Submission to the Competition and Markets Authority

Market Study into the Supply of Private Dental Services in the UK

Submitted by: Dentist | Qualified: 2008 | Experience: NHS and private practice

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Executive Summary

I am a dental professional with over 16 years of clinical experience across both NHS and private practice. I welcome this market study and wish to draw the CMA's attention to a structural argument that I believe is central to understanding why private dental fees have risen so sharply: the problem did not originate in the private market. It originated in the systematic dismantling of the NHS dental model, beginning with the 2006 contract change and accelerated by the subsequent entry of large corporate bodies into practice ownership.

This submission directly addresses the CMA's proposed scope questions and includes a specific request that the investigation examine the role of corporate consolidation in the dental sector — a matter which I understand to be within the CMA's remit and which I believe is essential to any meaningful analysis of consumer outcomes.

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1. Response to CMA Scope Questions

1.1 How has the growth of private dentistry affected consumers?

The growth of private dentistry has not been driven primarily by consumer preference or genuine market demand. It has been driven by a contraction in NHS provision that has left patients with little or no alternative. The data supports this: in 2024, 36% of people who turned to private care did so because they could not get NHS treatment at all, and a further 31% because they could not access it quickly enough. This is not a functioning market choice — it is a rationing failure that has been monetised by private providers.

The consumer harm is compounded by inequality: those with higher incomes are disproportionately able to access regular dental care, while lower-income groups increasingly defer or forgo treatment entirely. Tooth decay remains the most common reason for hospital admissions in children aged 5–9 in England — a public health failure with direct roots in NHS access collapse.

CMA Scope Question A: *How well does the private dental market work for consumers?*

It does not work well, because for the majority of patients it is not a freely chosen market — it is a forced alternative to an NHS service that has been deliberately or negligently allowed to deteriorate. Prices have risen over 23% for new patient consultations between 2022–2024 alone, in a market where consumers have limited ability to compare providers, limited clinical knowledge to assess treatment necessity, and limited alternatives. These are the conditions for systematic consumer harm.

1.2 What structural features of the market are driving high prices?

I submit that the single most important structural feature driving high private dental prices is the corporate ownership model that took hold following the 2006 NHS dental contract. I set out this argument in full in Section 2 below, but summarise the key mechanism here: corporate owners, accountable to shareholders rather than patients, have progressively shifted revenue from NHS to private treatment not in response to patient demand, but in order to sustain profit margins as NHS contract values stagnated and workforce costs rose. This has created a supply-side withdrawal from NHS dentistry that has been the primary driver of increased private demand and therefore private pricing power.

CMA Scope Question B: *What are the key features of the market that may harm competition or consumers?*

Corporate consolidation of practice ownership; the NHS/private two-tier structure that creates artificial scarcity; high barriers to entry for independent practitioners (GDC registration, indemnity, CPD costs); and the information asymmetry between dentist and patient on treatment necessity and pricing. I specifically request the CMA investigates the degree to which corporate consolidation has reduced local competition, consistent with its concurrent work in the veterinary sector.

1.3 What factors affect dental professionals' ability to provide services?

Two structural factors are pushing dentists — particularly newly qualified ones — away from NHS provision and toward private practice, regardless of their personal preferences.

First, graduate debt. Current dental graduates leave training with student debt in the region of £50,000. NHS dentistry, paid on a Units of Dental Activity (UDA) basis, frequently does not generate sufficient income to service this debt at an acceptable rate. The rational economic response — maximise private income — is predictable, widespread, and structurally baked in by government tuition fee policy.

Second, the cost of professional compliance. The aggregate annual cost of maintaining dental practice in the UK — GDC registration fees, professional indemnity insurance, mandatory CPD, accountancy, and professional membership — conservatively amounts to two to three months' net salary. This burden has no parallel in comparable professions and acts as a powerful ongoing incentive to maximise private earnings. The GDC's annual retention fee alone has increased substantially over recent years, adding to financial pressure on practitioners.

CMA Scope Question C: *What factors affect the decisions of dental professionals to provide NHS vs private treatment?*

The UDA payment model systematically undervalues complex NHS treatment. The cost of professional registration and compliance creates financial pressure toward private work. Graduate debt compounds this. These are not individual choices — they are rational responses to structural incentives that government policy has created and failed to address. Any CMA recommendations that do not engage with these supply-side factors will address symptoms rather than causes.

2. The Corporate Ownership Model: Root Cause Analysis

2.1 The pre-2006 model and its strengths

Prior to 2006, NHS dentistry was predominantly delivered through practices owned by the dentists who worked in them. This alignment of clinical and financial interests had important consequences: practice surpluses were reinvested in equipment, training and staffing; practitioners were willing to absorb the cost of loss-making NHS treatments as part of a mixed practice model; and the system was largely self-regulating because the person bearing the financial risk was the same person making clinical decisions.

2.2 How the 2006 contract enabled corporate entry and what followed

The 2006 contract change restructured NHS dental commissioning in a way that allowed corporate bodies to hold NHS contracts and employ dentists as salaried staff. This decoupled ownership from clinical practice, introducing a profit-extraction dynamic that had not previously existed in primary dental care.

Corporate owners, unlike dentist-owners, have no clinical stake in the quality of care provided and no professional obligation to patients. Their obligation is to shareholders. Initially, corporate groups were able to sustain NHS activity by exploiting accumulated capacity in the system — underutilised chair time, low overhead bases, and a workforce that had not yet adjusted its expectations. Over time, as NHS contract values failed to keep pace with inflation and overheads grew, this slack was exhausted.

Simultaneously, corporate workforce planning had relied heavily on recruiting dental professionals from EU member states, particularly Portugal and Greece, who were willing to work at lower wage rates than UK-trained dentists. As these practitioners gained experience and seniority, they reasonably sought fair pay. Post-Brexit restrictions on freedom of movement closed off the supply of new lower-cost recruits. Corporate margin pressure became acute.

The response was systematic: a shift away from NHS provision toward private treatment, not because of patient demand, but to preserve shareholder returns. This is the structural origin of the private dentistry boom that the CMA is now investigating.

2.3 The ‘revolving door’ and regulatory capture

The CMA should be aware that the policy environment which enabled corporate entry into NHS dentistry was shaped by ministers and advisers who subsequently took paid roles in the private healthcare sector. This pattern — sometimes described as the ‘revolving door’ — raises serious questions about whether the regulatory and policy framework governing NHS dentistry has been designed in the public interest, or whether it has been, at least in part, shaped by those with a personal financial stake in the growth of private and corporate healthcare. The CMA does not have jurisdiction over individual conduct, but it is within scope to consider whether the current regulatory framework adequately protects consumers and competition, and to recommend reform where it does not.

2.4 Request for investigation of corporate consolidation

I formally request that the CMA, as part of this market study, examines the following specific questions relating to corporate consolidation in dentistry:

- To what extent has the acquisition of independent practices by corporate groups reduced effective local competition for dental services?
- Have corporate pricing strategies — including the use of treatment plan upselling and finance products — contributed to above-inflation price increases in private dentistry?
- Does the current regulatory framework, including GDC oversight and NHS commissioning rules, adequately constrain anti-competitive behaviour by large corporate dental groups?
- Should ownership of dental practices be restricted to registered dental professionals, as is the case in some other jurisdictions, in order to realign financial and clinical incentives?

I note that the CMA's concurrent market investigation into veterinary services has examined similar questions around corporate consolidation. The dental sector presents a closely analogous set of structural concerns and warrants equivalent scrutiny.

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3. Summary of Recommendations to the CMA

Based on my professional experience and the structural analysis set out above, I urge the CMA to:

- Examine corporate consolidation in dentistry as a primary driver of reduced NHS provision and increased private pricing power, consistent with the scope of the market study and the CMA's work in analogous sectors.
- Investigate whether the regulatory and contractual framework introduced in 2006 has served consumer interests or has primarily benefited corporate owners and private investors.
- Recommend reform of the UDA payment system and professional compliance cost structure to rebalance financial incentives for NHS practice — without which any intervention in the private market will be addressing symptoms rather than causes.
- Consider recommending restrictions on non-clinical ownership of dental practices, or at minimum, greater transparency requirements for corporate owners regarding NHS contract performance, staff pay, and profit distribution.
- Recommend that government review the level of GDC registration fees and professional indemnity costs, which disproportionately penalise NHS-focused practitioners and act as a structural subsidy to the private model.

The CMA's investigation into private dental fees is an important and timely intervention. However, I urge the Authority to follow the evidence to its structural roots. The private dentistry crisis is not a market that has spontaneously malfunctioned — it

is the predictable consequence of policy decisions taken over twenty years that prioritised corporate entry over patient access. Addressing it requires structural remedies, not just transparency measures.

I would welcome the opportunity to provide further oral or written evidence to the CMA if it would assist the investigation.