Private Dental Services Market Study

Response to Statement of Scope

FAB Group Holdings Ltd • 2 April 2026

To	Competition and Markets Authority
Email	dentistry@cma.gov.uk
Re	Private Dental Services Market Study – Response to Statement of Scope
From	David Lewis, Co-CEO, FAB Group Holdings Ltd
On behalf of	FAB Group Holdings Ltd and Archway Dental (transitioning to FAB Teeth)
Date	2 April 2026

1. Introduction and Standing

FAB Group Holdings Ltd is a private dental group operating three clinical locations across the South West of England, comprising 12 surgeries. We write in response to the CMA's invitation for views on the proposed scope of its market study into private dental services.

We welcome this market study without reservation. We do so not because its conclusions are yet known, but because we have spent the past 18 months building an operational model that addresses directly the market failures the CMA has identified. This submission sets out what we have built, why we built it, and what it demonstrates about the structural problems in the private dental market and their solutions.

We are not a lobbying body. We are a working practice. Everything in this submission is evidenced from our own clinical and operational data.

2. Our Position on the Proposed Scope

We support the CMA's focus on all six identified areas. We offer the following observations from operational experience.

2.1 Price Transparency

The private dental market has no structural mechanism for transparent, staged pricing that patients can understand before committing to treatment. Practices routinely present treatment plans as lists of procedures and costs without explaining the clinical rationale for the sequence, the alternatives available, or the consequences of deferral.

FAB Group has developed and is deploying a four-stage clinical framework (Stabilise, Optimise, Youthful, Legacy) which governs the sequencing of all treatment recommendations. Every patient receives a staged treatment plan in plain English that explains what is needed, in what order, and why. Aesthetic and elective treatments are explicitly gated behind the completion of clinical foundations. This prevents the upselling of cosmetic procedures to patients whose underlying oral health has not yet been addressed, a practice we believe is prevalent in the private market.

We recommend the CMA consider requiring that treatment plans presented to patients include: (a) a clinical rationale for the sequence of recommended treatments; (b) explicit identification of which treatments are clinically necessary versus elective; and (c) the consequence of deferring each element.

2.1.1 The associate remuneration model and treatment plan compliance

We draw the CMA's attention to the structural mechanism driving non-compliance with treatment plan obligations. Industry research and patient advocacy reporting have indicated that a substantial proportion of private dental patients do not receive a written treatment plan before treatment commences, despite the legal obligation on practices to provide one. We believe this is a predictable consequence of the self-employed associate model. Associates operating on a revenue-share basis have an economic incentive to proceed to treatment quickly, and the sector has long operated on a cultural assumption that patient loyalty follows the individual clinician rather than the practice. Practices have tolerated this because it aids associate retention.

The legal position is unambiguous: the contract for dental services exists between the patient and the practice, not the treating clinician. The obligation to provide a treatment plan rests with the practice. Yet this obligation is routinely not discharged, and practices have historically not enforced it. The result is a systemic compliance failure rooted in commercial incentive structure, not individual misconduct.

FAB Group mandates written treatment plans at every clinical site as a contractual condition of clinician engagement. This is enforceable because our clinicians operate within a practice-owned framework, rather than as independent revenue-share associates. We would welcome CMA consideration of whether the associate remuneration model, as currently structured across the majority of the private dental market, is compatible with consistent delivery of the consumer protections that practices are legally required to provide.

2.2 Consumer Choice and the Information Asymmetry Problem

The fundamental problem in private dentistry is not price: it is information asymmetry. Patients cannot assess the quality of clinical advice they receive because they lack the clinical literacy to do so. This asymmetry enables poor practice to persist and makes genuine competition on quality impossible.

FAB Group's response to this is structural: we provide every patient with a persistent, longitudinal Clinical Intelligence Profile. This is a record of their oral health status, their treatment history, their SOYL stage, and their compliance with preventive guidance. It belongs to the patient. It travels with them. It makes switching between providers possible without loss of clinical context, which is the CMA's stated objective.

We recommend the CMA consider establishing a right for patients to receive their clinical data in a structured, portable format, equivalent in principle to the NHS Subject Access Request framework but operationalised as a standard output of every private dental practice.

2.2.1 Patient portability, the clinician relationship assumption, and corporate liability disclaimers

We draw the CMA's attention to a related structural problem: the absence of any formal portability framework means that patients who wish to change provider, or who transfer between sites within the same practice group, frequently lose their clinical history and must start again. This is a direct barrier to the switching and competition the CMA is seeking to promote.

The legal contract for private dental services sits between the patient and the practice. In practice, however, the sector has operated as though the patient relationship is personal to the individual clinician. This assumption has no legal foundation, but it persists because it serves the interests of clinician retention over patient continuity. Some large corporate groups have compounded the problem by formally distancing themselves from the patient relationship, structuring their operating model to describe their role as introducing patients to dentists rather than as the contracting party providing dental services. This approach, whilst designed to limit liability exposure, is directly contrary to the consumer protection intent of the practice-patient contract, and the CMA should examine it.

FAB Group has built its model on the opposite principle. The Clinical Intelligence Profile belongs to the patient, is portable, and accumulates clinical value over the course of membership. We would welcome the CMA establishing patient data portability, including intra-group portability, as a minimum standard across the private dental market.

2.3 Dental Payment Plans and Membership Structures

The CMA has identified dental payment plans and financing of treatments as a specific area of scrutiny. We welcome this. We draw the CMA's attention to a structural issue with the current market that is distinct from pricing transparency: the clinical content of the appointments members receive under their plan.

Membership plans typically include hygiene appointments as a core benefit. There is no structural mechanism, however, to ensure that what is delivered as "hygiene" meets the clinical standards a Dental Therapist or Hygienist operating at the full scope of their training would deliver. A scale-and-polish performed by a dentist, often in compressed time alongside a routine examination, is not the same clinical product as a hygiene appointment delivered by a DTH operating to scope. Plans systematically conflate these, and patients have no way of telling the difference.

Practices running membership plans but operating short on DTH capacity will, predictably, see the dentist filling the gap with a scale-and-polish marketed as hygiene. The economic incentive of the membership plan, combined with DTH undercapacity in the wider market, makes this outcome structurally likely. We have direct experience of this pattern in our own clinical operations, and we are willing to share specific evidence with the CMA case team on a confidential basis as part of the engagement offered in Section 4.

FAB Teeth Club, our membership product currently in deployment, is structured explicitly to avoid this conflation:

- No hygiene appointments are bundled into any tier. Members receive recognition (discounted) pricing on hygiene appointments, with the clinical content of those appointments determined by clinical assessment and delivered by DTHs operating to full scope.
- Pricing is published transparently at two tiers — founding member rates locked for 24 months, and prevailing rates — with the difference and the reason for it stated clearly.
- Members are assigned a clinical stage on joining, and the benefits available at each stage are determined by clinical criteria, not by the tier they have paid for.
- A compliance-based Smile Warranty is offered as a dynamic benefit reflecting real clinical engagement, rather than a static membership perk.

We recommend the CMA consider requiring that membership plan providers publish: (a) the clinical scope and grade of professional delivering each appointment type included in the plan; (b) the cost per service included versus the open-market price of that service; (c) the clinical criteria, if any, governing benefit eligibility; and (d) clear terms around price change notification.

2.4 The Role of Dental Therapists and Hygienists

The CMA's scope includes the regulatory framework and whether it supports good consumer outcomes. We draw the CMA's attention to a structural issue that is material to both price and access: the underutilisation of Dental Therapist Hygienists (DTHs).

Our own clinical data, drawn from three operating practices over the past 24 months, indicates that a substantial majority of treatments delivered fall within the scope of practice of a qualified DTH. The majority of what patients need from a dental appointment does not require a dentist. We hold the underlying breakdown by appointment type and procedure category, and we are willing to share it with the CMA case team on a confidential basis as part of the engagement offered in Section 4.

The current market structure, dominated by self-employed associate dentists operating on a revenue-share model, creates an economic disincentive to deploy DTHs efficiently. Associates earn on treatment delivered, not on prevention achieved. A DTH-led prevention model is economically viable only when the practice model is built around membership and longitudinal patient relationships, as FAB Group's model is.

We recommend the CMA consider the relationship between the associate remuneration model, the underutilisation of DTH scope, and the resulting upward pressure on private dental prices. Expanding DTH scope of practice and creating a regulatory framework that supports DTH-led care as a primary delivery model would have a material effect on both price and quality of access.

2.5 Prevention and the Consumer Responsibility Gap

The CMA has noted that demand for private dentistry has increased significantly, with prices rising sharply. We respectfully observe that a market study focused solely on supply-side factors, pricing, competition, and information, will not address a root cause: the systematic undervaluation of oral health prevention by consumers.

Clinical evidence suggests that approximately 95% of dental treatment is preventable. The cost of private dental care is rising in part because the volume of avoidable treatment being

delivered is rising. No amount of price transparency or competition will address this if patients continue to present for treatment of conditions that preventive care would have avoided.

FAB Group has built its entire model around closing this gap, through the Adaptive Clinical Feedback Loop, the Dr Fliss AI between-appointment guidance system, and the compliance-based Smile Warranty. We are willing to share outcome data with the CMA as it becomes available.

We recommend the CMA consider whether its final remedies address not only how private dentistry is sold and priced, but how preventive care is incentivised for both providers and consumers.

---

3. What We Have Built

FAB Group has built, and is actively deploying, an operational model that addresses each of the concerns set out above:

CMA Concern	FAB Group's Operational Response
Price transparency	Published pricing tiers; SOYL-staged treatment plans with clinical rationale per step
Information asymmetry	Persistent patient Clinical Intelligence Profile; portable and patient-owned
Elective upselling	SOYL framework gates aesthetic treatment behind clinical foundation completion
Membership plan opacity	FTC published pricing; compliance-based eligibility; no hygiene bundling
DTH underutilisation	DTH-led clinical model; 53% of treatments within DTH scope by design
Prevention gap	AI-governed between-appointment guidance; compliance-based warranty
Treatment plan compliance	Contractual obligation at all sites; enforceable within a practice-owned model
Patient portability	Clinical Intelligence Profile patient-owned and portable; intra-group portability standard

We are a small group. We do not claim to have solved these problems at scale. We claim to have demonstrated that they are solvable, and that the solutions do not require regulatory compulsion to implement, only the right commercial incentives.

---

4. Offer of Engagement

FAB Group Holdings Ltd is willing to:

- Brief the CMA's project team on our operating model and the design decisions behind it
- Share anonymised clinical and operational data as it becomes available
- Participate in any stakeholder panel or expert advisory group the CMA convenes
- Provide a site visit to one of our operating practices

A market study of this importance benefits from evidence of what is already working, not only evidence of what is failing. We offer ourselves as that evidence.

---

5. Contact Details

[✂]

FAB Group Holdings Ltd • CMA Submission • 2 April 2026 •
This submission may be published by the CMA in accordance with its market study procedures.