Competition and Markets Authority about the price of Teva's tablets in around January 2013 or was that after

your time?

A. It was after my time. I did not know that.

Q. At the time you had the meeting, and up until September 2012 -- it's probably difficult for you to picture where you were in your life then but did you -- let me ask you a general question first.

Presumably, you would not usually discuss matters that were commercially confidential to Teva with other pharmaceutical companies, would you?

A. Whilst I was with Teva, no.

Q. And prior to September 2012 did you ever discuss your dealings with the DH concerning the price of tablets with anyone from Flynn or Pfizer?

A. Definitely not with Pfizer. At some stage -- and I cannot remember when -- I did talk to Flynn.

Q. Can you help us roughly when?

A. No, I really do not remember.

Q. Was it in relation to this particular investigation that you had discussions --

A. It was in relation to -- yes, it was.

Q. So was that after the CMA had begun the investigation into Flynn? Was that why it came up?

A. When was that? I think so.

Q. Well, when you had the conversation with someone from Flynn, did they mention the fact they were investigated

by the CMA?

A. I think it was well-known. I am sure it was well-known at the time.

Q. It was well-known at the time --

A. That Flynn was being investigated. So presumably, it was after that investigation had started.

Q. Thank you, Mr Beighton. Sir, I do not have any further questions.

Questions from the PANEL

THE CHAIRMAN: Thank you, Mr Beighton. Just one or two little points. Is it the case that you have kept no papers of any kind about your time in Teva and this particular meeting with the Department of Health.

A. I did not keep them but I am pretty sure that there will have been some reference to that meeting in Teva files.

THE CHAIRMAN: You do not have any papers yourself?

A. No, the only thing that I do have is an old laptop, which funnily enough, as a result of another CMA enquiry, I remembered that I had, and there are some files on there which may or may not be helpful to you.

THE CHAIRMAN: It's not a question of being helpful to me. You did not find it necessary to add any papers to your witness statement?

A. This thing happened just a few days ago. I spoke to the legal team here.

THE CHAIRMAN: Right.

Second question. Different. You referred, I think, to -- this is the price of the Teva tablets, going up between 2005 and 2007. And you said:

"We had seen very high increases ..."

Something to that effect. That's what led to the meeting?

A. Mm-hm.

THE CHAIRMAN: Is this a process then of an increase in the price of tablets in which Teva played no part, you merely observed it, or did you contribute to it?

A. Yes, yes, Teva --

THE CHAIRMAN: Can you perhaps explain.

A. Yes, so the way that a company like Teva or indeed Concordia will look at the drug tariff is it will see how much its customers are being reimbursed for that medicine and take that into account as to how the company then sets its own price.

THE CHAIRMAN: Which is the cause and which is the effect in this circular process?

A. Yes, well -- so if you are a junior product manager responsible for what was at one stage a relatively small product, Phenytoin, you would see that drug tariff go up and then you would nudge your own price up. The following quarter the Department of Health would use

that new nudged-up price to determine the next quarter's drug tariff price and then the company will see that the pharmacists are getting reimbursed more and will then take the opportunity to push the price up again.

Usually it's doing it the other way round, you understand that, but on this occasion it was pushing up the price, whereas the system generally allows the price to spiral down.

THE CHAIRMAN: What in your opinion was the reason that for this product the price went up rather than going down?

A. It was a combination of Teva increasing its price at a relatively low level first --

THE CHAIRMAN: I understand that. You've explained that. What I mean is why was the general direction of this great circular process upwards rather than downwards?

A. Oh, I see. I think in that case because Teva were the only company making this product, which is --

THE CHAIRMAN: There were no other Phenytoin tablet manufacturers?

A. That is correct. That is correct. Sorry, so, yes, that is an important factor.

THE CHAIRMAN: So that enabled your product manager to nudge the price up, as you put it.

A. Yes.

THE CHAIRMAN: Until somebody blew the whistle and you had

your meeting and the price came down?

A. Yes.

THE CHAIRMAN: Final question from me. When you were in your intermission in this meeting, and you were wondering what price to table, how did you decide on £40?

A. I really do not remember and it was -- and it was -- kind of a frenetic little interlude and it was -- it was a -- trying to make a judgment about what -- what the officials would be satisfied with and what would also allow Teva to continue to have some decent revenue from this product.

THE CHAIRMAN: The observation has been made that it is substantially above the price that ruled in March 2005.

A. Yes, that is right.

THE CHAIRMAN: And you would have been aware of that?

A. Oh, yes, yes.

THE CHAIRMAN: Yes. I'm still a bit unclear why 40 came out of the ether. Was it just a nice round number?

A. It was probably around -- and this is not an absolutely specific memory, but it was probably around half the price that Teva were actually achieving at the time.

THE CHAIRMAN: And it did not actually work because the price then went down to 30.

A. Yes.

THE CHAIRMAN: Okay, thank you.

MR LOMAS: One question. Following on from what the chairman is just asking you, what multiple of increase was 40 by reference to the price at which the -- if you like, the pre-existing normal price, the price before Teva started to increase the price?

A. So the -- I think the -- the original price of Phenytoin tablets was around the same price as Phenytoin capsules, historically. So I think around about £3 a --

MR LOMAS: Right. So it was an increase of some 15 or 16 times -- more than -- yes.

A. I guess so.

PROFESSOR WATERSON: Were there parallel imports for Phenytoin tablets?

A. No, we never saw that.

PROFESSOR WATERSON: Is there a reason for that, do you think?

A. Yes, I think the Teva Phenytoin tablets were a purely UK phenomenon. This was a -- it -- the -- the medicine had had competitors in the past, other companies had made Phenytoin tablets in the past, but the -- the bar of quality, the regulatory bar, had increased and increased and a number of competitors had dropped out, which was why Teva ended up as a -- selling the product on its own. But it was a specific UK generic and was not sold

elsewhere in Europe.

PROFESSOR WATERSON: I see.

THE CHAIRMAN: Okay, thank you. Ms Kreisberger, do you wish to re-examine?

MS KREISBERGER: I do, thank you, sir.

Re-examination by MS KREISBERGER

MS KREISBERGER: Mr Beighton, just taking you back to your meeting with the Department of Health, you mentioned that the meeting was with two officials who you described as very influential. We are not saying their names of course. Can you recall what their titles were, what roles they held at the Department of Health?

A. I can -- I can check and tell you.

Q. You cannot off the top of your head give us a flavour of what they would have described their job title or their seniority perhaps?

A. No, I always felt they were quite senior. They reported to the head of department, the head of the pricing department.

Q. Okay, thank you --

A. Whose name I also remember very well.

Q. Mr Beighton, if I could then just take you back to the Jefferies presentation in November 2012, who was your target audience for that presentation? Who were you pitching to?

A. We were pitching to big pharmaceutical companies, whom we thought may want to acquire us at some stage in the future.
Q. So possible future investors?
A. Yes.
Q. So would it be fair to describe it as a sales pitch?
A. It was a sales pitch, yes.
Q. Thank you, Mr Beighton.
Just going back now in time to 2008, to the time of the changes in the tablet price, can I just, to be clear, check: were you -- you were involved in the BGMA in 2008?
A. Yes, I cannot remember if I was chairman or not at that time but as a pharmaceutical -- as a generic executive, I have pretty much always been involved in BGMA.
Q. So given that, would you say the industry was aware, the wider generics industry, was aware of the alteration in the tablet price in around 2008?
A. Yes.
Q. And final question, Mr Beighton: you were asked about your discussions with Flynn representatives relating to the tablet price. I just wondered whether you can recall where those discussions might have taken place?
A. Yes. I think it was -- it is a long time ago and it was not as significant as some of the other events we are

talking about but I am pretty sure it was at a Jefferies conference as well.

Q. So that could be the Jefferies conference in November 2012?

A. It could have been, yes.

MR HOSKINS: I am sorry, that's an astonishingly leading question.

MS KREISBERGER: We have only covered one Jefferies conference. Were there many, Mr Beighton?

A. Yes, they had one every year.

Q. And you are unable to recall which one you might have had that discussion with --

A. It would be irresponsible of me to try and guess.

MS KREISBERGER: Thank you, Mr Beighton. That's all.

THE CHAIRMAN: If the titles and positions of the two officials at the Department of Health meeting come back to your memory, perhaps you would be good enough to inform your counsel.

A. I just need to check on my phone because I have got their names ...

THE CHAIRMAN: Can we leave that to you? Thank you, Mr Beighton, I think you may stand down.

This would be a good moment to pause, I think.

MR BREALEY: I think it would, thank you.

THE CHAIRMAN: A few minutes.

(11.14 am)

(A short break)

(11.28 am)

THE CHAIRMAN: Mr Brealey. We move to the age of the experts.

MR BREALEY: We do. Could I call Professor Walker, please.

PROFESSOR MATTHEW WALKER (sworn)

Examination-in-chief by MR BREALEY

THE CHAIRMAN: Professor Walker, do sit down, make yourself as comfortable as you can in the circumstances.

A. Thank you very much.

THE CHAIRMAN: Counsel is going to put some questions to you.

MR BREALEY: Could you be taken to bundle D and M, please. First of all, can you go to bundle D and go to tab 9. That is your first report, dated 7 February 2017. Can you just flick through it and then go to page 17 and confirm that is your signature?

A. Yes, it is.

Q. And then if you can go to tab 10 of the same bundle. That is your second report, dated 19 May 2017. If you go to page 9, could you confirm to the tribunal that is your signature?

A. Yes, it is.

Q. And then if you have got bundle M --

A. Yes.
Q. -- in front of you, go to tab 2, which is entitled your third expert report and if you could go to page 2 again, can you confirm -- this is dated 25 October 2017. Could you confirm that is your signature?
A. Yes, it is.
Q. I will just ask you a few questions as to your report. Could you confirm that you have made clear which facts and matters referred to in these three reports are within your own knowledge and those which are not?
A. Yes, I have.
Q. And can you also confirm that those facts and matters referred to in the three reports which are within your own knowledge are true?
A. Yes, they are.
Q. And can you lastly confirm that the opinions expressed in these three reports represent your true and complete professional opinions on the matters to which they relate?
A. They do, yes.
Q. Thank you very much, Professor Walker. Mr Hoskins, to my far left, will ask you some questions.

Cross-examination by MR HOSKINS

MR HOSKINS: Good morning, professor.
A. Good morning.

Q. You stress in your evidence that Phenytoin is still an effective treatment for epilepsy. We have all read that. I just wanted to deal with some other aspects of Phenytoin and I need to hand up a document to you because it has got some confidential material in it. It is bundle J1, tab 2, for everyone else. (Handed)

You will see, hopefully -- you have been handed a document with Clifford Chance headed notepaper?

A. Yes.

Q. We will just wait for the tribunal to -- sorry.

So J1, tab 2. It's a document from Clifford Chance, who are the solicitors instructed by Pfizer, and this is a formal information response that Clifford Chance sent on behalf of Pfizer to the OFT, which is the precursor to the CMA. It's a legal response by Pfizer just so you know what the document is. I am not going to ask you about the legal aspects of it, you will be glad to hear. On page 1 there is a large paragraph in the middle and if you go up four lines from the bottom of that paragraph, what Clifford Chance said on behalf of Pfizer is:

"Phenytoin has been on the market for decades and has been superseded in many clinical situations by newer medicines which have a better safety and tolerability profile. A wider therapeutic index, no requirement for

blood monitoring and fewer drug interactions."

Do you agree that that is an accurate statement?

A. It is an accurate statement, yes.

Q. In your third report you exhibited a copy of a Cochrane epilepsy group study and certainly we could not see anything in that which altered the accuracy of the statements I have just shown you. Is that correct?

A. It is correct, yes.

Q. Could we go to your first report. So that's bundle D, tab 9, and turn to paragraph 5.4, it begins:

"There are a number of reasons why Phenytoin has fallen from favour in the UK. In particular its non-linear pharmacokinetics and narrow therapeutic index mean that it is difficult for practitioners to regulate the dose."

When you say "Phenytoin", my understanding is the points you make apply to both capsules and tablets. Have I understood that correctly?

A. Yes, you have. It applies to all forms of Phenytoin.

Q. And Phenytoin is now only recommended as a third line treatment. Is that correct?

A. It is, yes.

Q. And in the final sentence of paragraph 5.4 you say:

"... the way in which Phenytoin interacts with other drugs also makes it very difficult to use as a third

line treatment, since usually by this stage the patient is already taking one or more other AEDs."

Can you just expand on that a bit more. Why is it very difficult to use as a third line treatment?

A. It is difficult to use as a third line treatment because it interacts -- it may vary the levels of other antiepileptic drugs that people are taking concomitantly. So when you are adding it in as a third line treatment you may have to justify the doses of other drugs that people are on for that reason.

Q. If you go to paragraph 5.11 of this report you say four lines down:

"Phenytoin prescription still occurs in three main situations: (1) 'historical' patients who have already been prescribed Phenytoin; (2) in combination with other anti-epileptic drugs in patients with drug resistant epilepsy who have not responded to first line or second line therapies; and (3) patients who have been given Phenytoin as an emergency treatment and who are continued on the oral medication."

In relation to emergency treatment is that what you deal with in paragraph 5.10. In the middle of 5.10 you say:

"For this reason, and also because it is highly effective at controlling seizures, it remains a first

line treatment and one of the most frequently used drugs in the treatment of prolonged seizures (status epilepticus, which is a medical emergency)."

A. Yes, it is.

Q. That's the emergency you refer to?

A. It is.

Q. You go on to say:

"It is the injectable formulation of Phenytoin that is used in this situation."

So clearly that does not involve the use of Phenytoin capsules?

A. No, not for the emergency situation but it does thereafter. So people are given the injectable formulation and then will be given tablets or capsules afterwards.

Q. And paragraph 4.2 of this report, four lines up from the bottom you say:

"Third line AEDs are almost exclusively recommended in specialist epilepsy clinics such as mine."

Is that because of the difficulties you have described in using it as a third line treatment?

A. Yes, it is because it involves some understanding of the pharmacokinetic interactions with other medications and also because those patients with such refractory epileptic seizures are referred to clinics such as mine.

Q. So presumably, this type of use only occurs in a very limited number of cases. Is that fair?
A. That is correct, yes.
Q. And indeed the vast majority of prescriptions for Phenytoin sodium capsules therefore relate to the first category you identify, which is historical patients who have already been prescribed Phenytoin. Is that correct?
A. Yes, I do not know the precise breakdown of how Phenytoin is prescribed in the UK but I would suspect that most Phenytoin prescriptions are for those who are taking it on a historic basis rather than those who are newly starting on Phenytoin.
Q. What I would like to do next is to look first at the official guidance that has been published in relation to Phenytoin and then I want to come and look separately at the extent to which it has been followed in practice. Do you understand the distinction?
A. Yes.
Q. It is one you make in your own reports.
A. Yes.
Q. Let us begin with the contents of the guidance. Pick it up in your second report. That is tab 10 of this bundle, paragraph 2.2. You say in the first sentence:
"Since 2004, NICE has recommended consistent supply

of a particular manufacturer's AED unless the prescriber in consultation with the patient considers that this is not a concern."

So obviously, this advice applies to Phenytoin as an AED; correct?

A. Yes, it applies to all AEDs.

Q. And therefore if a patient is stabilised on Phenytoin sodium capsules manufactured by Pfizer, the recommendation is that they should always be supplied with capsules manufactured by Pfizer. Is that correct?

A. That is correct. That is the recommendation from NICE.

Q. And then paragraph 2.3 of this report -- perhaps you just want to read it quickly to refresh your memory. (Pause)

A. Yes.

Q. So the MHRA we see, as you tell us, recommended that patients stabilised on a category 1 AED should be maintained on a specific manufacturer's product and just to make it crystal clear, Phenytoin is one of the AEDs in the MHRA's category 1; correct?

A. Yes, correct.

Q. So your reports show us that, at least in relation to Phenytoin, since at least 2004 guidance has recommended that patients stabilised on capsules manufactured by Pfizer should be maintained on capsules manufactured by

Pfizer. Is that correct?

A. That is correct.

Q. Let us look at the practice then in relation to the guidance. As you state in your reports, you need to look at the extent to which the guidance was followed in practice. Just to clarify your area of expertise -- I do not want to make you blush but it is pretty clear from your CV that you are an eminent and specialised consultant with particular expertise in epilepsy. That's what you do?

A. That is correct, yes.

Q. If we go to paragraph 2.12 of your second report. You see half way down, roughly half way down that paragraph at the bottom of the page you say:

"I understand from my instructing solicitors that the vast majority of capsule prescriptions are open (ie do not specify a manufacturer), even after the publication of the MHRA guidance. This appears to reflect the fact that practitioners do not follow the guidance and may be explained by the fact that practitioners share my view and consider the risk of switching to be small."

You begin that sentence with the words:

"I understand from my instructing solicitors..."

So is it correct that the view you express here was

based on information which has been supplied to you by Clifford Chance, Pfizer's solicitors?

A. That's correct, they gave me some information about the capsule prescriptions.

Q. And you have not conducted any study of prescribing practices by doctors?

A. Absolutely not, no.

Q. Then paragraph 2.8(b). Sorry, bear with me a second.

(Pause)

Yes, it's the second part of (b). So you see there is two paragraphs in (b), it's the one without any letter beside it:

"As I have already referred to above, my experience prior to the MHRA guidance was that patients frequently reported that they had been switched from one brand to the other and also from capsules to tablets. I have noticed this less since the MHRA guidance."

Again, you have not conducted any study of the degree to which switching has taken place, have you?

A. No, I have not. That was my observation from clinics that I hold.

Q. It was an impression formed based on anecdotal evidence provided to you by your patients. Is that fair?

A. It is indeed, yes.

Q. And you also, as I understand it, have not conducted any

sort of study of dispensing practices by pharmacies in respect of Phenytoin?

A. No, I have not.

Q. And that is not an area that is within your knowledge or expertise. You are a doctor, not a pharmacist?

A. Indeed I am.

Q. And so you have no direct knowledge of pharmacist dispensing practice in relation to Phenytoin?

A. The only knowledge I have is indirect knowledge, which is from patients who tell me that they have been given a different medication from the medication that they were previously prescribed or given.

MR HOSKINS: Thank you, Professor Walker. Sir, I have no further questions.

THE CHAIRMAN: Thank you.

Do you want to re-examine?

MR BREALEY: I have no re-examination, sir, thank you.

Questions from the PANEL

THE CHAIRMAN: I just wanted to ask you, Professor Walker, why do you think it is that doctors who are given this guidance by NICE originally and then by the MHRA -- why they just prescribe generically, when the guidance suggests that the brand is quite important?

A. Well, in fact the guidance itself begins by stating that there is no evidence that switching actually is

associated with any clinical -- adverse clinical outcome. And this was just given as guidance and many of the doctors do not see in their practice that there is much difference in giving one rather than another. There may also be a certain amount of laziness on behalf of some of the doctors. I cannot say for GPs why they would just give Phenytoin but that is certainly what they have been doing.

THE CHAIRMAN: Okay. Thank you. Any questions? No? Well, I think in that case you are discharged, Professor Walker. Thank you very much.

A. Thank you.

MR BREALEY: I now call, sir, Mr Goosey.

MR RICHARD GOOSEY (affirmed)

Examination-in-chief by MR BREALEY

THE CHAIRMAN: Mr Goosey, please sit down and make yourself comfortable.

A. Thank you.

THE CHAIRMAN: Counsel will put some questions to you.

MR BREALEY: Could Mr Goosey also be given bundle D and M, please, D and M. If you go to bundle D and tab 6, there is your report dated 19 May 2017. If you flick through that and go, please, to page 21, just confirm to the tribunal that that is your signature.

A. Yes, it is.

Q. And then if you go to bundle M, tab 1, that is your second, short report dated 25 October 2017. It is a short report because your signature is on the first page. Could you confirm to the tribunal that that is your signature?

A. Yes, it is.

Q. And I am going to ask you again the same questions: can you confirm that you have made clear which facts and matters referred to in these two reports are within your own knowledge and those which are not?

A. Yes, I have.

Q. And can you also confirm that those facts and matters referred to in the two reports which are within your own knowledge are true?

A. Yes, they are.

Q. And can you lastly confirm that the opinions expressed in these two reports represent your true and complete professional opinions on the matters to which they relate?

A. Yes, I can.

Q. Thank you very much indeed. Mr Hoskins, I think, will ask you some questions.

Cross-examination by MR HOSKINS

MR HOSKINS: Good morning.

A. Good morning.

Q. Can I go to your first report. So that is bundle D, tab 6. You will see about two thirds of the way down the page is the heading "Summary of instructions". And you tell us that:

"Pfizer commissioned Kantar Health to conduct a survey amongst dispensing pharmacists in order to assess their likely practice when presented with a prescription for Phenytoin sodium."

So that was your summary of the instructions you had been given; yes?

A. That is correct.

Q. And then if you could be given, please, bundle N, tab 3, this is a letter from Clifford Chance, who are the solicitors instructed by Pfizer, and what happened was that we asked them to tell us what the nature of your instructions was and you will see in the second paragraph they say:

"We confirm that Mr Goosey did not receive a formal letter of instruction. The description of his instructions in his report is accurate. By way of further assistance we have set out in the appendix to this letter extracts from the contract between Pfizer and Kantar, to the extent that they touch on Kantar's work."

If you turn over the page, you will see the heading

"Annex", which hopefully is familiar to you because it should be the annex to the contract you signed with Clifford Chance. Is that correct? Do you recognise it?

A. Page 3?

Q. Yes. The heading should be "Annex"?

A. Yes.

Q. Is that an extract from the contract that you signed with Clifford Chance? Have you seen this before?

A. I am just cheeking it through. (Pause)

Q. We have been told it may not be in the exact form, it may be that someone has typed out what was in the contract. Is that --

A. It's in a different format, which is why I am just checking it.

Q. I understand but you recognise it having had a chance to look at it?

A. Yes, I do.

Q. If we go to page 5, appendix A:

"Works proposal, dispensing practices UK."

You see the first sentence, similar to what you set out in your report, not exactly:

"In the context of ongoing litigation proceedings, Clifford Chance have instructed Kantar to conduct a market research project with 200 pharmacists to obtain market intelligence in relation to the prescribing and

dispensing practices of certain drugs."

Then in the middle of the page, the heading "Research Needs":

"Research is required to understand and quantify the usual practices of pharmacists in relation to the dispensing of Phenytoin sodium. The survey seeks to understand how pharmacists dispense Phenytoin sodium when faced with a range of prescriptions".

And they list three broad possibilities:

"If the prescription specifies a brand or manufacturer name, if the prescription does not specify a particular manufacturer's brand of Phenytoin sodium."

And thirdly:

"If the prescription does not specify a particular formulation of Phenytoin sodium."

Were those research needs -- was that something that you came up with or did Pfizer come up with it or was it the product of discussion?

A. That was a product of discussion.

Q. And were you told at any stage that a crucial issue in these proceedings is the extent to which pharmacists will dispense NRIM capsules to patients who are already stabilised on Pfizer Flynn capsules or vice versa? Were you ever told that?

A. When the questionnaire was designed, then I was not

involved in that part of the process and I would not have been aware until I wrote the expert report and started going through that that was going to be one of the areas of interest.

Q. So when you came to look at this issue, had the survey already been done?

A. The survey had already been completed when I wrote the expert report, yes.

Q. So just to get the chronology right, the survey is done and then, after the survey is done, you come to write the expert report and at that stage you become aware that one of the crucial issues is the extent to which pharmacists will dispense NRIM capsules to patients stabilised on Pfizer Flynn capsules and vice versa; is that fair?

A. No not at that point. It was not until I was preparing for the tribunal.

Q. So it was even later than when you sat down to your expert report?

A. Yes.

Q. It was after you had written your first report?

A. Yes.

Q. After or before you wrote your second report?

A. Before I wrote my second report.

Q. Can we go to page 2, so back, sorry, to your first

report. So that is bundle D, tab 6.

THE CHAIRMAN: Mr Goosey, you are an eminent witness but I am going to have to ask you to speak up a bit.

A. I do apologise, yes.

THE CHAIRMAN: Advancing years are taking their toll.

MR HOSKINS: Do you have your expert report? And on page 2, the third paragraph, you refer to the sample of 201 pharmacists. Do you see that?

A. Yes, I do.

Q. Do you know roughly how many employed pharmacists there are in the UK?

A. Yes, I do.

Q. How many are there?

A. In the retail area we make reference to just over 14,000 and in the hospital area I am aware that there are just under 4,000.

Q. So you think there are about 18,000 employed pharmacists?

A. That is what my research tells me.

Q. Because the figure we have come up with is nearer 61,000, does that seem -- in 2016, 61,000.

A. As I say, the figures that I found as to what the full number of pharmacists are around about -- just below 4,000, just above 14,000.

Q. So around 18,000 on your figures. 200 out of 18,000 is not a very big sample, is it?

A. It is quite a large sample size, yes.
Q. 200 out of 18,000?
A. Yes.
Q. You think that is big enough to give robust results, do you?
A. Absolutely. In terms of pharmaceutical research, a sample size of 200 is a high sample size to try and achieve and it gives a level of accuracy to the data which is plus or minus around about 6.8 per cent at the highest level, and it also maintains that we are within the codes of practice of the professional bodies, which ensures that we do not over research any particular sector. We have to keep sample sizes down.
Q. Why do you have to keep sample sizes down?
A. For two reasons. One reason is that you do not need to have a very large sample size so as to report the data with statistical accuracy and, secondly, you do not want to overburden particular populations with too many surveys.
Q. So it is a balancing exercise between what you think is sufficiently robust and not bothering people too much, if I can put it in a colloquial way?
A. No, no, it is also what is achievable. So it is a balancing act between cost in terms of the level of accuracy against the increased cost of increasing the

sample size. You get small returns on investment the higher the sample size you go and the second part is to keep within the industrial -- sorry, the professional bodies' codes of conduct, which ensures that we do not increase the sample size beyond what would be required to be able to report with a certain level of precision and robustness.

Q. You tell us a little bit down that paragraph on page 2 that the sample was made up of 151 retail pharmacists and 50 hospital pharmacists. Have you investigated to what extent Phenytoin is dispensed in hospitals, as opposed to retail pharmacies?

A. I have not investigated that, no. I have been told that -- what the likely levels are but I have not investigated it.

Q. Told by whom?

A. By my team.

Q. Because we heard evidence from Mr Walters, a director of Flynn, last week that hospitals only account for around 5 per cent of Flynn's sales of Phenytoin. Were you here when that evidence was given?

A. What day was that on?

Q. It was when Mr Walters was giving evidence on Friday.

A. No, I was not.

Q. Thursday, I am sorry.

A. I was here on Thursday.
Q. So it was when Mr Walters was giving evidence on Thursday.
A. Okay.
Q. If, as one would expect, Mr Walters' evidence as to his own company's business is accurate, that means that your sample, 25 per cent of which is made up of hospital pharmacists, is not representative for Phenytoin, is it not. There is a problem there?
A. I think you are referring to volume rather than pharmacists, when you make that reference. So volume does not reflect the percentage of pharmacists and, secondly, the reason why we would have a sample of 50 in terms of hospital pharmacists is because we have to have a certain level of sample size to be able to make a reading or a measurement of the hospital sector and that needs to be at least above 30 and 50 is a level which we felt was the right level to be able to report on hospital pharmacists.
Q. So your sample is based on the number of pharmacists and not volume but do you accept that given Mr Walters' evidence, there is a potential issue with the accuracy of the results that your sample produces if Phenytoin is actually only dispensed around 5 per cent in hospitals and 95 per cent in retail pharmacies. It is a potential

problem, is it not?

A. If we were to be reporting on volume because obviously in each different location there will be different levels of volume, but the data which we are presenting here is not representative of volume; it is representative of hospital pharmacists versus retail pharmacists and we quoted the sample on those two separate groups.

Q. I understand. But I am asking you a different question, which is the next stage, which is do you accept therefore there is a potential problem with the reliability of your survey because it fails to reflect the 5 per cent/95 per cent, which one sees, at least for Flynn, in relation to volumes?

A. No, because we do not report on volume in our survey; we report on what the pharmacist prescribing behaviour is.

Q. Have you investigated what type of pharmacist is more likely to fulfil a repeat prescription for epilepsy patients, whether it is more likely at a retail pharmacist or hospital pharmacist. Is that something you have looked at?

A. We have not reported on repeat prescriptions in this report.

Q. Can we look at the screen-out questions, which is how you selected your sample of 201. What I want to focus

on is S4. So that is on page 3 of your report:

"Approximately how many items for the following therapy areas do you dispense in an average month?"

And then in red it is stated:

"Those inputting zero for epilepsy were screened out."

Does it follow that a pharmacy that dispensed only one epilepsy item in an average month would not be screened out?

A. That is correct, yes.

Q. So the sample you have is very likely to include some pharmacists who may have little experience of dispensing epilepsy drugs. Is that a fair comment?

A. No, it is -- the actual average we had on S4 was 207 in the average month.

Q. But that was the average?

A. Yes, that is right and it represents a range around that.

Q. So some within the average will have more than 207 and some will have less; correct?

A. That is correct.

Q. And you would only screen them out if they put zero?

A. That is right, that is one of the screening criteria.

Q. Can we go to survey question 5. So I am going into the body of the survey now. It should be at page 13 of your

report. Question 5 reads:

"If you are provided with a prescription for Phenytoin sodium capsules and the prescription does not specify a particular manufacturer's brand of capsules, what would you do?"

Then we see below in the same box that the survey provided two what you called closed options: first of all:

"Dispense Phenytoin sodium capsules that you have in stock."

Secondly:

"Dispense Phenytoin sodium tablets that you have in stock."

Those closed options make the question look a choice between capsules and tablets, do they not? That is what this question is aimed at?

A. There are two choice questions, choice replies, followed by, if the first two replies do not describe what they would do, then they are open to complete the third section, which is put in free text.

Q. But the closed questions, the two closed options, I am sorry, are a choice between capsules and tablets. That is correct, is it not?

A. Yes, the first one is capsules, the second one is tablets.

Q. And obviously, looking at the page, none of the closed options reflected a choice between different types of capsules? Neither of the closed options --
A. Yes.
Q. -- reflects a choice to be made by the pharmacist between different types of capsules?
A. That is correct.
Q. And we see from the graph that 32 per cent of the sample chose the other option. Do you see that; yes?
A. Yes.
Q. And if we go over the page, page 14, chart 5(b), I think what -- the way the survey was set up was if someone ticked the "other" option, they were then given the opportunity to give the reasons for ticking "other" is that correct?
A. That is right.
Q. We see from the graph chart 5(b), 89 per cent of those who answered "other", said that they would check or supply the patient's usual brand. Is that correct?
A. That is correct.
Q. With the benefit of hindsight, given the popularity of that open response, do you agree that it would have been better if that had been included as a closed option? So I'm not criticising the way you set it up. I am saying with the benefit of hindsight would it have been a good

idea to put that as a closed option?

A. Yes, if we were to repeat the survey again, where we find there are any items which are given in the "other, please specify" box, which are greater than 10 per cent, we would generally if the survey was repeated, include that as being an option in future options we give for a question.

Q. And question 5 -- I think this is clear from its face. Question 5 does not specifically address the question of the extent to which pharmacists will dispense NRIM capsules to patients stabilised on Pfizer Flynn capsules and vice versa, does it?

A. Question 5, it does not specify that. It specifies whether they would dispense capsules that they have in stock.

Q. And none of the questions --

MR BREALEY: Can he just finish --

MR HOSKINS: I am trying to.

A. We collect at S6 exactly what the pharmacists do have in stock and that is given in chart A, which shows exactly what percentage have stock of NRIM capsules.

Q. Can I go back to screening question S6. It is on page 4. The question is:

"Which oral Phenytoin sodium products do you stock?"

You will see that the options include:

"Phenytoin sodium Flynn hard capsules" and "Epanutin hard capsules."

Can you just explain the difference between these two products?

A. Sorry, I do not know the difference between those two products, except for the name which is given.

Q. If we go to page 7 of your report, hopefully -- I've asked for a clearer copy to be put in people's bundles so hopefully the bar chart is legible. The first column is "Epanutin Hard Capsules."

Can you see that?

A. Yes.

Q. And then the next one is "Phenytoin sodium Flynn hard capsules."?

A. Yes.

Q. And then the NRIM, Phenytoin sodium NRIM capsules are six along?

A. That is correct.

Q. And what you have here is -- there are two answers "aware" or "stock" and it is the pharmacists who stock the product I am interested in. So what this shows us is about 65 per cent of the sample stocked both -- either or Epanutin hard capsules and Phenytoin sodium Flynn hard capsules. You see their supply charts both come out about 65 per cent?

A. Yes, both 66 per cent.
Q. And for the NRIM, Phenytoin sodium NRIM capsules, the number who stock it is around 11 per cent. Is that correct?
A. That is correct, 11 per cent.
Q. If we go to page 13, back to question 5, we see from the charts there, 67 per cent of the sample said they would dispense Phenytoin sodium capsules they had in stock. Do you see that?
A. Yes.
Q. And we cannot tell from the survey or from your report whether any of that 67 per cent were amongst the 11 per cent who stocked NRIM capsules, can we?
A. Not from this report but we can say that a minimum of 56 per cent would have a Pfizer capsule.
Q. It is possible that none of the 67 per cent on page 13 actually stocked NRIM capsules, is it not? Just given the percentages, that is a possibility?
A. It is very unlikely but we can do that analysis and that is something which we do with market research. We can cross-check the questions to analyse exactly what the pharmacists stock versus what they have replied to this question.
Q. But that has not been done for the purposes of this report?

A. It has not been done for the purposes of this report but it can easily be done with the data and it can be looked at also in the data tables.

Q. If one were to assume that all of the 11 per cent who stocked NRIM were among the 67 per cent, then statistically speaking, that would show that at most 11 per cent of the sample could in practice actually dispense NRIM capsules instead of Pfizer Flynn capsules. That's correct, is it not? That's the absolute maximum, it follows?

A. Sorry, could you repeat the question?

Q. Of course. Assume for the moment that all of the 11 per cent of pharmacists who stocked NRIM capsules were amongst the 67 per cent?

A. Right.

Q. Then the maximum percentage of the pharmacists in your sample who could dispense NRIM capsules would be 11 per cent. It could not be any higher?

A. The maximum that stock NRIM in the sample is 11 per cent. That is the maximum that can dispense NRIM.

MR HOSKINS: Sir, I have no further questions. Thank you very much, Mr Goosey.

A. Thank you.

Questions from the PANEL

PROFESSOR WATERSON: Thanks. I've a couple of questions. I was interested in your survey. I have carried out surveys myself on occasion. I was puzzled by the screened-out people. Were they included in the 201 or are they excluded from the 201?

A. The screened-out respondents are excluded from the 201. There were 86 respondents that were screened out.

PROFESSOR WATERSON: Okay. So those -- in other words, you (inaudible) approached 287.

A. That is correct.

PROFESSOR WATERSON: Okay. Thanks.

Reference is made in the report to appendix 3, I think, which is the opinion of Miss Helen Rolf?

A. Yes.

PROFESSOR WATERSON: I do not have that. Can you -- could you summarise that for me, please.

A. Yes, basically her report summarises that the fielding, the questions that were used and also the report itself reflect industry standards and also reflect an unbiased market research study, looking at dispensing behaviour.

PROFESSOR WATERSON: And what is her position?

A. She is independent, from Kantar Health, which is why she was asked.

PROFESSOR WATERSON: I see, okay.

A. And she has 14 years' experience of working as a market

researcher in the healthcare sector.

PROFESSOR WATERSON: Thank you.

THE CHAIRMAN: Mr Goosey, just one question from me. Mr Hoskins, I think, was making a point about the number of hospital pharmacies that you surveyed and relating it to the percentage of NRIM products supplied in hospitals -- the percentage of the Flynn Phenytoin supplied in hospitals. Do I understand your answer to be that if the total population of hospitals is 4,000 -- hospital pharmacists is 4,000, you need a sample of the size of 30 plus in order to be able to make sensible statements about hospital prescribing or is it something else?

A. No, that is exactly the point. We have to have a certain minimum to be able to make a reasonable measurement of the behaviour of those pharmacists. The minimum which we would normally try to achieve in pharmaceutical research is 30. We would not go below that level. A comfortable level that we would try to achieve when we know that it is a harder respondent to recruit would be 50 and that would be reasonable.

THE CHAIRMAN: So if you had split it 95/5, instead of 75/25, which is what you did, you would not be able to say anything sensible about pharmacies in hospitals dispensing. It just would not have been statistically

reliable?

A. That is exactly the point, yes.

THE CHAIRMAN: Thank you.

MR LOMAS: One very basic question. We are talking here throughout about individual pharmacists, people not businesses.

A. Yes.

MR LOMAS: And the questions were directed to their personal dispensing practice, not the dispensing practice of the organisation for which they work.

A. Yes, this is the measurement of those individuals and what they do if they were presented with that type of prescription.

MR LOMAS: Thank you.

THE CHAIRMAN: Re-examination?

MR BREALEY: I have no re-examination, sir. Thank you very much.

THE CHAIRMAN: Right. It is all going very smoothly. Thank you. You are discharged, Mr Goosey. You may stand down.

A. Thank you.

THE CHAIRMAN: What do you want to do now?

MR BREALEY: Just on the appendix 3, D6, page 25. You can be provided a copy. You have appendix 3 and it is maybe on the other side of appendix 3.

THE CHAIRMAN: I think we have it.
PROFESSOR WATERSON: I did not notice it.
MR BREALEY: That is okay.
PROFESSOR WATERSON: Thank you.
MR BREALEY: We can start --
THE CHAIRMAN: It is the only piece of evidence that Professor Waterson has not so far noticed, for the record.
MR BREALEY: Just checking.
THE CHAIRMAN: Would you like to proceed?
MR BREALEY: Yes, I'll call Mr Ridyard.
THE CHAIRMAN: Would you like a further break?
MR BREALEY: We can have a five minute break.
THE CHAIRMAN: We might have five minutes to gather our thoughts.
(12.12 pm)
(A short break)
(12.21 pm)
MR BREALEY: Sir, thank you. Lastly, I call Mr Ridyard.
MR DEREK RIDYARD (affirmed)
Examination-in-chief by MR BREALEY
THE CHAIRMAN: Mr Ridyard, make yourself comfortable, please.
A. Thank you.
MR BREALEY: And could you be handed bundle D. Bundle D.

If you can go first to tab 7.

A. Yes.

Q. You will see your first report dated 7 February 2017. Go to page 54. Could you confirm to the tribunal that is your signature?

A. Yes, it is, yes.

Q. And then your second report is at tab 8, dated 19 May 2017. Go to page 38.

A. Yes.

Q. Can you confirm that that is your signature?

A. Yes, it is.

Q. And then your third report, dated 31 July 2017, is at tab 8A, and if you go to page 11, can you confirm that is your signature?

A. Yes, it is.

Q. I'll ask you the same three questions. Can you confirm that you have made clear which facts and matters referred to in these three reports are within your knowledge and those which are not?

A. Yes.

Q. And can you also confirm that those facts and matters referred to in the three reports which are within your knowledge are true?

A. Yes.

Q. And can you lastly confirm that the opinions expressed

in these three reports represent your true and complete professional opinions on the matters to which they relate?

A. Yes.

Q. Thank you, Mr Ridyard. I think Mr Hoskins will have some questions.

Cross-examination by MR HOSKINS

MR HOSKINS: Good morning, Mr Ridyard.

A. Good morning.

Q. Sorry to disappoint you, I think I may have to detain you a bit longer than the other witnesses this morning.

Can we begin by going to the decision, please, paragraph 4. 190.

A. 4.190?

Q. That is right.

A. Yes.

Q. It should have a heading "Summary of the CMA's findings on dominance."?

A. Yes.

Q. You will see that the CMA summarises the five factors it has looked at in relation to dominance and they are: market shares; pricing behaviour and financial performance; competitive constraints from parallel imports and NRIM; barriers to entry and countervailing buyer power. Do you agree it is fair to say those are

the classic factors to be considered when one is analysing dominance?

A. Yes, I agree that's a standard checklist of factors to analyse, yes.

Q. And the first factor is, as the CMA puts it in its decision, very high market shares, and the relevant product market -- you see it defined at paragraph 4.188(a) -- and I'm sure you are well aware in relation to Pfizer that the market is defined as the manufacture of Pfizer-manufactured Phenytoin sodium capsules that are distributed in the UK, which includes parallel imports, as they are distributed in the UK: Pfizer's share of that market is 100 per cent, is it not, because it also manufactures the parallel imports?

A. Yes, I would assume that must be the case.

Q. Can we look at your first report. That is bundle D, tab 7. We are going to have to come back to the decision in a little bit. You might want to ...

So bundle D, tab 7, paragraph 30?

A. 13?

Q. 30.

A. 30.

Q. You see there:

"The CMA decision indicates that the relevant market is limited to the supply in the UK of

Pfizer-manufactured Phenytoin sodium capsules. On this market, Pfizer is (trivially) found by the CMA to be a monopolist by virtue of being the sole supplier able to manufacture Pfizer-manufactured Phenytoin sodium."

Why do you add "trivially" to that statement? What do you mean by that?

A. I explain that in the following paragraphs of my report. In order to reach its view that the relevant market is this narrow manufacturer-specific market, the CMA commences its discussion of market definition and dominance with what it describes as the fact that prices are well above the competitive level and, as I explain, if you take that as a fact and then go into the analysis of the relevant market and dominance, you have hard-wired the conclusion of that section to one in which you will inevitably find that Pfizer-manufactured capsules are a separate market and I explain in my report -- in this report and also in my second report, where I seek to extend and clarify that, if it requires clarification, why that takes place --

Q. We are going to come to all this.

A. You asked the question and I was just trying to respond to it.

Q. The word "trivially" is intended to be in a sense pejorative, then, they were not entitled to make that

finding; is that what you are saying? It is just the word "trivial" that caught my eye.

THE CHAIRMAN: We did not mind it.

A. I am happy to explain why I use it.

MR HOSKINS: I do not think the tribunal is interested. So I will move on. Do you want him to answer it, if you would like.

A person of your experience is obviously aware that the case law of the Court of Justice establishes that as a matter of law very large market shares are in themselves and save in exceptional circumstances evidence of the existence of a dominant position. You are aware of that case law, are you not?

A. I am broadly aware, I am not an expert on the case law, I am an economist, not a lawyer. But clearly I have read some of the case law and I have certainly seen that statement quoted.

Q. Occupational hazard for an economist?

A. Yes.

Q. As a matter of economics, market share is a relevant factor as well, is it not?

A. Yes, but one must first of all make sure -- that's why economists go to such lengths to make sure when they define a market they do it according to well-established and robust principles. Having done that, then market

share can be an indicator of market power, of course but it is by no means a determinant of market power and, of course, it is very important to have done the market definition in a way that is truly probing of the evidence.

Q. So the question was is it a relevant factor and I think the answer is yes?

A. In a well-defined market, high market shares are a relevant factor but they are not determinative of market power.

Q. As a matter of economics, absent some sort of special consideration, a market share of 100 per cent would be a strong indicator of dominance, would not it, even economically speaking?

A. If you felt the market was robustly defined, yes, there are still some possible exceptions to that. I'm afraid there are always exceptions in economics, almost always but, yes, it would a strong indicator, yes.

Q. I could not find it -- you do not seem to acknowledge the relevance of the fact that Pfizer has a 100 per cent market share in your report when you consider dominance. Is that something you've omitted from your report?

A. Sorry, could you repeat the question, please.

Q. I could not find in your reports any reference by you in the context of dominance to the fact that Pfizer had

a 100 per cent market share as being a relevant factor?

A. Yes, the reason for that is that I do not think that the CMA has done a proper sort of -- a proper job of defining the market in the first place. As I say -- said in my earlier answer, it has adopted an approach to market definition which essentially presupposes the answer and therefore I think the answer it reaches is uninteresting, trivial, if you like, and so I do not think it is very useful in terms of understanding the fundamentals of the case.

Q. The heading here -- we are still in your first report -- the heading of the section is "Dominance". Are you telling us that if the tribunal finds the market is as defined by the CMA, you agree that Pfizer would be dominant in that market. Is that your position?

A. Depends exactly on what reasoning the tribunal uses to reach that conclusion. If -- if it uses a robust economic framework to reach that conclusion, then a market in economic terms is essentially something that it would be worthwhile to monopolise and therefore a 100 per cent share of a market that had been robustly defined would confirm market power.

Q. So far as --

A. You would -- obviously you would then need to consider aspects such as whether there was regulatory oversight

or intervention that would prevent the exercise of that market power. But I think at that point you would have -- I think almost by definition have concluded that competitive forces are not sufficient in that situation to provide an effective constraint.

Q. Even with the possibility of some regulatory oversight or intervention, it would still be dominant economically?

A. Well, I think -- there is a bit of a definitional issue here. Maybe just to be clear what one could and could not conclude. The way I look at this -- and it may not be the only way of looking at it -- is that if a firm -- let's take a different example. Take a utility company. That company -- a company that supplies my household with water -- clearly has latent market power and if it wanted to and if it was free to, rather, it could raise the prices substantially above the competitive level and I would not really have much alternative.

The way I would characterise that is that Thames Water does have a dominant position or it does have market power but that happens to be constrained by regulation. So in that sense the outcome hopefully of what Thames Water does when it supplies me with water is a competitive outcome but it is competitive because of regulatory intervention rather than market forces and --

sorry, I probably have not quite answered your question. Does that come close enough to answering your question?

Q. That is close enough. I'll ask you another question.

A. Okay, sorry.

Q. One of the other factors, as we saw, one of the classic considerations for dominance, I understand the way you have just described it is countervailing buyer power but you have not analysed countervailing buyer power in your reports, have you? We do not see that analysis?

A. And I think that is related to the answer to my previous question. I've certainly looked at what powers -- what evidence is there that the Department of Health had powers to constrain the freedom of pricing of the products that we are looking at. It's just under my categorisation, which I've just described, I personally think it is more sensible to regard that as being regulatory power, which steps in when otherwise there would be market power, so in that sense I have -- you know, I have certainly talked about the Department of Health's ability to constrain outcomes in this market but my personal approach is that I put that in the bucket of regulatory intervention after market power exists.

Q. I think from what you said so far, the focus of your critique on this part of the case is therefore on market

definition and not dominance. Is that fair to say from when you have just told the tribunal?

A. I do not think so because the focus of my critique is that CMA is -- has a long, 90-page-section on market definition and dominance, which essentially tells us nothing because of the way in which -- of the priors on which that chapter is made. So I think it is quite a -- it is a little bit frustrating in that sense that the -- there is not really any economics in that section.

Q. One of the other five classic questions to ask in relation to dominance are barriers to entry and you have not analysed barriers to entry in any detail in your report, have you?

A. Well, I have not -- I have certainly talked about the entry that actually occurred. So I think I have considered entry as a phenomenon, therefore -- there may not be a separate section in my report specifically going through barriers to entry but I think entry is an important -- clearly important story -- a part of the story of what competitive constraints operate in the pharmaceutical sector, particularly, obviously in the post patent pharmaceutical sector.

Q. Can I go on to your second report, so bundle D, tab 8, paragraph 91.

A. Yes.

Q. You say:

"Moreover, as I have discussed above, the CMA's description of the continuity of supply principle in this period, which is fundamental to its findings on market definition and dominance, also appears highly misleading."

A. Yes.

Q. "There is clear evidence that a number of pharmacists were willing and able to substitute between NRIM's and Pfizer's products based on commercial considerations in this period and it is evident that the two largest pharmacy chains did in fact switch whilst others purchased NRIM's product from wholesale suppliers."

A. Yes.

Q. You then have a footnote 70 and footnote 70 refers to:

"Pfizer's reply to defence, paragraph 3.6 and paragraph 3.11."

A. Yes.

Q. Your reports do not state that you have conducted your own independent analysis of continuity of supply. Have you in fact done so or are you simply relying on the Pfizer material you have seen?

A. I am relying on the totality of the evidence which I have looked at, which partly includes the evidence in the decision and partly it includes the famous

section 26 letters and partly it includes things like looking at the Alliance wholesale -- wholesaler data, which my colleagues had a look at. So it is a range of factors. I certainly did not just -- yes, I mean, I did look at quite a lot of the evidence to inform -- to reach that view, that I thought that -- and indeed the more the evidence was uncovered during this process, during the course of this year, the more question marks it raised in my mind as to the job that the CMA had done in its assumptions about continuity of supply and the role that it played in constraining switching.

Q. We will come back to some of that evidence in a little bit. I would like you next to go to your first report. So that is tab 7 at paragraph 37. You say there:

"It is important to stress that the competition that occurs in such markets as they develop from exclusivity of patent protection to the like for like competitive environment after generic entry is a dynamic process, not a binary distinction between monopoly on the day prior to patent expiry and perfect competition the day after."

A. Yes.

Q. That is one example, is it not, of a reason why it is important to assess both market definition and dominance over a suitable period of time, rather than simply

looking at a snapshot of a particular point in time?

A. It is an example of how it is important, if you are going to conduct a competition analysis to understand the context in which that competition takes place, and in this case the competition that takes place when originator products face generic competition for the first time, I think it is a process which, you know, the competition does unfold over a number of time periods, I certainly agree with that and it is relevant to look at that competitive process when assessing -- when evaluating how good or bad you think competition --or how well competition is operating in that particular sector.

Q. So for the purposes of assessing market definition or dominance, it is obviously advisable, is it not, to look at how what you call the dynamic process has evolved over time? That is obvious, is it not?

A. It was certainly obvious to me. It did not seem to be obvious to the CMA in all places and that is why I present in my report the reports -- rather, I talk about the studies which have been done of how generic competition does unfold in markets where originators face competition for the first time because my feeling is that that provides a useful context and indeed possibly a useful benchmark against which to assess

whether you think competition is working well in any particular sector, you are benchmarking it against what otherwise normally happens when this event occurs, that an originator faces generic competition for the first time.

Q. Okay, I do not want to turn this into a test of your legal knowledge but again I am sure you are aware that the core essence of dominance as defined by the Court of Justice is:

"... a position of economic strength enjoyed by an undertaking which gives it the power to behave to an appreciable extent independently of its competitors, customers and ultimately of its consumers."

Is that something you are familiar with?

A. I am familiar with those words, yes.

Q. One of the ways that dominance can manifest itself is by way of a significant price increase above cost, which is then maintained over time; correct?

A. No, I would say above the competitive level because you are pre-supposing that every increase price above cost is above the competitive level in your question and that is not obviously, I would have thought -- that is not a proposition with which I would agree.

Q. You accept, you agree that a price increase which takes the price above the competitive level and is maintained

over a period of time would be an indicator of dominance?

A. Yes, yes, that is right. But that rather begs the question of what the competitive level is.

Q. That is my next question: what if there is no competition?

A. If there is no competition, then a profit-seeking firm would raise the price as high -- well, it would raise the price to a point at which it maximised profits without worrying about -- you would have to worry about some things, like, you know, you would still need to understand what the shape of its demand curve was that was facing it, but it would not have to be worrying about what rivals' actual or potential were doing.

Q. Can we go to the decision again at table 1.1.

A. Which page is that?

Q. Page 7.

A. Yes.

Q. I am sure you are aware of the basic facts, which are that prior to 24 September 2012 Pfizer sold its Phenytoin capsules directly to wholesalers and pharmacies. You are aware of that?

A. Yes.

Q. And you are aware that after 24 September 2012 Pfizer sold its capsules to Flynn, who then sold the product to

wholesalers and pharmacies?

A. Yes.

Q. And what this table shows us, the pre-September 2012 price is the price that Pfizer sold its capsules at to wholesalers and pharmacies and then the second column is the price that Pfizer charged to Flynn.

A. Yes.

Q. And then we see the percentage increase. You might want to keep your hand in page 7 but can we go to paragraph 5.317 of the decision. Perhaps you would like to read that to yourself. (Pause)

A. Yes.

Q. That has not been challenged in these proceedings by Pfizer. So if you go back to page 7.

A. Yes.

Q. What we see are increases that go many times over what is necessary to recover losses. Those prices, those price increases or the higher prices, are then maintained from September 2012 to June 2016. You see that? This is exactly the sort of situation you described, is it not, of a dominant company, not facing any sufficient competitive restraints, will simply put the price up as far as the market can bear it. That is what these figures show, do they not?

A. Perhaps my earlier answer was not clear. I certainly

meant to say that a -- the definition of dominance is the ability to charge prices above the competitive level. I specifically, I hope -- if not I'll clarify it now if it is helpful to you -- say that it does not mean to say that a dominant position is where a company raises price above costs. I certainly acknowledge that the price increases that we are talking about in this case are price increases that took the price well above the costs of supply. The question is what is the competitive level and how does one go about assessing a competitive level for the -- for this product and a lot of the work that I have done in my reports is to try and put together some benchmarking comparisons which seek to answer that question because I believe that only by doing that kind of benchmarking against the market as we see it, can you really draw a robust conclusion to that. I do not think you can draw a conclusion simply by looking at the changing price over time or the increase in price relative to costs.

Q. It may be not a determinative conclusion but, Mr Ridyard, this is a strong indicator of dominance, is it not? It clearly is.

A. A strong indicator of dominance is the ability to sustain prices above the competitive level. So we are just skating around the question of what is the

competitive level.

Q. And if it were to be found that Pfizer did not face sufficient competition in relation to Phenytoin capsules, this would be a strong indicator, would not it, of dominance itself? If there is no competitive level, Mr Ridyard -- you keep going back to the competitive level; I am trying to put the point to you, what if there is no competition, there is simply a company which has a drug which has been on the market since 1930, long off patent, suddenly puts the prices up by the extent we see in table 1.1 and is then able to maintain those prices for almost a four-year period? That is a strong indicator of dominance, is it not?

A. No, for the reasons I think I have already explained. To have a strong indicator of dominance, you need to be clear that it has raised the prices above the competitive level, and that is the question that is obviously central to this case. Furthermore, I believe Pfizer reduced its prices at one point over this period. So ...

Q. You also say in your report -- you suggest that the provision of Phenytoin prior to September 2012 was distorted by the workings of the PPRS. You say that, do you not?

A. Yes.

Q. And what do you mean by that?
A. What I mean is that, as far as I understand it, Pfizer's price before the price rise was below the cost of supply. Normally -- a normal profit-seeking firm would try not to charge prices that were below its cost of supply and would do something about it. In this case, as I understand it, there was a regulatory power pushing the price down year on year and that is one of the factors that probably led to the situation where the actual price level before the price rise was subeconomic.

So when I say "distorted", I mean -- what I mean is that that price level is not a good benchmark for normal competition or anything else, and it is my understanding that that price was brought down, not because Pfizer did not want to make money on the product, but because the Department of Health, through the PPRS, was pushing the prices down, as it happens, to a point which was below even the costs of supply.

Q. When you refer to the price of Phenytoin prior to September 2012 being distorted by the workings of the PPRS, you are referring to the fact that Phenytoin was said to be loss-making at that stage. That is where that leads to. Is that correct?
A. Yes, that is correct.

Q. And you are not aware that, where a pharmacist has a choice of which drug to dispense, he will generally choose to dispense the cheapest one to him? Is that correct? Because that increases his profits, does it not?

A. There is certainly a financial incentive on the pharmacist to buy at the cheapest price, subject to meeting the conditions of the prescription, yes.

Q. So again if we look at the -- consider the size of the price increase by Pfizer in September 2012, that demonstrates they were not constrained by any fear that pharmacists would dispense an alternative product to their capsules, does it?

A. No, it does not really demonstrate that because we know that a very sizeable chunk of the market, very quickly after the price increase occurred -- a very sizeable chunk of the market did choose to exercise that choice of switching to an alternative because the alternative of NRIM did exist in the market at this point.

Q. I am looking at the time at which Pfizer decides to increase its prices, in September 2012, which was prior to NRIM entry. So on that basis, looking at that decision to raise the prices, do you accept it is clear that Pfizer was not constrained by any fear that pharmacists would dispense an alternative product to

Pfizer capsules?

A. No, I do not agree with that because one of the factors that you would take into account -- it goes back to your earlier comment that you need to look at competition as a dynamic process. One of the factors you take into account when pitching your price level would be how our actual and potential rivals are going to react to this price level. So it may well have been that one of the factors that was taken into account was to what extent does this open us up to the risk of parallel imports and also new entry by an another generic version of this product.

Q. Mr Ridyard, from what you have just said, it is clear that Pfizer did not have any such fear because they put the price up by the extent they did. The answer you have just given proves my point surely?

A. No.

Q. They were not constrained in any way by such fear of parallel imports coming in or whatever; otherwise, they would not have put the price up so boldly.

A. No, I do not agree with that premise at all. You would obviously need to know what the count -- to answer that question, you would need to know the counterfactual; what could the price change have been had there been complete assurance that parallel imports and entry would

not have happened.

Furthermore, you need to also look at the other factors that Pfizer took into account, or indeed Flynn took into account, when setting the price of this product, and that was indirectly a concern about regulatory constraints because that was the -- the why -- as I understand it, the reason that Flynn chose to peg the price against the tablet, which itself was a price which had been subject to intervention by the Department of Health, as we heard earlier this morning.

MR HOSKINS: Sir, I am going to move on to a different topic, so it is probably a good time to break --

THE CHAIRMAN: Okay.

MR HOSKINS: -- if you are happy to do so.

THE CHAIRMAN: Okay. We will resume at five to two.

(12.54 pm)

(The short adjournment)

(1.53 pm)

THE CHAIRMAN: Mr Hoskins, where are we on timing, do you think, so I can plan my day.

MR HOSKINS: I think I will be about another two and a half hours. I am touching wood as you tell you that.

THE CHAIRMAN: That takes us to the end of Mr Ridyard?

MR HOSKINS: Yes.

THE CHAIRMAN: If that is not too pejorative a word.

MR HOSKINS: Ms Bacon tells me she does not intend to call any of her witnesses today to start them and I would be very -- more than happy with that.

THE CHAIRMAN: So you have got the rest of the day. Okay, that is fine, carry on.

MR HOSKINS: Mr Ridyard, you are aware that NRIM first put its capsules on to the UK market in April 2013.

A. Yes.

Q. Let's go back to your first report, bundle D, tab 7. Paragraph 38.

A. Yes.

Q. Over the page there is a number of bullet points, which I think summarise what follows in your report, or this section of your report and you say in the first bullet:

"NRIM entered the UK market within six months of the transfer of the product to Flynn and gained a substantial proportion of 100 milligramme sales in the first six months of its entry."

Do you see that?

A. Yes.

Q. And then we know that the MHRA published its guidance in November 2013. You refer to that in the second bullet?

A. Yes.

Q. You go on to say in the second bullet:

"After the MHRA guidance was issued in November 2013, the data below indicate that NRIM's market share did not continue to increase."

Then at paragraph 41, the conclusion of this section, you say:

"I acknowledge that the evidence following the MHRA guidance does not show continued market share growth from NRIM."

Just to try and put that in context, on your analysis, the only period when NRIM gained sales at the expense of Pfizer and Flynn was between April and November 2013. Is that correct?

A. Essentially, yes, although one has to be careful with the monthly observations on these data because, as we discussed -- as was discussed last week, the -- each individual month stated can be subject to a number of influencing factors. But essentially, yes, the pattern that I observe here is very significant growth in NRIM's share up until, you know, let us say, some time towards the end of 2013. After that there is a fair bit of volatility for the next few months and then it does appear to stabilise at the levels that one observes in these charts.

Q. And the period between April and November 2013 is the period during which Boots and Lloyds did not follow

continuity of supply. You are aware of that?

A. Yes, it is my understanding that they switched -- over that period they switched their capsule purchases from Flynn to NRIM.

Q. Let's go back to paragraph 41. You continue:

"While volume shares alone cannot reveal the full competitive dynamics in this regard, this would suggest that Pfizer and indeed NRIM may have enjoyed some protection from the normal competitive dynamics in this period..."

This is the period after the MHRA guidance?

A. Yes.

Q. "... (albeit not one that appears to have engendered any further price response)."

You say:

"It was therefore the impact of regulatory intervention rather than any steps taken by Pfizer that afforded the suppliers of Phenytoin capsules seemingly greater protection from competition at this point."

The regulatory intervention you are referring to is the MHRA guidance. Is that correct?

A. That is correct, yes.

Q. For the purposes of this case, Mr Ridyard, it is irrelevant if dominance is obtained as a result of market dynamics or the MHRA guidance or a combination of

the two, is it not? It is still dominance, however you get there.

A. That is really a matter -- a legal question, I think, rather than an economic one but I can see the sense of that, yes.

Q. Go to your second report --

A. I should say in that I am not saying dominance occurred at that point; I am simply saying that looking at the market share trends alone, one shows remarkable -- well, clear growth in that early period followed by a bit of noise over a few months, followed by a flattening of shares. So looking at the share evidence alone, what I say in those words that were quoted to me was that some diminution of interbrand competition, in my view, probably took place there.

Q. Can we go to your second report. So that is tab 8.

A. Yes.

Q. Paragraph 94. It is the first bullet I want to look at. Do you see the heading, the main heading "7.4 Response: switching in the period after November 2013."

First bullet:

"Despite the guidance, I understand that over 90 per cent of Phenytoin capsule prescriptions in this period are open, ie do not specify a manufacturer name. It is not clear how such evidence can be consistent with

doctors adhering rigidly to continuity of supply principles."

Then you say:

"The CMA has not addressed this tension in its decision."

A. Yes.

Q. Can we pick up the decision, please. Can I ask you to turn first of all to paragraph 4.47. Here the decision says:

"Prescribers are typically encouraged to write open prescriptions, which allow the pharmacist to dispense the most cost effective version of that drug. The overwhelming majority of prescriptions for Phenytoin sodium capsules are left open. Accordingly, as set out above ... the CMA has focused its analysis on pharmacy dispensing behaviour. It is at the pharmacy level of the supply chain where substitution ... will primarily take place."

Then if you go on to paragraph 4.107, there is then quite a lengthy analysis from 4.107 to 4.145, of dispensing practice of pharmacies. So having seen that and the decision, I could not follow why you said at paragraph 94 of your second statement that:

"The CMA has not addressed the tension in its decision."

I.e. the tension that arises from the fact that most

prescriptions are left open because the decision expressly acknowledges that and then deals with it in some detail, does it not? Is that just an error on your report --

A. No, clearly the decision acknowledges that 91 per cent of prescriptions are open. Then the question is so how did the pharmacists then deal with that situation and the comment I make in my report is that in my view the CMA could have done a more thorough job trying to understand then so how did pharmacists actually react to that. I think in the decision quite a lot of the write-up of how the pharmacists did respond to that -- well, I think the CMA could have done a more thorough job and a more critical job of testing some of the responses, making sure that they differentiated clearly between the pre-MHRA guidance period and the post period and pushing back a bit on some of the statements that were made by the pharmacists. I was in the room last week when some of this was discussed in the opening arguments and I feel as though the CMA just had the option to do more, to understand what was going on there, and I do not think -- although there is a number of paragraphs dealing with that, clearly, I do not think it was dealt with in the way that -- in the best way possible.

Q. So go back to your second report, back to paragraph 94, but this time the second bullet. So that is behind tab 8.
A. Thanks.
Q. Bundle D. You say there:
"Evidence that Pfizer has obtained from some of the major pharmaceutical wholesalers indicates that two significant pharmacy groups ..."
I think we are allowed to say those names. Anyway, you see the two supermarkets referred to --
A. Yes, yes.
Q. "... in fact had their sources of Phenytoin sodium capsules switched from Flynn to NRIM despite their stated belief that continuity of supply principles would preclude this. This is evidence that I consider the CMA should have considered in more detail in its assessment of market definition and dominance."
A. Yes.
Q. The evidence that you are referring to here is the data that relates to Alliance Healthcare distribution, is it not?
A. Yes.
Q. Your report does not indicate that you have conducted any independent analysis of the Alliance data. Have you conduct analysis of the Alliance data?

A. I certainly looked at the data, yes, to see what it said about purchases from the different suppliers -- to see whether the pharmacists that -- let me step back one step.

In the decision the CMA says that -- famously -- only two pharmacy chains decided to switch. Therefore, it is interesting to look at what these other pharmacy chains did, given that they had an incentive to switch but maybe were put off by the guidance and so what I looked at when I saw the Alliance wholesale data was I wonder whether any of these other pharmacy chains actually bought from NRIM because on the face of it that would suggest that some of those pharmacies or some of the pharmacists within those pharmacies had indeed switched. So when I see that NRIM did make sales to these other chains, you know, beyond the two out of the ten that the CMA decision talks about, that is what I am referring to here.

Q. Did you look at the Alliance data yourself or did you get someone junior to do it? This morning you seemed to suggest that you got someone more junior in your office to look at it. Who looked at it?

A. I am working with at least two colleagues on this so ...

Q. But did you look at it yourself?

A. Yes.

Q. Can I go to bundle L at tab 3, please. This is the CMA's skeleton argument for this hearing. If I could ask you to turn to paragraph 54 first of all -- it is on page 21. Actually, if you turn to page 20 first of all, you will see the context. You will see the side heading "Alliance Data" beside paragraph 51?

A. Yes, indeed.

Q. Then paragraph 54 summarises figures that come from the Alliance data and the figures are confidential but you see in relation to Morrisons the total of packs of the product -- that is the Pfizer Flynn product and NRIM combined that Morrisons bought out of the total sales made by Alliance of the product and NRIM capsules, you see the disparity?

A. Yes.

Q. Superdrug, the same exercise, you will see the disparity?

A. Yes.

Q. So were you aware that Morrisons and Superdrug formed such a small part of the total sales by Alliance?

A. Yes, but in my view what is more interesting is what proportion of Morrisons' total purchases were NRIM, as opposed to Flynn, because once you get -- once you get beyond the first two pharmacy chains, everyone is pretty small in absolute terms and therefore I think the

juxtaposition of these two numbers in paragraph 54 of the skeleton argument is -- whether intentionally or not -- a bit misleading. The real question is, you know, Morrisons is not a huge pharmacy chain; the question is how many -- how much did Morrisons buy in total of Phenytoin sodium capsules and if you are going to play the percentages game, you should be calculating what share of their total requirements were sourced from Flynn as opposed to NRIM and these numbers do not speak to that comparison.

Q. But, Mr Ridyard, we are looking at the overall effect of switching in order to define the market here. Of course you do not just look at Morrisons and Superdrug in isolation because that would be misleading. What you have to do is look at Morrisons and Superdrug in context to see how much switching took place because that is what is relevant to market definition, is it not?

A. The background to this exercise is the statement in the CMA decision that only two pharmacies switched. When we look -- when we look behind that, whether you are looking at the survey that was talked about earlier this morning or we are looking at the detail of the Alliance wholesale data, you see evidence which strongly indicates that other people were switching too. So it was not simply two pharmacies that switched.

Furthermore, this was switching that seems to have taken place later on in the process.

So -- I mean, all of this is relevant to understanding what is going on in the market and whether the story told in the decision is an oversimplification and it's just an example of what I was taken to earlier. In my opinion, this is just an example of the CMA not having done a particularly thorough job looking at what happened. I fully -- obviously I agree with you that if you want to look at the total impact of the switching, it will come out in aggregate figures such as the market share numbers. That is the best place to look just to see if there is evidence of aggregate switching in one particular direction or another and that is the place you would go.

But I think Morrisons and Superdrug are both -- they are small in relation to Boots and Lloyds but then everyone is small in relation to Boots and Lloyds, nevertheless, they are chains of pharmacies and they did choose -- they appear to have chosen anyway, to switch brands of Phenytoin sodium capsules in this period and to my mind that is an interesting fact that says there is more going on in switching than the CMA decision concedes.

MR LOMAS: Can you help me with one small factual point

because we hear quite a lot about the Alliance data. Do we know what percentage of the supply market was accounted for by the product going through Alliance, what fraction of the market is Alliance? Does anybody know?

MR HOSKINS: I can find out whether we know. I do not know off the top of my head, sir.

A. I do not know either. I believe there were two major wholesalers, of which one is Alliance.

MR HOSKINS: You talked about oversimplification. None of this appears in your report. If you look at paragraph 56 of the skeleton argument, you will see what the rest of Alliance data shows.

A. Yes.

Q. And that shows very much that there was not any switching by the other pharmacies in the Alliance data and you will see at 57 a couple of very important retail pharmacists, did not buy NRIM at all. So if you are going to put the Morrisons and Superdrug data into context, you have to look at all these other examples in the Alliance data, do you not? That is clearly correct, is it not?

A. Well, it depends what the context of your analysis is. If the context is a decision which says there was no switching other than by Boots and Lloyds, then just

looking at a handful of people who have switched other than Boots and Lloyds I think is interesting and material.

Clearly, as I said earlier, if you want to look at the total -- market-wide impact of any switching that may or may not have happened, I think -- well, the market share numbers are probably the best -- the overall share numbers are the best place to go, given that each one of these individual pharmacy chains is pretty small in absolute terms, once you get beyond the biggest two.

Q. You told us earlier it did not matter how small they were. It was important that people switched. So why did you not, having looked at the Alliance data, having expressly referred to the Alliance data in your second report -- why did you not go through this exercise and deal with these sorts of issues? Because you are accusing the CMA of not having done a thorough job. You are accusing them of oversimplifying but your treatment of the Alliance data appears to be this bullet in paragraph 94 of your second report.

A. Because that's -- I think that what I've got in that bullet is enough to flag up the fact that the CMA could have done a more thorough job and papered over some what I think are interesting facts. I am not saying -- you

took me to earlier what I am saying about the overall market shares -- trends, I am not saying that NRIM continued to grow share at anything like the same rate after the guidance as it did beforehand. In fact, I think I say pretty bluntly and pretty clearly that NRIM's share pretty much flat lined certainly after the middle of 2014 onwards. So I am not saying that there was -- there was a constant stream of switching; I am just saying there is more going on in this market than the simple story and the decision suggests and that is the point I am trying to refer to here.

Q. Can we go back to your second report, paragraph 94. This time I would like to go to the third bullet, which is at the top of page 35.

A. Yes.

Q. You say:

"I have also seen a copy of a Kantar survey of pharmacists commissioned by Pfizer in which 70 per cent of pharmacists stated that if presented with an open prescription, they would dispense the brand of Phenytoin sodium capsules that they happened to have in stock."

A. Yes.

Q. Then the footnote reference you give is Pfizer's reply to defence paragraph 3.11.6. Did you yourself conduct an appraisal of the robustness of the Kantar survey or

are you relying on what Pfizer say about it in their reply?

A. I am not making any claims as to the robustness of the Kantar survey because, to be honest, I have not studied it in any kind of detail.

Q. At paragraph 95 of your second report, in relation to the period after November 2013 -- I am reading from the third line down at the end -- you say:

"There is no evidence --

A. I am sorry, which ...?

Q. Paragraph 95 on page 35 and you are still dealing with the period after November 2013 and I am picking it up at the third line, towards the end of the third line?

A. Right.

Q. "There is no evidence that they ..."

That is Pfizer and Flynn:

"... sought to benefit from any real or imagined insulation from the threat of interbrand switching by increasing their prices in this period. The pricing conduct to which the CMA objects was therefore clearly determined during the period prior to the MHRA guidance."

A. Yes.

Q. Are you suggesting that dominance in the period after November 2013 should take account of the pricing

conduct that took place before that date? I should say, sorry, the assessment of dominance in the period after November 2013 should take account of the pricing conduct that took place before that date.

A. I am not trying to suggest that. I am simply saying that -- I think this point goes more to the question of abuse because if -- if interbrand competition was restricted in that post 2013 period, then the best guess, if you were going to then take advantage of that reduction in competition is you would raise prices. So that is what I am referring to here. So I think my comments here go more to the question of how we look at the pricing behaviour and the abuse question rather than the dominance question.

Q. If you go back to page 32, you see the heading of this section is, "Issues relating to market definition, market shares and dominance."

A. Yes.

Q. So at least when you wrote this, you thought it was relevant to those topics rather than abuse, did you not? So can you not help us with what you are saying here?

A. No, I think my previous answer still applies; it is simply a forward-looking statement saying that, you know -- no, I mean, I do not draw any conclusions -- I do not draw any conclusion here saying therefore there

was or was not dominance in either of these periods. I think what I say in the whole treatment of market definition and dominance is that CMA's position is sort of circular and it is not very interesting and not very informative really to anyone. That is why I spent most of my time in my reports looking at the abuse question because I do not think there is a great deal to be gained from trawling over the dominance question, particularly given the way the CMA has approached it and the way which, as I said earlier, presupposes the answer.

THE CHAIRMAN: Can I just ask for clarification because I had a little bit of difficulty with paragraph 95, simply my own limited ability to understand these things.

Is what you are suggesting that -- I take your earlier observations -- there was evidence before 2014 of prices moving around, volumes moving around?

A. Certainly volumes, yes.

THE CHAIRMAN: Well, there was some price changes and some reactions to price change.

A. Yes, in early 2014.

THE CHAIRMAN: Then the situation stabilises.

A. Yes.

THE CHAIRMAN: Settles down if you like, the lines on the

graph go straight. Are you saying two things: first of all that the high prices, the raising of the prices by Flynn, which I take to be the pricing conduct to which the CMA objects in your last sentence?

A. Yes.

THE CHAIRMAN: You are saying that took place before 2014.

A. Yes.

THE CHAIRMAN: Axiomatically and it was determined in the conditions that were prevailing then, which I think -- I am not putting words in your mouth but they are less likely to indicate a dominant position --

A. Yes.

THE CHAIRMAN: -- than maybe the CMA thinks --

A. That is right, yes.

THE CHAIRMAN: So is it not a rather curious position that when you get after May 2014 when dominance becomes more plausible, to use a neutral word.

A. Yes.

THE CHAIRMAN: Then you do not have the pricing behaviour which the CMA objects to. Is that what you are saying?

A. Yes.

THE CHAIRMAN: You cannot have an abuse of a dominant position that does not exist.

A. I am sorry, the last bit?

THE CHAIRMAN: You cannot have an abuse if there is no

dominant position. So if the pricing conduct is an abuse. It has to have its own dominant position to be anchored in for the law to bite.

A. Yes, and I am saying in the earlier period I think there was -- obviously there was a big price rise and it is a big margin over costs. No one -- and I am not disputing that but I am saying there you have got to benchmark that against what you expect to happen in the market when originators face direct competition for the first time and I deal with that in that part of my report.

Here I am saying if at some point in time suddenly interbrand competition stopped and you did not have to worry about that competition any more, the expectation is that if you were then going to, you know, maximise your profits, you would then take that as an opportunity to raise prices because something you were worrying about has disappeared and therefore --

THE CHAIRMAN: So you would have expected on that theory Flynn's price to go up after 2014 and NRIM's to follow it up.

A. That would be the -- if behaviour was unconstrained by the threat of regulation and everything else, that is the obvious prediction that one would make if you believed that competition was no longer a problem.

THE CHAIRMAN: So your conclusion from the prices remaining relatively stable is that there was competitive pressure even though it was not manifested in price changes. Is that right?

A. I do not know that -- I could -- no, I do not think I would go that far. I am simply saying maybe it was simply the continued --

THE CHAIRMAN: Do not let me push you further than --

A. -- threat of regulation that caused them to choose not to raise prices at that point.

THE CHAIRMAN: Okay, thank you.

MR HOSKINS: You said in relation to the questions that you were addressed, if the behaviour was unrestrained by regulation but, of course, throughout this period of stability, the CMA investigation was going on.

A. Right, yes.

Q. So if Flynn and/or Pfizer were dominant, it is hardly a surprise, is it, that they would not necessarily seek to put their prices up further while the CMA was looking at excessive pricing?

A. Who knows? At this point it becomes confusing to figure out, you know, what impact the ongoing -- what the ongoing investigation had on behaviour.

Q. You said just before, you were asked questions by the chairman. You said:

"I think what I say in the whole treatment of market definition and dominance is that the CMA's position is sort of circular and it is not very interesting and not very informative really to anyone. That is why I spent most of time in my reports looking at the abuse question because I do not think there is a great deal to be gained from trawling over the dominance question, particularly given the way the CMA has approached it and the way which, as I said earlier, presupposes the answer."

A. Yes.

Q. That struck me as a rather odd thing to say because as the chairman just put to you, if there was not dominance, there was no abuse. So why do you say there is not much to be gained by trawling over the dominance question? I think Pfizer would probably disagree with you on that.

A. They may well but that is their prerogative. What I mean by that is it is intrinsically hard to get -- it is back to the cellophane fallacy problem. It is intrinsically hard to get an independent view on market definition and dominance that's independent of whether prices were excessive and that is particularly clear from the way that the CMA sets the discussion up. They completely presuppose the answer. I do not know whether

they realised they did that or not but they did. Therefore, the only way to answer the -- the only way to really answer the market definition and dominance question is to answer the abuse question. If you can answer the abuse question, you do not actually need to -- you do not really need to answer the prior question of market definition and dominance and that is the -- that's the -- the dilemma that I think one has looking at this case.

THE CHAIRMAN: It does not quite fit neatly within the various pronouncements of the European Court of Justice. That's the problem there.

A. I am pleased to say that is your problem, not mine.

THE CHAIRMAN: My words, not yours.

MR HOSKINS: So is your logic that if the tribunal were to form the view that the prices were excessive, then they would be entitled to and indeed they should, from what you have just said, find that Pfizer and Flynn were both dominant?

A. I am sure the tribunal is capable of making up its own mind on all these things.

Q. I am asking you because that is what you just indicated. You said that if the prices -- if -- in relation to the question of abuse, the conclusion was that the prices were excessive, then that would determine the question

of market definition and dominance. So I am putting that to you.

A. Okay. If the price is an exploitative abuse, then it must be the case that the market -- the market -- that they had market power, yes, in order to exploit that abuse.

Q. So looking at the level of prices is relevant to both market definition and dominance?

A. Yes.

Q. Go to your first report at tab 7, this time to paragraph 46. We have got to be a little bit careful with the figures here because the figures are confidential.

A. Understood.

Q. So we must try not to say them out loud. At paragraph 46 you say:

"As regards the scale of price responses, following a request from Flynn to reduce its supply prices (as per the terms of its supply agreement) Pfizer implements the price reduction for both 100 milligrammes and 300 milligrammes Phenytoin sodium capsules of X in February 2014, backdated to January 2014."

You have the words in brackets:

"As per the terms of its supply agreement".

What are you referring to there?

A. I understood that in the supply agreement there was provision for Flynn to go back to Pfizer saying it is harder for us to market this product than we thought, can we have -- we need to reduce our pricing, so can you reduce your price to us. I must say I do not have a perfect knowledge of the supply agreement but that is the understanding on which that comment is based.

Q. Were you in court last Thursday when Mr Walters was giving evidence on this topic?

A. No, I have had a look at the transcript. I cannot say I studied every word but I certainly had a look through it but I was not here.

Q. Have you seen the description he gave of this arrangement to revisit the supply prices after 12 months because of stock that Flynn had been holding?

A. I did not read that carefully. So you would have to take me to it again.

Q. It is not something then obviously you took account of when you were drafting your report, is the obvious statement. You did not know about it so you cannot have put it in your report?

A. You are saying I did not know about something but I do not know what you are talking about. So it is a little tricky to answer that question.

Q. You just told me you were not aware of the details of

what Mr Walters said related to the reduction that flowed from the supply agreement. Even now you are not aware of what the reason was.

A. What I wrote my report I was not aware of what Mr Walters was going to say a year later, yes, that is correct.

Q. Paragraph 47 you say:

"By comparison, I note that evidence from other products that faced generic entry indicates that the price of originator products falls by 10 per cent relative to pre-entry levels on average after two years."

A. Yes.

Q. Picking it up further down:

"Overall, therefore the price responses that we observe in this case, at least in relation to the 100 milligramme and 300 milligramme capsules appear to be somewhat greater than the levels that we observe in the industry more widely."

A. Yes.

Q. So you are assuming that the price reduction that took place by Pfizer in February 2014 and by Flynn in April 2014 was due to competitive responses. That is the assumption?

A. Yes, that is right, yes, that is the assumption.

Q. But you yourself have not investigated what the reasons for those price reductions actually were in fact?
A. Not in detail but I do observe that there is a substantial loss of market share and you would expect -- it is in line with what one would expect is that there would be a certain amount of reconsidering of the position and therefore recalculation of what your optimum price is if you find that you have lost one third of your market or 25 per cent of your market to a rival.
Q. So when you are looking at the sort of competitive interaction switching, it is important to look at prices with volumes, is it not, you don't look at either in isolation?
A. You would always like to look at both prices and volumes, yes. Sometimes you have to look at whatever information is available.
Q. You make a similar point in your second report at paragraph 93. I am going to pick it up in the middle of paragraph 93:

"Furthermore, both Pfizer and Flynn also conceded a price and profit margin reduction on the capsule sales they retained in the face of this competitive threat."

You describe as NRIM entry.
A. Yes.

Q. "In particular, Flynn's downstream price fell by around X per cent in the period following NRIM's entry and the Pfizer supply price fell by around Y per cent over a similar time period."
A. Yes.
Q. Then you have footnote 71 and you refer to CMA decision, table 4.1 and table 3.4.
A. Yes.
Q. Yes? And if we could go to decision table 3.4?
A. Do you have a page number?
Q. Sorry, I'll just get you a page number. It should be page 86.
A. Thanks.
Q. So this table to which you referred in your report shows that Pfizer's prices remained many multiples more than their pre-September 2012 price throughout the infringement period, i.e. from September 2012 to June 2016?
A. Yes, absolutely.
Q. Mr Ridyard, it is not normal, is it, to see an originator's product long out of patent increase its price by this level of magnitude overnight and then maintain it over an almost four-year period, is it?
A. I am not sure about that but I think the --
Q. Have you ever seen it before?

A. I have not studied -- I have not studied these situations before. I know there are a number of cases where other generic product prices have increased substantially --

Q. Sorry, before you go on, so you cannot say from your previous experience whether that is normal or not and also by implication you cannot say by virtue of the work you have done in this case whether that is a normal situation or not then.

A. On the latter, I do refer in my first report --

Q. The latter?

A. On the latter point. I do refer to a number of instances where other prices have increased. Yes.

Q. Can you say on the basis of the work you have done and your experience whether it is normal to see an originator's product, long out of patent increase its price by this level of magnitude overnight and then maintain it over an almost four-year period?

A. Let me just look back at what I do say in my first report on that subject. (Pause)

On page 49 of my first report, paragraph 30, a number of other generic products whose prices have increased --

Q. Sorry, which paragraph are you on?

A. It is table 5 on page 49 of my first report.

Q. Are you telling me that these are all products long out of patent where they have increased their price by the sort of magnitude we have seen overnight and then maintain it over a four-year period? Is that what you are telling me? That is not what this goes to, is it?

A. Let me just ...

These are other instances of pharmaceutical products with large price increases.

Q. So these were examples of price increases but you do not know if these products were long out of patent, do you?

A. I do not know -- that is what I am just looking to see whether -- how long out of patent. I'm not sure that I considered that relevant. Whether they are in patent or out of patent, I guess might be of some relevance. I must admit, my assumption was that these would have been out of patent products but I do not know that, I accept.

Q. Can we go to your third report, so that is tab 8A, paragraph 16. You say here:

"To recap, my point is that it is only after the Pfizer supply price increased that Phenytoin sodium capsule prices and margins were elevated to a level that is likely to attract generic entry in a way that mimics the process that arises with other originator products that lose patent production."

A. Yes.
Q. Is that observation based on the fact that NRIM only entered the market after Pfizer and Flynn raised the ASP of their capsules in September 2012 or have you conducted some economic analysis of the price at which generic entry would be likely to happen? So is that an observation or is it based on analysis?
A. Sorry, could you repeat the question, please.
Q. Of course. It was a long question. So you see the statement that I have taken you to in your third report?
A. Yes.
Q. I am asking whether that statement is based on the fact that NRIM in fact only entered the market after Pfizer and Flynn raised the ASP of their capsules in September 2012, or have you conducted some sort of economic analysis of the price at which generic entry would be likely to happen in this market? Is it observation or analysis?
A. Well, I -- as you know, I do refer to the studies that have been done of what happens when patent -- pharmaceutical products lose their patent protection and to look at what prices they then charge and how often does generic entry occur and when it does occur, what impact it has on shares and on prices.
So that is the -- that is -- and that is -- that is

the -- the most -- the background research which I did on this topic. Here I am just -- I am saying -- I am explaining why I think that that experience of what happens when you see instances of originators facing generic competition for the first time, why I think that is relevant -- a relevant benchmark against which to assess the -- the pricing and other behaviour of Pfizer and Flynn in this case.

And to answer the first part of the question, it does not surprise me that when that price increase occurred, prior to the price increase, prices were below cost or at least at an extremely low level, below Pfizer's costs, as far as I understand, certainly at a very low level, so not the kind of prices that would likely attract an entrant. So it does not surprise me that entry took place after the price increase happened because clearly an increase like that, which creates these large margins is something that is likely to attract entry by players such as NRIM in this case.

Q. Mr Ridyard, my understanding is you are trying to draw a comparison between what happened with Phenytoin and what happens with, as you put it, other originator products that lose patent protection; correct? That is what you are doing in this bit of the report?

A. Yes, I am drawing a comparison between what happened in

this case after the price rise and what happens in other cases, when originators face generic competition for the first time.

Q. And the difficulty in that comparison is that you are comparing originator products that lose patent protection and then the generic competition follows but the difficulty in this case is that patent protection was lost some decades ago. So that is a material difference, is it not, between this case and the ones you are seeking to compare; correct?

A. It is a factual difference but whether it is -- I mean, clearly the claim I am making here is I think it is -- it is not the same situation, I understand that but I think it is an analogous situation because it goes to the question of well, what is competition supposed to look like, when originators face generic rivals for the first time and the reason I think that is interesting and important for the case is -- takes us back to the -- to the circularity problem in the way the CMA looks at market definition and dominance. It has a benchmark, which it does not call a benchmark but is in effect a benchmark saying that unless we find that prices collapsed to cost on day 1 after a price increase and/or unless we find generic entry happens to such an extent that anyone who does not reduce their price down to cost

loses all their market share, I, the CMA, am not going to be satisfied that competition is effective and the point I am making here and I am making with my comparison of what actually happens in the real world when originators face generic competition for the first time is that it does not happen instantaneously and sometimes it happens quicker than others and therefore I think it is insightful to learn the lessons of what you can expect from competition in a situation where originators face competition from generic rivals for the first time.

THE CHAIRMAN: I think what is being put to you by Mr Hoskins is that it is pushing things a bit to describe Flynn supplied by Pfizer as an originator.

A. I do not agree with that at all.

THE CHAIRMAN: Mm-hm.

A. Because it is still -- it is still basically the Pfizer product. It is still a branded -- I know in legal terms it has been debranded but in economic terms it is clearly still a brand. It has still got the -- it has got the Epanutin name on the capsule. I think more importantly it is still clearly associated with the originator product throughout this period. Indeed, that is the source of the competitive advantage that Pfizer --

THE CHAIRMAN: So your comparison applies to an originator in the sense of a brand owner as well as to an originator in the sense of being a patentee.

A. Yes, because it is the -- because once a patent has expired, then the only thing the originator has going for them is their first move advantage and their brand image. In other respects they are facing competition from other suppliers whose product is supposed to be equivalent in -- to theirs. So the only thing they have going for them is, you know, a bit of inertia, some brand image and just having got there first and I think that is very similar to the situation that Flynn faced when it started marketing these products.

It did also have the benefits of in effect the Pfizer brand name and that origination advantage. So --

MR HOSKINS: Sorry, do you want to say something more?

A. That is why I think it is interesting -- I know it is not the same situation but I think it is an analogous situation to understand how does competition work in this Flynn situation and compare that with how competition works when another product suddenly loses its patent protection, has a high price and a high price/cost margin. How quickly does that get eroded by competition because in my view that tells you something about what normal competition looks like in this

scenario. That is my whole rationale for looking at this piece of evidence.

MR HOSKINS: The normal competition you describe is where an originator product loses patent protection and then because of its high price is exposed to generic competition. That is the paradigm, is it not?

A. Yes.

Q. And the reason you try or you are trying to draw an analogy between that paradigm and what happened in this case is, as you explain in paragraph 16 --

A. Yes.

Q. -- you say:

"My point is that it is only after the Pfizer supply price increased that Phenytoin sodium capsule prices and margins were elevated to a level that is likely to attract generic entry."

So what I understand you to be saying is it is all very well to say the patent protection was lost decades ago but that will not have been of any interest to generics. It is only when the price goes up that generic competition is likely in this market. Is that correct?

A. That is what I am saying, yes.

Q. And the Pfizer and Flynn price increases took place in September 2012, did they not?

A. Yes.
Q. And NRIM entered the market in 2013, yes?
A. Yes.
Q. Do you know how long it usually takes to bring a generic product to market?
A. That is reflected in the studies that I have summarised in my first report.
Q. You do not know off the top of your head?
A. I have not memorised it, no.
Q. Do you know when NRIM obtained regulatory approval to market its Phenytoin sodium capsules in the United Kingdom?
A. I have seen that information. I think it is some time in 2012.
Q. 13 September 2011.
A. 11, yes.
Q. Do you know how long it took NRIM to develop its generic Phenytoin sodium capsules before it obtained that approval?
A. I have read that information but I cannot remember it.
Q. It was around five to six years before they approved it?
A. Right.
Q. So it is clear from that, if you take what I have told you at face value, that NRIM began planning generic entry long before the price increases in September 2012?

A. Yes.
Q. Which means that your attempted analogy just does not work, does it?
A. I do not accept that at all because the proposition I make is that entry is going to look a lot more attractive when prices are high than when prices are low. It so happens on these facts that NRIM made steps to enter this market even when prices were low and only NRIM can really speak to why it did that or why it thought that was a good idea. Maybe it was looking at other markets than the UK. I do not know but the proposition I am making is still, I think, perfectly valid, that the way the whole of this generic price competition model works, on which -- you know, on which the UK health system is based, is the notion of, as Mr Beighton said earlier, freedom of pricing and then allowing entry to happen to bid away those high prices and high price cost margins.
THE CHAIRMAN: Are you suggesting that NRIM were looking at Teva's pricing behaviour as well? We have got no evidence for that, have we?
A. I have literally no idea what NRIM was thinking about. Maybe they had made a very bad decision and had got lucky. I just do not know.
THE CHAIRMAN: No.

MR HOSKINS: Can I go back to your first report, paragraph 49. It is behind tab 7. You say, paragraph 49:

"I note that except for the price reductions in 2014, we did not observe further price reductions from Flynn or NRIM nor are there any attempts to increase price to reflect any reduced risk of switching."

A. Yes.

Q. Put another way, there is no evidence of price competition between Flynn and NRIM after 2014, is there?

A. There is no evidence of further price reductions. There still is price competition between them because NRIM's product is, apart from one brief period, consistently below Flynn's and therefore all the time pharmacies are faced with a financial incentive, a commercial incentive, to switch, which may well, as we discussed -- may well have been overweighed by their desire or need to adhere to the MHRA guidelines. So there was still price competition there in the sense that there was an advantage in switching from the more expensive to the cheaper product.

Q. There was an advantage in switching that neither Flynn nor NRIM were actually dynamically actively competing against each other by adjusting their prices throughout that period?

A. There were not any further price reductions in that period, you are quite right.
Q. Which was an indicator there was no competition between them. It is an indicator of a lack of competition?
A. Well, that is -- is this a question or --
Q. It is a question absolutely.
A. Okay. Is that an indicator of lack of competition? Well, it would be more competitive if you saw them bidding away prices throughout that period than if they did not, yes. I'm not sure that means there is a lack -- it is a relative -- it is a relative difference.
Q. I am going to move into a different area of your evidence, evidence on excessive pricing. Go to your first report, paragraph 67. I want to pick it up on page 24. We see a paragraph that begins:

"Third ..."

You say:

"Third, the pharmaceutical industry is, of course, innovation based and strongly protected by IP rights with pharmaceutical companies competing to develop new and innovative drugs that treat medical conditions in increasingly effective ways. In particular, pharmaceutical companies invest significantly in research and development to develop drugs that may or

may not make it to market. In order to have a sustainable competitive equilibrium in any market based pharmaceutical system, sufficient profits must be earned on those drugs that do make it to market to compensate for those that do not. Overall, there are strong reasons to consider that across the sector as a whole prices would not tend towards costs of production, they would instead exceed that level in order to compensate for the losses made on other products."

A. Yes.

Q. You made it clear to me about 20 minutes ago you are not an expert on the workings of the pharmaceutical sector, are you?

A. No.

Q. And you are not an expert on intellectual property rights either? It's not a criticism.

A. No, I am not a specialist in those areas. I have come across both quite a few times in my career but I am not an expert in either.

Q. Can I take you to a legal authority. I am not going to ask you a legal question. It is authorities bundle A1, tab 1, which is the judgment of the Competition Appeal Tribunal in the Napp case that you may be familiar with. But I wanted to show you paragraph 416.

The tribunal says:

"Thirdly, we agree with the director's view ..."

That is the old DGFT.

A. Yes.

Q. "... that a manufacturer with an innovative product cannot demand or expect prices to remain at excessively high levels indefinitely. Indeed one of the principal purposes of the patent system is to confer a degree of exclusivity thus enabling companies to recover substantial research and development costs and investments in new medicines."

So from your experience, you do have, and as you are experienced as an economist, are you able to agree that one of the principal purposes of the patent system is to confer a degree of exclusivity, thus enabling companies to recover substantial research and development costs and investment in new medicines?

A. Yes. It is -- the patent period is not the only period in which they are enabled to recover those costs but clearly the patent exclusivity is designed to give them a time-limited chance to do that in a situation where they are protected from competition from generic rivals.

Q. And do you agree that a manufacturer with an innovative product cannot demand or expect prices to remain at excessively high levels indefinitely. Do you agree with

the CAT on that?

A. Yes.

Q. And Epanutin is an old product that has been off patent for decades, is it not?

A. Yes.

Q. And so can we agree that the period during which it is appropriate for the owner of Epanutin to obtain profits at a level necessary to contribute to its overall R and D costs has therefore long passed?

A. The period in which it had patent exclusivity to help it to do that is clearly long past. I do not agree that at the end of patent exclusivity, there is any requirement for prices to come down to cost and that is -- indeed this just goes back to the whole point of looking at the actual experience of what happens to these originators when they do lose patent protection. In very many cases the branded product retains a high price, possibly as high or in some cases an even higher price than when it enjoyed patent exclusivity. It may well lose volume. It does generally lose volumes in doing that but it is very common for pharmaceutical products, once they have lost patent exclusivity to carry on earning high price cost margins. Whether -- what you mean by excessive is a slightly separate question but certainly very high price cost margins after the end of patent exclusivity.

So it is not the case that you get your 20 or 25 years of exclusivity and the next day you are in the world of pricing at marginal costs. There is sometimes a substantial period in which the -- after the loss of exclusivity, you continue to high price cost margins. You have freedom of pricing to do what you like in that situation.

MR LOMAS: Would you expect in those circumstances when a product is in that situation for its price to go up 26 times?

A. Well, I think that -- if the other -- if the other influences on the -- on the market remain stable, then, no, you would not. I think -- the fact -- the set of facts that we have here is one where the -- the prices was -- as we said earlier, the price had been held down to a point that was below cost. There was then a -- there was then an opportunity, which the healthcare system, you know, presented -- presented to Pfizer and Flynn to change the status and then have a free -- a free run to decide what the price would be. It turned out that that is a very large price rise. Obviously that is an oddity and if that kind of price rise is an oddity, it is an oddity that arises from the oddities of the healthcare system in the UK.

Clearly, it is not something that you would expect

to observe in a market which was not so heavily influenced by these kind of regulatory factors.

But the question -- the question then, I think, is, you know, yes, it is a big price rise but when you look at that new price level, how does that compare to the prices of other products that have a similar value. That is when I get on to looking at the value of this product compared to the value of other products which do the same or a similar job.

MR HOSKINS: Can we go to your first report at paragraph 71. Tab 7.

A. 71?

Q. 71, yes, on page 25. I am going to pick it up five lines down. There is a sentence that begins in the middle of the page, five lines down:

"But none of the factors listed by the CMA ..."

Do you see that?

A. Yes.

Q. "... as to why the allowable ROS under the PPRS is 'useful and informative' addresses this fundamental issue - namely, that it is explicitly recognised within the PPRS that individual products may reasonably earn a significantly higher margin than the ROS of 6 per cent, based on the particular market circumstances of the products in question."

Having recognised that one of the facts -- factors that flows from the PPRS, ROS of 6 per cent being an average, is that some products within a company's portfolio will earn more than 6 per cent. It necessarily follows, does it not, that some of the products will earn less than 6 per cent?

A. Correct.

Q. Paragraph 73. You say -- it is the heading "Even the DH does not appear to consider that costs plus 6 per cent is a good test". Then at the start of 73:

"It is also notable that the DH does not appear to agree with the CMA's view as to the suitability of the PPRS 6 per cent rule. In particular, I understand that a representative of the DH indicated the 6 per cent ROS 'did not bind behaviour that much' and that (as indicated by the extract below) there were a number of potential issues with this benchmark."

Then you set out literally an extract from the document you are quoting from, which we see from footnote 45 is document 00806, yes?

A. Yes.

Q. Can you tell us what that document is, 00806? Do you remember?

A. I think it is a note of a meeting between the CMA and the Department of Health.

Q. And have you read this document yourself or is that a member of your team who dealt with this bit of the report?
A. I think I've read it. I cannot remember exactly everything I've read but, yes, I am pretty sure I did read that, yes.
Q. Let us have a look at it. I do not want to turn this into a memory test. Bundle J1, tab 20. I have to stress that the names of civil servants here are confidential.
A. I understand.
Q. So we must look after each other on this. So you see the heading, "Note of telephone call on 17 September 2014..."
A. Yes.
Q. "... between the Department of Health and the CMA."
You cite from the first page of that document. But if we turn over, and look -- first of all, look right at the bottom of page 1. The DH officials set out potential issues --
A. I'm not sure I am looking at the right tab, I am sorry.
Q. Of course. It is tab 20 and it should have the heading "Note of telephone call --
A. Yes, I have that.
Q. And the extract you took was from page 1. I have taken

to you the bottom of page 1, where the DH officials set out potential issues with using ROS for benchmarking including -- and the first bullet is the measures that is the 6 per cent ROS and the PPRS covers the entire portfolio of branded drugs because we are talking about branded drugs here, and therefore there can be a wide range of drug returns within it. We have just looked at that; that some drugs will be higher than 6, some will be less than 6, there will be a range, yes?

A. Yes, I would expect so, yes.

Q. And we see from the second bullet, there was a negotiation between government and industry in relation to the level of returns. So that tells us that the 6 per cent average figure was a result of the negotiation, as described there, does it not? That is what it says.

A. Yes.

Q. And the purpose of the negotiation was to arrive at an appropriate average to reflect the range of drugs in a portfolio, was not it?

A. Well, I think the -- I would imagine that there was quite a lot more going on in the discussion than that because it is not just about -- because the 6 per cent we are talking about here is just the return that is being allowed in the UK, sort of tip of the iceberg, as

it were, of these essentially global pharmaceutical companies. So I think the answer to your question is yes in relation to the UK return that is achieved by these companies under the PPRS but beneath that there is the -- you know, the iceberg itself, if I may use that term, and I imagine that some of the discussions that the Department of Health had with the industry -- I think this is picked up in Mr Williams' various reports -- there is a discussion there about where the UK part of the iceberg sort of starts and where the rest of it -- and where the rest of it takes over. So there is an awful lot more going on in this discussion than simply an average return of 6 per cent and what is the distribution around it.

Q. So 6 per cent is the reasonable average that is negotiated for the UK part of the business and then we are trespassing into Mr Williams' transfer profit --

A. Yes.

Q. -- price analysis. And then the fourth bullet, the DH said:

"... the difference between branded drugs which fell within the scheme and generics such as Phenytoin ..."

So they differ from you because they call Phenytoin a generic rather than a branded?

A. Yes.

Q. Leave that to one side for the moment. Let us assume Phenytoin is a generic, which were outside the scheme, generics prices were historically lower than the branded price once they came off patent?

A. Yes.

Q. And therefore it would be reasonable to adjust the ROS down if looking at a generic drug.

So we get from that, do we not, that the DH at least considered that Phenytoin should be considered to be a generic drug once it was withdrawn from the PPRS; correct?

A. If they did, I do not think they looked at the substance. They would have -- they must have been looking at the labels rather than the substance because I think -- I think it is clear that -- okay, legally as I said earlier, it is clear when it has been debranded, it is a generic but in reality it is not a generic, it has all the hallmarks of the originator and clearly that is the competitive advantage that Flynn is then able to sell out into the market. It is the fact of the installed base and everything else that it is selling.

MR LOMAS: Does it have all the hallmarks of the originator? It has been renamed so it is not carrying the Pfizer brand name. It may have Epanutin on the capsules but the pack is Flynn-branded?

A. Fine, okay. Well, perhaps -- perhaps that was taking it too far but in substance what is important -- what is important in this, just going back to the whole continuity of supply question, is does the first mover have an advantage in this product? Answer: clearly yes because to the extent that there is some continuity of supply that is driving -- driving which brand of Phenytoin sodium you take, does Flynn as this new -- the new seller of this product -- does it automatically benefit from whatever incumbency advantages Pfizer had.

MR LOMAS: Because of stabilisation on the product?

A. Yes, and commercially clearly that is important and that came across clearly in the evidence. So, yes, I mean, I mean obviously I accept that -- that it is a distinct set of facts and it is a very odd set of facts, frankly, that we are looking at here but in economic substantive terms I think when Flynn started marketing this product, it knew and the medical profession knew that whatever advantages Pfizer had the day before, Flynn would have the day after and obviously a lot of effort was spent by everyone concerned to make sure that that was the case.

MR HOSKINS: Mr Ridyard, the whole purpose of the arrangement between Pfizer and Flynn was to make sure that the Phenytoin capsules ceased to be a branded product because then they would be in the PPRS. The

whole purpose was to make them into what is called a generic product because that has a completely different system of regulation; correct?

A. Yes, but that -- I mean -- it is a question of -- in formal terms, yes, clearly that was the commercial purpose. An opportunity was seen whereby taking it out of the PPRS, they could have freedom of pricing and to charge -- to substantially increase the price in a way they could not within the PPRS. Clearly that was the commercial motivation for what was going on here. All I am saying is that once they had done that, made that change, they were then selling this new product on the basis that it was -- it was the same as the old one. It was not -- it was not as if they were going out into the market selling some brand new --

MR LOMAS: For continuity of supply purposes it met the test.

A. Yes, which is important in economic terms because that was the incumbency advantage that was bestowed on Flynn as it went to market.

MR HOSKINS: Let's -- there was a difference of opinion -- there is a difference of opinion between the DH here and you as to whether Phenytoin should be called a generic or not. Let's assume for a moment that the DH --

A. I am sorry, I think you are splitting hairs here. There

is the legal position and the substantive economic position and not for the first time they do not happen to align but I do not think there is any difference of opinion in terms of -- I accept that when the product came out of the PPRS, it was because it was debranded and therefore a generic, if you want to use that formal term. As I keep saying, in substance it still had the benefits that it had the day before.

Q. So Phenytoin is to be considered a generic drug once withdrawn from the PPRS and we see from the fourth bullet that the DH considered that a rate of less than 6 per cent ROS would be appropriate for a generic drug such as Phenytoin. We see that from the last two lines, do we not?

"Therefore it would be reasonable to adjust the ROS down if looking at a generic drug."

A. Right, but I think that -- that may have been their belief but I think they were misconceived in taking that view because I think what they are -- they are saying there is, because we are going to call this a generic product, let's assume that it is going to behave in the way in which rival generics price when competing against an incumbent but that was -- that is not the case here because this Flynn product became the incumbent. Effectively it became the -- it was the originator

product, not a generic copy. So it was NRIM who was in a position of undercutting that price. So -- and other rivals, had they turned up into the marketplace later on, were as -- I do not think it is a reasonable expectation to think that the originator would choose to suddenly slash its price just because it was no longer in the PPRS.

THE CHAIRMAN: So it is the "therefore" that you are taking issue with in that statement?

A. Yes, I think this statement -- I think this statement, you know, reflects the kind of confusion between the legal form and the economic effect.

MR HOSKINS: Are you in any position to disagree with the DH's comment that generics prices were historically lower than a branded price once they came off patent? They are quite experienced in this sort of matter, the DH, are they not?

A. They may be experienced but it sounds like they have not thought this one through because certainly it is true that generic copies when they compete against the originators -- the evidence on there is summarised in my reports but people have studied this in great detail and certainly generic entries come in, when they come in against the incumbent, they come in at a lower price and then over time that price often gets bid down and down

but it is not the case that the originator reduces its price in every case and in many cases the originator chooses to carry on charging a high price as the evidence very clearly shows in my reports.

Q. What happens in this circumstance where the generics come in with a lower price and the originator keeps its higher price -- what happens to volumes?

A. Clearly volumes switch towards the cheaper product but at a rate which differs from case to case.

Q. So the originator basically has a choice of whether to maintain a high price and lose volume or to reduce its prices to preserve a degree of volume.

A. It does indeed, yes.

Q. Can we go back to your first report. It is at bundle D, tab 7, this time to paragraph 112. You see the heading, towards the top of the page:

"4.3, Benchmarks for the economic value of Phenytoin sodium."

And paragraph 112, I want to pick it up five lines from the top, where you say:

"Equally, it is reasonable to expect that different pharmaceutical companies may implement different competitive strategies in response to the same or similar market conditions. One firm may choose to compete with generic entrants for volume by offering

discounts, whilst another may maintain prices to maximise profits from those customers who may not wish to switch."

And that is precisely the point we have just discussed, is it not?

A. Yes.

Q. And indeed, it is not a binary choice because the originator may choose something in between, it may --

A. Of course.

Q. -- draw some balance between price and volume. So you need to say yes.

A. Yes.

Q. Can we go to paragraph -- sorry, page 43 of this report and figure 3 is a comparative analysis of AED costs, September 2012, and over the page, table 4, comparative analysis of AED costs, September 2012 and what you do in these tables is you set out an analysis of a number of the other AEDs as potential benchmarks, do you not?

A. I do, yes.

Q. And in second Ridyard, paragraph 35, you focus on five of those AEDs in particular as what you say are appropriate comparators for Phenytoin and you see the names --

A. Yes.

Q. Topiramate et cetera?
A. Yes.
Q. You see the five listed against the bullet points. I assume I have got this right; you have focused on those five because you think they are the most appropriate benchmarks for Phenytoin amongst other AEDs. Is that correct? Why pick those five out for special treatment?
A. I picked them out because I thought it would be useful in this report to provide some further detail behind the chart that you just took me to in the first report and in doing that, yes, I felt that -- I think I explain this in the second report, that I thought it would be useful to focus in on these products which had also lost patent protection and I also chose products which were not in category 1 because I was conscious that if I chose products that were in so-called category 1, in other words had some protection from switching, that that would be subject to the criticism that they also had monopoly power; therefore they were not good -- they were tainted as benchmarks.

So it was a combination of choosing other AEDs which had lost patent protection but which did not have the same level of protection from switching Phenytoin sodium had. So I felt these were -- actually I think all the

comparisons are of interest from the first report, but these seem to be the ones which had -- to be relevant to take the analysis further.

Q. If we turn to -- still in your second report -- paragraph 38 and table 1. You summarise your findings in relation to the reimbursement prices of these five proposed comparators and Phenytoin?

A. Yes.

Q. And if we look at table 1, it is entitled "Comparison between the price of benchmark AEDs and their generic products/Phenytoin sodium, December 2016."

A. Yes.

Q. And we see at the bottom, just in small writing under that table:

"Source: RBB analysis of PCA data."

A. Yes.

Q. PCA is prescription costs analysis. Is that right?

A. Actually I do not know what it stands for.

Q. Have you looked at the data? Is it someone in your office who did this exercise?

A. It would have been -- the calculations were done by one of my colleagues.

Q. And have you -- so you would not actually have looked at the calculations to check them. Again not a criticism. I am just trying to work out --

A. I've certainly looked at some of the calculations, yes. I think there is -- to be frank there is a mixed answer to that. I have certainly gone over the calculations in -- and asked questions about the methodology and so forth but it was my colleagues who did the detailed work.

Q. PCA stands for prescription costs analysis and that is data relating to prescriptions dispensed --

A. Yes.

Q. And it is prepared by the NHS business services authority. Are you aware of that?

A. Broadly, yes, yes.

Q. And are you also aware that, as well as providing financial information of the sort that you have -- or your office has analysed for the purposes of this report, the PCA data also provides information on the quantities of Phenytoin capsules and tablets dispensed?

A. Yes, I am aware of that.

Q. Are you aware that the quantitative data allows one to distinguish between originators and generics?

A. It allows you to distinguish between prescriptions that were written with the originator name on and those that were written as open prescriptions, I think.

Q. And we know --

A. Yes, sorry, so whether it allows you to -- because

I think there are some situations where the originator will also supply some -- as well as selling its brand at the high price, it will also sell some of the products of its own brand at a lower price, as if it was a generic.

Q. So we have looked at the PCA data that you are --

A. Right.

Q. -- your analysis is based on and our understanding of it is that for Topiramate, looking at the total quantity of Topiramate dispensed, 3 per cent was branded, 97 per cent was generic. For Lamotrigine, 9 per cent of the total dispensed branded, 91 per cent generic.

MR BREALEY: Where is this data from --

MR HOSKINS: It is from the PCA data --

A. Those numbers surprise me because my understanding is that the penetration was between 11 and 22 per cent.

Q. This is a matter, sir -- this is data that RBB have relied on. This is our analysis of it, it can be sorted out --

MR BREALEY: It is simply not good enough. You cannot analyse the data and then spring it on to the expert in the witness box.

A. Just to be clear, I have -- obviously I was inquisitive about this question as well and I did take an interest in the data and my understanding is different from that

of Mr Hoskins. I am not saying that I am necessarily right and he is wrong but --

THE CHAIRMAN: I think Mr Brealey has a point. If you have done work on the data which you want us to take into consideration, then it would be a good idea to share it with the other side and to get their observations on it. By all means continue to talk to Mr Ridyard. He seems perfectly capable of looking after himself.

MR HOSKINS: So our analysis of the data is that it shows that all of the five AEDs that you rely on as comparators suffered a very dramatic loss of market share following the launch of generics. Is that your understanding of the position.

A. No, for two reasons. First of all, as I understand it, the penetration rates were -- of generics were less, so, as I said it was between 11 and 22 per cent that the brand owner retained.

Q. So it is the brand retained 11 to 22 per cent?

A. Yes, but I would need to check the date at which that was the case and that was the second point I was going to come to, which is that in -- I talk in my report about when the patent exclusivity was lost. So in some of these cases there has been a number of years since the patent protection was lost and therefore you expect the incursions of the generics to increase over time.

Whereas in the case of Phenytoin sodium, of course, we just had really the first year of experience to go from and then, you know, since then we have had the CMA investigation and other things which might have -- which might have, you know, prevented the -- affected at least the way in which the market develops from there.

So I think -- to make a statement to say that these products suffered quicker generic erosion than Phenytoin sodium, you would want to ask what was the situation one year or two years after patent expiry, whereas the current numbers, of course, in some cases are -- well, six or seven years after, depending on which one we are talking about.

Q. Mr Ridyard, this is your analysis that you are putting forward?

A. Yes.

Q. You put forward analysis of PCA data based on prices. You accepted, quite fairly, earlier, about 20 minutes ago, that an originator, the (inaudible) generic dynamic, the originator will have a choice to choose between prices and volumes?

A. Yes.

Q. You accepted that if the originator chooses to maintain high prices, it will usually suffer a very dramatic loss in volume. Why --

A. I did not say dramatic loss in volume. I said it would suffer a loss of volume and the loss of volume varies from case to case --

Q. We can go back to the transcript. My point to you now is why when you put forward this analysis based on prices did you not also deal with volumes because clearly it is absolutely fundamental, if one wants to understand if these are good comparators or not, to know what effect on volumes these prices had. Why did you not do that?

A. Very simply because the purpose of this analysis was to say there is nothing that unusual in the originator maintaining a high price.

Q. That is the only purpose then of this analysis, is it?

A. This is driving towards saying is it unusual to observe all of these extremely high price cost margins and therefore this is focusing on price. I did, as a matter of fact do a cross-check on the quantities and satisfied myself that in each case there was (inaudible) at least 10 per cent of the market and, as I understood it, that might well be a lower bound estimate of what the originator charges if it had been right down to 0.1 per cent, then you could say these price levels do not really mean very much but in each case I satisfied myself that there was still a significant chunk of the

market that was being served by the originators at these prices and, yes, the purpose of this whole analysis is to back up the table that I showed from my first report, which was looking at the price levels and addressing the question, are these -- are these high price/cost margins that we observe, Phenytoin sodium, are they out of the ordinary in the pharmaceutical sector for products which do a similar job to Phenytoin sodium.

Q. So is it the case -- I am sorry, sir?

THE CHAIRMAN: I was going to say it is probably a good time to break.

MR HOSKINS: I would like to finish. If you give me five minutes, I will finish this topic.

THE CHAIRMAN: You are going to finish what? Altogether?

MR HOSKINS: No, no, this section but I am in a flow, I really do not want to...

THE CHAIRMAN: Okay, I am conscious, going back to our last conversation, that Mr Brealey may be at a disadvantage on re-examination, so if, while we are breaking, there are figures that you could provide him, I think that would be helpful.

MR HOSKINS: If there is time. The point I am trying to make --

THE CHAIRMAN: If he still wants them.

MR HOSKINS: I do not want to make submissions, the point

I am making is this is an incomplete analysis.
THE CHAIRMAN: That's fine. That is your --
MR BREALEY: I really do not accept that because this is analysis of prices and it is describing prices.
THE CHAIRMAN: As I've said before, Mr Hoskins can make his submissions. What we make of them is our business.
MR BREALEY: I am sorry, I thought it might be a question to me. Sorry.
MR HOSKINS: Mr Ridyard, it is the case, is it not, given that you have accepted that originators have a choice between price and volume, in order to come up with what would clearly be robust comparators, you would have to offer an analysis that included assessment of both price and volumes, price alone just will not do, will it?
A. It depends what proposition you are testing. If the proposition is, is it only in situations of monopoly power -- abuse of monopoly power that you observe these high price/cost margins, then I think you can answer that question by saying, no, here is a comparator, which I happen to think is a relevant comparator and I am sure the tribunal will make up their mind about whether they agree with that, but here is a price comparator of a sale which is actually taking place in the market in non-trivial amounts where you do observe as high or higher price/cost margins in the face of effective

generic competition.

So I think for the proposition -- although in general, you know, when you were asking me the question earlier is it better to look at prices than quantities, generally it is better to look at both. On this particular question, this is a question about prices and specifically about price/cost margins and therefore I think it is relevant to focus on prices and price/cost margins and that is what I've done in this table.

Q. Mr Ridyard, you are trying to compare these five AEDs with Phenytoin and what we know in relation to Phenytoin is that there was a dramatic increase in price and yet Phenytoin's market share retained, even on your own figures, at least 40 per cent of the market even if one omits parallel imports. Whereas you have just told us that when you looked at the effect on volumes for the five AEDs you are putting forward, they were between 11 and 20 per cent. So Phenytoin, high increase, still a reasonable market share. Your five examples, high increase, very low market share. To do the comparison, you need all the information, do you not? And you have not provided it?

A. It depends which comparison you are making.

Q. A useful one.

A. I am delighted that you are so interested in comparators

all of a sudden. The comparison I am drawing here is with the price/cost margins of Phenytoin sodium, which the CMA says on a stand alone basis are, you know, in themselves abusively high because of how high they are. I am saying here, that may or may not be right but it so happens that here are a bunch of other comparators which are also charging extremely high price/cost margins, comparable or higher price/cost margins or higher price levels. So the question that I am addressing here, I think this is a perfectly reasonable -- reasonable assessment.

MR HOSKINS: Sir, that may be a good place to break.

THE CHAIRMAN: Thank you very much. Ten minutes.

(3.22 pm)

(A short break)

(3.34 pm)

MR BREALEY: Sir, before Mr Hoskins starts.

THE CHAIRMAN: Mr Brealey, are you happier?

MR BREALEY: I am not happy at all.

MR HOSKINS: Do you want to deal with it when I have finished because then you have a chance to look at it rather than in the middle of cross-examination. I think it would be more appropriate to make submissions at the end of it.

MR BREALEY: I formally object to this line of

cross-examination. Mr Hoskins was specifically asked by you, sir, not to spring documents on -- any further documents. This is not in the skeleton argument, this is not in the expert report and Mr Ridyard has not had a chance to look at it. We look at the dosages. Was it 100 milligrammes, 25 milligrammes? Maybe Mr Ridyard can deal with it but I formally object to this being put in evidence and it being sprung on an expert witness. That is not the way the cross-examination of experts is supposed to be done. That is why we have all these expert reports and if the CMA really wanted to put this point to Mr Ridyard, it should have been in an expert report, not when Mr Ridyard is in the box. So I do formally object and Mr Hoskins can clearly continue but I do object to this line of questioning.

THE CHAIRMAN: Okay, your objection is noted. I think you have finished that particular part of your questions --

MR HOSKINS: I have, yes.

THE CHAIRMAN: It is probably a good thing, Mr Hoskins.

MR HOSKINS: Probably a good thing. We will make our submissions on it at the end and if it is --

THE CHAIRMAN: I am sure I will have lots of submissions about lots of points but the main thing is to have --

MR HOSKINS: Absolutely.

Can I pick up your first report at tab 7,

paragraph 108.

A. Yes.

Q. You say:

"Second, I understand from Professor Walker's report, whilst other AEDs may be better tolerated, Phenytoin sodium is extremely effective at controlling seizures."

A. Yes.

Q. Were you here this morning when Professor Walker was giving evidence?

A. Yes, I was.

Q. So you are aware that his evidence, both written and oral, is that Phenytoin is now recommended as a third line treatment. You heard him give that evidence?

A. In newly -- in new patients but he also said it was still used for the patients who had been stabilised on it as well and that was the main use of the medicine from what I understand.

Q. Let's go to Professor Walker's written material then. It is in this bundle. First Walker is at tab 9. Could I ask you to turn through to page 8?

A. Yes.

Q. He says:

"There are a number of reasons why Phenytoin has fallen from favour in the UK."

Can I ask you just to read that paragraph, please, to yourself. (Pause)

A. Yes.

Q. You rely on Professor Walker's evidence about Phenytoin remaining an effective -- one of the most effective drugs at controlling seizures?

A. Yes.

Q. Do you agree it is also relevant therefore to take account of whether Phenytoin capsules are suitable for use as a first, second or third line treatment. Is that also relevant?

A. I am not sure actually. I do not...

Q. But you are sure that efficacy is relevant?

A. Yes, because it -- because it does -- it performs a medical function. That is why it has an enduring demand.

Q. So it is relevant to look at the medical function of Phenytoin?

A. Yes, it is -- I mean, obviously I am not in any position to address the technical aspects but to me as an economist, it is relevant to me that it has -- that it has a demand and meets a medical requirement and that is really -- that it -- it performs effectively as a -- as a medicine for certain patients.

Q. So if, as an economist you take account of one aspect of

the medical nature of Phenytoin, presumably you would accept once you take account of all relevant medical aspects of Phenytoin, not just one of them?

A. The medical properties of Phenytoin are not something that I am going to help the tribunal on. What I can help the tribunal on is the fact that it does have a, you know, a defined demand from a set of customers, patients, whatever you want to call them, who benefit from it and that is really the only -- that is the only piece of information looking at it -- the economics of this case, that is of interest and importance to me. Anything beyond that is a question that really has to be put to Professor Walker.

Q. Can we go up to Mr Williams' first witness statement. That is in tab 11 of this bundle.

A. Yes.

Q. Have you read this before, this statement?

A. Yes, I have read it, yes.

Q. Could you just read paragraph 32 to yourself, please.

(Pause)

Sorry, I think that is a wrong reference. If you bear with me, I'll just get the right reference. I am sorry. (Pause)

I'll move on to another topic and I'll come back to this, sir, so as not to waste any time.

Can we go to your first report, bundle D, tab 7?

A. Yes.

Q. Paragraph 84. You say -- you see the heading, it is the section:

"Margins obtained by companies selling originator versions of off-patent drugs also exceed the CMA benchmark."

A. Yes.

Q. You say:

"I note there is strong evidence that originator versions of off-patent pharmaceutical products charge prices in excess of the CMA's proposed benchmark."

But you do not in this section analyse any particular products, do you?

A. This is the section in which I would look at the studies which have been done of generic competition. There are two studies, both of which looked at 70 or 80 different molecules.

Q. So you referred to the studies and -- but what you do in table 2 is you present evidence on price trends, do you not? You see the heading to table 2:

"Price trends in off-patent drug markets with generic entry based on DG Comp and Kanavos."

You look at the two studies and then you produce this price trends table. Is that correct?

A. Yes, that is right.
Q. And then in paragraph 90 you draw some inferences on margins?
A. Yes.
Q. But the only evidence you cite relates to prices, does it not? You do not have any direct evidence of margins. You only have price trend information?
A. Not direct evidence but, as I explain here and I think elsewhere, I think it is a reasonable guesstimate to take the -- if you see a situation where the originator charges the price of 100, the generic entrant charges a price of 20, it is not perfect and obviously you would rather have the actual cost data but if the generic was happy charging a price of 20 and staying in business, then it is reasonable to assume that that covers -- at least covers the costs of the generic company, given that they are both making the same product. That strongly indicates that the originator who is charging the price of 100 is probably earning a very high price/cost margin on the product. Certainly, if it is as efficient in producing as the generic is, then that must be the case. So that's the -- I do not think it is a huge leap of faith but it is an inference, not a direct observation, as I hope I make clear in my report.

Q. So the only evidence you rely on here is price trends, there is no analysis of volumes in this section, is there?
A. Simply looking at prices -- you say this section; this section is a description of what happens in those studies --
Q. Yes.
A. -- which certainly did look at volumes as well as pricing (inaudible) report, the results on volumes as well as pricing in my report.
Q. But you do not refer when you summarise the studies and produce the price trends table, you do not seek to summarise the finding on volumes of the studies, do you?
A. Findings on volumes are in my report.
Q. Is there anything between paragraphs 84 and 90?
A. I do not know. I am not sure.
Q. Why don't you look at your report. (Pause)
On its face you rely on the price trend evidence from these reports for these paragraphs of your report. (Pause)
A. Yes, this section is focused on the pricing evidence.
Q. Go to paragraph 114 in your first report. You will see the heading above that:
"The Teva Phenytoin sodium tablet is in my view the most obvious benchmark."

A. Yes.
Q. In paragraph 114 you rely on the fact that the price of tablets was higher than the price for capsules, correct?
A. Yes.
Q. But we are here talking about a reasonable rate of return, are we not, in this section of the report?
A. No, we are talking about benchmarks for the economic value of Phenytoin sodium.
Q. If one were to refer to the price of tablets because one thought it might be a benchmark for the reasonable rate of return, so if you were to use it for that purpose?
A. Yes.
Q. Yes? It follows, does it not, you would have to know the costs of producing and distributing tablets?
A. Yes. Well, you would have to know or have a reasonable inference about that, yes.
Q. And you have not analysed the costs of tablets in your reports, so we cannot use your reports to refer to tablets as a benchmark for the reasonable rate of return, can we?
A. For a start this section is looking at the value question, not the reasonable rate of return. As regards the costs of making tablets and capsules, given they have got identical active ingredients -- I think there are other people who know the industry better than me

who -- on the file on this case who have said that the costs indications are not that different between making a tablet and a capsule and that sounds pretty plausible to me. Obviously, you would need to ask someone who did that for a living to know whether that was truly the case but it seems like it is pretty obvious.

Q. But you have not looked at the cost of tablets in any of your reports, have you?

A. I've looked at -- and referred to other people's comment -- industry experts' comments on the costs of making a tablet versus the cost of making a capsule in my report, yes.

Q. Based on what other people have told you or have said?

A. Because I do not have any primary knowledge of the costs of making a tablet or a capsule because I am an economist, not a manufacturing expert.

Q. No, but nor have you been provided with the relevant information?

A. Well, I am not sure about that because there are statements -- there are statements on the file from people who do do that for a living who said that the costs of making a capsule and a tablet are comparable and I have relied on that.

Q. Well, Mr Ridyard, do you know if the rate of return on tablets was greater or less than for capsules? Is that

information you have?

A. You are talking now about the rate of return, rather than costs of manufacturing?

Q. Mm-hm.

A. And do I know --

Q. Do you know if the rate of return on tablets actually achieved by Teva was greater or less than for Phenytoin capsules for Pfizer and Flynn?

A. I do not know that with certainty but I think it is not difficult to make an inference about that based on the knowledge that we have about selling prices of tablets, selling prices of capsules and the information that has been made available from people who do know about the costs of making those two things, about the costs -- the very small difference in costs of doing one rather than the other.

Q. Can we go to bundle G2, tab 96, and again I have to remind both of us that the names of civil servants are confidential.

A. Which tab, sorry?

Q. Tab 96. You see it is a note of a meeting between the Department of Health and Flynn on 6 November 2012?

A. Right. Yes.

Q. It is paragraph 7 I would like to take you to:

"DH understood the company's position ..."

That is Flynn's position:

"They emphasised that without more information, it was unable to consider whether the price increases were justified."

A. Yes.

Q. I am going down to the bottom of that paragraph:

"Further, the DH did not consider comparisons with the tablet relevant as the products are not interchangeable. They were different formulations which may incur different costs and the tablets had significantly less of the market so had less economies of scale, although a price increase might have been justified for Flynn's products, the scale of it was a concern."

I think it is correct, is it not, we do not find any consideration of the volumes of tablets dispensed anywhere in your reports? It is not something you have looked at, is it?

A. I certainly have looked at the difference in the size of the tablet segment compared to the capsule segment in the UK. I have not looked at that globally because if you are talking about manufacturing economies of scale, what you need to know is the global production of these products, rather than just what happens to end up in the UK but I know within the UK the tablets are a --

a smaller number of tablets than of capsules. Also, from looking at the cost data more generally, I do not have precise answers to the sorts of questions that Mr Hoskins is asking about but one can see -- you will get a feel just by looking at the variable costs and the common cost allocations and (inaudible) those calculations, you get some sort of feel for how important economies of scale might be.

Q. And where in your reports do you deal with the volumes of tablets, sorry? Can you help us with that?

A. I do not know. I do not know where -- whether it is in my report or not. I am saying --

Q. You do not know whether it is in your report or not?

A. I am saying I have looked -- I am aware that the volumes of tablets in the UK are smaller than those of the capsules. But I am not sure whether that is in my report or not.

Q. Can we go back to bundle D, please, at tab 8, your second report. I would like to look at paragraph 56?

A. Yes.

Q. Heading is:

"The defence does not address the evidence that the tablet reimbursement price was regulated by DH."

A. Yes.

Q. And you say -- you refer to the fact -- it is the second

sentence, I think:

"Since this tablet price had been set after a process of negotiation with the DH that concluded the concession of a substantial 70 per cent downward adjustment to the price that Teva had previously been charging for this product, it was reasonable to infer that the tablet price in 2012 provided a benchmark for non-abusive pricing."

A. Yes.

Q. You refer to Mr Beighton's evidence?

A. Yes.

Q. But the question of precisely how and why Teva introduced a price reduction is a matter of primary fact, not expert economic opinion, is it not? The question of precisely how and why Teva introduced a price reduction --

A. Is a question of fact.

Q. Is a matter of fact?

A. Yes, I guess so, yes.

Q. Paragraph 5 --

A. I think at this point I was responding to the -- carry on.

Q. Paragraph 57. You say:

"This evidence further confirms that DH was able to exert bargaining leverage to negotiate a tablet price

that it considered to be fair."

I mean, just look at the decision, paragraph 5.295. Paragraphs 5.295 to 5.297. If I could ask you just to read those again --

A. Yes. (Pause). How far do you want me to go?

Q. Down to 5.297.

A. Yes.

Q. Inclusive. Are you there?

A. Yes.

Q. The fact that DH was not able to prevent Teva from charging prices that were 15 times higher than its pre-March 2006 levels suggests that any bargaining leverage the DH might have had was actually very limited, does it not?

A. We do not know whether it was able to or not, do we? Listening to Mr Beighton's evidence this morning, I understood him to say that the Department of Health determined the drug tariff price that would apply --

Q. Sorry, let's not go -- we do not need to repeat Mr Beighton's evidence. The finding in the decision -- and it is not challenged -- at the end of 5.297:

"Teva's revised prices were still over 15 times higher than the pre-March 2006 levels."

I am asking you as an expert economist whether that indicates that the DH's bargaining power was actually

very limited or not?

A. No, it does not indicate that.

Q. Because?

A. Because maybe the DH felt that the price with which they ended up after this process was a price which was within the realms of what was a reasonable price. They might well have wanted a better price. Who does not? But they might well have felt that that was within the -- within the bounds of what was reasonable.

Q. Have you ever looked at the terms of Scheme M?

A. I've done some reading around it but it is not something that I would --

Q. Or category M? Is that something that you have looked at.

A. Obviously I have looked at it in the course of the work that I have done on this case.

Q. And so you are aware that Teva tablets but not Pfizer's capsules were subject to Scheme M?

A. Yes, that is what I understand, yes.

Q. Can you go to the decision at paragraph 3.140. Can you read that, please.

A. Yes. (Pause)

Okay, yes, read it.

Q. Were you aware that Scheme M had the features described in paragraph 3.140?

A. I have read this paragraph before, yes.
Q. So you were aware of it. Can I go to bundle H2, tab 26. It should be a document entitled "The community pharmacy: a contractual framework and the retained medicine margin."
And the date is 30 March 2010. Is that the document you have?
A. Yes.
Q. If we go to paragraph 1 on page 3, you will see the purpose of the report. Perhaps you could read paragraph 1. (Pause)
Have you read that?
A. Yes.
Q. Then go through to page 18, please, to paragraph 1.19, which says:
"Category M prices are deliberately set somewhat higher on average than average manufacture's prices in order to incentivise pharmacies to purchase more efficiently by allowing them to make some margin."
A. Yes.
Q. So that is a factor that clearly differentiates tablets from capsules, is it not?
A. Well, in the -- maybe on the specifics but in the capsule market where you have competition between -- between brands of capsule, you also have pharmacists --

that market is also driven by pharmacists chasing better -- better margins if they buy -- if they fulfil a prescription at a lower price. So they share that characteristic.

Q. What distinguishes them, Mr Ridyard, is that category M prices are deliberately set somewhat higher than average manufacture's prices in order to incentivise pharmacies to purchase more efficiently to allow them to make some margin. Category M prices are deliberately set somewhat higher. They are not the result of any competitive exercise. They are the result of regulatory intervention to set a higher price which is intended to be particularly attractive to pharmacies. That is one of the defining characteristics of category M prices, is it not?

A. I have to say I feel quite uncomfortable asking this question because I do not really know the full background to category M. So I do not really feel very easily able to answer this question in a helpful way. I do not --

THE CHAIRMAN: Perhaps, Mr Hoskins, you could take us back to the part of Mr Ridyard's evidence that this bears on. It will be easier for him to understand what you are getting at.

MR HOSKINS: The point is I am taking him to something that

he has not taken account of.

THE CHAIRMAN: So he is not going to find it in his evidence then, is he?

MR HOSKINS: No, but I am pointing out there is a relevant factor that has not been taken account of in the evidence.

MR BREALEY: Is Mr Hoskins going to explain -- this is 2010 and, as I understand it, the Department of Health intervened in 2007. Is Mr Hoskins going to put that point?

MR HOSKINS: I am not going to put a point. If Mr Brealey wants to re-examine, he is very welcome to.

THE CHAIRMAN: Are you coming back to Mr Williams' point? I have got a blank space in my notebooks.

MR HOSKINS: I am going to -- I am not there yet. I am going to finish where I am. I have not forgotten it, sir.

THE CHAIRMAN: Glad to hear it.

MR HOSKINS: Can we go to your second report, bundle D, tab 8.

A. Yes.

Q. You say:

"In summary, therefore, whilst prescribing practices may have been similar ..."

I am so sorry, paragraph 69. Page 27:

"In summary, therefore, whilst prescribing practices may have been similar for the capsule and for the tablet, it does not mean that continuity of supply principles precluded switching in the period that is relevant to assessing Flynn's use of the tablet price as a benchmark in 2012. To the contrary, available evidence on capsule sales indicates that switching did occur between competitors in relation to Phenytoin sodium products in that period. The evidence clearly contradicts the CMA's claim that patients were completely dependent on the Teva product."

A. Yes.

Q. And you refer to the available evidence in the preceding paragraphs. You see that above.

A. Yes.

Q. And paragraph 65 above, you say:

"First, I note that there is evidence on the CMA's file that there are a number of different suppliers of the tablet and that a number of significant wholesalers did in fact purchase tablets from these suppliers. This provides an indication that there were a number of firms active on the market giving rise to the possibility of competition over this period."

A. Yes.

Q. Referring to the possibility of competition is an

uncharacteristically tentative conclusion from you, Mr Ridyard.

A. It is appropriately tentative here because all I have is a few clues to go on, which is that there do appear to have been several suppliers of tablets and Teva does seem to have given substantial discounts.

Q. So I was going to put it to you, you cannot be more definitive than you are in paragraph 65 because you have not actually conducted any study of competition in the tablets market. That is correct, is it not?

A. It is based on those inferences, so it is -- yes, it is based on those inferences alone.

Q. And then paragraph 66, you say:

"Second, as noted in DR1, there is clear evidence that Teva offered significant discount to wholesalers ..."

A. Yes.

Q. Then you go through some figures and you pick it up about half way through that paragraph:

"Whilst I am not able to definitively determine the reason for this discount, as DR1 noted, such downward trends in prices provide evidence that Teva was subject to competitive constraints on its pricing."

But again, this is a best inference, is it not? You have not actually investigated the reasons for these

Teva discounts?

A. That is perfectly fair, correct.

Q. So in terms of dealing with tablets, in relation to this section of the report, whilst you suggest that there is some evidence of switching in relation to tablets -- that is between different types of tablets -- you yourself have not analysed how much switching there was between different makes of tablet, have you?

A. I was not in a position to do that. I did not have the evidence to do that, no. That is correct.

Q. And you also have not analysed the extent of any switching and indeed competition between tablets and capsules, have you?

A. I have looked at that in some detail, yes. I have not seen any competition between tablets and capsules.

Q. No competition?

A. I have not seen any competition between them, no.

Q. Can we go to your first report, so tab 7, paragraph 77 to 80?

A. Yes.

Q. The heading is:

"Evidence indicates that Flynn earns margins in excess of costs plus 6 per cent across its generic portfolio."

A. Yes.

Q. Then you refer to the fact that CRA has submitted evidence to the CMA on behalf of Flynn.

So this is analysis that relates to Flynn's margins across its portfolio?

A. Yes.

Q. Am I right that this section, so paragraph 77 to 80 of your report, are based on work done by CRA for Flynn?

A. Yes.

Q. As you say at paragraph 78, you have not had access to confidential versions of the evidence submitted by Flynn. So you have not conducted any independent appraisal of CRA's work because you have not had access to the necessary data; is that correct?

A. That's correct, yes. I am relying on CRA's work here.

Q. Paragraph 129 of this first report, page 47. You say:

"Furthermore, I consider that it is important to take evidence of price benchmarks in the round and that evidence of actual observed prices of comparable products should be given at least as much and arguably significantly more weight than historic prices or international prices in assessing whether a price is abusive."

So I think it is a fair understanding of what you say there that evidence of historic prices and international prices should be taken into account but

there is an issue as to the relative weight that should be given to those comparators?

A. Yes, I believe in an exercise like this, where you are trying to answer an extremely complicated and difficult question about what is an excessive price and what is an abusive price, that you should cast your net as wide as possible to look at all of the possible benchmarks that might be available to you, to make sure you are as well informed as possible when you make the final synthesis of that information into some sort of assessment.

Q. Can we go to paragraph 110 of your first report. You say there:

"In summary therefore, I consider that, much like other AEDs, Phenytoin sodium offers patients benefits and that those benefits are not obviously replicable for the patients that are stabilised on it. It is in my view normal that the supplier of such a product is able to charge a premium above its costs of production to reflect these unique benefits, and there is no proper or logical reason to limit that premium to 6 per cent."

A. Yes.

Q. And this then forms part of your economic value argument; correct?

A. Yes.

Q. Can I just confirm: it is common ground between us,

I hope, that Pfizer and indeed Flynn, should be entitled to make a reasonable profit and the question here in relation to economic value is whether they are entitled charge some sort of premium because of the characteristics of Phenytoin. Is that a fair description of the point?

A. The way I put it is that clearly you would expect them to cover the costs of being in business and if -- there are many instances in competitive markets where you expect an element of value-based pricing that would add some more on top of that minimum requirement to cover your costs and in my report I talk about a lot of circumstances in real life markets where you can have sustained -- substantial margins over costs because of the demand side factors, effectively that also drive pricing in competitive markets and this would be one instance where that was expected.

Q. If we go to paragraph 107, you say:

"First, I note that AEDs, of which Phenytoin sodium is one, are a class of drugs that treat a very serious medical condition and which have a significant social as well as medical impact on the individual."

Then at the bottom of that paragraph you say:

"As a class of drugs, AEDs therefore have a significant intrinsic value to the people that use

them that exceeds their costs of production."

A. Yes.

Q. So this observation here applies to all AEDs, not just Phenytoin, does it not?

A. All AEDs that do the job, yes.

Q. And you could apply this argument indeed to all medicines that treat serious medical conditions, could you not?

A. Yes -- well, and the value of them depends on what they do. I mean, there is a further question, which is addressed in the NICE approach to looking at pharmaceutical pricing, which is also looking to see what extra does this product add over the other products that are available in the marketplace. So there is a general sense of what benefit medicine brings but certainly when NICE is looking at what prices to allow in the UK pharmaceutical sector, they also look to see what does this product do that is better than or that is incremental to the contribution that other products make in the marketplace. So both the average and the incremental value contribution of the medicine are potentially relevant.

Q. Let's leave NICE on one side for the moment because I want to focus on the argument that you have put in paragraph 107.

A. Yes.
Q. Which is that because AEDs are a class of drugs that treat a very serious medical condition, they therefore have a significant intrinsic value to the people that use them.

And my point that I put to you, which I think you accepted, is you could apply that to any drug that treats a very serious medical condition, could you not?
A. If it treats it successfully, yes, I believe you could.
Q. And indeed you can actually apply that logic to any medicine because any patient who is ill and takes that medicine has a need for that medicine; it does not just apply to particular types of medicine; it applies to all medicines but the degree of intrinsic value might vary but it applies to all medicines, does it not?
A. It might vary but it would depend on both the benefits to the patient of being cured or treated but if you are looking at the value of a particular product, you would also want to be asking the question: what does this product do that other products would not do? So both aspects to that question, are, I believe, relative to assessing the intrinsic value of the product.
Q. And on your logic, taking those two points, the greater the need for the medicine by the patient, the higher the premium that is justified. That is your logic, is it

not?

A. That would certainly be the case, that if the -- if this was the only medicine that could treat this condition, then that would increase the perceived value to the patient of having it, yes.

Q. And that logic runs regardless of any supply side issues such as the costs or difficulty in producing the medicine, does it not?

A. Purely a demand side consideration, I agree, yes.

Q. At paragraph 108 of your report you say:

"I understand from Professor Walker's report that whilst other AEDs may be better tolerated, Phenytoin sodium is extremely effective at controlling seizures."

Then moving on to the last sentence:

"Overall, therefore, there appears little support for the CMA's view that Phenytoin sodium has been superseded by a number of newer medicines with improved efficacy."

A. Yes.

Q. So you are focusing here purely on efficacy as a justification for charging a premium for Phenytoin, are you not?

A. I am simply looking at -- well, I am relying on Professor Walker's expert knowledge of the products.

Q. Well, you say you are relying on Professor Walker, you

have obviously read Professor Walker's report?

A. Yes.

Q. And the one point from his report that you are relying on for this argument is efficacy, is it not?

A. That is one point that I am relying on but ...

Q. But Professor Walker makes a number of points in relation to Phenytoin?

A. Yes.

Q. We saw it earlier but let's just go back. Tab 9 in this bundle.

MR BREALEY: I do not want to interrupt, sir, but I do not (inaudible) have to re-examine on this. If Mr Hoskins is going to put Professor Walker's evidence to Mr Ridyard he has got to be fair in the way that he puts it. So it is not just cherry-picking bits and pieces.

THE CHAIRMAN: I must say, Mr Ridyard seems to be making a rather limited point in relation to Professor Walker's evidence and I am not sure you are going to take the argument very much further by pointing out that Professor Walker said a very large number of things, all of which we have read.

MR HOSKINS: I am grateful.

THE CHAIRMAN: Being practical.

MR HOSKINS: No, I am very grateful, that is very helpful, thank you.

The position is, Mr Ridyard -- I do not know whether you are aware of it -- it is in fact common ground between the parties that in spite of its efficacy Phenytoin sodium has been superseded by a number of new medicines because of certain problems it has in relation to it. Are you aware of that from --

A. It has not been superseded because of efficacy, which is the statement I picked up as being disagreed with by Professor Walker, who knows more about this than I do.

Q. But you are aware of the drawbacks in relation to Phenytoin?

A. Of course, of course.

Q. Can we go back to your first report, tab 7, paragraph 109. I am going to pick it up eight lines down. It is right at the end of the eighth line:

"I also understand that Phenytoin sodium..."

Do you see that?

A. Yes.

Q. "I also understand that Phenytoin sodium is used for patients that have been stabilised on it for a long time. For these patients, I understand from the expert report of Professor Walker, that there is a potential risk associated with switching patients to other AEDs."

Then again going down to the very last sentence:

"Clearly this indicates that for stabilised patients

Phenytoin sodium confers a benefit that cannot easily be replicated by other AEDs, even potentially by other types of Phenytoin sodium."

A. Yes.

Q. So is it fair to say that your view is the fact that patients stabilised on Pfizer's capsules should be maintained on Pfizer's capsules is a reason that justifies Pfizer charging a premium?

A. If that was all true, it would certainly be a reason that you would expect them to be able to charge -- be able to charge a premium commercially, which is exactly why in my report I said I think it is very important to benchmark the pricing that we are talking about here against the pricing of other AEDs, which do not benefit from this -- from this kind of protection because if you had found that the prices of Phenytoin sodium were well above the price of other AEDs which were not in category 1, for example, more obviously faced direct competition, interbrand competition, then that would be a problem but what I do observe when I make that comparison is that -- that is why I do all of this AED price comparison, I find that the prices we are talking about for the Phenytoin sodium capsules are not clearly out of line with the prices which have been charged for other AEDs which do not benefit from this element of protection

from competition. So that is precisely why I think that is a useful exercise to do.

I am certainly not saying that just because consumers are dependent on a product, therefore a supplier should be allowed to charge whatever they like. I explicitly deal with that -- twice actually because it was ignored the first time -- in my two reports. I am not saying that. I am saying that is a good reason to benchmark the pricing of Phenytoin sodium capsules against the prices of AEDs which do not benefit from this feature which could otherwise taint the comparison because it would simply be reflecting the power that the supplier has over the consumer.

Q. Mr Ridyard, you are not suggesting that continuity of supply entitles Pfizer and Flynn to charge whatever they like but what you are quite clearly saying in paragraph 109 is that continuity of supply means that Phenytoin sodium offers a benefit that cannot easily be replicated by other AEDs, or even potentially by other types of Phenytoin sodium?

A. That is clearly the case and therefore in the discussions that you heard with Mr Poulton about, you know, the possibility -- and obviously I cannot -- it says how remote or real the possibility was of the product being withdrawn because of the poor financial

performance of the product, if that was a genuine threat, then it would have potentially consequences for these patients.

So, yes, this is -- that is clearly a factor in what -- in the commercial constraints that operate on the suppliers of this product. As I keep saying, when you want to assess the question of abusive and exploitive/abusive prices, the way of testing whether that dependency has been exploited because of the dependency, I think a good way to test that is by benchmarking it against the prices of other products which do not benefit from that dependency.

Q. So continuity of supply creates a value in Phenytoin sodium capsules which justifies the premium which you talk about in relation to economic value. That is the logic, is it not?

A. That is not what I just said --

Q. I know it is not what you just said. I am trying to cut through to a different point. I am trying to understand what you said in paragraph 109. You said that --

A. I am saying that the -- a medicine which treats a set of patients, which couldn't be easily treated by a different medicine is intrinsically valuable. That happens to be the situation with these stabilised patients on Phenytoin sodium capsules, it works for them

and there is some sort of risk that it might not work if they were switched to something else. It may be fine but there may be a risk. Therefore that just explains why it is not surprising that there is a value -- there is an intrinsic value to this product.

MR LOMAS: So there is a value for them which is not captured in a purely supply side analysis of pricing.

A. It is not captured at all by the supply side. The definition of value is extremely simple; it's just -- it's just what the -- it is just what consumers are prepared to pay and so it is demand side, yes.

MR LOMAS: And implicit in what you are saying is there is a highly price inelastic demand function for this product.

A. There could well be, yes.

MR HOSKINS: Can we go to paragraph 41 of this report. I think we may have already seen this once today:

"I acknowledge that the evidence following the MHRA guidance does not show continued market share growth from NRIM. While volume shares alone cannot reveal the full competitive dynamics in this regard, this would suggest that Pfizer (and indeed NRIM) may have enjoyed some protection from the normal competitive dynamics in this period..."

A. Yes.

Q. It is the final sentence I am interested in. You say:

"It was therefore the impact of regulatory intervention ..."

And we have clarified that the regulatory intervention is the MHRA guidance, which stated the need for continuity of supply in relation to Phenytoin; yes?

A. Yes.

Q. "... rather than any steps taken by Pfizer, that afforded the suppliers of Phenytoin capsules seemingly greater protection from competition at this point."

So it is the regulatory intervention rather than any steps taken by Pfizer that leads to the greater protection for Pfizer at this point. And if we go to -- just to complete this picture -- second Walker at tab 10, paragraph 2.10, he tells us:

"It is right that Phenytoin sodium has a narrow therapeutic index and non-linear pharmacokinetics and I agree with the suggestion in paragraph 10 of the CMA's defence that it is these characteristics which underlie the MHRA guidance on continuity of supply for Phenytoin sodium."

Are you aware of that? Have you seen this before?

A. Yes.

Q. So continuity of supply is necessary because of limitations in Pfizer's product; that is its narrow

therapeutic index and its non-linear pharmacokinetics. Do you see that from Professor Walker's evidence; yes?

A. It is a feature of the -- of this and a number of other AEDs, yes, yes.

Q. Given that continuity of supply results from regulatory intervention, rather than any steps taken by Pfizer -- see paragraph 41 of your report -- and given that continuity of supply is necessary because of the limitations in Pfizer's product I have just shown you, it follows, does it not, that far from justifying any premium, continuity of supply confirms that Pfizer's products do not merit any premium above a reasonable rate of return, does it not?

A. It is a complete non sequitur, is it not? Not even close to being a logical --

THE CHAIRMAN: I think you are putting your case but I think Mr Ridyard can deal with it.

A. For a start, in the earlier evidence what I looked at was when the guidance came in, it is frankly a bit unclear what impact the guidance had but let us take it at face value that it stopped switching between one brand of Phenytoin sodium capsule and another. As I said earlier, what I looked for there is saying, well, is there evidence there that once that guidance came in -- and let us say for the sake of argument it did

stop interbrand switching and protected the suppliers from competition -- did they then raise price from that point because that would be the logical thing to do if you had suddenly been granted this gift of greater protection from competition, you would raise prices. They did not do that. So whether they could have done it and got away with it, I do not know or whether they did it because of commercial considerations or regulatory conditions, I do not know but I do know they did not raise prices at that point. Prior to that point, they were not protected from competition from other molecules because they just lost 33 per cent of the volumes of the 100 milligramme capsule and 25 or 27 per cent or whatever it was of the total market to a new entrant. So competition was alive and well at that point. Very alive and well when you benchmark it against the way competition works in these segments.

THE CHAIRMAN: We are talking about economic value, are we not?

A. Yes.

THE CHAIRMAN: And that is about the dependency of the stabilised patients which gives you the right to look at economic value or no right to look at economic value.

A. Exactly and the question really is, as was, I think, discussed in the panel's questions last week, all of

these products have got an intrinsic value. They do a good thing for patients and that is a demand side phenomenon and that can well justify price/cost -- price/cost margins. It can justify an element of value-based pricing. And that is true whether or not consumers are completely dependent or not. The question is if you accept as a matter of argument that suddenly consumers became completely dependent on this particular product or were completely dependent on this particular product, does that suddenly mean that you can therefore ascribe no value at all to the product just because consumers now need it rather than want it and that does not seem to me to make a lot of sense and that is, I think, the logic of the CMA's position. They suddenly say it is fine for all these products including other AEDs to be charging high price/cost margins because they are all providing a valuable service keeping people alive and giving them better lives but suddenly, because this product becomes necessary rather than just wanted, we are going to slash all of that away and take away all consideration of value-based pricing and impose a standard on them which is -- which is purely cost-related. That seems anomalous to me and that is why I go through the other AED comparisons in my work.

THE CHAIRMAN: We have reached the magic hour of half past

four.

MR HOSKINS: I am almost finished. I will be --

THE CHAIRMAN: We have some questions, I suspect. I am sure Mr Brealey has some re-examination.

MR BREALEY: Not at the moment.

THE CHAIRMAN: Not at the moment. Despite all the interventions.

MR HOSKINS: He has already made all his points.

THE CHAIRMAN: Because of the interventions. I do not like putting expert witnesses under a time pressure. We are quite happy to start in again tomorrow morning.

MR HOSKINS: Within ten minutes I will be finished.

THE CHAIRMAN: You have still got your Williams point to make.

MR HOSKINS: It is not going to detain us --

THE CHAIRMAN: We will carry on if you are happy.

A. I am more than happy to carry on this evening.

THE CHAIRMAN: You prefer not to come back tomorrow.

A. I might be happy to do something else.

MR HOSKINS: The rest of us do not have that luxury, unfortunately. Go to your second report, so tab 8, paragraph 102.

A. Yes.

Q. You say there:

"If Pfizer were to set an exploitatively high supply

price that clearly had a causal impact on the prices that Flynn charged downstream, there would be no quarrel with the CMA position."

Then you say:

"However, DR1 noted that evidence of a causal link between Pfizer supply price and Flynn's downstream price was unclear."

And it is right, is it not, that the question of whether there was any causal link between Pfizer's supply price and Flynn's downstream price is a matter again to be resolved by reference to factual evidence. That is what you seem to recognise here?

A. Yes, I think that is right, yes.

Q. Let me take you back to Mr Williams. Let me see if I can get it right this time. Bundle D, tab 11, at page 8 of his first report at paragraph 32. The heading should be "Rates of return"?

A. Yes.

Q. And is this something you've read before?

A. Yes -- yes, I have read this, yes.

Q. Can you just -- would you like to just quickly refresh your memory by looking through 32(a), (b) and (c).

(Pause)

A. Yes, yes.

Q. Mr Williams is an expert, he is an accountant who has

a lot of experience of the pharmaceutical industry. I realise you are not an expert in the pharmaceutical industry?

A. Correct.

Q. You are an economist, as we established earlier but Mr Williams has identified a number of factors that he says are relevant to rates of return in the pharmaceutical industry. You see that is what he says?

A. Yes, I see that.

Q. I just want to see whether you agree with him that these are relevant factors, at least from your economic perspective. Is it relevant to the rate of return whether a product is generic or branded?

A. It can be, yes.

Q. Is it relevant to the rate of return, the number of manufacturers or suppliers of a particular drug or competing drugs?

A. That can also be relevant. I mean, it is particularly relevant if you are one of the chasing pack of generics. The more generic suppliers that join that chase, the more you would expect that competition to become more commoditised and therefore lower margin.

Q. Can the volumes supplied be relevant to the rate of return?

A. It depends how you are measuring the rate of return.

Q. Why do you not help us. Can they be relevant? In what circumstances are they relevant?
A. If you had -- well, obviously, if you had high fixed costs -- well, the rate of return -- the rate of return ultimately is the total profit net of all costs. Therefore, if you had higher volumes, you might be able to spread your fixed costs across, say, a larger volume. I mean, it depends -- it depends on so many factors.
Q. But it may be relevant?
A. It could be relevant, yes.
Q. And the ease of manufacture, can that be relevant to rates of return?
A. I do not know because it would depend -- if it was easy for everyone to manufacture something, I mean, I would have thought that could be relevant to how many entrants you might attract in a particular molecule. I think Mr Williams' knowledge of all these things is greater than mine. I think I can make some decent speculations on these questions but, frankly, I think it would be better to rely --
Q. Let me try and short circuit this. You have read his paragraphs 32(a), (b) and (c) and he raises a number of different elements that he says are relevant to rates of return. Is there anything there that you disagree with or wish to comment on in relation to his description of

what are relevant factors?

A. Nothing in particular because I do not really make any strong conclusions about rates of return. I talk about -- I think it is more important to look at the -- at the price levels and look at the prices as benchmarks against which to judge the Pfizer prices that I have been asked to analyse in my reports.

Q. Paragraph 85 of Mr Williams' first report, page 20.

A. Paragraph what, sorry?

Q. Paragraph 85 on page 20. I think there is an appendix which has numbers and that is where I got lost earlier. So if you go to page 20, you should be safe.

A. Oh, right, yes, okay.

Q. Paragraph 85:

"As noted in paragraph 73 above, I recognise that comparison between different companies needs to be undertaken with caution as no two pharmaceutical companies are exactly the same either in the scope of their activities or the nature of the products they sell."

We see the different experts in this case making comparisons for a variety of different reasons. You, as you say, have looked at prices and some of the other experts look at comparisons for other reasons but you do agree with the general comment there, the recognition

that comparison between different companies needs to be undertaken with caution for the reasons given. Do you agree with that?

A. All analyses should be done with caution, yes.

Q. But it is particularly difficult in the pharmaceutical industry, is it not, because of the differences in drugs and companies' portfolios?

A. Compared to what?

Q. Compared to other industries, potentially.

A. I mean, it is a meaningless question.

Q. Let's finish up where -- with what you say about this, Mr Ridyard. Your second report at tab 8, paragraph 36. You say:

"In drawing these comparisons I acknowledge that as is clear from the information presented at figure 1 in DR1, some AEDs have lower reimbursement prices than Phenytoin sodium capsules. That reflects the fact that a wide variety of commercial, regulatory and historical factors contribute to the prices that are charged for such products and to the complexities of the UK healthcare system."

A. Yes.

MR HOSKINS: Thank you very much for your time. Sir, I do not have any further questions.

Questions from the PANEL

THE CHAIRMAN: Thank you, Mr Hoskins. Professor Waterson.

PROFESSOR WATERSON: So there is a couple of things that I would like to ask, one of which is something which we have skirted round but have not really faced head-on. So I would like to get your view in summary on this particular point, and this is to do with economic value. You've got a section of your report. It is section 4 -- which talks about economic value (inaudible).

A. Yes.

PROFESSOR WATERSON: And you've said that in considering economic value, one should think about demand-side features and supply-side features.

A. I think on value, just demand side.

PROFESSOR WATERSON: Okay, okay, and so -- right, okay.

Now, of course, there is a difficulty in the pharmaceutical area because demand is somewhat curious?

A. Yes.

PROFESSOR WATERSON: As we would accept. It is the patient who benefits but the patient does not pay or does not pay a price representative --

A. Yes.

PROFESSOR WATERSON: -- of that. And so then that leads to the question, well, how are we to establish demand and how are we to establish relative prices across pharmaceutical products.

A. Yes.

PROFESSOR WATERSON: So what is your view on that, how one might do that?

A. Well, I think it is -- well, clearly it is extraordinarily difficult -- a difficult task, which is why I think it is, you know, very dangerous to impose a very simplistic rule on -- as the CMA has done in its decision. I mean, the only -- I am not for a minute going to suggest that I know a neat answer to this question. The only thing -- that is why -- that is why what I have done in my report is to fall back on saying well, let's just look at what actually happens in this market because the Department of Health -- the whole remuneration system for the pharmaceutical sector involves the Department of Health handing large amounts of rents to the pharmaceutical companies -- and the same is true for other countries as well -- in the belief, which may be well founded or not, that that helps to generate the right incentives for the right amount of R&D and new products. It is a hugely complicated question and therefore it is not surprising that you observe anomalies between one product and another, between one country and another in the way in which prices are set.

So I think I do not have a good answer to your

question but what I tried -- what I think is a sensible way of approaching the problem that we are faced with here is to do as much work as possible, looking at the benchmarks of other products, other comparable products, to see whether what the prices we are talking about in this case, which are alleged to be an exploitive abuse, whether they fall outside of the range of what we observe, for all the faults and quirks of the pricing that we do observe, whether the prices we are looking at here are outside of the range of what actually happens elsewhere.

PROFESSOR WATERSON: I see, right. Yes.

And so in looking at this -- I mean, I think the system for new drugs is more straightforward, in the sense that the proposed price is compared with the -- there is a QALY, quality adjusted life --

A. Yes, I see, yes, yes.

PROFESSOR WATERSON: Is that approach relevant at all to existing drugs or is it not?

A. It is a good question and it is something that we did try to explore at one point but I'm afraid we could not find -- we could not find a good way of harnessing that approach to apply to the case here. It is something that my colleagues and I did some thinking about but we essentially drew a blank, which is why we fell back on

what is, I admit, a rather kind of pragmatic approach of just looking at the prices of other products and doing that comparison. We certainly thought about it but we could not come up with an answer that was going to be robust and good enough to be useful.

PROFESSOR WATERSON: Fine, thank you.

For the people taking notes. QALY is quality adjusted life year.

So the -- but the general point is that one takes into account the characteristics of the product alongside other things in arriving at what is a reasonable value?

A. Yes.

PROFESSOR WATERSON: The other thing that I wanted to ask you about is something quite different, has not arisen so far but I wondered whether you had investigated or not and that is the position of -- I mean, if you like, there is a sort of triumvirate here and one of them is rather mysterious, as the case with triumvirates sometimes. The mysterious one is parallel imports.

A. Yes.

PROFESSOR WATERSON: Were you able to examine the situation as regards parallel imports at all?

A. Certainly we took them into account when we looked at the market shares, the question with parallel imports is

a quantity one.

PROFESSOR WATERSON: Yes.

A. And I think when you heard the evidence last week, and you can kind of understand that if you are a pharmaceutical company and you had big price differences between one country and another, you would like to do everything that you can within the law, within your powers to limit the quantities that are coming out of Spain and Greece, which tends to be the two countries with the very low prices and to come back.

So all we have done on parallel imports is simply measure them as well as we can for what they are. We have not got into the value chain to see who is accruing the rents that are obviously available for anyone parallel importing a product from Spain or Greece to the UK.

PROFESSOR WATERSON: And also, presumably, you did not get into how these products become on sale here, given the relationship between Pfizer and Flynn.

A. No, no, that is right.

PROFESSOR WATERSON: Okay, thank you.

MR LOMAS: I have one limited question, Mr Ridyard. On paragraph 47 of your first report at tab 7, there is the heading, "Pre-divestment prices and international prices do not justify the conclusion that Pfizer's prices were

abusive."

A. Yes.

MR LOMAS: You did, as we have seen in your reports, an enormous amount of work on comparators.

A. Yes.

MR LOMAS: The only reference I can find in your report to the international comparators, despite that heading, is in paragraph 136, which is those four lines there.

I was interested to know why you did not think it relevant to look at the international or the prices for the same product coming from the same active pharmacological ingredient in the States, made in the same factory in Germany but as opposed to being sold and distributed in the UK, sold and distributed in other European countries. So a relatively close comparator?

A. Yes.

MR LOMAS: I was curious as to why you did not do more analysis or research on that and why your conclusion was as short as it was.

A. It is partly because I have been here before, trying to make -- what I found in looking at these international comparisons before is there are so many differences between healthcare systems that you soon bump into very big differences in the way in which the whole system is set up, whether there are co-payments or not and how

much -- how the products are regulated, whether they are regulated through reference pricing or price controls or other things.

But having said -- so essentially -- I mean, I agree that it is -- in principle it is attractive to look at international comparisons because it is the same product probably coming from the same source but I think there are, you know, many reasons to be doubtful about the -- the value of those as benchmarks.

Having said that, from the limited group of countries that -- whose prices is compared in the decision, included in those prices are -- some of them are actually, I think, above the CMA's view about what the -- what an abusive price would be in this case but they are all well below, obviously, the prices that we are talking about here. There is no question of that.

So, insofar as one did take those international price comparisons into account, it is clear that they were much lower than the prices we are talking about.

What that raises to me is something which I do address and we did think about quite a lot and I address in my second report -- is what do you do when you do some comparators and you find a big range of comparators, and I think in some cases it might be because it is just very hard to get to the truth and the

range just reflects the fact that you have not got to the truth.

But I think in this case the range probably reflects the fact that there is a big range of possible outcomes to the question of what is -- you know, what is a reasonable price.

And I think there there's a kind of policy question, which is again a question for you to address, necessarily, rather than me -- is what you do with that range. My view on it, which is what I tried to explain in my report, is that to find something -- to make this the basis of a finding of unlawful behaviour, I think you would -- one would want to be sure that the prices you observe are right at the top end of that range or beyond the range, but if they are in the range of the prices you observe, even though they are much higher than prices that happen to be near the bottom of that range, they are still within, you know, what is maybe a rather large margin of possible outcomes but it still is within the range of outcomes that can arise in a normal competitive setting, if you can get a normal competitive setting in such an abnormal market.

MR LOMAS: Just to come back to that, I think we established earlier that the prices in those other countries were either all profitable or all but one profitable. Is

what you are saying that the uncertainties of analysis are so much greater in relation to the same product on another European market that they should be neglected as a comparator by comparison with different products with unknown cost structures on the UK market which happen to treat the same disease? It just seemed to me there was a slight imbalance in the amount of analysis.

A. I think that is a perfectly fair point and I am not saying that. I am saying that there is clearly a set of prices for this product, which would cover costs and make it worthwhile, you know, I would have thought -- it is up to Pfizer, not me, but I would have thought would have made it worthwhile carrying on in business, that are considerably lower than the prices we actually observe, and then some of those prices crop up in these international price comparisons. But then there are some other prices which do allow a substantial price/cost margin to reflect the value of the products, and the question ultimately -- ultimately, the question is at what point do you draw a line and say that that price is an unlawful abuse.

So I am not saying the international prices are irrelevant here. I think it is -- obviously, it is relevant to look at prices in relation to cost but I do not think it is sensible to take that as the sole

citation for assessing the legality of the prices, particularly when one observes that other prices, which are valid comparators in my view -- and obviously you will make up your own mind on that -- are showing much higher price/cost margins and they seem to be sustainable and they do not seem to be because of the kind of monopoly power or whatever you want to call it that is being alleged in this case.

MR LOMAS: Thank you.

THE CHAIRMAN: Just a couple of quick wrap-up questions. We have not talked very much about the part of your opinions which deal with Pfizer as the supplier to Flynn.

A. Yes.

THE CHAIRMAN: And the arguable effect on the final consumer. I mean, is it your position as an expert that the effect on the final consumer of whatever conduct Pfizer is accused of has not been made out?

A. Yes, I am just -- I am just -- I am literally puzzled as to what the CMA is saying. Obviously, I understand the idea that if someone upstream sets a price, the person downstream will then set a -- probably a maximising price that takes that as given and therefore the input price will -- in most cases will be influenced -- sorry, the downstream price will be influenced by the upstream

price. But here there are some just facts floating around as to how -- as to where the causality does lie, if it does come from Pfizer to Flynn or whether the prices are kind of co-determined, and I do not think the CMA has sort of pinned that down and, until it does pin that down, then I do not think you can safely assume that Pfizer's price is affecting Flynn's price.

So it may be that there was not -- the CMA did not need to do much more work to pin that down but I do not think they have pinned that down. So I think it is left floating in my view.

THE CHAIRMAN: You are suggesting that you can never have a position where a supplier is abusing a dominant position even though it is working through a distributor?

A. That would be ridiculous, obviously, I am not suggesting that, and that is sort of the way the argument has been characterised in, I think, one of the CMA's responses. It is certainly not a position that I would be holding, clearly. It's just the fact that --

THE CHAIRMAN: Circumvention, I think, is the word --

A. -- it has been determined -- obviously, you would not accept that but it's just indeterminate where the causality lies between the two prices in this case. Until you pin that down, I do not think you have really

made that case.

THE CHAIRMAN: Right. The next point is comparators. You have talked a lot about comparators.

A. Yes.

THE CHAIRMAN: It runs through your two opinions. My question is just a sort of clarificatory one. Can a product be relevant in your view as a comparator, whether it's for economic value or for any other purpose in the analysis, if it is not a direct competitor with the relevant product, i.e. outside the relevant product market as defined?

A. Yes, it is a positive advantage. I think it would be a disadvantage if it was in the relevant market because then its price to be co-determined or influenced by -- for example, if one had used NRIM's price as the comparator for Flynn -- or at least on my understanding that NRIM and Flynn are in the same market -- then, obviously, I think there would be an intrinsic circularity which is a potential problem in that.

So that is why in principle the tablet price is such a beautiful comparator because it is not -- it does not interact competitively with the capsules as far as I can judge but it is in other ways the same product. Obviously, the tablet price has its problems as a comparator if you do not believe that the Department of

Health effectively regulated the price of the tablet, and that is a separate issue which is something one has to come to a view on, but not being in the same market is a positive advantage, not a weakness, when you want to find a comparator.

THE CHAIRMAN: It is not really fair to put this to you but when the Court of Justice all those years ago in United Brands talked about comparison with competing products, do you think they had that issue in mind? Sorry, you do not have to answer that.

A. I am not sure what they had in mind, Mr. Chairman but if --

THE CHAIRMAN: You do not have to answer. I think I have worked out what your answer is.

Okay, finally, and again another thread running through your evidence, I think, is when we talk about what the CMA have done by calculating costs and return on sales, and largely base their finding on that, is it your position that the price that is based on cost plus an appropriate return on sales, whatever it is, return anyway, that that creates what you describe, I think in one place as a normal economic profit. Is that right?

A. It could be, yes, yes, which would just be the profit that makes it just worth my while carrying on in business.

THE CHAIRMAN: But is it also your position that an awful lot of companies make more than a normal economic profit?

A. Yes.

THE CHAIRMAN: And that can be characterised in technical terms as supranormal?

A. Yes.

THE CHAIRMAN: Supranormal, therefore, does not carry with it necessarily a pejorative meaning?

A. That is correct.

THE CHAIRMAN: It's just an observation.

A. Yes.

THE CHAIRMAN: And that there is a price above this normal economic price, normal economic profit, but that the company is making, which sooner or later will become abusive and unfair and excessive?

A. Yes, I certainly agree with the principle of having the power to regulate abusive --

THE CHAIRMAN: We are above the return on sales calculation; we are in the sort of margin between what is clearly unfair and excessive and what you get by looking at costs plus.

A. Yes, yes. Clearly there is a big margin over costs here. There is no question about that.

THE CHAIRMAN: And I think I get from your evidence that

that -- what is actually, you know, against Article 102 might be anywhere within that range and you have to establish that by looking at whatever reasonable, justifiable comparisons are available. Is that what you are putting to us?

A. I think that is what you should do, yes.

THE CHAIRMAN: That is fine, thank you.

Right, Mr Brealey, you have the floor.

MR BREALEY: I have no re-examination.

THE CHAIRMAN: Well, then, I think you are discharged, Mr Ridyard.

A. Thank you very much.

THE CHAIRMAN: Thank you very much. We will meet tomorrow -- can we go back to 10.30?

MR HOSKINS: Part of the problem we have, I lost a day, remember, because some of the Pfizer witnesses were not available on Monday.

THE CHAIRMAN: Right. That was them that did it? I thought you took the day away from us, but obviously not.

MR HOSKINS: No, it was Pfizer's witnesses were not available. I think, sir, if we sit -- if we sit at half past 10 tomorrow, there is a small risk we have to sit a wee bit late. I will do Mr Williams in the day and then if we sit at 10.30 on -- I am losing track --

Thursday, I should be able to deal with Mr Davies in the morning and Mr de Coninck in the afternoon.

THE CHAIRMAN: We are very easy. If you feel your chances of getting through Mr Williams in a day are increased by starting at 10.00 am, I am happy to start at 10.00 am.

MR HOSKINS: It is safer. I mean, it is an art, not a science, in terms of the time estimate.

THE CHAIRMAN: Anybody else have any views?

MS BACON: I am sorry to raise this: I have a child care issue tomorrow evening. I am going to have to leave shortly after 5.00 pm. If the tribunal is thinking of sitting later than 5.00 pm, I would be in difficulties tomorrow.

THE CHAIRMAN: In that case we will start at 10.00 am tomorrow.

Thank you.

(5.00 pm)

(The court adjourned until 10.00 am the following day)

INDEX