British Dental Association evidence to the Competition and Markets Authority's private dental market study

April 2026

BDA
British Dental Association

Contents

Executive summary

The private dental market functions well, with competition and patient choice.

Patients can access dental treatment at around 12,000 dental practices across the UK, with high levels of satisfaction in care received. Practices and dentists offer a full spectrum of care, from routine treatment options to cosmetic dental procedures. Private dentistry enables dentists to offer the breadth of treatment that today's patients expect, including cosmetic and advanced treatments using innovative techniques and materials that are not always available within NHS frameworks.

There is a clear regulatory framework that requires dentists to act in the interests of patients and to be transparent on costs and treatment options.

The GDC's Standards for the Dental Team establish ethical and professional requirements for dentists and set out minimum professional standards. Dentists must put patients' interest first; explain treatment options and their costs; provide treatment plans and their estimated cost; and display pricing information, among other specific requirements to ensure transparency for patients. There are also clear mechanisms for patients to complain and seek redress at a practice level and through the Dental Complaints Service.

There has been a real terms reduction in the level of private fees, despite increases in input costs.

Between 2021 and 2025, private fees charged to patients have not kept pace with inflation, resulting in a decline in real fee levels of approximately 8%. Meanwhile, the costs of providing dentistry have increased. The average cost of private laboratory-made dental appliances, like dentures and crowns, increased by 4.9% in real terms between 2023 and 2025. The hourly pay of a dental nurse increased by between 4 and 9% from 2024 to 2025. Taken together, these findings suggest that dentists operate within a competitive environment where price increases are constrained, limiting the ability to fully pass on rising input costs.

Patients are sensitive to price increases and misperceive the costs involved with providing dental treatment.

Patients are very sensitive to price in their decision making about dentistry, whether this is private or NHS, with evidence that costs shape decisions about what treatments to receive or whether to receive them at all. This sensitivity acts as a disciplining factor on dentists' price setting, as it would

be difficult to maintain the long-term relationship that many dentists have with their patients if there was friction over pricing.

The NHS distorts patient perception of the costs of private dental treatment. In general, because healthcare services in the UK are mostly provided on a free-at-the-point-of-use basis, patients do not have a good sense of the costs of delivering these services. In dentistry specifically, NHS patient charges provide a cognitive anchor against which private prices are inevitably assessed. This depresses the price that it would be possible to charge for private treatment and increases the likelihood that private fees are considered expensive or unreasonable.

NHS dentistry is under-funded and is cross-subsidised by private income.

Most practices provide both NHS and private care. The under-funding of NHS dentistry across the UK means that many treatments are delivered at a loss. Dentists in Northern Ireland are paid £10.95 for recall examinations that cost them over £60 to deliver. In England, the cost of delivering NHS treatments exceeds the public funding provided by £1.2 billion, meaning that a proportion of the costs of NHS dentistry must be met from private income and therefore impacts on how dentists and dental practices set private fees. Governments are aware of this cross-subsidy and so it is either implicitly or explicitly their policy to rely on it. This is not a situation that we consider to be acceptable, and have long advocated for NHS dentistry to be funded adequately so that it is financially sustainable in its own right.

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Introduction

Almost all dental practices in the UK deliver some degree of private dentistry and in most cases this is delivered alongside NHS dental services. There is an established and well-developed private dental sector, which is worth around £8 billion. This market functions effectively, offering patients choice and dentists rewarding career opportunities.

Private dentistry makes a significant contribution to the oral health of the nation, with millions of patients actively seeking private care. Private dentistry enables dentists to offer the breadth of treatment that today's patients expect, including cosmetic and advanced treatments using innovative techniques and materials that are not always available within NHS frameworks. This flexibility supports the standards of care that our members take pride in delivering and which their patients expect.

This is reflected in patient satisfaction, with a YouGov poll we recently commissioned showing that 85% of UK adults who had been to the dentist in the last 5 years were satisfied with the dental care they'd received. This is in stark contrast to views about NHS dentistry as a system, where only 22% of the public report being satisfied with the service as a whole.

Contrary to some reports, our evidence points to a real terms fall in the prices patients have been charged for private dental treatments in recent years. These findings support the view that dentists operate within a competitive environment, where price increases are constrained and even the ability to fully pass on rising input costs are limited.

A major factor impacting on the private dental sector in recent years has been the crisis facing NHS dentistry. Underfunding of the NHS over many years has led to a situation where many dental treatments are now delivered at a loss in the public sector. For mixed practices to remain financially viable, this necessitates a cross-subsidy from the practices' private income stream. This has led to a shift in supply, as practices and dentists move increasingly to the private dental sector. Our analysis suggests that the full costs to practices of delivering NHS dental treatments in England is £4.18 billion – that is £1.22 billion more than the funding provided. This suggests that dentists are required to generate a significant cross-subsidy from their private income and this has a necessarily distorting

impact on the private sector. Our view has consistently been that NHS dentistry should be funded so that it is financially sustainable and does not need to rely on any cross-subsidy from private incomes.

The market for private dentistry, and in particular how patients make decisions about treatment, is distinct in a number of ways. Firstly, notwithstanding cosmetic treatments that patients may receive, the market is principally about the supply of clinically necessary treatment. The 'consumer' in this market is first and foremost a patient. Dentists have regulated responsibilities to act in patients' interests.

Secondly, each course of treatment delivered will be bespoke, based on the clinical need of the patient and their preferences for the care they want to receive. Each patient's mouth is unique and therefore the complexity, and costs, of common procedures like a filling or extraction can vary. There are also wide ranges in patient preferences from those seeking "smile makeover" results to patients who, maybe due to dental anxiety, opt for a minimally invasive approach to managing their oral health.

Thirdly, private dental services are delivered by regulated dentists, who must be registered with the General Dental Council in order to practise. There are clear standards that must be upheld, in general on acting in patients' interests, and specifically in relation to provision of information about pricing and discussing transparently the costs of treatments with patients. This is underpinned by mechanisms at a practice level and nationally for patients to make complaints and seek redress.

Further, while the system varies, NHS dental treatment is available across the UK, but its provision – as a government policy choice - is not comprehensive or universal. This has a range of distorting impacts on price and patient decision-making.

Finally, given the nature of the services, patients do not only consider price in their decision-making. Factors like their trust in an individual dentist are often an important factor. Equally, a patient may find the cost of a root canal treatment affordable, but opt for an extraction due to dental phobia and a consequent desire to avoid more complex and lengthy treatment.

In other ways, private dentistry is similar to many other markets in the provision of services and patients make decisions in similar ways to consumers in other markets. Patients have a wide range of choice about which dental practice to be treated at, and practices compete to attract patients. These practices provide a breadth of services from routine treatment to cosmetic, and from budget to luxury. Practices display price information, and dentists discuss costs of treatments and treatment options with patients. The market offers different ways of paying for treatment, such as fee per item, capitation plans, credit and insurance.

This paper responds to the CMA's statement of scope for its market study on the private dental sector, providing evidence and explanation on how the market functions and addressing the questions set out in that statement. The BDA considers the proposed scope appropriate for a review of the sector, notwithstanding our previously expressed view that the Chancellor's initial decision to seek a review of private dentistry is perverse, given the current crisis facing NHS dentistry and the Treasury's unwillingness to commit additional funding to address it. We believe that the CMA's description of a well-functioning private dental market is fair and accurate, and we broadly feel it applies to the status quo.

About the BDA and this paper

The BDA is the professional association and trade union for dentists practising in the UK. Our membership includes dentists working in general practice, community dental services, the armed forces, hospitals, academia and research, dental public health and dental students.

This paper focuses on 'high street' primary care dentistry. Where dentists are referred to throughout this report, these are General Dental Practitioners who work in this primary care setting. There are other dentists working in different settings who are beyond the scope of this CMA market study.

To support this paper, the BDA commissioned YouGov Plc to conduct a poll on the public's views, experiences and usage of dentistry. This polling was conducted between 23rd and 24th March 2026. The sample size was 2,181 adults in the UK. This survey was carried out online. The figures have been weighted and are representative of all adults in the UK (aged 16+). References to YouGov polling in this report are in reference to this research, with the exception of the references to Scottish and Welsh polls on access to NHS dentistry on page 13. In Scotland, YouGov Plc conducted a poll with a total sample size of 1,075 adults. Fieldwork was undertaken between 2nd - 10th February 2026. The survey was carried out online. The figures have been weighted and are representative of all adults in Scotland (aged 16+). In Wales, YouGov Plc conducted a poll with a total sample size of 1,092 adults. Fieldwork was undertaken between 2nd - 9th February 2026. The survey was carried out online. The figures have been weighted and are representative of all Welsh adults (aged 16+).

The BDA conducts an annual survey of general dental practitioners and the findings of these surveys are reported below. The BDA also participates in the Dental Market Study Group, and its analysis is also reported here.

1. Size and structure of UK dental market

The UK dental market comprises a large and diverse network of practices delivering both NHS and private care. When considering all practice types across the UK, the total number of dental practices in 2023/24 was 11,370, a 2.7% decline from 2019/20 when there were 12,052. Over the same period, the UK population has grown by 2.8%[1].

Practices have a range of structures from single-dentist practices through to large, multi-surgery practices that are part of large corporate chains. The services offered are also diverse, varying from those offering routine NHS and private care through to those who focus on cosmetic dental procedures. This provides patients with a broad choice as to which practice to receive treatment at, and there is necessarily competition to recruit new patients and to retain existing ones

In 2023/24, there were approximately 8,455 NHS General Dental Services (GDS) dental practices across the UK, representing a decline of 277 practices since 2019/20. This reduction was driven primarily by decreases in England and Wales, partially offset by small increases in Scotland. These practices will deliver at least some NHS treatment activity, but will in almost all cases mix this with private provision.

Table 1: Number of NHS General Dental Services Dental Practices by Country

Country	2019/20	2020/21	2021/22	2022/23	2023/24	Change
England	6,940	7,084	6,818	6,666	6,671	-269 (-3.9%)
Wales	437	458	475	473	415	-22 (-5.0%)

[1] Office for National Statistics - Annual Mid-Year Population Estimates

Scotland	983	978	976	1,016	1,005	+22 (+2.2%)
N. Ireland	372	368	365	363	364	-8 (-2.2%)
UK	**8,732**	**8,888**	**8,634**	**8,518**	**8,455**	**-277 (-3.2%)**

Source: Dental Market Study Group

Despite the overall contraction, the number of private-only practices remained relatively stable, falling only slightly from 3,320 to 3,275. As a result, the share of private-only practices increased marginally, from 27.5% to 27.9%.

Table 2: Structure of the Dental Practice Market						
Indicator	2019/20	2020/21	2021/22	2022/23	2023/24	Change
Private-only practices	3,320	3,500	3,380	3,087	3,275	-45 (-1.4%)
Total practices (all types)	12,052	12,388	12,014	11,605	11,730	-322 (-2.7%)
Share of private-only practices	**27.5%**	**28.3%**	**28.1%**	**26.6%**	**27.9%**	**+0.4 pp**

Source: Dental Market Study Group

Workforce trends

The number of dentists registered with the General Dental Council and therefore able to practise in the UK has steadily increased, with 47,002 registered as of the end of 2025. This was a 3% increase on the previous year, and up 11% since 2022.

Not all of these work in primary care dentistry, however. The number of dentists working in NHS GDS practices remained broadly stable over the period from 2019, increasing slightly from 29,491 in 2019/20 to 29,009 in 2023/24, with some variation across countries.

Table 3: Dentists in NHS GDS Practices by Country						
Country	2019/20	2020/21	2021/22	2022/23	2023/24	Change
England	23,905	23,028	23,640	23,591	23,685	-220 (-1.0%)
Wales	1,401	1,341	1,372	1,382	1,331	-70 (-5.0%)
Scotland	3,038	3,039	2,883	2,681	2,798	-240 (-7.9%)
N. Ireland	1,147	1,142	1,146	1,163	1,195	+48 (+4.2%)
UK	**29,491**	**28,550**	**29,041**	**28,817**	**29,009**	**-482 (-1.6%)**

Source: Dental Market Study Group

However, there has been a notable shift in the composition of the workforce. The number of private-only dentists increased significantly, from 5,980 in 2019/20 to 9,136 in 2023/24.

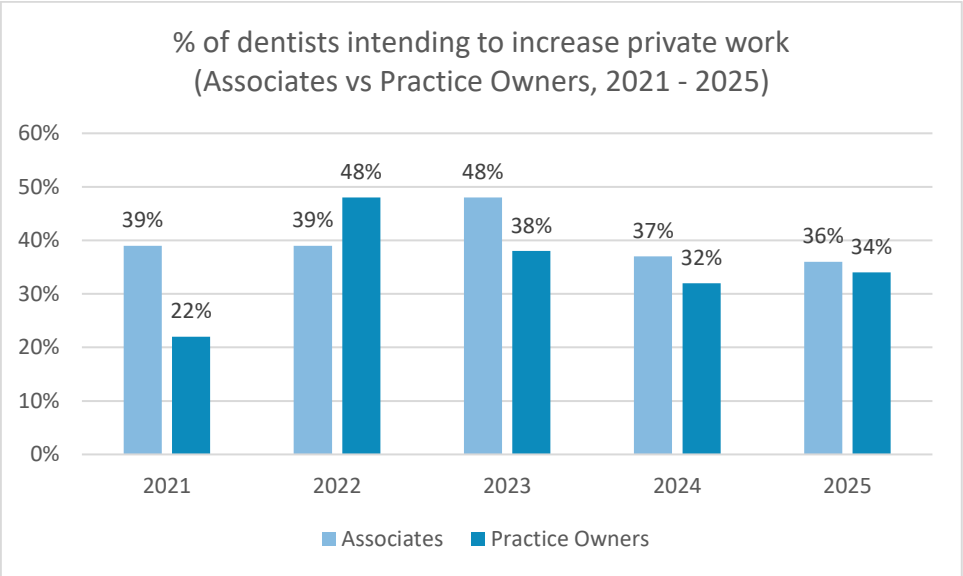
Consequently, the share of dentists working in private practice rose from 16.9% to 24.0%, indicating a clear shift in workforce allocation towards private provision.

Overall, patients have the choice to be treated by nearly 40,000 different dentists providing 'high street' primary care dentistry across the UK.

Table 4: Structure of the Dental Workforce						
Indicator	2019/20	2020/21	2021/22	2022/23	2023/24	Change
Private-only dentists	5,980	7,000	7,100	8,426	9,136	+3156 (+52.8%)
Total dentists (all types)	35,471	35,550	36,141	37,243	38,145	+2674 (+7.5%)
Share of dentists in private practice	**16.9%**	**19.7%**	**19.6%**	**22.6%**	**24.0%**	**+7.1 pp**

Source: Dental Market Study Group

Survey data indicates a growing and widespread preference among dentists to increase the proportion of private work they undertake, with a substantial share of both associates (dentists working within a practice) and practice owners reporting intentions to increase private activity in all years. While proportions fluctuate, the overall trend is clear, indicating a sustained directional shift.



Evidence from our survey on future intentions indicates growing negativity about long-term participation in NHS dentistry, alongside a clear divergence in planned activity.

A minority of dentists report plans to leave dentistry entirely in the short term, with around 12% intending to leave as soon as possible and a further 8% within the next 12 months. While the majority intend to remain in the profession, this masks significant variation in how they expect to participate.

In particular, intentions relating to NHS activity highlight a clear shift away from NHS provision. Around 23% report plans to leave NHS dentistry entirely, while a substantially larger share (44%) intends to reduce their NHS commitment over the next year. By contrast, only a very small

proportion (~2%) report plans to increase their NHS activity. The motivations for this are set out in more detail in section five.

This is consistent with reported recruitment dynamics. Among practices experiencing difficulties recruiting associates, around 70% cite reluctance to work in the NHS as a key factor, compared to only around 1% citing reluctance to work in the private sector.

NHS access and capacity

Changes in workforce and practice numbers are also reflected in measures of access. The UK population per NHS GDS dentist increased from 2,178 to 2,287 between 2019/20 and 2023/24, indicating a sustained reduction in NHS dental capacity relative to population need and growth.

Table 5 - Population per GDS Dentist

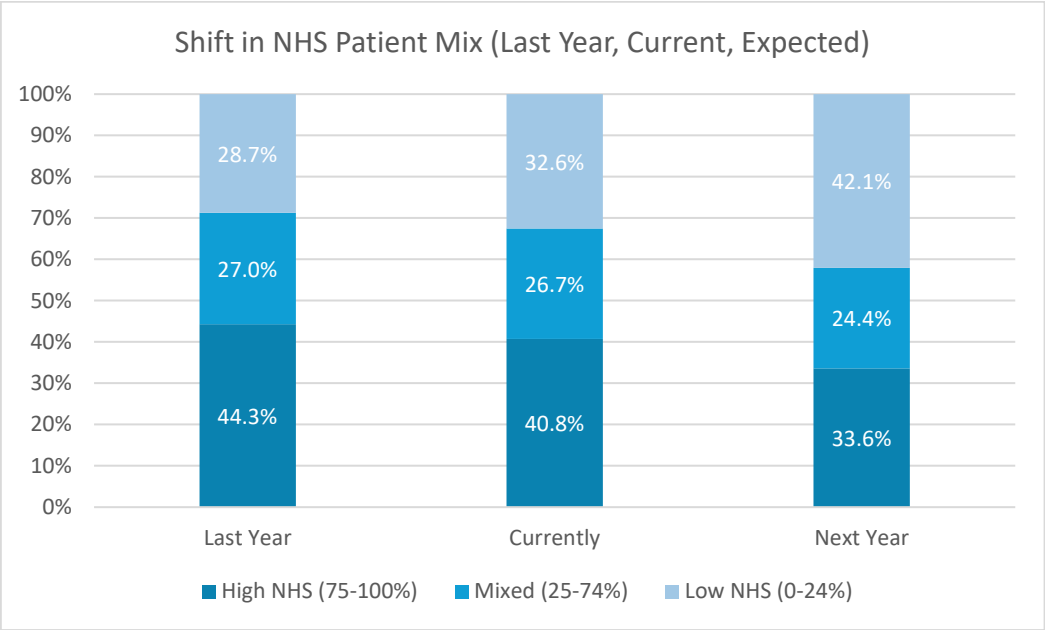
Country	2019/20	2020/21	2021/22	2022/23	2023/24	Change
England	2,279	2,373	2,331	2,365	2,385	+106
Wales	2,142	2,282	2,174	2,183	2,262	+120
Scotland	1,597	1,603	1,692	1,822	1,764	+167
N. Ireland	1,650	1,661	1,661	1,637	1,595	-55
UK	**2,178**	**2,258**	**2,234**	**2,276**	**2,287**	**+109**

Source: Analysis of Dental Market Study Group Data

This upward trend is observed across most nations, with Scotland experiencing the largest increase (+167), while Wales (+120) and England (+106) also saw substantial rises in population-to-NHS dentists ratios. These increases reflect a meaningful reduction in the availability of NHS dental provision per capita over the period. The figures are at headcount level, not Full Time Equivalent, capturing those who perform *any* NHS dentistry. The drop in NHS dental capacity per capita is likely to be greater than these figures indicate, because dentists have maintained *some* NHS activity but reduced the level of that activity.

Survey data indicates a clear and accelerating shift away from NHS provision in terms of patient mix. Between last year and current activity, the proportion of dentists treating predominantly NHS patients (75-100% NHS) has declined from 44.3% to 40.8%, and is expected to fall further to 33.6% next year. At the same time, the share of dentists with a low NHS commitment (0-24% NHS) has

increased from 28.7% to 32.6%, and is projected to rise significantly to 42.1%. The middle group (25-74% NHS) remains relatively stable but shows a slight downward trend over time.



This is reflected in the proportion of the population accessing NHS dentistry. This is measured differently in each part of the UK making direct comparison more challenging, but the overall patterns are clear.

In Northern Ireland, fewer than one million patients – just 50% of the small population of 1.9m people - are now registered with a Health Service practice. The service is shrinking at an unprecedented rate: by 17% over the past year alone, and by a staggering 389,132 patients since early 2023. The number of Health Service dental treatments delivered in December 2025 was 40% lower than in December 2018. The root cause of this is a contract with fees fixed by government which bear no resemblance to the actual cost to provide care, resulting in a severely underfunded service, so that an extraction, which alone would take around half an hour of surgery time and all of the expenses involved with that, is remunerated at just £12.75. Health Service dentistry in Northern Ireland is no longer viable to deliver by independent practices. This shift towards private dentistry is particularly stark given that the private dental market has historically been much smaller in Northern Ireland.

In England, 39.8% of adults were seen by an NHS dentist in the 24 months to 30 June 2025, compared to 50.19% in the period up to 30 Jun 2019. For children, in the 12 months to 30 June 2025 57.3% of the population were seen on the NHS, a smaller fall from 59% in the period to 30 June 2019. Analysis of the GP Patient Survey indicates that unmet need has increased from 1 in 10 of the adult population pre-Covid to 1 in 4 now.

In Wales, 40.6% of adults and 60.8% of children were seen in the 24 months to 31 March 2025. This compares to 56% and 68.7% in the same period to 31 March 2019. Based on a YouGov poll of adults in Wales, estimated unmet need for NHS dentistry stands at one-third of the adult population in Wales, with 20% saying they were unable to secure an appointment in the last 2 years, and a further 13% having effectively given up trying, assuming they would be unable to get one.

In Scotland, 62% of the population accessed an NHS dentist in the 24-month period to 31 December 2025. This is a slight improvement on the 60.7% seen in the period to 31 December 2024. Based on YouGov polling of Scottish adults, estimated unmet need for NHS dentistry stands at nearly one-fifth of Scotland's adult population, with 12% saying they were unable to secure an appointment in the last 2 years, and a further 7% having effectively given up trying, assuming they would be unable to get one.

Overall, the data points to a marked tightening of NHS dental capacity across most of the UK, with significantly more patients per dentist with any NHS activity than in 2019/20, increasing pressure on access to NHS care.

While there has been a shift of supply, it is important to note that there are fundamental challenges with NHS access arising from the policy decisions taken by governments, notably in England and Wales, to not commission sufficient NHS dental services for the whole population. Polling has found that the main reason patients would consider accessing private dental treatment in the next year would be an inability to access NHS care, with 32% stating this. This is compared to 9% stating that it would be because their existing dentist had gone private.

Income mix: NHS vs private dentistry

There has also been a clear and sustained shift in composition of practice income towards private dentistry. The share of income derived from private dentistry increased from 57.3% in 2019/20 to 63.7% in 2023/24, representing a 6.4 percentage point reallocation of income away from NHS dentistry and towards private provision. Correspondingly, the NHS share declined from 42.7% to 36.3%.

Table 6: Share of Practice Income from NHS and Private Dentistry (all practice owners)

Year	NHS Income Share	Private Income Share
2019/20	42.7%	57.3%
2020/21	45.0%	55.0%
2021/22	37.3%	62.7%
2022/23	35.9%	64.1%
2023/24	36.3%	63.7%
Change	-6.4 pp	+6.4 pp

Source: Dental Market Study Group

The shift was particularly pronounced between 2020/21 and 2021/22 and showed little sign of reversing, suggesting a structural change in the revenue model of dentists and dental practices rather than a short-term fluctuation.

Conclusion

Taken together, these trends point to a clear and consistent restructuring of the UK dental market:

- A contraction in NHS practice numbers
- A reallocation of the workforce towards private provision
- A deterioration in NHS capacity relative to population need
- A rebalancing of income away from NHS activity towards private dentistry

Overall, this evidence suggests that private dentistry is playing an increasing role in the provision of dental services, as NHS provision becomes more constrained in both capacity and relative share.

2. Private dental fees and costs

Our analysis shows that contrary to claims about significant price increases, private dental fees have declined in real terms. The evidence also indicates that price increase pressures in private dentistry are being driven by rising input costs rather than pricing behaviour.

This impact can be seen most directly in treatments with an associated laboratory bill, where there is a demonstrable real terms increase in costs, but not the same degree of inflation in the price charged to patients for these treatments. Laboratory costs have increased as a share of the fee charged to patients for these treatments, indicating reduced flexibility in pricing, tightening operating margins and greater sensitivity to input cost changes. The stability of private-to-NHS laboratory costs ratio further indicates that these pressures are system-wide and not driven by factors specific to private provision.

Non-dentist labour costs, such as employing dental nurses, receptionists and other practice staff, are a major component of the costs of delivering dentistry, and these costs have risen considerably in recent years. Partly this is driven by policy decisions, like the National Living Wage increase, but the dental specific labour market is also leading to inflationary pressures in this area.

While less acute than other cost pressures, dentists and dental practices must also cover the costs of providing the materials and equipment necessary to provide treatment, and there has been considerable inflation in these costs in recent years.

The cumulative impact of these cost pressures, alongside constrained increases in fees charged, has been to shift the proportion of private practice owners' gross income accounted for by expenses from 64.6% in 2014/15 to 72.7% in 2023/24.

Taken together, these findings suggest that dentists operate within a competitive environment where price increases are constrained, limiting the ability to fully pass on rising input costs.

As a result:

- Cost increases are only partially reflected in patient prices
- Providers are absorbing a share of rising costs
- Margin compression is likely, particularly for laboratory-intensive treatments

Trends in private dental fees

Overall, the observed trends are more consistent with a market characterised by rising input costs and constrained pricing, rather than one exhibiting excessive pricing or weakened competition.

Since 2021, the BDA has gathered data on private dental fees across a range of common treatments in our annual survey of dentists.

This data shows that private dental fees have increased in nominal terms between 2021 and 2025; however, they have not kept pace with inflation, resulting in a decline in real fee levels. On average, fees rose by approximately 14%, compared to CPIH[2] growth of around 24% over the same period, implying a real terms decline of approximately 8%.

This indicates that, at an aggregate level, private dental pricing has not kept pace with broader inflationary pressures.

While nominal fee increases are observed across treatments, these increases are generally insufficient to maintain their real value once inflation is considered. As a result, the purchasing power of fee income has declined over time.

Table 7 presents indexed fee changes across treatments. The UK average is shown alongside inflation-adjusted (real) indices.

Table 7: Indexed Private Dental Fees by Treatment (2021-2025, 2021 = 100)

Treatment	Nominal Price Index	Real Price Index (CPIH-adjusted)	Real % Change (vs 2021)
New patient examination	107.4	86.8	-13.2
Recall examination	115.4	93.3	-6.7
Radiograph (simple)	108.0	87.3	-12.7
Simple scale and polish	113.3	91.6	-8.4

[2] Office for National Statistics - CPIH

Hygienist simple scale and polish	114.5	92.6	-7.4
Extraction (one tooth)	119.5	96.6	-3.4
Composite filling (small)	122.6	99.1	-0.9
Composite filling (posterior large)	117.7	95.1	-4.9
Amalgam filling (large)	103.7	83.9	-16.1
Molar endodontics	114.1	92.3	-7.7
Upper metal denture (partial and medium-sized)	118.9	96.1	-3.9
Bridgework (per unit)	114.7	92.8	-7.2
Crown (bonded)	114.7	92.7	-7.3
Porcelain veneer (one tooth)	117.7	95.1	-4.9
Tooth whitening (both arches)	105.3	85.1	-14.9
Average across treatments	**113.8**	**92.0**	**-8.0**

Source: Analysis of BDA Survey of Practice Owners, 2021-2025

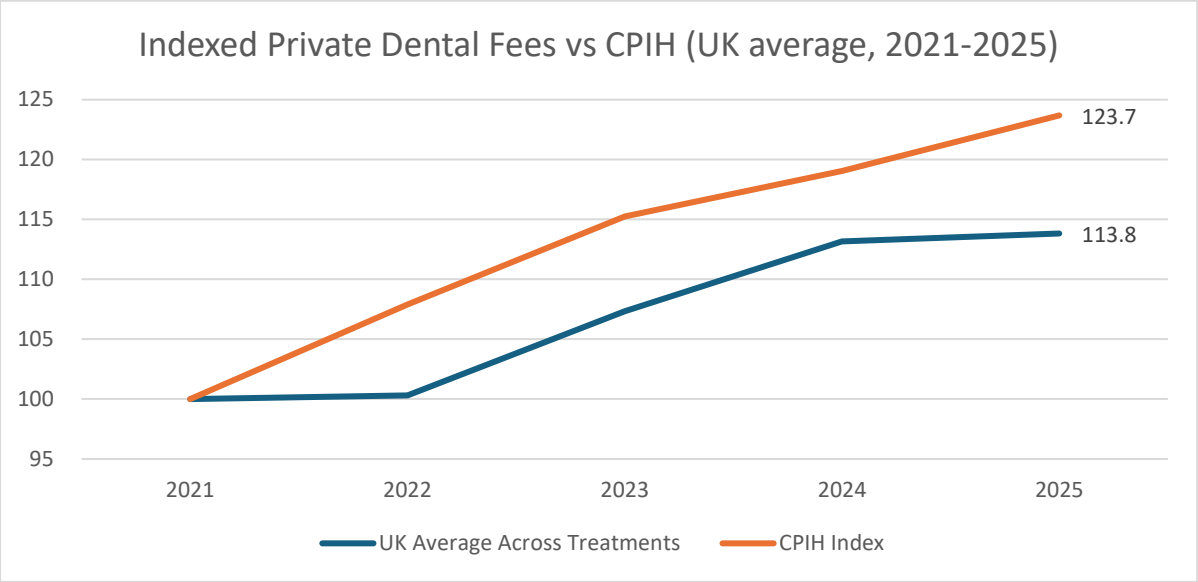
Note: CPIH (2021-2025) = 123.7. Real price indices adjust nominal UK average fees for inflation (2021 = 100)

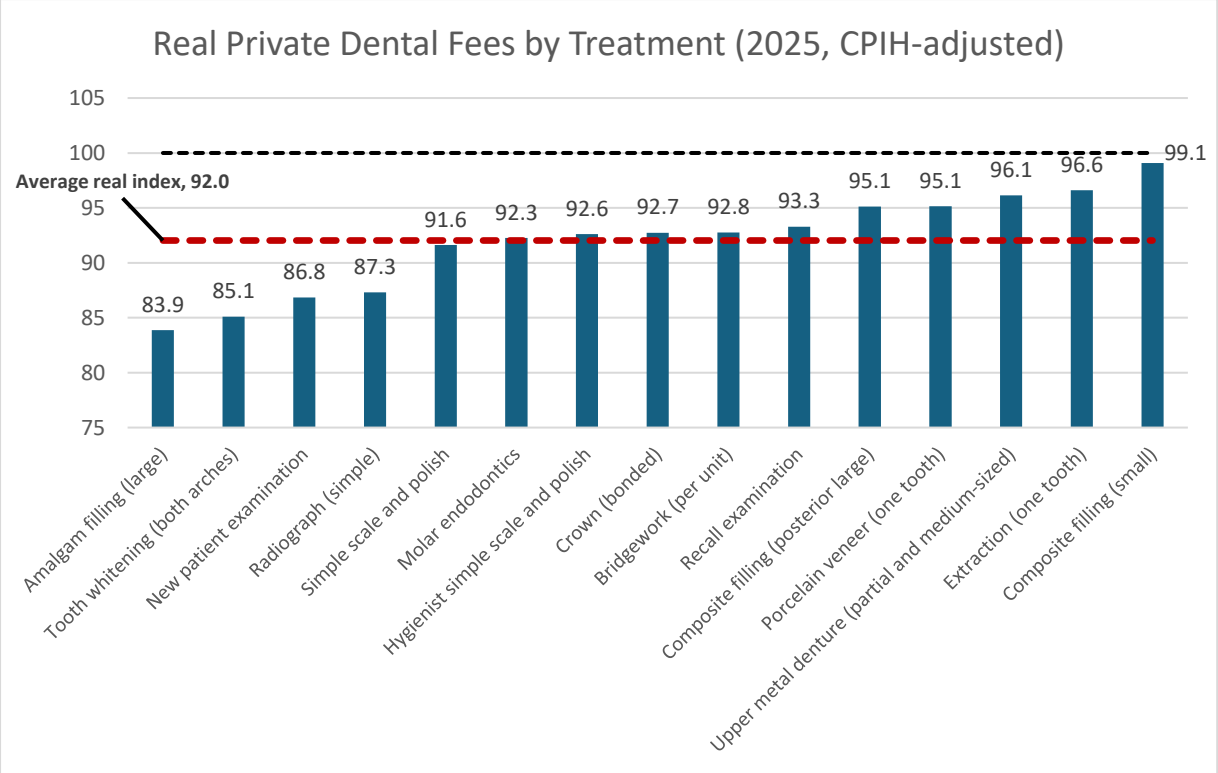
Example: Interpreting nominal vs real price changes

To illustrate the difference between nominal and real price changes, consider a new patient examination.

- The nominal price index is 107.4, meaning fees increased by 7.4% between 2021 and 2025.
- After adjusting for inflation (CPIH), the real price index is 86.8, equivalent to a 13.2% real terms decline (as shown in the real % change column in table 7)

This means that although prices have risen in cash terms, they have not kept pace with inflation, resulting in a reduction in the real value of fees.





Taken together, these charts show how private dental fees have evolved relative to inflation and how this translates into real terms outcomes across treatments.

Across treatments:

- The average real price index is approximately 92 (2021 = 100), implying an average real terms decline of around 8%.
- The majority of treatments fall below the inflation-adjusted baseline (100), indicating that fee increases have not kept pace with rising costs.

This points to a broad, system-wide real terms decline in fees, reflecting sustained pricing pressures rather than isolated effects.

Laboratory cost pressures

Laboratory costs are a significant component of the costs of providing treatments involving a lab-made dental appliance, such as a denture or crown. Since 2023, the BDA has tracked the costs to dental practices of a range of common lab-made appliances that are provided for both NHS and private dental treatment.

This has found that laboratory costs have increased for both NHS and private treatment between 2023 and 2025, with evidence of real terms growth driven by underlying input cost pressures.

Table 8: Laboratory Cost Growth and Real Changes (2023-2025)

Treatment	NHS Change	Private Change	CPIH (2023-2025)	NHS Real Change	Private Real Change
Porcelain veneers (per tooth)	12.2%	15.2%	7.3%	+4.9%	+7.9%
Inlays / Onlays (per tooth)	8.4%	16.0%	7.3%	+1.1%	+8.6%

Crowns (per tooth)	6.9%	7.7%	7.3%	-0.5 %	+0.3%
Resin retained Bridges (per unit)	17.2%	11.4%	7.3%	+9.9%	+4.1%
Conventional Bridges: Two-unit Cantilever (Simple bridges)	28.5%	7.4%	7.3%	+21.2%	+0.1%
Conventional Bridges: Two-unit (Complex bridges)	16.7%	12.1%	7.3%	+9.4%	+4.8%
Dentures: Acrylic - full upper and full lower	16.9%	10.7%	7.3%	+9.6%	+3.4%
Acrylic – Partial denture(s) (per arch)	18.4%	16.2%	7.3%	+11.1%	+8.9%
Metal - Partial denture(s) (per arch)	11.3%	10.9%	7.3%	+4.0%	+3.6%
Denture repairs (requiring an impression + fit stage)	19.9%	10.1%	7.3%	+12.5%	+2.7%
Special tray impression (necessitating an extra visit)	-21.7%	16.9%	7.3%	-29.1 %	+9.6%
Average	**12.2%**	**12.2%**	**7.3%**	**+4.9%**	**+4.9%**

Source: Analysis of BDA Survey of Practice Owners, 2023 & 2025

Note: Real change represents growth relative to inflation (CPIH). Positive values indicate costs rising faster than inflation.

While nominal increases average approximately 12%, the key finding is that, after adjusting for inflation (CPIH ~7.3%), laboratory costs have increased by approximately 5% in real terms. All positive real values in table 8 indicate that laboratory costs are rising faster than inflation.

Importantly, this pattern is observed across both NHS and private laboratory costs, showing that cost pressures are not confined to a single market. This would appear to show that these reflect labs passing on real cost pressures for the inputs to lab-made appliances.

In relation to NHS contracts, the uplifts applied to contracts have been insufficient to cover these increased costs in NHS lab bills. For example, in England, the Government has applied an uplift in respect of lab costs of 5.3% in 2022/23, 3.23% in 2023/24 and 1.68% for 2024/25. The shortfall in practice income that this leaves must be met from other sources, and is one factor leading to the private cross-subsidy for NHS treatment.

Relationship between fees and laboratory costs

Comparing fee trends with laboratory cost trends shows divergence between output prices and input costs once inflation is considered, although the underlying time periods differ[3].

- Private fees: 14% nominal increase from 2021 to 2025
- Laboratory costs: 12% nominal increase from 2023 to 2025

At face value, fee growth appears slightly stronger in nominal terms. However, after adjusting for inflation.

- Private fees: 8% real decline from 2021 to 2025
- Laboratory costs: 5% real increase from 2023 to 2025

This indicates that, while input costs from laboratory expenses are increasing in real terms, output prices are declining in real terms. This implies a margin squeeze, particularly for treatments with significant laboratory inputs. Fundamentally, this dynamic is indicative of constrained pricing behaviour rather than excessive price increases, with dentists and dental practices unable to fully adjust fees in line with costs.

Private vs NHS laboratory cost ratios

Private laboratory costs are consistently higher than NHS laboratory costs across treatments. The average ratio of private to NHS lab bills was 2.37x in 2023 and 2.35x in 2025. The range is from 1.2x to 2.9x.

[3] Laboratory costs data are available for 2023 and 2025 only. Private fee trends are presented over 2021-2025 to utilise the full available time series and provide broader context for pricing trends.

Table 9 - Private-to-NHS Laboratory Cost Ratios by Treatment		
Treatment	**2023**	**2025**
Porcelain veneers (per tooth)	2.22x	2.28x
Inlays / Onlays (per tooth)	2.45x	2.62x
Crowns (per tooth)	2.77x	2.79x
Resin retained Bridges (per unit)	2.50x	2.38x
Conventional Bridges: Two-unit Cantilever (Simple bridges)	2.77x	2.32x
Conventional Bridges: Two-unit (Complex bridges)	3.03x	2.91x
Dentures: Acrylic - full upper and full lower	2.73x	2.59x
Acrylic – Partial denture(s) (per arch)	2.44x	2.40x
Metal - Partial denture(s) (per arch)	2.02x	2.01x
Denture repairs (requiring an impression + fit stage)	1.90x	1.74x
Special tray impression (necessitating an extra visit)	1.19x	1.78x
Average	**2.37x**	**2.35x**
Median	2.45x	2.38x
Min	1.19x	1.74x
Max	3.03x	2.91x

Source: Analysis of BDA Survey of Practice Owners, 2023 & 2025

The ratio remains broadly stable over time, despite the real terms increase in laboratory costs identified in the previous section. This stability indicates that cost increases are occurring proportionately across both NHS and private laboratory markets, rather than being driven by factors specific to private provision. It is reasonable to conclude that the observed price differences reflect structural factors (e.g. specification, materials, supplier choice) rather than market power.

This reinforces the rationale that rising costs are being driven by common input factors across the system, rather than by changes in competitive conditions within the private market.

Laboratory costs as a share of private fees

Across the treatments analysed, laboratory costs account for a significant and growing proportion of total fees:

- Crowns: 33% increasing to 34%
- Bridgework: 52% increasing to 54%

- Porcelain veneers: 31% increasing to 33%
- Dentures: 52% increasing to 54%

Overall, this reflects an increase of approximately 1-2 percentage points in the share of laboratory costs within total treatment fees between 2023 and 2025. Laboratory costs are accounting for an increasing share of total treatment fees over time. This finding is consistent with earlier evidence that laboratory costs have increased in real terms, while private fees have not kept pace with inflation.

Table 10 - Private Laboratory Bills as Share of Private Dental Treatment Fees (2023 vs 2025)

Treatment	2023	2025	Change
Crown (bonded)	33.0%	33.9%	+0.9 pp
Bridgework (per unit)	51.9%	54.0%	+2.1 pp
Porcelain veneer (one tooth)	31.3%	33.3%	+2.0 pp
Upper metal denture (partial and medium-sized)	51.7%	53.5%	+1.8 pp

To take an example of this, in 2023, a crown cost [Redacted] from the lab and [Redacted] to the patient (33.0%). By 2025, this rises to [Redacted] and [Redacted] respectively, increasing the lab share of the patient fee to 33.9%.

The increase in laboratory cost share provides insights into how rising input costs are affecting the economics of dental provision. Specifically, it suggests that:

- A larger proportion of each treatment fee is now attributable to laboratory inputs
- The residual component of the fee (covering clinical time, overheads, and margin) is being compressed
- Providers have limited ability to increase fees sufficiently to offset rising costs

In effect, rising laboratory costs are being absorbed within existing fee structures rather than being fully passed on to patients.

Labour cost pressures

Non-dentist labour costs are a major component in the overall cost of dental services, accounting for around a fifth of practice owners' gross incomes[4]. This covers the costs of employing staff from dental nurses to receptionists and practice managers. Our surveys suggest that practices have faced double-digit inflation in staff costs. This has been driven by a combination of profound difficulties recruiting practice staff; increases to the National Living Wage; and the major increase applied to Employer National Insurance Contributions from April 2025.

[4] Dental Earnings and Expenses, 2023/24

The labour market for dental nurses, for example, demonstrates significant and persistent shortages in supply. Between three-fifths and four-fifths of practice owners have been seeking to recruit a dental nurse in each of the last five years and nearly all have experienced difficulties doing so. This inevitably has led to inflationary pressure on wages in order to attract and retain a sufficient workforce. Dentists are unable to provide treatment without being supported by a dental nurse.

Table 11: Recruitment of dental nurses	2021	2022	2023	2024	2025
Proportion of practice owners seeking to recruit dental nurses	63%	82%	80%	77%	73%
Of those seeking to recruit dental nurses, proportion of practice owners experiencing difficulties	80%	90%	85%	83%	77%

Source: BDA Survey of Practice Owners, 2021-25

Table 12: Percentage increase in hourly pay from 2023/24 to 2024/25	
Trainee dental nurses	9.36%
Registered dental nurses with five years of experience or less	5.25%
Registered dental nurses with more than five years of experience	4.39%
Orthodontic therapists	2.41%
Dental hygienists	2.37%
Dental therapists	4.64%
Dental practice managers	9.06%
Receptionists	4.57%

Source: BDA Survey of Practice Owners, 2024 and 2025

Material and equipment cost pressures

Alongside the costs of lab-made appliances, there are also inflationary pressures on practices for the materials and equipment needed to deliver dental treatment, from filling materials to dental chairs.

Using the ONS' CPI Medical products appliances and equipment measure, these costs increased by 21.8% from 2021/25. This is below CPIH for this period, but still represents a significant increase in costs when taken together with the other cost pressures practices are facing.

3. Patient choice and decision-making

Patient choice over provider

Patients have a wide range of choice over the practice where they receive private dental services, and of the dentist who delivers that care. There are also a range of different types of dental provision in the market. There are practices offering routine dentistry available on both an NHS and private basis, there are practices offering premium and luxury private dental care, and there are practices offering a range of cosmetic treatments. Patients are well served by this market and are very likely to be able to find provision that suits their needs, wants and budget in a location convenient to them.

While many patients seek NHS care, there are around six million adults in England who state that they prefer to access private care[5]. This is reinforced by the YouGov poll, which found that 29% of UK adults had mainly accessed private dentistry in the last five years, and that, since March 2020, 27% had a private check-up, 23% had their teeth cleaned on a private basis, and 15% had a filling done privately.

Around 1 in 10 (10%) UK adults state that their reason for seeking private provision is because they want treatments not available on the NHS and because of the perceived quality of care available privately relative to the NHS.

Related to this, where patients require care that is beyond the competency of a general dental practitioner, they will need to access the services of dentists with additional skills or who are on the GDC's specialist lists. NHS provision of these services, particularly in areas like restorative, endodontic or periodontal treatment, is typically limited, and therefore most of this treatment is offered on a private basis.

In addition to patients accessing care from dental practices in the UK, there has been an increase in 'dental tourism' in recent years, with patients seeking treatment from providers outside the UK.

Alongside this choice of provider, an important factor in the provision of dentistry is continuity of care. This has clinical value, particularly in delivering a preventative approach to care that improves patients' oral health over time, but is also valued by patients given the personal nature of dental treatments and the importance placed on trust in this dynamic. This is among the ways in which the market for dental services is distinct and not solely based on a relationship between supply, demand and price. Patients motivated by improving their oral health through a prevention-focused continuing care relationship are likely to attend the same dentist and not necessarily 'shop around'.

[5] Based on analysis of the GP Patient Survey

Dental anxiety is common, with 12% of adults in England with natural teeth having extreme dental anxiety and two-fifths having moderate anxiety[6]. A patient with dental anxiety who has built a trusted relationship with their dentist is likely to behave similarly.

Information on costs and patient choice of treatment

Dental practices display prices for private treatment, and the patient charges levied by the NHS where they provide NHS services. The regulatory requirements related to this are set out in section four. This price list is typically available on practices' websites, as well as being displayed in practices. It provides patients with an indication of the likely costs of treatment at the practice. Patients will be provided with the specific cost of their treatment options and treatment plan by their dentist.

Prices for private treatments are usually displayed for each treatment on a 'from £x' basis, making it clear to patients the costs that they can expect, while also being clear that the costs for each course of treatment will vary depending on the specific needs and choices of the patient. This can be seen in this example from a Lincoln dental practice. Some practices may opt to provide a range of prices – 'from £x to £x' – as is the case for this practice in Weymouth. Equally, where the practice offers private care on both a 'fee per item' and 'plan' basis, the prices will be set out for both, as can be seen from this Worcestershire dental practice.

Given the nature of clinical treatment, prices displayed by the practice will be the typical price, but the cost per course of treatment will vary based on the specifics of the treatment required and consented to by the patient. This will be discussed directly with patients in determining and agreeing a treatment plan. Dentists should provide patients with the range of clinically appropriate treatment options, and their associated cost. This may include treatments that are available on the NHS and options that can be provided privately. The price of private treatments will be based on the costs and complexity involved, and this will vary by patient based on their oral health and their treatment preferences.

Dentists will provide patients with estimates of the costs of treatments planned and this will be confirmed in the treatment plan provided to the patient. Some practices employ a treatment coordinator to support patients in understanding the costs of their treatment and their payment options.

Patients should also be provided with information about the guarantees offered in relation to any treatment provided.

Payment options

Dentists and dental practices will offer patients different ways of paying for private dental services. The most common is a 'fee per item' basis, where the patient pays a fee for each treatment they consent to receive as part of their course of treatment.

In addition to this, some practices will offer patients the option to pay for a 'plan' to cover some or all of the costs of their dental treatments. There are a number of models for this provision, as set out below. There are a number of plan providers in the market, offering practices template plans to follow, and guidance and support with their implementation. While plans may guide practices on

[6] Adult oral health survey 2021: service use and barriers to accessing care

how prices are set, these schemes still allow dentists to retain control of their charges for treatment. Practices may also design and operate their own plans.

Private capitation schemes are offered in many dental practices. For a fixed, monthly fee, these packages will entitle the patient to access a set of care that would usually include routine check-ups, hygienists' visits and x-rays, but some plans include some treatment items. Some will secure patients access to urgent care, in a way that those accessing on a 'fee per item' basis might not have. Most plans will exclude complex treatment and those involving a lab-made appliance. The care available within the plan will be set out and explained to the patient.

The policies usually tie a patient to a specific practice for treatment if they are seeking treatment under the plan. For patients, this allows them to secure regular ongoing access to dental care with a given practice and dentist.

The fees will usually be calculated on the basis of the patient's oral health when they signed up to the plan, how much treatment the patient is likely to need, and some plans use age as a proxy measure for likely treatment need. On the basis of this, the dentist will place the patient into a category which will determine how much they should pay each month. The fees for each category will be advertised to patients.

Where the plan doesn't cover certain treatment items, these would then normally be paid for on a 'fee per item' basis.

In addition to using models offered by dental plan providers, practices can create their own capitation plans suitable for their own patient bases.

In conjunction with 'fee per item' charging, these options create a marketplace where a diverse patient base can access private treatment.

Dental insurance and finance

Some patients will opt to take out private insurance to cover some or all their dental treatment costs. In some instances, these are provided by employer schemes.

Insurance companies reimburse a percentage of treatment costs for a monthly premium. They will set a total payout limit for various treatment types and reimburse a percentage of each type of treatment. For example, a check-up may be reimbursed at 100% of cost with a filling at 50% of cost, however the overall total will be £1,000 for a year. Insurance arrangements normally allow patients a choice of practice.

For some treatment items, such as adult orthodontics, there are practices that offer options to pay by instalment or that introduce patients to a third-party credit provider. Where necessary, practices will need to apply for consumer credit authorisation from the Financial Conduct Authority.

Patient sensitivity to price

There is evidence from a range of sources that dental patients are very sensitive to price in their decision making about dentistry, whether this is private or NHS. For example, among those polled by YouGov, for those who had delayed or gone without NHS treatment, cost was the most cited reason for this, with 52% stating this as the reason. Similarly, 47% said that cost was a factor in deciding

what treatment to receive on the NHS. That this is the case even for subsidised NHS treatment underscores the degree of price sensitivity among patients and it is reasonable to conclude that this will be more so the case when patients pay the full costs of their care privately.

The majority of those polled also felt that *any* increases in the costs of dentistry were unacceptable. This is similar in private and NHS dentistry, with 58% stating it was unacceptable for prices to increase in the former and 60% in the latter. Less than a third feel it is acceptable for prices to increase for both private (29%) and NHS (31%) dental services. This would suggest that practices and dentists will find it difficult to increase prices considerably without an adverse response from patients.

It is likely that patients' price sensitivity acts as a discipling factor on dentists' price setting. This is reinforced by feedback from our members who express an awareness of the need to set prices at levels patients will consider reasonable. It would be difficult to maintain the long-term relationship that many dentists have with their patients if there was friction over pricing. The need to maintain patient trust is therefore an important deterrent to unreasonable pricing behaviour.

Patient perception of price

The NHS distorts patient perception of the costs of private dental treatment. In general, because healthcare services in the UK are mostly provided on a free-at-the-point-of-use basis, patients do not have a good sense of the costs of delivering these services.

In dentistry specifically, NHS patient charges provide a cognitive anchor against which private prices are inevitably assessed. This can provide a misleading impression of the costs of dental treatment and lead patients to underestimate these costs. For example, in England, a patient receiving molar endodontic treatment on the NHS would pay £76.60. The NHS would pay the practice roughly £245 for delivering this course of treatment. The BDA estimates that the actual cost to a dental practice of delivering a molar endodontic treatment is around £340. Patients will often believe that the NHS charge is the fee that the dentist is paid, rather than merely a subsidised contribution, and therefore reflects the costs of the treatment. This again skews patients' perceptions of the costs of providing dental services.

This has two main effects on the market. First, because patients assess private costs against the NHS charge and dentists are aware of this, it depresses the price that it would be possible to charge for this treatment.

Secondly, when patients pay for private dental treatments, which have no public subsidy and must pay for the full cost, they are more likely to consider these as expensive or unreasonable.

Polling conducted by YouGov suggests that patients generally have a poor understanding of private costs, as 37% stated that they did not know the price of a check-up as a new patient and 43% said the same for a single filling.

Table 13: As far as you are aware, how much do you think it currently costs for a private dental check-up as a new patient in your region?

	All	NHS[7]	Private[8]	Non-attender[9]
£0 - £49	10%	12%	10%	4%
£50 - £99	34%	28%	53%	21%
£100 - £149	13%	13%	15%	12%
£150 - £199	3%	3%	3%	5%
£200 - £249	2%	1%	1%	4%
£250 - £299	0%	0%	0%	1%
£300 or more	1%	1%	0%	2%
Don't know	37%	41%	18%	50%

Source: YouGov

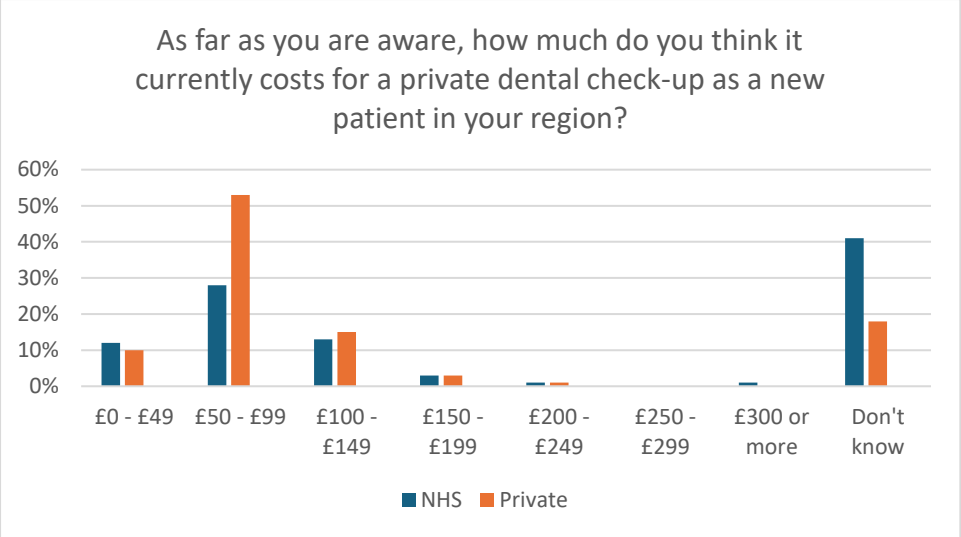
Table 14: As far as you are aware, how much do you think it currently costs for a single filling from a private dentist in your region?

	All	NHS[10]	Private[11]	Non-attender[12]
£0 - £49	2%	2%	2%	1%
£50 - £99	12%	12%	14%	8%
£100 - £149	17%	16%	23%	12%
£150 - £199	12%	12%	15%	9%
£200 - £249	8%	8%	11%	6%
£250 - £299	3%	2%	3%	4%
£300 or more	2%	2%	2%	4%
Don't know	43%	46%	29%	55%

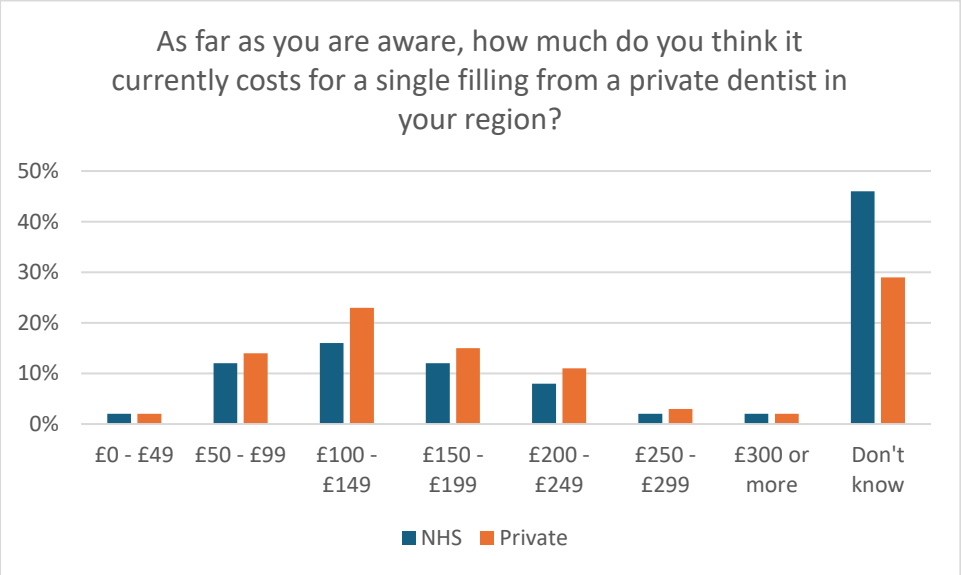
Source: YouGov

Comparing those who, in the last five years, have mainly gone to an NHS dentist and those who have mainly gone to a private dentist, the NHS group state that they think the private dental service has a lower price than those who accessed mainly private dentistry. This appears to support the idea that NHS dental services lower patients' perceived cost of delivering private dentistry.

[7] Mainly attended an NHS dentist in the last five years
[8] Mainly attended a private dentist in the last five years
[9] Have not gone to the dentist in the last five years
[10] Mainly attended an NHS dentist in the last five years
[11] Mainly attended a private dentist in the last five years
[12] Have not gone to the dentist in the last five years



Source: YouGov



Source: YouGov

Patient satisfaction

YouGov also found that, among those who have attended the dentist in the last five years, satisfaction with the dental care they received is high, with 85% stating that they are satisfied. The levels of satisfaction are the same whether this care was delivered mainly by an NHS dentist or mainly by a private dentist. This would suggest that, considering patients' price sensitivity, the current approach to pricing in the sector is not leading to widespread dissatisfaction, and that even with higher charges privately than those levied by the NHS this does not lead patients to be dissatisfied.

This satisfaction with care received stands in stark contrast to the public's view of NHS dentistry as a service, where only 22% of the public say they are satisfied and 54% dissatisfied[13]. This is likely to strongly reflect on the challenges in accessing NHS dentistry.

4. The regulatory framework

Dentists operate within a regulatory framework set out by the General Dental Council (GDC). Dentists must be registered with the GDC in order to practise in the UK. This framework sets out a range of requirements in relation to how dental services must be provided and sold. Alongside this, the GDC operates the Dental Complaints Service as a specific complaints service for private dentistry. Additionally, there are NHS regulations and contractual requirements on the provision of information on pricing and treatment, and in Wales similar regulations for private dentistry. These mechanisms help the dental market function competitively while protecting patients and providing a framework for patients to make informed treatment choices.

This regulatory framework avoids unnecessary restriction, while requiring dentists to adopt practices that are open, transparent and fair when approaching costs and pricing. The GDC's function is professional regulation, such as standards of conduct and fitness to practice. It does not regulate pricing or restrict the business models of a dental practice, but allows dentists to compete ethically by setting standards that speak to a standard of service and ethical business conduct. There is a regulatory arena that allows practices to compete for patients, while maintaining a safe and transparent standard of care.

Alongside individual professional regulation, there are also practice-based regulations, with more detail on this set out in section six.

GDC regulation and Standards for the Dental Team

The provision of private dentistry in a competitive market requires dentists to meet patient needs effectively and efficiently. The GDC's Standards for the Dental Team establish ethical and

[13] Nuffield Trust and Kings Fund, Public satisfaction with the NHS and social care in 2025

professional requirements for practitioners and set out minimum professional standards, ensuring that competition allows for focus on quality of service rather than unsafe practices.

Principle 1 requires dentists to put patients' interests first. Within this Principle the standards require dentists to discuss treatment options with patients, listening carefully to what they say and providing an opportunity to discuss and ask questions. The Standards require dentists to be honest and act with integrity particularly in relation to business, and make sure that any advertising, promotional material or other information is ethical. Dentists are required to put their patients' interest before any financial, personal or other gain and those practitioners who work in mixed practices must not pressurise patients to have privately treatment that is available on the NHS (although the patient can choose to have the treatment privately).

Principle 2 requires dentists to communicate effectively with patients by requiring a treatment plan to include a realistic indication of cost and to give a clear information on costs. The Standards require dentists to have a simple pricelist clearly displayed. Patients should not have to request this information.

Principle 3 requires dentist to obtain valid consent by including all the relevant options and possible costs. Where this estimate changes the practitioner must obtain the patients consent and document this.

Requiring dentists to provide clear communication and information on costs means patients are able to make informed decisions about their treatment and where they access care. In allowing patients to understand the cost of their treatment and compare providers the regulation creates effective competition.

Welsh private dental regulations

The 2017 Private Dentistry Regulations in Wales require every private dental practice to produce and maintain an eight-part patient information leaflet, which must be made publicly available and lodged with Healthcare Inspectorate Wales (HIW). This leaflet must include key information for patients—including treatment charges.

Dental Complaints Service

The Dental Complaints Service provides an independent service for complaints relating to private dental care. It ensures patients have a mechanism to resolve disputes and this provides patients with some confidence using the private service.

Practices should also have their own process for managing patient complaints made directly. The dental team should have training on complaint handling. The contracts between practices and dentists will normally make provision for how any patient redress, such as remedial work or refunds, is managed, particularly if the treating clinician no longer works at the practice.

NHS regulations

NHS contractual rules in all parts of the UK require practices and dentists to provide treatment plans to patients as well as details of NHS dental charges and ensure patients have information on costs when mixing NHS and private treatment. It is a requirement that NHS dental charges must be

displayed. This transparency again allows patients to understand their options and exercise their choice of providers.

In England, the form used for providing treatment plans to patients that is supplied by the NHS (FP17DC) sets out the responsibilities for the dentist when mixing NHS and private treatment. This states "You may choose to have some treatment provided privately as an alternative to NHS treatment. The dentist will discuss these options with you so that you can make an informed choice." There is a positive obligation on the dentist to provide private options to NHS patients as part of the consent process.

Regulation of Dental Bodies Corporate

The BDA believes that there is a need to consider stronger regulation of dental body corporates. By this, we do not mean small to medium-sized enterprises that happen to have incorporated. We refer to large, often private equity funded, dental providers who happen to fulfil the one regulatory requirement that the GDC currently sets for such entities, namely to have more than 50% of directors who are GDC-registered professionals. [Redacted]. There is no route to hold such companies to account in a meaningful way; there are no fitness-to-practise processes for companies in the way that there is for dentists.

The GDC has some limited powers in the Dentists Act to regulate dental body corporates, but this legislation was never enacted fully and would now need revision so as not to have the unintended consequence of increasing regulation for small practices. The BDA believes that reform is needed to ensure that the dental bodies corporate are required to put patients' interest first in a comparable way to the expectations placed on individually-registered dentists.

5. Interaction with the NHS

Across the UK, the four governments spend around £3.7 billion[14] on the provision of NHS dentistry. This is a major intervention into the market for the provision of dental services, which necessarily has a number of distorting effects.

The systems vary in their specifics, but, while all make a major intervention into the market for the provision of dental services, none are comprehensive or universal in their provision. This means that the governments assume that the private sector will provide some or all of the dentistry for at least part of the public.

England

In England, NHS dentistry is contracted on the basis of Units of Dental Activity (UDAs). Each contract with a dental practice sets out the number of UDAs that the contract will deliver and the amount of money the NHS will pay the contractor for delivering this. Contractors then claim for UDAs against courses of treatment delivered, with each treatment allocated to a band worth a given number of UDAs. For example, dentures are allocated to band 3 that is worth 12 UDAs.

There is no national monetary value to a UDA. It varies from contract to contract, meaning that the rate of payment for a given treatment varies. The NHS commissions a level of provision, and this

[14] Including NHS patient charge revenue.

effectively caps the amount of NHS dentistry that can be delivered in England. Only those working to a commissioned NHS contract can deliver NHS dentistry. This limits the supply of NHS dentistry in England, and, as a result, only 39.8% of adults were seen by an NHS dentist in the 24 months to 30 June 2025 and, for children, in the 12 months to 30 June 2025 57.3% of the population were seen on the NHS.

There are no allowances towards practice costs, like employing staff, rent, equipment or maintaining facilities. All costs must be met from the payments for clinical treatment.

Wales

NHS dentistry has been going through a process of system reform in recent years, with contract variations to the underlying UDA contract modifying what NHS dental contracts are asked to provide in exchange for their contract payments, and how this is measured.

From 1 April 2026, there will be a major reform of the contract. This will move to a system largely based on care packages, with capitation elements to encourage the treatment of new and new urgent patients.

The Welsh Government has introduced a Dental Access Portal for patients to register and be allocated to a practice to receive NHS dental treatment. This potentially has implications for patient choice over provider, particularly given that patients may elect to receive private treatments alongside NHS services.

The NHS commissions a level of provision, and this effectively caps the amount of NHS dentistry that can be delivered in Wales. In one year barely one third of the adult population is seen by an NHS dentist. Only those working to a commissioned NHS contract can deliver NHS dentistry.

The distribution of NHS dentistry across Wales is not uniform. Two health boards – Betsi Cadwalader in the North and Hywel Dda in the West – have significantly lower numbers of NHS dentists relative to the population. As a result, private dentistry in these more rural areas of Wales is the only option available for many patients.

Scotland

In Scotland, the NHS pays dentists on a 'fee per item' basis for delivering NHS work. This fee scale was reformed in 2023, with changes to the fee level and a consolidation of the fees claimable to 45 items. There are capitation payments paid in respect of registered patients. There are also some allowance payments to dentists and practices delivering NHS treatment. For example, there are contributions towards continuing professional development costs and rent reimbursements. Any GDC registered dentist in Scotland is able to provide NHS treatment under the NHS contract. There is no commissioned level of provision, but the Scottish Government does set a notional budget for NHS dentistry based on their expectations of how much care will be delivered. To provide NHS dentistry as part of the general dental service, a dentists must be included in the dental list of a Health Board.

Northern Ireland

In Northern Ireland, the Health Service pays dentists on a 'fee per item' basis for delivering NHS work. There are continuing care payments for registered adult patients – these are £1.07-£1.29 per

month. There are capitation payments for child patients worth between £2.09 and £6.20 per month. There are also some allowance payments to dentists and practices delivering NHS treatment. Any GDC registered dentist who has been accepted onto the dental list in Northern Ireland is able to provide HS treatment working in General Dental Services under fees set by DoH outlined in the Statement of Dental Remuneration. There is no commissioned level of provision, but the DoH does set a notional budget for NHS dentistry based on their expectations of how much care will be delivered. The dental payment system is recognised as being 'broken', and as such DoH has commissioned an independent Cost of Service Review to determine the true cost to provide Health Service dentistry at practice level.

NHS patient charges

The charges that non-exempt adult patients must pay are distinct. In England and Wales, patients pay one of three payments linked to the UDA bands for their course of treatment. In Northern Ireland and Scotland, patients pay a percentage of the 'fee per item' fee up to a cap.

Importantly, these charges are not retained by the dentist or dental practice in addition to the fee paid to them by the NHS, but are used to effectively subsidise the NHS contribution to the care. For example, in England, if a patient receives a molar endodontic treatment, the dentist will receive 7 UDAs that is worth around £245 and the patient will pay £75.30, and so the net contribution from the NHS is £169.70.

As set out in section three, these charges appear to have a distorting effect on patients' perception of price for dental services.

NHS fees to dentists

Given the variation in the NHS systems, there are differences in how much dentists are paid for treatments delivered. In Scotland and Northern Ireland, there are specific fees associated with specific treatments. In Wales, there are fees associated with care packages. In England, treatments are worth a number of UDAs with a variable final value. This makes direct comparison difficult.

It is also the case that in Scotland and Northern Ireland the fee is the cumulative total of all of the fees for the items delivered in that course of treatment, whereas in England the fee is related to the banding applied to the course of treatment as a whole. For example, a course of treatment that contains an examination, a radiograph and one filling would be paid at £30.11 in Northern Ireland, comprised of £10.95 for the examination, £5.35 for the radiograph and £13.81 for the filling. In England, this would be paid at 3 UDAs, which is worth around £105. However, if the course of treatment had involved two fillings rather than one, the Northern Ireland payment would increase to £43.92, but the England payment remains the same.

Similarly, for the example below, where anterior endodontics is provided, in Scotland the fee for this (£130.85) would be added to the other fees for the course of treatment, such as the examination, radiographs, preventive advice, scale and polish, and any other items provided. In England, this course of treatment would only be paid at five UDAs, with nothing additional claimable for the examination, radiographs or other treatment provided.

Table 15: NHS gross fees to dentists for selected treatments across the UK

	England	Wales	Scotland	Northern Ireland
Urgent course of treatment	£75 (from 1 April 2026)	£75 (from 1 April 2026)	£21.65	£10.43
Anterior endodontics	5 UDAs – worth approx. £175 (covers all other treatment provided)	£182	£130.85	£44.19
Crown	12 UDAs – approx. £420 (covers all other treatment provided)	£280.88 (lab bill paid separately)	£205.65	£100.17

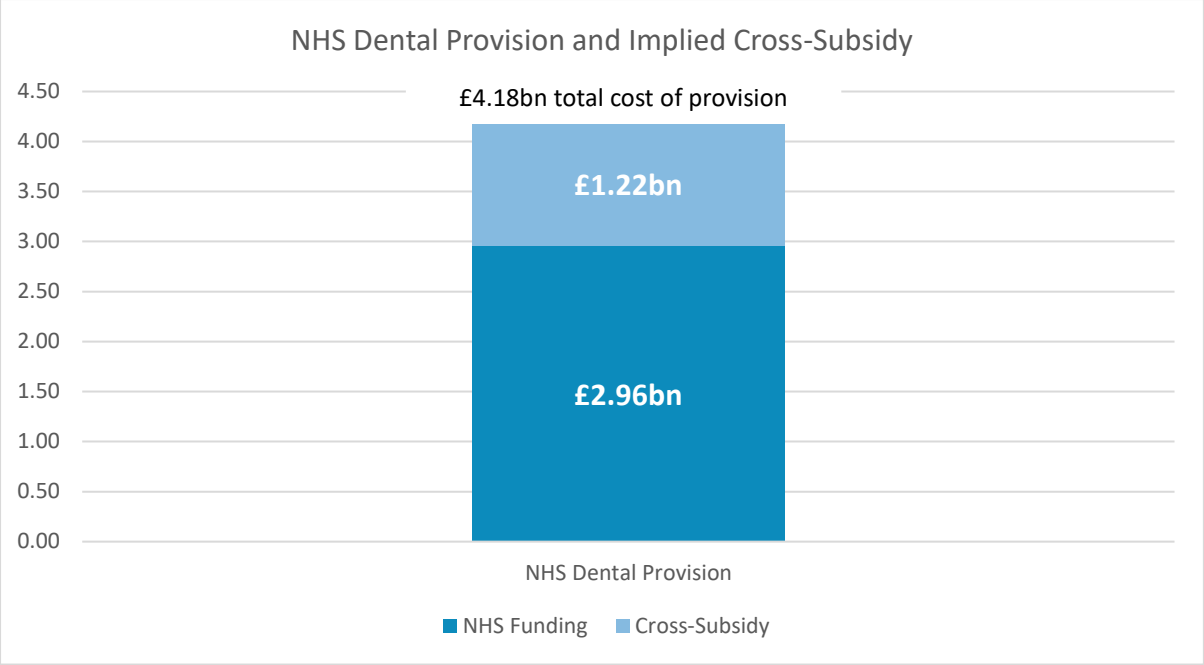
Fees cited are gross payments from which expenses, such the employment of the dental nurse, treatment materials, and equipment, must be deducted. The treating clinician is retaining, as their net income, only the minority proportion of this gross fee.

A dentist in Northern Ireland providing an urgent course of treatment might actually earn as taxable income less than £5. Our estimate is that the cost of providing an urgent examination, without considering any treatment need arising from it, is around £42. It is not difficult to see why many dentists in Northern Ireland have concluded that these NHS terms are simply not a reasonable or viable basis for them to provide care.

NHS underfunding and cross-subsidy from private provision

All four NHS systems are under-funded. The fees paid for NHS work do not fully cover the cost of delivering all treatments. Analysis based on treatment-level costings indicates a substantial gap between the cost of delivering NHS dental care and current levels of public funding.

Using treatment timings, an updated cost per clinical hour, and observed activity volumes, the total funding required to deliver NHS dental services in England is estimated at approximately £4.18 billion. This compares to an NHS dental budget of £2.96 billion in 2023/24, implying a funding shortfall of around £1.22 billion.



This gap reflects a structural misalignment between the cost of provision and NHS remuneration. In practice, this shortfall cannot be entirely absorbed through efficiency gains, but is instead offset through a cross-subsidy from private income, estimated at approximately £1.22 billion. While this analysis uses figures on spend and treatment volume from the NHS in England, we have every reason to believe that there is also a cross-subsidy for public dentistry in all other parts of the UK. In many instances, the fee provided by the NHS covers only a fraction of the costs incurred by the dentist in providing that care.

The implication is that private dentistry is not operating independently of the NHS system, but is increasingly supporting its financial sustainability. Revenue generated from private patients is used, in part, to sustain NHS activity that would otherwise be financially unviable under current contract values. Governments are clearly aware of this cross-subsidy and therefore, whether explicitly or implicitly, there is a policy decision to distort the market in this way.

For dentists, many of whom see delivering NHS dentistry as a moral obligation, the cross-subsidy is a rational response to this structural under-funding to allow them to continue to offer some NHS care. Without it, delivering any NHS dentistry would be all but financially unviable for their businesses. The BDA has consistently called for NHS dentistry to be funded in line with the costs of providing the service, so that no cross-subsidy from other income is required.

From a market perspective, this creates a strong and persistent incentive for practices to rebalance towards private provision. As the gap between costs and NHS income remains, the ability to cross-subsidise becomes a key determinant of whether, and to what extent, NHS care can continue to be delivered. It also means that price setting in the private sector is distorted by the need to support unviable financial commitments to public sector dentistry.

Illustrative treatment-level examples

The cross-subsidy mechanism is clearly observable at the level of individual treatments, where private fees materially exceed the estimated cost of delivery. Private fees cited below are based on averages taken from our surveys of dentists.

Recall examinations

The estimated cost of delivering a recall examination is £60.48. The average private fee is [Redacted].

In England, this would fall within band 1 and would be credited one UDA, worth around £35, but it can be as low £30.34. This band one claim would include all other treatment, such as radiographs and preventive advice, with no additional payment. In Northern Ireland, the fee for a recall examination is £10.95, in Scotland it is £21.65 and in Wales from April 2026 it will be £50. All of these NHS fees cover only a fraction of the cost of providing patients with the most basic level of provision.

Crowns

The estimated cost of delivering a crown based on the analysis is £325.51, incorporating both clinical time and laboratory costs. By comparison, the average private fee for a crown is around [Redacted].

This represents a substantial price–cost margin, which provides practices with the financial capacity to offset losses incurred on NHS treatments.

In terms of the relevant NHS fee in England, crowns fall within band 3 and therefore this treatment would be credited at 12 UDAs, worth around £420. This is the fee for the whole course of treatment, which will necessarily contain an examination and radiographs and is likely to contain a root canal treatment, and can contain any other treatment within bands 1, 2 or 4. The fee remains the same whether one crown is provided, or multiple crowns. It is not difficult to see how the costs involved exceed the NHS fee for this entire course of treatment, particularly for patients with high treatment need.

Looking at how this principle would apply elsewhere in the UK, in Northern Ireland, the NHS payment fee for a crown is between £100.17 and £146.40, depending on the specifics of the treatment. This is a fraction of the actual cost of delivering that care. While less stark in Scotland, the same under-funding is present. Dentists are paid £205.65 for providing a crown, well below the actual cost. In Wales, the care package for up to two crowns is paid at £280.88. Patients pay lab bills in addition to this. If one crown is provided, then this is on a roughly break-even basis, but if a second crown is provided then a considerable loss is made - costs effectively double, but the fee paid remains the same.

Bridgework

Using an average across bridge types:

- Resin retained bridges: £236.81
- Simple bridges: £364.06
- Complex bridges: £432.85

Average estimated cost: £344.57

This compares to a private fee of [Redacted] per unit.

In England, the NHS fee would again be based on band 3, worth around £420, and include the examination, radiographs and any other treatment provided within that course of treatment,

illustrating again a significant loss for this treatment item. In Scotland, the fee to the dentist would be £205.65 and in Northern Ireland the fee is between £127.96 and £191.06. In Wales, the care package for a bridge with up to three units is paid at £280.88. Patients pay lab bills in addition to this.

[Redacted].

These examples demonstrate a consistent gap between the costs incurred by practices and the NHS fee provided. Cumulatively, this means that NHS care is almost always delivered at a loss and requires a cross-subsidy from private income. It is reasonable to conclude that, as a result, private fees are higher than they otherwise would be.

As such, private income plays a supporting role in NHS provision, rather than operating independently of it. This dynamic also creates a clear incentive for practices to shift activity towards private care over time.

Mixing of NHS and private treatment

The interface between NHS and private dentistry happens most acutely in decisions over mixing within courses of treatment. In broad terms, it is permissible for patients to receive both NHS and private treatment within the same course of treatment across the UK, but the specifics of how this is permitted vary.

In England, dentists can provide any part of a course of treatment privately if they have obtained the patient's consent. In doing so, they must not advise the patient “that the services which are necessary in his/her case are not available from the dentist under the [NHS] contract” or seek to mislead the patient about the quality of the services under the contract. While this may appear straight-forward, in reality the specifics can be complex, as can be seen in the use of ‘top up fees’ in the Williams vs GDC case (2023).

In Wales, contractors may provide privately any part of a course of treatment, with patient consent In the 2026 regulations Schedule 3, paragraph 10(1) it explicitly states: A contractor may, with the patient’s consent, provide privately any part of a course of treatment, including where the patient has been referred for advanced services. There is no clause prohibiting mixing on the same tooth. Instead, the regulation focuses on clear disclosure, patient consent, proper documentation, and separation of NHS and private charges. The only exception to this relates to sedation.

In Scotland, a dentist can provide private treatment to NHS patients where it is necessary to manage the oral health of the patient or where the patient requests or agrees to private treatment. Where treatment relates to a single tooth, the dentist can provide treatment on both an NHS and private basis. For example, they can provide an NHS root filling and a private crown during a course of treatment.

In Northern Ireland, the Statement of Dental Remuneration (SDR) system allows for a mix of NHS and private treatments. This permits patients to receive available care under the NHS, while opting to pay for certain private treatments, such as white fillings. Dentists can see a patient and charge under the NHS model, while still being free to offer private treatment.

Child-only contracts

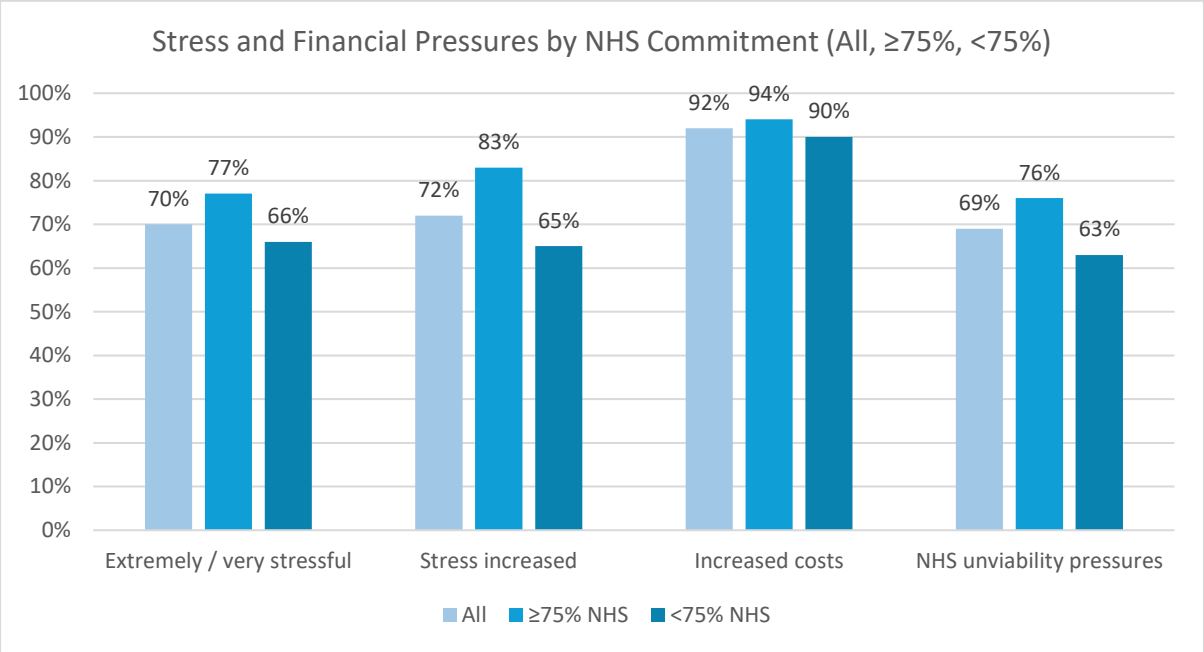
In England, there are a small number of contracts that are only for the provision of NHS dentistry to children. This inevitably leads to situations where families can only access care on the basis that adults receive private treatment and children can access NHS, or private treatment.

Where a contract is not specified as child-only, then services must be provided to all eligible patients and making access to NHS services conditional on accessing private services is not permitted.

Motivators for reducing NHS commitment or leaving the NHS

The crisis within the NHS is also having the effect of driving workforce behaviour and therefore shaping the market, as set out in section one. The workforce pressures of NHS dentistry are leading dentists to make career choices that shift them towards private provision, and thus increase the supply of private dentistry. The enormity of the pressures upon NHS dentistry, including failed contract models is clearly articulated by the Review Body on Doctors' and Dentists' Remuneration (DDRB) in its latest annual report. The factors leading to dentists leaving the NHS are not only financial, dentists are also motivated by greater professional autonomy, being able to care in a manner they are professionally satisfied with, avoiding bureaucracy and targets, and reducing the stress involved with managing an NHS contract.

To better understand the pressures associated with NHS provision, this analysis focuses on practice owners with a high NHS commitment (≥75% NHS activity). Survey evidence indicates that stress levels are particularly heightened among these practices, 77% report their job as extremely or very stressful and 83% report that stress levels have increased over the past 12 months.



This pattern is consistent across all key indicators, with high-NHS practices reporting systematically higher levels of stress and financial pressures. By contrast, practices with lower NHS commitment (<75% NHS activity) report materially lower levels of pressure across all indicators, highlighting a clear relationship between NHS exposure and financial and operational strain.

The drivers of stress among high-NHS practices are closely linked to financial and operational pressures:

- 94% cite increased practice costs
- 76% cite financial pressures specifically linked to the unviability of NHS dentistry
- 74% report staffing recruitment and retention issues
- 63% cite pressure from meeting NHS targets

Operational pressures are also evident:

- 69% report limited work-life balance
- 54% report inability to take annual leave
- 47% cite longer working hours

System-level pressures are prominent:

- 70% report lack of support or communication from government
- 70% cite regulatory and compliance burdens

These behavioural intentions are consistent with overwhelmingly negative perceptions of NHS dentistry. The vast majority of respondents report a negative or very negative view (~87%), with the remaining sharing either a positive, very positive, or neutral view. This inevitably leads to the patterns set out in section one.

6. Market entry

In general, the conditions for 'market entry' in the provision of private dental services are proportionate.

In order to provide private dental services, an individual must be registered with the General Dental Council. This is an appropriate and proportionate means of ensuring that dentists are appropriately educated and trained, and that they continue to provide dental services safely. Notwithstanding the need for reform in some areas, the process and standards for registration are appropriate. There are high standards set in order to be able to register as a dentist, but necessarily so. Improvements could be made in relation to the continuing professional development requirements for those rejoining the register and greater flexibility could be offered to avoid dentists inadvertently dropping off the register and being temporarily unable to provide dental services.

There is also regulation of dental practices and new practices providing private treatment would need to comply with this. Again, this is broadly proportionate to the need to protect the public and ensure that dentistry is provided safely.

In England and Northern Ireland, all practices, whether providing NHS or private care, must register with the CQC or the RQIA, respectively. In Northern Ireland, dental practices are heavily regulated, classified as 'independent hospitals' and inspected every two years. In Scotland, practices providing wholly private treatment must register with Health Improvement Scotland. In Wales, practices providing any private dental treatment must register with Health Inspectorate Wales. In order to register, practices must provide these bodies with the relevant information to comply with the regulations. While this information is often extensive and comes with a cost burden, it does not constitute an unwarranted barrier to market access. Practices are then subject to periodic inspections.

There are some specific issues with this practice regulatory regime. For example, the RQIA has recently reinterpreted Health Technical Memorandum 03-01on air ventilation, so that small high street dental practices area treated as if they were a hospital providing acute care. It currently means that practices adding a new surgery or refurbishing must undergo a ventilation engineer's

assessment and report, and adhere to all HTM requirements. This adds an additional cost of approximately £10,000-12,000 per surgery.

The BDA is not aware of any other issues, such as in access to finance, that are unreasonably limiting new entrants to the private dental market.

For dentists in England and Wales wishing to set up a new practice, doing so on a private basis is the only realistic option, as to become an NHS provider would mean winning a new NHS contract. This is challenging, not least because so little new commissioning takes place.