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

BACKGROUND

Rodericks Dental Partners Limited (RDP) operates 224 practices across England and Wales, with the majority in England and 15 in Wales. We are the second-largest provider of NHS dental services in England, treating approximately 1.2 million patients annually, alongside offering private general and specialist dental care. We currently have over 1,500 Dentists, nearly 400 Hygienists, and just over 70 Dental Therapists.

Our submission aligns closely with the ADG, and we at RDP look forward to engaging constructively with the CMA market study by assisting with evidence gathering and considering any practical proposals that improve patient outcomes, while avoiding unintended consequences for access and service delivery.

Throughout our response, we consistently refer to our clients as "patients" rather than "customers," in line with the healthcare sector in which we operate, although we acknowledge that this terminology does not affect their statutory rights.

We are fully aligned with and supportive of this enquiry and stand alongside the other ADG groups in engaging positively with the study.

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?

We agree with the geographic scope of the study.

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.

We agree that patients 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. 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 patient journey frequently involves understanding a combination of publicly funded and private options as part of consent to treatment.

Access constraints in the NHS are increasingly influencing patient choices, and leading to patients feeling that they have no option but to consider private dental care, to meet their oral health needs.

Therefore, it is essential the CMA explicitly considers how the well documented issues of NHS access and workforce impact on consumer journeys, and choices available in the private dental market. In this

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

context, the ADG requests the CMA reconsider its view that it will "not be looking…at the availability of publicly funded dental treatment".

Para 27 (a). We agree with the proposed approach to consideration of patient journey and choice but as indicated above, feel the scope may need to be broadened to fully understand the patient 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.

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 treatments**
  - 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.
  - Consumers can exercise choice over which dental practice they attend for 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. 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.
  - Dental practices routinely 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.
  - 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 options.

- **Regulatory frameworks support adequate information provision**
  - The GDC has set out clear expectations for registrants and dental practices in areas including transparency of pricing and patient consent under the GDC Standards.[2]
  - The Care Quality Commission regulations in England and equivalent health care regulators in the devolved nations also set out expectations for providers including in areas of consent, treatment planning and pricing transparency and outline what patients can expect from a dental practice[3]. These areas form a key part of regulatory inspections at a practice level.

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

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

- **Dental practices compete to win and keep customers**
  - The dental market in the UK (across all sectors) is relatively fragmented compared to other sectors such as veterinary or retail.[4]
  - 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. [5]
  - Patients are completely free to move between dental practices and dentists. Patients typically find private dentists through a range of options including recommendation and online searches.
  - Dental practices need to invest increasingly in best-in-class technology to service patients who are expecting new technology to support their treatment (e.g. intraoral scanners, CBCT etc.).
  - 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 patient care, quality of service and pricing to attract new patients.

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.
- Registration ceased to exist in England and Wales in 2006, although many patients 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 deterioration 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 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 patient 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

[4] Laing and Buisson Dentistry UK Market Report 7th Edition
[5] 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.

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.

The Community Dental Services (CDS) provides access to publicly funded care for vulnerable consumers with specific needs such as children with learning difficulties and bariatric patients etc who may not be able to be appropriately treated in a general dental practice, whether NHS or private. All NHS and private general dentists can refer to the CDS where patients meet the criteria. We are not aware of any consumer issues in relation to CDS, but it may provide insight into how the needs of some of the most vulnerable patients are currently met.

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 patient choice. There are a wide range of choices available for patients when considering 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 patient 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 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 patient the choice of spreading the costs across several years and allow them to access care they may not otherwise be able to afford – for example allowing a patient to choose implants rather than a less expensive denture.

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 regulatory frameworks support good competition and consumer outcomes.

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 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 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[6] 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[7]. 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 makes provisions for the conduct of Dental Body Corporates and requires that the majority of directors of a dental group (3 or more practices) must be either registered dentists or registered dental care professionals8. 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.

Q10b: Are there elements of these regulatory frameworks that create unnecessary or disproportionate barriers to entering the private dentistry market or to expending 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 etc.

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 government has recently announced significant investment in capacity in this area[9] 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 '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.[10]

However, workforce availability – especially in rural and coastal area - is becoming a potential barrier to entry with difficulties in recruitment into private practices is an issue not just for dentists but also for

[6] https://www.gdc-uk.org/raising-concerns/how-to-get-a-refund-or-make-a-complaint
[7] https://www.gdc-uk.org/docs/default-source/reports-and-publications/gdc-fitness-to-practise-report-2024.pdf?sfvrsn=453eb7d6_2
[8] https://www.gdc-uk.org/standards-guidance/supporting-the-dental-team/corporate-dentistry
[9] https://www.gov.uk/government/news/more-dentists-coming-as-government-boosts-number-who-can-practise
[10] https://www.christie.com/sectors/dental-practices/dental-market-review-2025/

dental nurses and the wider team. The ADG published a report in summer 2025 outlining solutions to workforce issues in the UK which you may wish to review.[11]

At a clinician level, dentists are self-employed individuals and are free to choose whether to work in private only practice, mixed or just NHS. As self-employed clinicians, the dentists are free to price private treatments based on their assessment of the patients' individual needs. However, practices typically have a 'from' price indicated to help guide patients. This allows the consumer choice and transparency on the available options. They are also able to move between practices and recent GDC data indicates that 39% of dentists work in more than one location.[12]

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

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