ADG RESPONSE TO THE INVITATION TO COMMENT ON THE STATEMENT OF SCOPE FOR THE CMA PRIVATE DENTAL SERVICES MARKET STUDY

BACKGROUND

The Association of Dental Groups (ADG) represents 33 dental groups across the UK. Our membership ranges from micro groups of 5 or fewer practices, mid-size groups and the 4 largest dental groups in the UK and is reflective of the mixed economy of dentistry with member groups offering a combination of private, NHS and Community dental care. The mix of treatment and funding types varies across the groups as does their ownership structure.

This is a general response on behalf of the ADG to the invitation to comment on the scope of the planned private market study. The CMA may also receive separate responses to this consultation from individual members.

We and our members look forward to engaging constructively with the CMA, including assistance with evidence gathering and consideration of any practical proposals that improve consumer outcomes whilst avoiding unintended consequences for access and service delivery.

Unless otherwise stated our responses apply to all 4 nations

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?

It is a matter of public record that current NHS dental funding in England is only adequate to provide necessary dental care for about half the population[1] and this is reflected in the fact that the UK dental market is a long-established mixed economy.

Public policy decisions affecting access, workforce and commissioning inevitably shape incentives and consumer outcomes in the private market. In mixed settings, the consumer journey frequently involves understanding a combination of publicly funded and private options as part of consent. Indeed, it is a mandatory GDC requirement for dentists to offer choice to patients as part of the consent process.

Access constraints in the NHS, caused by a shortage in the dentist workforce, are increasingly influencing patient choices and leading to patients feeling they have little other option other than to consider private dental care to meet their oral health needs.

Workforce challenges are a sector wide issue spanning publicly and privately funded care and including recruitment challenges, dental nurse shortages and delays for international dentist registration. Ultimately, they impact on consumer access and choice to both private and publicly funded care. We believe that the number of

[1] Ali Sparkes. NHSE. Public Accounts Committee- Fixing NHS Dentistry- Oral Evidence 13 February 2025

dentists practising in the UK is less than optimal and that this has a significant impact on the sector.

Therefore, it is essential the CMA scope explicitly considers how the well documented issues of NHS access and workforce impact on consumer journeys and choices in both publicly funded and private dental care.

More specific comments on the scope are: -

Para 23. For clarity we suggest this should state **all** dental care professionals as defined by the GDC to clarify this includes dental laboratory technicians and clinical dental technicians.

It is also important that the scope differentiates between general private dentistry and specialist private dentistry (endodontics, orthodontics, periodontics and intermediate oral surgery) and considers specialist treatment differently from a consumer journey and choices perspective as specialist treatment may involve more referral between dentists and dentist practices. Access to publicly funded specialist services (also known as Tier 2 in the NHS) is limited and is normally commissioned on a local basis by Integrated Care Boards.

We agree that consumers should be able to make informed choices including what publicly funded services are available to them (where relevant) and on what terms (if any).

Para 25/26. When considering publicly funded dental treatment, this should consider the full spectrum of dental services: primary general dental care, specialist dentistry (including Tier 2 and Tier 3 services), and the Community Dental Service. Each of these areas serves distinct functions in addressing patient needs and may lead to varied consumer experiences and choices regarding publicly funded and private dental care options.

The fact that more patients are choosing private care due to NHS access issues should not be taken as an indication that the private dentistry market is not delivering positive outcomes for patients.

Para 27 (a). We agree with the proposed approach to consideration of customer journey and choice but as indicated above, feel the scope may need to be broadened to fully understand the customer journey and choice across a mixed economy, where the most appropriate choice of treatment for a patient may be a blend of publicly funded and private dental care, a factor in which may be the limited choice of treatments, materials etc available through the NHS. Consideration should also be given to whether there is any difference in the customer journey and choice for clinically necessary private care (e.g. fillings) vs cosmetic treatments (e.g. tooth whitening).

The ADG does not recognise the price rises cited in the CMA's press release of 5 March, which in any case seem to suggest that prices had not kept pace with

inflation over the period. In considering changes to pricing and profitability, we encourage the CMA to consider the economic context in which practices are operating. For example, recent years have seen a high level of inflation, which has affected staffing costs, energy costs and other inputs such as consumables and equipment. There have also been public policy decisions on issues such as National Insurance Contributions, the National Living Wage, and taxation. Also, as the technology and sophistication of dentistry develops, it tends to become more expensive to provide.

To support our submission to the Doctors and Dentists Remuneration Board, we asked members to provide an indication as to increasing cost pressures. Members told us that staffing and other cost ratios continue to rise well above inflation. Staffing is of course a major cost for practices. We estimated an average annual increase of 9.5% for staffing costs for high street and community dental practices. We also asked members to provide an indication as to how they were increasing private prices. They indicated these were in the range of 3 to 10% with an average of 4.8%, which suggests that practices were not passing on all the cost increases they were experiencing. We have attached our full submission to the DDRB with this response.

In a report in 2025, the BDA suggested dental inflation was 9.2% to Jan 2025 and private price increases for the period were 9.6%. These are higher than ADG's data suggests, but may reflect associate/principal owned practices rather than groups who may benefit from scales of economy in areas such as energy and consumable costs.

In considering value for money, the CMA should also consider what benefits private dental care delivers to patients such as improved access, shorter waiting times, wider treatment options (e.g. implants and adult orthodontics), investment in technology and overall patient experience. All of these aspects are costly to deliver.

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 agree with the overall articulation of a well-functioning private dentistry market.

In para 20 you refer to consumers being provided with *'clarity about publicly funded and private dentistry options'*. We suggest this should be proportionate; private only practices should not be expected to provide detailed advice on NHS funded options; indeed, they may not have the relevant knowledge to do so appropriately.

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.

Broadly, yes.

Examples to demonstrate this include:

Consumers have choice and have access to relevant information including prices of treatment.

- There is good coverage of dental practices across the UK through a combination of independent and group practices and in many towns/cities there will be multiple practices offering both NHS and private care. Recent CMA reviews of the mergers of Portman Dentex[2] and Rodericks Dental Partners[3] found only very limited localised competition concerns in relation to private dental treatment. If there were concerns about the extent of competition between independent practices, we assume that the CMA would have taken a different approach to these merger decisions.
- Consumers can exercise choice over which dental practice they attend for private treatment and in addition can choose the dental professional they are treated by within that practice. Consumers can also switch easily between practices if they wish and dental practices will support transfer of patient records if requested by the patient. They can also choose to move between dentists and /or practices for different private treatments. For example, to receive specialist orthodontic or endodontic treatments which may not be provided by their routine dentist/local practice. The CMA should take into account that dentists are often self-employed, so competition even takes place between dentists within a single practice.
- Dental practices routinely publish prices on their websites so that patients can see the typical charges made by that practice. For routine treatments such as examinations and x-rays these will normally be a single price point but for other treatments, where the price depends on the extent of treatment required and the choice of materials etc, practices typically publish a range of prices. Patients who wish to access and compare information about prices before they visit the dentist are able to do so.
- Following assessment, the dentist will provide patients with treatment plans to explain the treatment options available to them, including costings for the treatment, use of different materials and including an explanation of publicly funded treatment where this is an option / provided at the practice. Patients can at that point shop around if they wish to do so.
- Consumers have a range of choices over how to pay for treatment including ‘pay as you go’ via cash or credit card, dental payment / membership plans and financing/loans.

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[2] https://assets.publishing.service.gov.uk/media/64185eb88fa8f547c0013177/A._Full_text_decision.pdf

[3] https://assets.publishing.service.gov.uk/media/632b0ef0d3bf7f75c0b6f2e1/P1_SLC_Decision__Riviera-Dental_Partners__.pdf

Regulatory frameworks support adequate information provision

- The GDC has set out clear expectations for registrants and dental practices in areas including transparency of pricing, treatment choice and patient consent under the GDC Standards.[4]
- The Care Quality Commission regulations in England and equivalent health care regulators in the devolved nations also set out standards for providers including in areas of informed consent, clear treatment planning and pricing transparency and outlines what patients can expect from a dental practice[5]. These areas form a key part of regulatory inspections at a practice level.

Dental practices compete to win and keep customers

- The dental market in the UK (across all sectors) is relatively fragmented compared to other UK health and social care sectors or wider markets such as veterinary or retail. Dental groups (defined as groups who own three or more practices) operate approximately 27% of the 12,218 dental practices across the UK.[6] For healthcare, the acute hospitals and clinics and mental health markets are both over 65% consolidated. Dentistry also remains highly clinician-led, with many dentists preferring autonomy of practice ownership and/or independent practice over group and corporate structures
- The dental market is also different to other primary and secondary healthcare sectors, where most care remains free at the point of service, and government funding is such that there is a far lower uptake of private care by patients.[7]
- Patients are completely free to move between private dental practices and dentists. Patients typically find private dentists through a range of options including recommendation and increasingly through online searches.
- To attract patients, dental practices compete in direct-to-consumer marketing approaches and through differentiation of their service offering e.g. extended opening hours, online booking etc.
- Some practices also offer initial consultations at zero or reduced charge to allow patients to meet the dentist and understand their treatment options and costs. Patients who find this attractive can find details on practices' websites.
- Dental practices increasingly need to invest in best-in-class technology to reflect current clinical best practice and to meet patient needs including new technology to support their treatment (e.g. intraoral scanners, CBCT etc). Investments of this nature also enhance the patient experience e.g. using an intraoral scanner to create digital images rather than traditional alginate impressions. Typical costs

[4] https://standards.gdc-uk.org

[5] https://www.cqc.org.uk/guidance-regulation/providers/regulations-service-providers-and-managers/health-social-care-act/regulation-11

[6] Laing and Buisson Dentistry UK Market Report 7th Edition, September 2025.

[7] https://www.health.org.uk/reports-and-analysis/analysis/is-the-use-of-privately-funded-health-care-on-the-rise#:~:text=Analysis%20of%20activity%20data%20shows,8.3%25%20in%202022/23.

are £35-40K (+VAT) for a CBCT machine plus any costs for installation and £8 - 16K (+VAT) for an intraoral scanner
- As such dental practices compete to win and retain customers using a variety of attraction and retention tools and utilise customer satisfaction surveys and online reviews (e.g. Trustpilot, Google Reviews) to demonstrate their customer care and quality of service and pricing to attract new customers.

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?

- From a clinical perspective the delivery of private dentistry and the range of treatments offered is broadly similar across all 4 nations.
  Key variations that arise are in NHS Dental contract, patient charges and access dynamics. Consideration should be given to the impact that these may have on consumer outcomes as well as whether there is any difference in patients understanding and expectation of what publicly funded dental cover is provided.
- In Scotland and NI, patients are still required to be registered as an NHS patient at a specific practice and with a specific dentist and this results in a different customer journey. Registration ceased to exist in England and Wales in 2006 although many consumers are still of the view this is the case.
- Patient charges for NHS care show some variation across the nations and it is not clear how this variation may affect patient's choices about both NHS and private care options.
- With the NHS Contract reform changes in Wales and England that will take place from April 2026, there will be some further divergence in the approach to publicly funded dentistry. The CMA may wish to consider the impacts of these changes on consumer journeys and choices in relation to consideration of private dentistry.

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?

The reduction in access to NHS dentistry has led to more people considering private dentistry either to access care not provided on the NHS (e.g. implants) or to access care more quickly and more regularly than is possible on the NHS.

These consumers may have a different expectation or understanding than those people who have chosen to use private dentistry even when NHS care was more readily available.

It may be useful for the CMA to examine whether there are any differences between the consumer journey and expectations /awareness for patients who have elected to pay for private dentistry for many years vs those patients who have moved to private care more recently.

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

The GDC and other health care regulations across the UK require all providers and dentists to consider the needs of all patients including the vulnerable. Patients may be vulnerable due to health conditions, financial status or because their dental condition is causing them significant pain. The difficulty in accessing publicly funded dental services often disproportionately impacts these patients and may affect their ability to both access services (whether NHS or private) and to make choices. This is another area where we could suggest the scope of your work should reflect the interplay between both publicly funded and private dental markets.

Across all four nations, the Community Dental Service (CDS) commonly provides care for groups including: children and adults with learning disabilities; patients with extreme dental anxiety or phobia; bariatric patients; and patients with a wide range of additional medical, behavioural, social, or physical conditions that make routine dental care in a general practice setting difficult or unsafe. General dental practitioners (NHS and private) can refer patients into CDS where patients meet locally defined acceptance criteria. In many areas, CDS therefore functions as a vital pathway for equitable access to clinically appropriate care for people who would otherwise struggle to receive treatment. There are however the same, if not more challenges, with access to CDS as there are for general primary care dentistry and so an increasing reliance on private dentistry.

Domiciliary dental care within publicly funded services, predominantly for elderly patients, is generally provided in accordance with an NHS triage flowchart, which typically links eligibility to severe disability, including being housebound. Where access cannot be met through this route, private domiciliary care is available in some areas. Similarly, where children are not eligible for NHS CDS care, they may be supported through other locally commissioned initiatives (for example Child Friendly Dental Practice schemes) or in the private sector.

The current limitations on access to NHS general dental practices for vulnerable groups may delay identification of need and delay referral into CDS, with potential consequences for oral health, pain, infection risk, and wider wellbeing.

While we are not currently aware of specific consumer issues directly relating to CDS, inclusion of CDS within the CMA's consideration may provide important insight into how the needs of some of the most vulnerable patients are currently being met, and where system pressures may create barriers to access.

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.

Payment mechanisms can be effective in supporting consumer choice. There are a wide range of choices for consumers about how they pay for their private dental

treatment including payment on a ‘pay as you go’ basis by cash or credit card and through staged payments where patients pay a proportion of the cost across multiple appointments rather than upfront.

Dental payment / membership plans support customer choices by offering a variety of pre-payment options to spread the costs of routine, preventative care across the year which both helps with budgetary planning but also encourages regular preventative attendance, at intervals based on a combination of clinical appropriateness and consumer preference and supports good oral health.

A range of financing options for larger treatment plans are also offered including 0% or subsidised financing arrangements through third party providers, with the costs borne between the practice owner and self-employed clinicians. These give consumers the choice of spreading the costs across several years and allow them to access care, treatments and/or materials they may not otherwise be able to afford – for example allowing a patient to choose implants rather than a less expensive denture, or a longer lasting, higher quality porcelain crown.

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 have any evidence of systematic competition concerns or any additional issues. As outlined in response to other questions we consider that the private dentistry market is a well-functioning market where dental practices compete on price, customer service, quality of facilities, dental technology and ongoing customer care to win and retain private patients.

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 are not aware of widespread problematic practices in the private dentistry market.

Private dentistry is subject to both GDC regulations and other healthcare regulations which address many of the risks which exist and the regulators have powers to intervene where there is a lack of compliance.

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?

We consider that current regulatory frameworks support good competition and consumer outcomes. However, it is important that these regulatory frameworks continue to evolve to reflect the fact that dentistry is being transformed by new technology, working practices, patient preferences and public policy.

Following the OFT report in 2012 their recommendations on areas such as pricing transparency have been embedded by the GDC in their professional standards and across the industry. The CQC and equivalent inspection processes in the other nations test compliance with these principles at a practice level and may include interviews with patients as part of their inspection process.

We also consider that it is important that complaint and redress routes are easy for consumers to understand. In our view, complaint and redress is best managed at a local level in the first instance. The GDC have produced helpful guidance for patients[8] as well as setting standards for the dental team.

The GDC publish reports on Fitness to Practice (FTP) cases including those relating to consumer outcomes[9]. In their 2024 report, the main consideration in cases was failure to provide good quality care (25.9%). Whilst this is clearly an important issue, not communicating effectively (4.9%) and failure to obtain valid consent (3.1%) suggest that the process of informing patients of their options may not be a material issue. It should of course be noted that the number of FTP cases heard by the GDC is small in the context of the number of patients receiving care each year.

In addition to the general regulations and standards that apply to individual GDC registrants, the Dentists Act of 1984 also make provisions for the conduct of Dental Body Corporates (DBC's) and requires that the majority of directors of a dental group (3 or more practices) must be either registered dentists or registered dental care professionals[10]. As such, the directors are also personally required to meet the overall GDC regulatory standards and failure to do so can affect their personal GDC registration. This brings personal liability for such compliance to an equivalent level as for dentists acting as partners in a partnership, and the same also applies to dentists operating through limited liability partnerships, which are considered to be DBC's under the Dentists Act.

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?

We do not consider that core regulatory approvals to open a new private practice are unnecessary or disproportionate. At times regulatory capacity may lead to delays in processing or inspection processes.

At a dentist level; limited capacity for GDC ORE and LDS exams may prevent international dentists from obtaining GDC registration in a timely manner. The

[8] https://www.gdc-uk.org/raising-concerns/how-to-get-a-refund-or-make-a-complaint
[9] https://www.gdc-uk.org/docs/default-source/reports-and-publications/gdc-fitness-to-practise-report-2024.pdf?sfvrsn=453eb7d6_2
[10] https://www.gdc-uk.org/standards-guidance/supporting-the-dental-team/corporate-dentistry

government has recently announced significant investment in capacity in this area[11] which over time will reduce the barrier to entry.

Once registered with the GDC, dentists can provide private dental care immediately but for clinicians looking to provide NHS care there is a further step required to obtain an NHS performer list number (or equivalent in the devolved nations). This is not always straightforward; the approach varies across different ICBs and Health Boards and the increase in LDS and ORE capacity is likely to add to further delays as more GDC registrants apply for NHS performer numbers.

As a result of the extended NHS performer list processes some dentists, who originally planned to work in mixed practice, decide to focus on private care rather than persist with the NHS performer list process. The regulatory framework therefore means that for individual dentists, barriers to entry into NHS dentistry can be higher than for private dentistry.

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?

We do not see widespread structural barriers to entry. At a practice level there continue to be examples of private new build (referred to as 'squat') practices being opened across the UK. There is also a buoyant open market of dental practice sales for those who prefer to enter through acquisition.[12]

However, workforce availability and constraints – especially in rural and coastal areas – is becoming a potential barrier and the main limiter to entry with difficulties in recruitment into private practices for dentists but also for dental nurses and the wider team. In our report Creating Dental Oases, we highlighted both current issues with workforce and outlined several solutions.[13]

At a clinician level, dentists across the UK are mostly self-employed individuals and are free to choose whether to work in private only practice, mixed or just NHS. They are also able to move between practices and recent GDC data indicates that 39% of dentists work in more than one location.[14]

Ruth Chesmore, Director of Operational Affairs, Association of Dental Groups

1 April 2026

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[11] https://www.gov.uk/government/news/more-dentists-coming-as-government-boosts-number-who-can-practise

[12] https://www.christie.com/sectors/dental-practices/dental-market-review-2025/

[13] https://usercontent.one/wp/www.theadg.co.uk/wp-content/uploads/2025/06/Final-Creating-Dental-Oases-June-25-whitepaper.pdf?media=1748871380

[14] https://www.gdc-uk.org/news-blogs/news/detail/2025/04/10/gdc-publishes-dentists'-working-patterns-data