Competition & Markets Authority

Completed acquisition by Oasis Dental Care (Central) Limited of Total Orthodontics Limited

ME/6530/15

The CMA's decision on reference under section 22(1) of the Enterprise Act 2002 given on 2 September 2015. Full text of the decision published on 8 October 2015.

Please note that [✂] indicates figures or text which have been deleted or replaced in ranges at the request of the parties for reasons of commercial confidentiality.

SUMMARY

1. On 5 February 2015, Oasis Dental Care (Central) Limited (**Oasis**) acquired Total Orthodontics Limited (**Total**) (the **Merger**). Oasis and Total are together referred to as the **Parties**.

2. The Competition and Markets Authority (**CMA**) considers that the Parties have ceased to be distinct and that the share of supply test is met on the basis of the Parties' combined share of supply of NHS orthodontic treatments in the Tonbridge and Brighton postcode areas. The four-month period for a decision, as extended, has not yet expired. The CMA therefore considers that a relevant merger situation has been created.

3. The Parties overlap in the supply of orthodontic services to the NHS and the supply of orthodontic treatments to NHS patients and private patients in Kent, Surrey and Sussex. They do not overlap in the supply of general dentistry services as Total provides orthodontic services only. The CMA has therefore assessed the impact of the Merger in respect of:

    - competition **for the market** to supply orthodontic services under contract to the NHS in the area corresponding to the boundary of the relevant NHS commissioning entity;
    - competition **in the market** for the provision of orthodontic treatments to NHS-eligible patients by current NHS contract holders within the 80% catchment area around each of the Parties' sites; and

- competition **in the market** for the provision of orthodontic treatments to private patients within the 80% catchment area around each of the Parties' sites.

4. With respect to competition **for the market**, the CMA considered whether the loss of an established independent rival bidder for NHS orthodontic contracts would give rise to unilateral horizontal effects by weakening the competitive outcome of NHS tender processes because NHS commissioning entities would face a smaller pool of orthodontics providers that could credibly bid for contracts to supply orthodontic services to the NHS.

5. During its investigation, the CMA found that there was an absence of material concerns from NHS commissioning entities regarding the number of bids for future NHS contracts to provide orthodontic services in the areas where the Parties overlap and the presence of a number of credible bidders, currently providing services either inside or outside of the boundary of the relevant commissioning entities. The Parties also had a low combined share of supply of orthodontic services under contract to the relevant NHS commissioning entities in Kent, Surrey and Sussex. Accordingly, the CMA does not consider that there is a realistic prospect that the Merger will give rise to a substantial lessening of competition for the market for the provision of orthodontic services under contract to the NHS in the areas where the Parties overlap.

6. With respect to competition **in the market**, the CMA notes that, while price is a relevant parameter of competition for the provision of orthodontic treatments to private patients, NHS orthodontic treatments are provided to eligible patients free of charge and the amounts paid by the NHS to providers of NHS orthodontic services are fixed according to the contracts agreed by the provider with the relevant commissioning entity. Therefore, with respect to the provision of orthodontic treatments to NHS patients, the CMA considered whether the Merger would give rise to unilateral horizontal effects as a result of non-price factors such as lower quality treatment, a reduced range of services, a reduced level of service or reduced innovation.

7. The CMA found that the existing NHS contractual framework for the provision of orthodontic services provides for a maximum number of units of orthodontic activity (**UOAs**) that each orthodontic practice is permitted to perform.[1] In addition, there are capacity constraints in the sector as providers are not reimbursed for carrying out any additional UOAs over and above their contractual requirements. Accordingly, there are lengthy waiting lists for NHS orthodontic treatment and very limited incentive for competition between

[1] UOAs are used as a mechanism to specify the total amount of NHS orthodontic treatment that a provider of orthodontic services to the NHS is required under its contract to deliver over the course of a year.

orthodontic practices. The CMA therefore considers that, at present, the contractual framework for NHS orthodontic services serves to dampen the potential for competition in the market between providers of orthodontic treatments to NHS patients, including between the Parties.

8. The CMA also found that the fact that a significant proportion of the Parties' business is derived from private patients provides an incentive to invest in a good quality practice environment; that the ability of the Parties to discriminate between NHS and private patients is somewhat limited; and that there are additional incentives for the Parties not to lower quality or service, including the need to maintain a reputation for quality with referring dentists and the need to optimise the chances of successfully bidding for future NHS contracts. Accordingly, against the background of the dampening of the potential for competition in the market, the CMA considers that the Parties do not have sufficient ability or incentive to decrease quality or service levels in providing orthodontic treatments to NHS patients post-Merger. Therefore, the CMA does not believe that the Merger gives rise to a realistic prospect of a substantial lessening of competition in respect of the provision of orthodontic treatments to NHS patients in the areas where the Parties overlap.

9. The CMA notes that existing NHS contracts for the supply of orthodontic services will be expiring in the next two years, with new contracts to be procured by NHS England. The CMA therefore considers that the design of the tender process and the new contractual framework will be a key driver for influencing the level of competition between providers in the market and in ensuring appropriate incentives for providers of NHS orthodontic services to deliver high quality treatments for NHS patients.

10. With respect to private patients, the CMA also considered whether the Merger would allow the Parties to raise prices for orthodontic treatments. The CMA's analysis of the impact of the Merger in each local area around the Parties' sites indicated that a sufficient number of other providers of orthodontic treatments to private patients remain post-Merger. Therefore, the CMA does not consider that there is a realistic prospect of a substantial lessening of competition in relation to the provision of orthodontic treatments to private patients in the areas where the Parties overlap.

11. The Merger will therefore **not be referred** under section 22(1) of the Enterprise Act 2002 (the **Act**).

ASSESSMENT

Parties

12. Oasis provides NHS and private dental services in the UK from over 280 dental practices throughout England, Wales and Northern Ireland. It is active in both general dentistry and orthodontics. The ultimate parent company of Oasis is Bridgepoint Advisers Group Limited, which is an international private equity group active in a broad range of sectors, including business services, financial services, healthcare, and media. The turnover of Oasis in the year ended 31 March 2014 was approximately £158 million.

13. Pre-Merger, Total provided a mix of NHS and private orthodontic care in the South East of England from 11 sites. The turnover of Total in the year ended 31 October 2014 was approximately £7.8 million, all of which was attributable to the UK.

Transaction

14. The Parties signed and completed a sale and purchase agreement on 5 February 2015, pursuant to which Oasis acquired the entire issued share capital of Total.

Jurisdiction

15. As a result of the Merger, the enterprises of Oasis and Total have ceased to be distinct.

16. The UK turnover of Total does not exceed £70 million, so the turnover test in section 23(1)(b) of the Act is not satisfied.

17. The Parties overlap in the supply of orthodontic services. Oasis estimates that the Parties' combined share of supply of orthodontic treatments to NHS patients in England is [0–5]%; in the South of England is [5–10]%; and in Kent, Surrey and Sussex is [20–30]%.

18. Based on population data from the 2011 Census and the Parties' contracted UOAs, the CMA considers that the Parties' combined share of supply of orthodontic treatments to NHS patients is [30–40]% (with an increment of

approximately [5–10]%) in the Tonbridge (TN) postcode area and is [40–50]% (with an increment of [10–20]%) in the Brighton (BN) postcode area.[2]

19. The CMA considers that each of these postcode areas constitutes a substantial part of the UK. The CMA therefore considers that the share of supply test in section 23 of the Act is met.

20. The Merger completed on 5 February 2015 but was not made public by Oasis. The CMA received material facts about the Merger on 17 April 2015. The four-month decision deadline under section 24 of the Act is 4 October 2015, following extensions under section 25(2) of the Act.

21. The CMA therefore believes that it is or may be the case that a relevant merger situation has been created.

22. The CMA opened an own-initiative investigation into the Merger by sending an enquiry letter to Oasis on 10 April 2015.[3]

23. The initial period for consideration of the Merger under section 34ZA(3) of the Act started on 8 July 2015 and the statutory 40 working day deadline for a decision is therefore 2 September 2015.

Counterfactual

24. The CMA assesses a merger's impact relative to the situation that would prevail absent the merger (ie the counterfactual). For completed mergers the CMA generally adopts the pre-merger conditions of competition as the counterfactual against which to assess the impact of the merger. However, the CMA will assess the merger against an alternative counterfactual where, based on the evidence available to it, it considers that, in the absence of the merger, the prospect of the pre-merger conditions continuing is not realistic, or there is a realistic prospect of a counterfactual that is more competitive than these conditions as between the merging parties.[4]

25. In this case, neither the Parties nor third parties have submitted arguments or evidence supporting an alternative counterfactual. Therefore, the CMA considers the pre-Merger conditions of competition to be the relevant counterfactual.

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[2] According to the 2011 Census, the Tonbridge postcode area had a population of 680,816 and the Brighton postcode area had a population of 802,831.

[3] See *Mergers: Guidance on the CMA's jurisdiction and procedure (CMA2)*, paragraphs 6.9–6.19 and 6.59–60.

[4] *Merger Assessment Guidelines (OFT1254/CC2)*, from paragraph 4.3.5. The *Merger Assessment Guidelines* have been adopted by the CMA (see *CMA2*, Annex D).

Frame of reference

26. The CMA considers that market definition provides a framework for assessing the competitive effects of a merger and involves an element of judgement. The boundaries of the market do not determine the outcome of the analysis of the competitive effects of the merger, as it is recognised that there can be constraints on merger parties from outside the relevant market, segmentation within the relevant market, or other ways in which some constraints are more important than others. The CMA will take these factors into account in its competitive assessment.[5]

27. The Parties overlap in the supply of orthodontic services to the NHS and in the supply of orthodontic treatments to NHS patients and private patients in Kent, Surrey and Sussex.[6]

Product scope

28. Oasis has not made specific submissions about the appropriate product scope of the frame of reference in this case, although it noted that it considers secondary care providers to compete in the provision of orthodontic treatments to NHS patients.

29. In previous cases, the CMA and the Office of Fair Trading (OFT) have distinguished between NHS dentistry and private treatments, and between general dentistry and specialist treatments (including orthodontics).[7]

30. The CMA has also established that competition for the award of NHS dentistry contracts (including orthodontic contracts) in England and Wales is characterised by a tendering process, giving winners of such contracts the right and ability to offer dental services to patients located within the area specified by the relevant NHS commissioning entity (that is, competition for the market).[8] Competition for the provision of treatments to NHS patients subsequently takes place at the retail level between dental practices that have been awarded contracts (that is, competition in the market).[9]

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[5] *Merger Assessment Guidelines*, paragraph 5.2.2.
[6] They do not overlap in the supply of general dentistry as Total provides orthodontics only.
[7] Completed acquisition by Oasis Dental Care (Central) Limited of JDH Holdings Limited (***Oasis/Smiles***), CMA decision of 28 July 2014; Anticipated acquisition by a merger between the Carlyle Group and Palamon Capital Partners LP of Integrated Dental Holdings Group and Associated Dental Practices (***IDH/ADP***), OFT decision of 10 June 2011.
[8] Commissioning in the NHS is the process of planning, agreeing and monitoring services provided to NHS patients. The NHS commissioning system has undergone significant changes in recent years (see, for example, guidance provided on the NHS England – NHS Commissioning website). References to 'commissioning entities' in the context of this decision refer to the NHS entities that commission orthodontic services on behalf of NHS patients.
[9] *Oasis/Smiles*, paragraph 27.

31. The approach adopted in previous cases is compatible with the evidence that the CMA has found during its merger investigation in this case.

Private and NHS orthodontic providers

32. Within England, patients eligible for NHS funding of non-acute orthodontic treatments are broadly children between the ages of 12 and 18 who score at least 3.6 on the Index of Orthodontic Treatment Need (**IOTN**).[10] NHS orthodontic care is not usually available for adults, but may be approved on a case-by-case basis if needed for health reasons and patients who are assessed before their 18th birthday may still have orthodontic treatment funded after their 18th birthday.[11]

33. Orthodontists are contracted by NHS commissioning entities to perform a set number of UOAs, with the annual contract value determined by the number of UOAs specified in the tender and the price that the winning bidder agrees with the commissioning entity during the tender process for performing the specified number of UOAs. Providers are paid monthly in arrears based on the annual contract value (not on actual performed work), but may have payments clawed back by the relevant commissioning entity for any underperformance of contracted UOAs.

34. NHS orthodontic treatments are mainly provided by orthodontic specialists and experienced general dentists, referred to by the NHS as primary care providers. However, in some complex cases (eg, where surgery is required) orthodontic treatment is provided within hospitals, referred to by the NHS as secondary care providers. Orthodontic treatment for NHS-eligible patients is free of charge, but only certain services or products (eg, certain types of braces) are available. Orthodontic treatment commonly takes place over 18 to 24 months, after which the patient reverts to their dental practitioner. The NHS only funds one treatment per patient. Therefore, if a patient ends their orthodontic treatment before it is complete, he or she cannot elect to restart the NHS-funded treatment with a different provider.

35. Private orthodontic treatments are available to anyone and there is a wider range of services and products available to private patients than to NHS-funded patients (eg, lingual fixed incognito braces are not available to NHS-funded patients).

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[10] The IOTN is used to score patients' eligibility for NHS orthodontic treatment. This is a rating system consisting of 5 grades based on the severity of the malocclusion, ranging from 1 ('no need for treatment') to 5 ('severe need for treatment').
[11] See explanation on the NHS Choices – Accessing orthodontics website.

36. Oasis submitted that private providers that do not currently hold an NHS orthodontic contract, including both corporate and independent orthodontic providers, are credible bidders for future NHS orthodontic contracts. Third party responses to the CMA's merger investigation were mixed on this point. The responses confirmed that larger private providers could potentially bid for future NHS contracts, but indicated that their willingness to do so would depend on the location and size of the contract. Some independent providers expressed doubts about their ability to successfully win NHS contracts, particularly if bidding against a corporate orthodontic provider that currently holds NHS contracts.

37. In relation to competition in the market, NHS England confirmed that in order to supply orthodontic treatments to NHS patients, a practice must have a contract with an NHS commissioning entity, which is not the case for the provision of private treatments.[12] The CMA considers that this indicates there are limits to switching capacity easily and quickly from private to NHS provision for many practices.

38. The CMA therefore considers that providers of orthodontic treatment to private patients should be excluded from the frames of reference for the supply of orthodontic services to the NHS and the provision of treatment to NHS patients. However, the CMA has taken into account the constraint from providers of orthodontic treatments to private patients in its competitive assessment, where the evidence indicates the existence of such a constraint.

General dentists and specialist orthodontists

39. Oasis submitted that some general dentists, particularly dentists with enhanced skills, are capable of providing some orthodontic treatments (such as discreet braces), but noted that there is a wide variation among individual dentists with enhanced skills as to the additional experience, qualifications and training undertaken.[13] Oasis also submitted that most contracts for the supply of orthodontic treatments to NHS patients are held by full specialist orthodontists.

40. Third party general dentists who responded to the CMA's merger investigation indicated that they would not typically be interested in tendering for future NHS orthodontic contracts as they considered that they lacked the skills to service them. However, large corporate chains providing both general

[12] Holders of NHS orthodontic contracts can also supply orthodontic treatments to private patients.
[13] Dentists with enhanced skills, previously known as dentists with a special interest, are dentists who have additional experience or training to develop additional competencies. Full orthodontic specialists have been awarded a Certificate of Completion of Specialist Training, which is the responsibility of the General Dental Council.

dentistry and orthodontics that responded to the CMA's merger investigation submitted that they could bid for contracts by extending provision at an existing general dental surgery to include orthodontics.

41. On the demand-side, third party general dentists indicated that substitution between general dental and orthodontic treatments is limited, as there are different treatments for different dental and orthodontic requirements.

42. The CMA has therefore excluded general dental practices and dentists with enhanced skills from the frames of reference for the supply of orthodontic services to the NHS and the provision of orthodontic treatments to NHS patients. However, the CMA has taken into account the constraint from general dental providers and dentists with enhanced skills in its competitive assessment, where the evidence indicates the existence of such a constraint.

Secondary care providers

43. Oasis submitted that secondary care providers can credibly bid for future NHS contracts to provide orthodontic primary care services to the NHS. Oasis provided an example of one hospital ([✂]) successfully winning a primary care orthodontics contract and another ([✂]) subcontracting the treatment of some NHS orthodontic patients to Total. Oasis submitted that this demonstrates secondary care providers are a constraint on primary care providers and may have strong incentives to bid for NHS primary care contracts in the future.

44. The evidence from third parties indicated that secondary care providers historically have not generally demonstrated an interest in competing for primary care contracts. Secondary care providers' views on the feasibility of bidding for primary care contracts in the future were mixed, indicating that they would only bid if contract locations were suitable and if the delivery of the additional activity appeared feasible (eg, it did not involve establishing a new unit or separate infrastructure away from an existing site). The CMA received evidence from secondary care providers that they would bid if they were encouraged to do so by the relevant NHS commissioning entity or NHS England, but the evidence also suggested that there remains a preference among secondary care providers for focusing on specialist orthodontic activity that is best carried out in a secondary care setting.[14] While some secondary care providers that responded to the CMA's merger investigation noted that they did treat some patients who could have been treated in a primary care

[14] Specialist orthodontic activity would include treating patients who have complex requirements and who would benefit from treatment in a surgical setting (eg, because they require jaw surgery in addition to their orthodontic treatment or there are other complicating factors).

setting, they did not necessarily consider that they would wish to expand this provision and indicated that taking on additional patient volumes would limit their ability to achieve the 18-week waiting list requirement for NHS secondary care providers.

45. NHS England stated that in the future hospitals will be able to bid for primary care contracts, but noted that hospitals were not being positively encouraged to do so. NHS England also confirmed that where hospitals do bid for such contracts they will be treated like all other bidders and that in the future there is likely to be greater overlap between the IOTN levels that are treated by primary care providers and those treated by secondary care providers.

46. The CMA has therefore excluded secondary care providers from the frame of reference. However, the CMA has considered, in the competitive assessment, the constraint arising as a result of the ability of secondary care providers to bid directly for NHS primary care orthodontic contracts in the future.

Geographic scope

Competition for the market

47. In *Oasis/Smiles* and *IDH/ADP*, the CMA and the OFT, respectively, considered that the relevant geographic frame of reference was the geographic boundary that correlates with the relevant NHS commissioning entity.[15] Oasis submitted that it agreed with this approach.

48. The CMA notes that commissioning within the NHS has been reconfigured since *Oasis/Smiles*, at which time the relevant NHS commissioning entities in England were the local area teams (**LATs**). In April 2015, the 27 LATs were replaced with four regional teams, which cover a significantly larger area than the areas covered by the LATs that previously existed.[16] Within Kent, Surrey and Sussex (part of the NHS England South Regional Team), NHS England commissions orthodontic services through two area teams: the NHS England Surrey and Sussex Area Team and the NHS England Kent and Medway Area Team.

49. The NHS commissioning entities that responded to the CMA's merger investigation submitted that the area within which orthodontic services will be delivered would be specified by the contract. That is, within the boundaries of the relevant commissioning entity, the NHS will put out to tender a number of contracts, each covering specific local requirements. The NHS commissioning

[15] *Oasis/Smiles*, paragraphs 45–47; *IDH/ADP*, paragraphs 23 & 34.
[16] See the explanation on the NHS England – Regional Teams website.

entities explained that the location specified for the provision of orthodontic services in a particular contract will generally be narrower than the geographic boundary of the relevant commissioning entity.

50. On the supply side, the NHS commissioning entities indicated that a range of providers may be able to bid for these contracts, including those without any current presence in an area. Third party competitors that responded to the CMA's merger investigation agreed with this and generally indicated that they would be likely to bid for upcoming contracts, even though some independent providers thought the tendering process placed them at a disadvantage compared to larger corporate providers. Some third party competitors also indicated that they may bid for contracts in areas where they did not already have a practice. NHS commissioning entities and third party competitors considered that the set of credible bidders may vary across contracts within the boundaries of the relevant commissioning entity.

51. On the basis of the evidence before it, the CMA has considered the impact of the Merger based on a geographic frame of reference comprising the provision of orthodontic services under contract to the NHS within the boundary of the commissioning entities covering Kent, Surrey and Sussex, namely the NHS England Surrey and Sussex Area Team and the NHS England Kent and Medway Area Team.

52. However, because the findings of the merger investigation suggest that providers currently located outside the boundary of the relevant commissioning entity could also credibly bid for contracts, the CMA has considered in its competitive assessment the strength and credibility of the various potential bidders for local contracts, including those not present within the boundary of the relevant NHS commissioning entity, if the evidence indicates that they might impose a constraint.

Competition in the market

53. Oasis submitted that the catchment areas[17] around the Parties' practices are relatively large, as patients are willing to travel to receive specialist treatment from a well-regarded provider. It further submitted that there did not appear to be any grounds for altering the starting point of the analysis from an 80% catchment area, which was the approach adopted by the CMA in *Oasis/Smiles* and the OFT in *IDH/ADP*.[18]

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[17] That is, the area from which the great majority of a practice's patients are drawn.
[18] *Oasis/Smiles*, paragraph 59; *IDH/ADP*, paragraph 31.

54. Third parties who responded to the CMA's merger investigation had mixed views. Most third parties submitted that the catchment area for both NHS and private patients was no wider than approximately 10 miles, although some noted that this varies according to the character of the area, with urban areas having narrower catchments than rural areas.

55. As a starting point, the CMA generally uses the catchment area within which 80% of the Parties' customers reside as a pragmatic approximation for a candidate geographic frame of reference.[19] As mentioned above, in *Oasis/Smiles* and *IDH/ADP*, the CMA and the OFT, respectively, used the Parties' 80% catchment areas, based on a sample of their practices, as a starting point to assess the competitive effects of those transactions.[20] On the basis of third party responses to its merger investigation, the CMA considers that the same approach is appropriate in the present case.

56. The CMA has therefore used data provided by Oasis on the Parties' 80% catchment areas as a starting point for its analysis. The CMA also considered other information such as the patient travel times identified in the orthodontic needs assessment carried out on behalf of NHS England for the Kent, Surrey and Sussex area in April 2015 (the **KSS Orthodontic Needs Assessment**), which was provided to the CMA by Oasis.[21]

Conclusion on frame of reference

57. For the reasons set out above, the CMA has considered the impact of the Merger in the following frames of reference:

- competition for the market to supply orthodontic services under contract to the NHS in the area corresponding to the boundary of the relevant NHS commissioning entity;

- competition in the market for the provision of orthodontic treatments to NHS-eligible patients by current NHS contract holders within the 80% catchment area around each of the Parties' sites; and

[19] These are calculated by calculating the area within which 80% of patients travel from to access the practice (based on home postcodes). They are typically expressed as isochrones of travel time.
[20] *Oasis/Smiles*, paragraph 59; *IDH/ADP*, paragraph 31. The CMA notes that a catchment area is typically narrower than a geographic market identified using the hypothetical monopolist test (see *Merger Assessment Guidelines*, Section 5.2, and in particular paragraphs 5.2.2 & 5.2.25).
[21] Brett Duane and Christopher Allen, 'Orthodontic Needs Assessment for the Kent, Surrey and Sussex areas', April 2015, from p36.

- competition in the market for the provision of orthodontic treatments to private patients within the 80% catchment area around each of the Parties' sites.

58. However, it was not necessary for the CMA to reach a conclusion on either the product frame of reference or geographic frame of reference, since, as set out below, no competition concerns arise on any plausible basis.

Competitive assessment

59. The CMA has assessed whether it is or may be the case that the Merger has resulted, or may be expected to result, in a substantial lessening of competition in relation to unilateral horizontal effects in:

    - the market to supply orthodontic services under contract to the NHS in the area corresponding to the boundary of the relevant NHS commissioning entity (that is, competition for the market);
    - the market for the provision of orthodontic treatments to NHS-eligible patients by current NHS contract holders within the 80% catchment area around each of the Parties' sites (that is, competition in the market for NHS patients); and
    - the market for the provision of orthodontic treatments to private patients within the 80% catchment area around each of the Parties' sites (that is, competition in the market for private patients).

60. Horizontal unilateral effects may arise when one firm merges with a competitor that previously provided a competitive constraint, allowing the merged firm profitably to raise prices or degrade quality on its own and without needing to coordinate with its rivals.[22] Horizontal unilateral effects are more likely when the merger parties are close competitors.

Competition for the market

61. The CMA considered whether the loss of an established independent rival bidder for NHS orthodontics contracts may weaken the competitive outcome of NHS tender processes (such as the price, quality or level of innovation offered in the bid) because NHS commissioning entities would face a smaller pool of orthodontics providers that could credibly bid for contracts to supply orthodontic services to the NHS.

[22] *Merger Assessment Guidelines*, from paragraph 5.4.1.

Framework for contracting NHS orthodontic services

62. According to NHS England, the framework for the provision of NHS orthodontic services is currently in transition. The KSS Orthodontic Needs Assessment explains that in the past the contracting framework for dental services (including the provision of orthodontics) was established through Primary Care Trusts (**PCTs**), with hospital based orthodontic services often commissioned as part of a secondary care block contract. However, NHS England (rather than the PCTs) is now responsible for commissioning and funding primary and secondary care orthodontic services.[23]

63. The KSS Orthodontic Needs Assessment indicates that, since 2006, NHS orthodontic services in Kent, Surrey and Sussex have been provided through a mixture of Personal Dental Service (**PDS**) contracts and General Dental Service (**GDS**) contracts.[24] The KSS Orthodontic Needs Assessment also indicates that providers of orthodontic services to the NHS in Kent, Surrey and Sussex have received extensions to all of their orthodontic agreements until 31 March 2016.[25]

64. Under the current NHS contracts, as explained above, orthodontists are contracted in UOAs, with the annual contract value based on the requirement to provide a specific number of UOAs.[26] NHS England confirmed that under the existing contractual framework, providers of NHS orthodontic services are not reimbursed for carrying out any additional UOAs over and above their contractual requirements, are not able to 'carry over' additional or unused UOAs into the following year, and may have payments clawed back by the relevant commissioning entity for any underperformance of contracted UOAs. The CMA therefore considers that providers of NHS orthodontic services in Kent, Surrey and Sussex currently have an incentive under their contracts: (i) not to exceed the amount of actual NHS work performed beyond their number of contracted UOAs; and (ii) not to deliver fewer NHS treatments than their number of contracted UOAs.

65. NHS commissioning entities that responded to the CMA's merger investigation said that for the next round of orthodontic tenders, which are expected to be invited in the next two years, locations will be specified within Kent, Surrey and Sussex for the provision of orthodontic services (the number of UOAs to be provided at each of those locations will also be specified). As

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[23] KSS Orthodontic Needs Assessment (April 2015), pp10 & 11.
[24] PDS contracts are fixed term contracts usually lasting approximately five years; GDS contracts are rolling contracts with no fixed end date.
[25] KSS Orthodontic Needs Assessment (April 2015), p11.
[26] KSS Orthodontic Needs Assessment (April 2015), p10. As explained above, UOAs are used as a mechanism to specify the total amount of NHS orthodontic treatment that a provider of orthodontic services to the NHS is required under its contract to deliver over the course of a year.

noted above, the location specified for the provision of orthodontic services in a particular contract will generally be narrower than the geographic boundary of the relevant commissioning entity (ie, a tender would specify a certain number of UOAs to be carried out in, eg, Sevenoaks).

Shares of supply

66. Oasis provided estimates of the Parties' shares of supply of orthodontic services to the NHS based on NHS Dental Services Vital Signs data available on the NHS Dental Portal.[27] Oasis submitted that there is no reliable data source for actual UOAs delivered, but that in the majority of cases the UOAs are delivered in line with the contract. In that regard, the CMA notes that providers of NHS orthodontic services are contractually bound to deliver at least 96% of their contracted UOAs.[28]

67. On that basis, Oasis submitted that the Parties' combined share of contracted UOAs in Kent, Surrey and Sussex is around [20–30]% post-Merger, with an increment of [5–10]%.

Competitive constraints

68. Oasis submitted that there are a large variety of potential bidders for future NHS orthodontic contracts in Kent, Surrey and Sussex. Oasis's view is that NHS and private orthodontic providers, general dentists, and secondary care providers already present in the area are all credible bidders. In addition, Oasis submitted that there is also the potential for new entry by large corporate providers or independent providers not currently present in the area. Therefore, the CMA considered whether general dentists, dentists with enhanced skills, and/or secondary care providers exert a competitive constraint on the Parties.

69. Third parties who responded to the CMA's merger investigation gave mixed views. They generally indicated that there are incumbency advantages for existing contract holders. However, NHS England commented that although existing contract holders would be likely to score highly in any assessment in relation to premises identified in a local area (since they are already present) and may also benefit from the fact that previous performance would be taken into account, both factors would only form a small part of the overall score when assessing the strength of a bid.

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[27] See the NHS Dental Services – Vital Signs Reports website.
[28] *IDH/ADP*, paragraph 8.

70. In general, the NHS commissioning entities that responded to the CMA's merger investigation indicated that they were not concerned about a lack of sufficient bidders for future contracts (albeit they were more sceptical about the ability of all such bidders to put together a credible offer) and responses from other third parties indicated that there may be entry from bidders outside of the market. NHS England indicated that in the future there is likely to be: (i) greater overlap between the IOTN levels that can be treated currently by primary care and secondary care providers; and (ii) where hospitals bid for contracts to provide services that are currently primary care services, they will be treated like all other bidders. Some large corporate chains providing both general dentistry and orthodontics that responded to the CMA's merger investigation submitted that they could bid for contracts by extending provision at an existing general dental surgery to include orthodontics.

71. Oasis also submitted that the tender design, which is controlled by the NHS commissioning entities, can have an impact on the level of competition for any given tender and can be specifically designed to increase the number of credible bids. On the basis of the evidence before it, the CMA considers that the framework of the tender process will be a significant driver of the level of competition in bidding for NHS orthodontic contracts in the future. In that regard, the CMA notes that the Department of Health and Monitor have both issued guidance on how NHS commissioning entities should procure health services.[29]

72. Overall, on the basis of the evidence it has found, including the Parties' combined share of supply in Kent, Surrey and Sussex, the presence of other credible providers and the absence of material third party concerns, particularly from commissioning entities, the CMA does not consider that there is a realistic prospect that the Merger will substantially weaken the competitive outcome of future NHS tender processes for orthodontic services. Therefore, the CMA does not consider that there is a realistic prospect that the Merger will give rise to a substantial lessening of competition as a result of horizontal effects in competition for the market for the provision of orthodontic services under contract to the NHS.

Competition in the market

73. The CMA notes that, while price is a relevant parameter of competition for the provision of orthodontic treatments to private patients, NHS orthodontic treatments are provided to eligible patients free of charge. Furthermore, as

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[29] See Department of Health (2010), *Procurement guide for commissioners of NHS-funded services*, and Monitor (2013), *Substantive guidance on the Procurement, Patient Choice and Competition Regulations*.

explained above, reimbursement of NHS orthodontic activity is set by the individual contracts that each provider of orthodontic services to the NHS has with the relevant commissioning entity and the annual contract value is paid monthly in arrears to each provider. Therefore, the CMA considered whether the merged entity would have the ability and incentive to lower quality, reduce the range of services, reduce the level of service or reduce innovation in respect of NHS patients, so as to reduce the costs associated with non-price factors of competition and increase profits.

The provision of orthodontic treatments to private patients

74. The CMA considered the impact of the Merger in each local area around the Parties' sites by adopting 80% catchment areas as a starting point for its analysis.

75. Based on that analysis, the CMA identified that at least seven other providers of orthodontic treatments to private patients remained in each area where the Parties overlap. The CMA considers therefore that a sufficient number of other providers remain post-Merger and does not consider that there is a realistic prospect of a substantial lessening of competition in relation to the provision of orthodontic treatments to private patients in the areas where the Parties overlap.

The provision of orthodontic treatments to NHS patients

76. As explained above, orthodontists are contracted by the NHS on the basis of UOAs and, because NHS orthodontic treatments are free at the point of provision, the CMA considers that there is no price competition between providers of NHS orthodontic treatments at the retail level.

77. Accordingly, the CMA has considered whether non-price factors may nevertheless be affected by the Merger. As set out in *IDH/ADP*, non-price factors that could be affected include the length of the waiting list for an appointment, the length of the waiting time at the practice before an appointment, the convenience of the practice's opening hours, the general quality of the practice environment, and the ease of access to the practice by telephone or internet.[30]

78. Oasis submitted that the Merger will not lead to a reduction in service, quality or innovation for NHS patients on the basis that:

[30] *IDH/ADP*, paragraph 50.

- following the Merger sufficient primary and secondary care providers remain in the areas where the Parties overlap;
- the range of services provided by the Parties and certain non-price parameters, including opening hours and the general quality of the practice environment, are covered by the contractual and quality assurance obligations imposed by the NHS contractual framework;
- waiting lists are not driven by competition, but rather by capacity constraints under the NHS contractual framework and the reputation of the clinician; and
- the Parties' ability to degrade the service offered to NHS patients will be constrained by the fact that the Parties provide orthodontic treatments to private patients, given that the Parties' NHS patients and private patients are treated in the same surgeries and thus share the same practice environment and services.

79. The CMA considers that the baseline for the level of competition in the market is, as Oasis submitted, determined by the existing contractual framework for the provision of NHS orthodontic services. At present, capacity in the market is constrained by the fact that providers of orthodontic treatments to NHS patients have no incentive to perform more UOAs than the number specified in their contracts and that there are lengthy waiting lists for NHS orthodontic treatment because demand outstrips supply. As noted above, NHS England confirmed that under the NHS's contractual framework, providers are not reimbursed for carrying out any additional UOAs over and above their contractual requirements, are not able to 'carry over' additional or unused UOAs into the following year, and may have payments clawed back by the commissioning entity for any underperformance of contracted UOAs.

80. Based on the evidence before it, the CMA considers that at present the NHS contractual framework for orthodontic services serves to dampen the potential for competition in the market between providers of orthodontic treatments to NHS patients, including between the Parties. The CMA also considers that the design of the future tender process and contractual framework by NHS England will determine whether this dampening of the potential for competition remains a feature of the market after the end of the current NHS contracts.

81. Against that background, the CMA has assessed the extent to which the Parties would, following the Merger, have the ability and the incentive to decrease quality, service or innovation in providing treatments to NHS patients, in order to reduce costs and increase profitability.

82. The CMA considers that, although private providers do not fall within the frame of reference for the supply of orthodontic treatments to NHS patients, the fact that a significant proportion of the Parties' revenue from orthodontic treatments is derived from private patients provides the Parties with an incentive to invest in a good quality practice environment, which also benefits NHS patients. While the CMA notes that there may be some ability for the Parties to discriminate between NHS patients and private patients at the margins, eg in relation to the convenience of opening hours or the level of experience of the orthodontist providing the treatment, the CMA believes that this ability is somewhat limited because other aspects of treatment provision cannot easily be differentiated, eg the application of practice-wide safety protocols or the general quality of the practice environment. Furthermore, the CMA considers that the Parties' incentives to discriminate in this way are constrained for the reasons set out below.

83. Third party responses to the CMA's merger investigation indicated that it is important for orthodontic providers to maintain a reputation for quality with referring dentists in the area in order to attract referrals for NHS (and, in some cases, private) patients. The CMA considers that this indicates that, absent the dampening of the potential for competition resulting from the existing NHS contractual framework identified during the merger investigation, there is scope for there to be stronger competition in the market between providers of orthodontic treatments to NHS patients. Furthermore, the responses indicated that a number of NHS patients referred by dentists are found to be ineligible for NHS-funded orthodontic treatment following the initial orthodontic assessment because they do not meet the qualifying criteria. The CMA therefore considers that, as a result of operating mixed private and NHS orthodontic practices, the Parties may have additional incentives not to lower the quality of the existing practice environment for NHS patients.

84. Similarly, although secondary providers of orthodontic services do not fall within the frame of reference for competition in the market, the CMA considered whether they may still provide a constraint on the merged entity. Based on the responses from third parties to the CMA's merger investigation, which indicated a general preference among secondary care providers for focusing on more complex cases rather than expanding into primary care, the CMA considers that, at present, secondary providers provide only a limited constraint on the Parties in the provision of orthodontic treatments to NHS patients. However, the CMA notes that the importance of such secondary care providers may increase following future NHS tender processes.

85. The CMA considers that the importance of winning NHS contracts for orthodontic services (that is, competition for the market) means that allowing quality or service to be impaired in the short term for NHS patients (assuming

discrimination is possible) is likely to be a risky strategy for the merged entity as it may jeopardise its chances of successfully bidding for contracts in future NHS tenders. For the reasons set out above, including the fact that the merged entity does not have market power at the regional level and that there are a number of credible bidders for NHS orthodontic contracts, the CMA believes that the Merger does not give rise to a realistic prospect of a substantial lessening of competition for the market. On that basis, and in the context of the dampening of the potential for competition in the market resulting from the NHS contractual framework described above, the CMA considers that the need to optimise the chances of successfully bidding for future NHS orthodontic contracts in the context of a competitive process constrains the incentive for the Parties to reduce quality or service levels in respect of NHS patients post-Merger.

86. Finally, the CMA notes that the Parties are also subject to the contractual quality requirements specified in their contracts with the NHS, eg in relation to opening hours, in addition to being subject to external quality assurance as NHS primary care providers. However, while the CMA accepts that regulation plays an important role in ensuring minimum standards of quality, it notes that it does not lead to all providers providing the same levels of quality and does not remove the incentive for providers to compete on quality.[31] That is, providers can strive to exceed minimum regulation standards, which is in the interest of patients. The CMA notes that Oasis submitted that the Parties outperform the minimum standards imposed by the NHS contracts.

87. On the basis of the evidence before it, the CMA considers that, until the end of the current NHS contracting period, providers of orthodontic treatments to NHS patients in the areas affected by the Merger compete only to a limited extent on non-price factors given the capacity constraints imposed by the contractual framework and the levels of excess demand indicated by the length of waiting lists for NHS orthodontic treatment. Furthermore, the CMA considers that the Parties' ability to reduce service and quality standards for NHS patients, along with their incentive to discriminate between NHS and private patients, are also constrained.

88. Therefore, the CMA considers that the Merger does not give rise to a realistic prospect of a reduction in the quality of orthodontic treatments provided to NHS patients in the areas where the Parties overlap.

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[31] See the *CMA guidance on the review of NHS mergers (CMA29)*, paragraph 6.52, and the Competition Commission *Report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust*, 17 October 2013, paragraphs 6.179–6.184.

Conclusion on horizontal unilateral effects

89. On the basis of the evidence it has found, the CMA considers that the Merger does not give rise to a realistic prospect of a substantial lessening of competition as a result of horizontal unilateral effects in relation to:

- competition for the market to supply orthodontic services under contract to the NHS in the area corresponding to the boundary of the relevant NHS commissioning entity;
- competition in the market for the provision of orthodontic treatments to NHS-eligible patients by current NHS contract holders within the 80% catchment area around each of the Parties' sites; and
- competition in the market for the provision of orthodontic treatments to private patients within the 80% catchment area around each of the Parties' sites.

Barriers to entry and expansion

90. Entry, or expansion of existing firms, can mitigate the initial effect of a merger on competition, and in some cases may mean that there is no substantial lessening of competition. In assessing whether entry or expansion might prevent a substantial lessening of competition, the CMA considers whether such entry or expansion would be timely, likely and sufficient.[32]

91. However, the CMA has not had to conclude on barriers to entry or expansion as the Merger does not give rise to competition concerns on any plausible basis.

Third party views

92. As part of its merger investigation, the CMA received comments from NHS England and the relevant NHS commissioning entities for the area where the Parties' activities overlap: the NHS England Surrey and Sussex Area Team and the NHS England Kent and Medway Area Team. The CMA also received comments from providers (including independent providers and corporate chains) of orthodontic services to the NHS, orthodontic treatments to NHS patients, and orthodontic treatments to private patients, as well as from secondary care providers and general dental practitioners.

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[32] *Merger Assessment Guidelines*, from paragraph 5.8.1.

93. Third party comments have been taken into account where appropriate in the competitive assessment above.

Decision

94. Consequently, the CMA does not believe that it is or may be the case that the Merger has resulted, or may be expected to result, in a substantial lessening of competition within a market or markets in the United Kingdom.

95. The Merger will therefore **not be referred** under section 22(1) of the Act.

Alex Chisholm
Chief Executive
Competition and Markets Authority
2 September 2015