Bupa Dental Care's Response to the Draft Statement of Scope in relation to the CMA's Market Study into Private Dentistry

Bupa Dental Care is a provider of both NHS and private dental care, operating more than 360 practices across the UK and the Republic of Ireland (ROI) under the Bupa Dental Care, Total Orthodontics, and Platinum brands (and the Smiles brand in ROI). Bupa Dental Care forms part of Bupa, a provident association with no shareholders, to fulfil Bupa's purpose of helping people live longer, healthier, happier lives and making a better world. With no shareholders, Bupa reinvests profits to provide more and better healthcare for current and future customers.

Bupa Dental Care has been delivering dental services for more than a decade and today supports approximately 9,000 employed and self-employed colleagues, who collectively treat more than 2 million patients each year. We recognise and value the essential work undertaken every day by our clinical teams, including (but not limited to) dentists, hygienists, therapists and orthodontists, alongside our wider practice teams, including (but not limited to) practice managers, dental nurses and reception staff, in delivering high-quality, safe and effective care and supporting positive patient outcomes.

Bupa Dental Care welcomes the opportunity to engage constructively with the Competition and Markets Authority (CMA) in relation to its market study into the private dentistry market. We look forward to continuing to work collaboratively through the course of the study. We are supportive of initiatives that enhance customer understanding and choice and that help patients access high-quality, safe and effective dental care in a sustainable and well-functioning market.

Q1: Do you agree with our proposed scope (both the product and geographic scope) for this market study, as set out in paragraphs 22 to 28. If not, what areas would you suggest we include, exclude or prioritise, and why?

We broadly agree with the CMA's proposed product and geographic scope for the market study. However, it is important that the scope takes into consideration, and explicitly recognises, the wider structural and regulatory pressures that have shaped private dentistry over recent decades, which are critical to understanding pricing, market behaviour and patient outcomes. For example, the following factors influence the costs of running a dental practice and consequently the cost of treatment, and should therefore be considered when assessing price movements and trends:

- Since Brexit and the COVID-19 pandemic, dental practices have experienced sustained and significant pressures and cost increases. The national shortage of dentists (including in delivering NHS care), rising staffing costs, reduced workforce mobility, and increased costs of clinical materials, laboratory services, equipment and utilities have all factored into the market dynamics.
- As a highly regulated sector, the private dentistry market has significant regulatory and compliance demands including clinical governance requirements, mandatory reporting, inspection activity, and a complex medico-legal environment. See also comments in question 2 with regard to the regulatory environment.
- Technological advancements in digital dentistry, while enhancing patient experience and clinical outcomes, also require significant capital investment.

We support the inclusion of the full range of *dental services* within scope, encompassing care provided by the wider dental team, including hygienists and therapists. It is important to acknowledge that clinical decision-making does not always rest solely with a dentist; hygienists and therapists may act as lead clinicians, particularly where they operate under direct access arrangements. Any assessment of market behaviour should recognise these differing models.

We agree that the mixed delivery model is relevant for an understanding of the provision of private services and it is correct that this is noted within the scope. Patients may access a combination of NHS and private services as a result of choice or due to the limits of NHS provision. A clearer national approach to public education on the NHS dentistry model in each region and nationally, could help patients to understand the options they have available across the sector and ensure consistency.

We also agree that that the scope should extend to all four nations in the United Kingdom. The regulatory regimes across the four nations and the availability and commissioning of publicly funded dentistry differ significantly both between and within nations. These dynamics require careful interpretation when drawing UK-wide conclusions.

Taken together, the proposed scope is appropriate, but the study will benefit from fully acknowledging the economic, regulatory and operational realities in which private dental practices operate. These contextual factors are integral to understanding market conditions, pricing behaviour and patient choice.

Q2: Do you agree with our articulation of the characteristics of a well-functioning private dentistry market as set out in Paragraph 20? If not, what should be changed and why?

We broadly agree with the CMA's articulation of the characteristics of a well-functioning private dentistry market as set out in paragraph 20. The focus on informed choice, transparency, trust, and effective regulation reflects essential principles that support good patient outcomes. There are a few areas where the articulation could be enhanced to capture other key characteristics of a well-functioning private dentistry market.

First, clinical quality and patient safety are fundamental components of a well-functioning market. Regulators such as the Care Quality Commission (CQC) oversee these areas (and CQC inspection reports into dental practices are publicly available), which are central to patient outcomes and underpin customer confidence.

Second, the articulation of consumer choice requires recognition of the broader mixed delivery model in the United Kingdom. Public funding for NHS dentistry has an impact on how patients access dental care and their consumer journey experience, including in the private dentistry market and we welcome the CMA's intention to consider this within the scope of its market study. NHS dental provision operates differently across regions, and further changes to the existing contract in England and Wales are in place from April 2026. Any changes as a result of NHS dental contract reform may have secondary impacts on the private dentistry market.

Third, private dentistry already incorporates strong mechanisms to support informed patient decision-making. The General Dental Council (GDC) Standards set out expectations that require clinicians to present treatment options, including associated benefits, risks and expected costs, enabling patients to accept, decline, or seek alternative options. In some cases, final costs may vary from a clinician's best estimate of pricing due to unforeseen clinical developments, and clinicians are expected to inform patients of the potential for changes in costs. Clinical decision-making must be ethical, based on valid consent, and focused on recommending only appropriate treatments. While patient choice is important, it should not create the expectation that any treatment can be provided simply because a patient is willing to pay. In a well-functioning market, clinicians should be empowered to decline inappropriate treatment to safeguard patient safety and ethical care, particularly in areas such as cosmetic dentistry. Prices may also vary between dentists depending on factors such as specialism, experience, and materials used as part of a treatment plan. This reflects the nature of healthcare delivery and should be considered when assessing the characteristics of the market.

Q3: Do you consider that the private dentistry market currently displays the characteristics of a well-functioning market set out in paragraph 20? If not, please explain why you consider this to be the case, what is driving this, and how this could potentially be addressed.

We consider that the private dentistry market in general displays the characteristics of a well-functioning market, with the added context outlined in the answer to question 2 above.

Competition within the market is healthy, supported by a range of providers to meet different customer expectations and needs. Patients have meaningful choice between providers (as well as between appropriate treatment options, and payment options) and are then able to make informed decisions that best meet their needs.

Additionally the functioning of the market is supported by the GDC standards, as described in the response to question 2.

Q4: What, if any, are the key differences in the private dentistry market across the 4 nations that should be reflected in our analysis? What drives any differences?

There are meaningful differences in the structure, regulation and operating environment of private dentistry across the four nations of the UK, and these should be reflected in the CMA's analysis. While many professional standards and regulatory expectations are consistent (for example across all nations GDC standards apply equally to all registrants which provides consistency in core professional expectations), each nation has distinct policy frameworks and inspection regimes that shape how private dentistry operates and therefore, the consumer experience. In particular:

- Each nation has a separate healthcare regulator: the CQC in England, Healthcare Improvement Scotland (HIS), Healthcare Inspectorate Wales (HIW) and the Regulation & Quality Improvement Authority (RQIA) in Northern Ireland. Although their overarching objectives are similar and focus on safe, effective and patient-centred care, there are notable differences in their requirements.
- There are differences in regulatory requirements between the nations. For example:
    - Specific clinical equipment and facilities are mandated in Northern Ireland and Scotland e.g. decontamination equipment, which differs from Wales and England.
    - There are specific facility requirements in Scotland e.g. to have specific types of sinks.
    - Learning disability and autism training has recently been mandated in England & Wales, but this is not mandated in Scotland and Northern Ireland.
    - The CQC requires the practice to have evidence of GDC registrant's continuing professional development (CPD) (5 yearly requirement by GDC), whereas other regulators are content to accept the registrant's confirmation that they have completed the applicable learning, across their CPD cycle.
    - The mandated audit requirements differ e.g. IPC, Ionising radiation audits are specific to nations.
    - There is a requirement to provide internal assurance to practices in Wales and Northern Ireland annually, and provide a report, which is not required in Scotland or England.
    - Northern Ireland faces additional regulatory considerations related to the post-Brexit arrangements for the movement of medicines and medical products. For example, requirements under the Human Tissue Authority differ from those in the rest of the UK, affecting areas such as implant dentistry.
- The structure and funding of NHS dentistry differs substantially across the four nations, and these differences directly influence the size, shape and behaviour of the private market. NHS contracting models and capacity vary significantly, leading to different levels of NHS access, impacting the private dentistry market.

Recognising these divergences will support a more accurate and nuanced assessment of how the private dentistry market functions across the UK and what drives any variations in consumer experience. Standardising nationwide expectations would in our view be helpful as consistent regulatory

standards would reduce complexity, support standardisation in relation to customer experience and reduce the financial burden on dentists of managing multiple regulatory environments

Q5: Are there specific areas we should focus on in relation to the consumer journey and choice, including consumers' ability to make informed choices, access and switch private dental services, or aspects to the consumer experience? Why?

We do not consider there to be specific areas in relation to the customer journey and choice that require particular CMA focus from a scoping perspective.

We agree with the CMA that consumers' ability to make informed choices and ease of accessing or switching private dental services support a well-functioning private dental market.

We are aligned with the CMA that accurate pricing information throughout the patient journey, as required by GDC Standards, supports informed decision making. This includes the digital journey and the information displayed on websites, booking platforms and advertising. Not all elements of value would be visible in standard treatment descriptions in a price list – for example, practices may offer enhanced technology, different appointment lengths, or clinicians with specialist expertise that influence the overall patient experience and clinical outcome. It is therefore important that practices support transparency at all stages of the patient journey (including beyond the price at booking). As the market is fragmented and the majority of dentists are self-employed, there will likely be differences in approach as to how treatment information is presented and carried out.

Similarly, the accuracy and clarity of treatment plans, particularly for more complex clinical or cosmetic treatment proposals and ensuring those treatment plans are consistently provided and clearly explained is important from the perspective of a consumer's ability to make informed choices.

Patients are able to access and switch between private dental providers. Given the variety of providers in the market, there will naturally be variations in processes for patients wishing to move to a different practice, such as requirements for initial consultations or assessments.

Q6: Are there any specific areas that we should focus on because they have the potential to disproportionately affect vulnerable customers?

Customers may be vulnerable as a result of a range of factors which include financial, cognitive, linguistic, physical, sensory or emotional factors. These factors can make it harder for individuals to understand their choices, assess risks, or access consistent and appropriate care. However, in our experience these challenges can be mitigated through adherence to the existing regulatory framework, including equality legislation and protected characteristics, and the provision of reasonable adjustments by dental practices to support vulnerable customers (including those with dental anxiety).

Ensuring informed consent

For vulnerable patients, the legal, regulatory and ethical principle of informed consent is an essential protection. Individuals with reduced capacity, learning disabilities, neurodiversity, or communication needs may require enhanced explanation, additional time, or support from carers to understand treatment options, risks and costs. Without appropriate safeguards, these patients could be at increased risk of agreeing to treatment they do not fully understand or consenting to extensive or high-value treatment. Ensuring that clinicians act in line with their regulatory obligations, follow clear protocols, provide information in accessible formats, and document decision-making rigorously are key steps that support the provision of services to vulnerable customers.

Reasonable adjustments

Physical, cognitive, sensory and language needs can all create barriers to accessing private dental care. The additional support vulnerable patients may need will depend on their specific need but could include mobility requirements and wheelchair or other physical access requirements, translation

services, quieter appointment times or additional time for discussions, support for dyslexia, dyscalculia, neurodiversity or dental anxiety, and the provision of Makaton resources to support patients with specific communication needs. Vulnerable patients, or specific groups of vulnerable patients, may in theory benefit more from stable clinical relationships, predictable environments, and consistent follow-up – but this may in practice depend on the needs of the specific individual.

In line with existing regulations, including equality legislation and protected characteristics, providers seek to work with the individual and their advocates and employ reasonable adjustments to support these additional needs. At Bupa, for example, we seek to support patients with visual or hearing impairments through accessibility measures such as hearing loops and large print resources and we are launching a pilot programme to train clinical teams in British Sign Language (BSL).

Financial hardship / low income groups

People on low incomes or facing financial hardship may be disproportionately affected by limited access to, or long wait times for, clinically necessary NHS dental services. As a result, they may face greater challenges in accessing timely care and may be more exposed to the costs of seeking private treatment. It is therefore important that clear, accessible information is available to help patients make informed decisions about their care, including an understanding of the options available to them.

Q7: Do dental payment plans/financing of dental treatments impact the consumer journey and choice in the private dentistry market? If so, please explain how.

Dental payment plans and treatment finance options offer additional choice for consumers, expanding access and affordability and therefore help shape the consumer journey and influence choice within the private dentistry market more generally (although customers who use payment plans currently make up a smaller sector of the market as a whole).

Payment plans allow patients to spread the cost of care over predictable monthly payments. They provide a range of options to support patient choice and meet with their clinical needs, this can offer different ways to pay, encourage regular attendance, and support better long-term oral health. Preventative care delivered through these plans may also help reduce the incidence of more complex treatment needs, with wider benefits for general health given the strong evidence linking oral health to systemic conditions such as diabetes and cardiovascular disease.

Finance options can enable patients to proceed with clinically necessary or desired treatments that would otherwise be less affordable upfront. When offered responsibly, finance increases the range of choices available to patients and supports equitable access to care. These products are regulated by the FCA, which provides an additional layer of protection for consumers.

Q8: Are there any specific issues we should focus on in terms of how, and the extent to which, dentists compete to win customers and are incentivised/disciplined to meet customers preferences and needs? Why?

We do not consider there to be specific issues necessitating focus by the CMA in terms of how dentists compete to win customers. However, we have highlighted below two factors that influence competition between dentists to provide the CMA with additional market context: (1) ethical standards; and (2) customer switching behaviour.

(1) Ethical standards

Competition within the private dentistry market operates within the boundaries of professional and ethical standards. Dental professionals and practices are required to comply with GDC Standards, particularly in relation to ethical advertising, communication, and putting patients' interests first. This

framework on competitive behaviour supports patient trust, informed choice and safe clinical decision-making.

Patient preferences must be considered in accordance with GDC Standard 1, “Put patients’ interests first.” Preferences should be accommodated where it is clinically appropriate to do so. However, there will be circumstances where a patient’s request cannot be met—for example, when a proposed treatment would be inappropriate or not in their best interests. Ethical obligations require that treatment recommendations are based solely on clinical need, not commercial opportunities and competitive pressure must not be allowed to compromise these safeguards.

(2) Customer switching behaviour

Patients are able to choose between private providers. While consumer preference is often driven by the location of the practice, other factors may also influence the choices made by patients.

A patient’s choice of provider may be influenced by:

- Location, availability of parking, and proximity to home.
- Relationship with the dental professional and practice team.
- Appointment availability
- Condition of the practice.
- Understanding who owns a particular practice. Patients may have a preference for a particular brand, or for a local independent.
- Any practical and financial switching costs.
- Availability varies between the four nations of the United Kingdom and regions within those nations. Areas with lower NHS availability will mean greater reliance is placed on private provision in that area.

Q9: Are there any particular conduct or practices we should focus on that may adversely affect consumers/competition? What are they and why should we focus on them?

We consider competition in the market to be generally healthy and conduct effectively governed by existing professional and ethical regulatory frameworks and wider legal obligations. We anticipate the following factors relevant to competition will become apparent to the CMA throughout the market study.

- Transparency and accuracy of treatment costs and plans available in-practice and online. This is important to ensuring that consumers are able to choose between private dentistry providers and we see this as particularly important for higher cost treatment such as cosmetic dentistry, where treatment is often advertised as a package.
    - We do consider there is an opportunity to provide greater consistency and clarity in industry-wide expectations around fee presentations.
    - Specifically, we are supportive of appropriate additional guidance being issued to dentists and practices to ensure that the publishing of pricing information on websites and in practice is consistent across the sector as a whole and reflective of representative costs a customer may be required to pay.
    - Our view is that transparent and accurate pricing information should: be available both digitally and in practice, be kept up to date, include a comprehensive list of dental services and treatments and describe the dental services and treatments in a way which allows a customer to understand the prices offered by different providers as far as possible given variations in treatment methods, materials and appliances.

- Clinician indemnity products. We consider there is an opportunity to support customers and make complaint mechanisms more effective by reviewing clinician indemnity propositions in the market. More consistency across products, alongside greater guidance to clinicians (particularly at the early stages of their career) on the options, benefits and limitations on the products available to them would be helpful. Additional detail on this point is included within our response to question 10a.

Q10a: We are interested in whether regulatory frameworks across the UK, and their enforcement, along with complaint and redress mechanisms, support good competition/consumer outcomes. Are there any particular areas we should consider? Why?

Regulatory frameworks across the UK play a central role in safeguarding patients and supporting fair, competitive dental markets with strong consumer protection. There are a range of regulators with different responsibilities for aspects of private dentistry, including the CQC, HIS, HIW, RQIA, the GDC, CMA, FCA and Advertising Standards Authority (ASA).

Additional commentary on the differences in the regulatory frameworks across the UK is included at question 4.

GDC Standards

The GDC standards form the foundation of professional regulation. There are 9 principles that all GDC registrants must apply to the delivery of dental care to ensure that they remain within the law and meet and sustain their professional duty as registrants. The four principles of particular relevance to the CMA's proposed market study are:

- Putting patients' interests first (Principle 1);
- Communicating effectively with patients (Principle 2);
- Obtaining valid consent (Principle 3);
- Having a clear and effective complaints procedure (Principle 5).

These principles help ensure patients receive safe, ethical care and clear information, supporting informed choice and trust in the market.

Complaints handling

All clinicians are required to comply with their professional duty of candour when something goes wrong and to inform the patient. In addition, all organisations that deliver healthcare are mandated to comply with the statutory duty of candour requirements (pursuant to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014), where there has been or could be patient harm as a result of regulatory activity (as defined by the healthcare regulators).

There are some differences between the four nations in terms of the regulatory approach to duty of candour but all healthcare regulators across the UK require a complaints procedure to be in place and for this procedure to be communicated to patients. The timelines for complaint investigation and resolution is left to the provider, and the approach may differ between larger corporate providers and smaller independents given the differences in resourcing and organisational structure.

Healthcare regulators do not manage or investigate complaints. CQC, HIS & HIW however, may inform providers if they receive concerns about a practice or clinician to enable providers to assess and respond as necessary.

Where a patient makes a complaint related to private dentistry, and it is not resolved to their satisfaction, they can contact the Dental Complaints Service to support them in resolving their complaint.

The relationship between complaints and indemnity providers

The majority of dentists in the private sector are self-employed and are required by the GDC to maintain their own professional indemnity policy with an appropriate level of cover for their delivery of dental services. Practice owners including Bupa may also include specific contractual requirements on the minimum level of financial cover any dentist providing services at the practice must have in place.

There are a number of products available on the market for clinicians to meet their needs. This includes both discretionary indemnity policies, typically offered by medical mutual organisations, and insurance based contractual policies. In summary, discretionary indemnity products – which are a common feature of the medical indemnity market - mean that an indemnity provider is not contractually bound to respond to a complaint or claim and the indemnity provider maintains discretion as to when to assist its member. These indemnity policies work in a different way to a contractual insurance policy under which the insurer will respond to complaints / claims provided the conditions of the contract are met. Within indemnity products themselves, there is further differentiation between products with some indemnity products operating on an occurrence-based basis i.e. cover will operate in respect of incidents that arise during your period of cover, irrespective of when the claim is made; or on a claims made basis i.e. cover will operate in relation to any claims made and reported whilst a clinician holds the cover. The nature of discretionary products and the fact that both indemnity and contractual products are available on the market results in inconsistency in complaint handling depending on the type of product an individual dentist may have (which may impact on the experience of the customer when things go wrong, as more particularly set out below). Support to dentists to ensure they understand the scope (and any limitations of their indemnity/insurance product) is key so that they can properly evaluate the product e.g. alongside price, the level of clinical and legal advice that is accessible.

Complaints management and resolution of clinical (rather than service) complaints requires engagement by the individual clinician who, in turn, will typically engage their professional indemnity provider. In practice this means that this model can only work effectively where clinicians purchase effective policies, engage with their policy provider and their policy provider responds swiftly to support the clinician and, where appropriate support patients with financial recourse. This is because, in most cases there would be no direct relationship between a corporate practice owner and an individual clinician's policy provider. Often if a patient has a concern, this may need to be dealt with urgently by a practice or clinician. The current insurance and indemnity model does not always operate in a way that facilitates this.

A specific example of where the current indemnity landscape does not operate as effectively as it could is when a dental professional has moved practices, retired or does not engage with the complaint. This can lead to complaints taking longer to resolve and cause patient detriment as a result, as indemnity providers act on the instruction of their member (and not the practice / practice owner). If indemnity providers were required to have standard processes to engage with practice owners (even when a clinician is not engaging), this would support good patient outcomes.

Q10b: Are there elements of these regulatory frameworks that create unnecessary or disproportionate barriers to entering the private dentistry market or to expanding existing businesses?

Overall, the current regulatory frameworks are designed to ensure patient safety, high clinical standards and safe care environments, and in that respect they are appropriate and proportionate. CQC regulation supports quality and safety of practice environments.

The impact (in terms of barriers) of the requirements of regulatory frameworks will likely depend on the relative resources, expertise and knowhow of the provider in question.

The regulatory frameworks and how each regulator applies the framework differs materially across each nation of the United Kingdom. For providers who operate in multiple jurisdictions in the United Kingdom, this can create duplication and increase administrative workload. Please see our response to question 4 above.

Q11: More generally, are there any barriers to entering the private dentistry market, or to expanding existing businesses, that you believe are unnecessary or disproportionate. If yes, please explain. Are there particular barriers for smaller businesses?

Beyond regulatory considerations, factors that can influence a decision as to whether to enter a particular private dentistry market or expand existing businesses include the upfront capital investment to meet modern clinical and patient expectations and workforce shortages and recruitment issues. Recruiting a team of dental professionals continues to be challenging in the current environment.