PRIVATE DENTAL SERVICES MARKET STUDY INTERIM REPORT

26 November 2026



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The Competition and Markets Authority has excluded from this published version of the final report information which it 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 Some numbers have been replaced by a range.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

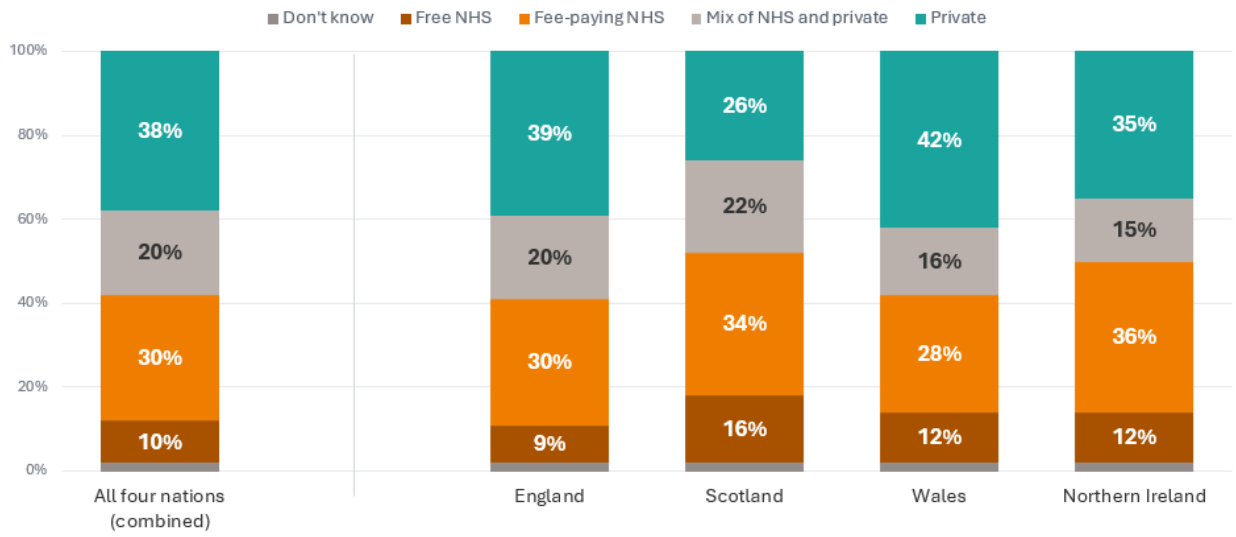
16. Dental care is essential to health and wellbeing. Preventative care can reduce pressure elsewhere in the health system, while poor oral health disproportionately

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.

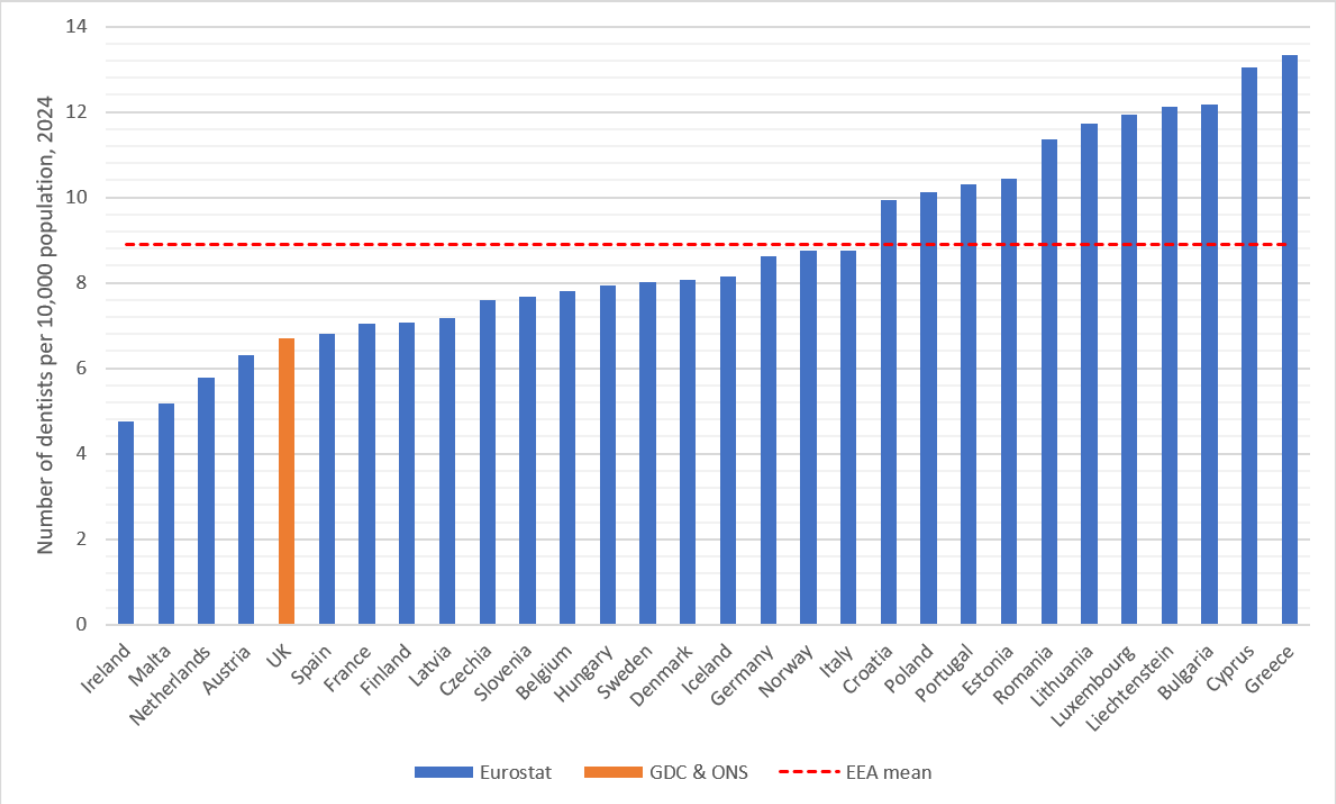
22. These features weaken the pressure that patients can exert on practices and mean that they are unlikely to switch to cheaper treatments, even though our evidence suggests there are significant differences in local prices. The substantial

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



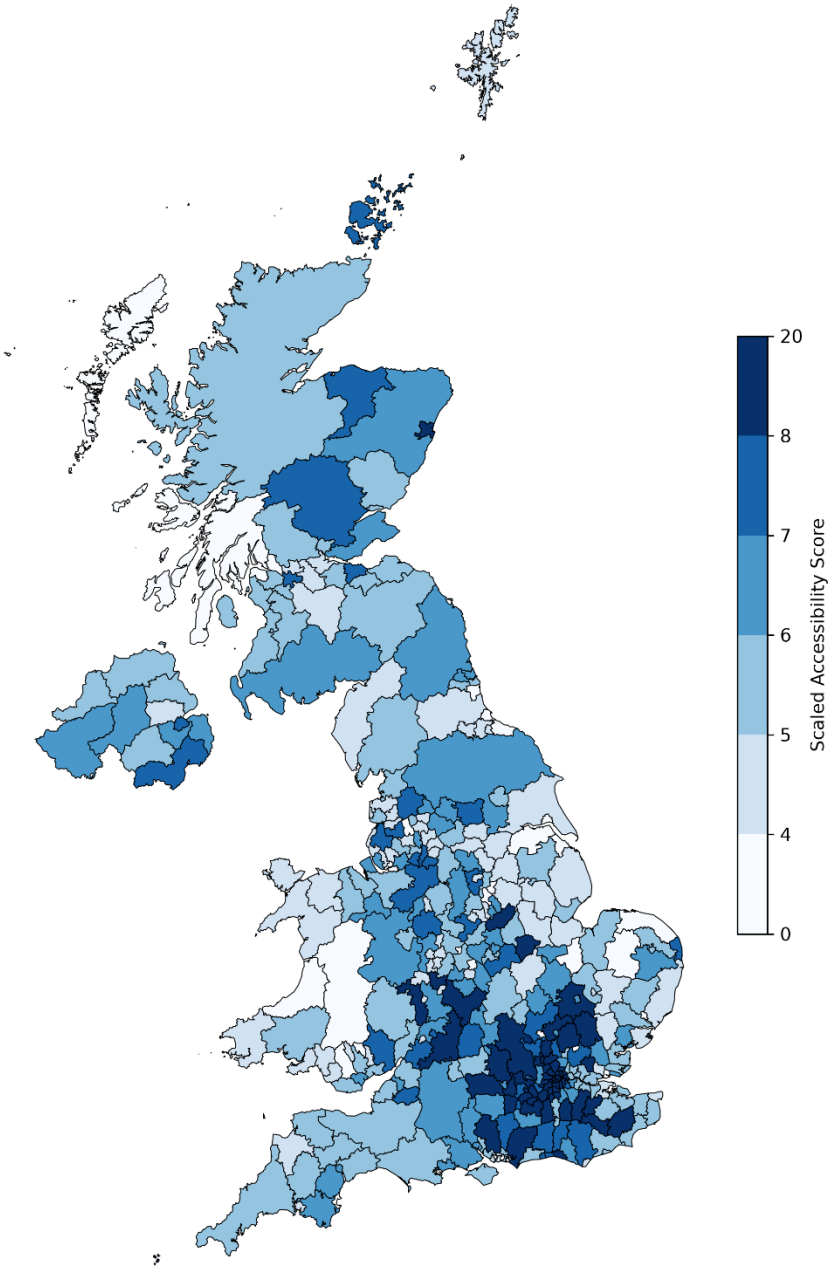
Source: UK ratio is based on CMA analysis of GDC and ONS data. Ratios for other countries are sourced from Eurostat.

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



Source: CMA analysis of data from LaingBuisson.

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

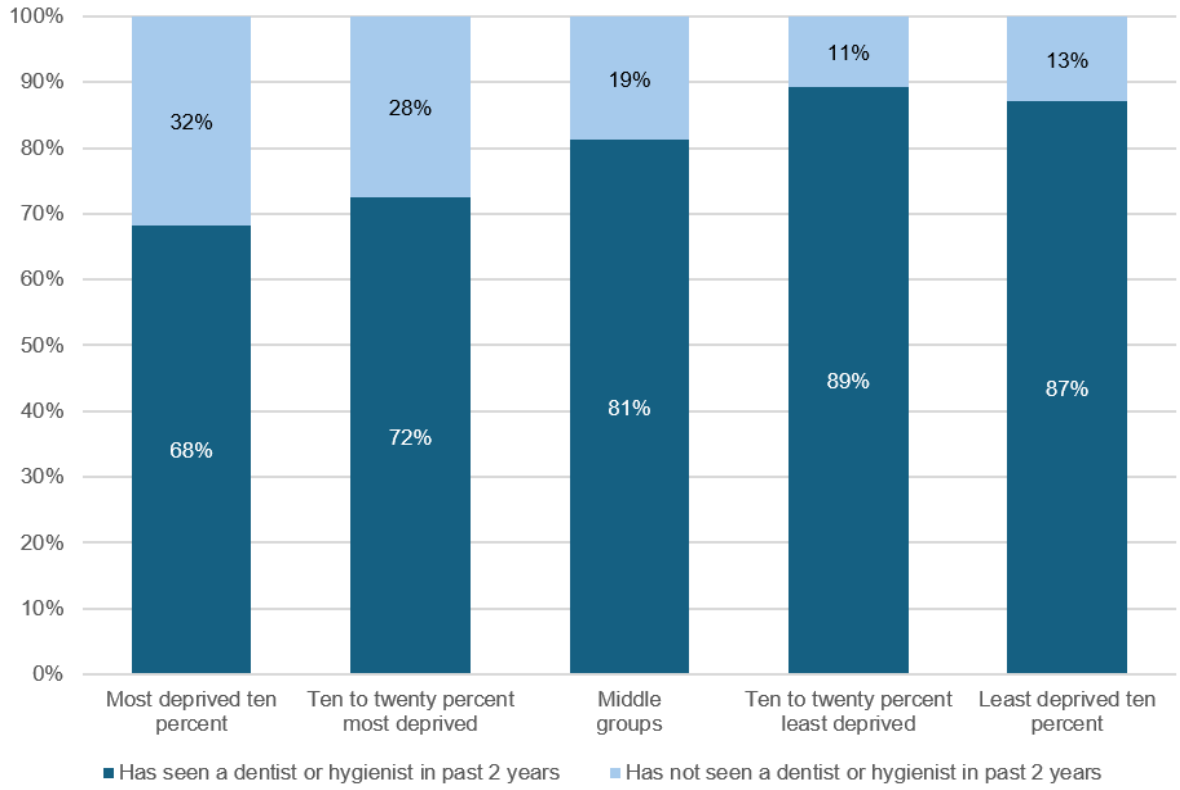
33. Private care may fill a gap where NHS treatment is unavailable, including for essential treatment and for those on low incomes. Forty per cent of consumers on state benefits and 52% of those experiencing financial difficulties reported receiving some private treatment.

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; and

    (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.

1. Our market study

Background to and focus of the market study

1.1 We launched our market study into private dentistry on 5 March 2026. Work in the private dentistry market aligns strongly with our strategic objectives. Across all of our work, we focus on delivering tangible benefits for the UK's economy, its citizens and businesses. In particular, as set out in our Strategy 2026 to 2029, the CMA helps improve household prosperity by promoting competition and protecting consumers. We take particular care to prevent harm to consumers in areas of essential spend and at moments of vulnerability.

1.2 Dentistry plays a critical role in overall health and wellbeing, including preventative dentistry which also reduces the burden on other parts of the public health care system.[1] The impact of poor oral health disproportionately affects vulnerable and socially disadvantaged individuals and groups in society.[2] Statistics show that a large, and growing, proportion of adults have reported their oral health negatively impacting their quality of life, with better oral health and quality of life reported by those who were more socioeconomically advantaged.[3] Similarly, statistics show economically disadvantaged children experiencing higher rates of oral health-related quality of life impact.[4]

1.3 The private dentistry market has become increasingly important, with a significant and growing proportion of households using private dental services, through choice or because people are unable to access NHS treatment either at all or quickly enough.[5] Market reports indicate that the overall dentistry market in the UK was worth approximately £11-12bn in 2024 – with private (including cosmetic) treatment revenues accounting for approximately 60%-70% of the total.[6]

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[1] To illustrate, tooth decay remains the most common reason for hospital admissions in children aged between 5 and 9 years in England. See: Short statistical commentary for hospital tooth extractions in 0 to 19 year olds 2024, updated 12/11/25.
[2] Inequalities in oral health in England: summary, published 19/03/21.
[3] Adult Oral Health Survey (2023): Report summary, updated 17/12/25. Adult oral health survey 2023, published 09/12/25. Survey covers England. Usual pattern of attendance varied by household income with a clear social gradient. Visiting the dentist for regular check-ups rose as household income increased, while reported rates of only visiting because of a problem declined. Similar social gradients were observed by area deprivation.
[4] Dental epidemiological inspection of school year one (5-year-old) children in Wales 2022/23, Welsh Oral Health Information Unit.
[5] Research commissioned by the General Dental Council in 2024 found that people in the UK started to have private dental care because: they couldn't get NHS treatment at all (36%), they couldn't get NHS treatment quickly enough (31%), their dental practice/professional stopped offering NHS treatment (25%) or they preferred it (18%). The same research found that almost three in ten (28%) of those cutting back on essentials agreed strongly that they will only go to a dentist in an emergency, versus only 13% of those not cutting back. Figure 4: GDC (2024) General Dental Council – Views and experiences of dentistry, p18.
[6] A market report from Mintel indicates the total dental expenditure in the UK in 2024 (including NHS, private general dentistry and cosmetic dentistry) was £10.61bn, of which £4.10bn was NHS, £3.95bn was private general dentistry, and £2.56bn was private cosmetic. Mintel, UK Dentistry Market Report 2024, pages 7-8, accessed 09/07/26. A market report from LaingBuisson indicates that the UK 'high street' dentistry market value was £12.16bn in 2023/24, of which £9.25bn

Our market study focus

1.4 We have been examining five broad themes in the market study, as set out in our Statement of Scope and confirmed in our July update.

1.5 Those themes are:

(a) Consumer journey and choice, including the availability of dental services and how consumers access, assess and act on information to make informed choices.

(b) How, and the extent to which, dentists compete to win and keep customers and are incentivised/disciplined to meet consumers preferences and needs as effectively and efficiently as possible.

(c) Whether dentists engage in any unfair practices/anticompetitive conduct or other conduct that may adversely affect consumers/competition.

(d) The extent to which regulatory frameworks and their enforcement support good competition and consumer outcomes, including consumers getting the right information at the right time to make decisions that are right for them.

(e) Market outcomes, including prices and relative profitability.

1.6 While our market study focusses on the supply of private dental services, it also considers publicly funded dentistry and related policy where they affect incentives, competition and consumer outcomes in the private market.

Our approach to information gathering

1.7 As set out in our Project Roadmap, over the past few months we have gathered information from a wide range of sources to develop our understanding of how the private dental market operates across and within the UK nations. To date:

(a) We have received 21 responses to our Statement of Scope, 1,825 responses to our Consumer Call for Views and 961 responses to our Dental Professionals Call for Views, published on launch of the market study.

(b) We issued statutory information notices under section 174 Enterprise Act 2002 ('statutory information notices') to the four largest dental groups (mydentist, Bupa, Portman Dentex and Rodericks); 12 large dental groups (with 30+ practices); and 10 small to mid-size dental groups (with 3-29 practices).

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was NHS and £8.37bn was private. LaingBuisson, Dentistry UK Market Report, 7th Edition, 2025, page 18, accessed 09/07/26.

(c) We issued a statutory information notice to the National Association of Specialist Dental Accountants and Lawyers (NASDAL) to obtain anonymised financial information from c.500 independent dental practices; and received 189 responses to our independents' voluntary questionnaire. In November, we issued over 400 statutory information notices to independent dental practices.

(d) We issued statutory information notices to 10 firms who invest in/own large dental groups.

(e) We commissioned quantitative consumer research with 3,259 UK adults: Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research (the Verian research); and qualitative research with 102 dental professionals: Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations (the Revealing Reality research).

(f) We reviewed 8,373 dental practice websites to assess how transparently they presented key information, such as that on price, practice type, complaints and quality indicators. We also analysed 10,911 dental practices to estimate levels of practice supply relative to local populations.

(g) We held roundtables with dental groups, independents, and consumer groups and teach-ins with three of the largest providers.

(h) Finally, we met (and continue to meet) a variety of stakeholders including government officials and the Chief Dental Officers in each nation; regulators; industry associations, professional bodies; academics and insurers.

MIR decision

1.8 When the findings of a market study give rise to reasonable grounds to suspect that a feature or combination of features of a market in the UK prevents, restricts or distorts competition, the CMA may decide to make a market investigation reference (MIR) where it would be appropriate and proportionate to do so.

1.9 As set out in the remainder of this report, we have provisionally identified a number of core concerns in this market arising from weak demand-side responsiveness, weak competition between dental practices, the effect of incentives acting on practices, and aspects of the regulatory framework. We currently consider that the main levers for addressing those concerns, as set out in Chapter 7, sit with governments and regulatory bodies, meaning that recommendations and advice are more likely to be a more appropriate means to improving outcomes than the order making powers that would be available to the

CMA through an MIR. We have not received any representations to the effect that an MIR should be made.

1.10 We are therefore currently not minded to make an MIR. However, we consider it premature to rule out an MIR at this stage. In particular, the next phase of our work, which we describe further in this report, will add to our evidence base and inform how we evolve our recommendations.

Next steps

1.11 We are undertaking further targeted information gathering and analysis to finalise our assessment of the market. We recognise the demands this places on dental businesses, but it is critical to ensuring we have the best evidence to underpin our assessment of the market and for further consideration of potential interventions. We are very grateful to those businesses and other stakeholders who have provided information to inform our market study.

1.12 We welcome feedback on our analysis, emerging findings and possible interventions as set out in this report by **5pm** on **17 December 2026**. This will be extremely valuable as we move into the final phase of our study.

1.13 We will carefully consider the feedback we receive to inform our conclusions, and any measures we propose to take ourselves or recommend to others, which we will set out in our final report. We will publish our final report by **4 March 2027**.

2. Market background

2.1 In this Chapter we describe features of the UK private dentistry market to provide context for our assessment of how the private dentistry market is working, and whether it could be delivering better outcomes.

2.2 Specifically, we set out:

(a) A summary of key features of the market;

(b) How dental professionals and practices are regulated;

(c) How dentistry is provided and accessed by patients;

(d) The mix between NHS and private provision;

(e) Market size, ownership types and structure; and

(f) Principal ownership and operating models in the sector.

Key features of the market

2.3 The UK dentistry market has a number of key features which we will refer to throughout this report.

(a) **Mixed sector:** Estimates indicate that the majority of dental practices in the UK provide NHS treatments, either alongside private treatment (mixed practices) or as their sole focus (NHS-only practices). Over time there has been a shift (in revenue terms) to private treatment, with private revenue generally growing faster than NHS revenue, albeit without a marked decline in the number of dentists providing NHS services.[7] However, the balance between NHS and private provision varies significantly by nation, region and firm. For example, we estimate there are significantly more private-only practices in Wales (26%) and England (25%) than in Scotland (8%) and Northern Ireland (4%).

(b) **Consumers' use of private dentistry is shaped by NHS availability**: While consumers may be eligible for free or fee-paying dental care under the NHS, they may not necessarily be able to access it. Therefore, the availability of NHS dental care shapes consumers' use of essential dental services provided privately.

[7] With the exception of Wales where there has been a 4.6% fall in the number of NHS dentists between 2020 and 2025 (as set out later in the chapter).

(c) **Devolved:** Publicly funded dentistry is devolved, so the arrangements for commissioning, paying for and accessing treatment differ across the four UK nations.

(d) **Fragmented market:** There are about 12,000 dental practices in the UK, with independent firms,[8] which are typically owner-operated or part of a partnership, collectively accounting for over 60% of the market (by number of practices). There has been some consolidation in recent years. The four largest dental groups account for around 12%, and the 19 large dental groups[9] (including the four largest) for around 19% of the market.

(e) **PE involvement:** More than half of the 19 large dental groups are private equity backed, although private equity backed groups are more prevalent in some parts of the UK than others.

(f) **Prevalent revenue-share model:** The main model for remunerating dentists for delivering private dental treatments across dental firms is the associate revenue-share model. This links the associate's earnings to the revenue and costs generated by the treatments they provide.

2.4 These features provide the context for our assessment of consumer outcomes, competition and commercial incentives in the chapters that follow.

Dental professionals and regulation

Dental professionals

2.5 A **dentist** is someone qualified to treat diseases and other conditions affecting teeth and gums, especially repairing and extracting teeth and inserting artificial ones, and is registered with the General Dental Council (GDC) to work in the UK. A **dental care professional (DCP)** is someone qualified to practise certain aspects of dental care. The category of DCP covers dental nurses, dental technicians, dental therapists, dental hygienists, orthodontic therapists and clinical dental technicians, each with their own qualifications and scope of practice.[10]

2.6 In this report, we use '**dental professionals**' to mean both dentists and DCPs and '**clinicians**' to mean dentists, dental hygienists and dental therapists.

2.7 As of October 2026, 135,641 dental professionals were registered with the GDC to practise in the UK, a 4.2% increase from October 2025. Of these, 49,079 (36%) were dentists and 86,562 (64%) were dental care professionals.[11]

[8] Firms with 1-2 practices.
[9] Those with 30 or more practices.
[10] GDC, Types of registrants, accessed 25/08/26.
[11] GDC, Registration report - October 2026, accessed 01/11/26.

How regulation works

2.8 Regulation of private dentistry operates at two levels. Dental professionals are regulated across the UK by the GDC. Dental practices are subject to nation-specific regulation, which can also differ according to whether they provide publicly funded treatment, private treatment or both.

2.9 All registered dental professionals must comply with the GDC's standards of conduct, performance and ethics.[12] These cover clinical care[13] and general consumer obligations, including price transparency.[14] The GDC regulates individual dental professionals, but it does not have powers to regulate businesses that offer dental services.[15]

2.10 The Dentists Act 1984 requires that a practice owner (an individual or a partner) must be a registered dental professional,[16] and that a majority of the directors of a body corporate carrying on the business of dentistry must be registered dental professionals.[17]

2.11 Practices offering private dental treatment are subject to care quality regulation in the nation in which they operate, with each nation having its own healthcare inspectorate. Those in England, Wales and Northern Ireland regulate all private and mixed dental practices in their nation;[18] Scotland's regulates private practices only.[19] Practices providing NHS treatments must also comply with nation-specific NHS dentistry rules and regulations.

2.12 Dental professionals and dental businesses may also be subject to general consumer law, such as the Consumer Rights Act 2015 and the Digital Markets, Competition and Consumers Act 2024. Government departments and public bodies involved in the delivery of publicly funded dentistry perform additional regulatory or quasi-regulatory roles.

2.13 Chapter 5 and Appendix H set out our emerging findings and further information on the regulatory framework.

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[12] GDC (2014) Standards for the Dental Team.
[13] For example, "You must take a holistic and preventative approach to patient care which is appropriate to the individual patient" (Standard 1.4).
[14] For example, "You must give clear information on prices in your practice literature and on your websites" (Standard 2.4.2).
[15] The GDC standards may apply indirectly to a business, for example to a self-employed dental professional, or to individuals who own practices outside of a company structure (who are legally required to be registered dental professionals).
[16] Dentists Act 1984, section 40.
[17] Dentists Act 1984, section 43.
[18] Care Quality Commission (England); Healthcare Inspectorate Wales; The Regulation and Quality Improvement Authority (Northern Ireland). For completeness, Health Inspectorate Wales does inspect NHS practices not carrying out any amount of private dental services, but it does not register or otherwise regulate these practices.
[19] Healthcare Improvement Scotland. In Scotland, territorial health boards inspect dental practices that provide NHS services (whether solely NHS services or mixed practices).

Intersection of NHS and private dentistry

2.14 While our market study is concerned with private dentistry, it is important to understand the wider system in which private dental services are delivered. Across the UK, NHS and private dentistry are closely intertwined. Most practices provide both NHS and private treatment, many dentists divide their time between NHS and private work, some treatments may be available both privately and through the NHS, and consumers may move between NHS and private care over time or use a combination of both. The availability of NHS dentistry also influences consumers' decisions about whether to seek private treatment and the options available to them. This means that incentives and outcomes in NHS dentistry directly affect how the private market operates and the outcomes it delivers for patients.

How dentistry is provided and accessed

The mixed sector and publicly funded dentistry

2.15 Dentistry in the UK is delivered through a mixed sector model. Publicly funded dentistry is devolved: each UK nation decides its own policy, funding arrangements and systems to deliver public dental care. The UK and devolved governments are each undertaking, or have recently undertaken, policy changes in this area.

2.16 The publicly funded system is the NHS in England, Scotland and Wales and the Health and Social Care system in Northern Ireland. For simplicity, we refer to these systems collectively as the **NHS**. Broadly, NHS dentistry covers treatment considered necessary for oral health, although the arrangements for commissioning, paying for and accessing it differ between nations. Consumers may receive NHS treatment through an NHS-only or mixed practice. A mixed practice may, however, accept a consumer only for private treatment or may not have NHS appointments available.[20] Below we outline how the different UK nations publicly fund dental treatment.

England

Provision and funding

2.17 Thirty six Integrated Care Boards (ICBs) are responsible for planning, commissioning, and securing NHS dental services in their area – exercising functions delegated by NHS England. They contract with providers (which could be a corporate group, partnership or individuals)[21] mainly through General Dental

[20] Patient-facing descriptions and commissioning language differ across the UK nations.
[21] See NHS England, General Dental Services (GDS) contract, revised September 2026, Schedule 1.

Services (GDS) contracts. These are usually of unlimited duration and cover 'mandatory dental services' which are clinically necessary routine and urgent treatments needed to keep the mouth, teeth and gums healthy and free of pain.[22] They specify a minimum set of clinical procedures which must be delivered if clinically necessary. The contract value is renegotiated periodically. The much less common Personal Dental Services contract (**PDS**) is awarded for a fixed term and often for specialist services such as orthodontics, though they can also include mandatory dental services too. Some NHS dentistry is provided in the community and in hospitals.[23]

2.18 Under reforms proposed by the UK government in the Health Bill introduced in May 2026, ICBs would assume statutory responsibility for commissioning primary dental services following the abolition of NHS England, while national oversight and contract-setting powers would remain with the Secretary of State.[24] The Department of Health and Social Care's (DHSC) role is to ensure that arm's length bodies deliver agreed plans and to review whether legislative, administrative and policy frameworks are fit for purpose.

2.19 Contract holders are generally paid for delivering an agreed number of units of dental activity (UDAs) by the end of the financial year. Providers are expected to deliver between 96% and 102% of contracted activity (reflecting the potential variation in patient demand and treatment needs). If a contract holder delivers fewer than 96% of contracted UDAs, the difference is recovered, while delivery above 102% of the contracted volume is not paid (unless the provider obtained prior approval from their commissioner).[25]

2.20 Treatments are grouped into NHS bands based on complexity, with each band attracting a specified number of UDAs. Broadly, contract holders are credited with the number of UDAs of the most complex treatment in a course of treatment. This means that under the UDA system, courses of treatment involving patients with significantly different clinical needs can attract the same number of UDAs. Reforms introduced in April 2026 enable dentists to enrol patients on new complex care pathways which attract set rates of payment.[26]

2.21 A practice's 'UDA rate' represents the amount paid per UDA and is calculated by dividing its annual contract value by its annual UDA target. These UDA rates can

[22] General dental services contracts can also include advanced mandatory services.
[23] House of Commons (2025) NHS dentistry in England, page 11.
[24] Department for Health and Social Care (2026) 'Health Bill: ICBs as strategic commissioners - fact sheet' accessed 22/10/26.
[25] NHS Business Services Authority 'What happens if I under or over-perform on my contract? · Customer Self-Service' accessed 09/09/26.
[26] Government response to consultation on NHS dentistry contract: quality and payment reforms - GOV.UK accessed 09/09/26.

vary considerably between practices and often reflect historic contract arrangements.[27] The minimum UDA value was raised to £28 in April 2024.[28]

2.22 Associate dentists (who are not contract holders) are typically remunerated by the contract holder at a separately agreed per-UDA rate, which determines their compensation for each UDA completed.

2.23 ICBs have flexibility to consider increasing the UDA value of a contract, including to provide support to contractors with lower UDA values where this will deliver improved service provision. To boost NHS dentistry delivery rates, some ICBs have implemented their own minimum UDA rates.

2.24 NHS England has published guidance for commissioners that outlines relevant considerations in relation to increasing UDA rates, as well as wider opportunities for flexible commissioning.[29]

Access

2.25 Consumers in England must find a practice offering NHS appointments and contact them directly. They do not formally register with an NHS dentist or practice offering NHS dental treatment. Practices may ask new patients to complete a registration form, but NHS guidance is explicit that this does not guarantee ongoing access to NHS care at that practice in the future, beyond the agreed treatment for the current course of treatment.[30] Not all practices are accepting new NHS patients or have NHS appointments available and many have a waiting list.

Eligibility and charges

2.26 Most adults pay a contribution towards NHS treatment through one of three charge bands, paying the charge for the highest band required during a course of treatment.[31] [32] This includes dental examinations which are charged in band 1. Treatment is free for specified groups, including people under 18, those under 19 in full-time education, pregnant women and those who have had a baby in the previous 12 months, some hospital patients, and people receiving specified benefits or qualifying under the NHS Low Income Scheme (which can provide partial assistance with dental costs, or full relief in some circumstances).[33]

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[27] House of Commons (2025) NHS dentistry in England, page 16.
[28] Before this, the minimum UDA value was £23 (introduced in October 2022).
[29] NHS England NHS England » Opportunities for flexible commissioning in primary care dentistry: A framework for commissioners, accessed 14/10/26.
[30] NHS, How to find an NHS dentist, accessed 02/09/26.
[31] NHS England, Who can get free NHS dental treatment or help with dental costs - NHS, accessed 28/10/23.
[32] Note that this is different to the rate that the contractor (dental firm) delivering the treatment(s) is compensated per unit of dental activity (UDA).
[33] NHS England, Who can get free NHS dental treatment or help with dental costs - NHS, accessed 28/10/26.

Scotland

Provision and funding

2.27 NHS Boards are responsible for arrangements with dentists and for managing dental lists and services in their area. Dentists are paid under the Statement of Dental Remuneration (SDR) framework. This is an 'item-of-service' system under which they receive the specified fee for each treatment provided, rather than a single payment for an activity band. The SDR was substantially revised in November 2023 to reduce the number of treatment codes, with the stated aims of simplifying remuneration for dentists and making it easier for patients to understand.[34]

Access

2.28 Consumers in Scotland must find a practice accepting new NHS patients and register directly with it. Registration is for life, continuing unless the consumer or dentist asks for it to be withdrawn. Not all practices are accepting new NHS patients, and a practice may operate a waiting list before registration.

Eligibility and charges

2.29 NHS dental examinations are free for all NHS patients, regardless of age or income. Other NHS treatment is free for people under 26 and for certain other groups, including pregnant women or those who have had a baby in the previous 12 months, receive specified benefits, or qualify under the NHS Low Income Scheme. Other adults receive fee-paying NHS treatment, paying 80% of their dental treatment costs up to a maximum of £384 per course.[35]

Wales

Provision and funding

2.30 Seven Local Health Boards (LHBs) are the main commissioners of NHS dental services. The previous UDA-based funding model was replaced in April 2026 by a care-package model with the stated aim of giving priority to people with the highest clinical need.[36] Remuneration for contractors[37] takes into account complexity and time required for treatment. Unless the patient is exempt, each care package has

[34] NHS National Services Scotland 'Dental Reform – An Overview | National Services Scotland' accessed 09/09/26
[35] NHS Inform (Scotland), 'Your dental check-up' accessed 09/09/26.
[36] NHS Business Services Authority 'Dental Contract Reform in Wales | NHSBSA' accessed 09/09/26.
[37] Contractors may include partnerships, corporate dental entities and individual practitioners.

an associated patient fee for a single course of treatment. Dental appliance costs are charged separately.[38]

Access

2.31 Consumers who do not already have an NHS dentist access services through the NHS Wales Dental Access Portal (DAP), rolled out in 2025. LHBs use the portal to allocate consumers to a practice offering NHS dentistry when a place becomes available. The DAP was introduced with the stated aim of providing a single equitable route into NHS dentistry and to give the Health Boards a clearer picture of demand for NHS dentistry.[39]

Eligibility and charges

2.32 NHS dental examinations are free for people under 25 and those aged 60 or over. A full range of NHS treatment is available free to children under 18, those aged 18 in full-time education, pregnant women and recent mothers, certain hospital patients, and people on qualifying benefits or low incomes. Other adults pay a fixed fee for each course of treatment, up to a maximum of £384 per course.[40]

Northern Ireland

Provision and funding

2.33 Dental services are delivered through the Health and Social Care (HSC) system. Policy responsibility sits with the Department of Health (Northern Ireland). The Strategic Planning and Performance Group (SPPG) is responsible for commissioning and operational management, including contract management. As in Scotland, dentists are paid for each treatment they provide under an item of service model set out in a Statement of Dental Remuneration. General dental practitioners are paid for registration of patients under capitation (for children) and continuing care (for adults) arrangements.

Access

2.34 Consumers access dentistry by finding a practice that is accepting new Health Service patients and registering with it directly. Registration lasts for 24 months but is automatically extended if the patient attends another examination or treatment during that period. If the patient does not return within the 24 months, their

[38] Senedd Research 'NHS General Dental Services contract reform' accessed 09/0926.
[39] Welsh Government, Finding an NHS dentist in Wales easier with new digital portal, accessed 02/09/26.
[40] Welsh Government, NHS dental charges and exemptions | GOV.WALES, accessed 28/10/26.

registration lapses. Not all practices are accepting new Health Service patients, and a practice may operate a waiting list before registration.[41]

Eligibility and charges

2.35 Free NHS treatment is available to children under 18, qualifying students aged 18 and in full-time education, pregnant women and those who have had a baby in the previous 12 months. People may qualify for help with costs if they are on a low income or receiving certain benefits. Other patients contribute towards the cost of treatment, generally paying 80% of the treatment cost, up to a maximum charge of £384 per course.[42]

Limitations on access to NHS dental care

2.36 Free and fee-paying NHS appointments can be limited. Most large dental groups said their ability to deliver NHS treatment was limited by either the constraints of their existing contracts and/or workforce supply issues.[43]

2.37 For children, although NHS dental treatment is free for those under 18 in England, Wales and Northern Ireland and for those under 26 in Scotland, practices do not have to accept a child as a new NHS patient where they lack NHS capacity or have reasonable grounds to refuse.[44] The Verian research found that the most common difficulties for accessing NHS dental care for children were in finding a local NHS dentist, waiting lists or waiting times, and practices not accepting new patients.[45]

2.38 Some policy measures incentivise the prioritisation of NHS capacity based on need. For example, in England, DHSC introduced reforms in 2026 which require practices to offer a minimum number of urgent appointments each year. In 2026/27, this is set at 8.2% of their contract value. This is supported by fairer payment for urgent care via a set tariff.[46] In Wales, patients are encouraged to register via the DAP to be allocated to a dental practice with NHS availability.[47] Recent reforms of the NHS dental contract in Wales also require contract holders

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[41] NI Direct Government Services, Seeing a dentist | nidirect, accessed 28/10/26.
[42] NI Dental Finder, NHS Dental Charges & Costs in Northern Ireland | NI Dental Finder, accessed 28/10/26.
[43]Almost all dental groups indicated that the number of appointments they can offer is ultimately limited by their contracted NHS capacity. Several parties further stated that these capacity constraints are currently limiting new patient sign up. Several parties also cited clinician capacity (covered in more detail in Chapter 4). Parties that identified NHS contracted capacity as the ultimate constraint on appointment availability: [✂]. Parties that identified NHS contracted capacity as the ultimate constraint on appointment availability and that this is currently restricting new patient sign up: [✂]. Parties who also cited clinician capacity: [✂].
[44] NHS England, 'Who can get free NHS dental treatment or help with dental costs', accessed 27/08/26; NI Direct, 'Seeing a dentist', accessed 27/08/26; NHS Inform, 'Help with costs', accessed 27/08/26; NHS Wales, 'Dental health for children', accessed 27/08/26.
[45] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, ACCNHS_CHILD.
[46] Department of Health and Social Care, 'Government response to consultation on NHS dentistry contract: quality and payment reforms' accessed 21/10/26.
[47] Welsh Government, 'Accessing NHS dental services' accessed 21/10/26.

to deliver a certain number of urgent appointments for new patients.[48] Some dental businesses also told us about allocating NHS appointments based on the urgency of patient need, including appointments for children.[49]

2.39 We discuss the impact of availability of NHS dentistry on the consumer journey in Chapter 3.

The mix between NHS and private provision

The growing role of private revenues

2.40 Estimates, although not definitive due to limitations in the available data, indicate that the majority of dental practices in the UK provide NHS treatments, either alongside private treatment (mixed practices) or as their sole focus (NHS-only practices).

(a) The Nuffield Trust estimated that 56% of practices in England offer NHS treatments, as of March 2026. As noted by the Nuffield Trust, this estimate has some limitations. In particular, the estimate may understate the provision of NHS dentistry by attributing large NHS contracts to a single practice when this contract may fund NHS dentistry across several practices.[50]

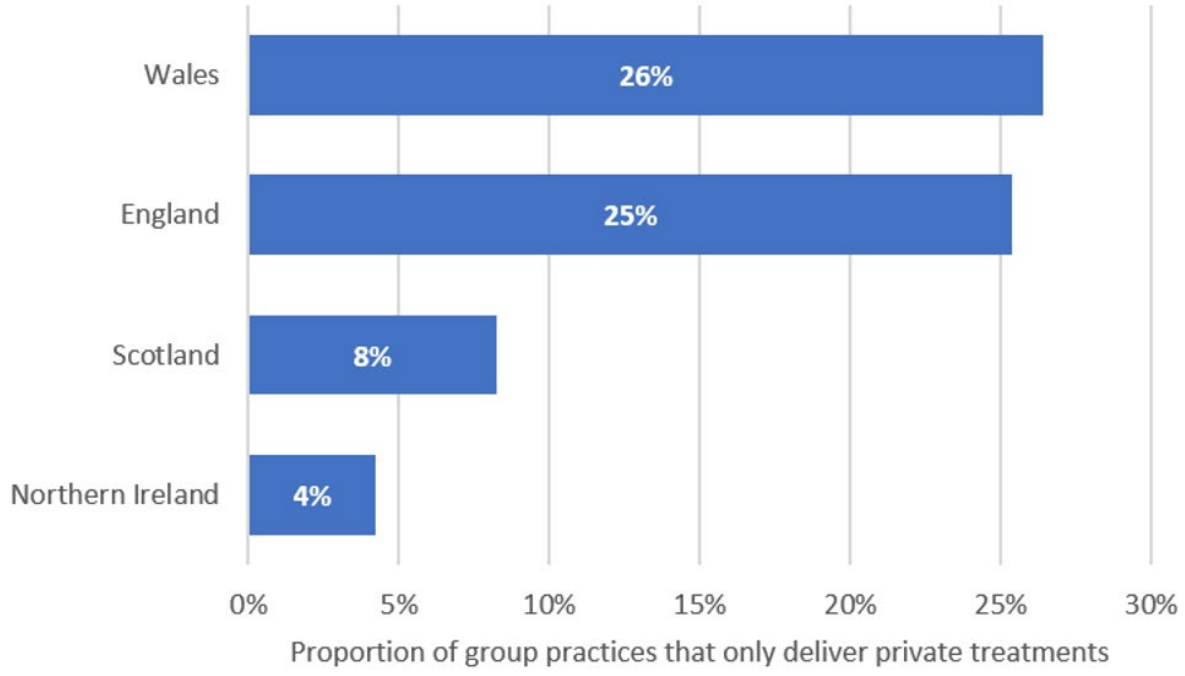
(b) Although no definitive estimate has recently been published on a UK-wide basis, the proportion of practices in our sample that were mixed varied between 70% and 80%, as of April 2026, depending on the size of the firm. In our sample fewer than 5% delivered only NHS treatment, and around a quarter provided only private treatment.[51] These estimates are only indicative due to the small and potentially non-representative nature of our sample – particularly for small and medium sized dental groups and independents (and in the case of independents, it is a subset that have employed a specialist accountancy firm). The potentially non-representative nature of our sample may explain why it gives different estimates to Nuffield Trust's estimate above, which has fuller coverage of practices, albeit coverage that is limited to England. Other potential reasons for the different estimates include the

[48] The National Health Service (General Dental Services Contracts and Patient Charges) (Wales) Regulations 2026, Schedule 1, Part 1.
[49] Responses to the CMA's information requests: [✂].
[50] Nuffield Trust, The great extraction: the changing state of NHS general dental services in England | Nuffield Trust, accessed 12/11/26.
[51] Responses to the CMA's information requests: [✂]. CMA calculations based on NASDAL data. We note NASDAL data may not be representative of the wider population of independents, as the data only includes a relatively low proportion of independents that employ specialist accountants. The British Dental Association also estimated a similar share of private-only practices, having estimated that between 2019/20 and 2023/24, the proportion of private-only practices has remained relatively stable, at approximately 27-28%. British Dental Association's response to the CMA's statement of scope, page 10.

wider geographical area of our sample and different methodologies for recording a practice as providing NHS treatments.

2.41 There may be some national and regional variation in the mix of NHS and private treatment offered by practices based on our indicative estimates of this mix for the dental groups. For these estimates, we use a subset of the sample noted above (one used to estimate the percentage of practices that are mixed in the UK), which focuses on the dental groups. We exclude independents given the smaller sample we have on this segment. Given this exclusion and the potentially non-representative nature of our sample, these estimates are only indicative. These estimates indicate that around one in four practices in Wales and England provide private treatment only, compared with fewer than one in ten practices in Northern Ireland and Scotland. The graph below shows the estimated proportion of dental group practices in each UK nation that only deliver private treatments.[52] There is also variation across the English regions, which we describe in detail in Appendix A.[53] Variation across the UK in the usage of NHS and private dentistry (set out in Chapter 3) provides further indication of geographic differences in the provision of NHS and private dentistry.

Figure 2.1: Estimated proportion of dental group practices in each UK nation that only deliver private treatments, April 2026



Source: CMA analysis of evidence gathered from large dental groups and small to mid-size dental groups
Note: We have gathered evidence from a relatively small proportion of the small to mid-size dental groups in the market – the estimates above are therefore primarily reflective of evidence from large dental groups and should be considered as indicative

[52] See Figure A.3 in Appendix A: Further evidence – market structure and competition between suppliers.
[53] See Figure A.4 in Appendix A: Further evidence – market structure and competition between suppliers.

2.42 For analysis and information gathering, we grouped firms by the number of practices they own or control:[54] the **four largest dental groups** (mydentist, Bupa, Portman Dentex and Rodericks);[55] other **large dental groups** with 30 or more practices;[56] **small to mid-size dental groups** with 3-29 dental practices;[57] and independent firms with 1-2 practices (**independents**).[58]

2.43 We have only been able to examine the split between NHS and private treatment in revenue terms, based on the available data. Given that private treatment is likely to be more expensive to the patient than NHS treatment, analysing the split in this way is likely to produce a higher proportion of private treatment than would be the case if we looked at treatments by volume. Our data is also primarily based on the larger groups so may not be fully representative of all types of firms.

2.44 Our analysis of revenues across firms of all sizes shows that private treatment, including cosmetic treatment,[59] accounts for a higher share of revenues than NHS dentistry. We estimate that private treatment on average accounted for around two-thirds of dental firms' revenues, although the (relatively limited) data we collected from small to mid-size dental groups suggests their revenues might be more equally split.[60]

2.45 The split between NHS and private revenues for the four largest dental groups indicates that they adopt a similar mix of NHS and private care across their practices in the UK nations. We estimate that private treatment accounted for 64% of the four largest dental groups' revenues in England, 63% in Northern Ireland, 60% in Scotland, and 56% in Wales.[61] We note that looking only at this part of the market may understate differences between nations in the NHS/ private split, however, practices that are part of the same large dental group may be similar to each other even if they are in different nations.

2.46 Our analysis indicates that the share of revenues earned from private treatment has been rising recently across dental groups of all sizes. Over the latest three

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[54] We chose this segmentation to best align with existing industry understanding, in particular it closely aligns with market insights produced by Christie & Co and LaingBuisson. Christie & Co segments firms into three sizes: 'Corporate and large groups' (30+ practices), 'Mid-sized and small groups' (3-29 practices) and 'Independent single or dual site operators' (1-2 practices). Christie & Co, Dental Market Review 2026, page 5, accessed 18/09/26. LaingBuisson defined corporate dentistry as firms operating three or more practices in its latest edition of its Dentistry UK market report. LaingBuisson, Dentistry UK Market Report – 7th Edition, page 54, accessed 03/07/26.
[55] According to data from Christie & Co, these groups accounted for over 1,400 practices as of September 2026.
[56] According to data from Christie & Co, these groups account for approximately 800 practices as of September 2026.
[57] According to data from Christie & Co, these groups accounted for over 1,800 practices as of September 2026.
[58] According to data from Christie & Co, independents accounted for nearly 8,000 practices as of September 2026.
[59] Cosmetic treatment revenues are reported as part of private treatment revenues due to data availability constraints and inconsistencies in how the large dental groups and small to mid-size dental groups defined and apportioned those respective revenues. It is unclear from the data on independents if the private revenues include revenues from cosmetic treatments.
[60] We note that we have gathered evidence from a relatively small proportion of the small to mid-size dental groups, and therefore the small to mid-size dental group's estimate should be considered as indicative. Responses to the CMA's information requests: [✂]. CMA calculations based on NASDAL data. We note NASDAL data may not be representative of the wider population of independents, as the data only includes a relatively low proportion of independents that employ specialist accountants.
[61] Responses to the CMA's information requests: [✂].

financial years, the share of revenues from private treatment is likely to have increased for dental groups because private revenues grew faster than NHS revenues.[62] It is important to note that increasing private revenues does not necessarily imply increasing private volumes, given likely price differences between private and NHS treatments.

2.47 We have more limited evidence on independents. NASDAL data covering 2008-2025 suggests that, during that period, the proportion of independent practices generating at least 20% of their revenues from private treatment may have grown from approximately three quarters to around four fifths. Over the same period, the proportion generating at least 80% of their revenues from NHS treatment may have fallen from approximately a quarter to around a fifth.[63] Moreover, NASDAL data covering 2020-2025 suggests that the share of revenues from private treatment has slightly increased for independents over those years.[64] We note NASDAL data may not be representative of the wider population of independents, as a relatively low proportion of independents may employ specialist accountants.

2.48 The evidence above of an increasing share of revenues earned from private treatments does not mean that NHS dentistry volumes are falling. While the number of NHS dentists does not fully capture NHS volumes as dentists can vary how much NHS work they do, it provides some indication of potential trends in NHS volumes. The number of NHS dentists has remained broadly unchanged between 2020 and 2025 in England (only a 0.5% decrease), Scotland (only a 0.4% decrease) and Northern Ireland (a 3.3% increase). Only in Wales has there been a larger fall over the same period of 4.6%.[65,66]

[62] Nearly all dental groups experienced growth in both private and NHS revenues, although higher growth in private revenues led to increases in the shares of private. The increase in private revenues could be at least in part due to increasing cosmetic revenues (see below that describes rates of growth in cosmetic revenues), but we cannot say from this data due to constraints disaggregating cosmetic revenues from private revenues. We note that we have gathered evidence from a relatively small proportion of the small to mid-size dental groups in the market, and therefore these trends should be considered as indicative. Responses to the CMA's information requests: [✂]. Only two large dental groups experienced drops in NHS and private revenues over the three year period – one in their NHS revenues and the other in their private revenues. Responses to the CMA's information requests: [✂]. Additionally, the British Dental Association estimated that over the period of 2019/20 to 2023/24, the proportion of dentists that work in private-only practices has grown from 17% to 24%, and that the average share of practices' income from private treatments grew from 57% to 64%. British Dental Association's response to the CMA's statement of scope, pages 10-11, 14.
[63] We note that the data is based on a relatively small proportion of the independents in the market, and therefore these results should be considered as indicative. Response to the CMA's information request: [✂].
[64] CMA calculations based on NASDAL data.
[65] Review Body on Doctors' and Dentists' Remuneration, Fifty Fourth Report 2026, paragraphs 3.5-3.8.
[66] While some practices do not meet their contracted NHS activity and hand back funding from NHS contracts, there may be enough demand from other practices to re-allocate the returned NHS funding. In England, for example, returned money has been recycled to fund dental programmes so total underspend on NHS general dental services in England fell from £392 million in 2023-24 to just £36 million in 2024-25, a fall from 10% to less than 1% of the gross budget. See: BDA, '£900m clawback reflects perversity of failed contract' accessed 13/11/26.

Private and cosmetic treatment revenues may grow further

2.49 Overall, feedback from dental firms and market reports indicate private and cosmetic treatment revenues may grow further, although our evidence from the independents that make up the majority of the market is more tentative.

2.50 Most large dental groups and over half of small to mid-size dental groups responding to our information notices (as Table 2.1 below shows, the small to mid-size dental groups may be a non-representative sample) told us they do not expect their mix of activities to change significantly over the next two years.[67] However, some large dental groups and a few small to mid-size dental groups told us they expect an increase in the proportion of private treatments and/or revenues.[68] Some dental groups referred to expected growth of (or increasing demand for) cosmetic treatments specifically.[69]

2.51 We only have responses from a non-representative sample of independents. They indicate that some firms may increase private and cosmetic treatments over the next two years, but that the majority expect to deliver roughly the same proportions of treatments.[70]

2.52 Consistent with this feedback, a market report from LaingBuisson predicts average annual growth of 11% in cosmetic treatment revenue between 2024 and 2030, compared with predicted annual growth rates of 3% for NHS revenue and 6% for private treatment revenue between 2024 and 2028.[71]

2.53 Dental groups identified several factors that could change the mix of activities they provide. These included NHS contract obligations, success in winning retenders of NHS contracts where they arise,[72] and the ability to recruit and retain clinicians willing to deliver NHS dentistry.[73] They also identified changing consumer

[67] We note that we have gathered evidence from a relatively small proportion of the small to mid-size dental groups, and therefore these findings should be considered as indicative.
[68] Responses to the CMA's information requests: [✂].
[69] Responses to the CMA's information requests: [✂].
[70] Approximately a third of independents said they would significantly increase the proportion of private treatments over the next two years, around a quarter said the same for cosmetic treatments, while a very small proportion said they would significantly increase NHS treatments. Conversely, over a third said they would significantly reduce the proportion of NHS treatments, while very small proportions said the same for private and cosmetic treatments. The remainder – representing the majority of independents – said they would deliver roughly the same proportions of treatments. Responses to the CMA's Independents' questionnaire issued 13 July 2026, question 6. We note that we have gathered evidence from a relatively small proportion of the independents in the market, and therefore associated results should be considered as indicative.
[71] LaingBuisson, Dentistry UK Market Report, 7th Edition, 2025, pages 26, 49. A 2024 dentistry market report from Mintel estimates the value of cosmetic treatments in 2025 as approximately £2.6bn and predicts cosmetic revenues will grow at an average annual rate of 3% between 2025 and 2029. Mintel, UK Dentistry Market Report 2024, page 8, accessed 09/07/26.
[72] Responses to the CMA's information requests: [✂].
[73] Responses to the CMA's information requests: [✂]. In addition, survey data from the British Dental Association on dentists' future preferences toward treatment mix indicates growing interest in delivering more private treatments while delivering less NHS treatments. British Dental Association's response to the CMA's statement of scope, pages 11-12.

preferences, including greater demand for cosmetic treatments,[74] and greater use of dental plans[75] as factors that could increase cosmetic and private revenue.

Market size, ownership types and structure

2.54 There are around 12,000 dental practices in the UK: approximately 10,000 in England, 900 in Scotland, 500 in Wales and 300 in Northern Ireland.[76] According to data from Christie & Co, the total number of dental practices in the UK fell between 2022 and 2026, from 12,582 to 12,040.[77]

2.55 Table 2.1 below shows the estimated market shares of the four largest dental groups, other large dental groups, small to mid-size dental groups and independents, and the estimated proportion of each covered by our information notices, independents' questionnaire or NASDAL data.

2.56 Some large dental groups operate in more than one UK nation,[78] while others operate in only one.[79] Small to mid-size dental groups usually have a local or regional presence,[80] and independents have a local presence.

Table 2.1: Estimated market shares (2026) of dental firms segments and estimated proportion of segments covered with information notices, independents' questionnaire or NASDAL data

Segment	*Estimated market share (by practices)*	*Firms covered by information notices or questionnaire*	*Firms covered by NASDAL data*	*Estimated segment coverage – information notices or questionnaire (by practices)*	*Estimated coverage – NASDAL data (by practices)*
Four largest dental groups	12%	4	N/A	100%	N/A
Other large dental groups	7%	12	N/A	90%	N/A
Small to mid-size dental groups	15%	10	N/A	7%	N/A
Independents	66%	189	c.500	3%	6%

Source: CMA analysis of data from dental groups, NASDAL, and Christie & Co.

2.57 We distinguish three main ownership types for dental firms: (i) private equity-backed groups, meaning groups majority owned or controlled by private equity firms or funds; (ii) corporate dental groups, meaning groups not controlled by private equity firms or funds, including founder-owned, family-owned, mutually

[74] For example, [✂] response dated [✂] to the CMA's information request issued [✂]. In addition, an internal strategy document from one of the four largest dental groups noted that although cosmetic treatments have grown strongly in the UK, future growth is expected to be dampened by cost-of-living pressures and prevalence of dental tourism. Response to the CMA's information request: [✂].
[75] For example, [✂] response dated [✂] to the CMA's information request issued [✂].
[76] Dentistry Database Subscription - LaingBuisson, accessed 27/08/26.
[77] See Figure A.5 in Appendix A: Further evidence – market structure and competition between suppliers.
[78] Among the four largest dental groups, Bupa, mydentist and Portman Dentex have practices in all four UK nations, while Rodericks is present in two nations. Among the other large dental groups, examples that have practices in more than one UK nation include Smart Dental Care and the Real Good Dental Company. Responses to the CMA's information requests: [✂].
[79] Examples of large dental groups that have practices in only one UK nation include [✂].
[80] All nine small to mid-size dental groups we gathered evidence from do not have practices in more than one UK nation. We note that we have gathered evidence from a relatively small proportion of the small to mid-size dental groups in the market, and therefore this should be considered as indicative.

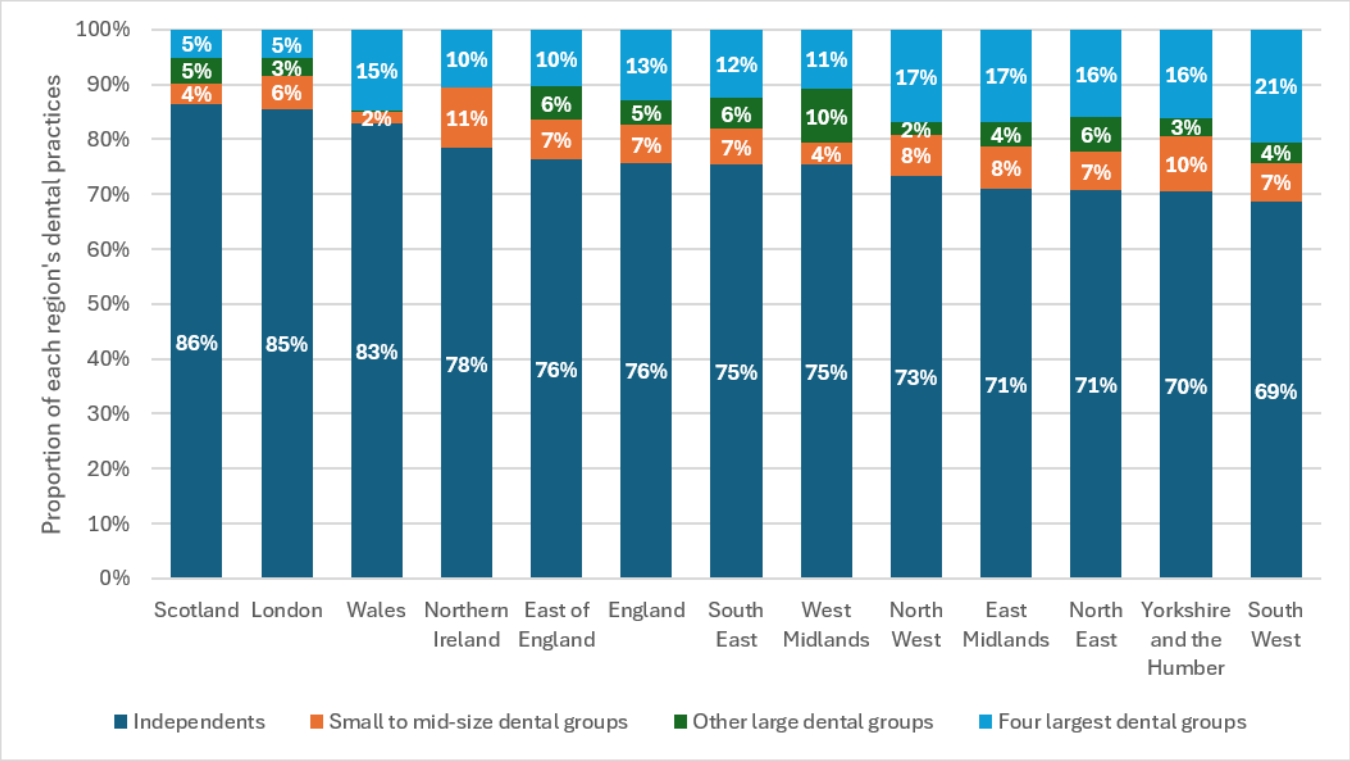
owned and other privately or institutionally owned groups; and (iii) independents, which are generally owned and run by a principal (ie a dentist who is an owner/ director/ partner of a dental practice) or multiple principals.

A fragmented market with some consolidation

2.58 The market is highly fragmented. Independents account for over 60% of all dental practices by number.[81] Similarly, by revenue, we estimate independents and small to mid-size dental groups accounted for more than two-thirds of the UK market in 2024.[82]

2.59 As shown in Figure 2.2 below, there is some regional/national variation in concentration.[83] However, the market is similarly fragmented across Scotland, Wales, Northern Ireland and each of the nine English regions.[84]

Figure 2.2: Estimated proportion of practices in each region/nation owned by groups of different sizes and independents, August 2026



Source: CMA analysis of data from LaingBuisson.

[81] Data from Christie & Co gives splits as of September 2026 of 66% for independents, 15% for small to mid-size dental groups and 19% for large dental groups. Similarly, data from LaingBuisson gives splits as of 2025 of 73% for independents, 15% for small to mid-size dental groups and other large dental groups combined and 12% for the four largest dental groups. Christie & Co, Dental Market Review 2026, page 5, accessed 25/09/26. LaingBuisson, Dentistry UK Market Report – 7th Edition, page 14, accessed 03/07/26.
[82] CMA analysis based on LaingBuisson, Dentistry UK Market Report – 7th Edition, page 57, accessed 03/07/26.
[83] See Appendix A: Further evidence – market structure and competition between suppliers.
[84] The UK is divided into 12 administrative geographical regions. Each of Wales, Northern Ireland and Scotland are a region and England is divided into nine regions. Office for National Statistics, Administrative geographies - Office for National Statistics, accessed 31/07/26.

2.60 There has been some consolidation in recent years. The four largest dental groups' share of revenue increased from 10% in 2014 to 15% in 2024,[85] mainly through mergers with, or acquisition of, other large dental groups rather than substantial acquisition of smaller groups or independents.[86] More recently, consolidation at the top end of the market has slowed. Christie & Co reported that corporate dental operators significantly reduced acquisition activity since 2022, as larger groups focused on organic growth.[87] Evidence from large dental groups also shows that groups outside the largest four have expanded their practice portfolios faster than the four largest dental groups.[88]

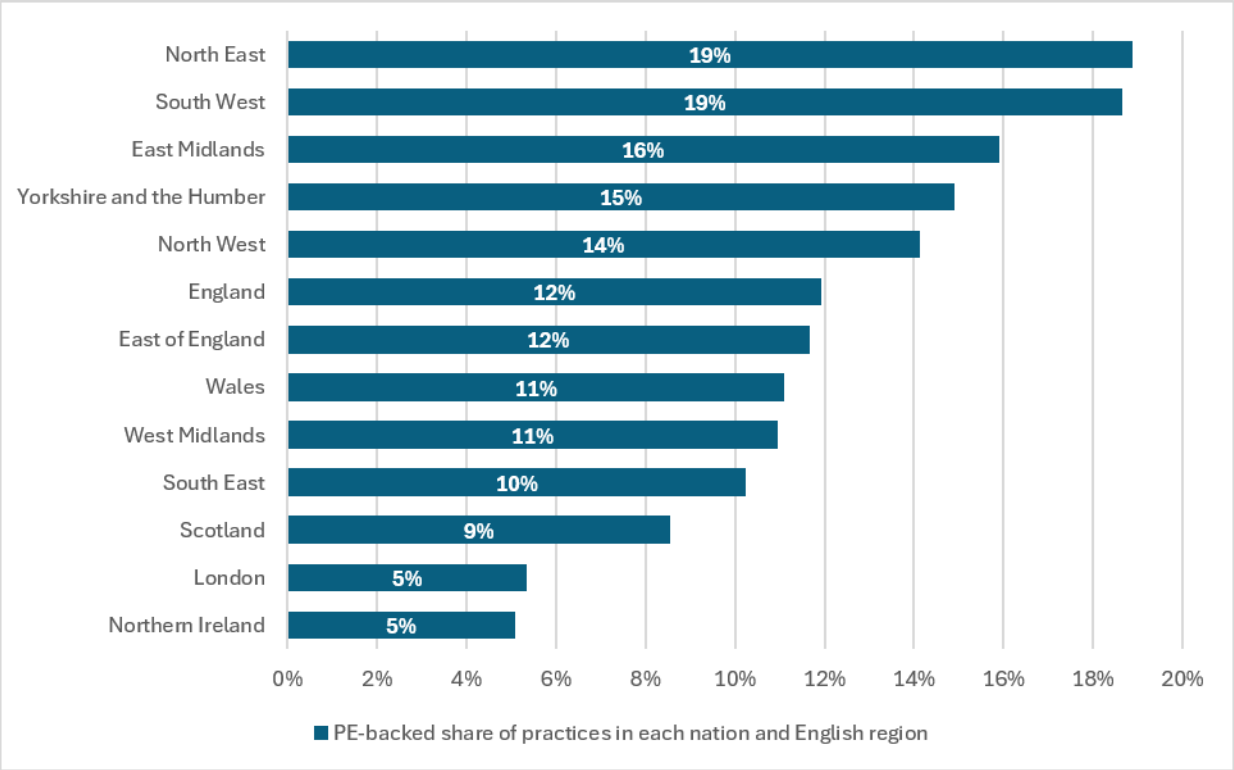
A significant private equity presence

2.61 More than half of the 19 large dental groups are private equity-backed.[89,90] Small to mid-size dental groups are generally not private equity-backed;[91] and independents are typically owner-operated or part of a local partnership.

2.62 Private equity-backed large dental groups are more prevalent in some parts of the UK than others. Figure 2.3 below shows the estimated proportion of practices in each English region or UK nation that are part of large dental groups backed by private equity.[92]

[85] Analysis of data from LaingBuisson. LaingBuisson, Dentistry UK Market Report – 7th Edition, page 58, accessed 03/07/26. In addition, an internal strategy document from one of the four largest dental groups describes consolidation activity in the dentistry sector since 2010. It notes that private-equity backed acquisitions led to the emergence of larger dental groups, with ownership by groups increasing more than threefold between 2016 and 2024. Response to the CMA's information request: [✂].
[86] For instance, Bupa, Rodericks and Portman Dentex greatly increased their number of dental practices through mergers and acquisitions in 2017, 2022 and 2023 respectively. In addition, Figure A.5 in Appendix A: Further evidence – market structure and competition between suppliers shows the share of segments broadly static over the period 2022-2026.
[87] Christie & Co, Dental Market Review 2025, page 8, accessed 03/07/26. Further, Christie & Co's Business Outlook 2026 publication indicates that the profile of buyers has shifted since 2023 from the biggest cohort being large dental groups to first-time buyers, Independents and small to mid-size dental groups. Christie & Co, Business Outlook 2026 | Dental | Christie & Co, accessed 18/07/26. Additionally, an internal strategy document from one of the four largest dental groups explains that consolidation has slowed in recent years due to macro-economic factors, such as high interest rates, as well as poor corporate performance vs. independents – due to having higher overheads. Response to the CMA's information request: [✂].
[88] In the past six months, the other large dental groups have purchased more practices and sold or closed fewer than the four largest dental groups, resulting in bigger net increases in practice numbers. Additionally, the other large dental groups are in the process of buying more practices over the next six months compared to the four largest dental groups. Responses to the CMA's information requests: [✂].
[89] Examples include mydentist, Portman Dentex, Rodericks and Riverdale. Responses to the CMA's information requests: [✂].
[90] According to Christie & Co, there were 19 large dental groups in the UK as of September 2026. Christie & Co, Dental Market Review 2026, page 5, accessed 18/09/26.
[91] Only one out of nine small to mid-size dental groups we gathered evidence from is private equity-backed. We note that we have gathered evidence from a relatively small proportion of the small to mid-size dental groups in the market, and therefore this should be considered as indicative.
[92] See section 'PE-backed large dental group-owned practices vs other' in Appendix A: Further evidence – market structure and competition between suppliers.

Figure 2.3: Estimated proportion of practices by each nation and English region that are part of large dental groups backed by private equity, August 2026



Source: CMA analysis of data from LaingBuisson
*Note: Data limitations in the data from LaingBuisson may mean th*at some large dental groups are not identified, leading to a potential underestimation of the proportion of practices private equity represent.

Operating models

2.63 We have found some differences in the way firms of different sizes operate. For example, large dental groups typically have centralised management structures, supported by professional management teams covering finance, operations, clinical governance, HR, legal and IT.[93] Independents are less likely to have the same substantial support functions, which may instead be undertaken by the practice owners themselves or employed practice and compliance managers.[94]

2.64 Moreover, large dental groups have expanded rapidly in recent years by acquiring or opening new practices,[95] which may be more difficult for small to mid-size dental groups and independents.

[93] Responses to the CMA's information requests: [✂].
[94] Note of roundtable with independents, 01/07/26 [✂].
[95] For example, Envisage has nearly doubled and grown from 48 to 88 clinics between April 2024 and April 2026, Damira Dental has grown from 22 to 53 practices since April 2022 and Roderick's purchased Dental Partners 66 practices in 2022. Responses to the CMA's information requests: [✂]. Gov.uk, Completed acquisition by Riviera Bidco Limited of Dental Partners Group Limited, page 7, accessed 07/09/26.

2.65 However, we have not found systematic differences by firm size in the mix of NHS and private treatments offered, or the share of revenue generated by each. For example:

(a) Mixed practices make up the majority of practices across the sector (see the section above).

(b) Cosmetic treatments are offered by groups of all sizes as well as independents.[96]

(c) How patients pay for their treatment is consistent across most groups and independents. Most patients pay per appointment, accounting for the majority of dental revenues. Dental payment plans are the second most common payment method, followed by finance (ie consumer credit agreements or other loans). Patients may also cover costs using insurance. This was not offered by all dental groups or independents, but a small minority of large dental groups identified it as the third most common payment method.[97]

2.66 We have also found similarities in the way private equity-backed dental groups and corporate dental groups operate. For example, private equity-backed dental groups (eg mydentist, Portman Dentex and Rodericks) and corporate dental groups (eg Bupa) both generally manage their dental practices as part of a wider corporate organisation, with centralised administrative and commercial functions.[98] We have set out the evidence we have found in relation to these dental groups' acquisition strategies in Chapter 4. To date, we have found that dental groups are seeking to drive EBITDA growth, often through revenue growth or cost savings. This includes documents from these groups providing some indication that having NHS business can increase the acquisition value of a dental practice and is seen by some acquiring firms to provide stable income with potential to grow revenues by offering private treatments to NHS patients.[99] We intend to undertake further work on this topic.

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[96] Responses to the CMA's information requests: [✂]. Note of roundtable with independents, 01/07/26 [✂].
[97] Pay per appointment accounted for around 80% of the revenue of the four largest dental groups. All the other large dental groups and all but one of the small to mid-size dental groups submitted that pay per appointment was the most important payment method by revenue (overall pay per appointment was still the most important payment method for small to mid-size dental groups and independents). Dental payment plans accounted for around 11% of the revenue of the four largest dental groups. 8 out of 12 of the other large dental groups listed dental payment plans as the second most important method of payment. For the small to mid-size dental groups this was 9 out of 10. In our July questionnaire to independents 72% said that they offered a dental payment plan, 38% said they offered the option to pay by finance, and 32% said patients could pay via insurance. There were a small number of groups which had different rankings of the payment methods: [✂]. Most dental groups listed insurance as the fourth or fifth most used payment method or did not know. The groups who ranked this third were: [✂]. Responses to the CMA's information requests: [✂].
[98] Responses to the CMA's information requests: [✂].
[99] Responses to the CMA's information requests: [✂].

How dentists are remunerated

2.67 Evidence and our analysis indicate that most dentists across dental firms are associates. Based on data from dental groups (subject to lower representation of small and mid-size dental groups), we estimate that 93% of FTE clinicians working at large dental groups' practices are associates, and that more than 80% of FTE dentists working at small to mid-size dental groups' practices are associates.[100] Even at independents (also subject to lower representation), associate dentist FTEs were significantly higher than principal dentist FTEs.[101] Associates are generally remunerated for delivering private dental treatments through the revenue-share model.[102] This links the associate's earnings to the revenue and costs generated by the treatments they provide (see Chapter 4, which considers the associate-revenue-share model and its potential incentives).

2.68 The BDA maintains templates of typical contracts between dentists and practices.[103] For example, an associate contract for use with NHS and mixed dentistry in England, where the practice owner holds the contract to provide NHS services, typically provides that the associate pays the practice for the use of specified facilities. The fee which the associate pays could be quantified in one of several ways, for example, a fixed percentage of revenue generated by the associate; a fixed fee; or a sliding scale.[104] The template states that the associate is liable for all alleged clinical negligence on the part of the associate, and is

[100] Response to the CMA's information requests: [✂]. We note that we have gathered evidence from a relatively small proportion of the small to mid-size dental groups in the market, and therefore this should be considered as indicative.
[101] CMA calculations based on NASDAL data. We note NASDAL data may not be representative of the wider population of independents, as the data only includes a relatively low proportion of independents that employ specialist accountants.
[102] For delivering NHS treatments, associates are generally remunerated through an agreed fixed fee (for example, a fixed fee per UDA delivered in England) or a percentage fee.
[103] The BDA has provided the following model contracts to the CMA:
220 - new associate, for use with NHS and mixed dentistry, England, where the practice owner holds the General Dental Services (GDS) or Personal Dental Services (PDS) agreement with the NHS. See further below;
221 - worker associate contract for use with NHS and mixed dentistry, England, where the practice owner holds the GDS contract or PDS agreement with the NHS. In this model, the associate is entitled to paid leave and certain other worker-based rights;
222 - traditional, associate contract for use with private dentistry only;
223 – worker associate contract, private only. Paid leave and other worker-based rights;
260d – appendix for apportionment of unscheduled NHS care fees in England – to apportion NHS retentions between the practice and the associate;
261d – associate contract for mixed NHS and private dentistry in Wales – Similar to template 220, but adapted to the Welsh NHS;
267d - associates operating through a limited company to provide both NHS and private dentistry in England. Similar to template 220, but the contract is with the company. See also the unnumbered template to the same effect;
Unnumbered template – associate contract for Northern Ireland for mixed NHS and private dentistry. See further below;
Unnumbered template – associate contract for NHS and mixed orthodontics in England. Similar to template 220;
Unnumbered template – associate contract for NHS and mixed dentistry in Scotland. Similar to template 220, adjusted for Scottish NHS;
Unnumbered template – associate contract for private treatment only within a mixed practice in Scotland. Similar to template 222.
[104] The sliding scale might, for example, provide for the associate to pay [✂]% for private fees up to £[✂] per month; [✂]% for private fees between £[✂] and £[✂] per month; and [✂]% for private fees over £[✂] per month.

responsible for the entire cost of any laboratory work which they commission from a dental technician.[105]

[105] Hughes v Rattan [2022] EWCA Civ 107 at 68 held that, in relation to NHS treatment, the principal holding the NHS contract [the practice owner] has a non-delegable duty of care to the patient even if the treatment is carried out by an associate dentist. However, at 88 and following it held that the holder of the NHS contract is not vicariously liable in tort for the actions of associates because the associates were not employees of the NHS principal on the facts of those specific associate contracts.

3. Consumers' experiences of the dentistry market

Summary

3.1 In this chapter, we set out our findings on consumers' experiences in the private dentistry market. How consumers engage in this market is also relevant as we go on to consider the behaviour of firms, and the nature of competition between them (set out in Chapter 4), and outcomes (explained in Chapter 6).

3.2 Dentistry is a credence service.[106] Consumers are usually unable to assess the necessity, appropriateness, quality or value of treatment, including after it has been provided, and as such are heavily reliant on professional advice. This inherent limitation on consumers' ability to assess the service they receive reduces their ability to make informed comparisons between practices or treatments.

3.3 Our evidence indicates that, in addition to these inherent barriers, consumers face constraints at each stage of choosing a practice and treatment. Consumers' needs and preferences can further limit their scope to shop around: their choices are strongly influenced by whether a practice offers NHS treatment and its proximity to their home or work. Pain and the need for urgent care constrain choice further.

3.4 Together, these barriers to effective practice and treatment choice – some inherent – contribute to low levels of switching.

3.5 Most consumers report high satisfaction with their care and treatment outcomes, though satisfaction with cost is lower. Complaint rates are low, but (as we go on to discuss in Chapter 5) this may partly reflect barriers within, or perceptions of, the complaints process.

3.6 Consumers may seek private treatment by choice, but our work to date indicates that many do so because NHS care is unavailable. Among consumers who received private treatment in the last two years, 25% attempted to receive their treatment on the NHS.

3.7 In selecting their private treatment, we have found limited evidence of switching with only around 6% of consumers of private only dental care using different practices for different treatments and 5% switching practices in the previous two years.

3.8 We have also found that many consumers lack the accessible information needed to compare available providers. Among consumers who had switched practice in the previous two years, 51% did not compare practices before choosing. Of those

[106] A credence service is one for which consumers may be unable to assess the necessity, quality or value of what they are purchasing, even after it has been provided. Examples of other credence service markets include veterinary services, private healthcare, and legal services.

that did not compare practices, 24% said comparison was inconvenient and time-consuming and 17% assumed that there would not be meaningful differences between dentists.

3.9 These constraints are not experienced equally across the UK or across consumer groups. NHS availability, local capacity and patterns of private use vary by nation and region, and consumers under financial pressure may be less able to absorb the cost of private treatment (which is not supported by public funds).

3.10 Competition can be expected to drive good outcomes in private markets where consumers are able to exercise effective choice. In this market, however, we see that consumers are unable to exert this competitive pressure. We consider the implications of these conditions for competition in Chapter 4.

3.11 In the remainder of this chapter we set out our findings to date on:

(a) issues relating to accessing NHS treatment;

(b) the issues consumers encounter in finding and choosing a practice; and

(c) the related issues in choosing between treatments.

Accessing NHS dental care

3.12 NHS availability is an important driver of practice selection, with 38% of UK consumers citing this as a key factor in the Verian research. This was second only to proximity to home or work, cited by 45% of UK consumers.[107]

Availability of NHS dentistry

3.13 While NHS availability is one of the most important factors for choice of practice, many struggle to find NHS options. The Verian research found that among the 20% of UK consumers who did not have a regular practice where they receive check-ups or treatments,[108] 44% cited an inability to find an NHS dentist and 3% cited an inability to find a private dentist.[109] According to the GP Patient Survey for England, over 20% of consumers who had tried to obtain an NHS dental appointment in 2025 were unsuccessful;[110] while one third of consumers with children reported difficulty obtaining an NHS dentist.[111] Among consumers who

[107] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, PRACCHOICE.
[108] When responding to this question, participants were asked whether they have a regular dental practice in the UK where they receive check-ups or treatment. Depending on the UK nation, consumers may not need to officially register. See Chapter 2 for more details. The proportion of consumers who did not have a regular practice across the four nations are 21% in England, 21% in Wales, 13% in Scotland, and 13% in Northern Ireland. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, REGPRAC.
[109] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, NOREGWHY.
[110] Review Body on Doctors' and Dentists' Remuneration, Fifty Fourth Report 2026, paragraph 3.51.
[111] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, ACCNHS_CHILD. Other sources corroborate this finding that about 60% of children in the UK accessed NHS dentistry in the last 12 months

received private treatment, 25% had first tried to obtain some of that treatment through the NHS and 11% had tried to obtain their most recent treatment through the NHS.[112] Forty per cent of consumers on state benefits and 52% of those experiencing financial difficulties reported receiving some private treatment.[113]

Determining NHS availability

3.14 Consumers find it difficult to locate the information needed to determine NHS availability, with the available tools potentially not always providing a reliable or a convenient source of information. Consumers can search for an NHS dentist by checking practice websites, speaking to practices directly, or using websites and tools designed to support consumers in their search for an NHS dentist. In England, consumers can use the NHS find a dentist tool,[114] although some stakeholders considered that it was not always up to date.[115] In Wales, consumers without an NHS dentist use the DAP to be allocated to a practice when a place becomes available. We heard anecdotal evidence that the DAP may increase waiting times or require some consumers to travel further, although the evidence remains limited.[116]

3.15 The Verian research found that consumers struggle to identify an NHS practice with availability, with 35% reporting difficulty in identifying whether a particular practice had NHS availability, rising to 47% among consumers experiencing financial difficulties.[117] Our review found that 20% of mixed practices did not state

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with children in places like Hackney, Merton, Somerset, Thurrock, Barnet, Plymouth, Kensington and Chelsea, Devon, Barking and Dagenham and Richmond upon Thames accessing NHS dentistry the least. Children's commissioner, 'The childhood lottery', accessed 19/10/26. BBC, 'Postcode lottery' driving children's inequality in England, commissioner warns', accessed 19/10/26.

[112] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, DR_TRIEDNHS_ANY, DR_TRIEDNHS_REC.

[113] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, NHSPRIV.

[114] NHS England, 'Find a dentist - NHS', accessed 28/07/26.

[115] Note of roundtable with consumer organisations, 02/07/26 [✂]; Which? response to the CMA's statement of scope, p3.

[116] One of the four largest dental groups reported that whilst it is early days, it has heard of patients having to travel farther and it becoming more inconvenient. Note of meeting with [✂]. The Revealing Reality research found that one dental nurse from Wales reflected that since NHS waiting lists became centralised through the DAP, waiting lists for private patients had also become longer, and she thought this was due to the increase in patients registering privately to avoid longer NHS waiting times. Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations, section 5.1.2.

[117] The breakdown across the four nations is 36% of consumers in England, 25% of consumers in Scotland, 42% of consumers in Wales and 37% of consumers in Northern Ireland. Forty-seven per cent of UK consumers experiencing financial difficulties reported difficulty in accessing NHS availability information. This result is statistically significant in comparison to those who report experiencing no financial difficulties. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, NHSFIND.
Some vulnerable consumers that are eligible for free NHS dental treatment are receiving private or mixed treatment. Of the 22% of state benefit users who were receiving private treatment (n=70), 42% reported that they were eligible for free NHS treatment and 4% that they had been eligible in the last 2 years. Of the 19% of state benefit users who received mixed NHS and private treatment (n=61), 39% reported that they were eligible for free NHS treatment, and 7% had been eligible in the past 2 years. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, NHSPRIV, ELIGIBLE.

on their website that they offered NHS dentistry and around 55% did not state whether they were accepting new NHS patients.[118]

3.16 In the case of access by children, there is evidence of access to NHS care or continued treatment being made conditional in a manner prohibited by regulations. We consider this issue further below in Chapter 5.

Variation in NHS access across the UK

3.17 Access to NHS dentistry varies across the UK. Consumer research indicates a stronger NHS presence in Scotland and weaker in England and Wales, while patterns of access and private use also vary materially within England. Evidence on practice location, NHS activity and the balance of NHS and private provision supports this overall picture, although the measures capture different aspects of access.

Variation between UK nations

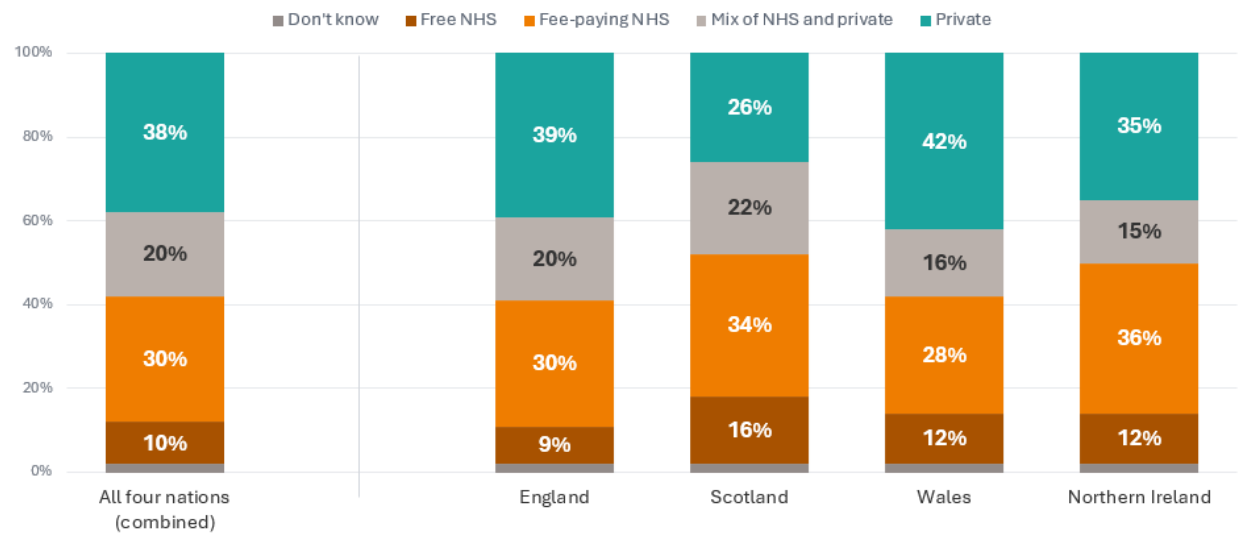
3.18 The proportion of consumers citing inability to find an NHS dentist as the reason why they are not registered with, or do not have, a regular dentist was 53% in Wales, 46% in Northern Ireland and 44% in England compared to 29% in Scotland.[119]

3.19 Reported treatment patterns are consistent with this broad picture, although usage is not a direct measure of availability. As shown in Figure 3.1, the Verian research found that in the last two years, 50% of dentistry users in Scotland have received free or fee-paying NHS dental care (and another 22% had mixed NHS/private dental care). The equivalent figure is 48% in Northern Ireland (with another 15% receiving mixed NHS/private) but only 40% in Wales (and 16% receiving mixed NHS/private) and 39% in England (with 20% receiving mixed NHS/private).

3.20 Challenges getting children access also varies by nation: 41% reported issues in Wales, 34% in England, 30% in Northern Ireland and 18% in Scotland, although the differences between Wales, England and Northern Ireland were not statistically significant.[120]

[118] Appendix C: Review of dentistry websites.
[119] See Figure 4.03, Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, NOREGWHY.
[120] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, ACCNHS_CHILD.

Figure 3.1: Type of dental service received, in UK and UK nations

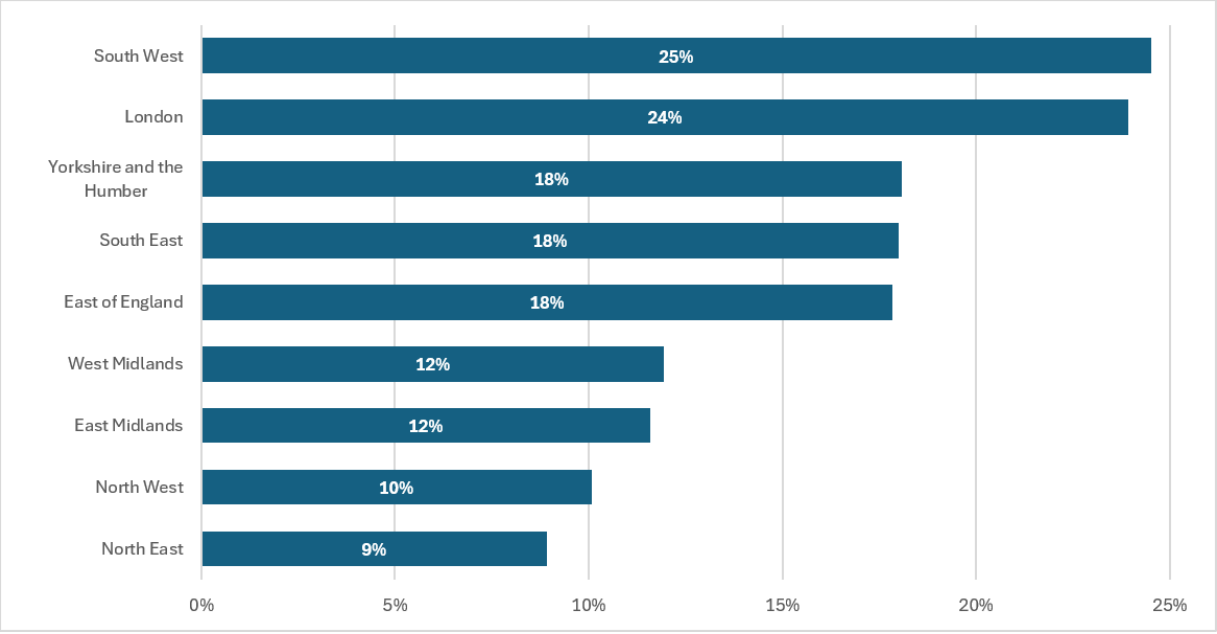


Source: Chart taken from Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, NHSPRIV.

Variation within England

3.21 The balance between NHS and private treatment also appears to vary across English regions. While these estimates are only indicative due to not having data on private and NHS provision for all practices (see note in the Figure below), among the nine English regions, there appears to be high variation in the proportion of dental practices delivering private only treatments – ranging from 25% in the South West, to 9% in the North East (see Figure 3.2).

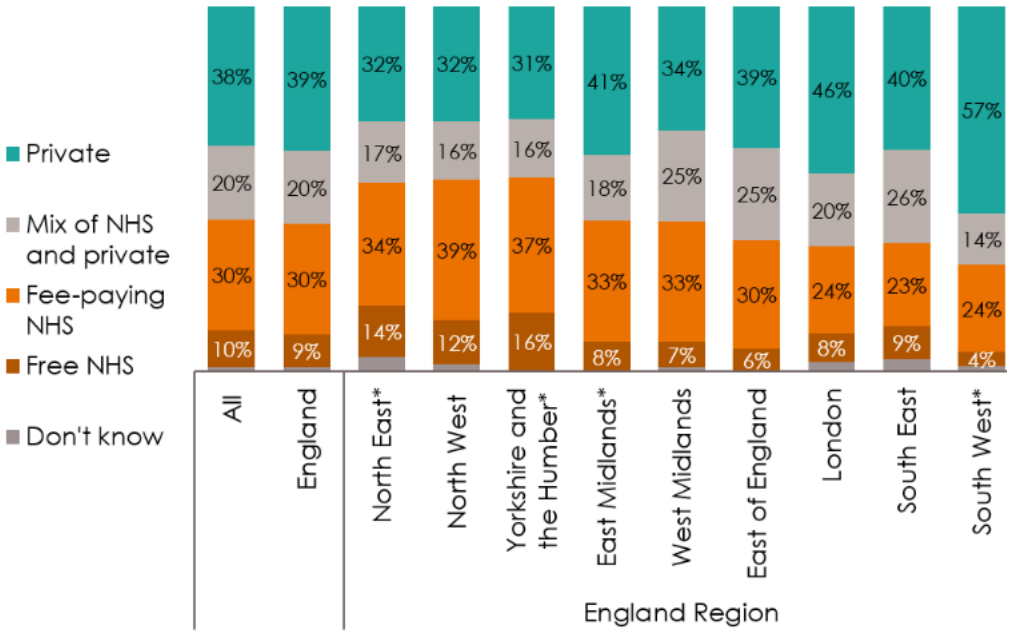
Figure 3.2: Estimated proportion of practices in each English region that only deliver private treatments, August 2026



Source: CMA analysis of data from LaingBuisson.
Notes: For each region, there was missing data in the dataset. This equated to between approximately one in ten and one in four dental practices having missing data on the type of treatment they deliver.

3.22 We also see variation in NHS usage by region within England. Users in the South West were almost twice as likely to receive private treatment at 57% as those in the North East, North West and Yorkshire and the Humber (see Figure 3.3).

Figure 3.3: Type of dental service received, in England and England regions



Source: Chart taken from Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, NHSPRIV.
Notes: 'All' refers to the four UK nations

Local variation and supply-side evidence

3.23 Supply-side evidence also indicates substantial local variation within England.[121] A 2026 study identified areas with no NHS-listed dental practice within five kilometres, with highly deprived rural areas particularly affected.[122] Local Government Association analysis similarly found wide differences in the number of active NHS practices per head and some association between greater deprivation

[121] Additional studies include: Association of Dental Groups (2022), England's Dental Deserts and the urgent need to 'level up' access to dentistry, assessing dental deserts in England. University of Leeds (2024), Mapping NHS-funded dentistry to protect against 'dental deserts', an academic paper that maps NHS dental deserts in England.
[122] Devlin H, (2026), High-need dental deserts in England: a national spatial analysis of NHS access and deprivation, British dental journal, 241(3), 191–194. The reported top three local authorities with the greatest number of people living in high-need dental deserts are Cornwall (17.9%), East Lindsey (13.5%) and King's Lynn and West Norfolk (8.1%). High-need dental deserts were defined as Lower Layer Super Output Areas (LSOAs) that have an Index of Multiple Deprivation (IMD) rating of 1-3 and no NHS-listed provider within 5km.

and lower provision.[123] National Audit Office analysis also found substantial regional variation in NHS treatment activity.[124]

3.24 Taken together, the evidence indicates that consumers' ability to access NHS care depends materially on where they live.

Finding and choosing a private dental practice

3.25 For competition to function effectively, is it essential that consumers have both a genuine choice of providers, and high-quality information to allow them to make informed comparisons. This exerts pressure on providers, via a credible threat to switch, to improve their offer in ways that matter for consumers, driving good outcomes. As we describe in this section, from what we can observe these conditions are not present in this market.

3.26 Consumers choose practices in different circumstances: when first seeking a dentist, when moving (i.e. switching) practice, or when considering another provider for a specific treatment.

3.27 We found little evidence of consumers having trouble finding a private practice. However, this does not mean that consumers have plenty of choice: 17% of private only users, and 30% of users of both NHS and private services, felt they had no choice when selecting a dental practice that suited their needs or had to go with whoever would accept them.[125] For consumers with a choice of practices, the evidence indicates that information about prices, appointment availability and quality is often incomplete, inconsistent or difficult to compare.

3.28 We find that switching is rare. Only 5% of consumers have switched practice in the last two years and only 6% of UK consumers receiving private-only dental care had used a different practice for a specific treatment. [126] Moving home or work was the most common reason for switching practice.[127] Consumers may use practice websites, online searches, social media, online reviews, word of mouth and, more recently, AI tools to find a practice. Online sources are used more often than

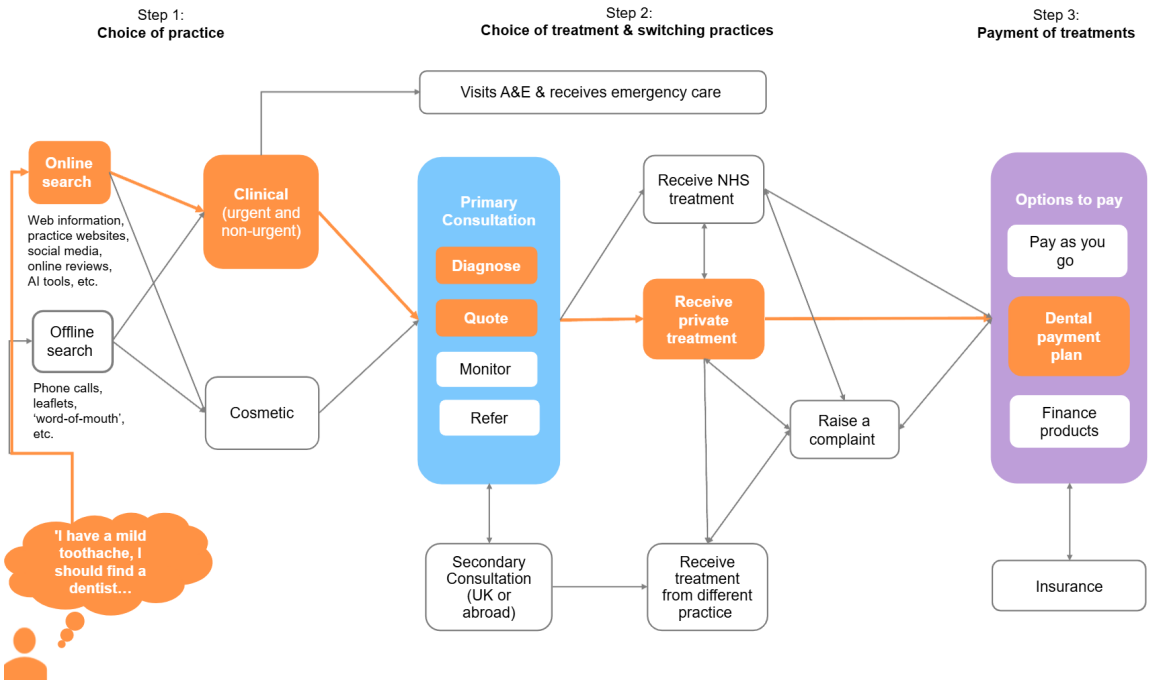
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[123] Local Government Association (2025), Persistent 'dental deserts' risk deprived and rural communities being left behind | Local Government Association. The report states that people living in areas with the poorest health outcomes in England were less likely to find an NHS dentist in their area than those in areas with the best health outcomes. For example, in Middlesborough, an area of high deprivation, there are 10 NHS dental practices per 100,000 people, compared to Richmond upon Thames, a low deprivation area, where there are 28 per 100,000 people.
[124] National Audit Office (2024), Investigation into the NHS dental recovery plan, pp12-27. The analysis found variation in NHS dental activity carried out across England. By region, courses of treatment per 1000 people in 2023-2024 varied from a low of 475 in the South West to a high of 713 in the North West. Within that range, London had 543, the South East 548, the East of England 572, the Midlands 621, and the North East and Yorkshire 683.
[125] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, PRACCHOICE.
[126] Eight per cent of all UK consumers (NHS only, private only and mixed dental care) used different practices for different treatments and 5% switched. For consumers who received mixed dental care in the last two years, 14% used different practices for different treatments and 5% switched practices. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, PRACMANY, SWITCHPRAC.
[127] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, SWWHY.

offline sources, although offline information remains important for consumers affected by digital poverty.[128]

3.29 The *'orange'* pathway in Figure 3.4 below is an illustration of one possible consumer journey.

Figure 3.4: An illustration of one possible consumer journey in 'orange'



Source: Illustrative consumer journey created by the CMA

3.30 This difficulty consumers face in comparing practices and the low levels of switching limits dental practice incentives to compete on price, leading to weak competition, as we discuss in Chapter 4. Weak competition in turn leads to undesirable outcomes for consumers, including in relation to affordability (as discussed in Chapter 6).

3.31 In Chapter 6, we also discuss how prices can vary significantly within a local area, implying that consumers unable or unwilling to shop around potentially face additional costs.

[128] Approximately 13-19 million people in the UK over the age of 16 are experiencing some form of digital poverty. Digital poverty in the UK: A socio-economic assessment of the implications of digital poverty in the UK, accessed 15/08/26. One representative in the roundtable with consumer organisations reported concerns with most information that dental practices are sharing being online, making it inaccessible for many experiencing digital poverty. Note of roundtable with consumer organisations, 02/07/26 [✂].

Availability of necessary information to compare practices

Price information

3.32 Dental professionals are required to provide basic price information online.[129] Nevertheless, roughly one-sixth of the over 8,000 practice websites we reviewed did not publish a price list online, with most of these providing no indication of prices anywhere on their website.[130]

3.33 Where prices are published online or displayed in reception, they do not always enable consumers to identify the likely final price or compare practices easily. Treatment names often vary between price lists,[131] and more complex treatments are likely to be shown using a "from" price without a maximum or sufficient explanation.[132] Associated costs, including diagnostic requirements, are often stated separately or omitted, and few websites explain what is included.[133] See below an illustration of a dental price list.

[129] The GDC requires that dental professionals give clear information on their prices on their website. Dental costs, accessed 29/07/26
[130] Appendix C: Review of dentistry websites; Which? response to the CMA's statement of scope, page 3.
[131] myTribe private dental pricing research, accessed 18/08/26; DentaClarity's response to the CMA's statement of scope, page 2.
[132] In addition, 81% of websites with a price list had a price term such as fee(s), price(s), cost(s) and charge(s) but there is a wide variation in how these price terms were used and incorporated in the title or link of the price list. Appendix C: Review of dentistry websites, including table C.1: Quality of Price Information displayed on websites. Examples of price lists shared in response to the CMA's information requests: [✂].
[133] Appendix C: Review of dentistry websites; DentaClarity's response to the CMA's statement of scope, page 2.

Figure 3.5: An illustration of a dental price list



Source: Mock dental price list created by the CMA

3.34 Some dental groups told us that consumers could obtain a more tailored estimate by contacting or visiting the practice.[134] The four largest dental groups also said that prices could differ according to treatment complexity and materials,[135] and an independent representative explained that a clinical assessment was needed to give a more accurate estimate.[136]

3.35 This fundamental lack of consistency leaves consumers having to review several websites, interpret different terminology and make assumptions about the likely total cost in order to carry out any form of like for like comparison between practices.

[134] Responses to the CMA's information requests: [✂].
[135] Responses to the CMA's information requests: [✂].
[136] Note of roundtable with independents, 01/07/26 [✂].

Appointment availability

3.36 Consumers may face challenges assessing and comparing availability of dental care. In the context of dental care, availability of appointments and timeframes to commencement of treatment are often of critical importance. A practice website may show availability for an initial consultation, but follow-up treatment is generally booked only after that consultation.[137] Consumers may therefore be unable to compare waiting times for the treatment itself before incurring the cost and time of an initial appointment.

Quality

3.37 Given the credence nature of dentistry, as described above, direct observation by patients of the quality of a dentist or practice is often difficult or impossible. In addition, quality may mean different things to different consumers (or even to the same consumer over time), including speed, pain experienced during treatment, and the appearance of the outcome.[138]

3.38 Consumers use testimonials, online reviews, word of mouth and recommendations as indicators of quality.[139] Reviews appeared on 75% of dental websites.[140] Inspection reports may provide another indicator. Practices receive narrative inspection reports (as opposed to overall quality labels or ratings) from HIW in Wales, RQIA in Northern Ireland, HIS in Scotland and CQC in England. Practices are not required to publish these reports on their websites, and consumers may find it difficult to locate the relevant report.[141]

3.39 Among the consumers in the Verian research who had compared practices before switching, around half found it easy to compare treatment quality, about a quarter found it difficult and the other quarter found it neither easy nor difficult.[142]

Ownership

3.40 Ownership information can help consumers understand whether apparently different practices are part of the same group. Around 18% of UK practices belong to a large dental group: approximately 12% are part of one of the four largest

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[137] Responses to the CMA's information requests: [✂].
[138] Note of roundtable with dental groups, 08/07/26 [✂].
[139] The Verian research found indicative evidence that of those who compared practices, 52% consulted online reviews and 38% relied on personal recommendations. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, SWCOMPYES, low base size (63).
Note of roundtable with dental groups, 08/07/26 [✂].
Note of roundtable with independents, 01/07/26 [✂].
[140] Appendix C: Review of dentistry websites.
[141] Dentists: information for providers - Care Quality Commission, accessed 04/11/26; Dental practices | Healthcare Inspectorate Wales, accessed 04/11/26; Regulation of independent healthcare – Healthcare Improvement Scotland, accessed 04/11/26; Inspections | Regulation and Quality Improvement Authority, accessed 04/11/26.
[142] Sixteen out of 31 found it easy to compare, 7 out of 31 found it difficult and 8 in 31 found it neither difficult not easy. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, SWEASEITEMS_C, low (unweighted) base size (27).

dental groups and 7% are part of another large dental group (as set out in Chapter 2).

3.41 Our review of practice websites found that three of the four largest dental groups are transparent about ownership on their websites,[143] but this is not always the case - one of the four largest dental groups did not consistently present it transparently and in an easy to find location.[144] Most dental professionals from small and mid-size dental groups also described displaying ownership on the practice website or social media, but the prominence and clarity of this information varied.[145]

3.42 The Verian research found that 51% of consumers did not know whether their practice was an independent, part of one of the four largest dental groups, or part of another dental group.[146]

Practice comparison and switching behaviour

3.43 Taken together, these informational barriers make it difficult for consumers to compare practices.

3.44 Indeed, among consumers who had switched practice in the previous two years, 51% did not compare practices before choosing. Of those who did not compare, 24% said comparison was inconvenient and time-consuming and 17% assumed that there would not be meaningful differences between dentists.[147] As set out in Chapter 6, if consumers could and did compare practices, they might be able to make significant savings because prices can vary within a local area by over 100% for a given treatment.

Understanding and choosing treatment

3.45 Beyond choosing a practice, consumers must assess treatment options and decide whether to accept a recommendation, seek a second opinion or indeed move to another provider. The evidence to date indicates that consumers do not routinely shop around for treatments that they need – only 5% of consumers who

[143] The website review found that three of the four largest dental groups websites display transparent, easy-to-locate ownership information on their website; Appendix C: Review of dentistry websites. Qualitative interviews with dental professionals also found that dental professionals working in large dental group practices often described their practices communicating ownership prominently through branding, signage, websites and social media. Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations, section 5.1.4.
[144] Appendix C: Review of dentistry websites. The Verian research also found indicative evidence that the same one of the four large dental groups that was found not to always display transparent ownership information also has low levels of recognition by consumers. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, PRACGROUP, PRACGROUP_ACTUAL, some of the four largest dental groups have low base sizes.
[145] Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations, section 5.1.4.
[146] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, PRACGROUP.
[147] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, SWCOMPARE, SWCOMPNO, low base size (89).

had received non-routine care in the previous two years sought a second opinion, and only 5% of consumers switched practice during that period.[148]

3.46 As described above, dentistry is a credence service, meaning that, by its nature, a full and informed appraisal of treatment options by the patient is not always possible, and they are reliant on a professional's advice. In addition to this inherent barrier, the evidence points to three further barriers that can limit patients' ability to assess the treatment they need and the price they should pay, which gives practices significant influence over both the treatment people receive and what they pay:

(a) Information about treatment prices is not always presented clearly or consistently.

(b) Information about treatment options, including NHS or private options, and their risks and benefits, is not always presented clearly or consistently.

(c) Costs and inconvenience can deter consumers from seeking a second opinion, while trust in their existing dentist may reduce their inclination to seek another view.

3.47 In addition to these barriers, dental pain, anxiety and urgency can serve as a moderator, impairing consumer ability to assess and compare options.[149] Each barrier is discussed further below.

Information about treatment prices

3.48 In addition to providing basic pricing information online discussed above, practices are also required to provide a written treatment plan setting out the proposed treatment and a realistic indication of price before treatment begins.[150] However, almost a quarter (22%) of UK dentistry users did not recall being told the cost before treatment. Consumers in Northern Ireland were almost half as likely as those in England to recall receiving cost information before non-routine treatment.[151] By contrast, the Revealing Reality research found that most dental

[148] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, SECOP, PRACMANY, SWITCHPRAC.
[149] The Verian research found that 64% of consumers reported slight to extreme anxiety when visiting the dentist, including 16% who were very or extremely anxious. Anxiety was even higher for those experiencing financial difficulties. Forty-nine per cent of consumers reported being slightly anxious and 16% reported being very or extremely anxious when visiting the dentist. Of those with financial difficulty, 56% reported slight or fair anxiety and 24% report extreme anxiety when visiting the dentist. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, DENTANX.
[150] GDC standards, principle 2, accessed 03/08/26.
[151] Fifty-nine per cent of UK consumers who were given costs prior to treatment recall being given a breakdown of the different costs associated with the treatment. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, TREINFO.
Of those that do recall receiving cost information in advance of the treatment, 29% of consumers recall being told of the cost of treatment verbally only. Twenty per cent of consumers in England, 20% of consumers in Scotland, 30% of consumers in Wales and 37% of consumers in Northern Ireland were not notified of cost prior to treatment. Twenty-two per cent of those receiving complex treatment and 19% of those receiving cosmetic treatments recall being told of the

professionals described discussing costs verbally and commonly confirming them in writing through a treatment plan or estimate.[152]

3.49 Where they are available, our review of a selection of anonymised treatment plans found important variation in the content and presentation of the price information. Some plans clearly itemised prices alongside the relevant options, while others distributed prices through the document or itemised them inconsistently, making comparison more difficult.[153]

3.50 In practice, consumers may pay a final price that differs from the initial quotation because, for example, preferences or clinical circumstances change, further examination reveals different complexity, or laboratory fees change.[154] While this could add to uncertainty, quotations typically appear to provide reliable information about likely costs, with only 6% of consumers reporting paying more than quoted and 4% reporting paying less.[155]

Information about treatment options, risks and benefits

3.51 Given the nature of the service, dental consumers may struggle to assess whether a given treatment is in fact clinically necessary relative to other options, or the quality of the treatment, even after they have received it. Where consumers cannot assess necessity or quality confidently, they rely more heavily on their clinician's advice.

3.52 Consumers therefore require clear information about treatment options and their risks and benefits. The GDC requires dental professionals to explain available treatment options, including delaying treatment or doing nothing, and the risks and benefits of each (which does not have to be included in the written treatment plan);[156] and requires that treatment plans distinguish clearly between private and NHS options.[157] See further discussion in Chapter 5 on the regulatory framework.

Explanations of available treatment options

3.53 The Verian research found that most consumers expressed positive views about their dentist. Eighty per cent agreed that they understood the options and could

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cost of the treatment verbally only. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, TRECOST.

[152] Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations, sections 5.2.9 and 5.2.11.

[153] Based on a review of a selection of anonymised treatment plans provided by dental firms in response to the CMA's information requests: [✂].

[154] Responses to the CMA's information requests: [✂].

[155] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, ACTCOST.

[156] GDC standards, principle 2, accessed 03/08/26.

[157] GDC standards, principle 2, accessed 03/08/26. Principle 2 states that whenever you provide a treatment plan you must include whether the treatment is being provided under the NHS (or equivalent health service) or privately. If treatment is being provided as a mix of NHS and private, the treatment plan should clearly indicate which elements are being provided under which arrangement.

make an informed decision and 76% that treatment options were explained clearly.[158]

3.54 However, the Verian research also found that over a quarter of consumers (28%) reported that they were not given treatment options, and 15% said that they were given options but limited information.[159] Eighteen per cent did not agree that they had sufficient time to consider the alternatives.[160] Consumers receiving complex or cosmetic treatment were more likely to report receiving options.[161]

3.55 Revealing Reality research found that dental professionals generally described explaining options verbally, commonly supplementing this with printed plans or lists, and allowing consumers time to consider non-urgent or cosmetic treatment.[162]

3.56 Our review of treatment plans also found variation: some clearly presented two or more options with risks, benefits and costs, while others were less easy for a layperson to understand.[163] Some firms did not include alternatives in the written plan but may have explained them verbally. In some cases, there may be only one appropriate option, and urgent treatment may not permit time for extended or any consideration.

Distinction between NHS and private options

3.57 Practices told us that NHS patients may be offered private options because they can be provided sooner or offer aesthetic benefits.[164] Some consumer organisations reported consumer confusion about whether treatment had been provided privately or under the NHS.[165] However, dental groups told us that the

[158] Private users were statistically more likely than NHS-only users to be satisfied with information, care, quality of service and outcome of treatment. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, TRSATIS. This difference in satisfaction could be explained by the idea that consumers of private dentistry are statistically more likely to select their dental practices based on perceived quality markers such as recommendation from friends and family, good online reviews, good website or premises and competitive prices. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, PRACCHOICE.
[159] The proportion for the four nations is 27% for consumers in England, 29% for consumers in Scotland, 33% of consumers in Wales and 25% for consumers in Northern Ireland. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, TREOPT.
[160] Eighty per cent of UK consumers agree and 18% do not agree that they are given sufficient time to think through their treatment options before agreeing to the treatment. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, TREPRESS_A_A.
[161] Of those that received treatments in the past two years, 72% of those receiving cosmetic treatment and 75% of those receiving complex treatment defined as 'Standard dental procedures (NHS Band 3 equivalent)' recall being given options, compared to 64% of those receiving less complex treatment defined as 'Standard dental procedures (NHS Band 2 equivalent)'. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, TREOPT.
[162] Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations, sections 5.2.1 and 5.2.2.
[163] We reviewed a selection of anonymised treatment plans provided by dental firms in response to the CMA's information requests: [✂].
[164] Responses to the CMA's information requests: [✂].
[165] Note of roundtable with consumer organisations, 02/07/26 [✂].

standard NHS treatment plan template used in England and Wales should provide sufficient clarity.[166]

3.58 We have also seen marketing materials which present additional private care as routinely necessary.[167] For example, some materials state that consumers 'need' to see a private hygienist, in addition to their dentist, to keep plaque, cavities and gum disease under control. Where such treatment is clinically necessary, it should be available as part of NHS care assuming NHS care is available. However, marketing materials directing consumers towards private hygienist appointments may not make this clear. Concerns about such marketing literature have arisen in our discussions with government officials and Chief Dental Officers.

Second opinions and switching

3.59 Consumers rarely seek second opinions or switch practices.[168] A consumer seeking a second opinion will ordinarily need sufficient information about the proposed treatment. The consumer may also need to pay for a further consultation because practices require an initial examination before diagnosis. Cost or access being impractical were the most commonly reported reasons for not seeking a second opinion, followed by the inconvenience or difficulty of seeing another dentist. Other reasons included believing another opinion would not make a difference, trusting the existing dentist, wanting treatment quickly, or considering the treatment insufficiently serious or expensive to justify another view.[169] In Chapter 6 we also consider how consumers on a Dental Payment Plan (DPP) may be locked in to their practice due to cancellation terms.

3.60 Records and x-rays do not transfer automatically when a consumer registers with or attends another practice. Instead, the consumer must request a transfer.[170] Requesting a transfer can be onerous or perceived to be onerous which could act as a barrier to switching or seeking a second opinion. The Verian research found that, of those that have not switched in the past two years and perceive switching to be difficult, 4% said that this was because they thought transferring medical records would be onerous.[171] We have heard mixed evidence from dental groups about this. Two of the four largest dental groups said that requested transfers could be handled promptly and straightforwardly,[172] although another one said that

[166] Consumers in England and Wales are provided with an FP17DC treatment plan when offered Band 2 or Band 3 courses of treatment, and when offered Band 1 courses of treatment alongside private treatment, or upon request; NHS BSA Knowledge Base, accessed 03/08/26. Note of roundtable with dental groups, 08/07/26 [✂].
[167] Submission to the CMA: [✂].
[168] Five per cent of consumers who have had non-routine dental care in the last two years sought a second opinion. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, SECOP. Eighty-one per cent of consumers have used only one practice in the last two years with 5% switching practices. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, PRACMANY, SWITCHPRAC.
[169] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, SECOPNO.
[170] Under the GDC standards, Standard 4.4 requires practices to ensure that patients can have access to their records. Standards for the Dental Team, paragraph 4.4, page 8, accessed 14/09/26.
[171] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, SWPERCDIFF.
[172] Note of meeting with [✂]; Note of meeting with [✂].

a consumer might need to collect x-rays in person.[173] One of the four largest dental groups said that a new clinician would conduct a thorough examination whether or not historic records were available.[174] However, one dental group told us that longitudinal dental history is important to the quality and continuity of care, and therefore enabling automatic transfer of patient records would be useful for consumers.[175]

Satisfaction and complaints

3.61 Most consumers report satisfaction with the dental treatment and positive attitudes towards their dentist. The Verian research found that most consumers expressed positive views about their dentist, including 78% of consumers agreeing that their dentist focused on the highest standard of care.[176] Satisfaction with cost was lower than satisfaction with other aspects of care. Sixty-one per cent were satisfied with the cost of their most recent non-routine treatment, compared with around 90% who were satisfied with the quality of service, care received, treatment outcome, and information or advice.[177]

3.62 Complaints are uncommon. The Verian research found that 3% of consumers made a complaint in the past two years and a further 6% considered complaining but did not,[178] which is supported by evidence from two of the four largest dental groups that indicates complaints are uncommon (see Appendix B). However, this may also reflect consumers' difficulty in assessing clinical quality and barriers and the difficulty in complaining or seeking a second opinion. For example, 26% of consumers who considered complaining, but did not, said they were worried about how their dentist would react.[179] This concern for the reaction of the dentist may in turn reflect in part the lack of choice some patients face over dental providers.

3.63 Taken together, the information, structural and behavioural barriers we have described reduce the likelihood that consumers will seek second opinions or switch practices for treatment that may better meet their needs and preferences.[180]

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[173] Note of meeting with [✂].
[174] Note of meeting with [✂].
[175] Note of roundtable with dental groups, 08/07/26, [✂].
[176] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, GENATTS.
[177] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, TRSATIS.
[178] Consumers were more likely to have considered complaining but not having done so in England and Wales than in Northern Ireland – however there was no statistically significant difference between UK nations, or practice size, in the proportion of consumers who did make a complaint. There was also no statistically significant difference between Scotland and the other nations in the proportion of customers who considered complaining but did not do so. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, COMPLAINT.
[179] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, COMPNO.
[180] The top reasons for not seeking a second opinion were cost and access barriers (32%) and inconvenience or difficulty in seeing another dentist (25%). Some other reasons reported include: consumers didn't think a second opinion would make a difference (24%), trust in dentist's judgement (23%), consumers wanted a quick treatment done (25%) and the treatment didn't feel serious or expensive enough to warrant a second opinion (13%). Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, SECOPNO.
For switching, of those who had switched and experienced difficulty, they reported that the process took more time and effort than expected, and that knowing which practices to choose was confusing. Other reasons reported include difficulty in finding practices with availability, and cost arrangements making switching difficult, among other reasons. Verian

While consumers generally report high levels of trust and satisfaction, high satisfaction with clinical care or the dentist-patient relationship does not mean that consumers are able to assess value for money, compare alternatives effectively, or benefit from competitive pressure between providers. As discussed in Chapters 4 and 6, we consider that the constraints on switching – many of them inherent – are contributing to poor consumer outcomes, including higher prices.

(2026) Private Dental Services Market Study Quantitative Consumer Survey Research, SWWHYDIFF, low base size (30).
Fifty-five per cent of consumers who had not switched perceived that it would be difficult. Some of the reasons for perceived difficulty include too much trouble with finding a new dentist and transfer (29%) and difficulty finding another NHS provider (72%). Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, SWITCHPRAC, SWPERCDIFF.

4. What drives supply and pricing of private dental treatment

Summary

4.1 In this chapter we assess the supply-side of the market, in particular the incentives to compete on price, the incentives created to drive increased revenue and the extent to which these incentives are likely to result in good outcomes for patients.

4.2 In private dental care, like any private market, commercial incentives to increase revenues and profits can be expected to play a defining role in driving strategy. Private providers' incentives in this market are shaped by two main, interlinked factors: the revenue-share model through which dentists are commonly paid for private treatment; and practices' drive to grow private revenues.

4.3 Such incentives have the potential to deliver positive outcomes for consumers where effective competition rewards providers for offering better prices, quality, service and choice; patients are supported to make informed choices over dental treatments; and regulation, if required, is effective. Where those conditions are absent or ineffective, significant risks of poor outcomes arise. These risks are particularly acute where the private provision is in an essential market, such as dental care.

4.4 Although private dentistry has many independent providers, our evidence indicates that other conditions are leading to a weak competitive environment and a high likelihood of consumer harm.

4.5 Our analysis suggests that competition on price is weak due to features on the demand side as set out in Chapter 3. Patients are reliant on clinicians and cannot independently assess need, quality and therefore overall value for money. Patients' needs and preferences can further limit the scope to shop around on price, while information barriers often prevent them from exercising meaningful choice including through switching. This means that, despite the fragmented nature of the market, dental practices' incentives to compete on price are limited.

4.6 Workforce capacity constraints further reduce the incentives for practices to undercut their rivals on price. Almost all dental firms responding to us identified recruitment and retention as a key barrier to entry and expansion. The workforce capacity constraints can be seen in a vacancy rate of 8% for general dentist posts in England, which is significantly higher than the 2% vacancy rate across the UK economy. Increases in the workforce have not been enough to reduce these vacancy rates sufficiently. Government restrictions have limited the number of dental school places to 1,600 in 2025 despite there being 10,000 applicants that year (almost double the number of applicants in 2019), and in 2025 there were

around 5,000 overseas-qualified dentists waiting to sit the UK's overseas registration exam. The constraints on expanding the UK dentistry workforce are resulting in the UK having among the lowest ratios of dentists per 10,000 people at 6.7, compared with 8 or more in most countries in the European Economic Area.

4.7 The workforce issues make expanding provision challenging for firms. This means that, even if dental practices were to attract more patients by offering lower prices, there is limited scope for them to take those patients on. As such, the workforce capacity constraints reduce the incentives of practices to undercut their rivals on price.

4.8 While this is a UK-wide picture, the materiality of the supply-side issues differ by region. Our analysis suggests there are fewer dentists (including private, mixed and NHS) relative to the local population in parts of East Anglia, the Midlands, the North East of England, and remote parts of Wales and Scotland. Our analysis also indicates that in England, Wales and Scotland, more deprived areas may have lower levels of dentistry availability relative to population than less deprived areas, although this is not a strong correlation.

4.9 Evidence of how prices are set shows how the weak incentives to compete on price play out in practice in dental firms' strategies. While discounts are sometimes used to attract new patients, documents from the four largest dental groups indicate a focus on increasing prices so as to match or get closer to rivals' prices, rather than seeking to undercut a rival's price. Of particular note are documents from these groups on increasing prices at practices that they acquire and pricing strategies that involve increasing prices due to patients' limited price sensitivity.

4.10 We are concerned that the business practices and incentives we observe, when combined with the reliance patients necessarily place on their clinician, may leave patients vulnerable to being sold treatments that are not in their best interests.

4.11 In particular, dentists benefit through increasing revenues from the treatments that they sell to patients either directly when they own their practice and, for other dentists, through the widespread use of revenue share agreements. At least for the larger groups, the financial incentives from these revenue share agreements may be reinforced by KPIs, targets and other commercial practices.[181]

4.12 In terms of potentially disciplining factors, conduct regulation requires individual dentists to act in the best interests of their patients, but this does not apply directly to dental businesses, even though business decisions can influence patient outcomes. We assess the strength of the regulatory and policy framework further in the next chapter.

[181] References to KPIs or targets refer to business targets, not personal targets, unless otherwise indicated.

4.13 In the remainder of this chapter we set out in more detail:

(a) workforce challenges and other barriers to entry and expansion;

(b) evidence on pricing strategies and incentives;

(c) financial incentives for clinicians to grow private revenue; and

(d) firms' revenue-growth strategies.

Workforce challenges and other barriers to entry and expansion

4.14 In this section, we explain the relevance of workforce challenges and other barriers to dental firms' ability to enter and expand in contributing to weak competition in the private dentistry market.

4.15 Along with the demand-side factors noted above, these barriers limit the incentives of dentists and dental firms to compete strongly on price.

4.16 The workforce capacity constraints also likely contribute to higher costs of clinical staff, which are paid for by consumers through higher private fees. They also likely impact access to dentistry services, although predominantly for NHS services.

4.17 In the remainder of our market study we intend to assess further these workforce capacity constraints and the scope to increase the dentistry workforce.

Workforce challenges

4.18 The challenge of recruiting and retaining dental professionals was identified as a key barrier to entry and expansion by almost all dental firms, including dental groups of all sizes and independents, across all four UK nations.[182] Consistent with this evidence, some large dental groups' internal documents highlight clinician recruitment and/or retention within a practice as a point of consideration for the divestment or acquisition of dental practices.[183]

4.19 Feedback from dental groups indicates that these workforce challenges manifest in three ways:[184]

(a) Shortages in the number of dental professionals in the UK – including dentists, as well as other DCPs.

[182] Set out in section 'Workforce challenges' in Appendix A: Further evidence – market structure and competition between suppliers. Some large dental groups also noted that workforce challenges are the single most significant barrier.
[183] Set out in section 'Evidence from acquisition documents on clinician recruitment and/or retention' in Appendix A: Further evidence – market structure and competition between suppliers.
[184] Set out in section 'Workforce challenges' in Appendix A: Further evidence – market structure and competition between suppliers.

(b) Rising expectations from dentists on the levels of their remuneration.[185]

(c) Falling numbers of dentists willing to perform NHS dentistry (two groups noted this was primarily due to dissatisfaction with NHS contract terms and the opportunity for better remuneration and working conditions in private dentistry).[186]

4.20 This evidence from dental firms supports the concern that workforce capacity constraints are contributing to higher costs of clinical staff (compared to a dentistry market without such capacity constraints).

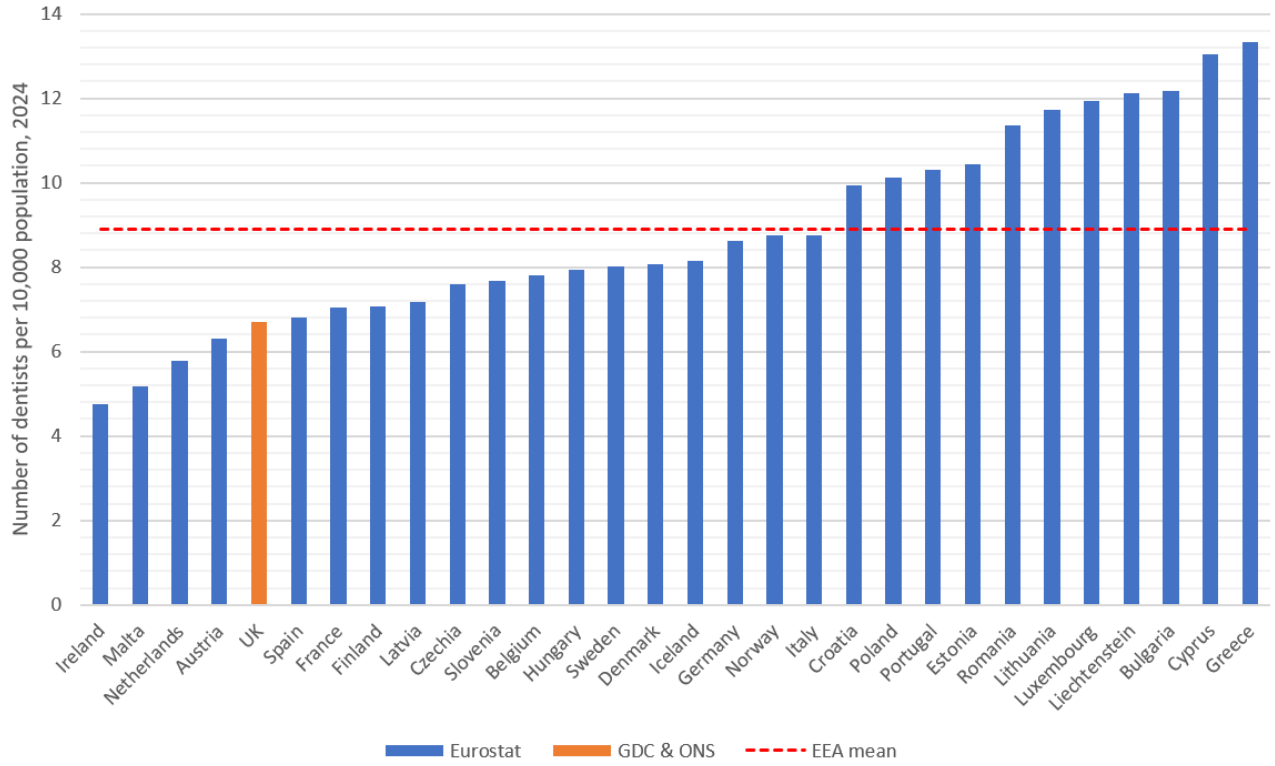
How workforce issues affect firms' ability to expand

4.21 A range of evidence indicates that the supply of dentists in the UK is tight, and that this is likely to be a key constraint on the ability of dental firms to expand their capacity and to compete more strongly to attract patients.

4.22 Figure 4.1 compares the ratio of dentists per 10,000 people in the UK[187] against most European Economic Area (EEA) countries in 2024.[188] The UK had among the lowest ratios at 6.7, compared with 8 or more in most EEA countries.

[185] As noted in Chapter 2, most dentists across dental firms are associates, who are generally remunerated through the revenue-share model.
[186] As we discuss below, with the exception of Wales, the number of dentists providing NHS services in the UK has not fallen materially between 2020 and 2025.
[187] GDC, Registration statistical report 2025, page 8.
[188] Eurostat, Healthcare personnel statistics- dentists, pharmacists and physiotherapists, Table 1, last accessed 13 October 2026.

Figure 4.1: Number of dentists per 10,000 population, 2024



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

- *The other European countries included in the chart are all EEA countries except Slovakia, for which data was not available.*
- *The number of dentists for the UK is based on the number that are registered to practice, while the number of dentists for the other countries is based on the number that are practising dentists – a likely subset of all those that are registered.*

4.23 In 2025, the UK ratio of registered dentists per 10,000 population was 6.9, and has increased from 6.2 since 2011.[189] We note available dentist hours per capita may actually be dropping, given many dentists work part-time.[190] Despite this small increase, from 2011 to 2024 (the latest year for which we could make international comparisons) the UK consistently had a lower ratio than most EEA countries, with the EEA mean increasing from 7.6 in 2011 to 8.9 in 2024.[191]

4.24 Evidence of vacancy rates also indicates that dental firms face challenges when seeking to maintain or expand their capacity, although there has been a reduction in vacancies since 2024. The overall vacancy rate for general dentists in England was 8% in December 2025 (down from 15% in December 2024). The figure for

[189] This is driven by greater percentage increases in dentist registrations compared to population growth. GDC, Registration statistical report 2025, page 8. GDC, Registration statistical reports (2019 – page 5, 2020 – page 5), Registration report (2018 – page 1) and Annual Report and Accounts (2011 – page 14, 2012 – page 16, 2013 – page 18, 2014 – page 19, 2015 – page 1, 2016 – page 17, 2017 – page 17). Office of National Statistics, MYE1: Population estimates: Summary for United Kingdom, mid-2021-2025.
[190] Survey data from the GDC showed that as of March 2026, just under half of dentists reported working 30 hours or less a week (GDC, Dentist work-pattern survey, Q6, March 2026) – therefore the actual capacity provided by the dentists in aggregate represents less than the dentists per 10,000 population ratio suggests.
[191] See section 'Trends in the number of dentists per population' in Appendix A: Further evidence – market structure and competition between suppliers for further details.

NHS dentists was higher at 10% (down from 19% in December 2024), indicating greater recruitment challenges for posts involving NHS work.[192] By comparison, the vacancy rate for the UK on aggregate, across all industries, was 2% in December 2024 and 2025.[193] Recruitment challenges for NHS posts could have an impact on the number of dentists offering private treatments given that the vast majority of dental practices offer both NHS and private treatment. There were 1,823 vacant NHS posts where recruitment had been tried but failed between April and December 2024.[194] We understand equivalent statistics for the other UK nations are not available.

4.25 As shown in Table 4.1 below, vacancy rates for general dentists varied materially in different parts of England, with vacancy rates lowest in London and highest in the South West. This is indicative of variation in the severity of workforce challenges across the country.

Table 4.1: General Dentist vacancy rates by English region, December 2025

		%
Region	*Vacancy rate*	*NHS vacancy rate*
East of England	8	10
London	6	7
Midlands	7	9
North East and Yorkshire	9	11
North West	8	10
South East	7	9
South West	13	18

Source: NHS England, Dental Workforce Management Information, December 2025

4.26 Internal documents from two of the four largest dental groups also note workforce constraints. One document from 2025 states there are workforce shortages, both in quantity and quality,[195] while another from 2025 notes that increases in the number of dentists is not corresponding to an increase in clinician supply, as the average clinician is working fewer hours.[196]

4.27 Finally, capacity utilisation data from dental groups indicates that constraints on the supply of dentists are resulting in limited spare clinical capacity at existing practices. Data provided by dental groups from the past five years points to almost

[192] NHS England, Dental Workforce Management Information, December 2025, last accessed 20/10/26. Review Body on Doctors' and Dentists' Remuneration, Fifty Fourth Report 2026, paragraph 3.33. The Review Body on Doctors' and Dentists' Remuneration, Fifty Fourth Report 2026, paragraph 3.35, refers to evidence from the BDA on greater recruitment challenges at practices with a 'high NHS commitment', including longer periods of unfilled vacancies. Practice owners or associates with a 'high NHS commitment' were respondents who indicated that their practice as a whole, or they as individual associates, delivered 75% or more NHS activity.
[193] CMA analysis of ONS data on UK job vacancies and jobs. ONS, X06: Single month vacancies estimates, last accessed 21/10/26. ONS, JOBS01: Workforce jobs summary, last accessed 21/10/26.
[194] Review Body on Doctors' and Dentists' Remuneration, Fifty Fourth Report 2026, paragraph 3.33. NHS England dental workforce survey, Dental Workforce Publication December 2024. We understand this is the most recent data available on vacant NHS posts where recruitment has been tried but failed. The breakdown of these NHS vacant posts is as follows: 218 in the East of England, 233 in London, 338 in the Midlands, 327 in the North East and Yorkshire, 194 in the North West, 298 in the South East, and 215 in the South West.
[195] Response to the CMA's information request: [✂].
[196] Responses to the CMA's information requests: [✂].

all of these firms having average utilisation levels of over 80%, and for the vast majority it was over 85%.[197] This level of utilisation means there is limited scope for dental firms to take on more patients using their existing capacity.[198,199] As noted in Chapter 2, lower representation among small and mid-size dental groups mean these figures are indicative.

4.28 As mentioned above, one of the workforce challenges highlighted by firms is the falling number of dentists willing to perform NHS dentistry.[200] It is the case that, with the exception of Northern Ireland, the number of dentists providing NHS services in the UK is generally either static or falling. However, while the reduction in Wales between 2020 and 2025 has been larger at 4.6%, in England and Scotland the falls are modest, at 0.5% and 0.4% respectively. In Northern Ireland the number of dentists providing NHS services has increased by 3.3% over the period.[201,202]

Root causes of workforce challenges

4.29 The following key reasons were identified by large dental groups for these challenges:[203]

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[197] See section 'Capacity utilisation' in Appendix A: Further evidence – market structure and competition between suppliers for further details.
[198] An exception might be if a dental practice has sufficient space, seats and equipment, as well as an ability to access locum dentists.
[199] Further, we would not expect to see utilisation levels of 100%, as naturally, dental practices will have some levels of cancellations and missed appointments that they are unable to subsequently fill. In addition, dental practices by default may also seek to keep available some capacity to handle urgent short-notice appointments – for example to provide emergency treatments.
[200] A 2025 internal document from one of the four largest dental groups cites data showing that between 2016 and 2024, the number of dentists performing NHS dentistry stagnated, with more of their time being dedicated to delivering private treatments. Response to the CMA's information request: [✂]. Further, the same document also points to an NHS underspend in financial year 2025, and notes this is due to dental practices struggling to meet contract delivery targets given workforce challenges. Response to the CMA's information request: [✂]. Additionally, a 2025 internal strategy document from another one of the four largest dental groups cites data which shows between 2019 and 2023, that although the number of dentists in the UK increased, in three of the four UK nations the proportion delivering NHS dentistry fell. Response to the CMA's information request: [✂].
[201] Review Body on Doctors' and Dentists' Remuneration, Fifty Fourth Report 2026, paragraphs 3.5-3.8. There were 24,543 dentists providing NHS services in England in the year to 31 March 2025, an increase of 1.4% over the year and a 0.5% decrease compared to March 2020; there were 3,411 non-hospital dentists providing NHS services in Scotland at 30 September 2025, an increase of 5.5% on the previous year and a 0.4% decrease compared to September 2020; there were 1,335 dentists providing NHS services in Wales in the year to 31 March 2025, a decrease of 4.6% on the previous year and a 9.8% decrease compared to 2020; there were 1,189 dentists providing NHS services in Northern Ireland in the quarter to December 2025, a decrease of 1.7% on the same period in the previous year but a 3.3% increase compared to the quarter to December 2020.
[202] There was also a mixed picture on NHS dentist-to-population ratios, and coverage: ratios improved in Scotland, Northern Ireland and England between 2024 and 2025, but declined in Wales, while coverage in 2025 remained below 2020 levels in England, Wales, and Scotland but rose above them in Northern Ireland. Review Body on Doctors' and Dentists' Remuneration, Fifty Fourth Report 2026, paragraphs 3.5-3.9. There were 41.9 NHS dentists per 100,000 population in England in 2024-25, up from 41.8 the previous year but below the 43.9 recorded in 2019-20. There were 58.6 non-hospital NHS dentists per 100,000 population in Scotland in 2024-25, up from 56.6 the previous year but below the 62.6 recorded in 2019-20. There were 41.9 NHS dentists per 100,000 population in Wales in 2024-25, down from 44.2 the previous year and from 47.9 in 2019-20. There were 62.6 NHS dentists per 100,000 population in Northern Ireland in 2024-25, up from 62.2 the previous year and above the 60.4 recorded in 2019-20. There were significant variations across regions: the number of dentists providing NHS services per 100,000 population ranged from 40.5 in the South West to 52.7 in London in the year to March 2025.
[203] Further information on these reasons is set out in section 'Workforce challenges' in Appendix A: Further evidence – market structure and competition between suppliers.

(a) Insufficient domestic training places for dentistry qualification – with demand for places substantially higher than supply.

(b) Limits on routes for overseas-qualified dentists to move to the UK and become registered, with lengthy waiting lists for places on the relevant exams (ORE or LDS) and other immigration requirements constraining the ability to join the UK workforce.

(c) Clinicians changing their working patterns, for example working fewer hours per week.

4.30 We have sought to understand the significance of each of these below. We also assess contractual restrictions on employment and non-compete clauses, as well as challenges other dental professionals may face.

Insufficient domestic training places

4.31 On domestic training, the number of undergraduate dental places for both home and overseas students is subject to government-controlled caps in each of the four UK nations.[204] Despite the number of applicants doubling from around 4,000 in 2019 to around 10,000 in 2025, the number of dental school places made available has only increased by around 250 (an 18% increase from the 2019 level).[205] That has meant that in 2025 some 10,000 applicants[206] competed for around 1,600 undergraduate dental school places.[207] In that same year, the total number of dentists registered to practise in the UK was just under 48,000.[208]

4.32 The geographic location of dental schools may also affect where dentists choose to practise after graduation, and therefore the supply of dentists in different areas. One participant in a roundtable with dental groups noted that, as a lot of dental training happens in London, UK-trained dentists are likely to remain in London.[209] Similarly, NHS England explained that there is a high correlation between where dental schools recruit students from and where they practise after graduation. For example, Plymouth dental school tends to recruit students from a wider geographic area and graduates appear more likely to disperse. By contrast,

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[204] UK Parliament, House of Commons Library, The cap on medical and dental student numbers in the UK, September 2023. England has maximum fundable limits (which was 809 places in 2025-2026), Scotland has annual intake targets (which was 172 places in 2025-2026), Wales has limits on commissioned places, and Northern Ireland has a medical and dental contract full-time-equivalent target. Office for Students, Medical and Dental Students survey 2025, page 3. Office for Students, Funding for medicine and dentistry. Scottish Funding Council, University Intake Targets for Dentistry AY 2025-2026.
[205] UK Parliament, House of Commons Library, The cap on medical and dental student numbers in the UK, September 2023.
[206] Dental School's Council analysis based on UCAS data. Fixing NHS Dentistry, page 5.
[207] Review Body on Doctors' and Dentists' Remuneration, Fifty Fourth Report 2026, Figure 3.3.
[208] GDC, Registration statistical report 2025, page 8.
[209] Note of roundtable with dental groups, 08/07/26, [✂]. The Office for Students indicates that London training places (King's College London and Queen Mary University of London) account for 27% of England's undergraduate dental places, or 18% of the UK's training places. Funding for medicines and dentistry, last accessed 16 September 2026.

London dental schools tend to recruit more locally and graduates appear less likely to move away.[210]

Limits on routes for overseas-qualified dentists

4.33 Overseas-qualified dentists moving to the UK could be one way to alleviate the effects of a domestic shortage. One route to registering to practise dentistry in the UK is the Overseas Registration Exam (ORE). In 2025 the ORE registered 501 new dentists,[211] while a May 2025 Parliament motion noted that there were around 5,000 overseas-qualified dentists waiting to sit the ORE.[212] The GDC (which runs the ORE) has indicated that this bottleneck has persisted over time, saying that 'demand for the exam has historically outstripped supply',[213] though capacity has increased from 160 dentists registered in 2022 to 501 in 2025. Government expects the ORE route to expand to over 1,000 overseas-trained dentists joining the register each year by 2028/2029, and the LDS route to expand from 180 to 1,800 places in the same timeframe.[214]

4.34 Measures to increase dentists joining the register through these overseas-qualified routes could mean a workforce that is more internationally mobile. This could potentially make retaining dentists more challenging if, for example, practising in another country became relatively more remunerative. Currently just over half the new dentists joining the roll are foreign-qualified.[215] By 2029, provided current plans to expand the capacity of qualifying exams delivered by the GDC and other organisations are delivered in full and pass rates remain at the average level seen in recent years, the GDC expects this figure to increase to around 70%,[216] compared to 30% qualified from UK dental schools.[217]

4.35 Wider immigration requirements may also constrain the number of overseas trained dental professionals who relocate to practise in the UK. One of the four largest dental groups told us that the Skilled Worker visa requires a specific sponsor with a guaranteed salary. They told us this creates contractual complexities as associates are typically self-employed.[218] Another of the four

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[210] Call with NHS England, 16/03/26.
[211] General Dental Council, Registration Statistical Report 2025, page 13.
[212] UK Parliament, Overseas-qualified dentists motion, 12 May 2025. Evidence from one of the four largest dental groups and another large dental group similarly indicates that there might be between 2,000 to 6,000 dental professionals already in the UK waiting to take the ORE examination. Responses to the CMA's information requests: Responses to the CMA's information requests: [✂].
[213] General Dental Council, Capacity of the ORE, 07/02/24, last accessed 08/09/26. It also said that the relatively low pass rate, of approximately 50%, contributes to this. Further, a GDC article from 06/05/26 notes demand for ORE sittings remains high and places are not expected to meet demand in the short term. General Dental Council, First ORE sittings and fees under new contract confirmed, 06/05/26, last accessed 18/11/26.
[214] Government press release: More dentists coming as government boosts number who can practice, 10/03/26.
[215] According to the General Dental Council, 53.1% of new additions to the dentist register in 2025 were qualified overseas and 46.9% qualified in the UK. The overseas qualified proportion is broken down by 27.6% EEA qualified, 4.4% Licence in Dental Surgery (LDS) examination, 20.4% Overseas Registration Examination (ORE) and 0.7% rest of world qualified. General Dental Council, Registration Statistical Report 2025, page 13, last accessed 11/11/26.
[216] Broken down into 35% via LDS, 20% via ORE and 15% EEA qualified.
[217] Call with the GDC, 03/09/26.
[218] Response to the CMA's information request: [✂].

largest dental groups told us that when the mutual recognition of professional qualifications between the UK and the EU ends, following the UK exit from the EU and subsequent temporary provisions, there will be additional strain on applicants from the EU coming to practise in the UK.[219,220] These factors may create some friction in the ability for overseas trained dental professionals to register to practise in the UK.

Clinicians changing their working patterns

4.36 We understand that part-time working patterns and peripatetic working are both common among dentists. Evidence from the GDC shows that 45% of all dentists work 30 hours per week or less, with the same proportion (45%) working between 30 and 40 hours per week.[221] Further, 38% regularly work across more than one location.[222]

4.37 Given how flexibly dentists work and the prevalence of below-full-time hours, in principle supply could be increased by the existing workforce working longer hours. However, the scope for such an increase in practice may be limited by the desired working patterns of dentists.

Contractual restrictions on employment and non-compete clauses

4.38 We have seen evidence of contractual restrictions that may exacerbate workforce challenges.

4.39 BDA templates[223] contain non-solicitation and non-compete clauses which apply both when the contract between an associate and a practice owner is in effect and after it is terminated.[224] On termination of the contract, the associate is prohibited from providing dental services to any person who was a patient of the associate in the 12 months preceding the termination date during the restricted period and in the restricted area.[225] The templates leave the definition of restricted period and restricted area open to negotiation.

4.40 We also found non-compete clauses in the acquisition documents of several large dental groups which applied to the clinicians selling their practice (vendor

[219] Response to the CMA's information request: [✂]; Professional qualifications – EU Exit standstill provisions: review by the Secretary of State, updated 07/09/23.
[220] One of the four largest dental groups also told us about the impact of immigration policy changes on dental nurse recruitment. Changes to the Skilled Worker visa in 2025 removed dental nurses from sponsorship eligibility. This created further challenges recruiting dental nurses at a time when turnover was already high ([20–30%] – [30-40%] over the past 12 months). Response to the CMA's information request: [✂].
[221] There has not been consistent quantitative tracking of part-time work over time.
[222] General Dental Council dentist' working patterns data for 2026, 17/03/26, accessed 04/09/26.
[223] See Chapter 2, paragraph 2.68, where these templates are described.
[224] For example, clauses 65 to 67 of BDA template 220 for traditional, self-employed, associate contract for use with NHS and mixed dentistry in England, where the practice owner holds the General Dental Services or Personal Dental Services agreement with the NHS primary care organisation.
[225] For example, clause 67 of BDA template 220.

clinicians) as part of the terms of the acquisition.[226] For example, a document relating to an acquisition by one of the four largest dental groups contained terms which restricted the sellers from practising as dental practitioners at premises situated within a twenty mile radius from the property for a period of six years after the completion date, 'whether as principal, associate, assistant, locum tenens, consultant or otherwise'.[227] We also saw evidence from one of the four largest dental groups of non-compete clauses for other associates at the target practice.[228]

4.41 We will seek to understand the prevalence of such restrictions and the impact they may have in the next phase of our work.

Challenges dental care professionals face in performing to their full capabilities

4.42 We have received feedback indicating that: (i) some dental therapists and hygienists face challenges working to the full scope of their roles, including gaining varied practical experience, and (ii) NHS contractual arrangements may influence or limit how dental care professionals are deployed.

4.43 An industry stakeholder told us dental therapists and hygienists do not perform to the full scope of their roles because they cannot gain experience performing varied clinical tasks following their dental education.[229] A lack of awareness from some dentists about all the tasks dental therapists can do reduces dental therapists' opportunities to develop additional experience, and over time this limits the tasks dental therapists perform regularly and deskills clinicians.[230]

4.44 An industry stakeholder noted that dental therapists cannot themselves hold NHS contracts, even where they undertake a substantial proportion of NHS activity, which may affect both the work they perform and the data available on their utilisation.[231] Similarly, a few large dental groups told us that current NHS remuneration arrangements do not always incentivise deployment of the most appropriate member of the dental team. One large dental group noted that dentists may be reluctant to support dental therapists to work directly with patients if they could ultimately be required to provide more complex treatment without adequate NHS remuneration,[232] while another observed that the UDA-based system in England provides no direct financial reward for using dental therapists instead of dentists.[233]

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[226] Responses to the CMA's information requests: [✂].
[227] Response to the CMA's information request: [✂].
[228] Response to the CMA's information request: [✂].
[229] Note of meeting with [✂].
[230] Note of meeting with [✂].
[231] Note of meeting with [✂].
[232] Note of meeting with [✂].
[233] Response to the CMA's information request: [✂].

4.45 One large dental group also identified operational barriers to the use of dental therapists. The group told us that, in Scotland, NHS treatment provided by dental therapists must be delivered under referral arrangements, and associates may be reluctant to refer patients where they remain accountable for the treatment provided.[234]

Regional variation in the supply of dentistry

4.46 To explore the extent of any regional variation in the supply of dentists, we have analysed, for each local authority district (LAD) across the UK,[235] the number of dentists (including those working in private-only, mixed and NHS-only dental practices) relative to local populations. While there are some limitations with our analysis,[236] it provides an indication of where there are more likely to be supply issues based on where the number of dentists relative to the population may be lower compared to other parts of the UK.

4.47 Table 4.2 below presents the findings of our analysis – which generated an overall 'spatial accessibility score' – for each of Wales, Northern Ireland, Scotland and the nine regions of England. A lower score indicates a lower supply relative to local populations, and vice versa.

Table 4.2: Spatial accessibility scores for Wales, Northern Ireland, Scotland and the nine regions of England, August 2026

UK region/nation	*Spatial accessibility score*
London	8.6
Northern Ireland	6.2
South East	6.2
East of England	5.4
Scotland	5.4
South West	5.3
North West	5.1
Yorkshire and the Humber	5.1
East Midlands	4.9
West Midlands	4.9
North East	4.7
Wales	4.4

Source: CMA analysis of data from LaingBuisson.

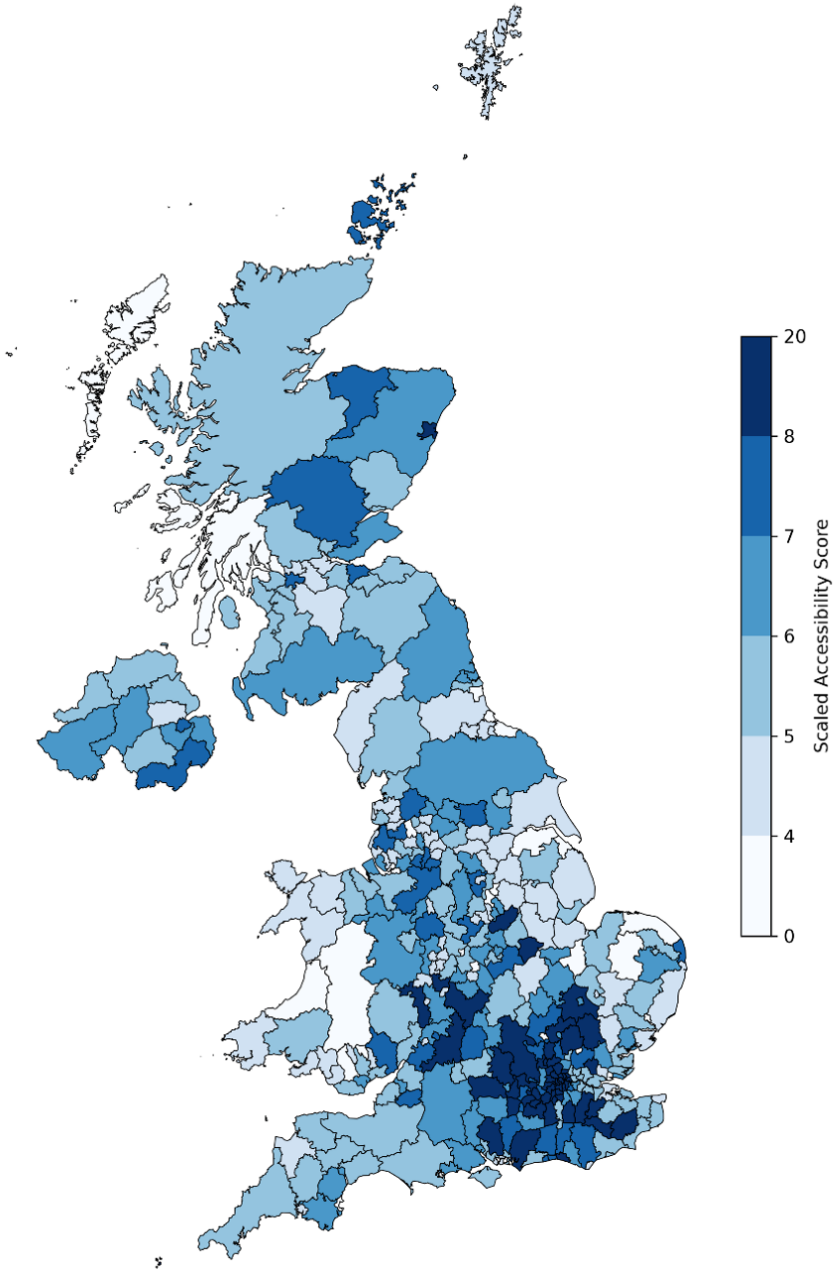
4.48 Looking at the UK nations, the scores indicate that Wales has a lower supply relative to local population than Northern Ireland, Scotland and England. Within

[234] Note of roundtable with dental groups, 08/07/26, [✂].
[235] Local authority districts (LAD) is a term used in England to refer to regional areas where local authorities have some responsibility for running local services. Each of the UK nations has a different term for this. In Wales they are known as principal areas; in Scotland they are known as council areas; and in Northern Ireland they are known as local government districts. We refer to all collectively in this section using the term local authority districts.
[236] Our approach has some limitations. For example, there were some inconsistencies in the availability of dental practice data across the UK and between public and commercial sources, we do not have access to data on the number of hours dentists at each practice are contracted to work, and we used a binary classification of urban and rural areas, while in reality the characteristics of urbanicity and rurality exist on a spectrum. See Appendix E: Local analysis of areas with lower dental supply for a detailed overview of the methodological approach used for this analysis and its limitations.

England, the North East has the lowest supply relative to local population, while London has the highest.

4.49 Figure 4.2 below presents the findings of our analysis at a more granular regional level – with a spatial accessibility score for each LAD, displayed in the form of a heat map. Areas with lower supply relative to local populations are shown in paler colours (lower score) and those with higher supply relative to local populations are shown in darker colours (higher score).

Figure 4.2: Spatial accessibility scores per UK local authority district



Source: CMA analysis of data from LaingBuisson.

4.50 Figure 4.2 shows that variation is also present within the UK nations and English regions. Taken together, Table 4.2 and Figure 4.2 show there are fewer dentists (including private, mixed and NHS) relative to the local population in parts of East Anglia, the Midlands, the North East of England, and remote parts of Wales and Scotland. Our analysis also indicates that in England, Wales and Scotland, more deprived areas may have lower levels of dentistry availability relative to population than less deprived areas, although this is not a strong correlation.[237,238]

4.51 These results are consistent with what we have heard through engagement with dental firms. Responses from large dental groups identified that the areas that experience the most acute recruitment and retention challenges include parts of Scotland and Wales, and rural and coastal areas of England. We also heard that challenges tend to be greater in areas of higher socio-economic deprivation.[239]

4.52 One large group and one independent told us that there are recruitment challenges in Northern Ireland.[240] Although we identified variation in Northern Ireland, we did not find any region in Northern Ireland to be among those with the lowest levels of dental supply relative to local populations.

4.53 Taken together, the spatial analysis and evidence we have received from firms suggests that certain parts of the country are more vulnerable to supply issues than others, and that there is a risk that areas of higher socio-economic deprivation achieve lower levels of provision.

The impact of workforce capacity constraints on access, choice and competition

4.54 The tight supply of dentists in the UK does not appear so severe that consumers cannot find a private dentist at all; as noted in Chapter 3, the Verian research found that only 3% of those not registered with a dentist, and only 4% of those who have not seen a dentist within the last two years, were in that situation because they had been unable to find a private dentist.

4.55 However, consumers being able to find at least one private dentist with spare capacity does not mean that consumers have plenty of choice. The evidence indicates that workforce capacity constraints limit this choice for a material

[237] For Northern Ireland the analysis relating to deprivation was not possible due to data limitations. See section 'Correlation between scores and deprivation' in Appendix E: Local analysis of areas with lower dental supply for further detail.
[238] We did not find systematic differences between urban areas and rural areas in the levels of dentistry supply relative to local populations. However, the Verian research found that, among consumers in Great Britain (excluding Northern Ireland) that are not registered with a practice, lack of access to an NHS dentist was more common as a reason for consumers in rural areas (at 62%) than for consumers in urban areas (at 41%). Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, NOREGWHY.
[239] Further information is set out in section 'Workforce challenges' in Appendix A: Further evidence – market structure and competition between suppliers.
[240] Further information is set out in section 'Workforce challenges' in Appendix A: Further evidence – market structure and competition between suppliers.

proportion of consumers including in private dentistry. Similarly, appointment availability is also adversely affected:

(a) Evidence from the Verian survey of dentistry users suggests that 27% of dentistry users felt they had no choice when selecting a dental practice that suited their needs or had to go with whoever would accept them. More specifically, this perception was the case for 17% of private only users, 30% of users of both NHS and private services, and 37% of NHS only users.[241]

(b) While the Verian research found that the majority of dentistry users (72%) agreed that they were generally able to get an appointment when needed, a material proportion (17%) disagreed. This included a material proportion of users that received just private provision in the past two years (12%), and a higher proportion for users who received both private and NHS provision or only NHS dental provision (both 20%).[242]

4.56 When capacity limits consumers' choice of dental practice, this limits the extent to which consumers shopping around can stimulate competition. The evidence of significant workforce capacity constraints therefore indicates that dental firms are not likely to be subject to strong competitive pressure on price even if consumers were to shop around.

Regulatory complexity and other barriers to entry and expansion

4.57 Our analysis of information from dental firms identified a number of further barriers to entry and expansion beyond workforce challenges.[243] However, the difficulty recruiting and retaining their dentist workforce was by far the most significant barrier reported to us, followed by regulatory complexity and burden.

4.58 Most dental firms identified regulatory complexity and burden as a key barrier to entry and expansion in the private dentistry market. Key regulatory complexities raised include:[244]

(a) The need to register new practices with multiple different public authorities, such as the Care Quality Commission (CQC) and national healthcare regulators – which also differ between UK nations.

[241] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, page 43.
[242] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, GENATTS. The proportion that disagreed was also higher for customers of practices providing only NHS treatments and of practices providing both NHS and private treatments (26% and 19% respectively) than for customers of practices providing only private treatments (9%) (the dental practice type was based on the service provision type perceived by the survey respondents).
[243] Further information is set out in Appendix A: Further evidence – market structure and competition between suppliers.
[244] Further information is set out in section 'Regulatory complexity and burden' in Appendix A: Further evidence – market structure and competition between suppliers.

(b) Extensive compliance requirements, including health and safety standards and regulations such as the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

(c) The need for Mixed practices to additionally deal with NHS contract terms and commissioning bodies.

(d) Differing regulatory regimes across the four UK nations for larger firms which operate across multiple nations.

4.59 In the section 'Barriers constraining NHS dentistry' in Appendix A, we also discuss regulatory barriers and contractual arrangements constraining the NHS dentistry workforce and firms' NHS offerings' expansion more generally.

4.60 Beyond workforce challenges and regulatory complexity, the following barriers appear to be the most significant:

(a) attracting private demand (particularly in areas of high availability of NHS dentistry);[245]

(b) upfront investment costs;

(c) access to suitable premises; and

(d) access to finance.

4.61 A detailed overview of the evidence on barriers is in Appendix A.

Evidence on pricing strategies and incentives

4.62 Dentists generally work in privately run businesses with financial incentives to maximise profits. Where competition works well, even strong revenue and profit incentives can deliver good outcomes for consumers, by rewarding providers that offer better prices, quality, service and choice. However, where competitive pressure from consumers is weak, as here, there is a significant risk of poor outcomes.

4.63 In this section we assess evidence on dental firms' pricing strategies, as one aspect of profit maximisation, and what this evidence tells us about the strength of price competition.

[245] In Chapter 3, we set out that there are limits to consumers' ability to identify and choose a dental practice that best meets their needs and preferences. In particular, consumers face difficulties accessing NHS treatment and identifying practices that offer it. Further, consumers may be paying significantly more than if they shopped around (see Chapter 6).

4.64 While some dental groups told us that price is an important competitive factor,[246] overall the evidence indicates that price is not a significant parameter over which firms have incentives to compete strongly. In particular:

(a) While cost inflation has contributed to price increases at large dental groups, and discounts are sometimes used to attract new patients, our analysis of internal documents from the four largest dental groups suggests there is a focus on increasing their prices so as to match or get closer to rivals' prices, rather than seeking to undercut a rival's price; and

(b) Evidence from other groups and independents indicates that price is less important than other factors.[247]

4.65 This evidence of a lack of incentive to compete strongly on price is consistent with our findings above on workforce capacity constraints and other barriers contributing to weak competition.

4.66 The lack of incentive to compete strongly on price is also connected to the demand-side issues set out in Chapter 3. As noted in that chapter, proximity was the most common factor consumers relied on when choosing a private practice. Consumers placed less weight on price (as well as other factors including access and appointment availability, or reviews).[248] Consistent with this, there is documentary evidence indicating that there are strategies that involve increasing prices due to consumers' limited price sensitivity.

4.67 In the remainder of this section we focus on evidence received from larger groups on drivers of price increases in the sector and internal documents from the four largest groups on their pricing strategies. Further evidence on pricing, including how prices are set based on local market conditions and the price sensitivity of local patient demographics, is in Appendix A.

Drivers of price increases

4.68 As explained in Chapter 6, private prices at the large dental groups rose faster than average earnings and inflation between 2023 and 2025. We asked the large dental groups to explain the main drivers of any increases (or decreases) above 5% in the average revenue per private treatment for their common treatments in recent years.[249] The responses pointed to the most common driver of price

[246] Set out in Appendix A: Further evidence – market structure and competition between suppliers.
[247] Set out in Appendix A: Further evidence – market structure and competition between suppliers. As we had lower representation among small and mid-sized dental groups and independents, those views are indicative.
[248] Sixteen per cent of UK consumers mentioned convenient opening hours and appointment times, 10% mentioned online reviews and 6% of UK consumers mentioned prices as a factor in their choice of dental practices. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, PRACCHOICE.
[249] We asked the large dental groups if their average revenue per private treatment for any of their most popular treatments increased or decreased on average by more than 5% per year over the past five years. The four largest dental groups and some of the other large dental groups reported that their average revenue per private treatment for

increases being cost inflation in materials, energy, laboratory bills and wage costs, including the national living wage.[250] One of the four largest dental groups also reported that they have increased private prices to compensate for below cost inflation increases in the value of their NHS contracts in England,[251] while other dental groups said that the increase in average revenue per treatment is due to a shift towards more complex treatments that cost more and take longer to provide.[252]

4.69 Similarly, the BDA submitted that pricing pressures in private dentistry are being driven by rising input costs. The BDA highlighted in particular increases in laboratory costs, as well as in labour costs and material and equipment costs (although it considered material and equipment costs less acute than other cost pressures).[253]

4.70 While costs may have increased for dental firms, a significant proportion of dental firms' cost base is clinical labour. Due to the revenue sharing mechanism, these staff costs are mechanically tied to increases in prices charged for treatment. This means that, rather than increases in clinical staff costs being a driver of higher prices, higher clinical staff costs may, in part, be a consequence.[254]

Evidence from internal documents on pricing

4.71 Overall, the documentary evidence on pricing reviewed to date indicates that the four largest dental groups have considered competitors' prices and consumers' willingness to pay (WTP) mainly to inform price increases rather than to keep prices competitive, and that increasing prices due to consumers' limited price sensitivity may be part of the four largest dental groups' pricing strategy.[255]

4.72 Some of the four largest dental groups' documents discuss introducing discounts to attract more patients.[256] However, most documents from the four large dental groups referring to the prices of competitors discuss increasing prices so as to match or get closer to rivals' prices rather than seeking to undercut a rival's price. The documents from the four largest dental groups also refer to consumers' WTP

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some of their most popular treatments increased on average by more than 5% per year over the past five years. One of the four largest dental groups noted that due to a variety of factors, including incomplete data in two years, this may not be reflective of the average price paid by the consumer. Responses to the CMA's information requests: [✂].

[250] Responses to the CMA's information requests: [✂].

[251] Response to the CMA's information request: [✂].

[252] Responses to the CMA's information requests: [✂].

[253] BDA's response to the CMA's Statement of Scope, pages 15–23.

[254] Other reasons for higher costs of clinical staff likely include workforce capacity constraints, which are discussed further in the section above.

[255] We note we may not have been provided with all internal documents relevant to the four largest dental groups' pricing strategy. We welcome further documents or submissions from dental groups on their pricing strategy.

[256] [✂] response dated [✂] to the CMA's information request issued [✂] indicates the dental group considered a discount on new patient check-up to boost patients. [✂] response dated [✂] to the CMA's information request issued [✂] shows a competitor price being used to reduce the price of a treatment. [✂] response dated [✂] to the CMA's information request issued [✂] indicates the dental group had 'Addressed last year's overpricing on gateway treatments and strengthened competitor analysis', but it is not clear whether any prices were reduced.

(ie how likely consumers would be to book a given treatment at a given price) in the context of implementing price increases rather than price reductions.

(a) A 2025 document shows that one of the four largest dental groups commissioned a specialist pricing consultancy to assess its prices and scope for price increases. The consultancy estimated customers' WTP by treatment and benchmarked the group's prices against those of competitors. It found that the group's prices were below patients' WTP, which had increased by [10-20]% since 2024. It also found that competitors had raised their prices, although the group's prices remained slightly higher on average. As a result of the findings, the consultancy recommended price increases for many treatments to align with competitor pricing and customers' WTP. For example, it suggested increasing private prices on average by [5-10]%.[257]

(b) A similar document was produced by consultants for the same group in 2024, suggesting that the group had previously considered patients' WTP and competitors' pricing when setting prices.[258] A 2025 document, produced by the same group following the pricing consultancy's 2024 assessment, indicates that new patients might be willing to pay an additional charge and might consider a premium reasonable. The group discussed the introduction of a new patient exam fee of £75.[259]

(c) A 2025 pricing update document of another of the four largest dental groups discusses using data to identify opportunities to capture customers' full WTP. The document discussed the potential for increasing prices more for dental practices where utilisation indicated high demand, where local competitors' prices are higher, where patient satisfaction is high and where the property is in good condition.[260]

(d) A document produced by a consultancy for another of the four largest dental groups in 2025 also shows that the group considered customers' WTP when reviewing its prices. The consultancy was considering dynamic pricing and had conducted a consumer survey on consumers' WTP for convenient appointments. The research found that customers are most inclined to pay extra for weekend appointments and approximately 50% would also be willing to pay a premium for early morning or late afternoon slots. The consultancy therefore recommended to trial a [£10-20] increase in treatment prices at the most popular appointment times, with potentially higher

[257] Response to the CMA's information request: [✂]. [✂] appears to confirm that these recommended price increases were implemented. Response to the CMA's information request: [✂].
[258] [✂] response dated [✂] to the CMA's information request issued [✂]. This document mentions price changes of [10-20]% weighted average agreed for January 2025 and that the group is 'priced below patient's willingness to pay (WTP)'. This group also submitted that independent analysis puts its private prices below the market average, with some of its prices c.30% below after the pandemic, and exam prices still [5-10]% below market in 2024. Note of meeting with: [✂].
[259] Response to the CMA's information request: [✂].
[260] Response to the CMA's information request: [✂].

premiums for more expensive treatments.[261] However, the group submitted that, following the consultancy analysis, the recommended approach was not implemented.

4.73 Some of the four largest dental groups' internal documents also indicate that they have introduced significant, above inflation price increases in recent years, and sometimes also refer to consumers' limited price sensitivity.

(a) One report dated December 2024 prepared for one of the four largest dental groups recommended to increase private treatment prices by between [5-15]% per year, stating that absence of price sensitivity and past price changes provided headroom for sustained price changes.[262]

(b) Another report dated [✂] states that the same dental group has a strong track record of delivering above-market price increases.[263]

(c) An internal document from another one of the four largest dental groups dated April 2025 states that external research from consultancies indicates that most dental treatments are largely demand price inelastic and that inflation can be absorbed through price increases. The document also states that the dental group has an effective process for increasing prices across its practices, and that although some practices had seen a drop in demand, this appeared to be localised.[264]

(d) Another internal document from the same dental group dated November 2024 states that the group expected to land price increases above inflation in the year.[265]

(e) An internal document from another one of the four largest dental groups dated February 2025 highlights that price increases in FY25 have contributed £[✂]m of incremental income, and discusses [10-20]% and [20-30]% average price increases for FPI [Fee Per Item] private treatments and DPPs respectively.[266]

[261] Response to the CMA's information request: [✂].
Another document of the same dental group (response to the CMA's information request: [✂]) includes among its key findings that, although important, price is not the primary driver of choice for customers and that quality is more important. The document also notes that price decreases in importance as income of respondents grows, and that customers report some shopping around when treatments are new or expensive, but 34% never shop around at all.
[262] Response to the CMA's information request: [✂].
[263] Response to the CMA's information request: [✂].
[264] Response to the CMA's information request: [✂].
[265] Response to the CMA's information request: [✂].
[266] Response to the CMA's information request: [✂].

4.74 Moreover, some of the four largest dental groups' documents discuss planned initiatives to increase prices after acquiring dental practices, which could negatively impact patients.[267]

(a) An internal document dated April 2026 produced by one of the four largest dental groups mentions initiatives including 'price catch up' on dentures, crowns and extractions after acquiring two dental practices. Both dental practices are relatively close to practices already part of the group.[268]

(b) An internal document produced by another of the four largest dental groups assessing the acquisition of a practice and its merger with one of the group's existing practices highlights that the group's existing practice has higher pricing, and shows the group intended to adjust the pricing structure of the target practice to be closer to that of the group's existing practice.[269]

Firms' revenue-growth strategies

4.75 In addition to considering pricing, the larger groups' strategies we have seen include measures to grow revenue using non-price levers. In this section, we set out and assess the evidence on the strategies of these larger groups, with a focus on non-price levers including increasing sales particularly of higher revenue treatments (including cosmetic treatments); converting NHS patients to private treatments; and selling DPPs and finance products to existing customers.

4.76 We have found that many firms focus on growing earnings before interest, tax, depreciation and amortisation (EBITDA). This is a key valuation metric in the sector, as evidenced in the documents of dental groups, industry benchmarking reports, and commentary from financial advisors to the sector working with smaller firms including independents. This evidence indicates that incentives to grow revenues and profits are present across all types of ownership and business model.

4.77 In the next stage of this study, we plan to expand our understanding of firms' commercial strategies – particularly those of dental groups – and their potential impact on consumer outcomes via their impact on clinicians' behaviour. As we discuss in Chapter 7, this evidence could be relevant to our remedy proposals if it

[267] Similarly, an internal document produced by another large dental group dated May 2025, which discusses four separate acquisitions, noted pricing opportunities for each. In relation to one, it noted that pricing was a 'huge opportunity', because the previous owner had 'extremely low' prices, and despite the principal being able to annually increase fees following investments in the practice, the fees remained low. Response to the CMA's information request: [✂].
[268] Response to the CMA's information request: [✂]. Price catch-up on dentures, crowns and extractions are also mentioned by the same large dental group in relation to two other acquisitions, one where the nearest of the existing group practices is 11 miles away. Response to the CMA's information request: [✂]. Also see response to the CMA's information request: [✂].
[269] Response to the CMA's information request: [✂].

found particular ownership and business models were connected to particular commercial drivers, business practices or outcomes.

Use of KPIs and financial incentives by large groups

4.78 Firms use KPIs and financial incentives as part of their wider commercial strategy to grow practice/ group-level revenue. This section sets out in more detail the evidence we have reviewed on the use of KPIs and financial incentives by large groups.[270]

4.79 As commercial organisations, dental groups use processes and systems to monitor and manage their business performance. Metrics frequently monitored include revenue and EBITDA, revenue split between private and NHS treatment, clinical compliance and diary or chair utilisation rates. Some dental groups use these metrics primarily for monitoring purposes, while others, including all the four largest dental groups, set explicit targets and KPIs against them.[271] We found evidence of:[272]

(a) Targets and KPIs aimed at driving revenue growth;

(b) Financial incentives for product sales and revenue growth; and

(c) Agreements between dental groups and their upstream suppliers based on increasing sales volumes of cosmetic treatments or dental plans.

4.80 This evidence included examples of targets and KPIs relating to[273] the conversion of NHS patients to private treatments (often referred to in internal documents as 'NHS upsell');[274] sales of certain high revenue or cosmetic treatments, such as whitening and implants;[275] sales volumes of related non-clinical products, such as dental plans or patient finance;[276] and patient recall success rates.[277]

(a) Examples of converting NHS patients to private treatments included documents from some [✂] of the four largest dental groups noting that conversions and upselling additional private treatments (eg hygiene plans) are an opportunity to increase revenue and profits,[278] to identify

[270] References to KPIs or targets refer to business targets, not personal targets, unless otherwise indicated.
[271] Responses to the CMA's information requests: [✂].
[272] The sub-sections below and the section 'Targets and KPIs' in Appendix D: Revenue growth strategies and incentives set out this evidence.
[273] Examples of these are set out in Appendix D: Revenue growth strategies and incentives.
[274] Responses to the CMA's information requests: [✂].
[275] Responses to the CMA's information requests: For example: [✂].
[276] Responses to the CMA's information requests: For example: [✂].
[277] Responses to the CMA's information requests: [✂].
[278] Responses to the CMA's information requests: [✂].

underperforming practices or clinicians and suggest increasing NHS upsell.[279]

(b) Examples relating to increasing sales of high revenue or cosmetic treatments included documents from some [✂] of the four largest dental groups containing targets for increasing the share of revenues from whitening, either alone or in combination with other high-value treatments, such as implants and clear aligners.[280] A document from one of the four largest dental groups noted a plan to shift volumes to deliver more high value treatments to grow revenue per patient and private mix.[281]

(c) Examples relating to increasing sales of non-clinical products included documents that explicitly track dental plan sign-ups at the practice level,[282] and set targets for plan sign-ups.[283] We also found evidence of an incentive scheme aimed at increasing take-up of whitening treatments being promoted as having the additional benefit of creating an 'opportunity to promote patient finance'.[284] Another document discussed 0% finances as part of a wider strategy to double the number of high value treatment plans.[285]

(d) Examples relating to patient recall success rates included KPIs relating to recalls, lapsed patients or future appointments booked[286] sometimes with financial incentives linked to recall success.[287]

4.81 Conversely, we did not find any KPIs relating to the communication or promotion of National Institute for Health and Care Excellence (**NICE**) guidelines, for example in relation to recommended patient recall rates.[288]

4.82 We also saw examples of dentist-level data tracking performance against KPIs/targets being shared with practice managers to inform individual (clinician) performance discussions.[289] One such example from one the four largest groups prompted practice managers to monitor conversion rates and discuss these with clinicians;[290] while another of these groups provided information for staff to track KPIs in real time.[291]

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[279] Responses to the CMA's information requests: [✂].
[280] Responses to the CMA's information requests: [✂].
[281] Response to the CMA's information request: [✂].
[282] Responses to the CMA's information requests: [✂].
[283] Response to the CMA's information request: [✂].
[284] Response to the CMA's information request: [✂].
[285] Response to the CMA's information request: [✂].
[286] Responses to the CMA's information requests: [✂].
[287] Responses to the CMA's information requests: [✂].
[288] NICE Clinical guidance, CG10, Dental checks: intervals between oral health reviews. We intend to undertake further work to understand the extent to which NICE guidance on recall rates is being applied.
[289] Responses to the CMA's information requests: For example: [✂].
[290] Response to the CMA's information request: [✂].
[291] Response to the CMA's information request: [✂].

4.83 The monitoring of KPIs and targets, and the communication of results to staff, are liable to create pressure on dental professionals to support the practice or group in achieving them.

4.84 Some large dental groups offer financial incentives for each additional sale of cosmetic treatments, such as teeth whitening, or DPPs, usually for employed staff (ie excluding self-employed associates).[292] Practice managers, who are responsible for developing and managing the business at a practice level, hold a salaried position typically with financial incentives/ bonuses linked to practice performance metrics including EBITDA and growth in private income.[293]

4.85 We have also seen evidence of financial incentives being offered to principals selling their practice(s) in the form of deferred payments linked to revenue, EBITDA and/or profit targets.[294] These deferred payments can be of significant value, with one of the large dental groups offering up to [✂] to be paid out over the 4 years following acquisition subject to a yearly revenue target being met, in addition to a base revenue-share remuneration agreement.[295]

4.86 Some large dental groups also hold contractual agreements with suppliers of cosmetic treatments or materials, or suppliers of DPPs.[296] A number of these agreements contain significant volume discounts and rebates conditional on gross value of orders, minimum volume of cases delivered (eg of clear aligners), or minimum membership thresholds for DPPs.[297] These agreements tend to be applied at a group level, although we found an example of a large dental group where the suppliers' discounts applied at an individual dentist level.[298]

Evidence in relation to acquisitions

4.87 As discussed further in Chapter 2, there has been significant corporatisation of the sector in recent years, with many examples of dental groups increasing the number of practices that they operate, often through acquisitions. Approximately 90% of all practices acquired since 2020 by large dental groups contacted by us are part of private equity backed groups.[299] The strategies behind these acquisitions provide another lens on how the market is functioning.

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[292] For example, one of the four largest dental groups stated that a revenue incentive was payable to employed members of staff only and not to self-employed clinicians (response to the CMA's information requests: [✂]). Another of the four largest dental groups offered its whitening incentive only to employees of the practice (response to the CMA's information request: [✂]).
[293] Responses to the CMA's information requests: For example [✂].
[294] Responses to the CMA's information requests: [✂].
[295] Response to the CMA's information request: [✂]. The Heads of Terms note that if the revenue target is missed in one year the shortfall may be made up by overachieving in subsequent years such that the deferred consideration (ie revenue-linked incentive) is still paid.
[296] Responses to the CMA's information requests: [✂].
[297] Examples of these are set out in Appendix D: Revenue growth strategies and incentives.
[298] Response to the CMA's information request: [✂].
[299] Response to the CMA's information request: [✂].

4.88 We are undertaking a review of acquisition documents that so far has focused on the largest groups - we will update our analysis for all large groups for our Final Report. Our review thus far has confirmed many of the findings in the strategy section above, including a focus on increasing revenue from private treatments. Generally, we find these firms implementing similar changes within their existing portfolio of practices as for new firms they acquire.[300]

4.89 As discussed above, a key indicator of value in the sector has historically been EBITDA, which firms may seek to increase through growing revenue, increasing efficiency, or both. Acquisition documents assume post-acquisition increase in the EBITDA of the target practice and/or of a nearby practice of the acquiring group into which the target would be merged.[301]

4.90 We also heard from financial advisors operating within the sector that firms consider EBITDA and the potential for efficiencies and economies of scale as part of their acquisition strategy, for example from better utilisation of practice space.[302] However, our financial analysis did not identify significant differences in dental practice cost structure driven by scale of operations.

4.91 A recurring focus in the acquisition documents is the perceived opportunity to grow private revenue, including through higher revenue private treatments, and increasing private treatment among NHS patients. Acquisition due diligence documents indicate large dental groups planning to employ strategies post-acquisition, some of which may not be in the best interests of consumers. As well as planned initiatives to increase prices after acquiring dental practices (as set out in the section above on pricing strategies), there was evidence of sales strategies that could give rise to potential consumer harm (depending on the wider context and the extent to which consumers are supported to make informed choices). These strategies included the introduction or increased sales of "high-value private treatments, such as aligners and whitening",[303] cross-selling private services to NHS patients, with one document indicating large NHS contracts were seen as an upselling opportunity;[304] and, sale of DPPs, with one acquisition screening tool referencing dental plan optimisation[305] as a revenue opportunity.[306]

4.92 Other documents identify revenue-growth initiatives that may benefit patients, including increasing fulfilment of existing NHS contracts,[307] expanding surgery utilisation,[308] increasing opening hours,[309] investing in equipment/ premises/

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[300] Responses to the CMA's information request: [✂].
[301] Response to the CMA's information request: [✂].
[302] Note of meeting with [✂]; note of meeting with [✂].
[303] Response to the CMA's information request: [✂].
[304] Response to the CMA's information request: [✂].
[305] Response to the CMA's information request: [✂].
[306] See Appendix D – Revenue growth strategies and incentives for further detail.
[307] Response to the CMA's information request: [✂].
[308] Responses to the CMA's information requests: [✂].
[309] Responses to the CMA's information requests: [✂].

software,[310] expanding services/ practice capabilities,[311] and recruiting additional clinical labour.[312]

4.93 Acquisition documents also provide some indication that having NHS business can increase the acquisition value of a dental practice and is seen by some acquiring firms to provide stable income with potential to grow revenues by offering private treatments to NHS patients.[313] As set out in chapter 6, this internal document evidence supports our analysis that NHS contracts deliver commercial benefits beyond cross-subsidisation, which include fuller utilisation of clinician time, more stable cashflows/income, and opportunities to generate additional private revenue from NHS patients.

Financial incentives for clinicians to grow private revenue

4.94 So far, we have discussed the price and non-price levers that dental groups use to maximise revenues and profits. In the remainder of this chapter, we consider the incentives of clinicians themselves – including dentists working in practices they do not own, and owner-operator dentists – to grow revenues.

How clinicians are remunerated

4.95 Data from our sample of dental groups and independents indicates that all dental groups and most independents use a direct revenue-share model to determine remuneration of dentist associates working at their practices (although lower representation of small and mid-size dental groups and independents mean this finding is indicative for them). Under this model, associates receive (or retain) an agreed percentage share of the revenue they generate. This revenue share can differ by firm, by associate within that firm (for example, specialists may receive a higher revenue share for relevant treatments),[314] and by revenue source (private vs NHS).

4.96 In independent firms, some clinical and non-clinical work is undertaken by principals, who own and operate the business. Owner-operator dentists tend to receive their income through dividends and realise the value of their ownership when they eventually sell the practice.

4.97 Revenue sharing with associate dentists is the single largest cost component for all dental firms. For every £100 spent by consumers at large dental groups, on

[310] Responses to the CMA's information requests: [✂].
[311] Responses to the CMA's information requests: [✂].
[312] Responses to the CMA's information requests: [✂].
[313] Responses to the CMA's information requests: [✂].
[314] Response to the CMA's information request: [✂].

average, £38 is paid to associates, often net of their share of laboratory and materials costs.[315]

4.98 Table 4.3 shows the range of revenue sharing rates for the dental groups and independent firms from which we gathered data for private and NHS dentistry. Where the revenue a dentist receives is based on a fixed amount per treatment, we have estimated this amount as a share of revenues to give an effective revenue share rate in this table.[316]

Table 4.3: Revenue sharing with Associate Dentists[317]

%

	Private Dentistry		*NHS Dentistry*	
	Minimum	*Maximum*	*Minimum*	*Maximum*
Four largest dental groups	35	60	35	50
Large dental groups	40	60	35	60
Small to mid-size dental groups	40	60	40	60
Independents	45	>50	45	>50

Source: CMA analysis based on dental group submissions and NASDAL data.
Note: Lower sample representation of small to mid-size dental groups and independents mean those figures are indicative.

4.99 The revenue-share model creates an inbuilt incentive for associates to increase revenue per hour worked. This could in principle influence recommendations to patients about particular treatment options, dental payment plans (DPPs), finance products, and/ or encourage the cross-selling of higher revenue services.

4.100 Table 4.3 shows that associates' revenue-share rates can be lower for NHS than private dentistry at the larger dental groups. For the four largest groups, the maximum rate was 50% for NHS work, compared to 60% for private work. For other large dental groups, the maximum rates were the same rates for both NHS and private dentistry but the minimum rate was lower for NHS work (35%), compared with private work (40%). This differential in revenue sharing could potentially influence individual dentist time allocation, as well as firm profitability.

4.101 Unlike associates, principals that undertake clinical work (owner operator dentists) at independent firms are less likely to be paid through revenue sharing and more likely to be remunerated from a mixture of business profit (via a dividend), some clinical earnings (via a salary), and, in some cases, the sale proceeds arising from the sale of their business (when exiting the market). Owner operator dentists in independent firms therefore also have an incentive to increase revenue and profits.

[315] Based on our financial analysis of the four largest dental groups and 12 large dental groups.
[316] Four largest dental groups, nine Large dental groups, four Small to mid-size dental groups, and c.500 Independents.
[317] In some cases, the Associate fee is netted off against a contribution from the Associate towards laboratory and material costs. Where this is the case, the fee that an associate earns will be a lower percentage of revenue than the revenue share percentage as shown in this table.

4.102 As discussed above, some groups have put in place KPIs and financial incentives aimed at driving higher sales of certain, high revenue, treatments (such as implants and teeth whitening), as well as related products including DPPs. These may reinforce the financial incentives for clinicians to maximise revenue via the revenue share. In the following section, we set out evidence on the extent to which clinical conduct may be influenced by commercial incentives.

The impact of commercial incentives on clinical recommendations

4.103 We have reviewed responses from large dental groups, dentists and consumers to help assess the extent to which incentives play through into clinical recommendations/decision making. While all groups and most dentists reported that clinical judgement is unaffected by the revenue-share model or other commercial incentives (including KPIs), there were some exceptions. We have seen evidence that for at least some clinicians the remuneration model could influence decisions on treatment mix, and KPIs and targets reduced 'professional freedom'.

4.104 A number of large dental groups told the CMA that their use of a revenue-share model was consistent with the industry norm.[318] The most commonly cited reasons for using the model were to align clinician remuneration with the activity they deliver,[319] and to help recruit or retain staff.[320] Notably, one of the four largest dental groups acknowledged that 'the associate percentage model is intended to align clinical incentives with practice revenue generation and efficiency'.[321] It also noted, however, that associates are bound by GDC Standards requiring treatment to be clinically appropriate, and that the group monitors clinical governance metrics 'to detect any concerns about over-treatment.'

4.105 Submissions from large dental groups also noted that KPIs, targets and other financial incentives are not designed to influence, and do not influence, individual treatment recommendations or sales decisions**.** Most stated that central targets are not passed to individual clinicians, and some emphasised the importance of retaining clinical freedom.[322] However, internal documents from each of the four largest dental groups showed at least some pass-through of information relating to KPIs or targets to clinicians, either directly to clinicians or indirectly via practice managers.[323]

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[318] Responses to the CMA's information requests: [✂].
[319] Responses to the CMA's information requests: [✂].
[320] Responses to the CMA's information requests: [✂].
[321] Response to the CMA's information request: [✂].
[322] Responses to the CMA's information requests: [✂]; note of meeting with [✂]; responses to the CMA's information requests: [✂].
[323] For example, one of the four largest dental group's internal documents showed that information is shared with practice managers to enable real-time tracking of KPIs to drive practice-level decision making. Response to the CMA's information request: [✂]. Further evidence of this is set out in section 'Evidence of these KPI/targets being passed on to clinicians' of Appendix D: Revenue growth strategies and incentives.

4.106 Dentists in the Revealing Reality research noted that clinical decisions remain independent of financial or commercial considerations. While some dentists mentioned that the revenue share model inherently incentivises doing more work (with a focus on working more/ longer hours), many explicitly stated that it did not affect their clinical decision making. However, one dentist noted they treat cosmetic dentistry as more of a 'business plan' and something they are 'financially driven by'.[324]

4.107 In relation to targets and KPIs, some dentists in the Revealing Reality research were aware they existed, but many were unclear about the specific measures being monitored.[325] Some dentists noted informal expectations to offer cosmetic treatments to patients rather than formal targets. Others expressed discomfort or pressure with targets and performance monitoring, but very few reported feeling pressured to alter treatment recommendations based on discussions about targets and KPIs.[326] They noted that the regulatory framework shapes their day-to-day practice and underpins their interactions with patients.[327] However, one participant working at one of the four largest dental groups described feeling pressure to perform against targets and not having the professional freedom to do what they want.[328]

4.108 Finally, some consumers in the Verian research reported feeling pressured by their dentist or dental practice to have certain treatments. Among respondents who had received private, non-routine treatment in the UK in the previous two years that they did not request, 12% said they felt pressured to proceed. This rose to 20% among those who had considered making, or had made, a complaint.[329] Similarly, a Which? poll found that 16% of respondents felt pressured to agree to particular treatment and 11% felt pressured to sign up to a DPP.[330] The Which? report noted that "this pressure could be particularly difficult for consumers to

[324] Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations – section 6.5.1, page 53.
[325] Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations – section 6.3.3, pages 46, 47 and 48.
[326] Dentists and DCPs reported having monthly or quarterly team meetings where practice or area managers reviewed performance, discussed targets and highlighted areas for improvement. Some professionals also described one-to-one discussions with practice owners or managers, either on a routine basis or when an individual was perceived as underperforming. However, no dentist reported facing consequences as a result of missing targets. Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations – section 6.3.4, page 49.
[327] Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations – section 7.1.2, page 56 [1st para and 3 subsequent quotes in 7.1.2]
[328] Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations – section 6.3.3, page 48.
[329] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, Qs TREPRESS B and COMPLAINT.
[330] Which? (2026) 'Consumer harm and complaints experience in private dentistry', page 7. Respondents to the Which? Survey were adults aged 18 and above who had experienced problems, or whose dependents had experienced problems, with private dental treatment within the last two years.

challenge because of the imbalance of knowledge between patients and the dental team".[331]

4.109 Although we do not have direct evidence of financial and commercial incentives influencing clinicians, we provisionally conclude that the difficulties that patients face in assessing the treatments they need and their reliance on dentists to help them make treatment choices (as set out in Chapter 3), may leave patients vulnerable to being sold treatments that are not in their best interests.

4.110 In the remainder of the study, we will seek to understand the impact of KPIs and financial incentives further, including through examining how groups themselves monitor their impact.

[331] Which? (2026) 'Consumer harm and complaints experience in private dentistry', page 9.

5. Regulatory framework

Summary

5.1 An effective regulatory framework is important in a market for credence services, particularly in healthcare. Whilst commercial incentives encourage providers to expand and innovate in their service delivery, appropriate constraints are also needed to ensure good outcomes for consumers, particularly where competitive pressures are limited. In healthcare markets, effective regulation supports the maintenance of high standards of quality and safety of care across different forms of provision, and ensures consumers have appropriate avenues to obtain redress when things go wrong, while also minimising the additional cost and burden placed on providers. Under an effective framework:

(a) consumers get the right information at the right time to make decisions that are right for them;

(b) dentistry businesses are not inhibited by unnecessary regulation or regulatory barriers that can restrict competition; and

(c) consumers can easily access and navigate complaint and redress mechanisms when things go wrong.

5.2 In this chapter, we set out our findings to date in relation to the UK regulatory framework for dentistry (in relation to both dental practices and dental professionals) and the complaints and redress mechanisms available to consumers.

5.3 As outlined below, the evidence gathered to date demonstrates that:

(a) The existing regulatory framework is not well suited to ensuring that information transparency and informed choice obligations are embedded consistently at the dental practice and business level, leaving consumers continuing to face the barriers identified in Chapter 3 in relation to finding and choosing a practice and choosing between treatments.

(b) Some features of the existing regulatory framework may be adding costs or delay to dental practices.

(c) Consumers may face barriers to accessing current complaints and redress mechanisms, given the lack of information that may be available about how to complain as well as the complexity and limitations of the current mechanisms.

Transparency and informed choice for consumers

Existing regulatory framework

5.4 The regulatory framework for both dental practices and dental professionals, as summarised below, sets obligations in relation to many important aspects of consumer information and choice.

5.5 Private dental practices are subject to nation-specific care quality standards, which set requirements relating to information transparency and consumer choice. These can include requirements to obtain informed consent, provide transparent information on fees, and have effective complaints procedures.[332] However, each nation has different inspection frameworks and timescales,[333] and the emphasis of inspections by nation-specific care quality regulators can vary.[334]

5.6 Dental practices providing NHS treatments must also comply with nation-specific (and, in some cases, region-specific) NHS rules and regulations, which can include obligations relating to information transparency. For example, the standard GDS contract in England includes an obligation to compile and make available a patient information leaflet with specified information, including how patients may make a complaint relating to the service.[335]

5.7 All UK nations also have regulations in place which prevent NHS dental professionals or contractors from using NHS care, or NHS treatment options, to inappropriately steer patients towards private treatment.[336]

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[332] The principal care quality standards legislation is: in England, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations; in Scotland, the National Health Service (Scotland) Act 1978 (as amended by the Public Service Reform (Scotland) Act 2010) and the Public Bodies (Joint Working) Act 2014 (independent service providers must comply with obligations in the Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011); in Wales, the Care Standards Act 2000, the Health and Social Care (Community Health and Standards) Act 2003 and the Private Dentistry (Wales) Regulations 2017; and in Northern Ireland, the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and associated Regulations.

[333] For example, inspection timescales can typically range from once every two years (by the RQIA in Northern Ireland) to once every ten years (by the CQC in England).

[334] The healthcare regulators across the UK do not assign quality grades or star ratings to dental practices, unlike for private hospitals or care homes. Instead, they publish narrative reports noting whether the practice is meeting overall standards and any recommendations or areas for improvement.

[335] NHS England, 'Standard General Dental Services Contract' Clause 209 & Schedule 3, accessed 15/09/26.

[336] In relation to England, Schedule 3, paragraph 1(4)(b) of the NHS (General Dental Services Contracts) Regulations 2005 says that a contractor may refuse NHS services only on reasonable grounds, and those grounds must not relate to a person's decision to accept or refuse private services for themselves or a family member. The National Health Service (General Dental Services Contracts) Regulations 2005. The same restriction applies in Wales (Schedule 3, paragraph 1(5)(b) of the National Health Service (General Dental Services Contracts and Patient Charges) (Wales) Regulations 2026). In Scotland, Schedule 1, paragraph 17(2)(a) of The National Health Service (General Dental Services) (Scotland) Regulations 2010 requires that a contractor shall not, with a view to obtaining the agreement of a patient to undergo care and treatment privately, (a) advise a patient falsely that the care and treatment which is necessary in the patient's case under a capitation arrangement or on referral is not available from that contractor under NHS general dental services, or (b) seek to mislead the patient about the quality of care and treatment available under general dental services. The same provision applies in Northern Ireland (Schedule 2, paragraph 16 of the General Dental Services Regulations (Northern Ireland) 1993.

5.8 Furthermore, the GDC standards of conduct, performance and ethics (the GDC Standards) require dental professionals across the UK to:

(a) put patients interests first, including by making it clear which treatments can be provided on the NHS, not misleading patients about what can only be provided privately, and not pressurising patients to receive treatment privately;[337] and

(b) provide consumers with clear information; however, they do not contain explanatory guidance on the granularity or format of information (including pricing information) that should be provided to consumers,[338] beyond providing that dental professionals can use 'from - to' prices where items vary in cost.[339] Some other dental regulators appear to have stronger pricing transparency for ranged prices for certain treatments.[340]

5.9 The GDC has also produced guidance for dental businesses, but it does not regulate their conduct.[341] The existing GDC Standards also do not apply to non-clinical staff.

5.10 The Revealing Reality research has found most dental professionals were familiar with the GDC Standards, describing them as shaping day-to-day practice, and underpinning interactions with patients,[342] indicating that these obligations are well-understood.

Evidence that the existing framework may not be offering consumers sufficient protection

5.11 The existing framework means that providers should put patient needs first and provide them with information and, in the case of providers of NHS dental services, should not be inappropriately steering patients towards private treatment. Despite those rules, we have received evidence suggesting that those obligations may not be adequately protecting consumers from the ways in which commercial

[337] The General Dental Council requires via its *Standards for the Dental Team* that dental professionals must put patients' interests before their own or those of any colleague, business or organisation. This includes making it clear which treatments can be provided under the NHS and which can only be provided privately (paragraph 1.7.2), not misleading patients into believing that treatments which are available on the NHS can only be provided privately (paragraph 1.7.3), and not pressurising patients into having private treatment if it is available to them under the NHS. See: GDC (2014) 'Standards for the Dental Team,' paragraph 1.7.
[338] The GDC has a dedicated webpage for the Standards containing case studies which consider the application of the Standards, as well as FAQs for dental professionals: GDC, 'General Dental Council - Focus On Standards' accessed 14/09/26.
[339] GDC (2014) 'Standards for the Dental Team', paragraph 2.4.1.
[340] For example, in the Republic of Ireland, the Dental Council or Ireland requires that dentists must (rather than have the option to) display fees for certain treatments by using a range and must not only give a minimum price.
[341] See Appendix H: Regulatory framework.
[342] Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations, section 7.1.2.

incentives within the NHS-private mixed market could influence providers' behaviour.

5.12 As described in Chapter 3, consumers still face barriers to comparing practices and private treatment options, including related to the availability of clear and comparable pricing information necessary to make informed choices. More generally, the regulatory framework and its enforcement may not adequately be preventing consumers from potentially receiving misleading information on accessing NHS care, on necessary recall intervals or in marketing materials promoting private services (such as the issue we described in Chapter 3 relating to the advertisement of private hygiene treatments as routinely necessary).

5.13 As regards NHS access, some consumers also told us they experienced conditions attached to obtaining NHS care for their child.[343] The Verian research found that among private dentistry users whose children received NHS treatment at the same practice, 16% reported that they had to switch from NHS to private care to register or enrol their children for NHS services and 6% reported that they had to join a private dental plan.[344] The Revealing Reality research also found that, while it was rare for practices to attach conditions to registration, the most common condition reported by dental professionals was allowing a child to join as an NHS patient only where the parent was already registered privately or joined privately.[345] While dental groups, when asked to describe any conditions or restrictions on sign-ups or appointment booking, either did not report making registration conditional on a parent receiving private care, or explicitly stated that they did not do so, the other evidence we received nonetheless gives cause for concern.[346]

5.14 An effective regulatory framework ought to prevent, or enforce against, these sorts of behaviours in order to protect consumers. In the following sub-sections, we identify a number of potential weaknesses in the current regulatory framework,

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[343] Concerns have also been raised publicly about practices accepting a child as an NHS patient on the condition a parent or guardian becomes a private patient, or joins a dental payment plan (DPP). For example, a BBC article from 2022 highlighted that some dental practices said they would take on a child under the NHS only if a parent signed up as a private patient: Full extent of NHS dentistry shortage revealed by far-reaching BBC research - BBC News accessed 20/11/26.

[344] When introducing this question to respondents, we explained that by 'registered' we meant 'a practice where your child is registered or enrolled, or simply where they have been to before and expect to visit again'. This could mean a parent either needing to join the practice for the first time as a private patient, rather than as an NHS patient or, if already an NHS patient at the practice, losing access to NHS services once registering as private patient. This survey result does not differentiate between these two scenarios. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, REQPRIV.

[345] Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations, section 5.1.3.

[346] Parties who did not report making sign up conditional on a parent receiving private care when asked to 'Describe any common restrictions or conditions that your dental practices place on patients trying to sign-up to one of your practices and/or book appointments or treatments, and why these restrictions or conditions are imposed. Additionally, explain if these are different for patients under 18, and if so, how and why': Responses to the CMA's information requests: [✂]. Parties who noted explicitly they do not make sign up conditional: Responses to the CMA's information requests: [✂].

which may be leading to this lack of sufficient protection for consumers in relation to information transparency and informed choice.

Accountability for business-level commercial decisions

5.15 Notwithstanding the existing obligations described above, the current regulatory framework lacks clear mechanisms that correspond with how decisions affecting consumer transparency and informed choice are taken within dental businesses.

5.16 Prior to 2006, most practice owners had to be registered dental professionals.[347] Legislative changes in 2006 allowed corporate dental groups to enter and expand within the sector, creating a clearer separation between dental businesses and the professionals they employ or engage.[348]

5.17 This separation can create challenges where business decisions influence consumer outcomes. Commercial decisions relating to pricing, advertising and patient information matters may be determined by practices or at business level,[349] while professional duties relating to patient care and communication remain the responsibility of dental professionals. We have also seen evidence suggesting that some large dental groups use business targets and performance indicators aimed at increasing revenue (see Chapter 4 of this report).

5.18 Other healthcare sectors employ different regulatory models. In optometry, the General Optical Council (GOC) regulates both professionals and certain business entities.[350] In the pharmaceutical sector, the General Pharmaceutical Council (GPhC) regulates pharmacies as registered premises, and places governance responsibilities on designated individuals such as superintendent pharmacists.[351] Proposed reforms in the veterinary sector would similarly introduce direct regulation of veterinary businesses and clearer accountability for those responsible for their oversight.[352]

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[347] Only corporate bodies that carried out the business of dentistry on 21 July 1955 could continue to do so (subject to the other restrictions set out in section 43 of the Dentists Act 1984 at the time). The Office of Fair Trading's 2003 report on the private dentistry market in the UK estimated that corporates had 5% of the market (measured by turnover) at that time.
[348] See Chapter 2 for an overview of the market.
[349] See Chapter 4 for information on pricing, KPIs and incentives.
[350] GOC 'Standards' accessed 21/10/26; GOC (2025) 'Standards for Optical Businesses.'
[351] GPhC (2017) Standards for pharmacy professionals; GPhC (2018) Standards for registered pharmacies; GPhC 'Becoming a superintendent pharmacist' accessed 21/10/26; The GPhC has recently published its Standards for Chief Pharmacists. The GPhC expects to publish standards and rules for Responsible Pharmacists and standards for Superintendent Pharmacists in December 2026, following a recent consultation. See: GPhC (2025) Standards for Chief Pharmacists; GPhC (2026) 'Consultation analysis report RP standards and rules and SP standards.'
[352] See: Department for Environment, Food & Rural Affairs (2026) Our vision for a thriving veterinary sector, section 'Regulation of veterinary or animal healthcare businesses.' This follows the CMA's market investigation into veterinary services for household pets, which found that competition was not working well in this market, and made recommendations for reform. See: CMA 'Major reforms would require vet businesses to make fundamental changes to the way they support pet owners - GOV.UK' accessed 21/10/26.

How professional regulation is enforced

5.19 In addition, available enforcement mechanisms may not always be well suited to addressing breaches of information transparency or similar requirements placed upon dental professionals.

5.20 The GDC's enforcement regime is primarily designed to address serious concerns about a professional's fitness to practise (FTP), rather than routine compliance issues.[353] This may result in a lack of realistic enforcement routes against breaches of transparency and consumer information obligations. The GDC has acknowledged that some less serious matters may not raise fitness to practise concerns.[354]

5.21 Dental professionals also told us that the seriousness of the FtP process can contribute to a culture of fear among the sector, influencing professional behaviour and, in some cases, discourage dental professionals from undertaking more complex treatments.[355] This also suggests that the current framework may not provide a sufficiently graduated range of enforcement responses for less serious breaches.

Existing enforcement of NHS regulations

5.22 Existing NHS rules already provide some protection against providers inappropriately steering patients towards private treatment, or making NHS access conditional on the purchase of private services. Given the evidence above that these practices still occur, more systematic enforcement of existing NHS requirements may be needed in this area and we intend to consider this issue further in the next phase of our study.

Taken together, the current regulatory framework and its enforcement may not adequately protect patients

5.23 Our analysis has identified weaknesses in the regulatory framework intended to protect patients. Oversight of private dentistry is complex and spread across several different regimes, without clear mechanisms for enforcement at the business and practice level of consumer information and informed choice

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[353] The GDC can take formal action against individuals in a limited number of circumstances of serious unfitness to practise, including where there is a public safety concern, or the public confidence in the profession could be undermined. Data published by the GDC on Fitness to Practise investigations in 2025 suggests a small number relate to information transparency and informed choice issues instead, or in addition to, clinical harms. Of the total allegations considered at the 'Assessment' stage of the Fitness to Practise process (1,293), a small number were categorised as "Not listening to patients" (13), "Failure to obtain consent before treatment starts" (10), "Failure to provide full information on treatment" (10). See: GDC (2026) Fitness to Practise Statistical Report 2025, p32.
[354] For example, see: GDC 'Dealing with feedback and concerns' accessed 14/01/26.
[355] Note of roundtable with dental groups, 08/07/26, [✂]; Note of roundtable with independents, 01/07/26, [✂]; Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations, section 7.1.2; response to the CMA's information request: [✂]; note of meeting with [✂].

obligations. This is despite important commercial decisions being made at this level. Further, our evidence identifies areas where existing regulatory requirements (including those designed to protect NHS access) do not appear to be working effectively, particularly around dental practices making access to NHS services conditional on a patient's or family member's decision to accept or refuse private services.

5.24 We will undertake further work in the next phase of the study to understand more about the extent to which such conditions are being placed on access to NHS services and why this might be happening despite existing regulatory requirements.

5.25 We will also explore whether there may be a role for the CMA where we have concerns about compliance with UK-wide consumer protection law (see Chapter 7 on Remedies).

Impact of the existing regulatory framework on entry, expansion and innovation

5.26 Effective regulation should protect consumers and support confidence in markets whilst being mindful of imposing unnecessary burdens on businesses. Regulatory requirements that are proportionate and targeted can address harm where it arises while minimising compliance costs and administrative complexity. This can be particularly important in healthcare markets, where excessive or poorly designed regulation may divert resources away from patient care, deter innovation and reduce providers' ability to respond to consumer needs.

5.27 We have received evidence that the level and nature of the existing regulatory frameworks may result in operational burdens and challenges for dental practices, which may be acting as a barrier to entry and expansion and innovation.

5.28 The Revealing Reality research indicates that many dental professionals perceive the sector as highly regulated, with compliance processes (eg record keeping and inspection preparation) often seen as time-consuming and resource-intensive.[356] Although some dental professionals recognised the necessity of some regulation to protect the public and ensure high standards of care, a small number felt it would be beneficial to place more emphasis on the quality of treatment rather than practice requirements.[357]

[356] Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations, section 7.1.1.
[357] Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations, section 7.1.1.

5.29 Among those who had a view, GDC Standards and the relevant national care quality standards were seen as complementary,[358] but small number of professionals felt there was some duplication.[359]

5.30 We have also heard that the different national care standards across the UK nations create operational challenges and compliance costs for large dental firms, particularly where such standards seek to achieve the same outcome.

5.31 We received feedback that diverging standards can increase complexities. Two of the four largest dental groups indicated that the different regulatory requirements (which could include, for example, different approaches to inspection preparations and timescales, or different clinical or operational standards across nations) increase complexity, create operational challenges for dental professionals working across multiple nations, and potentially slow the rollout of new services and investments to consumers.[360]

5.32 In addition, we heard that fulfilling regulatory requirements can slow entry or expansion. One of the four largest dental groups submitted that registration and approval timelines for care quality regulators can create uncertainty when opening new practices.[361] Another said that separate registration is required for each practice in England, regardless of a corporate group's existing compliance record, which increased administrative burden.[362] We also heard that CQC registration processes can take up to 16 weeks to complete, adding delays.[363]

5.33 In summary, providers have told us that they perceive the existing regulatory framework to be complex, costly and resource-intensive to navigate. Providers also perceive this complexity as a barrier to entry and expansion.

5.34 Clearly, regulation of dental services exists to set and uphold appropriate professional standards and to ensure clinical care quality. These are crucial objectives for patient safety and wider trust in the dental professional. However, when viewed alongside the impact on information transparency and informed choice for consumers, the evidence points to a regulatory system which could work more effectively to provide sufficiently clear and effective consumer

[358] Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations, section 7.1.4.
[359] For example, one dental professional observed different continued professional development ('CPD') requirements from the CQC and the GDC, and queried whether this was a good use of clinician time. Another dental professional noted that a practice could be subject to inspections by multiple bodies (such as NHS England, the CQC or the GDC) and queried whether this resulted in overlaps. See: Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations, section 7.1.4.
[360] Response to the CMA's information request: [✂]; Note of meeting with [✂]; Submission to the CMA: [✂]; Note of roundtable with dental groups, 08/07/26, [✂].
[361] Response to the CMA's information request: [✂].
[362] Responses to the CMA's information requests: [✂].
[363] Note of roundtable with dental groups, 08/07/26, [✂]; Note of meeting with [✂].

protection in some areas, without imposing unnecessary regulatory complexity and burden.

Impact of the existing regulatory framework on consumers' access to complaints and redress routes

5.35 Effective complaints procedures are an important part of ensuring good consumer outcomes in healthcare markets. They provide patients with a clear route to raise concerns, seek redress where appropriate, and help resolve issues when things go wrong. Effective complaints systems can also support accountability and service improvement, by helping providers identify recurring problems and areas where standards may need to improve. This can strengthen consumer confidence and contribute to higher-quality care across the sector.

Complaint routes available to consumers

5.36 Complaint routes differ depending on the type of treatment received, but they can generally be summarised as follows:

(a) In relation to private treatment:

(i) complaints can be raised with the dental practice and resolved locally. If the consumer is not satisfied, they can raise a complaint with the Dental Complaints Service (DCS) (as described in Appendix B).[364]

(ii) patients can provide intelligence to the GDC to initiate FtP proceedings, if they consider a dental professional is causing significant harm to patients, the public or colleagues, or if they are undermining confidence in the dental profession; or they can provide intelligence about poor care or service to health inspectorates, although most health inspectorates do not investigate individual complaints.[365] Neither of these routes are likely to result in direct redress.

(b) In relation to NHS treatment: Consumers can raise complaints about NHS dental treatment through their dental practice, with support available from organisations such as Healthwatch.[366] Formal complaints arrangements vary across the four nations, but patients may also be able to escalate concerns to

[364] See: DCS 'https://dcs.gdc-uk.org/' accessed 07/09/26.
[365] See: Care Quality Commission (CQC) 'Complain about a GP, dentist or eye care - Care Quality Commission' accessed 07/09/26; Healthcare Inspectorate Wales (HIS) 'Concerns and Complaints about Health Services in Wales' pages 5 – 6, accessed 07/09/26; Regulation and Quality Improvement Authority (RQIA) 'Raise a Concern about Health and Social Care Service | Regulation and Quality Improvement Authority' accessed 07/09/26; Appendix H: Regulatory framework; Table H.1.
[366] Local Healthwatch bodies may direct consumers to, for example, specific bodies who can assist with their NHS complaint and advocacy bodies who can provide assistance. Healthwatch 'Help to make a complaint | Healthwatch' accessed 14/09/26.

the relevant care or health board.[367] Where a complaint remains unresolved, it may be referred to the relevant Ombudsman, which provides the final stage of the NHS complaints process.[368]

5.37 Consumers can also take private legal action against a dental professional or business to seek redress.

5.38 Dental professionals are legally required to have indemnity arrangements in place to practise dentistry, allowing patients to claim compensation where they may have an entitlement. There are a range of different policies available in the UK, which can include personal indemnity cover, commercial insurance products, and schemes provided by employers.[369]

Barriers to making complaints and obtaining redress

5.39 As explained in Chapter 3, consumers rarely complain about their dental treatment. This low level of complaints may partly reflect barriers within, or perceptions of, the complaints process, including lack of information about the complaints process or a lack of confidence in the outcome.

Lack of information

5.40 The evidence we have gathered points to there being a lack of information about how to lodge a complaint with some dental practices and how to escalate complaints beyond the practice. The Verian research found that of those who considered making a complaint but did not (6%), 36% said they didn't know how, and 27% said they did not know who to complain to.[370] A recent Which? poll asked 1,009 consumers who had an issue with their dental treatment about their experiences making a complaint. Though this poll was not a representative sample of dental consumers, it found that of the 62% of consumers who did not complain, 19% considered that process would be too time consuming and 15% that the process was too complicated.[371]

5.41 Information on how to complain may not always be easily available to consumers. Around 35% of the practice websites we reviewed did not appear to explain how to make a complaint.[372] Of the websites in our review that provided complaints information (about 65%), the most commonly occurring routes were submitting complaints by telephone (about 81%), in person (about 72%) by email (about

[367] See Appendix H: Regulatory framework; Table H.1 for information on the arrangements in each nation.
[368] In England, the Parliamentary and Health Service Ombudsman; in Wales, the Public Services Ombudsman for Wales; in Scotland, the Scottish Public Services Ombudsman (SPSO); in Northern Ireland, the Northern Ireland Public Services Ombudsman (NIPSO); Appendix H: Regulatory framework; Table H.1.
[369] GDC (2024) 'Guidance on professional indemnity and insurance cover' p3 – p4.
[370] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, question COMPNO.
[371] Which? (2026) 'Consumer harm and complaints experience in private dentistry', p12.
[372] Appendix C: Review of dentistry websites.

69%) and by letter (about 60%).[373] Similarly, of the consumers who responded to the recent Which? poll who experienced a problem with their dental treatment but did not complain (62%), 8% said their dental practice did not provide clear information on how to complain.[374]

5.42 Consumers may also be unaware of how to escalate their complaint beyond the practice, and the remit of escalation bodies may be unclear. The Verian research found that, of the consumers who complained about their dental treatment (3%) only 12% complained to the DCS.[375] Information about the remit of the DCS or GDC may not always be easily available. Of the dental consumers who responded to the recent Which? poll who complained to their dentist but chose not to take their complaint further (91 consumers), just over a fifth (23%) said their practice did not provide information on how to take their complaint further.[376] In its most recent Dental Complaints Service Review, the DCS reported that in 2024 it received 1,259 (27%) new enquiries that were outside its remit. Of those new enquiries, over two thirds (859) were subsequently referred to an NHS or HSC body.[377]

5.43 Even some dentists appear uncertain about the complaints process. The Revealing Reality research found that almost all dental professionals reported that their practice had a complaints procedure,[378] but some had limited understanding of the process or how complaints could be escalated beyond the practice.[379]

Lack of confidence

5.44 Consumers may have low levels of confidence in complaints systems, whether or not they complained. The Verian research found that, of the 6% of consumers who considered complaining but did not, almost two thirds (64%) said the reason they did not complain was that they thought nothing would come of their complaint.[380] The recent Which? poll also found that of the consumers who experienced a problem with their dental treatment but did not and would not complain (383 respondents), 31% said they did not complain because they did not think they would be successful and 15% said there was no way to take action they felt comfortable using.[381] The Verian research found that, for those who raised a

[373] Appendix C: Review of dentistry websites; Table C.2. Multiple complaints routes are beneficial as they can provide consumers with flexibility in submitting a complaint in a way that best suits their needs.
[374] Which? (2026) 'Consumer harm and complaints experience in private dentistry', p12.
[375] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, COMPWHO (Base = n60)
[376] Which? (2026) 'Consumer harm and complaints experience in private dentistry', p19.
[377] Dental Complaints Service (2025) 'Dental Complaints Service Review 2023 and 2024' p9.
[378] Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations, section 7.3.1.
[379] Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations, section 7.3.1.
[380] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, question COMPNO (Base = n153).
[381] Which? (2026) 'Consumer harm and complaints experience in private dentistry', p12.

complaint (3%), more than a third (37%) said nothing happened as a result of their complaint, and 40% overall were dissatisfied with the outcome.[382,383]

5.45 As set out in Appendix B, the DCS reporting on case outcomes suggests that around a third of patients disengage with the DCS process or choose not to progress a complaint (although this may, in part, relate to patients not providing an update to the DCS that the matter has been resolved locally).

Limitations with existing complaints and redress mechanisms

5.46 We have identified the following limitations with the current mechanisms:

(a) Complaints handling and escalation responsibilities are spread across multiple parties, including practice managers, clinicians and indemnity providers.[384] One of the four largest dental groups told us that coordinating between parties can delay resolution and worsen consumers' experiences.[385] Escalation mechanisms, such as the DCS, generally require engagement with the individual dental professional,[386] which may create additional barriers for consumers who are worried about how their dentist may react.[387]

(b) The DCS cannot set binding recommendations, including for redress when investigating a complaint.[388] While the DCS can refer serious cases to the GDC's FtP process, this is intended to address public safety concerns, rather than secure redress in individual matters.[389] Stakeholders told us that stronger complaints-handling arrangements, including binding remedies, could improve consumer confidence in dental services.[390]

(c) The current regulatory environment does not fully support learning from complaints. While the DCS publishes periodic reports on complaints and outcomes, these provide only high-level insight into trends (in part, as so not

[382] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, question COMPRESULT (Base = n60); question COMPSAT (Base = n54).
[383] The National Centre for Social Research 2024 consumer detriment survey also identified private medical and dental services as the fifth lowest of 43 market sectors considered in relation to positive outcomes following detriment, with only 33% of positive detriment outcomes. National Centre for Social Research (2025) 'Consumer Detriment Survey 2024', p70.
[384] Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations, section 7.3.1; Responses to the CMA's information requests: [✂].
[385] Submission to the CMA: [✂].
[386] DCS 'Process' accessed 11/09/26.
[387] The Verian research found that 26% of consumers who considered making a complaint but did not were worried about their dentist would react. See: Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, question COMPNO (Base = n153).
[388] DCS 'Process' accessed 11/09/26.
[389] In 2024, the DCS referred 59 cases to the GDC under its Fitness to practise process. See: DCS (2025) 'Dental Complaints Service Review 2023 and 2024' p19. The DCS will also refer matters under FtP if a dental professional is not engaging effectively with the DCS process.
[390] Note of meeting with [✂]; Note of roundtable with consumer organisations, 02/07/26, [✂].

to identify individuals) and are based on data with some limitations.[391] Which? suggested that greater publication of information on private dental complaints could help inform best practice.[392] We have also heard that the fear of regulatory consequences may inhibit learning from complaints within the profession.[393]

(d) We have heard concerns that the lack of a direct relationship between corporate providers and clinicians' indemnity providers can contribute to delays in resolving clinical complaints. Bupa told us that indemnity providers generally act on the instructions of the individual clinician, meaning corporate providers may be unable to progress complaints where a clinician has retired, moved practice or is otherwise unengaged.[394] One of the four largest dental groups also told us that indemnity providers may favour commercial settlements, even where clinical fault is not accepted, which can make it more difficult to deliver transparent, learning-focused outcomes for patients.[395]

5.47 In markets involving provision of essential services, regulatory frameworks that discipline and constrain market outcomes need effective routes for consumers to complain and seek redress, so that providers are held accountable for failings, problems are put right and learnings are taken on board. The evidence points to a regulatory framework which is not delivering these objectives. Complaints and redress routes are complex and outcomes uncertain – patients can therefore find it difficult to understand their entitlements and rights, or where to turn when things go wrong, and lack confidence in the system. Complaints intelligence sits adjacent to rather than at the heart of regulatory prioritisation and action, and it is also not clear that the current system supports providers to deliver continual improvement informed by patient complaints.

[391] The DCS publishes a biennial service review which contains information about the types of complaints it has mediated and the outcomes of the DCS process. See: DCS 'Dental Complaints Service Review 2023 and 2024' accessed 02/10/26; see also Appendix B: Complaints in the dentistry market.
[392] Which? (2026) 'Consumer harm and complaints experience in private dentistry' p24.
[393] Note of roundtable with dental groups, 08/07/26, [✂]; Note of roundtable with independents, 01/07/26, [✂]; Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations, section 7.1.2; Response to the CMA's information request: [✂]; Note of meeting with: [✂].
[394] Bupa's response to the CMA's statement of scope, q10a.
[395] Submission to the CMA: [✂].

6. Outcomes

6.1 In previous chapters we highlighted how an increasing number of consumers rely on the private dentistry market for essential dental care. This means it is particularly important that the private market is competitive and functions well.

6.2 Our analysis to date suggests that this is not currently the case. There are both inherent barriers to effective consumer engagement and choice in this market, and barriers created by a lack of transparency, which combine to make consumer-led competition difficult to achieve. Workforce issues make it more challenging to generate stronger competition between firms, particularly on price.

6.3 The regulatory and policy framework does not offer sufficient protection, nor can it prevent commercial incentives that may not fully align with patients' interests.

6.4 We consider that this combination of conditions has a number of undesirable outcomes for consumers.

6.5 First, we find that affordability has worsened for at least some private patients in recent years, which is likely to translate into financial pressure for some and unmet need for others. Of particular concern is that around 4 million people did not go to the dentist in the past two years as they find treatment expensive. DPPs offer one route by which some patients may be helped in meeting the cost of dental care, but this is not a solution for all, and we also find that these have mixed impacts, including potentially leading to over-treatment.

6.6 Second, we see considerable variation in listed private prices within local areas. Some variation is to be expected, and likely a reflection of differences in quality. However, given what we have learned about patients' limited ability and inclination to shop around, and the material price variation that we observe, we see a risk of significant extra costs being borne by those patients unable to search for the best available price.

6.7 Third, and as discussed in Chapter 3, NHS availability varies across the UK, and not all patients can access it. We find that patients potentially pay significantly more for essential treatment if they need to seek it privately. For the eight local authority areas we have examined to date, private listed prices for essential treatment can be as much as three times the price of their closest NHS equivalent.

6.8 Fourth, we find some indication of geographic variation in the underlying concerns and outcomes across regions of England and nations of the UK, including in relation to private fees, affordability and workforce issues.

6.9 Finally, we have examined profitability to help us understand how well the market is working for patients. Our preliminary analysis shows substantial variation in margins, particularly for independents, some of which appear to be earning high

margins even after we apply a proxy to adjust for costs that are potentially missing. We are undertaking further evidence-gathering and analysis to more accurately account for these costs; assess how widespread high margins are and potential drivers, including low-cost business models; and to understand large groups' financing arrangements, including those backed by private equity. If our final analysis confirms our preliminary findings, this, alongside our wider evidence, may indicate scope to substantially improve market outcomes.

Affordability

6.10 To understand the extent of affordability concerns among patients, the Verian research asked respondents whether they were always confident that they could afford dental treatment. It found that, regardless of whether they received NHS care, private care, or a mix of both, a significant minority of consumers were not always confident of this. Affordability concerns were greatest among consumers receiving a mix of NHS and private treatment: 31% were not always confident that they could afford treatment, compared with 21% of NHS-only users and 22% of private-only users.[396]

How the affordability of private dentistry has changed over time

6.11 To examine the affordability of private dentistry, we have examined recent changes in private dental prices, comparing them against recent developments in average earnings and inflation. This allows us to gauge whether prices have become more or less affordable over time. We have only been able to do this for the prices of large dental groups that together account for approximately 15% of dental practices in the UK given the limited availability of data.[397,398]

6.12 We estimate that the four largest dental groups and other large dental groups increased the private prices of their common treatments by an average of 7% a year between 2023 and 2025. Over the same period, average weekly earnings increased by approximately 5% a year and the Consumer Price Index (CPI) by 3% a year.[399]

6.13 We have also assessed whether price rises have varied by ownership type. We estimate that private equity-backed large dental groups increased their common

[396] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, PAYCONF.
[397] Analysis of data from Christie & Co, Dental Market Review 2026, page 5, accessed 21/09/26.
[398] We estimate the treatments included in the analysis accounted for around 40% of the large dental groups' private revenues. This is based on treatment level revenue data from the following large dental groups: [✂]. The following large dental groups could not provide treatment level revenue data but are still included in the analysis as they provided average price estimates: [✂]. The proportion varied across groups, partly reflecting differences in the level of detail provided in their submissions. For example, some providers reported revenues using broader treatment groupings than others.
[399] The treatments included in the analysis were similar across the large dental groups, although there was some variation. For example, for all the large dental groups the data included an exam/checkup, hygiene, implant and crown. The data was at treatment level, not at SKU (stock keeping unit) level. See Appendix F: Price Analysis.

treatment prices by an average of 6% a year, and corporate large dental groups (ie excluding private equity-backed groups) by an average of 9% a year, but note that this is based on data from only four corporate groups.

6.14 Prices at the large dental groups covered by our analysis therefore rose faster than average earnings and inflation, suggesting private dental treatments have become more expensive in real terms and less affordable for patients of those groups.[400,401]

6.15 Internal documents from some of the four largest dental groups are consistent with our pricing analysis and refer to significant above-inflation price increases. Some documents also indicate that consumers' willingness to pay (WTP) and competitors' prices informed price setting (see Chapter 4).

6.16 As a cross-check on our pricing analysis, and to learn more about smaller firms' pricing, we have also looked at the evolution of the prices of DPPs. In particular, we looked at evidence from a DPP provider that covers a large number of dental practices. We consider this evidence provides a good indication of pricing trends in the UK. This evidence shows that the four largest dental groups have increased the price of the provider's most common DPPs by 9% per year on average between 2021 and 2025,[402] compared with 5% for the other dental groups and 6% for independents. Over the same period, both average weekly earnings and the CPI increased by an average of 6% per year.[403] While this data only covers DPPs that include routine examinations and hygiene appointments, it provides further evidence that the four largest dental groups' prices have increased faster than both average weekly earnings and inflation in recent years.

6.17 Due to the challenges in obtaining responses from smaller firms and collecting more comprehensive pricing data from them,[404] the evidence for smaller firms is more limited. We were therefore unable to assess robustly how affordability may have changed across the private dentistry market as a whole. However:

(a) Data from a sample of small to mid-size dental groups and independents, covering pricing for a white filling and teeth whitening, suggests that between 2023 and 2025 prices for a white filling increased, on average, faster than

[400] This could include customers on working-age state benefits who cannot access NHS dentistry. As working-age benefits have historically risen in line with CPI inflation, price rises above CPI inflation at the larger groups would adversely affect the affordability of dentistry for such customers.
[401] The evidence and our analysis do not identify differences in price changes between UK nations or regions, so we are not able to estimate whether prices at these large dental groups rose more in some nations or regions than in others.
[402] The average annual price change was [✂]% for Bupa, [✂]% for mydentist, [✂]% for Portman Dentex, and [✂]% for Rodericks.
[403] See Appendix F: Price Analysis for further discussion of the DPP provider's evidence.
[404] While we were able to collect data from the vast majority of large dental groups, we were unable to collect evidence from a representative sample of small to mid-size dental groups and independents due to challenges in obtaining responses from these smaller firms. To limit the information-gathering burden on small to mid-size dental groups and independents, we limited our request to two treatments. As we obtained price data from a relatively small proportion of the small to mid-size dental groups and independents in the market, the results should be considered as indicative.

both inflation and average weekly earnings, suggestive of worsening affordability, while the price of teeth whitening increased broadly in line with earnings but above inflation.[405]

(b) The evidence from a DPP provider described above indicates that many independents and small to mid-size dental groups have increased the price of their most common DPPs by less than the four largest dental groups and broadly in line with average weekly earnings and inflation. However, this data only covers DPPs that include routine examinations and hygiene appointments.

(c) Evidence from an insurance provider, myTribe, the BDA and the ONS, considered in Appendix F, is also inconclusive on whether private dentistry costs increased by more or less than average weekly earnings. For example, the BDA submitted that the price of private dental treatments did not keep pace with CPIH[406] between 2021 and 2025, resulting in an estimated real-term decline in prices of approximately 8%.[407] However, we have placed limited weight on this evidence as we have found that the BDA analysis behind these estimates has significant limitations.[408]

The implications of unaffordable private dental care

6.18 We estimate that around 4 million people did not go to the dentist in the past two years as they find treatment expensive.[409] Through our engagement with consumers, we have sought to understand the impact that unaffordable private dental care has on outcomes. We have heard that concerns about cost translate into unmet need as well as financial pressure, leading consumers to delay or avoid care,[410] or to seek treatment only when it becomes urgent or an emergency.

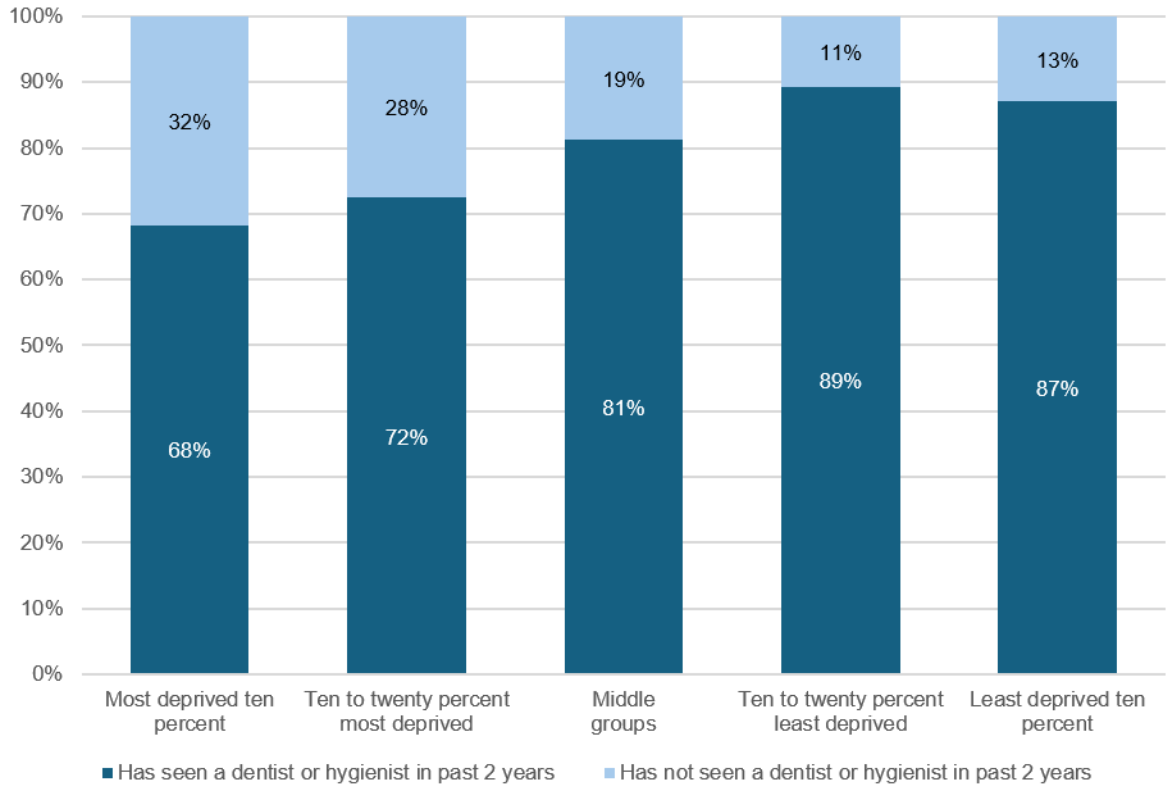
6.19 The Verian research found that 31% of consumers who did not have a regular dentist or were not registered with a dentist said they did not attend because of cost.[411] Among consumers who did have a regular dentist or were registered with a practice but had not attended in the previous two years, 37% said cost was the reason and that they try to get by without dental care as a result.[412] This can result

[405] See Appendix F: Price Analysis
[406] CPIH includes owner-occupiers' housing costs such as mortgage interest payments, council tax and maintenance and repair costs, whereas headline CPI excludes these costs.
[407] BDA's response to the CMA's Statement of Scope, page 16
[408] See Appendix F: Price Analysis for further discussion of the BDA evidence and its limitations.
[409] CMA Analysis of Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, DENTHYG2YR, NO2YEAR, NOREGWHY and ONS mid-2025 population estimates. Relates to UK adult population.
[410] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, NO2YEAR.
[411] In the Verian survey, when asking a respondent about their regular practice, we defined this as 'a practice you've been to before and expect to visit again, or one where you are registered or enrolled, even if you have not actually been for a long time'. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, NOREGWHY.
[412] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, NO2YEAR.

in poorer oral health outcomes and increase pressure on emergency services and other parts of the NHS.[413]

6.20 Financial barriers to accessing dental care may be particularly acute for some groups. There is a relationship between deprivation[414] and dentistry access: 32% of consumers from the most deprived decile reported that they had not visited a dentist or hygienist in the past two years, compared to 13% of those in the least deprived decile (see Figure 6.1).[415]

Figure 6.1: 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
Note: Verian assigned an area-based measure of deprivation to survey respondents based on their residential location, using the relevant national Indices of Multiple Deprivation

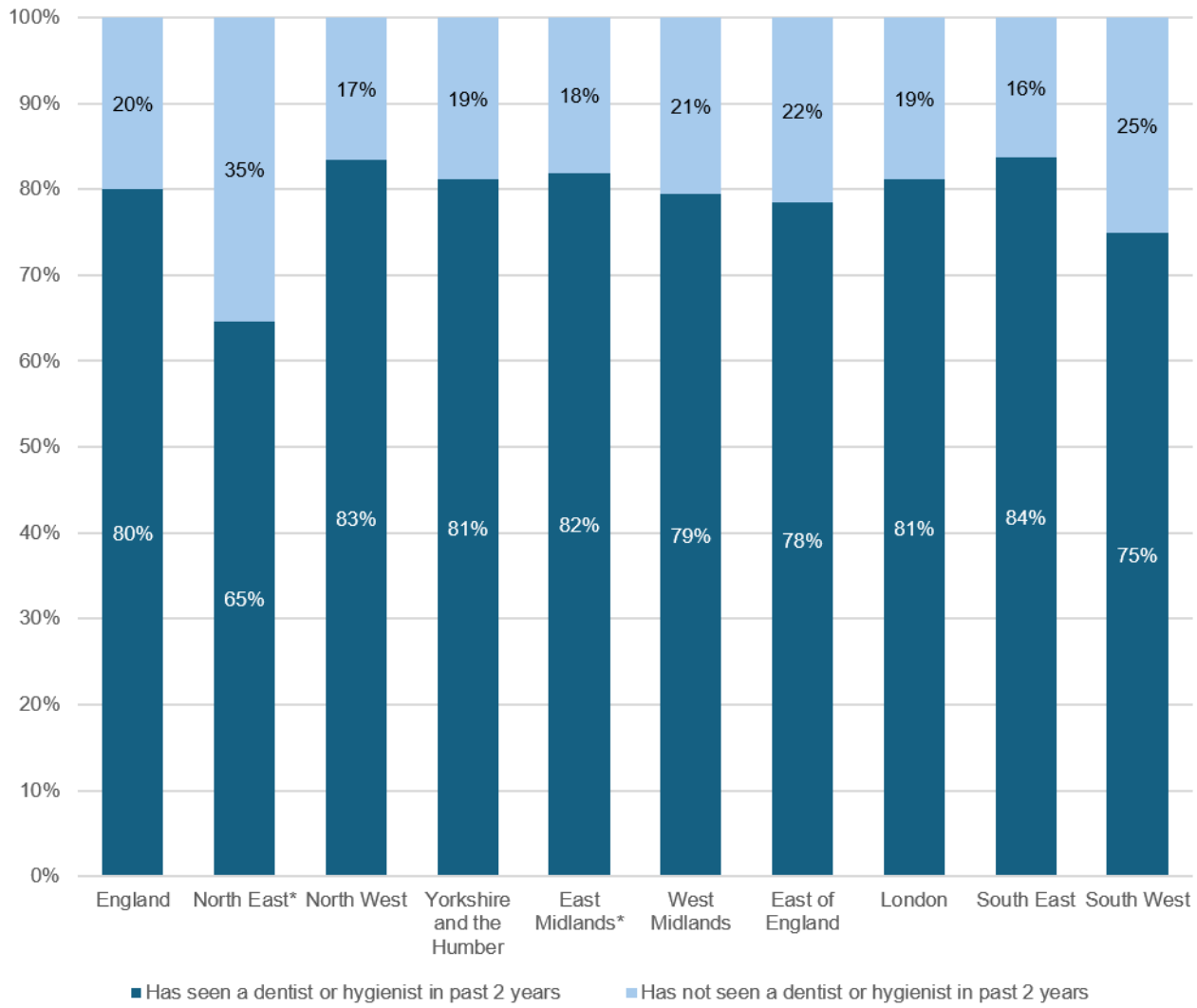
6.21 We also find differences across the regions of England, which may correlate with deprivation. For example, consumers in the North East, one of the most deprived

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[413] Younger people and those experiencing high socio-economic deprivation are more likely to require emergency dental care. Public Health England (2019), Urgent dental care: Evidence review. The Adult Oral Health Survey (2023) found that those who last visited the dentist more than 5 years ago were significantly more likely to have tooth decay, or one or more teeth with pulpal involvement (where the dental pulp is affected by decay, trauma or instrumentation) and one or more PUFA signs (PUFA is an index of the clinical consequences of dental decay). Department of Health and Social Care (2023), Adult Oral Health Survey.
The GDC's public survey report (2024) found that those struggling financially and hence with affordability were more likely to prioritise dental treatment over preventative dental care and that about 28% of those struggling with affordability expressed that they would only go to a dentist in an emergency compared with 13% of those not struggling financially. General Dental Council (2024), Views and experiences of dentistry.
[414] Using the relevant national Indices of Multiple Deprivation.
[415] CMA analysis of Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, NO2YEAR.

regions in England, were substantially less likely to report having been to a dentist or a hygienist in the last two years at 65%, compared to 80% for England overall (see Figure 6.2).[416]

Figure 6.2: Whether has been to a dentist or dental hygienist in the past 2 years, by England region



Source: CMA analysis of Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, * *indicates low base size (North East n= 66, East Midlands n= 97).*

6.22 More than three-quarters of consumers experiencing financial difficulties were not confident that they could pay for dental treatment. Consumers on state benefits were also less confident than those not receiving state benefits.[417] Consumers in Scotland were the most confident that they would be able to afford treatment with just over a third (34%) saying they are always confident, compared to 31% in

[416] CMA analysis of Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, DENTHYG2YR. Note low base size for North East (n=66)

[417] Forty-two per cent said they were not at all confident they could afford treatment, and 35% said they were not always confident. In comparison, 82% of those not experiencing difficulties felt confident they could afford it. Similarly, 38% of consumers on state benefits were confident they could afford dental treatments and 52% were not confident, compared to 69% of users not on state benefits feeling confident, and 28% not confident. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, PAYCONF.

Northern Ireland and a quarter in England and Wales (26% and 25% respectively).[418]

Dental payment plans as a way of improving affordability

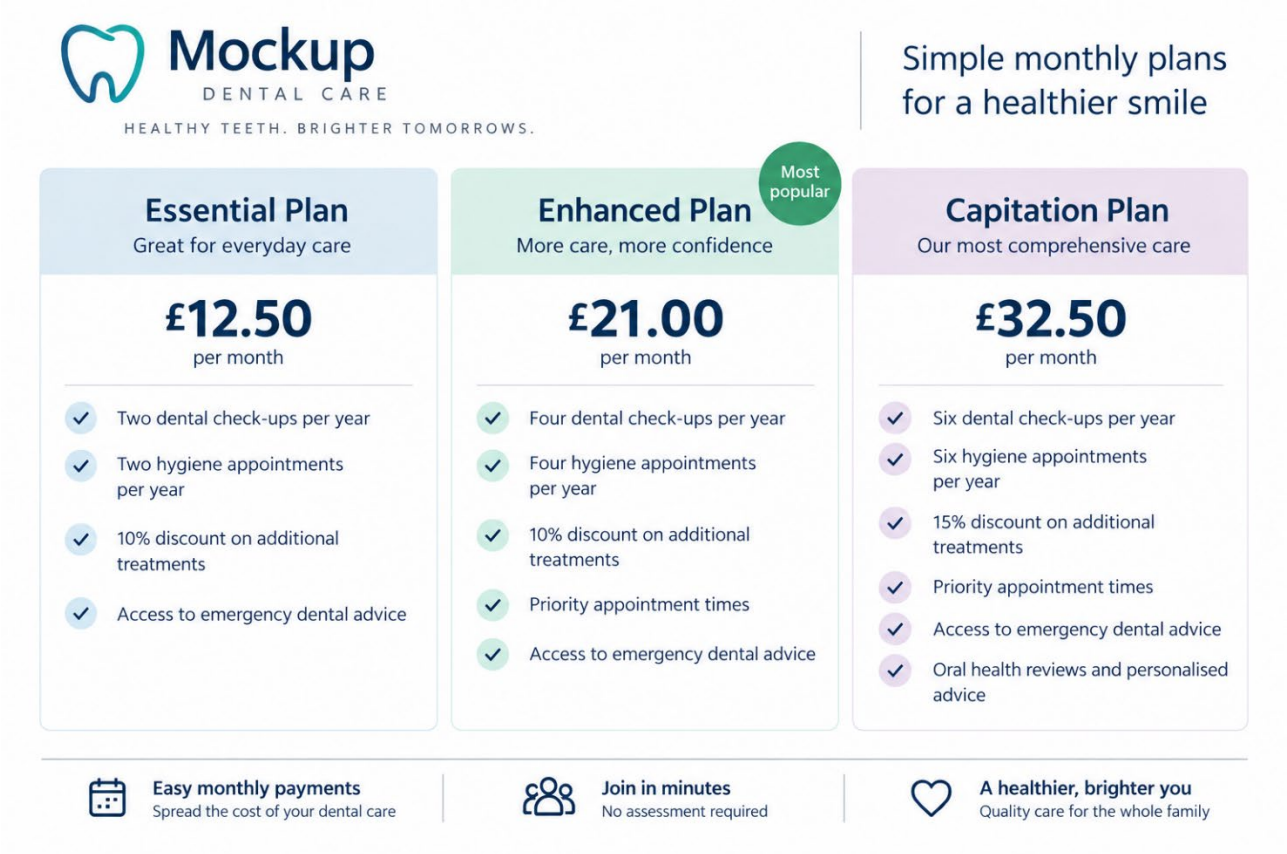
6.23 DPPs offer, in principle, a means of mitigating some of the affordability concerns. Under these agreements a consumer typically pays a set monthly amount to a practice in return for treatment (see Figure 6.3).[419] Most offer two or fewer consultations and/or two or fewer hygiene visits a year.[420]

6.24 DPPs can benefit consumers. They provide guaranteed access to preventative treatment, spread payments over time and may come with discounts on additional treatments.[421] The Verian research found that consumers on a DPP were more likely to report confidence in their ability to afford treatment, generally regarded their plan as good value,[422] and most commonly said that they had joined to spread the cost.[423] Consumer representatives also confirmed that DPPs can improve affordability and predictability for consumers.[424]

6.25 DPPs are widely offered across private dentistry. Around 65% of practice websites we reviewed offered a DPP and, of those, around 63% displayed the price.[425] Take-up of the plans appears more modest, with 14% of UK consumers reporting that they have a DPP.[426]

[418] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, PAYCONF.
[419] There are broadly three types: 'Essential' plans, which provide two or fewer consultations and/or two or fewer hygiene visits each year; 'Enhanced' plans, which provide between three and four consultations and three and four hygiene visits each year; and; 'Capitation' plans, which can include four or more consultations each year, four or more hygiene visits each year, restorative treatments and bespoke dental services.
[420] Sixty-nine per cent of DPPs are basic plans out of n=4,273; Appendix C: Review of dentistry websites.
[421] About 65% of DPPs offer a discount of 10-20% on some additional treatments, subject to exclusions. See Appendix C: Review of dentistry websites.
[422] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, PAYMETHOD_A.
[423] Thirty-five per cent of people stated this was the most comment reason. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, PAYMETHOD_A, DPLANRES.
[424] Note of roundtable with consumer organisations, 02/07/26, [✂].
[425] Sixty-six per cent of websites have DPPs and of these about 63% display price information; Appendix C: Review of dentistry websites.
[426] Reported use varies across nations: 13% in England, 12% in Scotland, 17% in Northern Ireland and 28% in Wales. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, PAYMETHOD_A.

Figure 6.3: An illustration of three types of dental payment plan



Source: Mock dental payment plan offers created by the CMA

6.26 However, we have four concerns with DPPs.

(a) First, a plan may include more appointments than a consumer needs. The National Institute for Health and Care Excellence (NICE) guidance indicates that recall intervals should reflect individual clinical need and may range from three to 24 months for adults, and three to 18 months for children. Adults who can maintain good oral health and are not at risk of oral disease may be able to attend once every 24 months.[427] Given that most DPPs offer more frequent appointments than this, there is a risk that DPPs encourage patients to have, and therefore pay for, more appointments than is clinically necessary.

(b) Second, even where the number of appointments included in the plan is appropriate, consumers may not use all the appointments included in their plan.[428] In these circumstances consumers may effectively pay for appointments that they do not use.[429]

[427] NICE Guidance, Oral and dental health, 'NICE Guidelines – Dental checks', accessed 05/08/26.
[428] Responses to the CMA's information requests: [✂].
[429] It is a consumer's responsibility to book themselves in for the treatments that they pay for via their DPP. This means that consumers may pay for treatment and not receive it. For example, if a consumer signs up for a DPP which includes

(c) Third, some DPPs may make cancellation or switching more difficult.[430] Most of those we reviewed permitted cancellation on notice, but some imposed a minimum term of 12 months.[431] Some plans offering discounts on additional treatment also required the consumer to repay the discount if the plan was cancelled.[432] Consumer organisations referred to reports of patients feeling trapped and unable to return to NHS dentistry.[433] However, Revealing Reality research also found that some practices had experienced consumers cancelling after receiving appointments or treatment provided for under the plan, with some dental professionals reporting that the practice absorbed the loss.[434]

(d) Fourth, the use of a DPP may not always be wholly voluntary. The Verian research found that one in five DPP users had signed up to the plan to continue receiving treatment and one in ten had signed up to access the practice. In Wales and Northern Ireland, more consumers report having to sign up to a DPP to receive treatment from their practice.[435] This is particularly concerning in light of the potential value-for-money and switching issues described above.[436]

6.27 Our review of internal documents from the four largest dental groups also found evidence that some firms may capitalise on the fact that consumers on DPPs tend to purchase additional treatment to try and sell them further treatments.[437]

6.28 In sum, we are concerned that, although they may help with affordability, DPPs could be leading to over-treatment in some cases; that their value for money may be reduced if all included appointments are not used; and that they may be used as an access condition or a source of lock-in, and as such, may weaken competition.

Variation of private prices within local areas

6.29 To understand how much prices for broadly equivalent treatments can vary within a local area, we have compared the lowest and highest minimum price of one simple private treatment within each of eight local authority areas – one rural and

two consultations and two hygiene visits a year, but only books or attends appointments for one consultation and two hygiene visits a year, then they will have paid for one consultation that they did not receive, underutilising their DPP.
[430] This view is supported by Which?. Which? response to the CMA's statement of scope, p5, q7.
[431] Examples of DPP initial period terms and conditions shared in response to the CMA's information request: [✂].
[432] Examples of DPP discount clawback terms and conditions shared in response to the CMA's information request: [✂].
[433] Note of roundtable with consumer organisations, 02/07/26, [✂].
[434] Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations, section 6.2.3.
[435] The proportion of consumers who reported signing up to a DPP to continue receiving treatment is 18% in England, 28% in Scotland, 36% in Northern Ireland and 40% in Wales. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, DPLANRES.
[436] Which? response to the CMA's statement of scope, p5, q7.
[437] Responses to the CMA's information requests: [✂].

one urban local area in each UK nation. We gathered this price data through our review of dentistry websites.[438,439]

Table 6.1: Price variation for selected treatments in the eight locations analysed

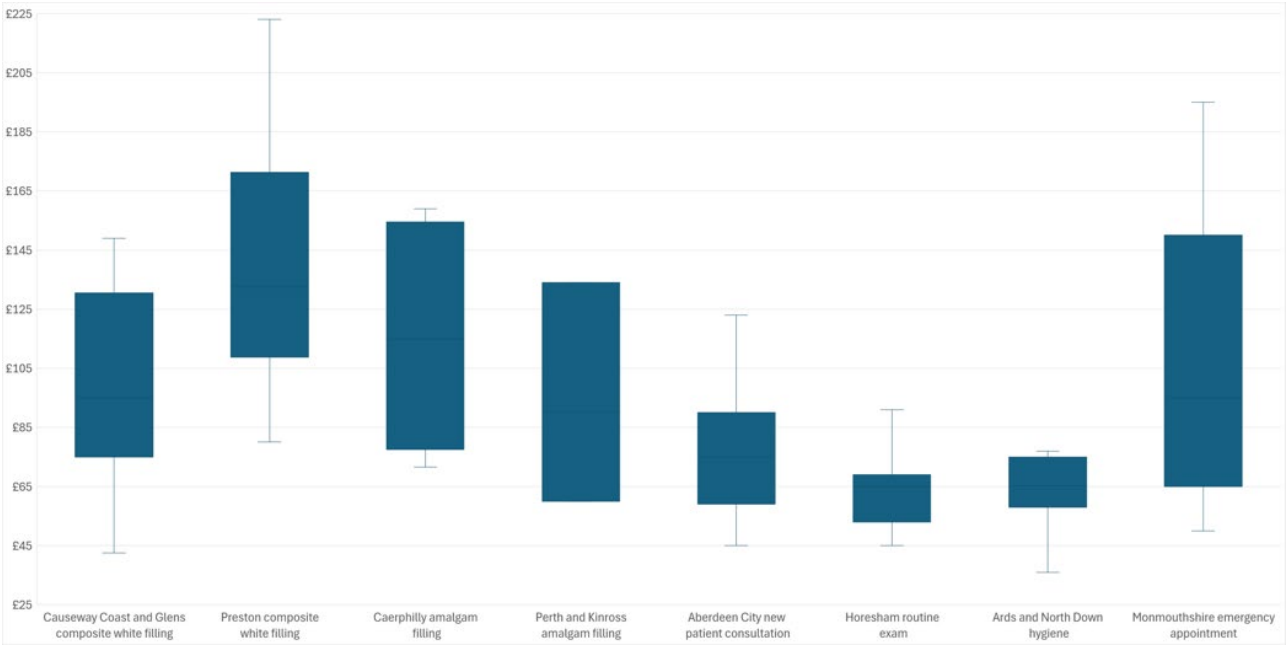
Location	*Nation*	*Urban / Rural*	*Treatment*	*Lowest minimum price (£)*	*Highest minimum price (£)*	*Difference (£)*	*Difference relative to the lowest minimum price (%)*
Aberdeen City	Scotland	Urban	New patient consultation	45	123	78	173
Perth and Kinross	Scotland	Rural	Amalgam filling	60	134	74	123
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

6.30 As shown in Table 6.1 above our analysis has found material price variation for the same treatments offered privately within the eight local authority areas.[440,441] For example, listed prices for a composite white filling ranged from £43 to £149 in Causeway Coast and Glens and from £80 to £223 in Preston.[442] New-patient consultation prices ranged from £45 to £123 in Aberdeen City, and amalgam filling prices from £72 to £159 in Caerphilly.[443] As shown in Figure 6.4 below the finding of significant price variation remains robust when looking at the interquartile range as opposed to minimum and maximum prices, although the degree of variation is reduced.[444]

[438] For further details on our analysis of private prices gathered through the review of websites exercise and its limitations see Appendix C: Review of dentistry websites, Price Variation analysis, section 'Implications of patients needing to access private care' below and section 'Variation in private fees and their affordability for essential dental care across the UK' below.
[439] Our analysis is limited to a few individual treatments in eight locations, and does not cover a basket of treatments for each dental practice.
[440] We assessed the price variation of relatively simple treatments (new patient consultation, routine exam, emergency appointment, amalgam filling, composite white filling, and hygiene).
[441] We note that differences in the quality of service or other quality differences may explain some of the price variation we observe. For example, in Monmouthshire the highest price practice offered free refreshments, Wi-Fi and on-site parking.
[442] We note the rural locations we analysed are significantly larger in area than the urban ones. In those rural locations, the distance between the lowest and highest price practices was significant (eg around 20 miles in Causeway Coast and Glens). For some consumers not willing or able to travel, these practices may not represent alternative options to each other.
[443] For more see: Appendix C: Review of dentistry websites, Analysis of list prices within eight local areas.
[444] Perth and Kinross had only three observations, and hence the boxplot should be interpreted with caution, but is included for completeness.

Figure 6.4: Box plot of price variation for selected treatments in the eight locations analysed



Source: CMA analysis of website review data

6.31 We recognise our data provides only a partial and indicative view of the true pricing situation in those areas (since not all practices were included in our dataset or have online pricing information). However, to the extent that our analysis excludes practices with lower or higher minimum prices than those we identified in a given local authority area, the inclusion of such practices would only increase the difference between the lowest and highest minimum prices in that area. Our price variation estimates are therefore conservative and even on this basis we have found material price variation within local areas.[445]

6.32 The following example from the Verian research illustrates the extent to which prices can vary locally and the potential benefits of comparing prices.

Case study: Consumer experience of price variation

Peter [not his real name] is in his 70s and lives with his wife in a town in Northern Ireland. Peter has been with the same dentist for around twenty years and with the practice even longer. Peter and his wife initially joined as NHS patients but received a letter from the practice explaining their dentist would be moving to private provision. They decided to stay with the dentist as private patients (without looking elsewhere). Peter joined the practice's dental plan and considered this good value.

[445] Our analysis also used listed prices, not necessarily the prices paid, and some include 'from' prices or a price range rather than fixed prices. This means our evidence of price variation indicates potential savings for some consumers (those where the final price paid would be based on the list price) and not others (those paying more than the 'from' price due to them needing a more costly treatment, for example a larger filling). For further details on our analysis of private prices gathered through the review of websites exercise and its limitations see Appendix C: Review of dentistry websites, Price Variation analysis, section 'Implications of patients needing to access private care' below and section 'Variation in private fees and their affordability for essential dental care across the UK' below.

He feels that the transition to private provision has not had a significant impact on him but notes that though prices are higher for check-up and minor treatments they remained affordable and that he has access to earlier appointment dates. Peter recently had more complex treatments – extraction, crowns and bridges – and he was shocked at the cost of some of these treatments. He also learned that friends with other dentists have paid significantly less for similar treatments. He paid £1,350 for bridges including a 10% discount for the dental plan but, asking around, has found out that friends have paid £300 - £500 less for similar work in other practices nearby and have been happy with the results. He is concerned about being overcharged and confused at how prices can vary so much.

"It seems strange that it can be so different, for what I assume is basically the same work and materials. How one place is charging that much [£1,350], and somewhere else less than a grand it doesn't make sense."

Source: Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, chapter 6.

6.33 Independent analysis published by the insurance comparison company myTribe also found significant price variation within five-mile local areas it examined. Its analysis indicates that a routine examination was typically £64 in Manchester and £53 in Leicester, but could cost up to £94 and £82 respectively in each city. It also reported UK-wide differences for eight common treatments, finding, for example, potential price differences of up to £890 for a single implant. Like ours, its analysis was subject to limitations, including that it covered advertised rather than realised prices and did not adjust for treatment content or quality.[446,447]

6.34 Some variation in prices at a local level is to be expected; the quality of services being offered may vary in material ways, and we would expect this to be reflected in prices. Our further investigation of the characteristics of the practices in our sample has identified examples of such quality differences, including some practices offering free Wi-Fi or on-site parking.

6.35 However, from the variation we observe, combined with what we have found about consumers' limited ability, inclination and incentive to shop around for private dental treatment,[448] we see a risk of significant extra costs being borne by those patients unable to search for the best available price.

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[446] myTribe, How much does private dental treatment cost in 2026?, accessed 08/09/26.
[447] myTribe submitted its analysis has a number of limitations and caveats. For example: its analysis only includes the prices of practices for which it could obtain prices; the prices analysed are those dental practices advertised, not those that customers paid; and the prices are not adjusted to reflect what a treatment includes or differences in quality. See submission to the CMA: [✂].
[448] Some consumers (17%) who switched in the last two years and reported not comparing practices, did not compare practices because they didn't expect much difference between practices. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, question SWCOMPNO, caution low base size. Consumers do not consider competitive prices as one of the top criteria for choosing a practice, as only 6% of UK consumers selected price as a main reason for choosing their dental practice. Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey. Research, question PRACCHOICE.

Implications of patients needing to access private care

6.36 In Chapter 3, we showed how access to NHS treatment can be challenging, including for lower-income groups. To understand the impact of these access difficulties, we have estimated the additional cost associated with having to access private dental care for essential treatment, relative to the price of the most comparable NHS treatment, utilising the same pricing data analysed in section 'Variation of private prices within local areas' above.

6.37 Our analysis (shown in Table 6.2 below) indicates that generally the lowest minimum listed price for a given private treatment is significantly higher than the price of the most comparable NHS treatment.[449]

Table 6.2: Lowest minimum listed private prices compared to the equivalent NHS price for select locations and treatments

Location	*Nation*	*Urban / Rural*	*Treatment*	*Lowest minimum private price (£)*	*NHS price (£)*	*Difference (£)*	*Difference relative to NHS price (%)*
Aberdeen City	Scotland	Urban	New patient consultation	45.00	0.00	45.00	NA
Perth and Kinross	Scotland	Rural	Amalgam filling	60.00	14.00	46.00	329
Ards and North Down	Northern Ireland	Urban	Hygiene	36.00	14.46	21.54	149
Causeway Coast and Glens	Northern Ireland	Rural	Composite white filling	42.50	12.05	30.45	253
Caerphilly	Wales	Urban	Amalgam filling	71.50	36.03	35.47	98
Monmouthshire	Wales	Rural	Emergency appointment	50.00	37.50	12.50	33
Preston	England	Urban	Composite white filling	80.00	76.60	3.40	4
Horsham	England	Rural	Routine exam	45.00	27.90	17.10	61

Source: CMA analysis of website review data and data from: Receiving NHS dental treatment in Scotland, Dental treatment | NHS inform, accessed 23/09/26; Northern Ireland Statement of Dental Remuneration 2026, Northern-Ireland-Statement-of-Dental-Remuneration-2025-26-FINAL.pdf, accessed 23/09/26; NHS dental charges and exemptions, NHS dental charges and exemptions | GOV.WALES, accessed 23/09/26; How much NHS dental treatment costs, How much NHS dental treatment costs - NHS, accessed 23/09/26.

Notes: Perth and Kinross had only three observations of the private fees of an amalgam filling but is included for completeness and, such, its results should be interpreted with caution. In Causeway Coast and Glens and in Preston, we have compared the private price of a white filling with the NHS cost of a filling; typically, the NHS use amalgam fillings, unless it is clinically necessary for the patient to have a white one. In Northern Ireland, the NHS prices included in the table are the minimum prices a customer may pay for a treatment; if the treatment is more complex or requires multiple visits, then the price may be higher. In Scotland, patients pay 80% of the cost of private treatments; the charge patients pay for NHS treatments is capped at £384 for the course of a treatment, meaning that a patient will never pay more than this.

6.38 Our analysis highlights that costs for dental care can be significantly higher if NHS services are unavailable or difficult to access. For example, in Horsham, a routine exam was listed from £45 privately, compared with an NHS patient charge of

[449] Our findings should be seen as illustrative and not as representative of what prices are like in each of the nations, and they should not be used to compare prices across nations. We have considered lowest minimum private prices. These were listed prices, not necessarily the prices paid, and some include 'from' prices or a price range rather than fixed prices. Across our whole website review, the proportion of websites with price information that listed 'from' prices and fixed prices varied by treatment. For example, 17% of websites had a 'from' price for a new patient consultation, compared with 77% for composite fillings. For further information see Appendix C: Review of dentistry websites, Table C.1. We note a recent news article refers to analysis conducted by the insurance comparison website myTribe indicating that the typical 'from' price for most treatments is higher than the typical price at practices that list a fixed price (Private dentists' misleading pricing exposed after 'collapse in NHS provision' - The Mirror, accessed 20/11/26). We understand this analysis is based on the same myTribe dataset discussed in the next section.

£27.90, and Ards and North Down a hygiene appointment was listed from £36 privately, compared with an NHS patient charge of £14.46.

6.39 A significant proportion of patients have had difficulty in accessing NHS services and are therefore paying more for private dental care. Over a third of respondents (36%) to an external survey reported that the lack of NHS availability had led them to seek private treatment.[450] Further, of the 20% of respondents in the Verian research that have not seen a dentist or hygienist in the past 2 years, 21% said it was because they could not find an NHS dentist.[451]

6.40 The extent and nature of NHS availability varies across the UK, reflecting differences in national systems and local supply. As discussed in Chapter 3, the Verian research indicates that:

(a) the strongest presence of NHS dentistry is in Scotland, where 72% of respondents had had at least some of their dental care provided via the NHS, with 26% going fully private

(b) in Northern Ireland, 63% of people had at least some of their dental care provided through the NHS, with 35% fully privately

(c) the weakest presence was in England and Wales, with only 59% and 56% in each respective nation at least partly using the NHS, with 39% and 42% respectively going fully private.

6.41 We would expect private prices to be higher: by design, NHS prices are capped and NHS care is supported by public funds. This would likely be the case even in a competitive and well-functioning market. However, access to NHS dentistry is generally not allocated according to financial need (as explained in Chapter 2, consumers may be eligible for free or fee-paying dental care under the NHS, but they may not necessarily be able to access it). This means that the least well-off patients can find themselves with no choice but to seek private treatment, and our analysis indicates that this can cost them significantly more than the NHS equivalent.

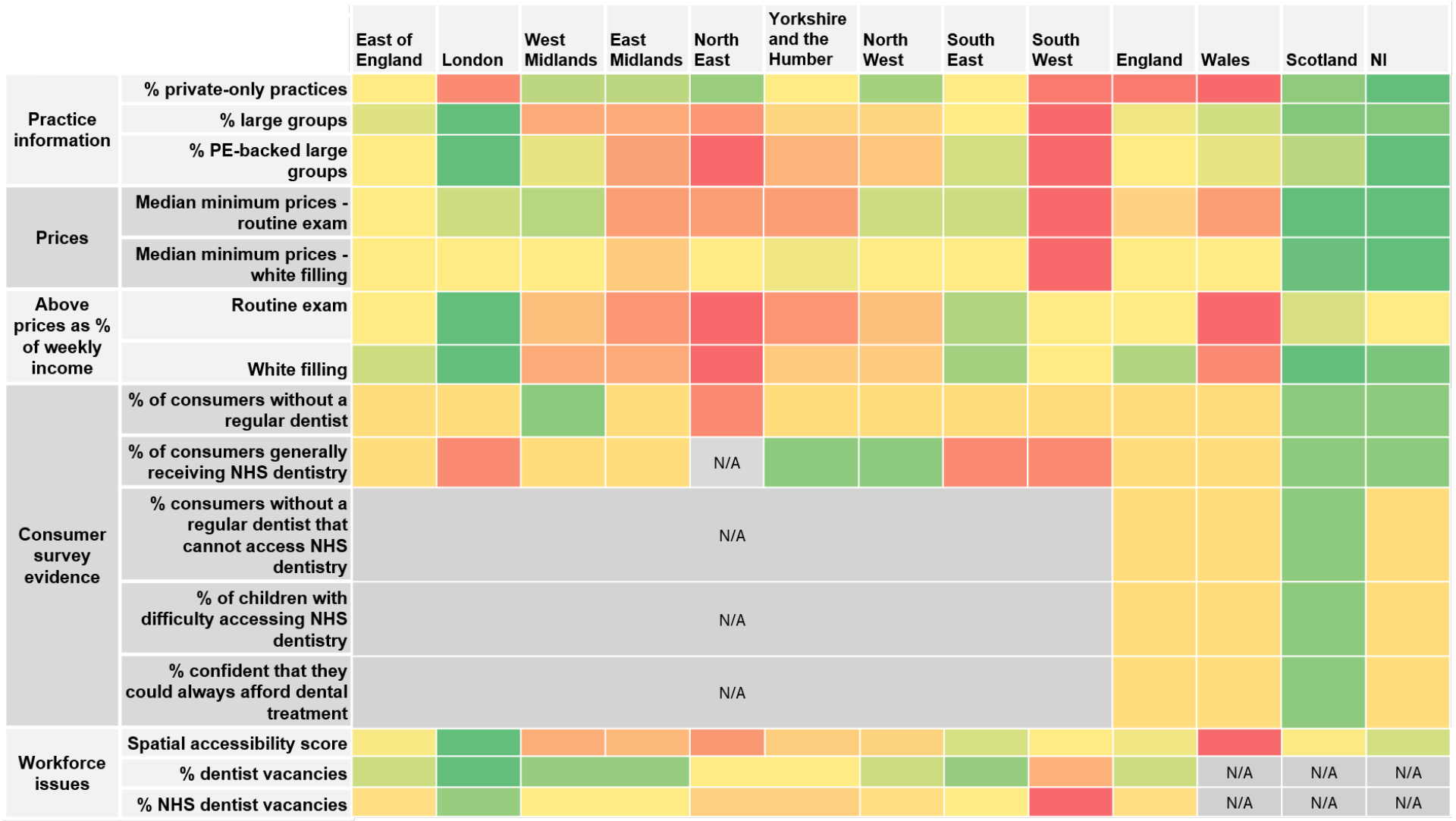
Variation in outcomes and competition across the UK

6.42 We find some indication of geographic variation in the underlying concerns and outcomes across regions of England and nations of the UK, including in relation to

[450] Research commissioned by the General Dental Council in 2024 found that people in the UK started to have private dental care because: they couldn't get NHS treatment at all (36%), they couldn't get NHS treatment quickly enough (31%), their dental practice/professional stopped offering NHS treatment (25%) or they preferred it (18%). The same research found that almost three in ten (28%) of those cutting back on essentials agreed strongly that they will only go to a dentist in an emergency, versus only 13% of those not cutting back. Figure 4: General Dental Council – Views and experiences of dentistry, accessed 20/11/26.
[451] Verian (2026) Private Dental Services Market Study Quantitative Consumer Survey Research, NO2YEAR.

private fees, affordability and workforce issues. The heat map below (Figure 6.5) illustrates this variation.

Figure 6.5: Heat map of geographic differences in dentistry provision across 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.

6.44 While there are limitations in the pricing data available,[452] private dental fees appear to be significantly lower in Scotland and Northern Ireland than elsewhere in the UK. However, prices alone do not show how affordable treatment is for patients. Comparing fees with average disposable incomes reveals even greater differences across the UK.

6.45 Private fees also appear to be lower in Scotland and Northern Ireland as a proportion of mean disposable weekly income. By contrast, fees in Wales appear less affordable compared to mean weekly disposable income.

(a) For example, the price of a composite white filling represents 35% of weekly mean disposable income in Wales compared with 20% in Scotland and 22% in Northern Ireland. [453]

(b) Wales not only has greater affordability concerns but is also the part of the UK with the greatest workforce issues.[454] As noted above, greater workforce challenges are likely to weaken competition in private dentistry.

6.46 Within England, patients in the North East and South West regions appear to face private fees that are higher relative to average disposable income and there are also greater workforce shortages.

(a) For example, prices of composite white filling represent 36% of mean disposable income in the North East and 32% in the South West compared with 20% in London.

(b) Both regions have higher dentist vacancy rates and lower scores on our measure of geographic access to dental care than London and other parts of the UK.

6.47 The reasons why private care is less affordable differ between English regions: some have higher prices, while others have lower household incomes.

(a) In the North East, private fees appear similar to those in other English regions, but average household disposable incomes are lower. Patients may therefore find private care harder to afford, even where prices are no higher than elsewhere.

(b) In the South West, by contrast, our data suggest that private fees are the highest in the UK. One possible explanation is that practices target higher-income patients in a region with higher mean disposable incomes. However,

[452] As set out in the next section, our analysis gives an indicative view of geographic differences in prices since not all practices were included in our dataset or had online pricing information for us to draw on.
[453] This analysis is based on the minimum prices published for a composite white filling at each practice and taking the median of these prices across all practices in a region in our dataset. We refer to this as the median minimum price.
[454] This is based on our spatial accessibility score metric, a measure of geographic access that reflects the number of dentists relative to the population of an area.

patients on lower incomes in this area still face these higher fees (if they cannot access NHS care.)

6.48 Access to dentistry also appears to vary across the UK. Scotland and Northern Ireland have the lowest proportion of consumers (13%) without a regular dentist in contrast to Wales and most parts of England where this proportion is around 20%. The regions in England where this proportion varies significantly from 20% are the West Midlands with 10% and, most concerning, the North East with 41%[455]. The higher proportion of consumers without a regular dentist in the North East is consistent with this being a region with greater affordability concerns and workforce issues.

Variation in private fees and their affordability for essential dental care across the UK

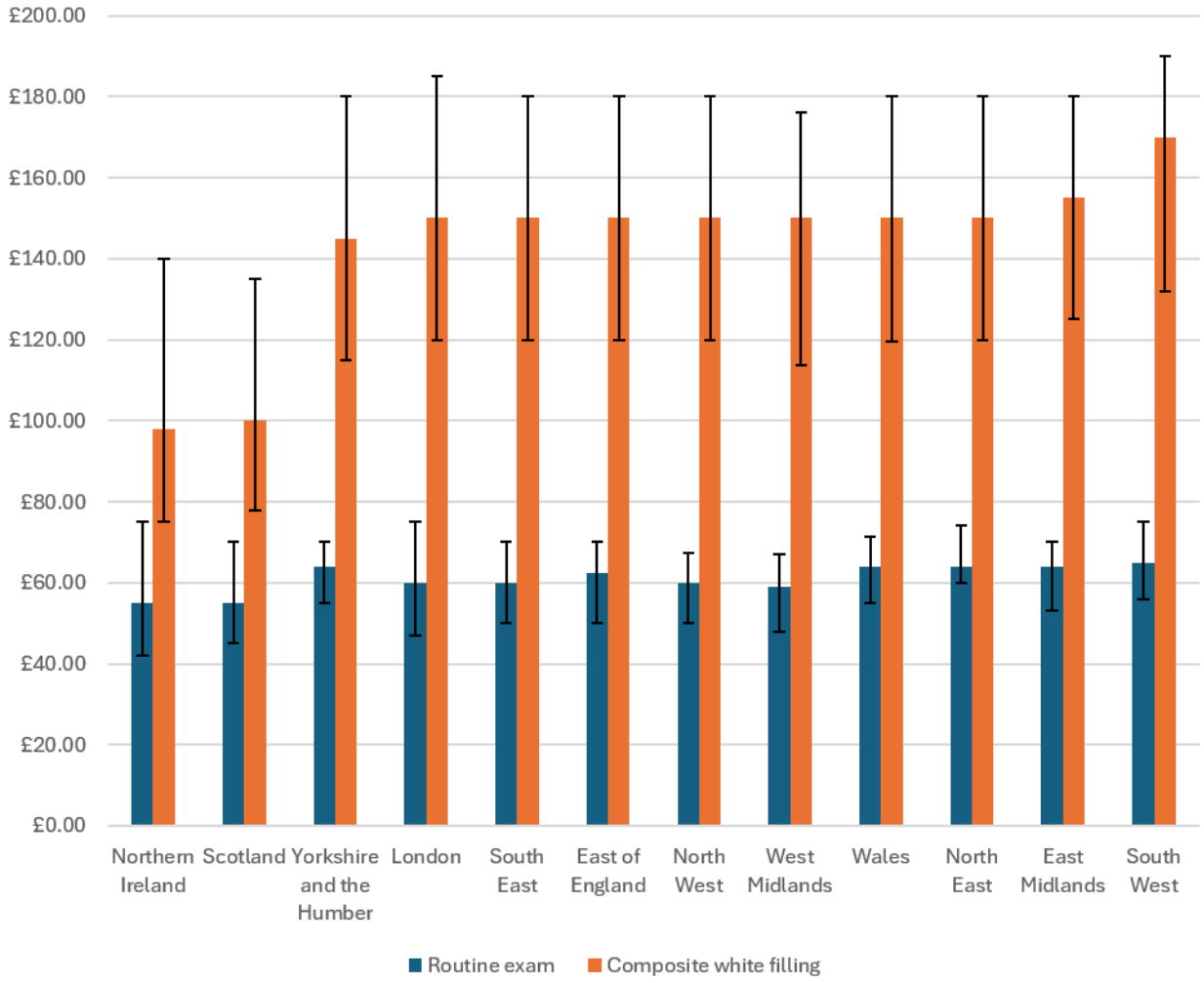
6.49 In this section we set out in more detail our analysis of geographic variation in the private fees and their affordability for essential dental care outlined in the previous section. We have used pricing data gathered via a website review exercise to compare median minimum prices in each UK nation and English region to weekly mean disposable household income per head in those places.[456] We refer to this latter measure as mean disposable income.

6.50 For each region of England, and the nations of Northern Ireland, Scotland and Wales, we have reviewed the listed private prices we were able to observe for two essential services: a routine exam and a composite white filling. We recognise that this will be an indicative view of the true pricing situation in those areas (since not all practices were included in our dataset or have online pricing information).

6.51 As shown in Figure 6.6, the median minimum prices (and interquartile ranges)[457] we were able to observe for a routine exam are broadly similar across all England regions and UK nations, with the notable exceptions of Northern Ireland and Scotland, both of which are cheaper. For a routine exam, the median minimum price in the least expensive nations, Scotland and Northern Ireland, was £10 or 15% lower than in the most expensive England region, the South West. We found greater price variation for white fillings – compared to the South West, the median minimum prices were £70 or 41% lower in Scotland and £72 or 42% lower in Northern Ireland.

[455] Note low base size (n=66)
[456] Regional gross disposable household income, UK: 1997 to 2024, Regional gross disposable household income, UK - Office for National Statistics, accessed 01/10/26.
[457] We have used interquartile ranges to illustrate the uncertainty associated with our results. The substantial variation in prices within regions and considerable overlap in the distributions of prices observed across regions mean that, while our analysis indicates where there may be regional differences in median prices, we cannot have high confidence in the level of these differences.

Figure 6.6: Median and interquartile ranges of minimum private price of a routine checkup and a composite white filling across UK nations and regions

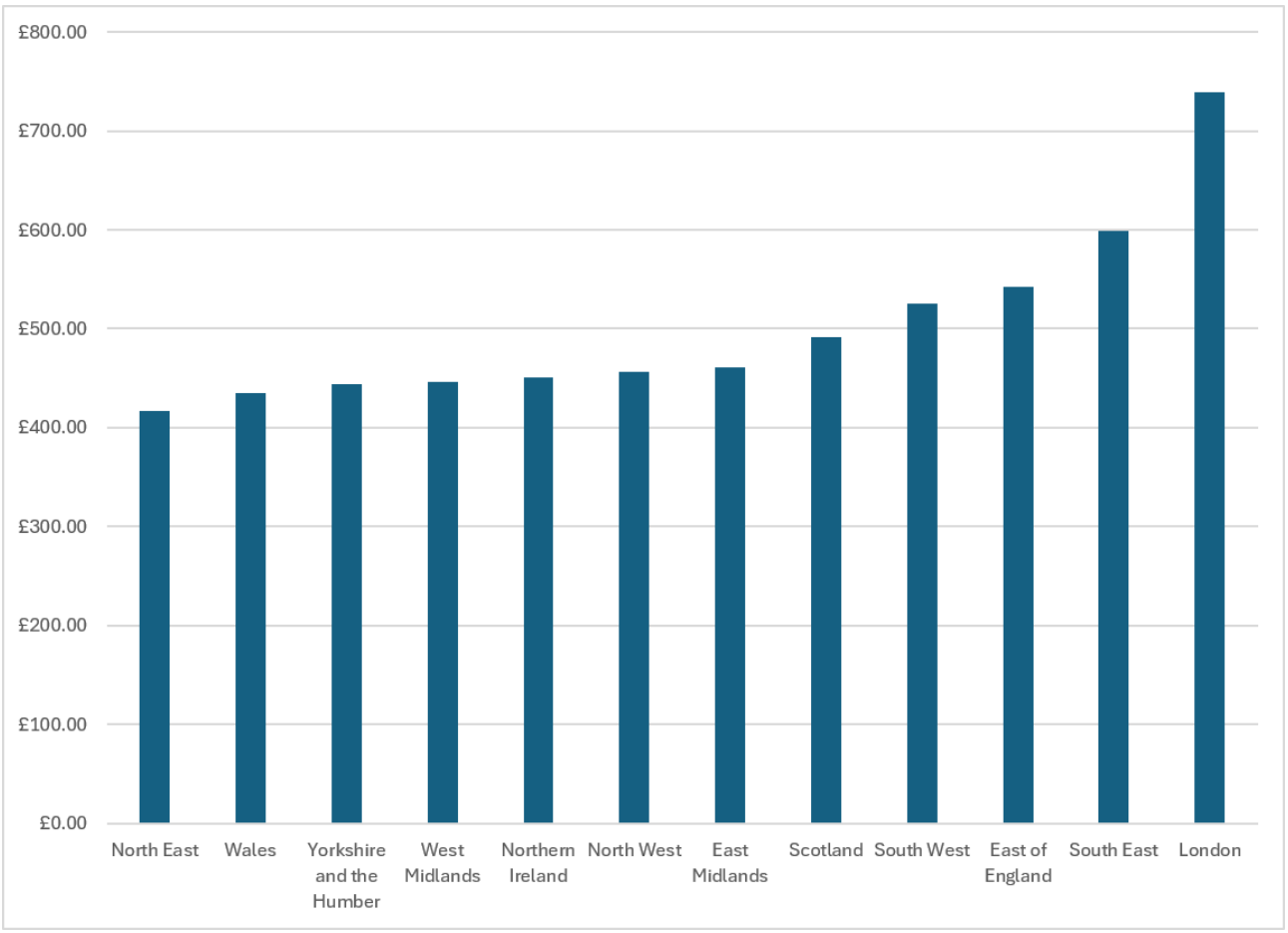


Source: CMA analysis of website review data

6.52 Some variation in prices between the England regions and nations of the UK is to be expected, given that practices' input costs will also vary across the country. Further, consumers' incomes also vary geographically, meaning a variation in prices does not necessarily imply the same variation in affordability – the variation in mean disposable incomes is shown in Figure 6.7.[458]

[458] As regional disposable income data is only available until 2024, we used the growth rate from 2024 to 2026 in national level data to uprate the 2024 regional disposable income estimates. See Appendix C: Review of dentistry websites.

Figure 6.7: Weekly mean disposable household income per head across UK nations and English regions



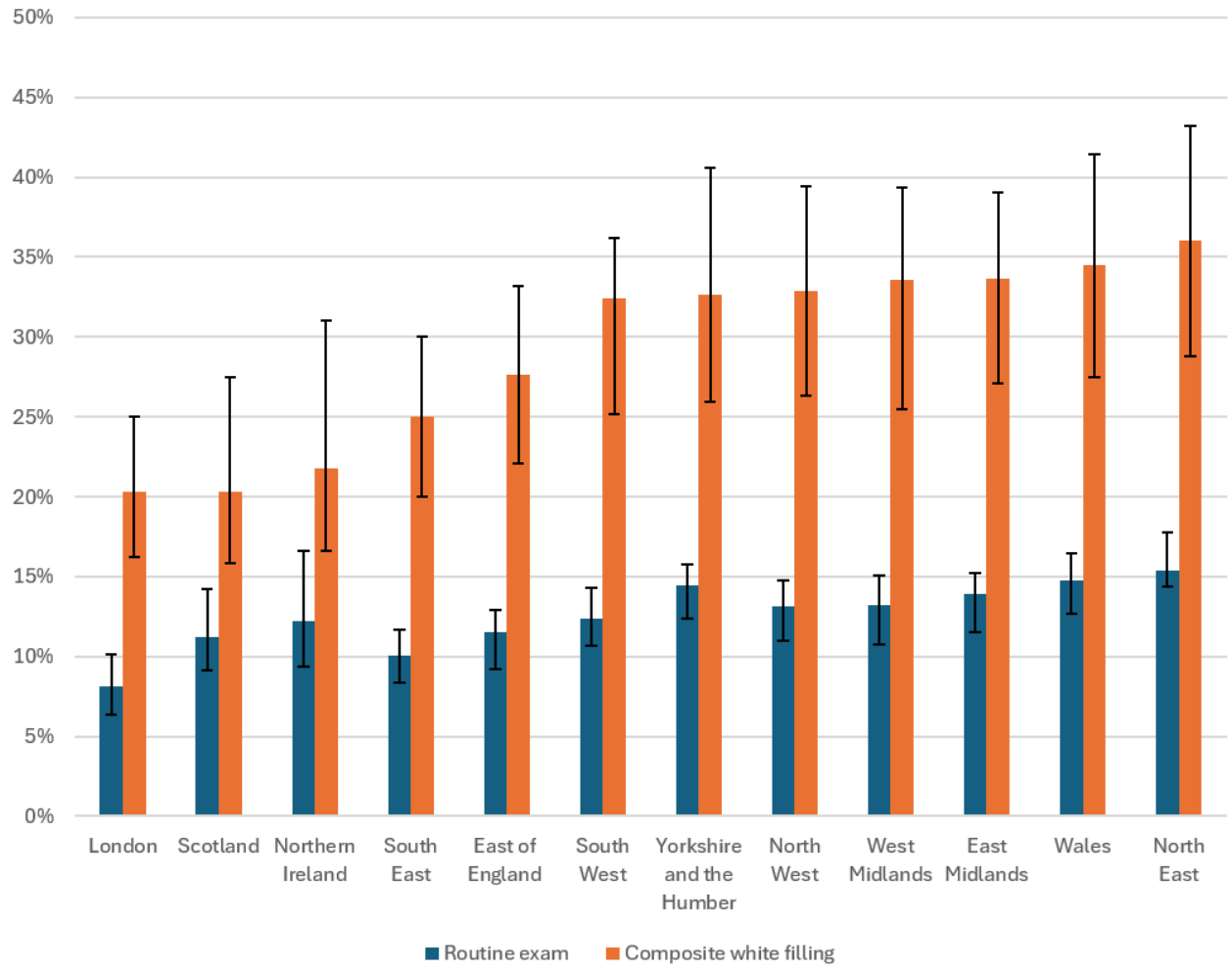
Source: CMA analysis of ONS data

6.53 To examine whether affordability varies across the UK, we have therefore expressed prices as a percentage of mean disposable income, with a higher percentage being indicative of worse affordability.

6.54 Our analysis indicates that when prices are expressed in this way, the variation across the UK increases, suggestive of varying affordability. For example, the median minimum price of a routine exam represented 15% of mean disposable income in Wales and the North East, compared to 8% in London. For a composite white filling, the median minimum price represented 35% of mean disposable income in Wales and 36% in the North East, compared with 20% in London.

6.55 For white fillings, which are substantially more expensive than routine exams, our analysis indicates the least affordable areas include the North East, Wales, the East Midlands, the West Midlands, the North West, Yorkshire and the Humber, and the South West.

Figure 6.8: Median and interquartile ranges of minimum private prices for a routine check-up and composite white filling relative to mean disposable income across UK nations and English regions



Source: CMA analysis of website review and ONS data

6.56 We have considered other evidence in relation to price variation across the country. The insurance comparison company myTribe found that the most price variation it could identify between practices occurs between practices in the same local area: within five miles of a typical practice, the highest price for an everyday treatment is typically 2.7 to 4.1 times the lowest.[459] Between-region differences, and between-local authority differences, generally both have a much smaller role. However, myTribe's analysis only compares prices in absolute terms, and not relative to incomes as in our analysis above, meaning the two analyses are not necessarily inconsistent.

6.57 MyTribe also identified that the South West is the most expensive region in the UK for private dentistry: across 68 dental treatments, the South West costs more than

[459] The 'everyday treatments' analysed include emergency appointments, root canal treatments, extractions, new patient examinations, white fillings, hygiene appointments, amalgam fillings, routine examinations and crowns. myTribe, How much does private dental treatment cost in 2026?, accessed 08/09/26.

the UK median price on 56 of them, and is the most expensive region for 27.[460] While myTribe's analysis is extensive and detailed, we note it is subject to a number of limitations and caveats (similar to the limitations of our own analysis as it is based on similar data).[461]

6.58 We consider that, although these analyses have limitations,[462] they provide some indication that the affordability of essential private dental care varies across the regions and nations of the UK.

Profitability

6.59 In our Statement of Scope, we set out that we would look at the relative profitability of providers, and of the different services they provide. In doing so in our work to date, we have focused on their earnings before interest, tax, depreciation and amortisation (EBITDA) margins, ie the profit firms make from operations, before considering non-operating costs such as funding.

6.60 Dental groups and independent firms typically have very different ownership and remuneration models, so direct financial comparisons for these types of providers should be treated with caution. We have therefore analysed these two types of providers separately.

6.61 As described earlier in Chapter 2, the private dentistry market is highly fragmented, with independent firms making up over 60% of the market and dental groups making up the rest. Dental groups generally maintain an in-house finance function, whereas independents typically rely on a mix of in-house staff for data collation and bookkeeping, as well as third-party accountants for the preparation and filing of financial accounts. We have therefore adopted a different data collection approach for each. We obtained strong data coverage for large dental groups (those with more than 30 practices), supporting the representativeness of our findings for these providers. Coverage of other dental groups and independents is less complete, reflecting the size and more fragmented nature of

[460] myTribe, How much does private dental treatment cost in 2026?, accessed 22/10/26.
[461] myTribe submitted its analysis has a number of limitations and caveats. For example: its analysis only includes the prices of practices for which it could obtain prices; the prices analysed are those dental practices advertised, not those that customers paid; and the prices are not adjusted to reflect what a treatment includes or differences in quality. See submission to the CMA: [✂].
[462] Our pricing data is not based on a representative, random or full sample of dental practices so there is uncertainty over what the actual median minimum price is in each region. The estimated coverage of our sample varies by region/nation and by treatment. It ranges between 31% and 70% for routine appointments, and between 32% and 60% for white fillings. Linked to the sampling limitation just above, our data is based only on dental practices with prices listed on their website. To the extent practices without online price lists differ systematically from those with online price lists, this may bias our results. We identified minimum prices, but differences in how practices presented their price lists and website review errors may have affected our data. This limitation is mainly relevant for our analysis in this section, where we focus on median minimum prices (and not on lowest and highest minimum prices. For each region/nation, we manually checked several of the highest and lowest minimum prices identified by the web-scraping exercise, and manually corrected any mistakes we found. However, it was not feasible to manually verify all the prices identified in every region/nation. This is further detailed in Appendix C: Review of dentistry websites, Price variation analysis. These limitations (unless otherwise stated) generally apply to all our analysis based on the review of websites exercise.

these segments, and our findings may therefore not be fully representative of these providers. We are seeking to collect further data to allow us to analyse independent margins on a more representative nature for our final report.

6.62 We found that while some firms record revenue by type of treatment (eg filling or crown) or between private or NHS treatments, they do not consistently allocate costs between types of treatments. In this context, our results are presented at a firm-level, rather than split by treatment. Further detail on data gathering and data limitations are set out in greater detail in Appendix G.[463]

Independent practice EBITDA margins

6.63 EBITDA margins vary substantially across our sample of 500 independent practices, with some reporting high margins. The indicative weighted-average margin was 30% over the last three years, declining slightly over the period. This overstates underlying profitability where owner-operator labour and property costs are not fully reflected. Using drawings as a proxy for owner-operator labour costs reduces the average margin to an indicative 16%, but this adjusted figure should be treated with caution: drawings are an imperfect proxy and introduce further comparability issues between practices. The substantial variation in margins does not appear to be explained by the balance of NHS and private revenue.

Average margins

6.64 The indicative weighted average EBITDA margin for our sample of independent practices is 30% over the last three years. However, we consider this to be an overstatement of true underlying profitability, likely to a significant degree, because the data obtained from independent practices is such that some important costs are understated, in particular: (1) property costs; and (2) labour costs.

Property costs

6.65 Whether dental practices own or lease properties is likely to have a significant impact on reported EBITDA margins. However, this is not reflective of differences in the return earned on the direct provision of dental services. Rather, it is linked with how a practice or firm has chosen to finance its assets.

6.66 We expect that properties used by independent practices will be a mix of both owned and leased properties. Where premises are owned, either outright or with a

[463] We sent detailed financial RFIs to the large dental groups, and issued voluntary questionnaires to 400 independent dental practices, aiming to receive 200 responses. However, we only received a small number of responses from independents and have therefore relied, for our independent analysis, on three years of anonymised financial data from NASDAL. While this sample of 500 independent firms represents 6% of the market, we cannot be sure it is representative of the universe of independents. Further, the 500 practices included in each year of data are not necessarily the same, and practices may move in and out of the dataset over time.

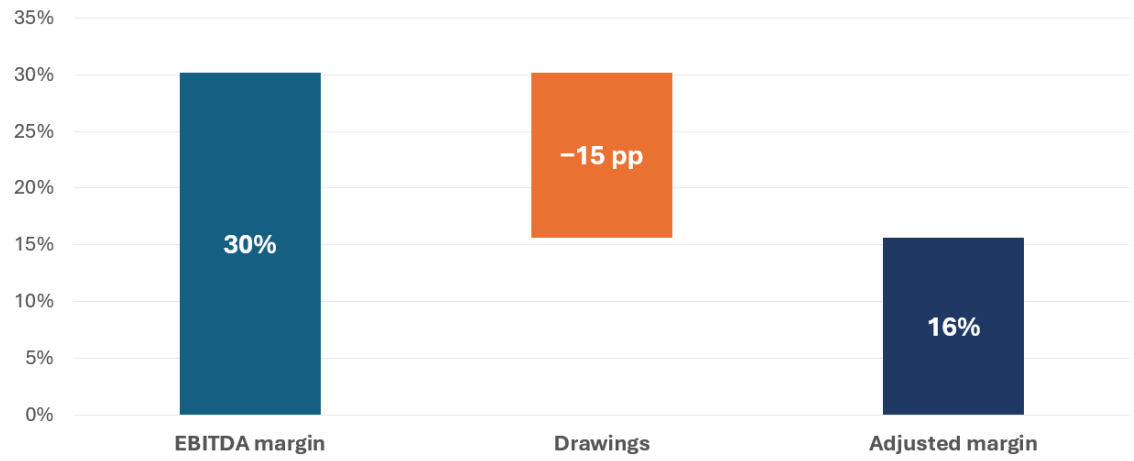
mortgage, the property costs reflected in EBITDA are likely to be lower than for leased premises, because whereas rent is deducted[464] mortgage interest and depreciation are not. The direct consequence is that margins will appear higher for practices where properties are owned not leased, even where all other elements of the profit and loss statement (including prices and other costs of the practice) are the same.

Labour costs

6.67 In independent firms, some clinical and non-clinical work is undertaken by principals who own and operate the business. Unlike associates, principals are generally not paid through revenue sharing. Instead, these owner-operators typically take some of their remuneration through dividends rather than a revenue share or salary. As shown in Figure 6.9, the indicative margin of these firms falls to 16% if we deduct drawings (which we expect to be mainly dividends, though may include some salary payments) as a proxy for the value of the clinical and administrative work undertaken by these owner-operators.

6.68 However, the amount drawn varies considerably and is not closely related to in-year profitability. In addition, owner-operators may not fully compensate themselves for their clinical and administrative work, because they can take benefits through dividends at any time, or when they eventually sell the business. The rest of our analysis therefore focuses on EBITDA.

Figure 6.9: Independent 3 year weighted average EBITDA margin and adjusted margin

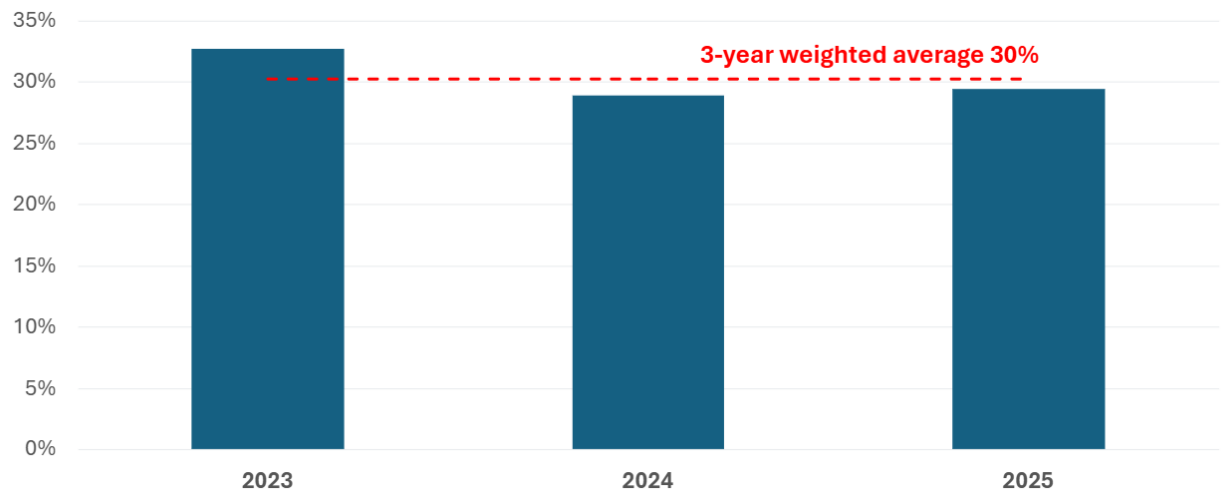


Source: CMA analysis of anonymised data provided by NASDAL.
Note: We have calculated the three-year weighted average EBITDA margin for the independent firms (30%). We have then calculated the weighted average amount of drawings included in our dataset, as a percentage of revenue (15%). We have removed 15 percentage points from the calculated EBITDA margin to obtain an adjusted margin (of 16%). These figures are necessarily an approximation because drawings can vary from year to year and may not fully reflect profits in that year. They are therefore not directly comparable between firms.

[464] Given financial accounting standards employed by these firms, and reporting period.

6.69 Figure 6.10 shows the average (unadjusted) EBITDA of the independent practices in our dataset for each of the last three years as well as the weighted average over that period.

Figure 6.10: Weighted average EBITDA margin of independent practices



Source: CMA analysis of anonymised data provided by NASDAL.

6.70 As can be seen in Figure 6.10, the weighted average EBITDA margin of independent practices declined slightly, from 33% to 29% over the three-year period, averaging 30%. However, these headline averages mask wide variation, and the data is not fully like-for like as there are some differences in the individual practices appearing in the dataset each year.

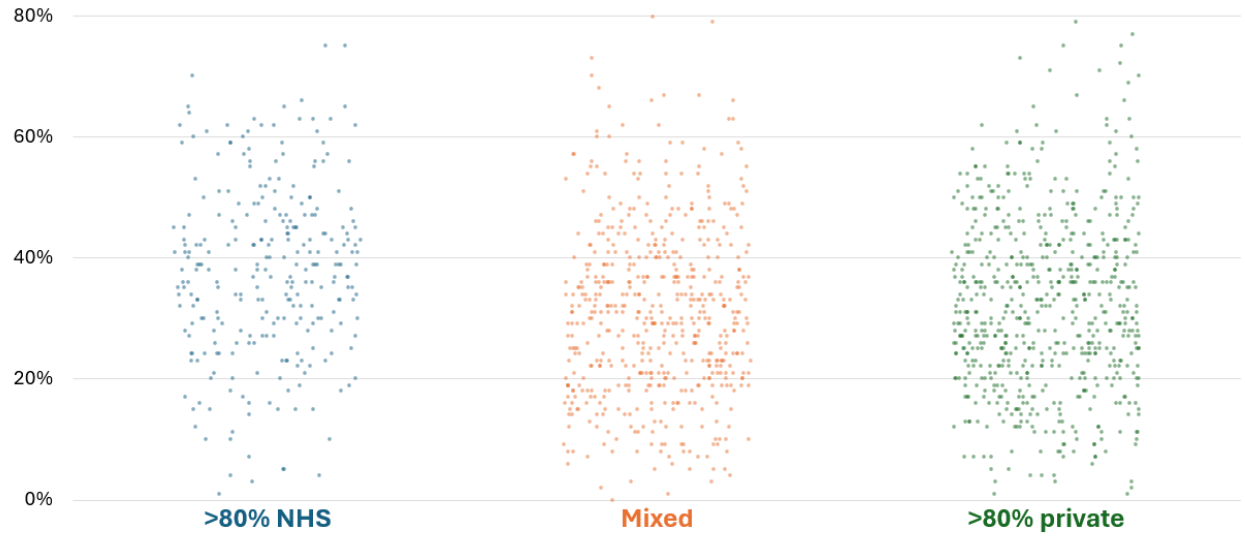
Variation in margins

6.71 Our results indicate substantial variation in independent practices' EBITDA margins, with some practices reporting very high margins relative to others. These margins will overstate underlying profitability where property and owner-operator labour costs are not fully reflected. However, even allowing for these costs, some practices still appear to be earning high margins. The variation in margins does not appear to be explained the proportion of NHS or private revenue earned by the practice.

6.72 We compared providers in our dataset that were mostly NHS focused with those focused mostly on private work. We used our dataset of independent practices, divided into three groups: those earning 80% or more from NHS funded treatment, those earning 80% or more from private treatment, and those in between. We then assessed the distribution of EBITDA as a percentage of revenue for each over the last three years.

6.73 The following chart shows how EBITDA margins varied across practices in each category. Each dot represents one practice. This tells us how much of every pound a consumer or patient pays is retained by the practice, after operating costs. The higher that proportion, the more relevant it becomes to the question of whether consumers are getting good outcomes from the market.

Figure 6.11: Independent practices EBITDA margin – all datapoints for the three most recent years



Source: CMA analysis of anonymised data provided by NASDAL.
Notes: The dataset for independent practices includes c. 500 practices for each year but these practices may not be common across each year of the dataset. We have therefore included each datapoint relating to an independent practice across all three years in this chart, totalling c. 1,500. The chart focuses on margins between 0% and 80%, covering 99.8% of observations. Three observations outside this range are not shown for clarity.

6.74 As can be seen in Figure 6.11 there is wide variation between the EBITDA margins of independent practices, but this variation does not appear to be explained by the balance of NHS and private revenue.

6.75 We also observe relatively high margins for some independents (eg 30% earn >40% EBITDA), although, as noted above, we recognise that margins may be overstated if they exclude some owner-operator labour and/ or property costs.

6.76 Comparing the blue and green dots representing practices which comprise mostly (> 80%) NHS and mostly (> 80%) private revenues respectively, we see that there is significant variation in returns across the sample.

6.77 Some practices which comprise mostly (> 80%) NHS revenue earn higher margins than some mostly (> 80%) private revenue-driven practices. For example, many predominantly NHS-revenue driven practices earn over 40% EBITDA margin, and many of the mainly private-revenue driven practices earn under 40%.

6.78 We recognise that the variance in returns for firms that mostly earn revenue from NHS treatments may be driven by differences in the compensation received from

the NHS for NHS treatments. As set out in Chapter 2, in England, UDA rates vary considerably, and do not necessarily align to practice costs.

6.79 However, we also find that some private-focused practices can earn more than some NHS-focused practices. We are not yet able to confirm whether the practices in our sample are representative and therefore cannot draw market-wide conclusions on this basis. In this context, we do not conclude that mostly NHS practices always earn more than mostly private practices. We discuss inferences we can draw in relation to cross subsidisation more broadly below.

Large dental group EBITDA margins

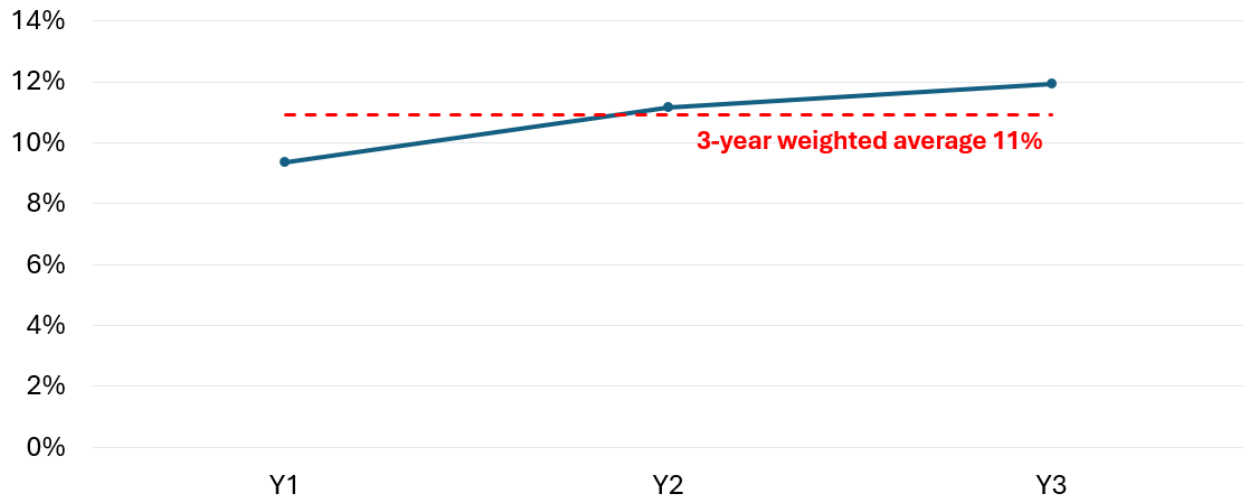
6.80 For the 16 large dental groups we analysed, covering 94% of practices operated by large dental groups, the weighted-average EBITDA margin was 11% over the last three years and increased moderately over this period. Private equity-backed groups had a weighted-average EBITDA margin of 13%, compared with 5% for other large groups, although margins varied considerably within both categories and their ranges overlapped substantially. Despite their higher average EBITDA margin, substantial interest charges left private equity-backed groups loss-making on a weighted-average basis after interest. We are investigating debt financing arrangements further.

6.81 Dental groups account for a third of dental practices and operate over 4,100 practices. 19 are large dental groups (defined as firms with over 30 practices) and collectively represent 19% of practices in the market. Over the past decade, these groups have grown through a combination of major mergers as well as acquisitions of smaller independent practices. Our financial analysis includes 16 of these 19 large dental groups, covering 94% of large dental group practices.[465]

6.82 We also have some financial data for small to mid-size dental groups (those with 3 to 29 practices), which collectively account for 15% of practices in the market. However, this financial data is less complete and may not be fully representative of this cohort. We have considered this data together with the other financial data we have but focussed our analysis of dental group EBITDA margins on the 16 of the largest groups.

[465] Christie & Co (2026) Dental Market Review 2026 – An insight into the UK dental market, p5.

Figure 6.12: Weighted average EBITDA margin of large dental groups over the past three years



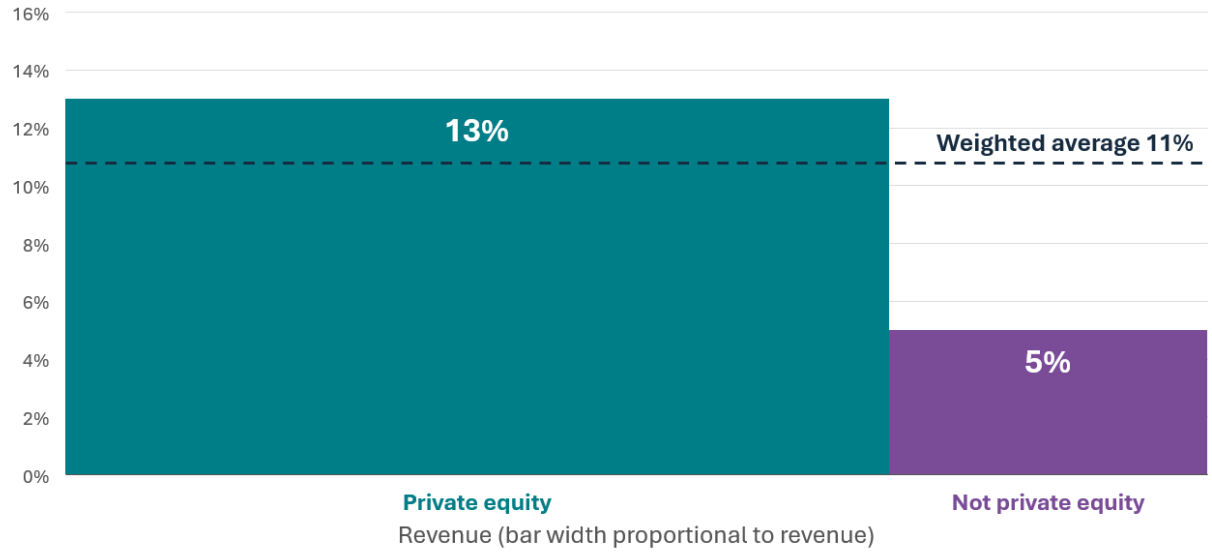
Source: CMA analysis based on submissions from Large Dental Groups.
Notes: There is variation in the firms' year-ends. In this chart we show the latest financial year for which we have data as 'year 3' and prior year as 'year 2' and so on. For example, 'year 3' includes some firms with the most recent year end of March 2026 and earlier year end of March 2025.

6.83 We set out in the chart above the EBITDA margins earned by 16 of the large dental groups. The dark blue line shows the weighted average EBITDA margin for these groups in each year, and the red line the average for the three-year period.

6.84 Weighted-average EBITDA margin of these 16 large dental groups increased slightly over the three years, from 9% to 12%, with the weighted average EBITDA margin over this period being 11%. However, the EBITDA margins of these groups varied considerably between dental groups, ranging between 2% to 19% over the three-year period. We note that the data we have on margins has been impacted by ongoing restructuring at some groups over our sample period as well as merger integration.

6.85 Of these 16 large dental groups we analysed the 10 groups that are private equity backed, comparing their weighted average EBITDA margins over the last three years with the weighted average EBITDA margins of the other six large dental groups over this same period. Figure 6.13 shows this comparison.

Figure 6.13: Three year weighted average EBITDA margin of large dental groups – private equity backed vs not private equity



Source: CMA analysis based on submissions from Dental Groups.

6.86 Weighting by revenue (x-axis), the three-year weighted average EBITDA margin for the large dental groups owned by private equity was 13%, compared to 5% for non-private equity backed large dental groups – an 8-percentage-point difference. The equivalent weighted average EBITDA margin for the total set of 16 large groups over the last three years was 11%, as described earlier.

6.87 However, there was considerable variation among the largest groups, with margins ranging from 4% to 19% for those that were private equity backed and from 2% to 14% for those that were not. The two ranges overlapped substantially.

Further work on understanding the financial analysis following the Interim Report

6.88 We plan to undertake additional work to further add to these emerging findings. We are considering the following analysis:

(a) **For independent practices**: we are extending our sample of independent practices, in order to obtain a more fully representative sample of financial margin data to allow us to make market-wide conclusions – including understanding if the variation of margins we have observed in our sample is a feature of the wider market – and further refine our analysis of independents to date.

(b) **For dental groups**: we have requested information which will allow us to develop a better understanding of the structure of debt financing of the 16

large dental groups, including who provides the debt, available credit lines, the interest costs involved, and expected returns over time. In addition, we will also do an in-depth review of dental groups' strategy documents, alongside the acquisition document review to which we refer in Chapter 4, to better understand value creation drivers as well as whether and how dental groups realise benefits of scale.

Understanding if there is private subsidisation of NHS dentistry

6.89 We said in our statement of scope that we may consider cross subsidisation to the extent that it arises as an issue through our wider consideration of prices and profitability.[466] As part of our analysis to date, we examined whether private dentistry cross-subsidises NHS provision. We have heard two distinct concerns: whether dentists rely on private earnings to supplement their income from NHS work and whether firms rely on private profits to offset losses on NHS provision. These concerns overlap for owner-operators of independent practices, whose income reflects both their clinical work and the profitability of their business.

6.90 We conclude that private treatment may cross-subsidise NHS treatment in some practices, as some providers told us, but we found no direct financial evidence to establish whether, or to what extent, this occurs. The profitability of some predominantly NHS practices suggests that cross-subsidy is not necessarily a pre-condition of viability, although it does not establish that their NHS activity is profitable in its own right. Combining NHS and private work may also offer other benefits, but these are distinct from cross-subsidisation.

6.91 Firms do not consistently allocate costs to individual treatments on a comparable basis, preventing us from comparing the profitability of NHS and private treatments directly. We therefore considered two sources of evidence: (1) the EBITDA margins of NHS-focused and private-focused independent practices; and (2) what dental groups told us about cross-subsidisation.

EBITDA margins of independent practices

6.92 As set out above, we assessed the operating profitability of independent practices to understand if levels of profitability are related to the level of provision of NHS or private services. We focused this assessment on independent practices as this allows for a comparison at a practice-level and avoids group-level distortions.

6.93 As set out at paragraphs 6.72 and 6.79, some NHS-focused practices earn EBITDA margins as high as or higher than some practices with a greater proportion of private revenue, and vice versa. These findings suggest that NHS-

[466] Statement of scope, 05/03/26, paragraph 27(e).

focused provision is not necessarily dependent on cross-subsidy from private treatment. They do not, however, establish whether the NHS treatments within any individual practice are profitable in their own right, or rule out cross-subsidisation in some practices, given that we cannot separate the profits of NHS and private treatment.

What dental groups told us about cross subsidisation

6.94 We asked dental groups whether profits from their private dental work are used to offset any shortfall in the profitability of their NHS/Health service dental work:

(a) The four largest dental groups emphasised the shared cost base associated with operating mixed practices and the resulting difficulties in identifying direct cross subsidisation. All noted that they focus on reviewing their financial results on a mixed basis and do not operate a direct policy of using private profits to subsidise NHS activity.[467]

(b) Some of the other dental groups agreed with this sentiment.[468]

(c) However, some dental groups told us that private dentistry subsidises NHS dentistry and indicated that private dentistry is necessary to ensure practice financial viability.[469]

What this means for our understanding of whether firms use private dentistry to subsidise NHS dentistry

6.95 Private treatment may therefore cross-subsidise NHS treatment in some practices, consistent with evidence received from some dental groups. We have not been able to assess treatment-level profitability and therefore cannot establish whether, or to what extent, profits from private treatments offset losses on NHS treatments. However, our analysis identifies some predominantly NHS that operate profitably, suggesting that cross-subsidisation is not necessarily a pre-condition of viability.

6.96 Combining NHS and private provision may offer commercial benefits, distinct from cross-subsidisation. The majority of dental practices provide both, which may help them make fuller use of clinician time, maintain more stable cashflows and generate additional revenue by offering private services to NHS patients. Profitability does not, however, appear to depend simply on the proportion of private work: some independent mixed practices generating mainly NHS revenue achieve higher EBITDA margins than some with a higher private share.

[467] Responses to the CMA's information requests: [✂].
[468] Responses to the CMA's information requests: [✂].
[469] Responses to the CMA's information requests: [✂].

Differences in remuneration for NHS treatment, including UDA rates in England, may partly explain this pattern.

6.97 Our analysis above of the commercial benefits that may accrue from NHS contracts is supported by our review of internal business documents set out in Chapter 4. These documents provide some indication that having NHS business can increase the acquisition value of a dental practice and is seen by some acquiring firms to provide stable income with potential to grow revenues by offering private treatments to NHS patients.[470] We intend to undertake further work on this topic.

Dentist NHS renumeration

6.98 The British Dental Association (BDA) has raised concerns that NHS remuneration does not cover the cost of providing treatment and that private income makes up the shortfall.[471] The Association of Dental Groups (ADG) has also raised concerns about historical underpayments and proposed improvements to the contract uplift process to support financial stability.[472] These concerns may indicate that NHS work is less financially lucrative than private dentistry for some dentists (as individuals, rather than as dental practices or firms). This is consistent with our findings in Chapter 4 that dentists can receive a lower share of the revenue generated by NHS treatments than by private treatments. This difference may support firms' NHS treatment profitability, but firms do not consistently record data which would allow us to assess this level of granularity.

[470] Responses to the CMA's information requests: [✂].
[471] British Dental Association's response to the CMA's statement of scope, p36 – p37.
[472] Association of Dental Groups (2026) 'ADG Paper: NHSE Dental Contract Reform Priorities' p5 – p6.

7. Remedies

A. Our assessment and the case for reform

7.1 Our emerging findings indicate that the private dental market is not consistently working well for patients or delivering the outcomes people should expect from these essential services. Patients face inherent limits on their ability to assess clinical need, quality and value for money; practical barriers impede comparison and switching; workforce constraints weaken competition; and inbuilt financial incentives to grow revenues, KPIs, targets and other commercial practices have the potential to drive outcomes that are not in patient's best interests. Regulation does not adequately address these weaknesses. The resulting pressures on access and affordability differ between and within the UK nations but are widespread.

7.2 Supported by our statutory information-gathering powers, we have explored the drivers of poor outcomes in this market. The issues we have found are systemic, and in putting forward proposals for change we are acutely conscious of the critical care being provided by thousands of hard-working dental professionals every day, both privately and through the NHS. Our proposed recommendations look to support this work by ensuring it is delivered in a system designed to promote as far as possible access and affordability for all patients.

7.3 We provisionally propose a mutually reinforcing package of measures which, if recommended in our final report, would be directed to the UK, Scottish and Welsh governments and the Northern Ireland Executive, as well as relevant regulators and public bodies. The package includes, but is not limited to:

(a) supply-side measures to increase the availability and effective capacity of the dental workforce;

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

(c) better-focused regulation and enforcement.

7.4 These are necessary measures to improve the functioning of the private dental services market. But we do not believe they will be sufficient.

7.5 Greater workforce capacity and better-informed choices will not fundamentally reshape provider or patient behaviour, remove the credence nature of dental services or fully counteract providers' revenue-maximising incentives. Thus, without further government intervention, patients will still be at risk of unnecessarily high prices and commercial practices that are not in their best interests. Put another way, our provisional view is that unconstrained private

provision cannot be relied up on to deliver good outcomes for patients, especially for those patients for whom affordability is particularly challenging but who cannot access NHS provision. 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.

7.6 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 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.

7.7 The starting point for our proposed remedies is the continuation of a system whereby some and quite possibly the majority of essential dental care is not NHS-funded. We also assume that independent practices and corporate groups will continue to combine NHS and private work. Delivered fairly and transparently, these mixed offerings give patients convenience, allow premises, equipment and staff costs to be shared efficiently, and support profitability and NHS participation. This mix is also part of what makes the UK dentistry sector attractive to UK-trained and overseas-qualified professionals and future dental students.

7.8 At the same time, our provisional view is that the interconnectedness of private and NHS-funded provision, including the prevalence of mixed providers, provides a real opportunity for governments more strategically to shape the market, including to take account of the interests of private patients.

7.9 In this scenario, public intervention might support the viability of mixed practices that meet the needs of patients dependent on affordable private provision of dental

care: for example, the holding of an NHS contract could be linked to meeting those expectations; financial benefits flowing from NHS contracts could be increased for qualifying practices; and/or relevant practices could be granted kitemark accreditations or similar quality signals. In the next part of this study, we will explore further how this can be achieved.

7.10 Where affordability concerns persist and commercial incentives are not or cannot be addressed through these kinds of market shaping tools, governments also have the ultimate lever of regulated price controls. Price controls are a relatively blunt tool so our recommendation would be to explore the market shaping options first. However, it may be necessary to return to the question of price controls more closely if other means are not likely to be practical or effective.

7.11 Through this study, we have been able to shine a spotlight on variation in local and regional outcomes. There is unlikely to be a single UK-wide solution to the issues we have identified. The appropriate responses by governments will need to reflect differences between the nations and geographic priorities across localities. For example, comparison and switching remedies will be more effective where patients have a meaningful choice of practices with spare capacity, and less effective where supply is constrained or few practices are accepting new patients. In respect of market shaping remedies, these would need to balance potential improvements in access and affordability against risks to provider viability, workforce supply and NHS participation, recognising that conditions will differ across nations and regions.

7.12 Our work to date has also highlighted wider questions about how scarce NHS capacity is allocated, including whether it reaches those least able to afford private care, and how historically determined and variable UDA payment rates in England might influence providers' incentives to offer NHS services. These issues extend beyond our study's main focus, but we stand ready to assist governments in considering their implications for patients across both NHS and private dentistry.

Developing our position on remedies

7.13 We invite stakeholders responding to this Interim Report to react not just to our supply-side, demand-side and regulatory proposals, but also to assist the CMA in identifying ways in which broader changes could be brought to bear to shape and influence outcomes for private patients across the sector.

7.14 On the supply-side, demand-side and regulatory measures, our consultation will help assess likely patient responses, clinical and operational practicality, other implementation considerations, and the scope for national and local tailoring to institutional arrangements and specific market circumstances.

7.15 On the scope for more impactful forms of market shaping, we intend - during and after this consultation - to engage closely with governments, Chief Dental Officers, regulators, commissioning and contracting bodies, industry stakeholders and consumer organisations to test the forms such market shaping could take. In the study's remaining time, we will deepen our evidence base, explore the practical effects of market shaping measures and build our analysis of potential options. We will test commercial viability, incentives, risks to workforce supply and NHS participation, and the levers available to governments.

7.16 We will adopt a forward-looking stance and consider the likely impact of our recommendations as a package, including how our competition-enhancing and consumer protection recommendations might alter incentives and conduct across the sector.

7.17 This work will inform our Final Report, which we will publish by our statutory deadline of 4 March 2027.

B. Supply-side measures: increasing effective workforce capacity

7.18 Increasing clinician availability and making fuller use of the wider dental team are essential to improving access and competition. A practice operating at or near capacity has little reason to lower prices to attract additional patients. More effective labour supply gives practices the scope and incentive to compete, while giving patients realistic alternatives. Without it, richer information and easier switching are unlikely to generate sustained price rivalry.

7.19 We propose that governments review remaining workforce constraints and prioritise capacity-building measures to:

(a) further expand domestic training capacity and consider where to target increases in dental school places, given current regional differences in workforce supply;

(b) improve retention and encourage greater participation by the existing workforce;

(c) enable dental therapists and hygienists to work fully within their scope; and

(d) reduce barriers to recruiting and registering overseas-trained professionals.

7.20 We recognise existing UK government investment in dental school places and work to address the backlog of registration examinations for overseas-qualified dentists. We also recognise that domestic skills education and funding, and skilled immigration policy, are complex policy areas involving significant trade-offs for governments. Our role is not to weight these policy interests, but to make clear the

consequences for access, patient choice and competition if underlying capacity constraints remain unresolved.

7.21 We note in particular that the pool of 6,000 or more overseas-trained dental professionals awaiting the Overseas Registration Examination represents a potentially significant supply lever. Accelerating appropriate routes into practice, alongside better use of existing clinicians, could help ease constraints more quickly than domestic training alone.

7.22 Potentially quicker benefits might also be realised by limiting unjustifiably long non-compete clauses in associate dentist contracts (if general legislation to restrict post-term non-competes is not taken forward by government) and similar terms in contracts for the sale of dental practices. This is an area where we are undertaking further information gathering and analysis to inform our ultimate recommendations.

7.23 In considering the role of other members of the dental team, including dental therapists and hygienists, governments and regional NHS bodies should consider how these professionals are provided with a stable and predictable level of high-quality work for them to practise to their fullest scope post qualification. This might help overcome cultural or structural barriers to them operating to the extent of their practice today. This might further strengthen labour supply in the dental workforce, and potentially allow these professionals to hold their own NHS contracts as service providers in future commissioning activity.

Summary of supply-side measures: We propose that governments prioritise increasing workforce capacity through expanded and appropriately targeted domestic training, better retention and participation, fuller use of therapists and hygienists, and fewer barriers to overseas recruitment and registration. We are also exploring limits on unjustifiably long non-compete clauses in associate and practice-sale contracts.

C. Demand-side measures: transparency, comparison and switching

7.24 We are consulting on recommendations to increase transparency and support patients to compare and switch practices. Better, clearer and genuinely comparable information on treatment options, what is clinically necessary, the components and total price of treatment, and the distinction between essential elements and optional additions could help patients make more informed choices and respond to the large price variation we observe. Easier access to and sharing of patient records and diagnostics could also support second opinions, alternative quotations and switching. These measures will have limited effect where treatment is urgent or local practices lack spare capacity, but could improve outcomes where patients have a meaningful choice.

Consumer information and Treatment Plan Plus

7.25 Better information for patients and clearer prompts at key decision points would reduce opacity around NHS and private options, support informed consent and help distinguish genuine consumer demand from supplier-led demand, and support shopping around, multi-homing and switching.

7.26 We propose improvements in the completeness, consistency and accessibility of information online, in practices and from dental professionals before patients decide to commence private treatment. We also propose that patients be given clearer information on the ownership of dental practices and businesses.

7.27 In particular, we would like to see patients given better and clearer written information in private Treatment Plans on:

(a) the clinical necessity of a treatment and whether it would be available on the NHS, and for elective treatments not available on the NHS, the oral-health benefits of those treatments

(b) the treatment components and prices, with clarity over optional additions

(c) applicable clinical guidance on recall rates (where relevant)

(d) whether a treatment could be provided by a therapist or hygienist

(e) patients' second-opinion rights, their entitlement to access to their patient record and diagnostics, and a reminder of the opportunity to shop around before treatment

(f) in nations where registration is a condition of NHS access, the message that choosing another provider for a particular private treatment would not affect registration status

(g) where to find patient information from governments (see our recommendation below on an online patient information resource).

7.28 The benefits of such information are likely to be greatest where patients have time and realistic alternatives: for example, non-urgent, moderate- or high-cost treatment, elective procedures, or decisions involving functional, aesthetic, durability or convenience differences. Prompts to ask questions, take information away, compare providers or obtain a second opinion or quotation could help patients access benefits from price variation that is currently difficult to assess and act on. They could also support using different practices for different services (multi-homing).

7.29 Irrespective of shopping around, these transparency measures would also better protect patients when they rely on trusted clinicians' advice. Decisions that private

patients make within their current practice should be as informed and effective as possible. They should always understand their NHS entitlement, allowing them to understand options where NHS services are available to them, and they should also know what private treatments they need, allowing them to spend on true essentials. This goes to understanding clinical necessity (or oral health benefits), what frequency of recall is needed for someone with their oral health, and relatedly whether any dental payment plans they may be offered represent good value. They should also understand whether the treatment could be delivered, potentially more cheaply, by a dental therapist or hygienist, potentially in the same practice.

7.30 At the same time, we recognise that trust in one's dentist, proximity of the practice, continuity of provider (based for example on previous pain avoidance and perceived clinical quality), speed of access, and the extent of realistic local alternatives (other practices with current spare capacity) all influence patient decisions. Especially for urgent or clinically necessary care, shopping around may be unrealistic or undesirable, and the effect of transparency measures prices may be limited.

7.31 Information and behavioural prompts are therefore important, proportionate measures, but only a partial answer to poor consumer outcomes in this market.

Public information resource for patients (covering NHS and private options)

7.32 In addition to enhancing the information patients receive from their practices and dental professionals, we propose a complementary source of publicly-provided online patient information.

7.33 This would bring together authoritative government information on NHS and private dental services, and reinforce providers' information obligations with a patient-facing source of guidance. This resource would bring together in one place key information and advice on:

(a) NHS entitlement and how to find an NHS dentist, and the relationship between NHS and private options

(b) Questions to ask before private treatment

(c) How to access patient records and diagnostics

(d) Switching rights

(e) What to consider when taking out a dental payment plan

(f) How to complain.

7.34 We would expect private Treatment Plans to refer patients to this online resource for more information on their rights and entitlements.

7.35 The online resource should also bring together the narrative inspection reports which practices receive from their national care quality regulators (CQC, HIW, HIS or RQIA). While it would be a more significant change to the regulatory framework, narrative reports could also be supplemented with quality labels or ratings to improve comparability. Similarly, the online resource would be a natural place for patients to search for and verify those practices awarded with any government-backed certifications, accreditations of kitemarks under market-shaping initiatives of the kind discussed elsewhere in this Chapter.

Price comparison enablers

7.36 Our evidence shows that treatment prices can be difficult for patients to predict and compare in advance. This is particularly the case where patients must compare information across multiple practice websites, navigate inconsistent treatment terminology and make assumptions about the likely final cost.

7.37 As part of this consultation, we invite views on how greater standardisation in the way treatments are described and presented could be achieved. This could take the form of a programme of work for regulators and clinicians to create a taxonomy or conventions for:

(a) treatment pathways, encompassing those core necessary parts of the treatment (including any lab work typically needed)

(b) common patient-specific modifiers (tooth groups, root canal requirements, pain management and sedation requirements, specific lab work requirements, etc)

(c) choice-based modifiers (eg functional vs aesthetic choices).

7.38 Our objective here is to provide a stronger basis for like-for-like comparison by patients, reducing the assembly challenge that patients face today. Although consumers may prioritise factors other than price, material local price variation means that consumers who are motivated to compare prices or switch providers should be able to do so without significant friction.

7.39 We cannot easily quantify the benefits of such price comparability measures, given the uncertainty around the likely consumer response to better price signals. While affordability is a concern among some consumers, they tend to focus on NHS availability and rarely mention price as a reason for choosing their dentist, even though dental professionals are already required to publish basic price information. Choosing a practice based on price is complex as it involves considering a wide range of prices and there is uncertainty over what treatments a consumer may

need. Therefore, the likelihood that price comparison enablers would incentivise practices to drop their prices significantly is tied most closely to the number of consumers that would, if able to, shop around effectively based on price or multi-home between practices. However, the significant local price variation we have found is something which could, if better signalled, prompt some greater shopping around by at least some patients.

7.40 We see price comparability solutions as going beyond the simple consistency of practice literature and online information, important though this is. A common treatment taxonomy would help providers of second opinions to review an existing Treatment Plan and provide their own price quotation in a way that helps consumers weigh up their options. It would also facilitate the entry into the market of price comparison services and digital assistants, helping patients to quickly assess the value for money of a Treatment Plan compared to other providers in their area before committing. Finally, the delineation of core pathway elements and choice-based modifiers could also allow for greater transparency around quality (eg reliability and durability) differentiators, strengthening consumer choice and driving competition between practices on non-price factors.

7.41 We acknowledge that careful design, with clinical expert input, would likely be needed to avoid oversimplifying treatment complexity. Patient-specific requirements could also make it challenging to standardise treatments, potentially even for relatively simple procedures (for example a small filling on a front tooth versus a large filling on a back tooth). We do not think it would be sensible to devise a complex scheme of layered sub-classifications when the essence of this remedy is to drive greater comprehension and comparability.

7.42 We invite views on the feasibility of pathway standardisation as described above, as well as alternative price comparison enablers. These might take the form of consumer information standards with core fields and minimum disclosure principles (potentially in a structured machine-readable form to improve consistency for search engines, comparison services and digital assistants). This might achieve some greater price comparability should the clinical and practical challenges of devising a workable treatment taxonomy appear too great. We will develop our understanding of these challenges and how they might be overcome during the next phase of the study.

Patient records and diagnostics portability

7.43 Easier access to and sharing of patient records, diagnostics and Treatment Plans could reduce friction when seeking second opinions or alternative quotations, support patient control of information and facilitate switching or use of multiple practices.

7.44 While barriers to accessing patient records may be more perceived than actual, we are concerned that patients may face a general disincentive to requesting their records and that high trust may exacerbate the disincentive for patients to seek a second opinion.

7.45 Clearer guidance on existing access rights and behavioural prompts (as proposed in our other remedies above) may help here, but we invite views during this consultation on measures that would go further and make it as straightforward as possible for patients to control and share their records. One digital option would be patient-led sharing through simple online permissions or application programming interfaces (APIs).

7.46 We recognise that measures to facilitate more common and normalised sharing of patient records for the purposes of obtaining second opinions and quotations would not displace each clinician's own professional standards and care quality obligations. Before a dental professional undertakes a treatment, they provide a Treatment Plan based on their own clinical judgement. For a new patient, this will involve such initial examination and diagnostic testing as they consider necessary. Similarly, for a transferring patient, the dental professional will determine what diagnostic processes are necessary before producing their own Treatment Plan, and that Treatment Plan may not necessarily be the same as a that produced by a previous clinician.[473]

7.47 Notwithstanding these points, we think it is important to explore ways in which diagnoses and quoted prices for treatment can operate within a marketplace of providers beyond the incumbent clinician-dentist relationship.

7.48 As part of this, we are also considering whether enforced pauses or cooling-off periods between diagnoses and treatment stages could support second opinions and competitive quotations. Any such measures would need to balance these benefits against convenience, patients' expectations of prompt treatment, clinical urgency and the importance of continuity between diagnosis and treatment. There could be lighter requirements for routine care and stronger separation for high-cost and more complicated procedures.

7.49 We invite views on these potential measures and related solutions to overcome behavioural barriers to patient switching and to better enable alternative providers to access these records to inform second opinions and alternative quotations, even where they might need to be conditional on subsequent examination of the patient by the alternative provider.

[473] Dental professionals are however under existing obligations to treat testing as an aid to diagnosis, and not an end in itself; and it should be appropriate, necessary, in the patient's best interests, and done with the patient's informed consent. This is particularly true for radiographs, where specific regulations aim to keep exposure to ionising radiation to the minimum necessary.

Supporting action by governments and the CMA against specific conduct concerns

7.50 In this section, we flag three areas of concern, which we wish to examine further in the next phase of our study, about specific forms of conduct which reduce transparency for patients over their options, unduly influence their purchasing decisions, or hinder them from switching practices.

7.51 Existing GDC professional standards are relevant here, particularly the general expectation on professionals to put patients' interests first. More effective and flexible enforcement against professionals, as well as steps to bring business-level decisions affecting patient information and choice within the scope of conduct regulation, would help address these concerns. We explore these measures in paragraphs 7.67 to 7.74 below. Our recommendations on the information that patients receive from practices, including in their written Treatment Plans, will also improve protections.

7.52 There are additional supporting actions that the CMA and governments can also take, potentially in the shorter term.

7.53 In respect of mixed practices, governments, ICBs and health boards also have existing levers to control the conduct of providers where patients interact with NHS and private services. There may therefore be a case for their more systematically enforcing existing conduct requirements in NHS contracts and associated NHS regulations, where relevant rules already exist, or introducing further transparency and fairness obligations on contracted providers where necessary.

7.54 We will also consider whether it is necessary to recommend further specific supporting action against particular conduct, including where protections need to extend to patients of private only practices to which NHS rules and regulations will not apply.

7.55 Across each of the three areas of concerns below, we also intend to do more work in the next phase of study to understand the extent to which these practices arise and the reasons for them. In addition to action by governments, we will also explore whether there may be a role for the CMA where we have concerns about compliance with UK-wide consumer protection law, such as signposting providers to our existing guidance, publishing further guidance or potentially prioritising enforcement action.

NHS treatment being made conditional

7.56 As set out in Chapters 3 and 5, we have seen evidence that some practices may make access to NHS dental treatment conditional on the purchase of private services, including seeking to link NHS access for children to the purchasing decisions of parents.

7.57 Such practices may create pressure on consumers at a point where access to dental care is particularly important and may limit the ability of those consumers to switch practices in future.

7.58 Existing NHS rules already provide some protection in this area but as we have received evidence that these practices still occur, we question the adequacy and consistency of current enforcement arrangements. We will consider this issue further in the next phase of our study, but more systematic enforcement of existing NHS requirements may be needed in this area.

Patient recall and dental payment plans

7.59 As set out in Chapter 6, dental payment plans can provide consumers with a convenient means of budgeting for dental expenditure and may support regular engagement with dental care. However, our evidence also suggests that these plans may lead to over-treatment in some cases and may not represent value for money. Plan terms and conditions, including any restrictions, notice requirements or financial consequences that may apply when consumers seek to terminate a payment plan arrangement, also have implications for patients, particularly when they are looking to switch between practices.

7.60 We are doing further work to understand the adequacy of pre-contractual information provided to prospective purchasers before they enter into a payment plan, including whether patients are receiving the right information about the expected frequency of routine examinations and hygiene visits (for example, by reference to applicable NICE guidance and the recall interval that patients are likely to fall within based on their clinical circumstances).

7.61 Depending on what we find, we may make further targeted recommendations to governments or regulators on these matters. As part of this, we will consider whether to recommend measures to strengthen the separation of decisions relating to choosing a practice or choosing a treatment and decisions relating to the purchase of payment plans.

Potentially misleading marketing material

7.62 We have seen marketing materials which present additional private care as routinely necessary. For example, patients being told that they “need” to see a hygienist in addition to their dentist to keep on top of plaque, cavities and gum disease. Where such treatment is clinically necessary, it should be available as part of NHS care, but this may not be clear to patients in marketing material directing them towards private hygienist appointments.

7.63 Presenting additional optional services as routinely necessary, especially where it is not clear that clinically necessary treatments are available on the NHS, may

make it harder for patients who rely on professional advice to distinguish between what is clinically necessary care and optional services they may choose to purchase.

7.64 Again, we wish to explore these concerns further and the option exists for further targeted recommendations to governments or regulators.

Summary of demand-side measures: We propose clearer patient information and advice, including in written Treatment Plans and through a public online resource, to improve consumer agency. We invite views on comparable treatment descriptions or disclosure standards and easier sharing of records and diagnostics (potentially with proportionate pauses before treatment) to support greater price comparison and switching. Where we have specific conduct concerns, we may recommend stronger conduct obligations or more systematic enforcement of existing regulations. We will also explore whether concerns about consumer law compliance may require targeted action and guidance.

D. Supporting regulation and enforcement

7.65 Regulation, in particular given the evidence in this market of weak competition combined with strong commercial incentives, plays an important potential role in the safeguarding of patients.

7.66 Our objective is better-focused and more effective protection: obligations falling where relevant decisions are made, strong enforcement mechanisms, and accessible redress, while avoiding duplication or processes that burden providers without improving patient outcomes.

Professional and business conduct

7.67 Our evidence has identified risks at the boundary between individual professional duties and commercial, business-level incentives and issues with the current enforcement of professional regulation.

7.68 The current regulatory framework focuses heavily on individual dental professionals. However, activity-linked rewards can arise for owner-principals and for associates paid a share of revenue, in independent practices and groups alike. Better targeted regulation, with greater accountability for businesses and more effective enforcement mechanisms, should improve protections for patients, while also supporting greater agency for patients to compare options and around.

7.69 Current enforcement processes deal with the most serious forms of misconduct and can ultimately result in professionals being stripped of the right to practise. We have found that this may result in under-enforcement when consumer

transparency failures do not engage the fitness to practise process because they are not deserving of such strong professional sanction, or where they derive from business-level decisions not taken by clinicians. Rules in NHS contracts and associated NHS regulations relevant to consumer information and choice may also lack effective enforcement.

7.70 We are therefore proposing to recommend that the UK government, alongside devolved nation governments, should review the existing regulatory framework in light of our concerns, drawing where appropriate on precedents from other regulated healthcare sectors. In doing so, governments should have regard to the burdens on practitioners and practices, complexity or duplicated or diffuse responsibilities.

7.71 Our proposal is two-fold: first, that governments should put in place alternative tools to discipline the conduct of professionals; and second, that they introduce means for existing professional conduct rules to discipline business-level behaviour (including that which might seek to influence the behaviour of dental professionals, such as through incentive structures). On the second point, potential options include:

(a) bringing practice owners and practice managers (where they are not already registered dental professionals) within the scope of professional regulation;

(b) creating clearer accountability on professionals for business conduct; or

(c) exploring whether appropriate existing bodies could be responsible for enforcing standards for dental businesses, recognising that multiple regulatory bodies already have remits relevant to dental services.

7.72 As noted above, there is also a role for governments and NHS bodies to reinforce conduct expectations in their oversight and enforcement of relevant obligations on service providers sitting under NHS contracts and associated NHS regulations. This is an important complement to professional and business-level conduct regulation.

7.73 In our final report, we anticipate that particular findings on consumer outcomes in the market will be highly relevant for the GDC's ongoing work. We envisage making targeted recommendations to the GDC in relation to those findings. In that context, the GDC's work to adopt a new *Framework for Professionalism* replacing its *Standards for the Dental Team* also provides an opportunity to clarify what is expected in respect of communication with consumers, supporting informed choice and shared decision making in light of the issues we have identified in Chapter 3 of this interim report (on consumer outcomes and barriers to effective choice). This may include:

(a) Information that must be provided about dental payment plans

(b) Information that must be provided to consumers about alternative options, including NHS options, at key milestones of the consumer journey

(c) Information on complaints processes that must be provided, including online and in practice literature

(d) Greater transparency on the ownership of dental practices and businesses.

7.74 During the next phase of the study, we will test how to secure effective enforcement across professional and business conduct. We invite views on the allocation of responsibilities and coordination needed for regulation to operate effectively and proportionately.

Complaints and redress

7.75 Some patients face perceived or practical barriers to complaining, lack confidence in outcomes or worry about effects on their relationship with their dentist. We propose to recommend strengthening complaints and redress arrangements to provide meaningful recourse and deterrence, improve access and consistency, and ensure recurring problems inform regulatory oversight.

7.76 Our objective is to improve accountability and provide consumers with meaningful recourse when things go wrong. This is particularly important in dental services, where consumers often struggle to assess quality and value before purchase.

7.77 We invite views on three particular measures:

(a) an independent ombudsman route for private patients whose complaints remain unresolved after consideration by the Dental Complaints Service (DCS);

(b) binding DCS recommendations to improve compliance and confidence;

(c) a single point of entry to receive, triage and allocate complaints across NHS and private complaints bodies. This would go beyond basic signposting or information about existing channels.

7.78 During the next phase of the study, we will assess how these options would operate, individually or together, their impact and implementation requirements.

7.79 We will also explore how complaints intelligence might be better used to identify recurring problems and complaint trends to better inform regulatory oversight and prioritisation.

7.80 Finally, as part of our input to the GDC's ongoing review of professional conduct standards and its new Framework for Professionalism, and our wider recommendations on regulation (including of dental businesses), we also expect to

highlight where clarity of complaint process information, both online and in printed materials, and the manner in which complaints can be submitted, will support consumers to raise concerns and seek redress.

Summary of regulation and enforcement measures: Governments should review regulation to strengthen proportionate accountability for professional and business conduct, particularly with appropriate mechanisms for oversight of dental businesses, with the objective of coordinated and targeted enforcement without duplication. We anticipate recommendations to the GDC on patient information, informed choice and shared decision-making. We invite views on an independent ombudsman for private complaints, binding Dental Complaints Service recommendations, and a single complaints entry point; alongside better use of complaints intelligence and clearer practice complaints information with accessible submission routes.

E. Governments' role in shaping the mixed NHS and private sector

7.81 The measures above – across the supply-side, demand-side and supporting regulation are necessary measures to improve the functioning of the private dental services market. But we do not believe they will be sufficient.

7.82 Individual patients, however well informed, cannot be expected to drive sufficient change simply by 'voting with their feet', given the credence nature of dental services and the other reasons why patients stay with their existing dentists, even where cheaper alternatives may be available.

7.83 Proportionate conduct regulation can improve consumer protection, but it cannot be expected to compensate for weak competitive constraints or to fundamentally reshape behaviour, market dynamics, and outcomes. Moreover, there is a risk that an over-reliance on regulation to improve market outcomes could place undue burden and costs on dental providers and professionals.

7.84 Therefore, alongside measures to improve weak competition and strengthen accountability through effective regulation, our preliminary view is that further market shaping interventions are needed to change underlying economics and incentives across this essential market, and the CMA plans to explore with governments what shape these might take. These would go beyond but be complementary to the first three groups of remedies discussed above.[474]

[474] The UK and devolved nation governments play various significant roles which affect the mixed public-private sector. Most obvious is their direct participation, through the NHS, as buyers who secure the delivery of dental services necessary for achieving and maintaining oral health. They also indirectly participate through regulation, principally to maintain essential standards of care and public confidence in the dental profession. Through these and other forms of influence, governments are already playing an active role in shaping market structures across publicly funded and private dental services, on such things as:

a. the supply of the dental workforce (eg policies on the registration of professionals, qualification and examination requirements, access for overseas registered professionals, and the nature of services that the workforce can provide, including whether they have NHS performer status);

7.85 In the next phase of the study, we will examine how governments might best harness the private sector's responsiveness to commercial incentives and strengthen the attractiveness of delivering access to affordable essential private dental care. In doing so, we will consider the likely changes to market dynamics resulting from our remedies as a whole, rather than examining market shaping measures in isolation.

7.86 Most dental practices operate as mixed NHS and private providers. Governments therefore have the opportunity to use their significant role as purchasers of NHS dentistry to shape commercial incentives across the whole system through strategic purchasing that seeks to replicate some of the constraints and rewards that stronger competition might provide, making lower private prices for essential services more commercially advantageous, while discouraging conduct that produces dissatisfactory outcomes for patients.

How market shaping might be achieved

7.87 We highlight below the forms that greater market shaping might take. These are illustrative ideas and not intended to be exhaustive. Our consultation and ongoing engagement may identify additional models worthy of exploration. At this stage, we are not proposing a particular delivery body or institutional arrangement, or recommending a preferred mechanism. However, 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.

7.88 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 should enable them to encourage more affordable private prices for patients buying essential dental treatment, as well as better transparency and other beneficial practices.

7.89 The detailed design of market shaping measures will require a proper understanding of underlying practice economics, clinician and owner-clinician remuneration and provider differences. While the aim of our recommendations will be to maintain the attractiveness of mixed provision to providers, it will be important to understand potential unintended consequences, particularly in respect of clinician and practice participation in NHS provision and the potential impact on NHS services.

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b. the entry or expansion of businesses in the dental services market (eg policies on the inspection and registration of new practices); and
c. the scope and the pricing of clinically necessary dental services (eg policies on what services are available on the NHS, at what price to consumers, and at what level of remuneration for service providers).

7.90 However, the initial evidence at least gives some cause for optimism. The continuing importance of NHS contracts to many businesses and the profits some mixed providers appear to achieve suggests that it should be possible to improve outcomes for private patients while at the same time sustaining or even enhancing the attractiveness of the mixed model.[475]

7.91 In principle, there are a range of measures that could be used by governments to influence provider incentives and improve outcomes for patients relying on private dentistry for essential care:

(a) NHS provider eligibility requirements could make access to NHS contracts conditional on certain private patient outcomes being shown or a commitment to deliver those outcomes.

(b) Preferencing certain providers (e.g. by awarding a greater volume of NHS activity) or designing performance incentives could link the financial benefits from NHS contracts to private as well as NHS patient outcomes. As part of this, governments could also leverage the consequences of non- or under-performance of contracts.

(c) Quality signalling schemes (such as government-backed certifications, accreditations or kitemarks) could help practices that meet certain standards of affordability for their private dental services to differentiate themselves successfully in the market.

7.92 We are not, at this stage, suggesting that strategic purchasing approaches should be used to promote particular commercial ownership and business models. This may be relevant to consider further, were we to establish in further analysis a connection between these and particular commercial drivers, business practices or pricing outcomes. This is something we will examine further before our final report. However, as we have noted above, we do propose that patients be given clearer information on the ownership of dental practices and businesses.

7.93 In further refining our views on market shaping options, as well as taking account of the desired outcomes for patients and the risks of unintended consequences (in particular to existing NHS capacity), we will:

[475] In particular, the prevalence of NHS contracts is consistent with NHS funding being important for many dental firms' strategies. Mixed private/NHS practices remain the most common (see Chapter 2). NHS dentistry revenues were about £4.1 billion and accounted for over a third of all dentistry (Mintel, UK Dentistry Market Report 2024, pages 7-8, accessed 09/07/26). The number of dentists providing NHS care has remained broadly unchanged in three out of the four nations since 2020 (see Chapter 2). At the same time, as we set out in Chapters 4 and 6, both the internal documents of large groups and our analysis of the profitability of independents demonstrates the commercial attractiveness of at least some NHS contracts. NHS dentistry can support practice utilisation, operational efficiency and financial sustainability and increase the acquisition value of a target, and some independent mixed practices focused mainly on NHS care achieve higher percentage operating margins than some with a higher private share.

(a) take a forward-looking and holistic view of the sector and the expected impact of our supply-side, demand-side and regulatory measures in assessing what strategic leverage might exist for governments; and

(b) consider which market shaping functions might need national scale or coordination, and those which might require regional or local knowledge and responsiveness; and how responsibilities, powers, information and capacity might be aligned to support effective delivery.

Shaping provision by supporting alternative delivery models

7.94 In some cases, it may be that access to affordable essential dental care is better achieved through or supplemented by alternative provision models that reduce dependence on traditional mixed practices.

7.95 We are aware of existing initiatives across the UK based on community, hub-based and outreach models, including mobile services, social enterprises, and bespoke local contracts addressing identified access gaps or population needs.

7.96 Supporting such flexible service provision options may have particular value where local market circumstances pose specific and/or acute issues that are unlikely to be resolved through improvements to the prevalent delivery models.

Supporting market shaping through information on private provision

7.97 To support strategic market shaping, governments should have broader visibility of the sector in which they purchase NHS dental services. Governments and regional NHS bodies generally have extensive information on NHS dentistry but much less visibility about non-NHS dentistry, despite it often being provided by the same businesses. This limits policy-makers' understanding of provider incentives, patient pathways, and overall patient outcomes.

7.98 We propose that governments collect, analyse and monitor relevant private market information to reveal how changes in public provision affect the mixed sector, and assess the effect of interventions on access, affordability and patient outcomes.

7.99 Key data would include:

(a) private pricing information

(b) how appointments are allocated across NHS and private patients

(c) NHS to private patient conversion rates

(d) patient recall intervals for NHS and private patients, and how they differ

(e) private patient access information (including for particular demographics or populations), and

(f) private patient experience measures.

Direct price controls

7.100 Where affordability concerns persist and commercial incentives are not or cannot be otherwise addressed, governments could consider direct price controls – setting the prices patients pay for care in order to guarantee more affordable access.

7.101 Direct price regulation could, for instance, be used to place an upper limit on what private patients pay for specific clinically necessary treatments. NHS dentistry already operates under 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.

7.102 The persistence of affordability concerns despite the package of measures discussed earlier would not in itself establish a case for price controls, which are a particularly strong form of intervention. It would be essential to assess the potential benefits and risks of direct price regulation, including the risk of unintended consequences such as reduced investment, accelerated exit or consolidation, and threats to workforce supply.

7.103 Our preference is to explore with governments the market shaping tools discussed above. 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.

Summary of market shaping measures: During the next phase of the study, we plan to test whether and how governments might use market shaping levers which design for desired incentives and behaviours (rather than correct for market failures) to improve outcomes for private patients. Ultimately, if this is not achievable, and patient-led competition remains insufficient, governments may consider private price controls where it is assessed to be of benefit and the risks to provider participation and workforce supply are manageable.

8. Responding to the interim report

8.1 At this stage, our views are provisional. We invite interested parties – including dental businesses of all sizes, dental professionals, trade and professional associations, consumer/patient organisations, public bodies and other interested parties – to respond to the issues set out in this interim report and provide any relevant evidence to support their views. This will help us determine our conclusions, including any measures to improve outcomes, which we will publish in our final report by 4 March 2027.

8.2 We welcome responses by **5pm** on **17 December 2026**, in particular to the questions in the box below. We would particularly welcome responses which provide evidence or specific examples of good practice we can use to inform our further work.

Questions

In your response, please state the question number you are responding to.

Type and location of respondent

Question 1a: What type of organisation do you represent?

Question 1b: If you are a dental business, please state whether you are responding as (i) an independently owned business or, ii) a corporate group.

Question 1c: If you are a dental professional, please state the nature of your role (eg: dentist, dental hygienist, dental therapist etc).

Question 1d: Does your response relate to the whole of the UK, or just part? Please state whether:

(a) the response relates to the whole of the UK; or

(b) it relates to a specific region (or regions) or nation or (nations) of the UK, and please tell us which region(s)/nation(s):

(i) England – all regions; (ii) East of England; (iii) East Midlands; (iv) London; (v) North East England; (vi) North West England; (vii) South East England; (viii) South West England; (ix) West Midlands; (x) Yorkshire and the Humber; (xi) Scotland; (xii) Wales; (xiii) Northern Ireland.

Emerging analysis

Question 2: Do you have any views on our emerging findings set out in Chapter 3: Consumers' experiences of the dentistry market?

Question 3: Do you have any views on our emerging findings set out in Chapter 4: What drives supply and pricing of private dental treatment?

Question 4: Do you have any views on our emerging findings set out in Chapter 5: Regulatory framework?

Question 5: Do you have any views on our emerging analysis set out on Chapter 6: Outcomes?

Potential remedies

In responding to the questions below explain (i) how the measure could improve outcomes for patients (ii) any potential unintended consequences.

Question 6: Do you have any views on our proposed supply side measures for increasing effective workforce capacity?

Question 7: Do you have any views on our proposed demand-side (patient-facing) measures on transparency, comparison and switching?

Question 8: Do you have any views on our proposed measures for supporting regulation and enforcement?

Question 9: Do you have any views the broader role for governments in shaping the mixed NHS and private sector, including the forms that greater market shaping might take?

Other

Question 10: Do you have any further views you wish to provide to inform our conclusions and/or potential measures?

Responding to the consultation and next steps

8.3 You can respond via CMA Connect (please see our consultation page for how to respond) or email written submissions to dentistry@cma.gov.uk by **5pm** on **17 December 2026**.

8.4 Please ensure that all personal data, other than your contact details, is redacted or excised from your response and any documents you submit to us. Please try to avoid including any sensitive personal data (for example, medical data), in your response, or any personal data (including sensitive personal data) concerning others.

8.5 We propose to publish full responses, or where appropriate, a summary of responses to this report. Therefore:

(a) Please supply a brief summary of the interests of organisations you represent, where appropriate.

(b) Please consider whether you are providing any material that you believe to be confidential, and if so, please explain why this is the case. Please provide both a **confidential** and **non-confidential version** of your response where applicable.

(c) If you are responding as an individual (ie you are not representing a business or other organisation), please indicate whether you wish your response to be attributed to you by name or published anonymously.

(d) An explanation of how we will use the information provided to us is in Annex A (below).

Annex A: Use of information provided to the CMA

This annex sets out how the CMA may use information provided to it during the course of this market study, in line with our legal responsibilities.

Why is the CMA asking for information?

The information you provide will help the CMA to understand the market for the supply of private dental services in the UK and identify any competition or consumer issues.

What will the CMA do with the information I provide?

Your information will inform the CMA's final market study report, and any interim updates. The CMA may publish information you provide and identify you as the contributor of it in those reports, or alongside them on our website. The final market study report will set out the CMA's findings and any proposed remedies to any existing or potential issues it finds.

The CMA may disclose any information provided by you for the purposes set out in sections 7, 170 and 241 to 243 of the Enterprise Act 2002, where it considers such disclosure to be appropriate. In particular, the CMA may choose to put information provided by you to third parties, such as other government departments and other parties providing information to the CMA, for the purpose of facilitating any further related work. The CMA may also appoint one or more experts to assist us in understanding information provided to us or obtained by us.

Where appropriate, the CMA may share your information within the CMA to facilitate the performance of its functions. Similarly, the CMA may use information you provide to take enforcement action, including against businesses operating in the markets within the scope of this study, using its competition or consumer powers. The CMA may also share your information with another enforcement authority or with another regulator for them to consider whether any action is necessary.

Unless an exemption applies, the CMA may disclose the fact that you have provided information to it, and the information you have provided, in accordance with its obligations under the Freedom of Information Act 2000.

Will the CMA take steps to protect my information?

The CMA may only publish or share information with others in specific circumstances set out in legislation (principally Part 9 of the Enterprise Act 2002). In deciding whether to publish or otherwise disclose information received, we will have regard to, among other considerations, the need for excluding, so far as is practicable, any private or commercial information.

The CMA will redact, summarise, or aggregate information in published reports where this is appropriate to ensure transparency whilst protecting legitimate consumer or business interests.

How will the CMA handle any personal data I provide?

Any personal data you provide to us will be handled in accordance with the CMA's obligations under the UK General Data Protection Regulation and the Data Protection Act 2018. The CMA's personal information charter sets out the standards you can expect from it when it collects, uses or shares personal data and provides details of your rights in relation to that personal data as well as information on how to contact the CMA.

What should I do if I have concerns about how the CMA will use any information I provide?

You should make clear to the CMA any information that you consider to be confidential when you provide it to the CMA and set out why you consider it to be confidential.

If the CMA wants to include any sensitive commercial or personal information in a document that will be published it will, save in exceptional circumstances, give you an opportunity to tell it about any concerns you may have regarding that publication.

Where can I find further information?

Further details of the CMA's approach can be found in Transparency and Disclosure: Statement of the CMA's Policy and Approach (CMA6).