PRIVATE DENTAL SERVICES MARKET STUDY

Interim report summary

26 November 2026



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The Competition and Markets Authority has excluded from this published version of the final report information which the inquiry group considers should be excluded having regard to the three considerations set out in section 244 of the Enterprise Act 2002 (specified information: considerations relevant to disclosure). The omissions are indicated by [✂]. Some numbers have been replaced by a range. These are shown in square brackets. Non-sensitive wording is also indicated in square brackets.

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Summary

1. Millions of people across the UK rely on private dentistry. Around 60% of patients pay privately for at least some dental care. For many people, including those on low incomes and receiving state benefits, private care can be a necessity rather than a preference: it is their only route to essential treatment when NHS care is unavailable. Those unable to access NHS care or afford private treatment may delay care or go without altogether.

2. Thousands of dedicated dental professionals across the UK work hard to deliver dental care every day. Since millions of people rely on private dental provision for essential care, it is critical that the market is working well to deliver fair and affordable outcomes. This is why, in March 2026, the CMA launched a market study into private dental services.

3. Private provision of an essential service can work well where effective competition rewards providers for offering better prices, quality, service and choice. Our emerging findings show that the private dental services market is not consistently working well for patients. The problems we see are systemic: patients are unable to make well-informed choices; workforce capacity is constrained, particularly in certain nations and regions; commercial business practices, KPIs and incentives may not operate in patients' best interests; and the regulatory landscape risks being both burdensome and to some extent ineffective.

4. Throughout our work it has become increasingly clear that public and private dentistry are deeply interconnected, often sharing the same practices and workforce. Government decisions on NHS funding, commissioning, contracts and workforce therefore shape not only patients' choices about use of private care, but also providers' incentives and behaviour and outcomes across the sector.

5. Our assessment of the evidence points to a market where patients often cannot exert the competitive pressure that would normally discipline prices and commercial behaviour. Dental care is a credence service: patients rely heavily on their dentist's advice and cannot readily assess whether treatment is necessary, appropriate, good quality or good value, even after it is provided. Their ability and willingness to shop around is further constrained by their needs and preferences, including the importance of NHS availability, proximity and continuity of care or the need for urgent treatment. The information that is available on prices and treatment is often incomplete and difficult to compare. As a result, switching between practices is low and the competitive pressure exerted by patients is weak. Where patients do switch, the most common reason is moving home or workplace rather than seeking better value.

6. Workforce constraints further weaken competition. The UK had 6.7 dentists per 10,000 people in 2024, compared with 8 or more in most European Economic

Area countries. Recruitment and retention difficulties limit practices' ability to expand and new providers' ability to enter. Practices operating near capacity have little incentive to lower prices to attract more patients, while patients have fewer alternatives. Price competition is weak, despite a fragmented market in which independent firms account for over 60% of practices. We found examples of documents from among the four largest dental groups that focus on raising prices towards those of nearby practices rather than undercutting them. Some also refer to opportunities to increase prices due to patients' limited price sensitivity, as well as to increase prices following acquisitions.

7. At the same time, practices and clinicians have commercial incentives to increase revenue. Dentists' pay typically takes the form of a substantial share of the revenue generated by the treatment they provide, and owner-dentists benefit from practice profits and value. Internal documents from large groups show strategies to increase prices, convert NHS patients to private care, sell higher-value treatments and dental payment plans, and increase treatment and recall activity. Commercial incentives to increase profits are part and parcel of a private market and when combined with strong competition which rewards providers for offering better quality and prices, can be aligned with customer interests. But in private dentistry, patients' reliance on professional advice and workforce constraints create a risk that commercial incentives to increase revenue may conflict with patients' interests in obtaining good value dental care.

8. The outcomes we observe are consistent with that diagnosis. Prices at large dental groups increased by an estimated 7% a year on average between 2023 and 2025, ahead of consumer price inflation and wage growth. We have also seen significant variation in prices in local areas, For example, listed minimum prices for a composite white filling ranged from £80 to £223 in Preston. But patients are not easily able to find and switch to potentially better-value options.

9. In addition, we have identified variation in outcomes across the regions and nations of the UK, for example in terms of access to dental services, affordability and workforce capacity. This means that where a patient lives can affect both what care is available and what it costs relative to income.

10. Regulation provides important consumer protections, but it is both complex and not as effective as it could be. It focuses heavily on individual professionals, even where many decisions that impact patients are taken by practice owners, managers or groups. Enforcement is often geared towards the most serious professional misconduct, complaints and redress routes are difficult to navigate, and relevant NHS or consumer protections do not always appear to be enforced. Providers also report complexity, duplication and administrative burden. In our emerging view, the answer is therefore not more regulation but better-focused accountability, proportionate enforcement and accessible redress.

11. Our provisional view is that a substantial package of interconnected changes is required to deliver better outcomes in this market. Our proposals aim to create the conditions in which dental professionals and businesses can thrive by meeting patients' needs well, while widening access to affordable essential care. The issues we have found are systemic, rather than a judgement on individual dental professionals.

12. We provisionally propose a mutually reinforcing package of measures which would: increase the availability and capacity of the dental workforce; make it easier for patients to compare and switch between dental practices and treatments; deliver a more targeted and better enforced regulatory regime; and, critically, create an enhanced role for governments to more actively shape improved market outcomes across both NHS and private dentistry.

13. Measures to improve information, comparison and switching, increase workforce capacity, and reform regulation and redress should together deliver substantial improvements for patients. These reforms are necessary, but not in our view sufficient on their own to address the systemic issues in this market. Patients cannot be expected to transform this essential market simply by voting with their feet, and regulation cannot substitute fully for effective competitive constraints. Rather, governments will need to intervene further, playing a more direct market-shaping role, and using their position as major purchasers and commissioners of dentistry to influence incentives and outcomes for private as well as NHS patients. Failing this, price controls might be needed to ensure good outcomes.

14. These are interim findings and proposals and we invite further input and insight from across the sector. During the next phase of the study we will consult on our analysis, deepen our evidence on prices, profitability, ownership, financing and local outcomes, and work with stakeholders to understand how real change could be achieved in this critically important market.

15. Our final recommendations will aim to take into account policy and practical differences between nations and regions, as well as the importance of preserving clinical judgement, workforce supply, and provider viability. In assessing their feasibility and likely impact, we will take account not only of the market as it stands today but consider how different market dynamics arising from a package of measures might combine to change incentives and outcomes over time.

The market we are examining

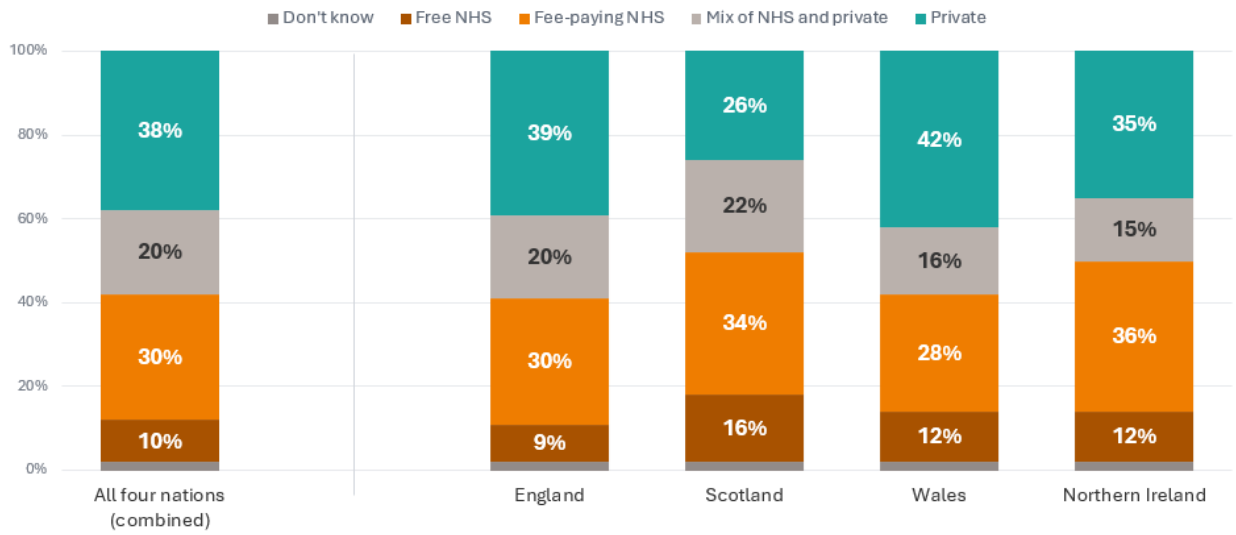
16. Dental care is essential to health and wellbeing. Preventative care can reduce pressure elsewhere in the health system, while poor oral health disproportionately affects the vulnerable and socially disadvantaged members of society. Patients may seek care when they are in pain, anxious or in urgent need. These features

make it especially important that the market supports informed decisions, value and access to clinically necessary treatment.

17. Dentistry in the UK has long been delivered through a combination of NHS-funded and private care. The majority of dental practices combine the two, usually using the same premises and workforce. Around 60% of patients pay privately for at least some care, and around 20% use a mix of NHS and private services. Among patients who received private treatment, 25% had first tried to obtain some of that treatment through the NHS. More than a third of respondents to an external survey said that lack of NHS availability had led them to seek private treatment.

18. Patterns of NHS and private use differ across the four nations. In our consumer research, 72% of respondents in Scotland had received at least some NHS dental care, compared with 63% in Northern Ireland, 59% in England and 56% in Wales. The proportions using wholly private care were 26%, 35%, 39% and 42% respectively.

Type of dental service received, in the UK and in each UK nation



Source: Chart taken from Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, NHSPRIV.

19. The more closely we have examined this market, the clearer it has become that private market outcomes cannot be understood by looking at private provision alone. NHS availability is important to patient choices, while NHS contracts and payment models affect provider decisions, as well as workforce allocation. Many practices earn a mix of public and private revenue and customers may receive NHS and privately funded services from the same practice. Government decisions therefore shape incentives and outcomes across the sector. Consistent with our Statement of Scope, we have examined publicly funded dentistry and related policy insofar as they affect incentives, competition and consumer outcomes in the private market, not on a standalone basis.

20. The picture is not uniform. Publicly funded dentistry is devolved and the arrangements for commissioning, payment, patient charges and access differ across England, Scotland, Wales and Northern Ireland. Patterns of NHS and private use, workforce pressures, prices and affordability also differ between and within nations.

Our interim findings

Patients cannot readily drive competition

21. Competition can keep prices down and reward quality, service and innovation when people can understand their needs, can readily compare offers and make an informed choice about which practice they go to. Those conditions are unusually difficult to achieve in dentistry:

    (a) Patients generally cannot assess for themselves whether treatment is necessary, appropriate or good quality, or whether it represents value for money. They therefore rely heavily on the advice of the clinician who may also supply the treatment.

    (b) NHS availability, proximity, continuity of care, trust and speed of access are central to patients' choices. The need for urgent treatment or pain may further limit their ability or to shop around.

    (c) Information is often incomplete or difficult to compare. Our review of more than 8,000 practice websites found that around one in six did not publish a price list online (despite General Dental Council requirements to give clear information on prices on practice websites), and published prices often did not allow patients to establish the likely final cost or compare like with like.

    (d) Choice may be limited in reality when practices do not have availability to take on new patients. Seventeen per cent of private users and 30% of mixed NHS-private users felt they had no choice of a suitable practice or had to use whoever would accept them.

    (e) Switching is low. Records, diagnostics, treatment descriptions, payment-plan terms and the importance of an ongoing clinical relationship can all create further friction.

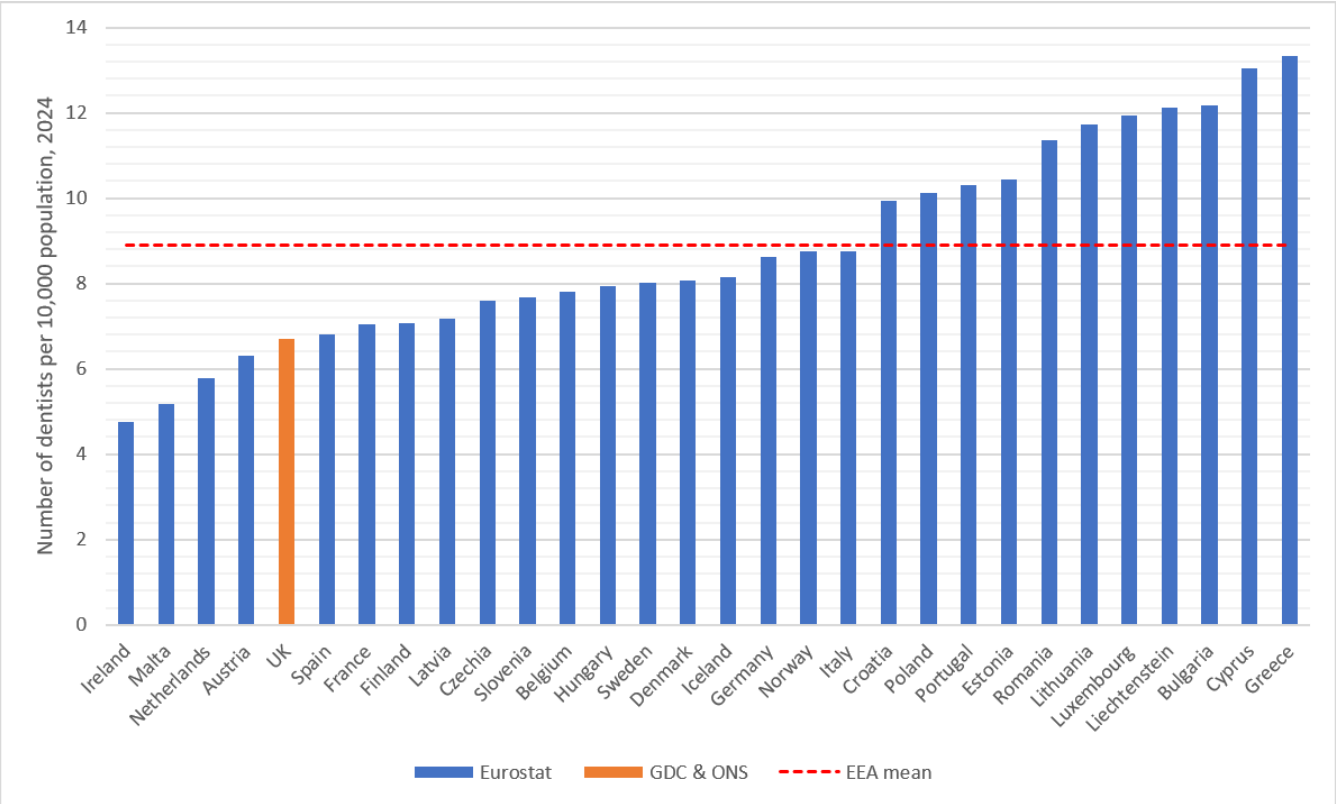
22. These features weaken the pressure that patients can exert on practices and mean that they are unlikely to switch to cheaper treatments, even though our evidence suggests there are significant differences in local prices. The substantial price differences we observe do not, on their own, prove that the higher prices are excessive: differences in treatment, materials, clinician expertise and quality may explain at least some variation. But where patients cannot readily compare or

switch, large price differences create a clear risk that some pay substantially more without receiving commensurately better care.

Workforce constraints weaken competition

23. Almost all dental firms we heard from identified recruitment and retention as key barriers to entry and expansion. This is reflected in an estimated vacancy rate of 8% for general dentist posts in England that is significantly higher than the 2% vacancy rate across the UK economy. As shown in the chart below, the UK had 6.7 dentists per 10,000 people in 2024, compared with 8 or more in most European Economic Area countries. In 2025 there were around 1,600 dental school places for around 10,000 applicants, while around 5,000 overseas-qualified dentists were waiting to sit the overseas registration examination.

Number of dentists per 10,000 head of population, 2024



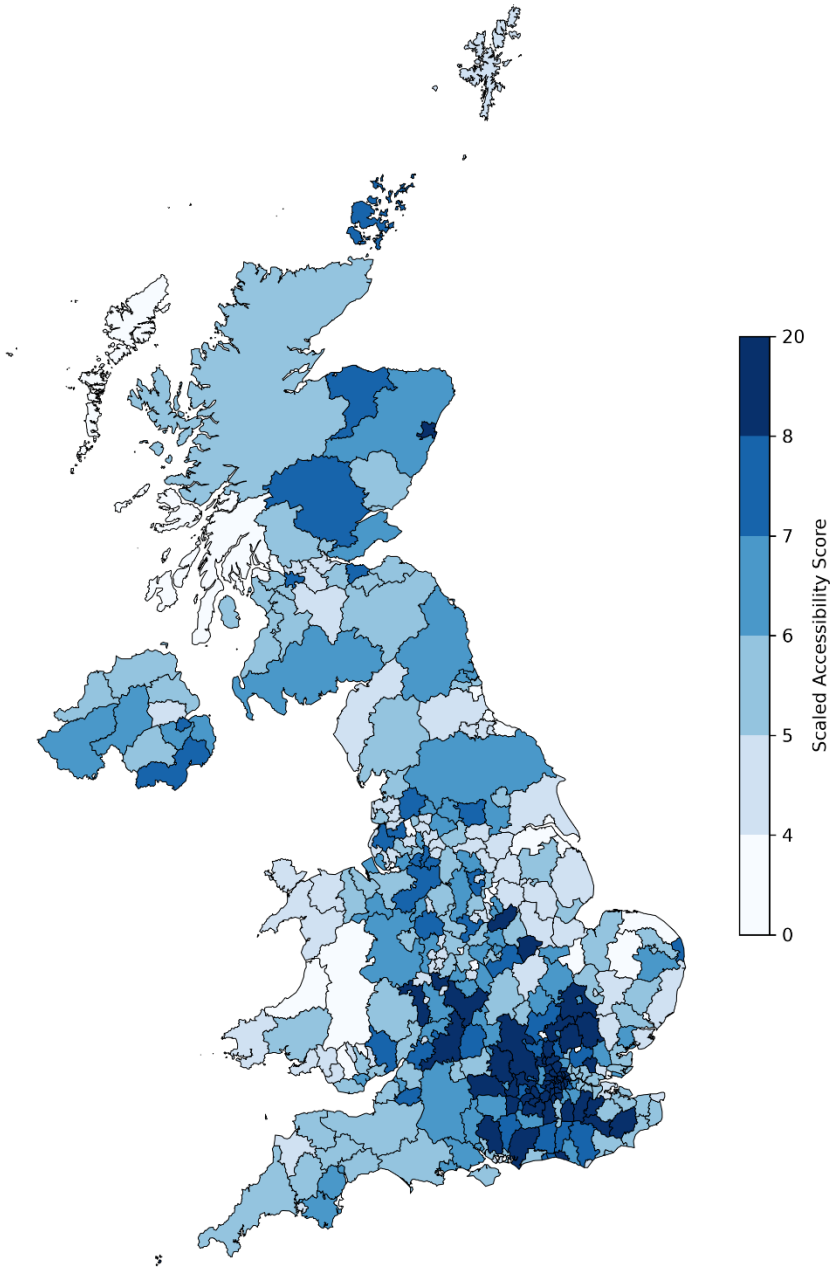
Source: UK ratio is based on CMA analysis of GDC and ONS data. Ratios for other countries are sourced from Eurostat.

24. Capacity matters directly for competition. A practice that is full or struggles to recruit has limited ability to take on additional patients and therefore little reason, to lower prices to attract them. Patients in turn have fewer realistic alternatives.

25. As well as the dentist-to-population comparison between countries, we have looked at the supply of dentistry relative to surrounding populations in the UK. Our analysis suggests that workforce capacity constraints are greater in some parts of East Anglia, the Midlands, North East England, and remote parts of Wales and Scotland. Across England, Scotland and Wales, they are also somewhat greater in

more deprived areas. The map below illustrates the differences between areas with a paler colour indicating less dentistry supply relative to surrounding populations.

Dentistry supply relative to surrounding populations across the UK



Commercial incentives, business models and profitability where competition is constrained

26. Private dentistry is offered across a fragmented and diverse market. Independent firms with one or two practices account for more than 60% of practices; the four largest groups account for around 12%, and the 19 large groups together account for around 19%. More than half of those large groups are private equity backed.

27. Dentists commonly have a direct financial stake in treatment revenues. Associate dentists are typically paid a revenue share, receiving on average £38 of every £100 of treatment revenue across group practices. Owner-operators receive returns through practice profits, dividends and eventual sale. At larger groups, we have seen KPIs and targets linked to increasing revenue: including sales of higher-revenue treatments, converting NHS patients to private care; selling dental payment plans and improving recall success.

28. Commercial incentives are a normal part of any private market and can support beneficial outcomes, including investment, extended opening hours, better utilisation of capacity and a wider range of services. Where competition works well, so that providers gain business by offering better prices, quality, service and choice, then commercial incentives and patients' interests are aligned.

29. Our concern in private dentistry is that competition is weak, particularly because patients depend heavily on clinical advice and workforce constraints limit alternatives. The combination of these conditions with the incentives and business practices we observe creates a real risk that patients may pay more than they need to or buy treatments or services that do not offer them good value. These risks are particularly concerning given patients' reliance on private dentistry for essential care.

Regulation does not provide a sufficiently effective backstop

30. The sector is subject to a substantial regulatory framework encompassing UK-wide professional regulation, national care-quality regulation, general consumer protection law and NHS contractual requirements on service providers. Regulation has an important role to play in safeguarding patients and contains important obligations, including those relating to transparency, informed consent and patient choice. However, we are concerned that the overall system is complex and accountability is not always aligned with where decisions are made.

31. We have identified a number of issues with the regulatory regime:

    (a) Professional regulation is focused principally on individual clinicians, while pricing, targets, incentives and patient communications may be set at practice or group level by people or businesses beyond that framework.

    (b) Fitness-to-practise enforcement is understandably directed towards serious misconduct and can culminate in loss of the right to practise. That may be too blunt a mechanism for less serious but potentially widespread transparency or consumer-protection failures.

(c) Patients face multiple and sometimes confusing routes for complaints and redress, and may lack confidence that complaining will lead to an effective outcome.

(d) Existing NHS rules can prohibit conduct such as making access to NHS care conditional on buying private services, yet 16% of respondents to our consumer research reported that they had to switch from NHS to private care to register or enrol their children for NHS care.

(e) Providers report overlapping requirements, divergence between national systems and administrative complexity that can increase costs and constrain entry, expansion and innovation.

32. Our emerging view is that the sector needs regulation that is better focused rather than simply more extensive: clearer business-level accountability, proportionate and usable enforcement tools, stronger complaints oversight and redress, and less unnecessary duplication.

Evidence on outcomes

Private care and affordability

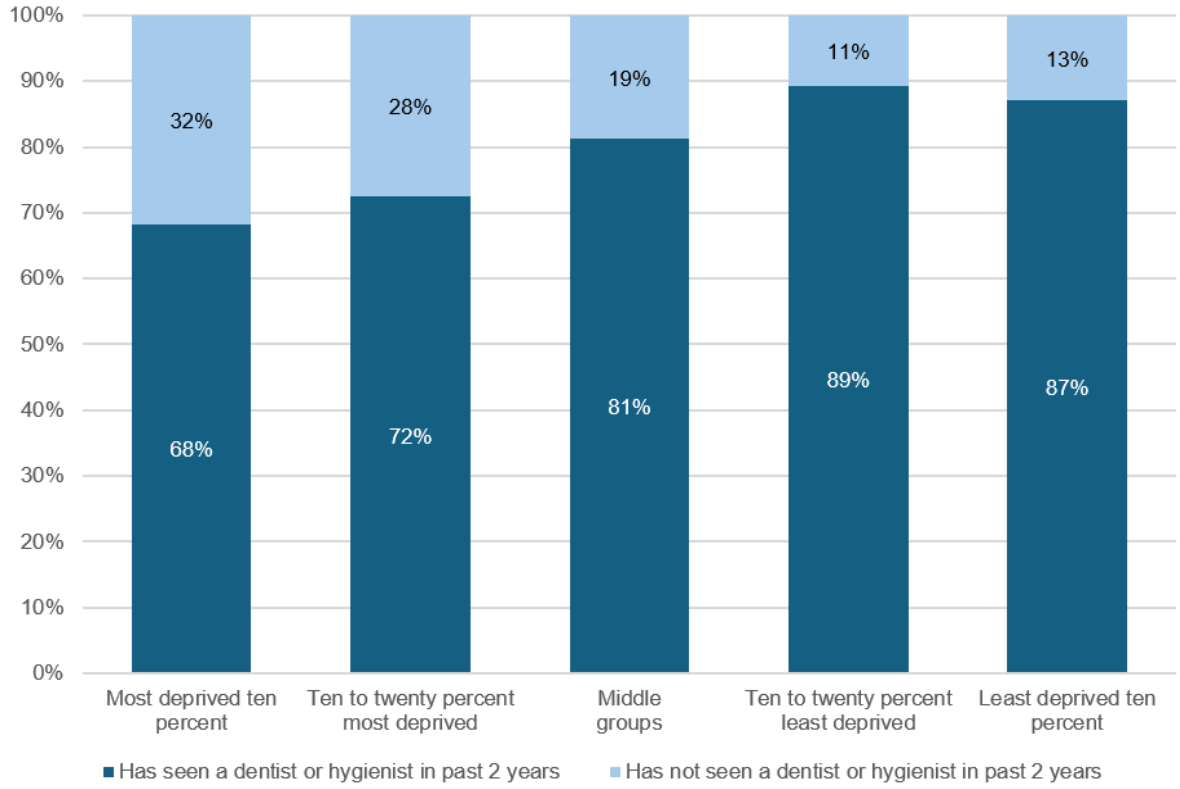
33. Private care may fill a gap where NHS treatment is unavailable, including for essential treatment and for those on low incomes. Forty per cent of consumers on state benefits and 52% of those experiencing financial difficulties reported receiving some private treatment.

34. Patients unable to access NHS care can face substantially higher charges. NHS care is subject to nationally determined charging and provider payment arrangements supported by government funding. Across the eight local areas we examined, even the lowest minimum listed private price was generally substantially above the closest NHS equivalent.

35. For some patients, paying for care creates financial pressure; for others, cost could mean going without. Among consumers receiving a mix of NHS and private treatment, 31% were not always confident they could afford treatment. We estimate that around 4 million people did not go to the dentist in the past two years as they find treatment expensive.

36. Attendance also differs markedly by income. Thirty-two per cent of consumers in the most deprived decile had not visited a dentist or hygienist in the previous two years, compared with 13% in the least deprived decile. This does not establish that price explains the whole difference but sits alongside the evidence of affordability barriers.

Dentist or hygienist visit in the past two years by level of deprivation, UK



Source: CMA analysis of Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research

37. One option for consumers concerned about the affordability of private dental care, is to take up a Dental Payment Plan (DPP). DPPs allow patients to spread payments for private treatment over time and may come with discounts on additional treatments. However, we have concerns with DPPs: they may risk over-treatment in some cases and may not offer value for money, for example if not all appointments are taken up; they may be difficult to cancel or transfer to another practice; and in some cases, a practice may make signing up to a DPP a condition of being accepted as a patient.

Price increases and local variation

38. Affordability has worsened for at least some patients over time. Our analysis of the realised prices of the most common treatments suggests that the large dental groups have increased prices by 7% a year on average between 2023 and 2025, faster than consumer price inflation and wage growth.

39. Patients can also face significant variation in listed prices within the same local area. This price variation is clear from our analysis of listed private prices on practice websites in eight local authority areas (one rural and one urban in each UK nation). For example, we found listed prices for a composite filling varied by over £100 in Preston.

Price variation for selected treatments in the eight locations analysed

Location	*Nation*	*Urban / Rural*	*Treatment*	*Lowest minimum price (£)*	*Highest minimum price (£)*	*Difference (£)*	*Difference relative to the lowest minimum price (%)*
Aberdeen City	Scotland	Urban	New patient consultation	45	123	78	173
Perth and Kinross	Scotland	Rural	Amalgam filling	60	134	74	123
Ards and North Down	Northern Ireland	Urban	Hygiene	36	105	69	192
Causeway Coast and Glens	Northern Ireland	Rural	Composite white filling	43	149	106	247
Caerphilly	Wales	Urban	Amalgam filling	72	159	88	121
Monmouthshire	Wales	Rural	Emergency appointment	50	195	145	290
Preston	England	Urban	Composite white filling	80	223	143	179
Horsham	England	Rural	Routine exam	45	91	46	102

Source: CMA analysis of website review data

40. Some variation is to be expected and may reflect differences in quality. However, where patients struggle to compare offers or switch practices, these differences create a risk that they pay substantially more without receiving commensurately better care.

Profitability analysis

41. The fragmented and complex operating structure of the private dental market means that our profitability analysis is preliminary and ongoing and limits the conclusions we can draw at this stage of our study. We are prioritising further analysis in the remainder of the study and will include updated findings in our final report. However, our initial profitability analysis supports our view that market outcomes could be improved, showing in particular substantial variation in indicative profit margins between practices. This variation does not appear to be driven by the balance of NHS and private provision offered by the practice.

42. At this stage, our findings do not establish that a particular size or ownership model delivers better or worse patient outcomes. Before our final report, we will carry out further analysis related to ownership models, acquisition strategies, financing and returns.

Where patients live shapes access and affordability

43. Our evidence indicates patients face different combinations of prices, incomes and workforce constraints depending on where they live. Prices alone do not show how affordable care is, and workforce shortages can leave patients with fewer alternatives. This is reflected in the heat map below.

44. Across the nations, Wales stands out for the combination of affordability pressures and workforce challenges. The median minimum published price of a composite white filling represents around 35% of mean weekly disposable income, compared

with 20% in Scotland and 22% in Northern Ireland. Our geographic-access measure also indicates particularly significant workforce challenges in Wales.

45. Within England, the North East and South West both face substantial pressures, but for different reasons. In the North East, private fees appear similar to those elsewhere, but lower average household incomes make treatment harder to afford and workforce constraints are heightened. In the South West, our data suggest that private fees are the highest in the UK – prices that lower-income residents also face if they cannot obtain NHS care.

46. A composite white filling represents around 36% of mean weekly disposable income in the North East and 32% in the South West, compared with 20% in London. Both regions also have higher dentist vacancy rates and poorer geographic access than London.

47. The proportion of consumers without a regular dentist also varies across the UK. The North East stands out: 41% of consumers report having no regular dentist. This is consistent with our wider findings of greater affordability pressures and workforce shortages in the region.

48. These comparisons are indicative: published-price data do not cover every practice, and average incomes do not capture every household's circumstances. Nevertheless, they show the importance of ensuring measures to improve outcomes can take account of differences in local affordability and capacity, alongside the different national systems.

Heat map of geographic differences in dentistry provision across regions of England and nations of the UK



Note: Heat map uses a green-to-amber-to-red relative colour scale. For practice info, red refers to higher percentages. For all other metrics, red refers to areas scoring more poorly based on the metric compared to other areas and green refers to areas scoring more highly in relative terms (rather than red and green indicating the lowest and highest possible scores). In the case of consumer survey evidence, different colours are based on statistically significant differences. Grey refers to where no or not enough data is available. Where geographical areas are grouped together into a wider area that indicates the score across the wider area due to data not being available on a narrower basis.

Implications and proposed actions

49. No single intervention is likely to address these issues. Our emerging view is that the evidence instead points towards a package of mutually reinforcing measures, including:

    (a) supply-side measures to increase the availability and effective capacity of the dental workforce, including on a national and regional basis;

    (b) demand-side (patient-facing) measures to improve transparency and support comparison and switching; and

    (c) better-targeted regulation and more effective enforcement.

50. These measures are required to improve outcomes for patients, but we do not believe they are sufficient. Many of the features of this market mean that strong competition is unlikely to emerge even under improved demand and supply-side conditions. Put another way, we consider that an unconstrained private market cannot, without more, be relied on to deliver good outcomes. Rather, our current view is that governments will need to deploy market shaping levers fundamentally to change the underlying economic conditions and incentives under which providers operate, in particular by using their position as substantial purchasers of dentistry to incentivise better outcomes for private patients. We intend to explore further in the next part of our study how best this might be achieved.

51. The goal of our measures is a better functioning mixed dental sector where:

    (a) the supply of dentists increases to support expansion and stronger competition on price, in particular in nations and regions where dental practices face greater recruitment challenge

    (b) patients can make better informed choices both between different practices and between individual treatments so they can access dental treatment that best suits their needs and budget as well as stimulate stronger competition

    (c) regulation and market shaping combine proportionately and effectively to constrain individual dental professionals, dental practices and business owners from engaging in commercial practices that do not operate in the patient's best interests

    (d) private providers may operate with differentiated but clearly understood and transparent commercial offerings and ownership models

    (e) the market dynamics support a commercially viable mixed practice model which provides for more affordable pricing for essential dental services and better safeguards in interests of private patients.

52. The appropriate response and combination of measures by governments will need to reflect differences between the nations and geographic priorities across localities. As we have explored, patients' experience is currently dictated by where they live, which may point towards the adoption of regionally or locally differentiated solutions.

53. Any greater market shaping role for governments would need to sustain or even enhance the commercial attractiveness of providing NHS dentistry within a mixed practice. In this context, the evidence indicates that NHS dentistry is an important part of the business strategy for many practices, and that NHS dentistry can be commercially attractive, for example because it provides stable revenues as well as opportunities to sell private treatments to NHS patients. Consistent with this, our evidence indicates that some independent mixed practices providing mainly NHS care achieve higher practice operating margins (as a percentage of revenue) than some practices with a higher private share. We are undertaking further work to understand more about the underlying economics of these practices.

Supply side measures (workforce)

54. Workforce constraints appear to be among the most significant barriers to improved outcomes. Limited capacity restricts access, weakens competitive pressure and reduces the effectiveness of many consumer-focused interventions.

55. Addressing these constraints alongside other interventions is therefore likely to have a greater impact than relying on behavioural or information measures in isolation.

56. Governments could increase the availability of clinicians by expanding domestic training capacity, improving recruitment and retention, enabling dental therapists and hygienists to work more to the full extent of their skills and qualifications, while reducing barriers affecting overseas-qualified professionals. It would be important to target these interventions to those areas which currently experience the greatest workforce constraints.

57. Many of these issues intersect with broader government decisions regarding workforce planning, education and immigration policy. Nevertheless, they are likely to be central to improving outcomes in the private dental market.

Demand-side (patient-facing) measures

58. Empowering patients to make effective decisions and exercise greater agency by comparing and switching practices is an important part of any remedy package. Patients should be better supported to understand the treatment options available to them and the extent to which proposed treatments are clinically necessary or discretionary. Our proposed recommendations combine

improvements in information from providers, including in treatment plans given before treatment commences, with a public online information resource provided by governments offering guidance for patients covering both NHS and private systems.

59. We also seek views on how price transparency and comparability might be improved, including through greater consistency in the description and presentation of treatment pathways.

60. Easier access to their records and diagnostic information could help patients seek a second opinion or move to another practice. We invite views on whether and how this could be achieved without imposing disproportionate burdens.

61. These measures are necessary to improve decision-making and place some greater competitive pressure on providers. However, their impact should not be overstated. Transparency, comparison and switching mechanisms are inherently less effective where treatment is urgent, capacity is constrained or only a small number of practices are accepting new patients.

Better-focused regulation and enforcement

62. The evidence points to a need for better targeted rules, more effective enforcement and clearer accountability. This includes ensuring that regulation can address incentives and practices that affect how patients are treated when those decisions are made at a practice or business-wide level. Patients also need complaints and redress mechanisms that they can use with confidence, supported by stronger regulatory oversight of complaints.

63. The objective should be to better safeguard consumers while avoiding unnecessary burdens that could further restrict supply or raise costs unnecessarily.

64. Regulation is an important part of the picture, and a partial safeguard to protect patients. However, it is not a solution to wider market challenges.

Government market shaping

65. Our current view is that measures to increase patient-led competitive pressure, combined with more effective regulation, while necessary, will not on their own achieve the improvement in patient outcomes we want to see.

66. The credence nature of dental services, and the various reasons why patients may prioritise staying with their existing dentist rather than switching to an alternative provider (where the option exists), mean that individual patients, even if better informed and better directed, cannot be expected to drive change simply by ‘voting with their feet’.

67. At the same time, we are wary of seeing regulation as the full answer. Proportionate conduct regulation can improve consumer protection, but it cannot be expected to substitute for competitive constraints where they are lacking, or to fundamentally reshape patient behaviour and preferences. It would not remove the credence nature of dental services or fully counteract revenue maximising incentives on providers.

68. Therefore, alongside measures to improve weak competition and strengthen business-level accountability through enforcement and redress, we are considering how governments could best intervene more directly to shape outcomes for those who use private dental services, particularly when it comes to essential care.

69. There are a range of measures that could in principle be used by governments to influence provider incentives and improve outcomes for patients relying on private dentistry for essential care. As a major buyer of dentistry services, we would expect governments to have substantial strategic leverage, particularly with practices that serve both NHS and private patients. Harnessing this could enable them to encourage more affordable private prices for patients buying essential dental treatment as well as improvements to transparency and other consumer-friendly behaviour.

70. In the next phase of this study, we will undertake further work and engagement to inform any final recommendations on the form that greater market shaping might take, sensitive to national and regional differences. In particular, we wish to:

    (a) explore market shaping mechanisms which may be appropriate, such as NHS provider eligibility requirements or preferencing criteria linked to private patient outcomes for essential services and quality signalling/kitemark schemes for mixed NHS/private practices, and

    (b) understand the conditions under which they could lower private prices for essential dental services while maintaining or enhancing the commercial attractiveness of hybrid provision.

    In doing so, we will take account not only of market conditions as they exist today but also of the likely impact of our package of measures as a whole, including how our competition-enhancing and consumer protection measures might impact incentives across the sector.

71. At this stage, we are not suggesting that market shaping approaches should be used to promote particular ownership and business models. These questions of ownership would be relevant insofar as the evidence were to link them to particular commercial drivers, business behaviours or pricing outcomes, rather than being targets in themselves. This is something we will examine further before our final report.

Direct price controls

72. Where affordability concerns persist and commercial incentives are not or cannot be addressed, governments also have the ability to directly regulate prices.

73. Direct price controls would place an upper limit on what private patients pay for defined clinically necessary treatments. NHS dentistry already operates under forms of controlled pricing, with remuneration of dentists for NHS treatments set by governments and either free for eligible patients or provided at a defined patient contribution level set by governments.

74. Affordability concerns persisting despite the measures discussed above would not in itself establish a case for price controls. This would require its own assessment of potential benefits and risks, including unintended consequences such as reduced investment, accelerated exit or consolidation, and threats to workforce supply.

75. Our preference is to explore with governments alternative market shaping tools. However, if our work over the next phase of the study were to indicate that these levers were not practicable for whatever reason, we would examine the question of price controls more closely.

Market investigation reference

76. We are currently not minded to make a market investigation reference. Our emerging view is that the main levers for delivering change lie with governments and public bodies. Recommendations and advice to those bodies are likely to offer a more appropriate route to improving outcomes rather than powers available to the CMA through market investigation.

77. However, we consider it premature to rule out a reference at this stage. The next phase of our work, outlined below, will add to our evidence base and inform how we evolve our recommendations.

Next steps

78. For the remainder of the study, we will consult on these interim findings and proposals and finalise our analysis and proposals in light of consultation responses and further evidence. We expect to deepen our analysis of business strategies, ownership models, profitability and financing across independent firms and larger dental groups. We intend to further examine workforce capacity constraints and non-compete clauses and the application of guidance on recall periods. We will work with governments and other stakeholders to evolve our recommendations seeking to take account of differences between national systems and local market conditions.

79. The recommendations in our final report will reflect this further work and our assessment of the action needed in this critically important market to help change market dynamics and improve outcomes for patients now and over time.