Neutral Citation: [2025] UKFTT 00241 (TC)

Case Number: TC09434

FIRST-TIER TRIBUNAL
TAX CHAMBER

Taylor House, London

Appeal reference: TC/2018/04377

VAT – whether hair transplants to treat androgenetic alopecia are exempt supplies of medical care - Items 1 and 4, Group 7, Schedule 9, VAT Act 1994

Heard on: 26 to 29 February and 29 April 2024, with subsequent written submissions dated 19 July, 2 August and 10 August 2024
Judgment date: 20 February 2025

Before

TRIBUNAL JUDGE NICHOLAS ALEKSANDER
GILL HUNTER

Between

ADVANCED HAIR TECHNOLOGY LIMITED

Appellant

and

THE COMMISSIONERS FOR HIS MAJESTY'S REVENUE AND CUSTOMS

Respondents

Representation:

For the Appellant: James Rivett KC and Ronan Magee, counsel, instructed by Azets

For the Respondents: Joseph Millington, counsel, instructed by the General Counsel and Solicitor to HM Revenue and Customs

DECISION

INTRODUCTION

1. Advanced Hair Technology Limited ("AHT") appeals against the following decisions:

   (1) A decision dated 6 June 2018, in which HMRC decided that the majority of AHT's supplies of hair transplant services were standard rated for VAT;

   (2) A decision dated 21 May 2019, by which the HMRC compulsorily registered AHT for VAT with effect from 1 July 2007; and

   (3) A notice of assessment of civil penalty as a result of AHT's failure to register for VAT at the right time pursuant to section 67 of the Value Added Tax Act 1994 ("VAT Act")

The VAT under appeal is £2,498,232. The penalty was levied at the rate of 15% and is £374,734.

2. AHT appeals on the basis that its supplies are exempt supplies of medical care. It was agreed that the hearing, and this decision, would not consider the quantum of any liability, but would consider only the principle of whether the exemption for supplies of medical care was engaged.

3. At the hearing AHT was represented by Mr Rivett and Mr Magee, and HMRC was represented by Mr Millington.

4. The hearing was originally listed for four days on the basis of the time estimates given by the parties. Given that there were two witnesses of fact and two experts, and a complex legal background, the time estimate proved to be unrealistic. Although the parties had agreed a timetable at the start of the hearing, and we commenced hearings early and sat late on the hearing dates, we did not finish hearing the evidence until day four, leaving insufficient time to hear closing submissions. Following submissions from the parties, we directed that a further day be listed for submissions, with the parties providing written closing submissions in advance of the hearing date in order to make as efficient use of the time available as possible.

5. Following the conclusion of the hearings, the attention of the Tribunal was drawn to the decision of Judge Tilakapala in *Gillian Graham t/a Skin Science* [2024] UKFTT 352 (TC). Although it does not bind this Tribunal as it is a decision of the FTT, it may be of persuasive authority. We therefore gave directions permitting the parties to file written submissions in respect of that decision. This decision takes account of those written submissions. Unfortunately, due to staffing issues within the Tribunal's administration, it took roughly one month from those submissions being received by the Tribunal's offices to being forwarded to the Tribunal panel.

6. Counsel for the parties made helpful submissions for which we are grateful. We have carefully considered these in reaching our decision, but in so doing have not found it necessary to refer to each and every argument advanced by them on behalf of their respective clients nor to all of the authorities cited.

EVIDENCE

7. We heard oral evidence from Dr Bessam Farjo, a director and shareholder of AHT, and from Charles Olatoye, a senior officer in HMRC who was at the relevant time an investigating officer in HMRC's hidden economy team. Mr Olatoye was the decision maker within HMRC responsible for making the assessments which are under appeal. Expert evidence was provided by Dr Christopher Rowland Payne for AHT and by Dr Sarah Walsh for HMRC, both eminent dermatologists.

8. In addition, two bundles of documents, of 4061 and 275 pages respectively, were produced in evidence. Included within the bundles were examples of invoices and the contractual arrangements concluded with patients. Also included were ten case studies, with anonymised documentation, relating to a representative sample of patients. These case studies were analysed by the experts. We also viewed four short videos that are available on AHT's website and YouTube channel.

9. We found Dr Farjo to be a credible and reliable witness.

10. Some implicit criticism was made on behalf of AHT of Dr Walsh's expertise as very few of her patients seek treatment for androgenetic alopecia ("AGA"), and because she had not referred to the guidelines produced by the European Dermatology Forum ("EDF") in her first report (she referred to the guidelines in her later report). We find any such criticism to be misplaced. We note that Dr Rowland Payne had not referred to these guidelines in his first report either. However, her expertise as a dermatologist was clear from her *curriculum vitae* and her evidence, and this was acknowledged by Mr Rivett. She is an eminent dermatologist, a senior consultant at a London teaching hospital, undertakes research in dermatology, and holds editorial roles in a number of leading medical journals. We are in no doubt that even though she does not treat AGA herself, she has a clear understanding of the medical nature of AGA and its treatment. We found both Dr Rowland Payne and Dr Walsh to be credible and reliable in their evidence.

11. As HMRC were no longer pursuing penalties, Mr Rivett's cross examination of Mr Olatoye was primarily focussed on the basis on which he had reached his decision to assess AHT to VAT, and in particular the reasons why he had decided that most of the supplies made to men treated for AGA were taxable. Mr Olatoye was not a helpful witness, and we found him to be evasive in his answers on a number of occasions. He was unable to give any direct factual evidence in relation to the nature of the services provided by AHT, since he relied on the information provided to him by AHT. As regards his reasons for deciding which services qualified for exemption and which did not, we find these to be either matters of the interpretation of the relevant law – which is an issue for the Tribunal to determine – or a question of medical opinion – on which Mr Olatoye is not qualified to give evidence. We did not find Mr Olatoye's evidence to be relevant to the issues before us, and have disregarded it.

PENALTIES

12. At an early stage on the first day of the hearing, Mr Rivett made an application to admit into evidence a copy of an email dated 20 June 2007 to Dr Farjo from a partner at AHT's then accountants, UHY Hacker Young. The email reported on a telephone call between the partner and an HMRC officer who was a policy advisor on social reliefs. The telephone call concerned the extent of the VAT exemption for medical services. The email reported that the officer had confirmed that HMRC adopt a wide interpretation to the definition of medical and surgical treatment in registered hospitals and clinics, and that (apart from beauty procedures using lasers and IPL machines) "the exemption from VAT remained appropriate irrespective of the purpose of the treatment". Mr Millington did not object and we gave our consent to the admission of this email exchange into evidence.

13. Mr Rivett, rightly, has not suggested that AHT has any legitimate expectation to hold HMRC to the statements made in this email exchange. The information given by UHY Hacker Young to HMRC does not even begin to meet the requirements set out in *R v Inland Revenue Commissioners, ex parte MFK Underwriting Agencies Ltd* [1990] 1 WLR 1545, and in any event, we do not have jurisdiction to determine questions of legitimate expectation in the circumstances of this appeal. However, the email exchange does go to the issue of whether AHT had a reasonable excuse for its failure to register for VAT, given that the professional advice it received was that its services were VAT exempt.

14. During the course of the second day of the hearing, we asked Mr Millington to consider with his clients whether they wished to pursue the penalty assessment, and to revert back to us at the commencement of the hearing on the following (third) day. Mr Millington was unable to obtain instructions on this issue overnight, nor over the lunch adjournment on day three. At the end of day three he informed us that HMRC's position had not changed since the start of the hearing – a penalty assessment had been issued, the relevant evidence would need to be heard, and the Tribunal would need to adjudicate on the issue.

15. We had directed that the hearing should commence on day four at 09:30 – starting with the evidence of Mr Olatoye. The hearing in fact had to start later than 09:30 because Mr Olatoye did not arrive at the hearing centre in sufficient time to clear security before the time the hearing was due to commence. When the hearing commenced, Mr Rivett told us that at 09:28 he had asked whether Mr Millington had received instructions on this issue, and was told that he had not. Only after Mr Olatoye arrived (late) in the court room was Mr Millington able to confirm that HMRC had decided not to pursue the assessment for penalties, and the penalty assessment would be withdrawn. Mr Rivett noted that because of the lateness of the withdrawal, he had had to spend time the previous evening preparing to cross-examine Mr Olatoye in relation to the penalty assessment.

16. We invite AHT to consider whether it wishes to make an application for costs incurred in consequence of the failure of HMRC to notify its intention to withdraw the penalty assessment until after the commencement of the hearing on day four, and to make submissions on whether HMRC's failure to notify the withdrawal until minutes before Mr Olatoye was due to give evidence constitutes unreasonable conduct for the purposes of Rule 10(1)(b) of the Tribunal's procedure rules. We draw the attention of the parties to the requirements of Rule 2(4)(b) which requires parties to co-operate with the Tribunal generally. As regards the procedure to be adopted for any application for costs, we draw the attention of the parties to paragraphs (3) and (4) of Rule 10, and direct that the time limit in paragraph (4) shall be varied to read 28 days after the date on which this decision notice is released.

BREXIT

17. The supplies under appeal were all made prior to the end of the Brexit implementation period, namely IP Completion Day at 23:00 GMT on 31 December 2020.

18. Under the terms of the European Union Withdrawal Act 2018 various concepts of EU law continue to be recognised and enforced in UK domestic law. This includes the continued application of decisions of the Court of Justice of the European Union ("CJEU") in binding lower courts (s6(3)(a), (4) and (5A) of the European Union Withdrawal Act 2018).

19. We note that s22, Retained EU Law (Revocation and Reform) Act 2023 provides that s3 (abolition of supremacy of EU law) and s4 (abolition of general principles of EU law) of that Act do not apply in relation to anything occurring before the end of 2023. However, the effect of s28 Finance Act 2024 is to reverse s4 of the 2023 legislation and reinstate general principles of EU law in relation to VAT and excise duties. We note also that s28(4) provides

that EU law (such as the VAT directives) continue to have effect for the purposes of interpreting VAT and excise law.

20. We find that EU law (including the jurisprudence of the CJEU prior to IP Completion Day) applies to the determination of this appeal.

THE LAW

21. AHT appeals on the basis that its supplies are exempt supplies of medical care.

Legislation

22. Chapter 2 of Title IX of Directive 2006/112/EC (the Principal VAT Directive, "PVD") contains exemptions for certain activities in the public interest. So far as relevant, Article 132 PVD provides:

> Article 132
>
> 1. Member States shall exempt the following transactions:
>
> […]
>
> (b) hospital and medical care and closely related activities undertaken by bodies governed by public law or, under social conditions comparable with those applicable to bodies governed by public law, by hospitals, centres for medical treatment or diagnosis and other duly recognised establishments of a similar nature;
>
> (c) the provision of medical care in the exercise of the medical and paramedical professions as defined by the Member State concerned;

23. Those exemptions are given effect in the United Kingdom by s31(1), and Items 1 and 4, Group 7, Schedule 9, VAT Act 1994 ("VAT Act"):

> 31.— Exempt supplies.
>
> (1) A supply of goods or services is an exempt supply if it is of a description for the time being specified in Schedule 9.
>
> […]
>
> SCHEDULE 9 EXEMPTIONS
>
> […]
>
> GROUP 7- HEALTH AND WELFARE
>
> Item No.
>
> 1 The supply of services consisting in the provision of medical care by a person registered in any of the following-
>
> (a) the register of medical practitioners
>
> […]
>
> 4 The provision of care or medical or surgical treatment and, in connection with it, the supply of any goods, in any hospital or state-regulated institution.

24. For the purposes of Item 1, Group 7, Schedule 9 VAT Act ("Item 1"), there is no dispute that AHT's services were made by an appropriately qualified medical practitioner.

25. Article 132(1)(b) and (c) PVD replaced Article 13A(1)(b) and (c) of Directive 77/388/EEC (the "Sixth Directive"). The CJEU has held that Article 132(1)(b) and (c) must be interpreted in the same way as Article 13A(1)(b) and (c), Sixth Directive, and that the Court's jurisprudence in relation to Article 13A, Sixth Directive applies equally to Article 132 PVD.

26. For the purposes of this decision, we refer to the exemption from VAT provided by Item 1 and Article 132 (1))(b) and (c), PVD as the "medical exemption".

Case law

27. The term "medical care" used in Article 132 PVD and in Item 1 is not defined. Its meaning has been considered in a number of cases, principally decisions of the CJEU, but also by the UK courts and tribunals.

28. The meaning of "medical care" was considered by the Court of Appeal in its decision in *Mercy Global* [2023] EWCA Civ 1073. The Court decided that its previous decision in *Mainpay v HMRC* [2022] EWCA Civ 1620 was binding upon it (the Supreme Court having refused permission to appeal in *Mainpay*).

29. *Mainpay* concerned the supply of doctors to NHS trusts through a recruitment agency. The issue was whether the supply by the agency fell within the medical exemption. In her judgment, at [61], Whipple LJ approved the summary given by the Upper Tribunal of the jurisprudence of the CJEU ([2021] UKUT 270 at [89]):

> 89. The scope of the exemptions for medical care contained in Article 132(1)(b) and (c) of the Directive (and its predecessor Article 13A(1)(b) and (c) of the Sixth Directive) have been the subject of a number of decisions by the CJEU. The main principles can be summarised as follows:
>
> (1) The exemptions envisaged in art 13 of the Sixth Directive are to be interpreted strictly since they constitute exceptions to the general principle that VAT is to be levied on all services supplied for consideration by a taxable person: e.g. *Ambulanter Pflegedienst Kügler GmbH v Finanzamt für Körperschaften I in Berlin* (Case C-141/00) EU:C:2002:473, [2002] ECR I-6833 (*'Kügler'*) at para 28.
>
> (2) Those exemptions constitute independent concepts of Community law whose purpose is to avoid divergences in the application of the VAT system from one Member State to another (*Card Protection Plan Ltd v Customs and Excise Comrs* (Case C-349/96) EU:C:1999:93, [1999] STC 270, [1999] 2 AC 601, at para 15, *EC Commission v France* (Case C-76/99) EU:C:2001:12, [2001] ECR I-249, [2001] 1 CMLR 1244, at para 21, and *Kügler* at para 25).
>
> (3) As regards the place where the services must be supplied, in contrast to art 132(1)(b) which concerns services encompassing a whole range of medical care normally provided on a non-profit-making basis in establishments pursuing social purposes such as the protection of human health, art 132(1)(c) applies to services provided outside hospitals and similar establishments and within the framework of a confidential relationship between the patient and the person providing the care, a relationship which is normally established in the consulting room of that person: *Kügler* at para 35 and *EC Commission v UK* (Case C-353/85) at para 33.
>
> (4) Article 132(1)(b) and (c) have separate fields of application and are intended to regulate all exemptions of medical services in the strict sense. Article 132(1)(b) exempts all services supplied in a hospital environment while art 132(1)(c) is designed to exempt medical services provided outside such a framework, both at the private address of the person providing the care and at the patient's home or at any other place: *Kügler* at para 36.
>
> (5) The application of art 132(1)(c) is not dependent on the legal form of the person supplying the medical care. Thus, a limited company supplying

medical care through medically qualified staff fell within the exemption: *Kügler* at para 41.

(6) The concept of 'provision of medical care' does not lend itself to an interpretation which includes medical interventions carried out for a purpose other than that of diagnosing, treating and, in so far as possible, curing diseases or health disorders: *D v W (Österreichischer Bundesschatz intervening)* (Case C-384/98) [2002] STC 1200, [2000] ECR I-6795, at para 18.

(7) Although the provision of medical care must have a therapeutic aim, it does not necessarily follow that the therapeutic purpose of a service must be confined within an especially narrow compass. Thus, medical services effected for prophylactic purposes may benefit from the exemption under art 132(1)(c). Even in cases where it is clear that the persons who are the subject of examinations or other medical interventions of a prophylactic nature are not suffering from any disease or health disorder, the inclusion of those services within the meaning of provision of medical care is consistent with the objective of reducing the cost of health care, which is common to both the exemption under art 132(1)(b) and that under (c) of that Article: *D'Ambrumenil v Customs and Excise Comrs* (Case C-307/01) EU:C:2003:627, [2005] STC 650, [2004] QB 1179 ('*d'Ambrumenil'*), at para 58.

(8) It is the purpose of a medical service which determines whether it should be exempt from VAT. Therefore, if the context in which a medical service is effected enables it to be established that its principal purpose is not the protection, including the maintenance or restoration, of health but rather the provision of advice required prior to the taking of a decision with legal consequences, the exemption under art 132(1)(c) does not apply to the service: *d'Ambrumenil* at para 60.

(9) Article 132(1)(b) does not include any definition of the concept of activities 'closely related' to hospital and medical care. That concept does not, however, call for an especially narrow interpretation since the exemption of activities closely related to hospital and medical care is designed to ensure that the benefits flowing from such care are not hindered by the increased costs of providing it that would follow if it, or closely related activities, were subject to VAT: *Commission v France* (Case C-76/99), at paras 22–23.

(10) The provision of medical care which does not meet all the requirements laid down in order to benefit from the exemption from VAT under art 132(1)(b) is not, as a matter of principle, excluded from the exemption laid down in art 132(1)(c). It is not apparent from the wording of art 132(1)(b) that that provision is intended to limit the scope of art 132(1)(c). Article 132(1)(b) covers all services supplied in a hospital environment while art 132(1)(c) covers services provided outside such a framework, both at the private address of the person providing the care and at the patient's home or at any other place, in the context of the exercise of medical and paramedical professions as defined by the Member States: *Finanzamt Kyritz v Peters* (Case C-700/17) EU:C:2019:753, [2019] STC 2096, at paras 21, 27 and 28.

30. At [96] the Upper Tribunal stated that

> [96] The nature and characterisation of a supply is to be determined on the basis of the conventional approach set out, for example, in *Secret Hotels2 Ltd (formerly Med Hotels Ltd) v Revenue and Customs Comrs* [2014] UKSC 16, [2014] STC 937 (see Lord Neuberger at [31]–[32]) and *Revenue and*

> *Customs Comrs v Airtours Holidays Transport Ltd* [2016] UKSC 21, [2016] STC 1509, [2016] 4 WLR 87, *Van Ginkel Waddinxveen BV and Reis-en Passagebureau Van Ginkel BV v Inspecteur der Omzetbelasting te Utrecht* (Case C-163/91) EU:C:1992:435, [1996] STC 825, [1992] ECR I-5723, at para 21 *and Revenue and Customs Comrs v Newey (trading as Ocean Finance)* (Case C-653/11) EU:C:2013:409, [2013] STC 2432, viz that it is a matter of contractual interpretation viewed in the light of commercial and economic reality. An examination of the commercial and economic reality involves a consideration of all the relevant facts and circumstances in which the supply took place.

Whipple LJ endorsed the approach taken by the Upper Tribunal when she went on at [61(iii)] to set out a "basic proposition" that:

> the analysis of what is being supplied depends, in any given case, on economic realities of the transaction, that being a "fundamental criterion" for the application of the common system of VAT (see *Airtours Holiday Transport Ltd v HMRC* [2016] UKSC 21; [2016] 4 WLR 87 at [48], citing Case C-53/09 and C-55/09 *Revenue and Customs Commissioners v Loyalty Management UK Ltd and Baxi Ltd* [2010] ECR I-9187; [2010] STC 2651 at [39]-[40]); the contracts are the most useful starting point in that exercise, but not necessarily the end point: see *WHA Ltd v Revenue and Customs Commissioners* [2013] UKSC 24; [2013] 2 All ER 907. The UT recognised this approach in terms at UT [96], see para [33] above, and their encapsulation of the approach was not subject to any challenge in this appeal.

31. We were referred to the decision of the CJEU in *Skatteverket v PFC Clinic AB* (Case C-91/12). In this case, PFC provided both cosmetic and reconstructive plastic surgery and also some skincare services. The issue before the Court was whether the services it supplied constituted "medical care". The referring court had stated that (at [18]):

> the purpose of the interventions carried out is, in certain cases, to treat patients who, as a result of an illness, injury or a congenital physical impairment, are in need of plastic surgery. In other cases, the interventions carried out are more as a result solely of the patient's wishes to alter or improve his physical appearance. Irrespective of their purpose, and from a medical point of view, the various interventions are, according to the referring court, comparable services and can be carried out by the same personnel.

32. The procedures and treatments carried out by PFC were (at [13]):

> […] breast augmentation and reduction, breast lifts, abdominoplasty, liposuction, face lifts, brow lifts, eye, ear and nose operations and other plastic surgery. That company also offers treatments such as permanent hair removal and skin rejuvenation by pulsed light, anti-cellulite treatments and botox and Restylane injections.

33. In its judgment, the CJEU set out the issue that needed to be addressed as follows:

> 28 It follows, in the context of the exemption laid down in Article 132(1)(b) and (c) of the VAT Directive, that the purpose of the services such as those at issue in the main proceedings is relevant in order to determine whether those services are exempt from VAT. That exemption is intended to apply to services whose purpose is for diagnosing, treating or curing diseases or health disorders or to protect, maintain or restore human health (*Future Health Technologies*, paragraph 43).

> 29 Thus, services such as those at issue in the main proceedings, in so far as their purpose is to treat or provide care for persons who, as a result of an illness, injury or a congenital physical impairment, are in need of plastic surgery or other cosmetic treatment may fall within the concept of 'medical care' in Article 132(1)(b) of the VAT Directive and 'the provision of medical care' in Article 132(1) (c) thereof respectively. However, where the surgery is for purely cosmetic reasons it cannot be covered by that concept.

34. The CJEU went on to consider whether the subjective purposes of the patient were relevant and concluded that although the health problems which may be the subject of exempt medical care may be psychological, the medical assessment of whether an intervention has a therapeutic purpose must be based on findings of a medical nature made by a qualified person:

> 33 As far as concerns whether the subjective understanding that the recipients of services, such as those at issue in the main proceedings, have must be taken into consideration in the assessment of the purpose of a specific intervention, which is the subject of the third question, it follows from the case-law that the health problems covered by exempt transactions under Article 132(1)(b) and (c) of the VAT Directive may be psychological (see to that effect, in particular, Case C-45/01 *Dornier* [2003] ECR I-12911, paragraph 50, and Joined Cases C-443/04 and C-444/04 *Solleveld and van den Hout-van Eijnsbergen* [2006] ECR I-3617, paragraphs 16 and 24).
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> 34 However, the subjective understanding that the person who undergoes plastic surgery or a cosmetic treatment has of it is not in itself decisive for the purpose of determining whether that intervention has a therapeutic purpose.
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> 35 Since that is a medical assessment, it must be based on findings of a medical nature which are made by a person qualified for that purpose.
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> 36 It follows that the fact, referred to in the fourth question, that services such as those at issue in the main proceedings are supplied or undertaken by a licensed member of the medical profession or that the purpose of such interventions is determined by such a professional, may influence the assessment of whether interventions such as those at issue in the main proceedings fall within the concepts of 'medical care' or 'medical treatment' within the meaning of Article 132(1)(b) and (c) of the VAT Directive respectively.

35. The decisions of the CJEU in *D v W (Österreichischer Bundesschatz intervening)* (Case C-384/98), *CIG Pannónia Életbiztosító Nyrt v Nemzeti Adó- és Vámhivatal Fellebbviteli Igazgatósága* (Case C-458/21), *d'Ambrumenil* (Case C-307/01) and *Unterpertinger* (Case C-212/01) all considered the provision of reports by doctors for insurance purposes.

36. In its judgment in *D v W* the Court said:

> 17. In that regard, as the Advocate General observes in para 16 of his opinion, apart from the Italian version, all the versions of art 13A(1)(c) of the Sixth Directive refer only to medical care concerning the health of persons. It should be pointed out, in particular, that the German, French, Finnish and Swedish versions use the concept of therapeutic treatment or of care provided to the person.
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> 18. Clearly, therefore, the concept of "provision of medical care" does not lend itself to an interpretation which includes medical interventions carried out for a purpose other than that of diagnosing, treating and, in so far as possible, curing diseases or health disorders.

19. So, services not having such a therapeutic aim must, having regard to the principle that any provision establishing an exemption from VAT is to be interpreted strictly, be excluded from the scope of art 13A(1)(c) of the Sixth Directive and are therefore subject to VAT.

37. In its judgment in *d'Ambrumenil* the Court said:

57. In relation to the concept of "provision of medical care", the Court has already held in paragraph 18 of its judgment in *D. v W.*, and restated in paragraph 38 of its judgment in *Kügler*, cited above, that that concept does not lend itself to an interpretation which includes medical interventions carried out for a purpose other than that of diagnosing, treating and, in so far as possible, curing diseases or health disorders.

58. While it follows from that case-law that the "provision of medical care" must have a therapeutic aim, it does not necessarily follow therefrom that the therapeutic purpose of a service must be confined within an especially narrow compass (see, to that effect, *Commission v France*, paragraph 23). Paragraph 40 of the judgment in *Kügler* shows that medical services effected for prophylactic purposes may benefit from the exemption under Article 13A(1)(c). Even in cases where it is clear that the persons who are the subject of examinations or other medical interventions of a prophylactic nature are not suffering from any disease or health disorder, the inclusion of those services within the meaning of "provision of medical care" is consistent with the objective of reducing the cost of health care, which is common to both the exemption under Article 13A(1)(b) and that under (c) of that paragraph (see *Commission v France*, paragraph 23, and *Kügler*, paragraph 29).

59. On the other hand, medical services effected for a purpose other than that of protecting, including maintaining or restoring, human health may not, according to the Court's case-law, benefit from the exemption under Article 13A(1) (c) of the Sixth Directive. Having regard to their purpose, to make those services subject to VAT is not contrary to the objective of reducing the cost of health care and of making it more accessible to individuals.

60. As the Advocate General correctly pointed out in paragraphs 66 to 68 of her Opinion, it is the purpose of a medical service which determines whether it should be exempt from VAT. Therefore, if the context in which a medical service is effected enables it to be established that its principal purpose is not the protection, including the maintenance or restoration, of health but rather the provision of advice required prior to the taking of a decision with legal consequences, the exemption under Article 13A(1)(c) does not apply to the service.

61. Where a service consists of making an expert medical report, it is clear that, although the performance of that service solicits the medical skills of the provider and may involve activities which are typical of the medical profession, such as the physical examination of the patient or the analysis of his medical history, the principal purpose of such a service is not the protection, including the maintenance or restoration, of the health of the person to whom the report relates. Such a service, whose purpose is to provide a reply to questions set out in the request for the report, is effected in order to enable a third party to take a decision which has legal consequences for the person concerned or other persons. While it is true that an expert medical report may also be requested by the person concerned and may indirectly contribute to the protection of the health of such person, by detecting a new problem or by correcting a previous diagnosis, the principal

purpose pursued by every service of that type remains that of fulfilling a legal or contractual condition in another's decision-making process. Such a service cannot benefit from the exemption under Article 13A(1)(c).

62. It follows that supplies of services such as those described in paras (d) to (h) of the question referred, although effected in the exercise of the medical profession, do not constitute 'the provision of medical care' within the meaning of art 13A(1)(c). The purpose of such services is to provide expert reports concerning a person's state of health and covering, in particular, the injuries or disabilities by which he or she is affected, in order to treat administrative applications, such as applications for the payment of a war pension, or for the purposes of court proceedings for compensation, such as claims for damages for medical negligence.

63. In relation to services consisting in the provision of medical certificates of fitness, for example certificates of fitness to travel as mentioned in para (c) of the question referred, it is necessary to take into consideration the context in which those services are performed in order to establish their principal purpose.

64. Where fitness certificates are required by a third party as a condition precedent to the exercise by the person concerned of a particular professional activity or the practice of certain activities requiring a sound physical condition, the principal purpose of the service effected by the doctor is to provide the third party with a necessary element for taking a decision. Such medical services are not intended principally to protect the health of the persons who wish to carry on certain activities and cannot therefore be exempt under art 13A(1)(c).

65. None the less, where the purpose of a certificate relating to physical fitness is to make clear to a third party that a person's state of health imposes limitations on certain activities or requires that they are carried on under particular conditions, the protection of the health of the person concerned may be regarded as the principal purpose of that service. Therefore, the exemption under art 13A(1)(c) may apply to such a service.

66. Considerations similar to those set out in paras 63 to 65 of this judgment apply in relation to the services described in paras (a) and (b) of the question referred. Where medical examinations and the taking of blood or other bodily samples are carried out with the aim of enabling an employer to take decisions on the recruitment of, or on the duties to be performed by, a worker or to enable an insurance company to fix the premium to be paid by an insured person, the services in question are intended principally to provide that employer or that insurance company with evidence on which to take its decision. Such services do not therefore come within the meaning of 'provision of medical care' exempted under art 13A(1)(c).

67. By contrast, regular medical checks at the behest of certain employers and certain insurance companies may satisfy the conditions for exemption under art 13A(1)(c), provided that such checks are intended principally to enable the prevention or detection of illness or the monitoring of the health of workers or insured persons. The fact that such medical checks take place at a third party's request, and may also serve the employers' or insurance companies' own interests, does not preclude health protection being regarded as the principal aim of such checks.

38. In *CIG*, the Court confirmed its previous jurisprudence in *d'Ambrumenil* that, even though a medical examination might take place, as the expert report was the principal

purpose of the services supplied, and any therapeutic implications were indirect, the services cannot be regarded as having a therapeutic aim, and were therefore not exempt:

> 27. In the first place, as regards the IC service, it is apparent from the request for a preliminary ruling that it consists, for the doctors of Best Doctors, in reviewing the medical information of the insured natural person on the basis of the documentation sent to them, in order to ascertain whether that person is entitled to the insurance services. In particular, those doctors review, by confirming or invalidating it, the diagnosis initially made by the insured person's doctor, in order to ascertain whether he or she is really suffering from one of the five serious illnesses covered by the insurance contract.
>
> 28. It is the Court's case-law that, where a service consists of making an expert medical report, although the performance of that service solicits the medical skills of the provider and may involve activities which are typical of the medical profession, such as the physical examination of the patient or the analysis of his or her medical history, the principal purpose of such a service is not the protection, including the maintenance or restoration, of the health of the person to whom the report relates. Such a service, whose purpose is to provide a reply to questions set out in the request for the report, is effected in order to enable a third party to take a decision which has legal consequences for the person concerned or other persons (judgments of 20 November 2003, *Unterpertinger*, C-212/01, EU:C:2003:625, paragraph 43, and of 20 November 2003, *D'Ambrumenil and Dispute Resolution Services*, C-307/01, EU:C:2003:627, paragraph 61).
>
> 29 In that regard, the Court has also held that, while it is true that an expert medical report may be requested by the person concerned and may indirectly contribute to the protection of the health of such person, by detecting a new problem or by correcting a previous diagnosis, the principal purpose pursued by every service of that type remains that of fulfilling a legal or contractual condition in another's decision-making process (judgments of 20 November 2003, *Unterpertinger* , C-212/01, EU:C:2003:625, paragraph 43, and of 20 November 2003, *D'Ambrumenil and Dispute Resolution Services* , C-307/01, EU:C:2003:627, paragraph 61).
>
> 30 Thus, and even though, in the context of that IC service, the doctors of Best Doctors may carry out additional examinations, such as histological analyses, or use foreign medical experts, the expert report remains the main purpose of those services, their therapeutic implications being merely indirect, so that those services cannot be regarded as having a therapeutic aim."

39. It is a general principle of VAT law that exemptions are to be construed strictly. Mr Millington submitted that the adoption by the CJEU of a "principal purpose" test is a means of ensuring that the medical exemption is applied strictly. The CJEU expressly refers to this requirement at [52] in its decision in *d'Ambrumenil*. We were also referred to the decision of the CJEU in *Ambulanter Pflegedienst Kugler Gmbh -v- Finanzamt fur Korperschaften I in Berlin* (Case C-141/00) as an example of the strictness of the approach adopted by the Court. In its decision the Court distinguished between care linked to the prevention, diagnosis, or treatment of illness, and general care and domestic help.

40. There are a number of decisions of the FTT relating to the scope of the medical exemption. Although they are not binding upon us, we have regard to them, and as a matter of judicial comity should follow them, unless we are satisfied that they were wrongly decided. The principle of judicial comity was succinctly described by Judge Brown KC in the *Executors of the Estate of Linington and another v HMRC* [2023] UKFTT 89 (TC) at [177]:

> In summary, the principle requires that whilst courts of competent jurisdiction are not bound by the legal conclusions of one another's judgments, such conclusions will be highly persuasive and should be followed unless the second court is convinced that they are wrong. There was some debate as to the meaning of "convinced" (established by the Upper Tribunal to be the same as "satisfied" - see *Gilchrist v The Commissioners for Her Majesty's Revenue and Customs* [2014] UKUT 169 (TCC)), and whether the second court (or Tribunal) must consider them to be "plainly" or "clearly" wrong (as determined in *HMRC v Abdul Noor* [2013] UKUT 71 (TCC)).

41. In *HMRC v Suterwalla* [2024] UKUT 188 the Upper Tribunal stated (at [23]) that

> where a FTT decides not to follow the decision of another FTT on the same or a materially similar point, it should explain why it has taken a contrary view.

42. The issue before the FTT in *Ultralase Medical Aesthetics Ltd v HMRC* [2009] UKFTT 187 concerned the location from which cosmetic procedures were performed, and whether a treatment fell within Item 4 of Group 7 ("Item 4") if it took place in a hospital setting (as distinct from private rooms or a patient's home). The FTT stated at [11]:

> We are satisfied that it is necessary for the appellant to be shown to be providing a service which has as its purpose 'the diagnosis, treatment, and in so far as possible, cure of diseases or health disorders' for the VAT exemption to apply. It would be illogical for the interpretation of medical care in 132(1)(c) to be different to that in 132(1)(b). Cosmetic intervention does not need to be available to the general public 'to ensure that access to such care is not prevented by the increased costs of providing it …' If cosmetic intervention is required in circumstances where it does assist 'health disorders', after a road accident for example, then that assistance should be available in a hospital (through the NHS or privately) and ought properly to be exempt.

43. In *Joan Burke v HMRC* [2009] UKFTT 87, the taxpayer provided laser treatment for the removal of hair. She was not medically qualified, and the Tribunal held that she did not know and was not qualified to find out if her client needed laser treatment for a medical condition. She also failed to establish that medical disorders were the sole cause for variations in hair growth. The FTT dismissed her appeal. The FTT went on to state that:

> Appellant accepted that IPL treatment on its own did not treat or cure the underlying medical problem, if there was one, for excessive hair growth. IPL simply treated the symptom not the cause. The Appellant's admission undermined her case that the IPL treatment was applied for therapeutic purposes. (at [24])

Mr Rivett submits that no wide principle should be drawn from this statement, and we agree. Just because no medical treatment is available to address the cause of the condition (for example, because medical science has not yet advanced to a state where it is able to identify the cause of a particular medical condition – some cancers come to mind), does not mean that treatments that ameliorate the condition cannot benefit from the medical exemption. This is consistent with the jurisprudence of the CJEU, as summarised by the Upper Tribunal in *Mainpay*, where the reference is to the treatment "in so far as possible, curing".

44. In *Skin Rich v HMRC* [2019] UKFTT 514 the FTT considered the VAT liability of "injectables" (Botox and dermal fillers) and laser nail fungus treatment (where the nail fungus treatment was not provided by a registered healthcare professional). There was

evidence before the FTT that injectables are used in some circumstances to treat medical conditions. The FTT held at [96] that where the primary purpose of a client seeking treatment is to treat a medical condition then this may fall within the medical exemption, but with one exception, none of Skin Rich's clients had sought treatment for these reasons. The FTT made reference at [98] to the evidence of Dr Lalani – a dentist who had administered injectables -

> that there are occasions where the client's concern about their appearance affects their confidence and makes them anxious. [Dr Lalani] saw improved confidence and feeling better about yourself as a medical reason for seeking treatment. The decision in *Skatteverket* confirms that the determination of the purpose of intervention by a medical professional may influence our assessment of whether the treatments constitute medical care. Dr Lalani acknowledged that she has not been trained as a psychiatrist, although she has had some training in the psychology of patients, and this does affect the weight which we attach to her conclusions as to the reasons for clients seeking treatments. Furthermore, her evidence that clients are often happier and feel better about themselves after treatment could apply irrespective of the purpose for which treatment is sought.

The FTT considered the scope of "care" for the purposes of Item 4, and held that it was wider in scope than the treatments within the scope of Items 1 and 2. However, as Skin Rich was not state regulated, the conditions for exemption under Item 4 were not all satisfied, and the exemption did not apply. As regards treatment of nail fungus, the absence of expert medical evidence prevented the FTT from making any finding that the treatment was for a medical condition. We consider the FTT's decision in *Skin Rich* in more detail below.

45. *Window to the Womb v HMRC* [2020] UKFTT 201 concerned the supply of ultrasonic scanning services in pregnancy. Not all of the scans provided to clients were "clinically indicated", but the FTT held that the scans provided reassurance to clients and may reduce anxiety. However, the FTT was not satisfied that the services provided a psychological benefit, and held that simply providing reassurance is not sufficient for the service to fall within the scope of medical care. Nonetheless, the FTT held that the services, even if not clinically indicated, fall within the scope of the exemption, as the pregnant woman is herself choosing to monitor her medical condition, and that is her purpose in having the scan. The scans were held by the FTT to have had as their principal purpose the diagnosis or monitoring of medical conditions – even if there was no clinical requirement for such monitoring to take place.

46. The issue before the FTT in *Spectrum Community Health CIC v HMRC* [2022] UKFTT 237 was the provision of health care in prisons. The taxpayer asserted that its supply of prescription drugs was zero rated, and that its supply of non-prescribed sexual health products was taxable at the reduced rate. HMRC asserted that there was a single composite supply within either Item 1 or Item 4. The FTT held that the supplies made by the taxpayer were a single composite supply within Item 1. The FTT held that the exemption under Item 4 did not apply. It found that the taxpayer was not a state-regulated institution, because the reference in Item 4 to an "establishment" or "institution" was to a physical building, and not to an organisation, and prisons were not state-regulated for the provision of medical care.

47. *Epem v HMRC* [2023] UKFTT 627 concerned the removal of benign moles in a clinic which provided various skin treatments. The FTT held that where the mole is benign and is being removed because the client simply does not like it, the treatment is outside the medical exemption: "dissatisfaction with appearance does not automatically mean that the patient has a health disorder" (at [28]). However, the FTT recognised that a benign physical condition might cause psychological problems for a patient, and in such a case, treatment of the

physical condition may form part of the treatment of the psychological condition. But as there was no evidence of any medical assessment by the taxpayer, the FTT held that the treatments did not fall within the medical exemption and were standard rated.

48. *Illuminate Skin Clinics Ltd v HMRC* [2023] UKFTT 547 concerned the supply of services such as Botox and dermal fillers. The FTT held that the treatments were not provided after a diagnosis made following careful investigation of symptoms and history, but rather because the client wanted to use the taxpayer's services. The FTT held that none of the clients had a diagnosis of any recognised health disorder, and that the clinic simply helped people achieve their goals in relation to their appearance.

49. *Aesthetic-Doctor.com Ltd v HMRC* [2024] UKFTT 48 related to a clinic which provided services which included Botox and fillers ([361]), breast surgery, and hair transplants. It was a condition of the clinic's registration with Healthcare Improvement Scotland (the relevant Scottish regulator) that "No Follicular Unit Transplantation (FUT) strip hair transplants will be carried out". The taxpayer asserted that its supplies fell within the medical exemption on the basis of underlying psychological issues suffered by their clients. The FTT acknowledged that if the treatments provided by the taxpayer formed part of the treatment of an underlying psychological condition, then the medical exemption may apply. However, the FTT found that the taxpayer had failed to prove the nature or extent of any psychological issues for any individual patient.

50. *Graham t/a Skin Science v HMRC* [2024] UKFTT 352 was an appeal by an individual nurse prescriber involving the prescription of medicines following an assessment and diagnosis by her. The conditions for which she issued prescriptions included low self-esteem, social isolation, poor body image and anxiety. The taxpayer had no qualifications in psychology (and had never practised in the field of mental health), but her nursing training included a module relating to psychology. She considered that this element of her training as a general nurse qualifies her to make diagnoses "under the umbrella of psychological care". She submitted that her diagnoses were of conditions listed in the World Health Organisation's ("WHO") International Statistical Classification of Diseases or were "Recognised Nursing Diagnoses". Unlike the situation in this appeal, the FTT in *Graham* did not have the benefit of expert medical evidence, and stated that it was unable to understand the diagnoses in context, and was

> unable to conclude from the evidence presented to us that conditions defined by reference to the WHO categorisations or which are Nursing Diagnoses will inevitably be "diseases or health disorders" as contemplated for the purposes of the VAT medical exemption.

The FTT found that the taxpayer had not proved that diagnosing and treating conditions which are psychological was within the scope of her profession as a registered general nurse (notwithstanding that her training included a module on psychology), and that the requirements of Item 1(d) of Group7 were not met. The FTT was also not satisfied that the principal purpose of the treatments given by the taxpayer were therapeutic or that they met a medical need. In its decision the FTT considered the principal purpose test and the decision of the CJEU in *PFC*. It found that "medical treatments provided for purely cosmetic rather than therapeutic reasons cannot be said to have a purpose of providing medical care" (at [69]). It went on to reject (at [71] to [76]) an argument that the principal purpose test does not apply where the services provided are intrinsically medical in nature.

BACKGROUND FACTS

51. The background facts are, for the most part, not in dispute. We find them to be as follows:

AHT

52. AHT is a limited company, trading as "the Farjo Hair Institute", and operating from locations in Manchester and London. AHT was incorporated in 1993 and its directors are Dr Bessam Farjo and Dr Nilofer Farjo. For the avoidance of any doubt, references to “Dr Farjo” are to Dr Bessam Farjo, unless the context requires otherwise.

53. Dr Farjo qualified as a medical practitioner with the Royal College of Surgeons in Ireland in 1988. In 1990 he moved to the UK and registered with the General Medical Council. He spent the next few years training in various surgical fields before undergoing a preceptorship in hair restoration surgery and medicine in Canada in 1992. He started practicing in hair restoration surgery in Manchester through AHT in 1993. AHT added a London clinic in 1994. He joined the International Society of Hair Restoration Surgery (“ISHRS”) in 1993. This is a society based in the USA of doctors who specialise in hair loss treatments and restoration. He has the Fellowship qualification of the ISHRS and was elected its president in 2007 (the first doctor from Europe to be so elected). In 1996, he was one of the co-founders of the British Association of Hair Restoration Surgery. In 2003 he passed the qualification of the only Board certification in hair restoration in the world: the American Board of Hair Restoration Surgery (“ABHRS”), and the qualification was renewed in 2013. In the US health system, each medical and surgical specialty has a post-qualification examination that confers a "Board certification". US medical regulations require this to be renewed every ten years. Dr Farjo has served on the board of directors of the ABHRS and was for many years one of its examiners. Dr Farjo has served on the boards of a number of other organisations relating to hair loss and hair restoration. He has been engaged in both clinical and hair biology research with a number of recognised academic institutions. In 2012 he and Dr Nilofer Farjo were awarded the ISHRS Platinum Follicle Award for "outstanding achievement in basic scientific or clinically-related research in hair pathophysiology or anatomy as it relates to hair restoration", the only time it has ever been awarded to doctors based in the UK.

54. There is no post-qualification examination in the UK for specialisation in hair restoration surgery. The nearest equivalent is the Fellowship of the Royal College of Surgeons in plastic surgery – FRCS (Plas), which is held by Dr Greg Williams, who is the doctor responsible for AHT’s London clinic. Neither Dr Bessam Farjo nor Dr Nilofer Farjo are Fellows of the Royal College of Surgeons.

55. Dr Farjo has no qualification in psychology or psychiatry. Psychology and psychiatry were included in the curriculum that he studied whilst an undergraduate at medical school. The syllabus for the examinations of the American Board of Hair Restoration Surgery includes the psychology of a person with hair loss, and Dr Farjo read up on the materials and textbooks on this subject in preparation for the exams. Dr Farjo’s evidence was that this was intended to enable a hair restoration surgeon to identify a psychological issue within the hair loss patient, but not to actually treat patients with psychological issues. In the event of a patient presenting with some sort of psychological or psychiatric condition, Dr Farjo would refer them to a specialist psychologist or psychiatrist for treatment.

56. All of the doctors working for AHT are registered and regulated by the General Medical Council. They are all members of the Independent Doctors Federation who also act as the Responsible Officer regulating the doctors' annual appraisals and 5-yearly revalidation in accordance with the General Medical Council’s requirements for medical professionals.

57. AHT has been regulated by the Care Quality Commission (“CQC”) since 2010 and by the CQC’s predecessors before that date (the Regional Health Authority when AHT was first

established in 1993, and then the Healthcare Commission). In London it operates from premises in Harley Street, which are also registered with the CQC.

58. Dr Rowland Payne stressed that the process followed by AHT was a "medical model", where there was a "doctor/patient relationship" between AHT and its client. He distinguished this from a "retail model" where an aesthetic practitioner laid out a menu of offerings to its potential customers. In the retail model, the customer perceives him or herself to be healthy and is simply looking for an enhancing treatment, and would prefer not to be regarded as a patient, with its connotations of illness. In contrast, the medical model facilitates the incidental finding of concurrent medically important illnesses and allows time for the doctor to help the patient by either treating other illnesses found during the consultation, or by referring the patient to another specialist. In particular, the retail model does not facilitate consideration of pertinent psychological aspects. This approach to treatment was supported by Dr Farjo's own evidence where he distinguished the treatment provided through AHT from that provided by "commercial clinics" – and that the principal difference from a commercial clinic is that in the case of AHT, it is run by medical staff applying principles of medical ethics and professionalism.

59. Dr Farjo was asked whether patients of AHT consider themselves as having an illness. His response was that his patients do not consider themselves as being ill – but AHT consider that they have an illness which has a hormonal and genetic basis.

Androgenetic alopecia

60. AHT mainly treats hair loss conditions. Hair loss is not a medical condition in itself, rather it may be a symptom of several such conditions which can be broadly classified as patterned and unpatterned alopecia. The condition most often treated by AHT is AGA as this has the highest incidence. The experts, Dr Rowland Payne and Dr Walsh both agree that AGA is a:

> common hereditary, degenerative endocrine (androgen-mediated) disorder characterised by male or female pattern baldness with an important psychological component in some patients

61. Dr Walsh expanded on this in her report as follows:

> AGA is extremely common in the population, affecting up to 96% of men to some extent by the end of life. The original paper to estimate the prevalence of androgenetic alopecia in the population found that 30% of men have a degree of pattern hair loss by the age of 30; by the age of 50, 50% do.

62. During the course of the hearing, the various doctors attending the hearing (experts, appellants and observers) made the comment that almost all the males present in the courtroom (judge, lawyers, witnesses, and observers) exhibited symptoms of AGA to a greater or lesser extent.

63. In WHO's International Statistical Classification of Diseases and Related Health Problems (10th revision: 2019) ("ICD-10"), AGA is coded in Chapter XII under diseases of the skin and subcutaneous tissue as "L64 Androgenetic alopecia incl: male-pattern baldness". Dr Walsh's evidence was that the ICD is now in its 11th revision ("ICD-11"), and AGA is coded in ICD-11 as ED70.0 for male pattern hair loss and ED70.1 for female pattern hair loss. Dr Walsh notes in her report that:

> The ICD is a tool used for recording health data, and generating statistics on disease in primary, secondary and tertiary care, as well as on cause of death certificates.

In the course of her oral evidence she expanded on this statement as follows:

> ICD-10 (now 11) is a manual of diagnoses and the principal purpose of that, as is described on the website […], is to assist statistical comparisons principally between countries of the frequency of diseases. It has certainly been adopted for a secondary purpose, which I assume the WHO had not intended, for the purposes of coding for billing in jurisdictions where medical supplies are generally paid for. So, it was not originally designed, I guess, as a tool for doctors themselves to use when in front of a patient, its scope and purpose was intended to be somewhat larger than that.
>
> […]
>
> I mean we chose to take the definition of disease as disorder of structure or function, which in itself is quite reductive, it is a very simplistic way of looking at it, and I think applying that to something like the menopause would be problematic. Because although it does indicate that in this case the ovaries of not functioning as in a 60-year-old woman as in a 30-year-old, it is a disorder I suppose of function and therefore the term "disease" could be applied to that entity. In ICD-10 there are certainly things that people, including doctors and the general public would consider to be physiological inevitabilities.

64. Dr Walsh's use of statistics was questioned during cross-examination, and she confirmed in her oral evidence that the source of her reference to 96% of men being affected by AGA was a reference to a source that referred to the incidence of AGA amongst white men.

65. The guidelines issued by the EDF state that

> About 50-60% of men are affected by the age of 50 increasing to about 80% by the age of 70 and beyond. Hair loss progresses to a bald scalp (Norwood-Hamilton VI/VII) in 50-60% of men by the age of 70. The prevalence of androgenetic alopecia is reportedly lower and its severity less among Asians, Native Americans and African-Americans compared to the European population. Two studies in Chinese men found a prevalence rate of 10-20% in men aged 40-49, rising to 40-60% in men aged 70 and over.
>
> The frequency and severity of androgenetic alopecia is lower in women than in men but it still affects a sizeable proportion of the population. Two studies in Caucasian women in the UK and USA reported prevalence rates of 3-6% in women aged under 30, increasing to 29-42% in women aged 70 and over. As in men, androgenetic alopecia is less common and appears to start later in life in Asian women although nearly 25% of Korean women over 70 years of age show evidence of hair loss. The prevalence appears lower in Chinese women with 12-15% of women aged 70 and over reported to show hair loss.

66. AHT do not appear to have routinely recorded the ethnicity of their patients in their clinical notes. However, in his evidence Dr Rowland Payne stated that all of the patients included in the case studies were white men. We note that all of the patients in the YouTube videos that we saw were also all white men. Dr Farjo's evidence is that the case studies are a representative sample of AHT's patients and their treatment. We therefore find that AHT's patients are all (or at least an overwhelming majority) white men – and that for white male patients, such as these, AGA is extremely common and forms part of the normal progression of aging.

67. Both Dr Walsh and Dr Rowland Payne agreed that not all conditions to which a classification code has been applied in the ICD would constitute a "disease", as some classifications refer to processes which are physiological, such as menopause (G30.0) or

adolescence (XT7M). Dr Rowland Payne notes that diseases have many different aetiologies, for example, infective, hereditary or degenerative.

68. AGA is characterised by a reduction in size of the affected hair follicles, which is known as miniaturisation. Reduction in the size of the follicle leads to a reduction in the diameter of the hairs they produce – this process is accompanied by (and perhaps caused by) a mild inflammatory reaction, which is itself androgen dependent. Androgens are a type of hormone. The androgen (circulating testosterone) is converted at the follicle into a more active hormone (dihydrotestosterone – DHT) which causes atrophy of follicles that are genetically primed to be affected by DHT.

69. The pattern of hair loss caused by AGA typically affects the front and top of the scalp (being the location of the follicles that are genetically primed to be affected by DHT), leaving a rim of hair around the sides and back of the scalp. The degree of hair loss arising from AGA is graded on the Norwood-Hamilton scale in the case of males. This scale uses the sites, distribution and extent of hair loss to apply a score from I – VII. Type III represents the minimum extent of hair loss sufficient to be considered as baldness. In Dr Walsh's opinion, Types I and II are considered as variants of normal. Whereas in Dr Rowland Payne's opinion, for a patient with AGA, Types I and II should be considered as stages in the progression of AGA, as the patient passes from Types I and II to Type III and beyond.

70. The pattern of hair loss due to AGA in females is different and is assessed on the Ludwig scale. As we have noted above, AGA in women is much less common that AGA in men. The onset of AGA in women can often co-exist with the menopause because of the greater impact of androgenetic hormones, as oestrogens and progesterone diminish.

71. The unchallenged evidence of Dr Rowland Payne was (and we find) that hair has several important physiological and social functions which include photoprotection (protection from ultraviolet light), mechanical protection from minor trauma, thermal insulation, and sexual, social, and religious signalling.

72. In Dr Walsh's opinion, AGA is a condition that does not confer significant physical disability to the individual. A degree of functional impairment may be incurred as a result of hair loss due to AGA with respect to photoprotection, protection from trauma, and thermoregulation (temperature regulation). However, in her opinion these impairments can be easily overcome with use of sunscreens and head coverings. If an individual is suffering psychosocial distress which they attribute to hair loss, her opinion is that there is limited evidence that hair restoration surgery rectifies this. In her opinion, in the vast majority of instances, individuals do not come to physical or psychological harm as a result of AGA.

73. Treatment options for AGA are limited. Medical interventions include topical minoxidil or oral treatment with finasteride. Both interventions may delay hair loss, but do not alter the natural history of the condition, which is when the drug use stops, the condition progresses as it would have done were no treatment taken at all. There is a class action in respect of finasteride where it is claimed that the drug gives rise to sexual dysfunction.

74. In the case of hair transplants in men, follicles are taken from the side and back of the head (as these follicles are the ones least likely to be genetically primed to be affected by DHT) and transplanted to the top and front. However, hair transplant surgery does not alter the natural history of AGA – and although the transplanted follicles will generally survive, hair loss of the non-transplanted follicles at the front and top of the patient's scalp will continue. There is a danger that if a hair transplant is undertaken too early in the progression of AGA, the patient will have a thin line of transplanted hair at the front of his scalp (or small tufts of hair at his temples), whilst the remainder of the scalp gradually becomes bald. Part of

Dr Farjo's practice is engaged in (a) advising patients not to undertake hair transplant surgery too early, and (b) correcting or managing early hair transplants undertaken by other doctors.

75. Hair transplantation does not cause new hair to grow. Rather it moves hair follicles from the back and side of the head to the top and the front. There will therefore be some reduction in the density of hair at the sides and back of the head (although not necessarily noticeable).

The patient care pathway

76. AHT provides medical and surgical treatments for hair loss conditions. It only treats individuals who have made a prior appointment, and they are treated by qualified doctors.

77. The initial contact that most patients will have with AHT will be with a non-doctor patient co-ordinator. They are given the opportunity (without charge) to describe their concerns and invited to make an appointment to see one of AHT's doctors. This initial "triage" stage aims to ensure that doctor appointments are only made for those for whom such an appointment is appropriate. Sometimes it is evident from photographs that the patient needs referral to another specialist and is not appropriate for medical/surgical treatment at AHT. In other cases, it is apparent that it is either too early in the progression of their hair loss, or too late, for intervention and they can be advised against a consultation. This also means that patients for whom AHT can do nothing are not charged for a consultation. The coordinator will also discuss the likely costs of the various treatment options. The coordinator may also recommend that specified blood tests are done by the patient's GP before their appointment with one of AHT's doctors. In some cases, one of AHT's doctors may take a brief "look" at the patient at the triage appointment.

78. Some patients are referred to AHT by another doctor, and in those cases, where the other doctor has written to AHT with the patient's background, the triage stage can be skipped.

79. Prior to the appointment with the doctor, the patient will complete a medical history form, and at the appointment (which usually lasts about 45 minutes) the doctor will ask about the patient's medical history as well as making an examination of the patient's scalp. Five or ten minutes would be spent discussing the impact the patient's hair loss has had on him. The doctor will then make a diagnosis – there may be one or multiple diagnoses for the same patient. Where the diagnosis is unclear, further investigations may be necessary.

80. Complex cases may require a case conference with the wider clinical team or referral outside the practice to an expert team.

81. A treatment plan will follow from the diagnosis, and the patient will be advised of the likely cost and – in the case of surgical treatments – the length of time (this will take account of the number of follicles that will need to be transferred and whether there is a need for multiple surgeries).

82. A "no treatment" plan may be appropriate if the patient has an underlying condition that precludes treatment or a diagnosis that will make the condition worse if surgery is attempted, or a condition where surgery would fail. Illness, trauma, or surgery could be an explanation for temporary hair loss – for example weight gain could be explained by a thyroid problem, which would be associated with hair loss. In these cases, the requirement is to treat the underlying cause, rather than the hair loss.

83. A "medical only" treatment plan could include the use of licenced medicines (such as minoxidil and finasteride), low level laser or photobiomodulation, platelet rich plasma ("PRP"), and other therapies. A "no treatment" or "medical only" plan can evolve over time, so patients are encouraged to have regular follow-up appointments, as hair loss is an ongoing

process. Medicines are known to stop working in some patients after several years of use. In those cases (and in cases where there has been poor compliance by a patient in taking medicines) the patient and doctor may decide to switch to the surgical pathway. Dr Farjo's evidence was that even surgical treatments are not a "one off".

84. In the case of surgical treatment plans, this might be preceded by a medical phase. In some cases, this would be in order to prevent hair loss in an area that is not going to be treated by surgery (for example, if a patient is having surgery on a bald forelock but there is early thinning or a family history of crown alopecia). In other cases, surgical treatment could be compromised if there was not a preceding medical phase (for example, shock loss (*telogen effluvium*) can occur to thinning hairs near to the surgical recipient area. These hairs can be temporarily lost after surgery, and this can be prevented through the use of medicines prior to surgery).

85. As regards the surgery, the procedure normally utilised by Dr Farjo is follicular unit excision ("FUE") which is a technique of harvesting individual hair follicles. Another technique, but Dr Farjo told us was now uncommon, was follicular transplantation ("FUT"), which involves removing a piece of skin from the back and sides of the scalp, which is then cut down into smaller pieces and stitched together. The patient will end up with a scar that is like a line. PRP is often used as a surgery adjunct, as this aids healing, stimulates growth, and prevents shock loss.

86. On the morning of the surgery, the doctor will undertake a further examination of the patient and will draw the surgery plan on the patient's head. There would be no detailed psychological discussion with the patient on the day of the surgery. Photographs are taken. The patient is then prepared for surgery and a set of medications (including sedatives) are delivered. The patient's head is shaved and hair washed with an antiseptic shampoo. The doctor will inject local anaesthetic into the patient's scalp, and the patient will then be turned around to lie face down. The individual follicles are extracted one at a time using a tool that looks like a hollow drill bit. As this is less than 1mm in diameter, the operation is conducted using high magnification. Because the process of removing follicles is very intensive, AHT will typically have two doctors operating, taking turns. After two hours, the patient is turned to lie on his back, and the part of the scalp where the follicles are to be transplanted is numbed. Needle pricks are made in the scalp for the reception of the transplanted follicles. The doctors work with a team of nurses and technicians – so for example, a nurse will pick up hairs removed from the back of the scalp and put them in pots. The nurse will later insert the hair grafts into the holes that the doctor will have made to receive the transplanted follicle. It is important that there is a seamless process because of the need to control the time the follicle is out of the body, and if they are outside for too long, they could fail to regrow.

87. During the course of the day, there will be comfort breaks and a break for lunch. At the end of the operation, the patient is cleaned and given drinks. They are given post-operative instructions and told what to expect for the next couple of weeks, and given an emergency contact number for the doctor that operated.

88. The doctor will call the patient after two or three days to make sure that he is alright, and a further contact is made a week or two later. It is the hair root that is transplanted, and it takes three to four months before the new hair generated by the root grows through. The first review consultation occurs seven or eight months after the operation, and a final review occurs after 13 or 14 months.

89. Patients are, as noted above, followed-up in person as well as over the phone. If complications arise, these can usually be resolved either by giving advice remotely or by asking the patient to attend for an “in person” appointment as soon as possible. Dr Farjo has

contacts around the UK and internationally, and if the patient prefers, he or she can be referred to a doctor local to the patient to liaise with Dr Farjo when dealing with the complication.

90. Dr Farjo also discussed the use of micro-pigmentation – which is a form of tattooing that gives the impression of a hair follicle. In circumstances where AHT can undertake a hair transplant, but it will be "see through" because a transplant cannot achieve sufficient hair density, he might recommend supplementing the surgery with micro-pigmentation which can give the illusion that the patient's hair is fuller than that which can be achieved by a transplant alone. AHT does not provide micro-pigmentation treatment, and refers patients to another practitioner.

Case studies

91. Included in the evidence were ten case studies. These were the anonymised records representing patients treated by AHT over a two-week period in March 2021 for which AHT had a complete set of medical notes. Dr Farjo's evidence was that this was a representative sample of patients treated by AHT. The case studies were reviewed by both Dr Rowland Payne and Dr Walsh.

92. AHT uses a computerised system of patient records. Some of the patient records take the form of standardised computerised check lists. Dr Farjo explained that the doctor completing the record may have a drop-down list or yes/no options for some of the items on the list, and free text entry for other items (such as a description of the impact of hair loss on the patient). In the case of some patients, the computerised notes are supplemented by manuscript notes and check lists completed in manuscript.

93. Included in the case studies were COVID risk assessments, patient consent records, and copies of correspondence with the patient and the referring doctor or the patient's GP. Also included were operation checklists and care plans and operation notes. In the case of some of the records, a chart of the patient's scalp was included showing the extent of the patient's hair loss, the number of follicles to be transplanted, and the location of the donor sites and the transplant locations.

94. It was striking that in the case of many of the patient notes, no formal diagnosis of AGA was recorded. The evidence of both Dr Farjo and Dr Rowland Payne was that recording such diagnosis served no purpose, as it would be obvious that this was the reason for the hair loss. Dr Farjo's evidence was that at some point AHT amended its checklists to include a record formally diagnosing AGA. This change was undertaken as a response to HMRC questioning whether the treatments provided by AHT were in respect of a medical condition. Dr Walsh's evidence was that the primary purpose of the consultations described in the case studies was not diagnostic, as it would have been apparent to a primary care doctor, and to the patient themselves, that the diagnosis was AGA. Confirmation of this diagnosis would be obtained at the consultation with AHT, in order to ensure an alternative condition such as a scarring alopecia (not amenable to hair restoration surgery) was not present, but in the overwhelming majority of cases the patient would already have been aware of the diagnosis of AGA.

95. Dr Walsh assessed the degree of hair loss for each of the case studies using the Norwood-Hamilton scale on the basis of the photographs included in the evidence.

Patient 1

96. Male 45 years old. HIV positive. Norwood-Hamilton grade as assessed by Dr Walsh: Type IV.

97. The cited impact of hair loss recorded in the patient notes was social and psychological stress

Patient 2

98. Male 35 years old. Norwood-Hamilton grade as assessed by Dr Walsh: Type III (vertex)

99. No impact of hair loss was included in the patient notes.

Patient 3

100. Male 35 years old. HIV positive. Norwood-Hamilton grade as assessed by Dr Walsh: Type III/Type III (vertex).

101. The cited impact of hair loss recorded in the patient notes was that the patient "feels very self-conscious and blames 'vanity' – keen on subtle and natural restoration".

Patient 4

102. Male 40 years old. Norwood-Hamilton grade as assessed by Dr Walsh: Type III/Type III (vertex).

103. The cited impact of hair loss recorded in the patient notes was that the patient is "normally confident but hair loss affects outlook".

Patient 5

104. Male 40 years old. Norwood-Hamilton grade as assessed by Dr Walsh: Type II.

105. The cited impact of hair loss recorded in the patient notes was that the hair loss "bothers him significantly and takes great interest especially as he is a hairdresser".

Patient 6

106. Male 67 years old. There are no photographs in the evidence, so Dr Walsh was unable to grade the hair loss.

107. The cited impact of hair loss recorded in the patient notes was that the hair loss "affects confidence".

108. After the hair transplant the patient wrote to Dr Farjo confirming his "total and utter satisfaction" with the service received from Dr Farjo and AHT's staff.

Patient 7

109. Male 46 years old. Norwood-Hamilton grade as assessed by Dr Walsh: Type Va.

110. No impact of the hair loss is cited in the patient notes.

Patient 8

111. Male 49 years old. Norwood-Hamilton grade as assessed by Dr Walsh: Type IVi/VII.

112. No impact of the hair loss is cited in the patient notes.

113. Dr Rowland Payne notes that the patient attended on three occasions for hair transplantation, on 23 November 2012, 26 March 2014 and 26 March 2021. All procedures were conducted at one of AHT's facilities.

Patient 9

114. Male 48 years old. There are no photographs in the evidence, so Dr Walsh was unable to grade the hair loss.

115. The cited impact of hair loss recorded in the patient notes was that the hair loss "affects confidence and social interaction".

Patient 10

116. Male 48 years old. Norwood-Hamilton grade as assessed by Dr Walsh: Type III.

117. The cited impact of hair loss recorded in the patient notes was that the hair loss affects "confidence and social concerns".

Generally

118. Both Dr Rowland Payne and Dr Walsh were satisfied that the patient records for each of the case studies was for an individual with AGA. There was sufficient evidence to satisfy them that each patient suffered from the physical aspects of AGA but from no other physical harm consequent upon AGA. They both agree that there can be no doubt that the hair transplant procedures undertaken by AHT in these cases were intended to treat hair loss brought about by AGA.

119. Dr Walsh notes that pre-treatment clinical photographs were available for eight of the ten patients, constituting an objective assessment of the extent of hair loss. The notes did not include any application of an objective scoring system (such as the Norwood-Hamilton system) which would have allowed the recording of the extent of hair loss even in the absence of photographs, as was the case for two of the ten patients.

120. Dr Rowland Payne confirmed that none of the case study files contained a diagnosis of a psychiatric disorder or psychological syndromes, and that it was not his opinion that hair transplant surgery was being undertaken as a treatment for a psychiatric disorder or a psychological syndrome. However, he noted that in three of the files there was a record of impaired self-confidence, and social concerns and stress in another three. In his view, it is likely that hair transplant surgery would have improved these patients' psychosocial concerns, in particular their social and mental wellbeing – which would be an improvement in their overall health (according to the WHO definition of health – see below). His evidence was that in each of the ten case studies the hair transplant helped to restore the health of the patient and protect their skin from photodamage, minor trauma and thermal insult as well as to improve the psychological wellbeing of at least the majority of the patients. In his opinion, in at least seven of the ten patients, it is likely that there would have been some benefit to the health of the patient from the treatment.

121. Dr Walsh's evidence was that in none of the ten cases was there any citation of previous psychiatric conditions such as depression or anxiety, suicidal ideation or self-harm. None of the cases cited problems with thermoregulation or sun protection as factors which led the patients to consider treatment. Where recorded, the motivation of the patients related to self-confidence or appearance, rather than physical impairment. Although Dr Rowland Payne stated that hair loss impairs the functions of hair covering on the scalp, such as photoprotection, mechanical protection from trauma, and thermal insulation, Dr Walsh's evidence was that none of the cases cited any of these physical reasons for seeking hair transplantation.

122. Dr Rowland Payne's evidence was that AGA was associated with psychiatric comorbidities – in other words hair loss may provoke or trigger a state of anxiety and depression. We were referred to the guidelines published by the EDF which stated that:

> Today, in our societies, hair is an important feature of image: strong and dense hair is associated with youth, beauty, healthiness and success. Consequently, in patients presenting with AGA, progressive thinning of hair often causes a psychological distress

123. However, Dr Walsh's view was that no such psychiatric comorbidities were declared in any of the case studies and that while the motivation for seeking treatment in each of the case

studies provided appears to be a desire to have increased self-confidence, and confidence in social settings, in Dr Walsh's opinion, these do not obviously appear to amount to social phobia or anxiety.

124. Dr Walsh's evidence was that within the NHS it is common practice to apply one or more objective scoring systems to a particular disease and record the results in the clinical notes as a record of the severity of the condition. The purpose of using these scoring systems is two-fold: firstly, they provide an important record of the disease and its impact at baseline, such that any similarly qualified clinician seeing the patient subsequently could interpret the clinical state at the last consultation. Secondly, whenever a treatment is instituted, it allows a clear and objective demonstration of the impact of treatment in both physical and mental domains. Dr Walsh gave as an example in the case of psoriasis the PASI – Psoriasis Area and Severity Index – which is routinely used to measure extent and severity of psoriasis. In good practice a score which measures the psychological impact of the condition on the patient's day to day functioning and well-being would also be recorded, in the case of psoriasis, most commonly the DLQI (Dermatology Life Quality Index). She noted that AHT did not utilise any objective psychological scoring system (such as the Generalised Anxiety and Depression (GAD7) score, the Patient Health Questionnaire (PHQ9) or the Social Phobia Severity Scale) before and after treatment. It was therefore not possible to discern the extent of these features, if present at all, or whether treatment had any positive psychological impact. Dr Walsh's opinion was that it was necessary to apply, in so far as is possible, objective measures to consider the psychological impact of an intervention, and that it was not enough to say that "this is my impression having spoken to someone for 45 minutes". Rather, it was necessary to be able to demonstrate in some kind of reproducible way those things both before and after the intervention. The only assessment in the clinical notes of the psychological or psychiatric state of the patients was a "free text" field with a subjective assessment. As an objective assessment was key component of the medical therapeutic model and was not routinely applied by AHT, it was her opinion that the provision of hair restoration surgery by AHT constituted a cosmetic, and not a medical, intervention.

125. Dr Rowland Payne's opinion was that objective scoring systems are appropriate in the context of research and for organisations where many different doctors may see a particular patient on successive visits (such as in the NHS), but they are otiose in the context of private practice (such as AHT) where there is both plenty of time for consultations and continuity of care by doctors.

YouTube videos

126. In addition to the case studies, we looked at four of the videos available on AHT's own website and which are also published on AHT's YouTube channel. We also saw photographs of a number of AHT's patients which appeared on the website.

127. The videos and photographs are available to be viewed by members of the public. The individuals appearing in those videos and photographs are not parties to this appeal and did not appear before us as witnesses. We have been asked by both AHT and HMRC not to say anything in this decision which could identify the patients whose videos and photographs we saw. We appreciate the reasons for this request, and in consequence have decided not to give a detailed description of the videos and photographs, as this would enable the patients to be identified.

128. What we can say is that in the case of each of the four videos we saw:

(1) The subject of the video had been a patient of AHT and was a white man;

(2) The subject was clearly very conscious of his receding hairline;

(3) In two of the four videos, the subject expressed concerned about the impression that his hair loss had on his own clients or his family;

(4) In no case did the subject refer to problems with thermoregulation or sun protection as factors which led the subject to consider treatment; and

(5) The subject was pleased that he had had a hair transplant and was satisfied with the results.

Other patients

129. For completeness, we mention that we were taken to photographs, documents and correspondence in the evidence bundles and on AHT's website relating to other patients. We refer to the following three patients of AHT in particular:

(a) One patient had a congenital bulbosity at the front of their head, and had undergone major plastic surgery to his skull to correct this. Further remodelling of the patient's forehead was undertaken at a major London teaching hospital, and although there was an improvement, it had not achieved everything the patient would like. The plastic surgeon who had undertaken the further remodelling was concerned that any more plastic surgery might weaken the patient's skull. The plastic surgeon therefore referred the patient to AHT as a hair transplant to lower the hairline might be appropriate to disguise the bulbosity.

(b) One patient was undergoing male to female gender reassignment, and wanted their hairline to be changed to take on a female appearance.

(c) Another patient had suffered hair loss as a result of radiotherapy treatment for cancer. The patient had suffered hair loss in the area of their scalp through which the radiotherapy beam had been aimed, and hair transplantation was undertaken to cover the bald patch with transplanted hair follicles.

Expert evidence

130. Dr Rowland Payne and Dr Walsh were asked to consider the meaning of "diagnosis, treatment, and, in so far as possible, the cure of a disease or health disorder, or the protection, maintenance or restoration of human health."

131. They both agreed that the terms "protection" and "maintenance" of human health were not applicable to the treatment of AGA.

132. Dr Rowland Payne and Dr Walsh were able to reach agreement on the meanings of the following terms:

(a) Disease: Disorder of structure or function affecting part of all of an organism.

(b) Illness: Disorder of structure of function affecting part or all of an organism.

(c) Cosmetic (adj): Pertaining to the improvement of appearance.

(d) Medical: Pertaining to the science or practice of medicine or surgery.

(e) Treatment: Actions performed to relieve disease.

133. In the light of the agreed definition of "disease", both Dr Walsh and Dr Rowland Payne agreed that AGA was a disease in so far as it is a disorder of the structure of the skin and the scalp. Both experts made the point that this broad definition of "disease" would include some of the natural processes of aging.

134. In considering the application of these terms to the evidence in the case studies, the experts agreed on the following:

(a) The diagnosis of a disease or health disorder: Evidence exists in the ten case study case notes that the consultations were designed to establish the diagnosis of AGA and the patient's suitability for hair transplant treatment.

(b) The prevention of a disease or health disorder: No evidence.

(c) The treatment of a disease or health disorder: Evidence exists in the case notes that the consultations served the purpose of preparing the patient for hair transplant which is a treatment of disease or health disorder.

(d) The cure of a disease or health disorder: The answer to this depends upon the definition of the word cure. Using the definition "relief of a disease or its symptoms or signs", the term "cure" does apply. But in the context of its usual medical usage, "cure" carries an implication of permanence, and in this sense, "cure" does not apply to the treatment of AGA. Dr Rowland Payne contends that the supplies made by AHT had as their purpose, or one of their purposes, the diagnosis, treatment, and, insofar as possible, the cure (in its wider sense) of a disease or health disorder or the protection, maintenance or restoration of human health. However, Dr Walsh contends that while the supplies had as their purpose, or one of their purposes, the diagnosis and treatment of a health disorder, the supplies could not be said to "cure" the condition, in the sense that the effects of the treatment are not permanent.

135. Both Dr Rowland Payne and Dr Walsh agree that the hair transplant procedures undertaken by AHT constitute cosmetic procedures. Dr Rowland Payne is of the view that these are the provision of "medical care", whereas Dr Walsh is of the view that the provision is solely cosmetic.

136. Dr Walsh's evidence was that hair transplantation is not a "cure" for AGA. The natural history following transplantation is for regression over time to the density of hair prior to transplantation. The largest reported uncontrolled study to document long-term follow up following hair transplantation showed that after four years, more than 91% of patients had experienced a reduction in the hair density recorded post-transplantation: in other words, further hair loss. This is consistent with Dr Rowland Payne and Dr Farjo's evidence that patients are warned of the progressive nature of AGA and further rounds of transplant surgery may be required as the AGA progresses – as was the case for one of the patients whose notes were included in the case studies.

137. Dr Rowland Payne is of the view that while transplantation surgery may not be a permanent cure of AGA, it can be a cure for the visible consequences of AGA, as transplanted hair does not suffer from AGA, it having been transplanted from those parts of the scalp that do not suffer from AGA.

138. We find that for the purposes of the VAT exemption for medical interventions, "cure" carries an implication of permanence. We reach this finding on the basis of the decision of the CJEU in *D v W (Österreichischer Bundesschatz intervening)* where the Court at [18] qualifies the term "curing" with the phrase "in so far as possible": "in so far as possible, curing diseases or health disorders". If the term "cure" did not mean a permanent cure of the condition, there would have been no need for the court to qualify "curing" by "in so far as possible" to cover circumstances where treatment did not provide a permanent cure. We note that the same phraseology was used by the CJEU in *Kügler* at [38].

139. Mr Rivett submits that the transplanted follicles have a degree of permanency, and as such, they provide a "cure" to the atrophied follicles that they replace. However, we find that hair transplantation is not a "cure" for tax purposes, as hair loss is likely to continue in those parts of the scalp that do suffer from AGA, and – as Dr Rowland Payne and Dr Farjo acknowledge – further rounds of transplant surgery are often required. The evidence shows that hair transplantation does not provide a permanent cessation to hair loss from AGA. We therefore find that the supplies made by AHT cannot be said to "cure" AGA, although we find that AHT's supplies treat AGA.

140. Both Dr Rowland Payne and Dr Walsh agreed that head hair has physiological and social functions, including photoprotection, mechanical protection from minor trauma, thermal insulation, and social and religious signalling.

141. Dr Rowland Payne also referred us to studies showing that AGA is associated with metabolic syndrome, enhanced susceptibility to hypertension, hyperlipidaemia, coronary heart disease, prostate cancer and other outcomes. However, his report included no evidence that treatment for hair loss would reduce the incidence of any of these conditions.

142. Dr Rowland Payne also stated that there were psychosexual and employment consequences to AGA, and cited research papers stating that bald men had fewer lifetime sexual partners than non-bald men, and obtained fewer interviews when applying for jobs. It is unclear from Dr Rowland Payne's report whether he considers that having fewer lifetime sexual partners is a positive or negative impact of balding. One difficulty we had with Dr Rowland Payne's report is that only a limited number of the research papers that he cited were included in the hearing bundle. Only one of the annexed papers included any reference to the psychosexual effects of balding (an article in the British Medical Journal ("BMJ") by Dr R Sinclair in 1998) and it appears that the evidence is anecdotal – and the paper went on to state that "Nevertheless, most men deal with their hair loss without it impairing their psychosocial functioning". Dr Rowland Payne cited a research paper written by Dr Fang Liu et all (2019) on the "relationship between self-esteem and hair transplantation satisfaction in male androgenetic alopecia patients". This was written by researchers based at Nanfang Hospital and the Kafuring Hair Transplant Hospital in China and was undertaken in relation to patients undergoing hair transplantation at those two facilities. Dr Walsh's evidence was that this study was of high quality, but that there were differences in the pattern of AGA in Asian men, and there would be social and cultural differences as well, and she was unable to assess the extent to which the conclusions in this paper were relevant to the kinds of patients that would present themselves in London or Manchester. Given the differences between Chinese and European/North American cultures, and the significantly lower prevalence of AGA amongst Chinese men compared with Caucasian men, we find that the conclusions made in this paper in relation to Chinese patients cannot be relied upon in relation to patients in Europe and North America.

143. The evidence of Dr Walsh was that in the vast majority instances, individuals do not come to physical or psychological harm as a result of AGA, and cited Dr Sinclair's article in the BMJ in support. (Dr Rowland Payne criticised Dr Walsh for the use of "vast"). A degree of functional impairment may be incurred with respect to photoprotection (protection from ultraviolet light), protection from trauma, thermoregulation (temperature regulation). However, in her opinion these impairments can be easily overcome with use of sunscreens and head coverings.

144. Dr Walsh stated that a degree of dissatisfaction with body image can result from hair loss, particularly where this occurs at a young age or the extent of hair loss in particularly great. Very rarely an individual may present with a condition known as Body Dysmorphic

Disorder ("BDD") relating to actual or perceived hair loss. BDD describes excessive concern about a perceived or marginal defect in physical image leading to thoughts or actions which create distress, and accompanied by social or functional impairment of routine life. While there is some evidence that hair transplant may improve BDD severity, where the BDD is mild, and associated with a specific body feature, cosmetic interventions can also have the catastrophic effect of worsening BDD, with dissatisfaction worsening post-operatively, or indeed transferred to another point of fixation. If an individual is suffering psychosocial distress which they attribute to hair loss, any evidence that hair restoration surgery rectifies this is limited. None of the patients that were included in the case studies suffered from BDD.

145. Dr Rowland Payne's evidence included reference to psychological considerations in patients seeking treatment for hair loss - the psychological factors that drive patients to request treatment. His evidence was that doctors treating hair loss must consider psychological concerns and ensure that they are managed. In his view many men and most women suffering from AGA, when questioned, suffer psychologically from the disorder of AGA. His evidence included reference to BDD, however this was in the context of cosmetic rhinoplasty (nose), laser therapy and some other treatments, and not AGA.

146. Dr Walsh was critical of the psychological assessments made by AHT which were included in the medical notes for the ten case studies. There was no quantitative assessment of the psychological or psychiatric state of the patients, and it seemed to her to be very subjective.

147. Dr Walsh was closely cross-examined by Mr Rivett on her opinions and the sources of the evidence on which her opinions were based. In particular she was referred to Dr Sinclair's article in the BMJ, and the EDF guidelines on the treatment of AGA published in the Journal of the European Academy of Dermatology and Venereology ("JEADV"). Dr Walsh had not referred to the EDF Guidelines in her original report, even though she considers that the JEADV is one of her "go to" journals and she is listed as one of the five associate editors. Dr Walsh's evidence was that Dr Sinclair's article was written for an audience comprising largely doctors in general practice in the UK, whereas the EDF's guidelines were written for an audience of specialist dermatologists practising throughout Europe. We agree with her evidence that it is therefore difficult to compare and contrast the information contained in these documents as they have different purposes and different intended audiences. Dr Walsh distinguished between the European Academy of Dermatology and Venereology (the publisher of the JEADV) and the EDF. The EDF comprises representatives from each of the national dermatological organisations in Europe (so, for example, the British Association of Dermatologists would be represented in the EDF) - it is a grouping together of national representatives from the dermatology speciality which meets two or three times a year. Dr Walsh described the EDF as having as "one of its self-assumed functions" the provision of guidelines. Dr Walsh was critical of the basis on which the EDF guidelines were compiled, and contrasted them with the methodology adopted by the UK's National Institute for Health and Care Excellence ("NICE") when drawing up its guidelines. In her view the standards for the evidence that NICE include in their assessments and the granularity they go into is greater than that applied by EDF. Dr Walsh criticised the approach taken by the EDF in formulating its guidelines as follows:

> It certainly represents a range of opinion from across different jurisdictions geographically. The limitation of the way they formulate guidelines in the EDF is that it will be a culmination of a very small representation, albeit a respected representation from the individual country. Whether that represents the opinion and practice of a larger group of people is uncertain. So, as I say, the methodology is not rigorous enough to say that this will be

> something that all practising dermatologists or plastic surgeons in the United Kingdom would rely upon.

148. Dr Walsh considered the methodology adopted by the EDF to be less rigorous than the methodology used by the British Association of Dermatologists or NICE. However, as there are no guidelines on the treatment of AGA produced either by NICE or by the British Association of Dermatologists, Dr Walsh acknowledged that the EDF guidelines were the best available guidelines for the treatment of AGA.

149. Dr Walsh's evidence was that when you write a document - such as the EDF guidelines - with this number of authors, it is usual that some people will make concessions to others in order to get the document finished. When cross-examined about the detail contained in the guidelines she said:

> if you took out every single sentence individually from this guideline and put it in front of every single one of the 100 people, I would say that there would certainly be dissent.

150. We note that the EDF subcommittee responsible for developing the guidelines was composed exclusively of dermatologists, and the authors did not include psychologists or psychiatrists. For this reason, we place less weight on its statements relating to the impact of AGA on mental health, than we do in relation to its statements about the treatment of AGA.

151. There was a difference of opinion between Dr Walsh and Dr Farjo about a paper produced by NICE titled "Male pattern hair loss (male androgenetic alopecia)". Dr Farjo referred to this paper as being "guidelines". Dr Walsh's evidence was that NICE produced different kinds of publications for clinical consumption: technology appraisals, quality standards, clinical knowledge summaries, NICE guidelines and clinical guidelines, and that each of them has a slightly different purpose. We agree with her evidence that the NICE publication on AGA is a clinical knowledge summary ("CKS") which is a synthesis of available information that is intended for primary care practitioners. In contrast the intended audience for NICE guidelines (and the EDF guidelines) are specialists.

152. Dr Walsh was referred to the following paragraph included in the introduction to the "short" version of the EDF guidelines:

> Today, in our societies, hair is an important feature of image: strong and dense hair is associated with youth, beauty, healthiness and success. Consequently, in patients presenting with AGA, progressive thinning of hair often causes a psychological distress.

153. We would observe that in the full version of the EDF guidelines, the corresponding paragraph in the introduction is more nuanced:

> Age- and gender-independent, androgenetic alopecia may be associated with significant impairment in quality of life. Hair is an important feature of image. Hair loss affects self-esteem, personal attractiveness and may lead to depression and other negative effects of life. Androgenetic alopecia can be a burden for both sexes, but it is substantially more distressing for women.

154. Mr Rivett put it to her that whatever might be the case with people who do not present to doctors, amongst those who do go to see a doctor with androgenetic alopecia, they are likely to have suffered psychological distress. Dr Walsh disagreed saying:

> I am not sure I could say "likely" because I do not have any evidence to show that. I think it is an extremely dangerous precedent to set, to pathologize things that happen normally. I think the sentence they have before, "In our societies, hair is an important feature of image; strong and

> dense hair is associated with youth, beauty, healthiness and success", I think we need to be quite careful about buying into that concept and that is opinion that they have stated there. I appreciate that Dr Rowland Payne had some evidence to back that up, but it does not dissuade me from my opinion that pathologizing that which is usual is quite a dangerous path to take.

155. Mr Rivett noted that the guidelines had been approved by some 100 eminent dermatologists. Dr Walsh's response was that just because a particular individual signed his or her name to the guidelines does not necessarily mean that they agree with every statement included in the guidelines:

> I am saying that when you write a document with this number of authors, it is usual that some people will make concessions to others in order to get the document finished. In practice, that is what happens. In theory, yes, they should all be in agreement. However, just looking at the list of authors from this, they do not, for example, have any representation of psychiatry on the guideline panel. It is multi-stakeholder, but multi-stakeholder within the world of dermatology rather than multi-stakeholder in terms of all the other people who might have some input into this. That is what I was saying earlier when I was saying that given this is the only set of guidelines, that is what I was able to identify, but it would not be my preferred source for guidelines.

156. For the reasons we have given above, we have placed less weight on the content of these introductory paragraphs to the guidelines than the weight we have placed on the sections dealing with treatment.

157. Dr Walsh was closely cross examined on her opinion that hair transplantation was not a "cure" for AGA, and her evidence was contrasted with the EDF guidelines which stated:

> Hair transplantation in suitable candidates with a good donor hair supply performed by a skilled team of a surgeon and several assistants can permanently improve androgenetic alopecia by up to 3 stages on the Norwood-Hamilton scale.

158. Dr Walsh's view was that this statement referred to hair transplant surgery combined with some ongoing treatment (such as finasteride), and that would not fit with her concept of a cure. Whilst transplant surgery in combination with ongoing minoxidil or finasteride might permanently improve the symptoms of AGA, that did not amount to a "cure".

DISCUSSION

159. Both AHT and HMRC agree on the following principles as regards the meaning and application of the term "medical care" for the purposes of VAT, and Item 1 in particular.

(1) There is no statutory definition of "medical care". Its meaning has to be taken from the jurisprudence of the CJEU in relation to Article 132 PVD, but which has also been applied in domestic law.

(2) The "provision of medical care" excludes medical interventions carried out for a purpose other than that of diagnosing, treating and, in so far as possible, curing diseases or health disorders (*D v W* at [18])

(3) "Medical care" is to be considered at a high level of abstraction, and so medical interventions undertaken for prophylactic purposes may benefit from the VAT exemption (*Kügler* cited in *d'Ambrumenil* at [58]).

(4) Health problems within the scope of VAT exempt interventions include psychological matters (*Dornier* cited in *PFC* at [33])

160. The applicable VAT exemption in this case relates to the provision of "medical care", and the authorities provide that the exemption is intended to apply to services whose purpose is for "diagnosing, treating or curing diseases or health disorders, or to protect, maintain or restore human health". We therefore need to consider whether the services provided by AHT diagnosed, treated, or cured a disease, or protected, maintained, or restored human health. In doing so, we need to address whether AGA is a "disease" and whether AHT's treatments protected, maintained or restored the "health" of its patients.

Is AGA a disease?

161. Both Dr Rowland Payne and Dr Walsh take a broad view of the meaning of "health". Dr Rowland Payne referred us to the definition used by the WHO as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity". Dr Walsh also adopted this holistic definition of health as including social factors (although she qualified this by saying that this had to be measured objectively, and could not be adduced on the basis of an impression given after speaking to a patient for 45 minutes). Both experts were also able to agree on the meaning of "disease" as being a "disorder of structure or function affecting part of all of an organism".

162. The difficulty we face with both of these definitions is that they are given from the perspective of persons engaged in medical practice, rather than the meaning that they take in normal English usage. We consider that the terms "disease" and "health" as used by the CJEU were intended to take their ordinary and natural meaning, rather than having a special meaning adopted in the course of specialist medical practice. Such a medical approach to defining "disease" and "health" does not necessarily apply for the purpose of construing VAT legislation – particularly in the context of a VAT exemption, where the scope of an exemption has to be considered restrictively.

163. The concept of "medical care" in the context of VAT exemption is restricted to the diagnosis, treatment, and (so far as possible) the cure of diseases or health disorders. An interpretation which includes medical interventions carried out for a purpose other than those is outside the scope of the meaning of "medical care". It certainly does not extend to social well-being. Although we can understand why, from the perspective of the World Health Organisation, availability of, for example, clean water and sanitation is relevant to an assessment of health, we do not consider that these are relevant to whether a condition is a "medical condition" for the purposes of VAT. The activities of Water Aid, which provides clean water, decent toilets, and good hygiene around the world would not, in our opinion, amount to the provision of medical care, even if these activities would contribute to human health within the definition adopted by WHO. We find that neither the CJEU nor the UK courts had in mind the very wide and holistic approach to the definition of health adopted by the WHO when they use the term "health" in their decisions.

164. We also have doubts that the CJEU and the UK courts would consider that something that happens normally and usually can be regarded as a "disease" for VAT purposes. In particular, as Dr Walsh stated in her evidence, it may be dangerous to "pathologize things that happen normally". We note her evidence that the definition they have adopted for "disease" is "quite reductive" and applying it, for example, to the menopause, would be problematic. Her evidence was that the WHO classifications of disease included things that doctors and the general public would consider to be physiological inevitabilities. However, neither party submitted that a definition other than that given by the experts should be applied, and we had no evidence (for example from the Oxford English Dictionary) of the meaning of "disease" adopted in ordinary and natural English usage. In these circumstances we, reluctantly, adopt the meaning of "disease" agreed by the experts, and find that AGA is a "disease".

Is AHT treating a disease?

165. Although the experts disagreed as to whether the services provided by AHT included the diagnosis of AGA or cured AGA, they both agreed that the supply of hair transplant surgery "treated" AGA. In their joint report they stated that

> The experts agree that there can be no doubt that the hair transplant procedures were intended to treat the physical aspects of disease brought about by AGA

And

> The experts agree that there can be no doubt that the hair transplant procedures performed treated the physical harms of AGA.

166. We find that the services provided by AHT were treatments for AGA. As we have found that AGA is a disease, we find that in treating AGA, the services provided by AHT treat a disease. As we have found that AHT's services in relation to AGA treat a disease, we do not need to go on to consider whether AHT's treatments protect, maintain or restore the "health" of its patients.

167. For completeness, we agree with Dr Walsh and find that in those cases where a patient was referred to AHT by another medical practitioner, the diagnosis of AGA would have already been made and the primary purpose of the consultation with AHT would not have been diagnostic. However, in those cases where patients referred themselves to AHT for treatment, we find that AHT had undertaken a diagnosis of AGA (even in cases where that diagnosis was not formally recorded in the patient notes) before making any treatment plan.

168. We have already found at [139] that the services provided by AHT do not "cure" AGA.

Does hair transplantation have as its therapeutic purpose the treatment of psychological or psychiatric problems?

169. At the time AHT's supplies were being investigated by HMRC, AHT argued that their supplies were exempt because they had as a therapeutic purpose the treatment of psychological problems. Much of the correspondence between HMRC and AHT considers these issues, and this is an issue that is discussed in Dr Rowland Payne's report and his oral evidence. We understand that AHT are no longer pursuing this line of argument before us, but as it has been raised in the Statement of Case, and was raised in evidence, we consider that we should address it in our decision.

170. Whilst Mr Rivett accepts Dr Walsh's evidence that the majority of individuals suffering from AGA do not come to physical or psychological harm, he noted that Dr Sinclair's BMJ article went on to say that AGA is a "medical problem" only when it is subjectively seen as excessive, premature and distressing: but it is those who perceive it as such who are likely to seek medical help. He submits that patients treated by AHT fall into this latter category. He referred to Dr Farjo's evidence that although these patients may not be psychologically ill they are psychologically affected, and that a doctor can identify the emotional pain suffered by a patient (even though the patient may not admit this) from clues picked up in conversations with the patient, their facial expression, and the answers they give to questions about what hair loss is preventing them from doing.

171. While the short version of the EDF guidelines state that progressive thinning of hair may cause psychological distress, the full version refers to an impairment in quality of life, and that hair loss may lead to depression and other negative effects. While an impairment in quality of life may impact on a person's "health" (using the WHO definition), we find that, in view of the expansive nature of that definition, treatment in such cases would fall outside the medical exemption. We recognise that there may be more serious psychological effects, and

the evidence of both Dr Rowland Payne and Dr Walsh confirmed that hair loss can give rise to psychological conditions - Dr Walsh referred to BDD as an extreme example. We acknowledge that patients experiencing hair loss may have suffered psychologically as a consequence.

172. The CJEU held in *PFC* at [35] that for treatment to be justified on psychological grounds, that justification must be based on findings of a medical nature made by a person qualified for that purpose.

173. There was no evidence that any of the ten patients that were the subject of the case studies nor the patients we saw in the YouTube videos had been referred to a specialist psychologist or psychiatrist for an assessment of their mental health, nor that any of these patients had been referred to AHT for treatment by a psychologist or psychiatrist.

174. We accept the submission of Mr Rivett (made in writing in relation to the FTT's decision in *Graham*) that the case law does not require that the diagnosis of a psychological or psychiatric condition must in all cases be made by a specialist psychiatrist or psychologist. However, as Mr Rivett accepts, *PFC* requires that for the medical exemption to apply, there must be a medical diagnosis made by a person qualified for that purpose.

175. Dr Farjo's evidence was that although he had some understanding of psychology and psychiatry as a result of his training, he was not himself qualified to make psychological or psychiatric assessments, and would refer patients to a specialist psychologist or psychiatrist where such an assessment was required.

176. But even if we regard Dr Farjo's training as providing him with sufficient understanding of psychology or psychiatry to make a medical diagnosis in relation to mental health, we note that AHT did not utilise any objective measures to assess the mental health of their patients (such as one of the recognised objective scoring systems) and we agree with Dr Walsh that any comments made in AHT's patient notes about the mental state of a patient were subjective. We consider and find that a brief reference in a patient's notes to (for example) "lack of confidence", or to unspecified "social concerns" cannot be regarded as a diagnosis of a psychological condition for which the appropriate therapeutic treatment is hair transplantation.

177. We were not persuaded by Dr Rowland Payne's evidence that objective scoring systems were otiose in the context of AHT's private practice "where there is plenty of time for consultations and continuity of care". The evidence before us, at least as regards patients following the purely surgical pathway leading to hair transplantation, is that there are few consultations with a doctor prior to surgery. For a self-referring patient, the initial consultation will be with a non-doctor patient co-ordinator (there may be a brief "look" at the patient by a doctor at this time). The patient will then make an appointment to have a consultation with the surgeon to discuss his condition and to agree a treatment plan. After this initial consultation, the next time the patient meets a doctor will usually be on the morning that the hair transplant surgery is to take place. In essence there is only one consultation with the surgeon prior to the transplantation surgery taking place. The only opportunity for the patient to build a relationship with the doctor which might allow the doctor to make a reliable assessment of the patient's mental health is at that one consultation when the treatment plan is agreed. We accept the evidence of Dr Walsh and find that the assessment of a patient's complete state of wellbeing cannot be undertaken on the basis of an impression given after speaking to a patient for 45 minutes. Indeed, Dr Farjo's own evidence is that he spent no more than five to ten minutes of the consultation on discussing with the patient the impact of hair loss on his mental state and, on any basis, this cannot be enough time to be able to diagnose a psychiatric or psychological condition.

178. We note that in his report Dr Rowland Payne stated:

> it is not my opinion that hair transplant surgery was being supplied as a treatment for an underlying psychiatric or psychological condition in any of the sample patients whose files I have reviewed.

179. Dr Walsh reached a similar conclusion:

> […] none of the ten cases provided cited previous psychiatric conditions such as depression or anxiety. None of the cases cited problems with sun protection or thermoregulation as factors in driving them to seek hair restoration surgery. Where recorded, the motivation of each individual related to self-confidence and appearance, rather than any physical impairment […]. No recording of suicidal ideation or self-harm is recorded. To this extent, I am of the opinion that the supplies described in these cases were NOT primarily for the purpose of protection, maintenance or restoration of human health.

180. Whilst Dr Rowland Payne was not of the opinion that AHT was treating any underlying psychiatric or psychological condition, it was his opinion that hair transplant surgery would probably have improved these patients' psychosocial concerns, in particular their social and mental wellbeing. This would be an improvement in their overall health according to the WHO definition of health. We have found that the WHO definition of "health" is too expansive for the purposes of determining the scope of the medical exemption. It follows, and we find, that hair transplantation undertaken to improve the "health" of a patient is outside the scope of the medical exemption.

181. As regards the ten patients subject to the case studies and the patients we saw in the YouTube videos, we find that there were no medical findings by an appropriately qualified medical practitioner that these patients suffered from any psychological or psychiatric condition for which hair transplantation would be an appropriate therapeutic treatment.

Is the treatment of AGA "purely cosmetic"?

182. Both experts agreed on a definition of "cosmetic" as "pertaining to the improvement of appearance".

183. We were also referred to the Royal College of Surgeons' statement of Professional Standards for Cosmetic Practice, which defines cosmetic treatment as

> the choice to undergo an operation, or invasive medical procedure, to alter one's physical appearance for aesthetic rather than medical reasons.

This definition has been adopted by the Cosmetic Practice Standards Authority for the purpose of regulating hair transplant surgery.

184. We note that the The British Association of Aesthetic Plastic Surgeons and the British Association of Plastic, Reconstructive and Aesthetic Surgeons take a different view of hair transplant surgery, and they support the British Association of Hair Restoration Surgery in its position that hair transplant surgery for male and female pattern hair loss is a treatment for a diagnosable genetically caused and hormonally mediated medical condition, and that in the majority of cases should not be considered "cosmetic" surgery.

185. The criticisms we made above in relation to the experts' definitions of "disease" and "health" apply equally to the definition of "cosmetic" adopted by the experts and by the Royal College of Surgeons. However, in the absence of any evidence of an alternative definition reflecting the ordinary and natural meaning of the word, we reluctantly accept the experts' definition.

186. Both experts agreed that hair transplantation was, on the basis of this definition, "cosmetic".

187. Mr Millington submits that the focus of the Tribunal's enquiry for the purposes of VAT exemption should be the nature of the supplies made by AHT rather than any underlying medical condition. He submits that the identification of any underlying medical condition is not determinative of the VAT treatment of any given supply, and that it is supplies that are exempted, not medical conditions or illnesses. He submits that none of the supplies under appeal had as their principal purpose the diagnosis, treatment or cure of a disease or health disorder, or the protection, maintenance, or restoration of human health.

188. Mr Millington submits that in its decision in *PFC*, the CJEU distinguished between the treatment of patients in need of cosmetic treatment as a result of illness, injury or congenital physical impairment, and interventions carried out more as a result solely of the patient's wishes to alter or improve his physical appearance. When presented with two identical surgical interventions, the correct VAT treatment is ascertained by establishing the purpose of the intervention. Only by adopting the "principal purpose" test can the distinction between medical and cosmetic interventions be maintained. If a surgical intervention could qualify for exemption on the basis that one of its purposes was the protection, maintenance or restoration of human health, improved psychological wellbeing as a result of aesthetic enhancement would suffice to exempt the supply from VAT even where that intervention was:

> carried out […] more as a result solely of the patient's wishes to alter or improve his physical appearance (*PFC* at [18]).

189. We were referred by Mr Millington to the decision of the CJEU in *d'Ambrumenil* for authority that it is always necessary to determine the principal purpose of a supply when determining whether it qualifies for exemption as a supply of medical care.

190. Mr Millington submitted that the "principal purpose" test has been adopted by the FTT in its decisions, including *Skin Rich*, *Window to the Womb*, and *Aesthetic Doctor*.

191. Mr Rivett submits that the only purpose of the supplies made by AHT was for the treatment of AGA, and that there are no "competing" purposes - no matter the reason why a patient wishes to have his hair loss treated, what he wants to have treated is AGA – a disease. He submits that AHT's case can be distinguished from cases like *d'Ambrumenil*, *Unterpertinger* or *CIG* where there is a competing purpose to the medical services (i.e. one which does not lead towards treatment and, if possible, cure) such as fulfilling a legal or contractual condition in another's decision-making process such that any therapeutic effect or implications are only an "indirect" possibility.

192. Mr Rivett submits that *d'Ambrumenil* makes clear at [67]-[68] that the fact that employers wish to protect their employees' health for their own purposes is no bar to the exemption. What matters is that the services are aimed at protecting their employees' health. Similarly, whether a patient wishes to have a joint replacement because they wish to have their joint replaced or because they wish to be able to use their replaced joint to play sports is not a relevant question.

193. Mr Rivett submits that the FTT in *Aesthetic-Doctor.com*, was wrong to reject a submission that one should look for a principal purpose "only where there are competing purposes one of which is extraneous to the exemption". The FTT took support from the Upper Tribunal's reference to "principal purpose" in *Mainpay* at [89(8)]. However. Mr Rivett submits that the Upper Tribunal's reference to "principal purpose" (in turn a reference to *d'Ambrumenil*) was only where it could be established that there was a separate competing freestanding principal purpose separate from the therapeutic purpose. He submits that the

finding by the FTT that there will nearly always be more than one purpose was erroneous. It is only where there is more than one purpose which does not fall within the category of therapeutic purpose that there is any need to identify a principal purpose. If all the purposes in issue are therapeutic purposes, there is no need to distinguish between or rank those purposes.

194. Mr Rivett notes that the medical exemption is not precluded just because a treatment is not available on the NHS – see *Window to the Womb* where scans were provided in circumstances where they would not have been available on the NHS. The decision also makes it clear that the exemption can be available even if the treatment may not be medically necessary.

195. Mr Millington and Mr Rivett differ on their interpretation of *PFC,* and [29] of that decision in particular.

196. Mr Millington submits that the proper interpretation of [29] is:

(a) Reference to services whose purpose "is to treat or provide care for persons who, as a result of an illness, injury or congenital physical impairment, are in need of plastic surgery or other cosmetic treatment may fall within the concept of 'medical care'" is recognition that plastic surgery or cosmetic treatments may qualify for exemption where they satisfy the principal purpose test.

(b) References to surgery "for purely cosmetic reasons" is a reference to paragraph [18] of the judgment and comparable "interventions carried out are more as a result solely of the patient's wishes to alter or improve his physical appearance". Such services will not satisfy the principal purpose test.

(c) This paragraph does not create a separate test for exemption in the context of plastic surgery or cosmetic treatment. The CJEU's response to the questions posed is expressed as follows

> supplies of services such as those at issue in the main proceedings, consisting in plastic surgery and other cosmetic treatments, fall within the concepts of 'medical care' and 'the provision of medical care" within the meaning of art 132(1)(b) and (c) where those services are intended to diagnose, treat or cure diseases or health disorders or to protect, maintain or restore human health;

This must be read as a reference to the principal purpose test.

(d) The CJEU was not identifying any specific supply that will or will not qualify for exemption, but instead assisting an interpretation of the PVD in recognising that materially similar medical interventions may attract different VAT treatments depending upon their principal purpose.

(e) The adoption of a separate test of "purely cosmetic" in the context of plastic surgery and cosmetic treatment would frustrate a straightforward application of the exemption. This would be compounded if Mr Rivett was also correct that the principal purpose test only applies to supplies where there is a competing purpose.

(f) This approach was adopted in *Window to the Womb*: "One purpose of a supply may be to provide a medical diagnosis, but it is the principal purpose which is determinative. It is not sufficient if the medical care is incidental or ancillary to the principal purpose."

(g) A proper reading of PFC, consistent with the straightforward application of the exemption, is that there is one test for exemption: the 'principal purpose' test.

197. Mr Rivett submits that the diagnosis and treatment of AGA fall squarely into the first part of [29] of *PFC*. He submits that the CJEU's reference to "purely cosmetic" in that paragraph refers to the situation where there is no underlying medical condition for which the intervention or surgery is undertaken. It excludes the case where a perfectly healthy person wished to change some part of their appearance which is not caused by a health disorder of some sort. If that person simply wished to have a healthy part of their body changed in size, then [29] of *PFC* explains that that would not be medical treatment. The following paragraphs of *PFC* caution against an assumption that simply because the body part is itself healthy that this cannot be medical care since there may be a medical need for intervention to protect or restore psychological health.

198. Mr Rivett submits that it is clear from *PFC* that the subjective reasons why a patient seeks a particular intervention are irrelevant to the VAT analysis. For the medical exemption to apply, there must be an objective medical diagnosis made by a qualified professional. The court does not ask why the footballer wants an operation on his leg for a sports injury, and say that the operation falls outside the medical exemption if the answer is that the footballer wants to be able to run further and the surgeon wants to achieve that result for the footballer too.

199. Mr Rivett submits that the services provided by AHT fall into a different category to many of the previous services considered by the FTT where there was no evidence that the services were treating a medical condition. They fall, rather into the counterfactuals set out in *Skin Rich* at [96] where the services are seeking to diagnose and treat an identified medical condition, or in *Ultralase* at [11] where treatment is needed because of a health disorder or trauma. What the court ought to ask is, at a level of abstraction, what is the function of the service that is being provided: Is there a medical illness and is it to treat that? If the answer to these questions is "yes", that is the end of it and the treatment (in this case hair restoration surgery) falls within the medical exemption. It is a very long way from the types of investigation that are being made in the context of the Botox and fillers cases, where there is no evidence before the courts of an underlying pathology or disease that is being treated.

200. Mr Rivett made reference to the treatment of various conditions (other than AGA) where there was a cosmetic aspect to the treatment. *Acne vulgaris*, if not treated, can lead to scarring. Around half of the patients with *acne vulgaris* treated by Dr Walsh suffer from a degree of pain or tenderness. In treating such patients, Dr Walsh wishes to prevent scarring, even in the case of those patients that do not suffer any pain or tenderness. Dr Walsh's evidence was that she did not consider that she carries out cosmetic or aesthetic dermatology. Mr Rivett submits that there is a cosmetic element not only in a patient who wants to have reconstructive surgery after breast cancer but also for a teenager with acne who wants to get better. In both cases, the patient wishes to integrate into normal life. Mr Rivett referred us to the evidence of Dr Rowland Payne that a patient who had had a mastectomy and reconstructive surgery would not have died without the reconstructive surgery - but there would have been suffering, and it is the primary duty of a doctor to relieve suffering. In considering whether a patient who is suffering from a burn on a visible part of their body needs plastic surgery, again the patient will not die from not having the plastic surgery, but they will almost certainly suffer less having had it. Mr Rivett submits that the same considerations apply in considering the case of whether a patient who is suffering from androgenetic alopecia needs a hair transplant.

201. We disagree with Mr Rivett's submission that the principal purpose test only applies in circumstances where there is a non-therapeutic competing purpose. The CJEU at [29] of *PFC* distinguishes between treatment for patients who need plastic surgery (or other cosmetic treatment) as a result of illness, injury, or congenital physical impairment, and surgery undertaken for purely cosmetic reasons. We read the CJEU's decision as emphasising that there is a "need" for the surgery to treat an illness etc, rather than the treatment being primarily motivated for cosmetic reasons. *PFC* is not a case where there is some other (not therapeutic) competing purpose (such as an insurance report) that needs to be distinguished from the therapeutic purpose of the intervention.

202. In *d'Ambrumenil* at [60] the CJEU says:

> As the Advocate General correctly pointed out in paragraphs 66 to 68 of her Opinion, it is the purpose of a medical service which determines whether it should be exempt from VAT.

203. The Court then goes on at [61] to say

> Where a service consists of making an expert medical report, it is clear that, although the performance of that service solicits the medical skills of the provider and may involve activities which are typical of the medical profession, such as the physical examination of the patient or the analysis of his medical history, the principal purpose of such a service is not the protection, including the maintenance or restoration, of the health of the person to whom the report relates.

204. A similar point is made by the CJEU in *CIG* at [27]. We agree with Mr Millington that in these cases, although the doctor may intend to make a diagnosis for the purposes of his or her report, the purpose of the doctor's services is not the protection etc. of the health of the person about whom the report is made.

205. We find that there is nothing in the decisions of the CJEU that limits the application of the principal purpose test to cases where there are competing purposes, one of which is non-therapeutic. We agree with Mr Millington that the reference in [29] of *PFC* to "purely cosmetic reasons" is a reference to [18] of that judgment.

206. The question we need to determine is whether the supplies made by AHT were necessary to treat AGA. The evidence before us is that by the age of 70 (or beyond) at least 80% of Caucasian men suffer from hair loss due to AGA. AGA is (at least for Caucasian males) part of the normal process of aging. Unlike, for example, breast reconstruction following a mastectomy, or plastic surgery in the case of burns, hair transplantation is not required to restore (so far as possible) "normal" appearance, as the process of hair loss in Caucasian men is "normal". In the case of plastic surgery following a mastectomy or a burn, the plastic surgery is part of the treatment of the underlying disease or trauma, having as its purpose the restoration of the "normal" (so far as is possible) appearance of the patient, and not to "improve" the patient's appearance. It is, to adopt an expression used by Mr Rivett, part and parcel of restoring human health following illness or trauma. Similarly, in the case of *acne vulgaris*, the appearance of heavily scarred skin is not normal – and treatment to prevent scarring therefore differs from treatment to prevent hair loss (which is normal). Dr Walsh's evidence, which we accept, was that in the vast majority instances, individuals do not come to physical or psychological harm as a result of [untreated] AGA. Dr Rowland Payne accepted Dr Walsh's evidence, other than the use of the adjective "vast". Indeed, Dr Rowland Payne's oral evidence was that bald men who lose their hair do not need transplants. There is no need, in any sense of the word, for most patients suffering from AGA to undergo hair

transplantation in order to restore their health. We find that hair transplantation (at least in relation to the ten case studies and the YouTube videos) is not necessary to treat AGA.

207. We find that (at least as regards the ten case studies and the YouTube videos that we saw), the principal purpose of the hair transplant treatment supplied by AHT was "purely cosmetic". We are supported in this finding by the evidence of both Dr Farjo and Dr Rowland Payne. When questioned about the reasons why patients seek treatment from AHT for hair loss Dr Farjo said:

> Q. Would you agree that it is uncommon for someone to come and see you asking for you to provide them with an effective barrier against sun damage?
>
> A. Yes, it is uncommon for patients to come and say, "I am worried about sun damage."
>
> Q. Would you agree that it is uncommon for a patient to come and ask you for hair restoration surgery to keep them warm?
>
> A. I agree.
>
> Q. Or to provide an effective barrier against physical trauma?
>
> A. An effective barrier against physical trauma?
>
> Q. Yes.
>
> A. No. They do not say those words, no. That does not mean they are not worried about these things, but that is not how they interpret the reason they want hair back.

208. Dr Rowland Payne's evidence on this point was as follows:

> Q. Is it your evidence that the principal purpose of having a hair transplant surgery is to provide a physical sunscreen?
>
> A. No.
>
> Q. Is it your evidence that the principal purpose is to provide a mechanical protection?
>
> A. No.
>
> Q. Or as a thermal insulator?
>
> […]
>
> A. No.

209. In respect of the YouTube patients, our findings are reinforced by the consent form that they signed which states that:

> I [name] agree, in consideration of Advanced Hair Technology Limited (the Company) providing cosmetic surgery in the form of hair transplant treatment to me as previously specified…

210. Dr Farjo's evidence was that one of the strengths of AHT was in managing patient expectations, and producing aesthetic results that are age appropriate, rather than recreating the appearance of a full head of hair. This supports our finding that the treatment provided by AHT had as its principal purpose the cosmetic appearance of the patient, and undermines any submission that the principal purpose was the treatment of physical harms, given that the thickest hair possible would provide the greatest protection against photodamage, trauma and cold temperatures.

211. However, we must note that the application of the medical exemption has to proceed on a case-by-case basis – and just because we have found that the medical exemption does not

apply in the circumstances of the ten case studies and the four patients who were the subjects of videos – that does not mean that the medical exemption may not apply to other patients of AHT. In particular, we consider that the patient whose hair loss arose as a result of trauma from radiotherapy would fall within the exemption, as the treatment forms part of a continuum of their cancer treatment and the restoration of normal appearance following trauma caused by the cancer treatment.

212. We make no findings in relation to the patient suffering from a congenital bulbosity to their skull as we were not presented with sufficiently detailed information to be able to determine whether the patient suffered from a congenital physical impairment which the hair transplant surgery was intended to treat. For similar reasons, we make no findings in respect of the patient undergoing gender reassignment.

213. We also note that for many women suffering from AGA, its onset may be a consequence of the menopause. As we heard very limited evidence about the relationship of the menopause to female AGA, we make no findings as to whether the medical exemption applies in those cases (although we note that HMRC considered that the medical exemption would apply in such cases).

Prophylaxis

214. Mr Rivett referred us to the decision of the Upper Tribunal in *Mainpay* at [89(7)], which states that even where there is no underlying health disorder, services with a prophylactic aim fall within the exemption. He submits that given the protective functions carried out by hair, even if AHT's services did not otherwise fall within the medical exemption, they would fall within it in this regard.

215. We disagree. None of the case study files record that sun protection or thermoregulation (or any of the other protective functions of having hair) was mentioned by the patients or was a reason for providing treatment. None of the subjects of the videos referred to the protective functions of hair. Whilst the experts both agreed that hair transplantation mitigates the physical harms consequential from hair loss arising from AGA, we find, having regard to the case study files, the videos, and also the oral evidence discussed above, that the prevention of these physical harms was not the principal purpose of the supplies made by AHT. There was no evidence that any of these patients suffered physical harm as a consequence of their hair loss.

216. We find that the services provided by AHT do not fall within the medical exemption for the provision of prophylactic treatment.

Item 4

217. Item 4 exempts the "provision of care or medical or surgical treatment […] in any hospital or state-regulated institution".

218. Mr Millington submits that it is not open to AHT to argue that their supplies fall within Item 4, as this is a novel point, and the case had proceeded on the basis that the purpose of the supplies will determine their VAT liability. He referred us to the decision of the FTT in *Illuminate Skin Clinics Limited -v- HMRC* [2023] UKFTT 547 (TC) at [8] –[11], where the Tribunal refused to allow the appellant to take this point.

219. However, we do not consider that this is a novel issue. Paragraph 21 of HMRC's original statement of case cites Item 4 in terms. The later combined statement of case cites (at paragraph 31) Article 132(1)(b) and (c) of the PVD. Paragraph 32, however, only sets out Item 1 of Group 7. We find that this must have been a typographical error because the combined statement of case refers to the implementation of Article 132(1)(b) and (c), and because it sets out Note 8 (which is relevant to Item 4 and not Item 1). We note also that

paragraph 41 of the combined statement of case refers to the provision of hospital care. We find that the application of Item 4 to AHT's supplies is not a novel point.

220. In any event, in the case of tax appeals it is well established that there is a public interest in ensuring that the right amount of tax is paid and that tax tribunals should be open to considering issues that were not necessarily addressed in pleadings, see for example *General Motors (UK) Limited v HMRC* [2016] STC 965 at [67] to [70] and the Supreme Court's decision in *Tower MCashback LLP and anr v RCC* [2011] STC 1143 at [15] approving the decision of Henderson J in the High Court to that effect. Of course, this is subject to procedural justice – and it is important that parties are not taken by surprise and have an opportunity to make submissions on any novel issue. The applicability of Item 4 was raised in the Appellant's skeleton argument. HMRC were not taken by surprise and were able to make submissions in response.

221. In any event, we distinguish the facts in *Illuminate Skin Clinics* from this appeal. In *Illuminate Skin Clinics* the appellant, unlike AHT, was not state regulated for the period under appeal, and so it could not engage Item 4. It was for that reason that the Tribunal refused to allow the appellant to take the point. Nonetheless, the Tribunal made some *obiter dicta* statements about the application of Item 4 in its decision.

222. We find that AHT can argue that their supplies fall within Item 4.

223. AHT has been regulated by the CQC since 2010, and by the CQC's predecessors before that date (the Regional Health Authority when AHT was first established in 1993, and then the Healthcare Commission). In London it operates from premises in Harley Street, which are also registered with the CQC.

224. There was some debate before us whether, in the light of the decision of the FTT in *Spectrum*, AHT was state regulated for the purposes of Item 4. The point in *Spectrum* was that the appellant provided medical care in prisons – and although prisons are state regulated, they are not regulated for the provision of medical care:

> 98. I do not accept that regulation by the CQC confers the status of a hospital or centre for medical treatment or diagnosis on Spectrum. As the note on CQC regulation helpfully produced by HMRC showed, the CQC regulates activities (e.g. personal care, treatment of disease, disorder or injury, family planning services and diagnostic and screening procedures) not establishments or institutions.

225. We find that *Spectrum* can be distinguished from the facts in this case. The medical practitioners in the case of *Spectrum* were peripatetic – they visited prisons – and did not have a fixed base in a medical institution. In the case of AHT, the conditions of its registration with the CQC provides that the regulated activities (surgical procedures) can only be carried on at or from its premises in Manchester. Unlike the doctors in *Spectrum*, the conditions attaching to AHT's registration provide that it can only undertake medical activities from its permanent location. We find that AHT's premises are a "hospital or state-regulated institution".

226. Mr Rivett submits that the decision of the CJEU in *d'Ambrumenil* applied the "principal purpose" test to the construction of the term "medical care". It did not consider whether that test applied to the term "care" as used in Item 4. He submits that the FTT in *Skin Rich* decided that "care" in Item 4 was not restricted by the purpose test, and was wider in scope than the treatments within the scope of Items 1 and 2. The reason the taxpayer in *Skin Rich* failed in its appeal was because it was not state regulated, and not because the services it provided did not amount to "care".

227. Mr Rivett submits that it may be the case that the terms of Item 4, as drafted, go further than they are entitled to do by the European law, but that is not a point that can be taken against AHT. AHT are entitled to rely upon the domestic law if there is a divergence, and if it is wider than the European test.

228. Mr Millington referred us to the decision of the High Court in *CEC v Kingscrest Associates Limited* [2002] EWHC 410 (Ch) where Pomfrey J held:

> 9. In its context in item 4, on the other hand, the only context provided for the word "care" is the reference to medical or surgical treatment and the specific requirement that the care be supplied in a hospital or other approved institution. There is no limitation to the persons to whom the care may be provided. Thus the potential objects of the "care" include persons who are otherwise healthy, and cannot be limited to the class who are the objects of the "care" referred to in item 9. The tribunal concludes that the care must be medically or surgically related if it is to qualify for an exemption under item 4. The supply of care which is not medically or surgically related qualifies for exemption only if the additional requirements of item 9 are satisfied by the service and the supplier. The reference in item 4 to "other institution approved...." is, the tribunal concluded, apt to cover nursing homes, convalescent homes and the like not properly to be described as hospitals which nonetheless supply care of a medical or surgical nature. I would add clinics to this list.
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> 10. The Tribunal found that the words bore this meaning both as they stand and when construed in the light of Article 13A.1(b) of the Sixth Directive. The Tribunal held that properly construed item 4 was consistent with Article 13A.1(b), and that the services fell outside the scope of that Article.
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> […]
>
> 15. In my judgment, the conclusions of the tribunal are correct for the reasons which it gives. I consider that the tribunal was correct in saying that the difference between item 4 and item 9 lay in the failure of item 4 to specify the sort of person who is to be cared for. I consider that this is a key to identifying the relationship between item 9 and item 4. There is no doubt that some services falling within item 4 may be seen as a sub-class of the services referred to in item 9, in that they can be described as the "provision of care [or] treatment...designed to promote the physical...welfare of...sick persons" but it does not follow that other services falling naturally within item 9 also fall within item 4, or vice-versa. The use of the words "wide" and "narrow" can produce confusion, but I would say that the services of item 4 are narrowly defined, being limited to care of a medical and surgical nature. Services falling outside the narrower definition of item 4 must not be profit-making if they are to be exempt.
>
> 16 I consider that this interpretation is, as the tribunal found, consistent with art 13 of the Sixth Directive. I have no doubt that there is overlap between the various activities listed in the sub-paragraphs of art 13A(1), but each needs to be examined in its own context, care being taken to avoid the logical error to which I have referred. The distinction between art 13A(1)(b) on the one hand and (g) and (h) on the other is more clearly drawn than in the domestic statute, and it plainly calls for a construction similar to that placed by the tribunal on the domestic provisions. It is no doubt correct that the purpose of the provisions is to exempt supplies of services which have clearly beneficial objectives in the public interest, but that is an observation of such a degree of generality that it gives little assistance in construing the article.

229. Mr Millington referred us also to the *obiter dicta* statements made by the FTT in *Illuminate Skin Clinics*, where the FTT rejected a submission that "care" had a wider meaning for the purposes of Item 4 than "medical care" in Item 1:

> 131. The word "care" is followed by "medical" and "surgical". The latter two words connote activities where the main purpose is to protect, maintain or restore the health of the individual concerned. In our view "care" has to be read alongside, and in the same way, as the other two words (an application of the *noscitur a sociis* principle).
>
> 132. Its proper meaning, in this context, is one where an activity whose main purpose is to protect, maintain or restore the health of the individual concerned. For the reasons already set out in relation to our discussion of Item 1, we do not consider that cosmetic treatments of the type considered properly fall within this description, and so do not fall within the scope of Item 4.

230. The FTT in *Skin Rich* considered that "care" in Item 4 had a wider meaning than "medical care" in Item 1. However, it found that the meaning of "care" was nonetheless constrained and not wide-ranging:

> 124. Given that ECJ case law has established that the "provision of medical care" must have the principal purpose of protecting, maintaining or restoring human health, we note that on an ordinary reading the word "care" is also fairly constrained and, whilst it widens the scope of treatments within Item 4 beyond those in Items 1 and 2, the extension is not wide-ranging. We would suggest that "care" might construed as bringing a general welfare component into the services which could be within Item 4. However, Pomfrey J held in *Kingscrest* that "care" must be of a medical or surgical nature (although gave no further guidance as to what this might involve). This decision binds us, and we do not consider that the subsequent decisions of the ECJ in *Dornier* or *Ygeia* have cast doubt upon it. Indeed, they indirectly offer support to that decision in the constrained approach they have taken to the meaning of closely related activities.

231. The Tribunal went on to find that (in relation to the laser treatment of nail fungus) the absence of evidence that there was a treatment of a medical condition within Item 1 could not be overcome by relying on the treatment being "care" within Item 4:

> 132. Again, this leaves the question of "care". Our reason for concluding that the nail fungus treatment is not "medical…treatment" for the purpose of Item 4 was based on the absence of appropriate evidence of a medical condition and the purpose for which treatment was sought. This also prevents us from being able to conclude that the treatment is of a medical nature. Essentially, if evidence of the medical condition had been provided, then we would regard the treatment as within Item 4 on the basis that it is a "medical…treatment" and the lack of such evidence cannot be overcome by relying on "care" instead.

232. *Kingscrest* is obviously binding on us. It limits the scope of the meaning of "care" in Item 4 to care of a medical and surgical nature. This is consistent with the meaning of "medical care" in the PVD (and in the Sixth Directive previous to the PVD). Even if "care" has a somewhat wider meaning than "medical care" in Item 1, it is constrained by the words "medical" and "surgical". We agree with the Tribunal in *Skin Rich* that it is not possible to circumvent the limitations imposed by the meaning of "medical treatment" in Item 1 by relying on "care" in Item 4. We find that the principal purpose test that applies for the purposes of Item 1 applies in the same way to supplies made within Item 4.

233. We reach this conclusion using usual English law principles of statutory interpretation, and not because of any divergence between Item 4 and the corresponding EU directive to which it gives effect.

234. We find that the services provided by AHT, to the extent that they fall outside the medical exemption in Item 1, fall outside the exemption in Item 4 as well.

CONCLUSIONS

235. We find that in relation to the ten case study patients, and the patients that were the subject of the four YouTube videos that we saw, the supplies of hair transplant surgery made by AHT fall outside the scope of the medical exemption.

236. It is the nature of the medical exemption that it needs to be applied on a case-by-case basis to the patients of AHT. We make no findings in respect of any patients other than the ten case study patients and the subjects of the four videos. The liability of AHT to register for VAT, and its VAT liability (assuming it is liable to be registered), will need to be agreed between AHT and HMRC in the light of this decision. If the parties are unable to reach agreement, they have liberty to apply to this Tribunal to determine quantum.

237. As HMRC is no longer pursuing the assessment to penalties, AHT's appeal against the assessment to penalties is allowed.

RIGHT TO APPLY FOR PERMISSION TO APPEAL

238. This document contains full findings of fact and reasons for the decision. Any party dissatisfied with this decision has a right to apply for permission to appeal against it pursuant to Rule 39 of the Tribunal Procedure (First-tier Tribunal) (Tax Chamber) Rules 2009. The application must be received by this Tribunal not later than 56 days after this decision is sent to that party. The parties are referred to "Guidance to accompany a Decision from the First-tier Tribunal (Tax Chamber)" which accompanies and forms part of this decision notice.

Release date: 20th FEBRUARY 2025