Appendix A: Further evidence – market structure and competition between suppliers

A.1 In this Appendix, we set out further evidence that supports the analysis and findings in the topics of market structure and competition between suppliers in our main report.

Market structure

Regional analysis of concentration

A.2 We assessed regional differences in concentration among firms based on:

(a) the proportion of dental practices that are independents vs owned by groups;

(b) the proportion of dental practices that are owned by large dental groups that are backed by private equity vs other; and

(c) the proportion of dental practices that deliver private treatments only.

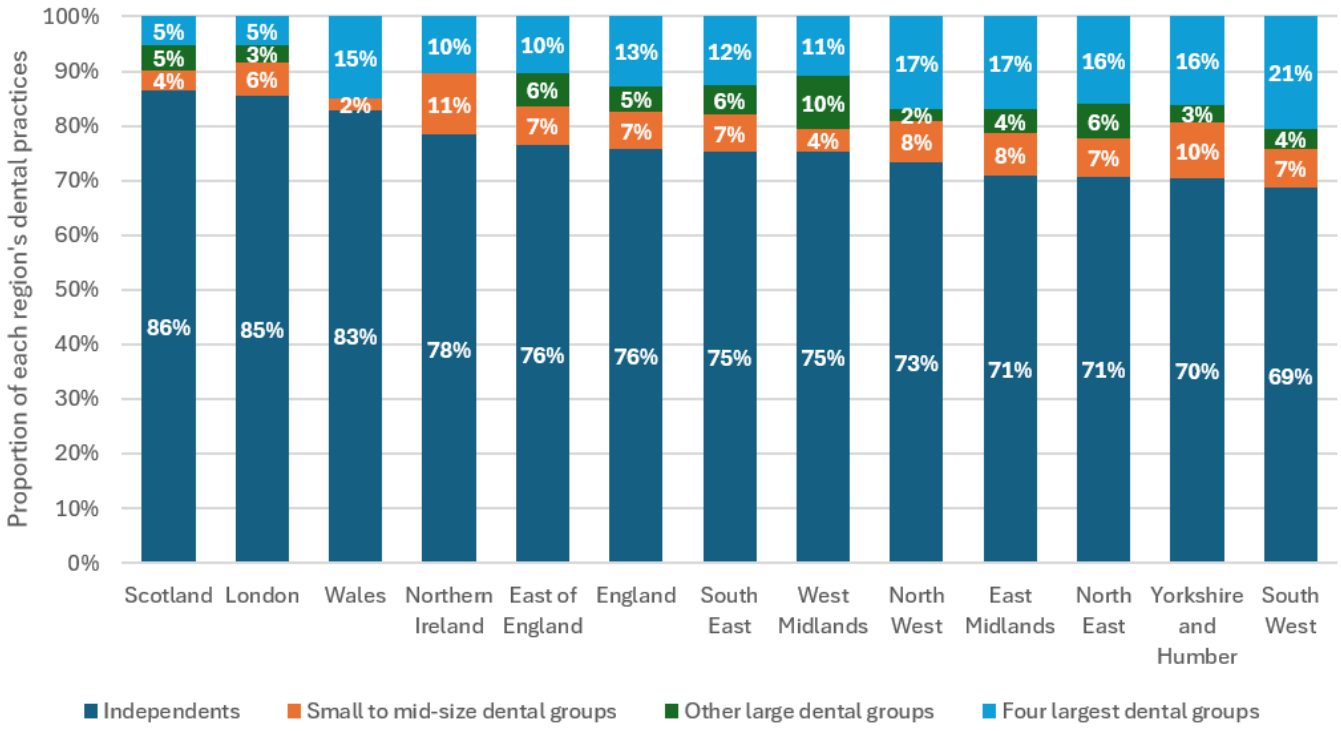
Independent practices vs group-owned practices

A.3 We estimated the proportion of practices in UK regions that are owned by groups (ie 3+ owned sites) vs independents (1-2 sites). The data used for this analysis was sourced from commercial data provider LaingBuisson.[1] For this analysis, the UK is divided into Scotland, Wales, Northern Ireland and the nine English regions.[2] Figure A.1 below shows some variability in the proportion of dental practices that are part of groups across the nations and regions, with Scotland having the lowest proportion at 14%, and Wales and Northern Ireland also among the regions with the lowest proportions, while all of England's nine regions – except London – had higher proportions, with the South West having the highest proportion at 32%.

A.4 Further, there is some variation in the prevalence of groups geographically. For instance, we estimate that across the English regions and UK nations, the proportion of practices that are part of one of the four largest dental groups varies between 5%-21%, and that the proportion of practices part of a small to mid-size dental group between 2%-11%.

[1] The dataset covers all UK dental practices, with various information for each dental practice, including for example which group a dental practice is part of (if applicable), the location of the practices, and whether the practices deliver only private treatments or a mix of private and NHS Dentistry treatments. Dentistry Database Subscription - LaingBuisson, accessed 19/11/26.
[2] This analysis uses the Office for National Statistics' International Territorial Level 1 (ITL1) classification, comprising Scotland, Wales, Northern Ireland and the nine English regions. Office for National Statistics, International geographies - Office for National Statisticshttps://www.ons.gov.uk/methodology/geography/ukgeographies/administrativegeography, accessed 19/11/26.

Figure A.1: Estimated proportion of practices in each English region and UK nation owned by groups of different sizes and independents, August 2026



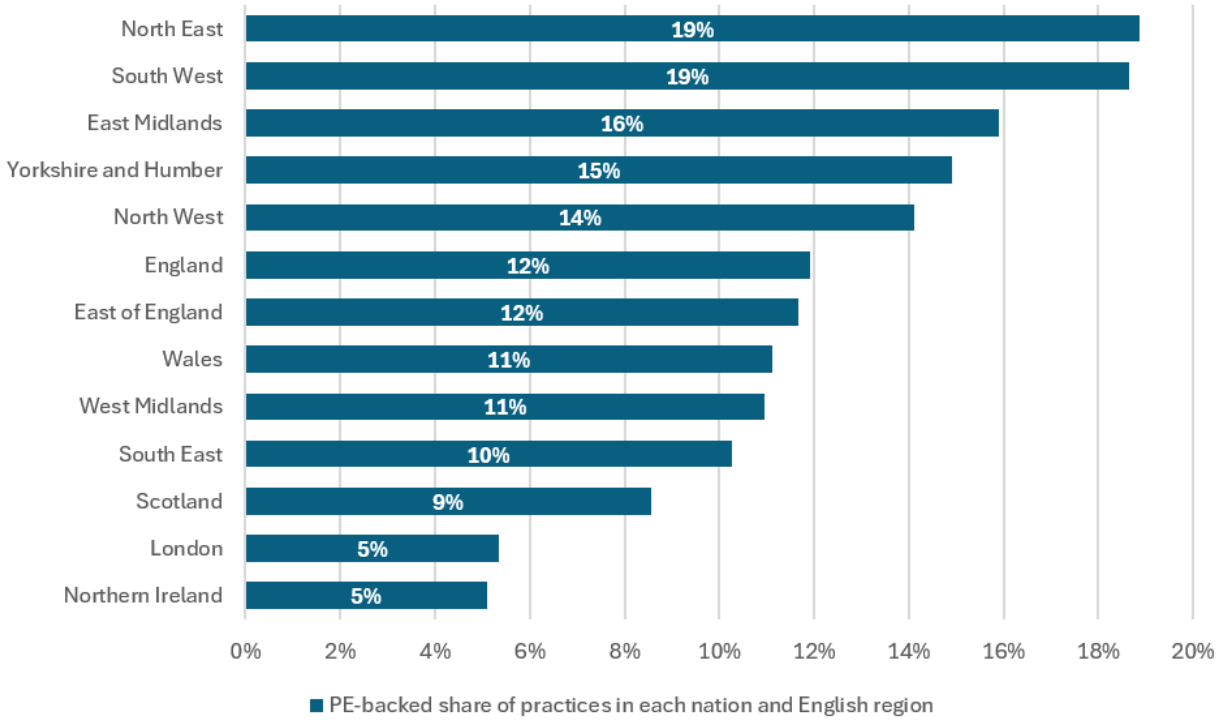
Source: CMA analysis of data from LaingBuisson.

PE-backed large dental group-owned practices vs other

A.5 Using the same dataset from LaingBuisson as described above,[3] we estimated the proportion of dental practices in each of the UK nations and the nine English regions that are part of a large dental group backed by private equity.[4] Figure A.2 below shows that those private equity-backed groups accounted for varying proportions of nations and regions' dental practices – with most of the highest proportions among the English regions, for example the highest proportions were in North East England and South West England at 19%, while the lowest proportion was in Northern Ireland at 5%. The pattern of proportions among the nations and regions closely resembles that observed in Figure A.1 above – with Scotland and Northern Ireland among the lowest proportions and England regions such as South West England and North East England ranking among the highest proportions.

[3] Dentistry Database Subscription - LaingBuisson, accessed 19/11/26.
[4] We used corporate ownership evidence gathered from RFIs that were issued to the four largest dental groups and most other large dental group segment, to identify which groups were backed by private equity. Due to this data availability limitation, we would expect the proportions for each region to be higher if we were able to comprehensively identify all groups in the market that were backed by private equity. However, as larger firms – ie those with more dental practices – are more likely to be backed by private equity, we don't expect the results here to materially underestimate. Responses to the CMA's information requests: [✂]

Figure A.2: 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 that some large dental groups are not all identified, leading to a potential underestimation of the proportion of practices private equity represent.

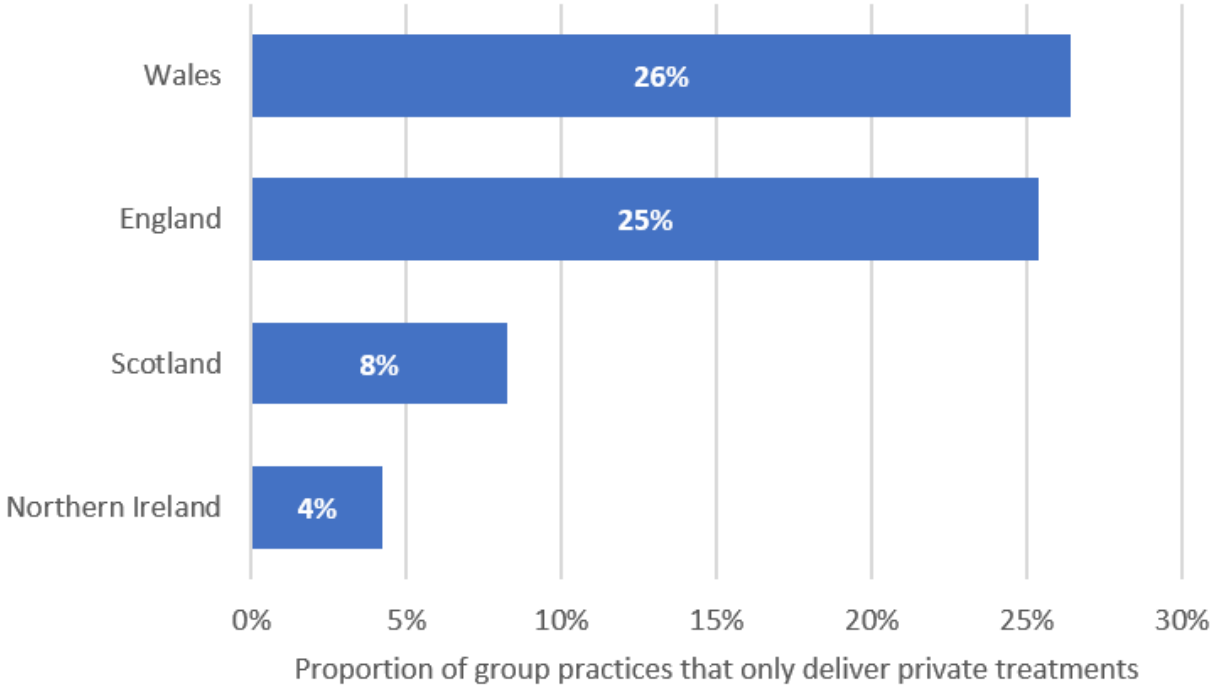
Private-only practices vs Mixed practices

A.6 Using both evidence gathered directly from groups in the large dental group and small to mid-size dental group segments[5] and also the same LaingBuisson dataset used above,[6] we first estimated the proportion of dental practices that deliver only private treatments in each of the four UK nations and then in each of England's nine regions.[7] Evidence gathered directly from the groups indicates a negligible number of dental practices deliver only NHS Dentistry,[8] therefore we assume that all remaining dental practices that are not delivering only private treatments are Mixed practices.

[5] Responses to the CMA's information requests: [✂]
[6] Dentistry Database Subscription - LaingBuisson, accessed 19/11/26.
[7] Due to data limitations in the LaingBuisson dataset for the type of treatments delivered by each practice in the three smaller UK nations, we first use the evidence from RFIs to show a comparison between the four UK nations, and then use the LaingBuisson dataset to compare the nine England regions. The former represents a sample of dental practices, as we did not directly gather evidence from every dental practice or group in the UK. The latter represents the whole market.
[8] Of the 2,206 practices represented by the groups that we gathered evidence directly from, only 4 practices deliver only NHS Dentistry – less than 1%.

A.7 Figure A.3 below shows that a considerably higher proportion of dental practices in Wales and England deliver only private treatments at 26% and 25% respectively, compared to Scotland and Northern Ireland at 8% and 4% respectively.

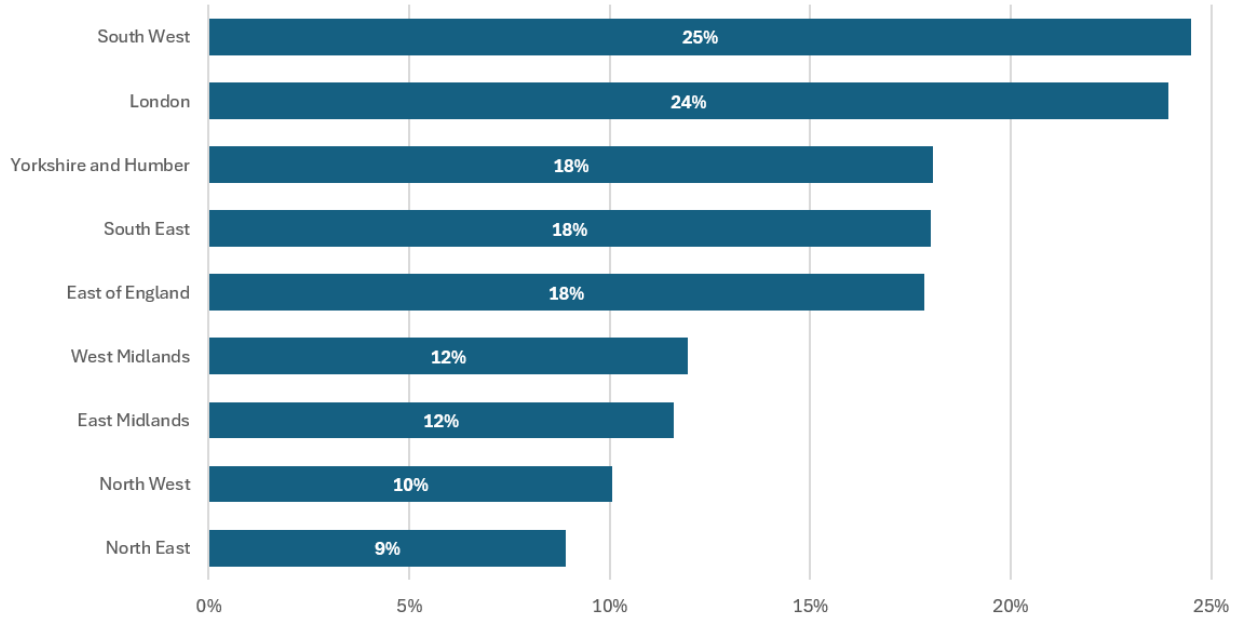
Figure A.3: Estimated proportion of group practices in each UK nation that only deliver private treatments, April 2026



Source: CMA analysis of evidence gathered from dental groups.

A.8 Figure A.4 below shows that among the nine England regions, there is high variation in the proportion of dental practices delivering private only treatments – ranging from 25% in South West England to 9% in North East England. These figures are only indicative due to not having data on private and NHS provision for all practices (see note in the Figure below).

Figure A.4: Estimated proportion of practices in each English region that only deliver private treatments, August 2026



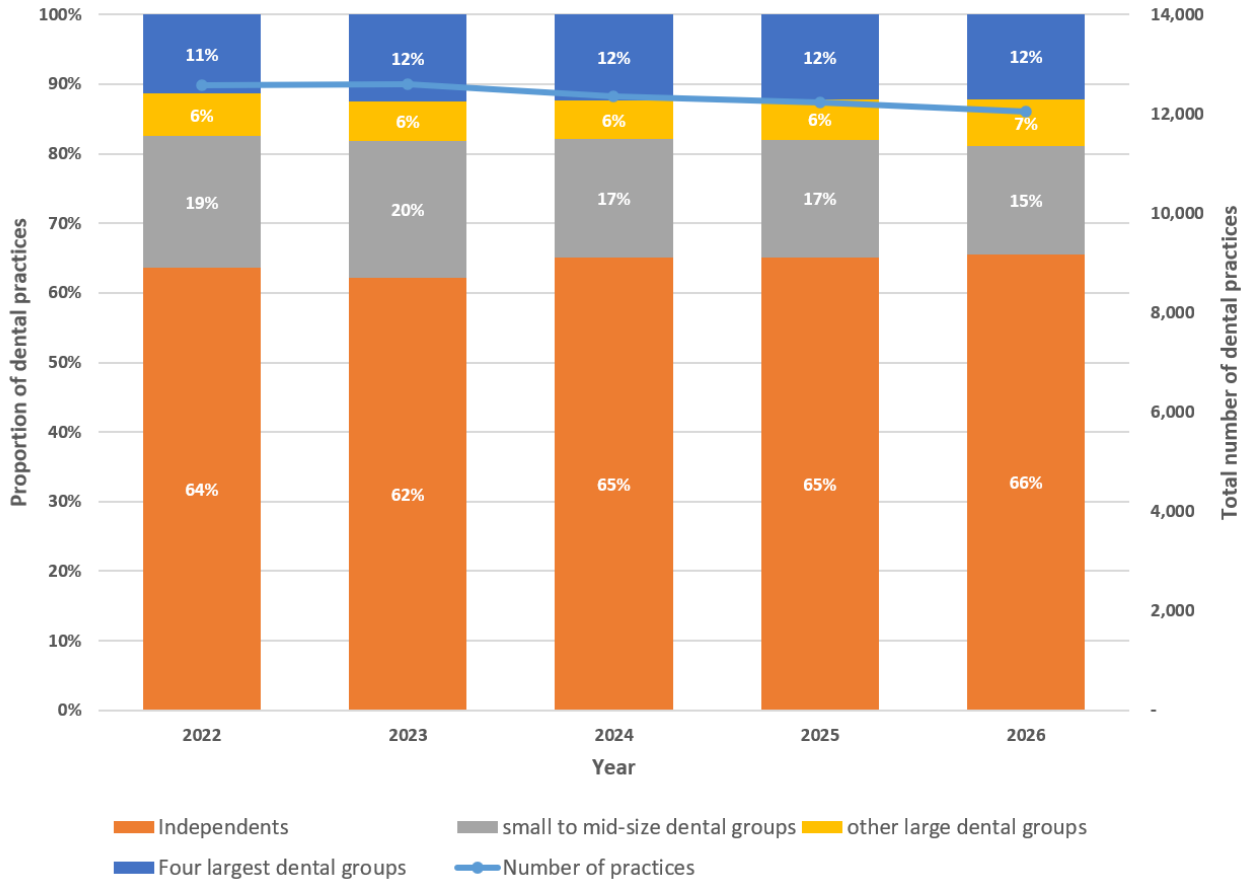
Source: CMA analysis of data from LaingBuisson.
Notes: For each region, there was missing data in the dataset. This equated to between approximately one in ten and one in four dental practices having missing data on the type of treatment they deliver.

Trends in market structure and number of practices

A.9 In order to examine trends in the market structure, we have examined timeseries data from Christie & Co to see changes in the share of the dentistry market between different segments based on the number of practices owned.[9] Figure A.5 below shows that over the period 2022-2026, the shares of dental firm segments were broadly static – with very minimal changes – specifically, the shares of the four largest dental groups grew from 11% to 12%, the shares of other large dental groups from 6% to 7%, the shares of small to mid-size dental groups dropped from 19% to 15%, and the shares of independents increased from 64% to 66%. At the same time, the total number of dental practices fell over the five-year period, from 12,582 to 12,040. This does not show if new practices have opened in the UK over the last five years, as without data on practice closures/mergers, we are unable to rule out the possibility that some practices closed and new ones opened – resulting in similar levels of overall practice numbers.

[9] Christie & Co is a specialist firm of business agents in the UK that deals with the valuation and sale of dental practices. Each year, it produces a report on the UK Dentistry market. Christie & Co, Dental market review 2026, page 5; Christie & Co, Dental Market review 2025, page 5; Christie & Co, Dental Market review 2024, page 5; Christie & Co, Dental Market review 2023, page 5; Christie & Co, Dental Market review 2022, page 7, accessed on 19/11/26.

Figure A.5: Share of dental practices among four segments, 2022-2026



Source: CMA analysis of data from Christie & Co's Dental Market Reviews, 2022-2026
Note: Percentages may not sum to 100% due to rounding. Christie & Co changed the definition of small & mid-sized dental groups from 3-22 in 2022 to 3-29 in 2023.

Trends in the number of dentists per population

A.10 We estimated the ratio of dentists per 10,000 head of population in the UK to understand the capacity constraints of the dentist workforce. Using equivalent information for other European countries, we can see how the UK's level compares.

A.11 The UK is not included in Eurostat's data set.[10] To allow us to compare the UK with the European Economic Area (EEA) countries for which data is available, we therefore estimated the UK's ratio using GDC data on the number of registered dentists and ONS data on the overall population of the UK.[11]

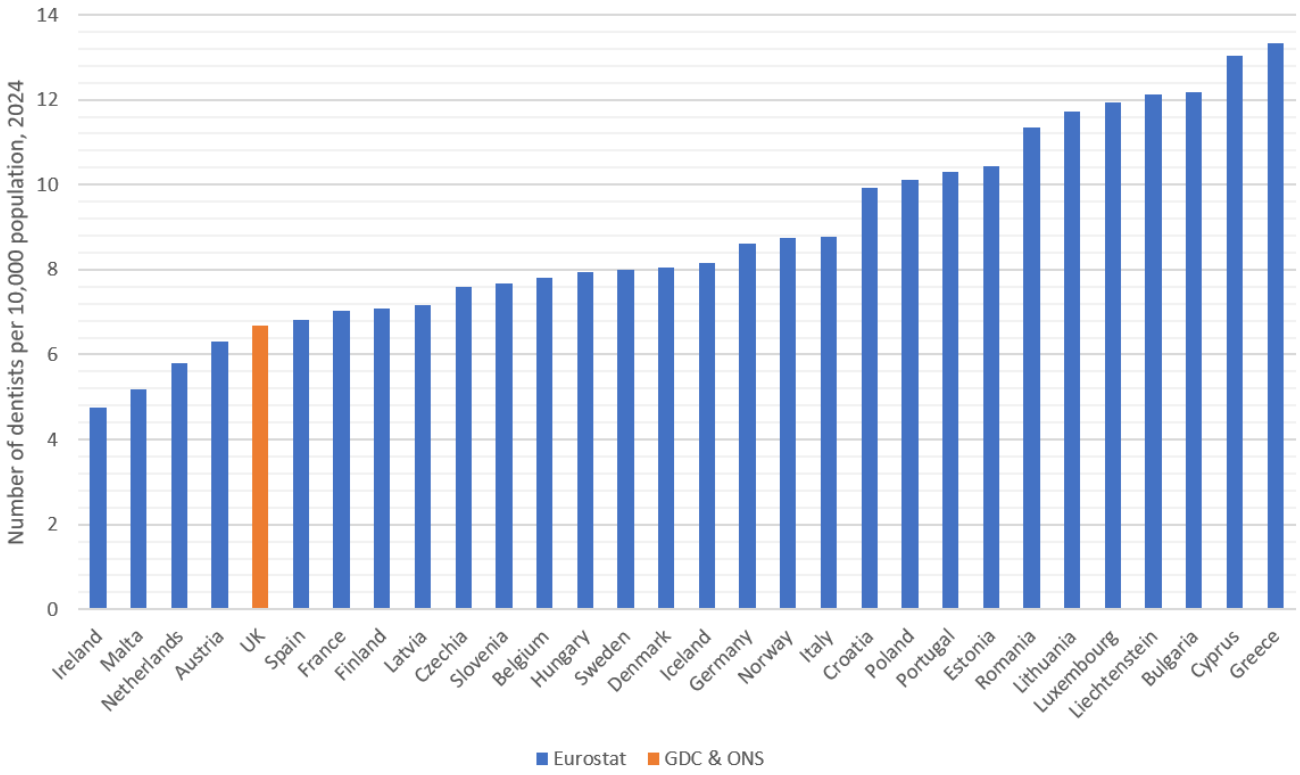
A.12 We have also compared the UK with a similar set of European countries using data from the World Health Organisation (WHO).[12] The WHO estimates exclude

[10] Eurostat, Healthcare personnel statistics- dentists, pharmacists and physiotherapists, Table 1, accessed 19/11/26.
[11] GDC, Registration statistical report 2025, pages 7-8. https://www.ons.gov.uk/file?uri=/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland/mid2011tomid2025/myebtablesuk20112025.xlsx, tab 'MYEB5', variable 'K02000001'.
[12] WHO, National Health Workforce Accounts, Dentists (per 10,000 population), 2025, accessed 19/11/26.

dentists that exclusively deliver private dentistry, and may contain some double counting, for instance where a dentist is registered in more than one UK nation. This means the WHO's figures underestimate the ratio of the number of dentists per 10,000 population in the UK. We therefore present our own estimate for the UK alongside the WHO estimate, which we consider to be more robust as it covers both NHS and private dentistry, and does not include any double counting.

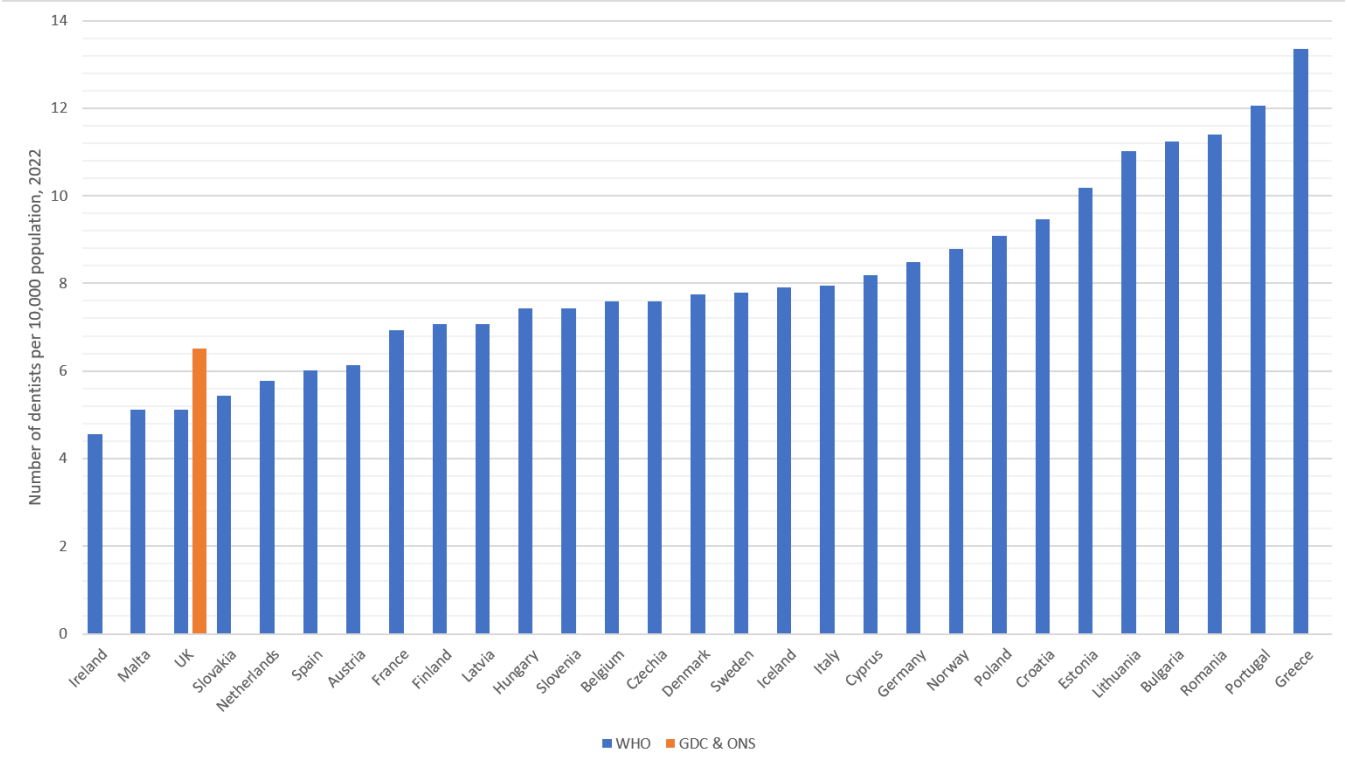
A.13 Figures A.6 and A.7 show that most countries in the European Economic Area had more dentists per 10,000 population than the UK, in the respective years of 2024 and 2022 (the most recently available data for each source). For example, in Figure A.6, the UK ratio of 6.7 was lower than all but four of the 29 EEA countries shown, while in Figure A.7, the UK ratio using WHO data was lower than all but two of the 28 EEA countries shown. Although there are some differences in the data used to estimate these ratios between the WHO and Eurostat estimates, and the UK's GDC and ONS estimate, the UK still consistently ranks among the lowest ratios among European countries in the two years.

Figure A.6: 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.
Notes:
(1) The other European countries included in the chart are all EEA countries except Slovakia, for which data was not available.
(2) 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 practicing dentists – a likely subset of all those that are registered.

Figure A.7: Number of dentists per 10,000 head of population, 2022



Source: One of the two UK ratios is based on CMA analysis of GDC and ONS data and the other is from the WHO. Ratios for other countries are sourced from the WHO.

Notes:

(1) The other European countries included in the chart are all EEA countries except Luxembourg and Liechtenstein, for which data was not available.

(2) The number of dentists for the UK is estimated twice. The WHO estimate excludes dentists that exclusively deliver private dentistry, and may contain some double counting, for instance where a dentist is registered in more than one UK nation. This means the WHO's figures underestimate the ratio of the number of dentists per 10,000 population in the UK. Further information about the data on number of dentists published by the WHO is available in this OECD document: Practising-dentists, page 14. The estimate that uses GDC data on the number of dentists is based on the number that are registered to practice – both for NHS and private dentistry, and does not include any double counting. We therefore consider that the estimate based on GDC data in the UK is more robust and we have used that in our main analysis.

A.14 Further, Table A.1 shows that over the period 2011-2024, the UK's number of dentists per 10,000 head of population was consistently among the lowest when compared with EEA countries, rising from 6.2 to 6.7 in that 15-year period. Whereas the mean for the EEA countries rose from 7.6 to 8.9.

Table A.1: Number of dentists per 10,000 head of population, 2011-2024

Country	*2011*	*2012*	*2013*	*2014*	*2015*	*2016*	*2017*	*2018*	*2019*	*2020*	*2021*	*2022*	*2023*	*2024*
Greece	13.1	12.9	12.7	12.7	12.3	12.3	12.4	12.5	12.7	12.9	13.1	13.3	13.6	13.3
Cyprus	9.2	9.5	9.6	9.8	10.2	10.2	10.7	11.0	11.3	10.4	10.8	11.6	13.2	13.0
Bulgaria	9.2	9.5	9.9	10.2	10.3	10.8	11.0	10.9	11.2	11.3	11.6	11.9	11.9	12.2
Liechtenstein	12.7	13.6	13.8	13.7	13.9	12.7	12.6	12.6	13.2	13.1	13.3	12.2	12.0	12.1
Luxembourg	8.4	8.3	8.5	8.5	8.8	9.2	9.4	9.8	10.5	10.6	10.9	11.1	11.6	11.9
Lithuania	8.2	9.0	9.0	9.1	9.1	9.7	10.0	10.3	10.5	11.0	10.4	11.0	11.6	11.7
Romania	6.6	6.9	7.1	7.5	7.8	8.3	7.9	8.4	8.9	9.7	10.6	11.5	11.3	11.4
Estonia	8.9	9.0	9.0	9.3	9.4	9.6	9.6	9.7	9.8	10.0	10.1	10.2	10.3	10.4
Portugal											10.5	11.4	10.5	10.3
Poland	3.4	3.3	3.2	3.4	3.3	3.5	3.5	3.4	8.9	9.0	9.4	9.5	9.8	10.1
Croatia	7.4	7.6	7.6	7.9	8.1	8.1	8.5	8.7	9.0	9.0	9.4	9.6	9.7	9.9
Italy			7.8	7.9	7.9	8.1	8.3	8.4	8.7	8.7	8.0	8.3	8.5	8.8
Norway	8.8	8.6	8.7	8.7	8.4	8.5	8.5	8.5	8.5	8.5	8.6	8.8	8.8	8.8
Germany	8.3	8.4	8.5	8.6	8.6	8.6	8.6	8.6	8.5	8.5	8.6	8.6	8.6	8.6
Iceland	8.9	8.4	8.4	8.4	8.4	8.3	8.1	8.2	7.9	7.9	7.9	7.9	7.9	8.2
Denmark	8.0	8.0	7.8	7.7	7.6	7.4	7.2	7.2	7.2	7.1	7.2	7.8	7.9	8.1
Sweden	8.2	8.2	8.2	8.1	8.2	8.1	8.1	8.1	7.8	7.7	7.7	7.8	8.0	8.0
Hungary	5.3	5.7	6.0	6.3	6.1	6.2	6.8	7.1	7.4	6.8	7.2	7.5	7.6	7.9
Belgium	7.0	7.1	7.1	7.2	7.4	7.5	7.5	7.5	7.6	7.7	7.7	7.6	7.2	7.8
Slovenia	6.2	6.3	6.5	6.6	6.7	6.9	7.0	7.2	7.3	7.5	7.5	7.4	7.7	7.7
Czechia	7.1	7.1	7.1	7.5		7.5	7.5	7.4	7.3	7.5	7.6	7.6	7.5	7.6
Latvia	7.1	7.1	7.2	7.0	7.2	7.2	7.1	7.1	7.1	7.2	7.2	7.1	7.2	7.2
Finland	7.3	7.3	7.3	7.3	7.3	7.1	7.0	7.1	7.3	7.2	7.2	7.1	7.1	7.1
France	6.4	6.4	6.4	6.3	6.4	6.4	6.4	6.4	6.5	6.5	6.6	6.7	6.8	7.0
Spain												6.0	6.4	6.8
UK	6.2	6.3	6.3	6.4	6.3	6.3	6.3	6.3	6.4	6.5	6.5	6.5	6.6	6.7
Austria	5.9	5.9	6.0	6.0	5.9	5.9	6.0	5.9	6.1	6.1	6.2	6.2	6.2	6.3
Netherlands	4.9	4.9	4.9	5.0	5.2	5.1	5.5	5.6	5.7	5.7	5.8	5.8	5.8	5.8
Malta	4.5	4.5	4.6	4.6	4.6	4.7	4.8	4.8	5.0	5.2	5.2	5.1	5.1	5.2
Ireland											4.6	4.5	4.6	4.7

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

(1) The other European countries included in the chart are all EEA countries except Slovakia, for which data was not available.

(2) 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 practicing dentists – a likely subset of all those that are registered.

Evidence from acquisition documents on clinician recruitment and/or retention

A.15 In the internal documents we have reviewed so far, some large dental groups highlight clinician recruitment and/or retention within a practice as a point of consideration for the divestment or acquisition of dental practices.

(a) Several documents that discuss proposed practice divestments or closures reference difficulties recruiting clinicians at the practices in question.[13]

(b) A document from one of the four largest dental groups presenting the business case for the acquisition of a practice noted that the 'quantity of [dental practitioners] needed to be sourced is the biggest challenge' and 'we would have to rely heavily on [overseas] to supply dentists to this project'.[14]

[13] Responses to the CMA's information requests: [✂]
[14] [✂] response dated [✂]

(c) A number of internal documents identify risks associated with reliance on the clinicians who are selling the practice (vendor clinicians), including the risk that these clinicians leave following an acquisition.[15]

A.16 Several large dental groups' documents refer to agreements designed to retain vendor clinicians for a specified period post-acquisition, often through the use of deferred payments.[16]

A.17 We also saw evidence of lock-ins for other associates at one of the four large dental groups, and we found documents from another which noted the inclusion of a 'retention' (which we interpret as a retainer fee) for a high grossing associate as part of one acquisition, and a '£[✂]k pot for high grossing clinician' as part of another.[17]

Competition between suppliers

How businesses compete

A.18 We asked large dental groups and small to mid-size dental groups to list the factors on which dental practices compete and to rate their importance. Dental groups consider location and quality of care as the most important factors. Most dental groups also considered appointment availability and reputation or reviews very important;[18] and price as either an important or very important competitive factor, although several dental groups gave it a lower rating.[19] A few dental groups said that price was more important in less affluent regions.[20]

A.19 Feedback from independents at our roundtable suggests that they consider quality of care, range of treatments, and quality of practice environment as key parameters of competition. This roundtable feedback also suggests independents

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[15] Responses to the CMA's information requests: [✂]
[16] Responses to the CMA's information requests: [✂]
[17] Responses to the CMA's information requests: [✂]
[18] Responses to the CMA's information requests: [✂]
[19] [✂], [✂], [✂], [✂], [✂], and [✂] gave price a rating of 3 for moderate, while [✂] did not give it a rating. [✂] response dated [✂], suggests that price was the most mentioned parameter in a survey (ahead of patient reviews and friendly staff). Another [✂] document found that relevance and offering NHS dentistry are crucial, alongside customer care. Even for private users being overly expensive will still be a turn off for some. [✂] response dated [✂]. Another [✂] document found that the relationship with the clinician was most important followed by the friendliness of staff and the practice environment, [✂] response dated [✂]. [✂] internal documents indicate that although important, price is not the primary driver of choice. Quality comes first with price decreasing in importance as income of respondents grows. Other factors that were important were location, consistency and relationship with clinician and waiting time. [✂] response dated [✂]. Responses to the CMA's information requests: [✂].
[20] [✂] said it was most pronounced in areas such as the North East. [✂] said that patients shop around where competitors were nearby. [✂] said that it mostly has practices in lower income areas and considered price a very important competitive parameter. Around half of the groups highlighted continuity of clinician and gave it an important rating ([✂]). A couple of groups said that patients would be more loyal to the clinician than to the group ([✂]). A few groups picked out other features as the most important aspects of competition including brand, practice environment, patient experience, opening hours, or range and technology. [✂] stated that practice environment and range were important. [✂] said practice environment and brand were key. [✂] listed brand as well as range. [✂] said patient experience and technology were key. [✂] and [✂] said opening hours was one of the most important factors. Responses to the CMA's information requests: [✂].

consider rapport, relationship with the dentist and trust as important, while price is generally less important.[21]

Prices are generally set to reflect local market conditions

A.20 Most large dental groups compete primarily at a local level.[22] Prices for private treatments generally vary across different practices of the same group, often reflecting factors such as local market conditions including competitor pricing and socio-economic demographics, as well as cost base variation.[23] For example, one large dental group submitted that its pricing decisions are informed by multiple factors including the cost of delivery at the relevant practice, local market competition, and the price sensitivity of the local patient demographic.[24] One small to mid-size dental group submitted that it considers local pricing and demographics to ensure its prices remain appropriate and competitive.[25] However, at some groups there may be some competitive monitoring nationally or regionally.[26] This monitoring may include some pricing decisions being made centrally, for instance evidence from one group shows pricing decisions being considered centrally at the group level.[27] Independents with only 1 or 2 practices can only compete on a local basis. Proximity to home and work being consumers' most popular reason for selecting a dental practice explains why competition is local.

A.21 The evidence indicates that, while some pricing decisions are made centrally at a group level and that prices are also set to reflect local conditions, the evidence does not indicate an additional regional component to how prices are set.[28] However, regional variations in the factors that influence local pricing (such as demographics and cost bases) are likely to result in different regions and UK nations having different average private treatment prices. This is consistent with findings from Chapter 6 on variation in private prices within local areas – which found material price variation for the same private treatments across eight local areas.[29]

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[21] Note of roundtable with independent dentists, 01/07/26.
[22] Responses to the CMA's information requests: [✂].
[23] Responses to the CMA's information requests: [✂]. Two documents from one of the four largest dental groups indicate that this group analyses the prices of local competitors when it considers acquiring dental practices. [✂] response dated [✂]. [✂] response dated [✂].
[24] [✂] response dated [✂].
[25] [✂] response dated [✂].
[26] Including [✂]. Responses to the CMA's information requests: [✂].
[27] A research paper from [✂] made price recommendations at group level for different treatments, having regard to factors such as customer willingness to pay, competitor pricing and customer price comparison behaviours. [✂] response dated [✂].
[28] However, one large dental group submitted its guide prices for common private services are initially set at a regional basis within England, [✂]. This group also submitted that London and the South East operate on a materially higher cost base than the North West or the Midlands, and that practice-level pricing reflects this. The group also referred to differences in the fees of local competitors between practices in central London and practices in Manchester or the Midlands, and to the significant variation in private dental spend per head across England, with the highest levels in central and west London and the lowest in deprived urban and rural areas. [✂] response dated [✂].
[29] For more detail, see Appendix C Review of dentistry websites.

A.22 A few of the large dental groups stated that they price match certain offers either when setting prices or when responding to customer requests for price matching.[30] NHS prices are generally not used as a benchmark for setting private prices.[31] The evidence also indicates that prices are typically reviewed annually, although smaller groups were more likely to make pricing adjustments more frequently.[32]

Clinicians can have some discretion around the final price paid

A.23 We have been informed that list prices are largely decided by practice owners, managers or dental groups. Where a practice owner is a clinician that would mean a clinician is deciding these prices.

(a) Most independent dental professionals in the Revealing Reality research reported that prices were set within the practice by the owner or principal dentist, sometimes in conversation with the practice manager.[33]

(b) The Revealing Reality research found that prices for dental groups were commonly set at the dental group level, with most dental professionals working within groups reporting that prices were determined centrally by the wider organisation. Within groups, there were varying degrees of input that dentists and practices could have into pricing. For some, prices were reported to be issued and fixed by the dental group, whereas for others there was a wider process that involved input from individual practices.[34] Evidence from groups was consistent with these findings. Some groups tend to set prices centrally for individual practices (as noted above, prices for private treatments generally vary across different dental practices of the same dental group).[35] Other groups give local practices more discretion to set prices locally.[36]

A.24 The final price paid by a patient may also depend on the individual clinician treating them and they may have some discretion over this final price (in addition

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[30] Responses to the CMA's information requests: [✂]. Responses to the CMA's information requests: [✂].
[31] NHS prices were generally seen as having limited influence on private pricing, although a few of the groups did not rule out using NHS prices as a benchmark ([✂] said they neither agreed or disagreed with the idea of using NHS prices as a benchmark). Most groups at most considered NHS prices as context (such as indicative of demand) or to have an effect on the operation of mixed NHS and private practices (including affecting practice cost recovery), See for instance, [✂]. The majority of the Independents that responded considered that NHS prices were not used as a benchmark for private prices. In our independents' questionnaire we asked "Does your practice benchmark private prices against NHS:" Strongly disagree 54%. (Disagree 22%, Neither 11%, Agree 5%, Strongly agree 7%). Responses to the CMA's information requests: [✂].
[32] For instance, [✂]. Responses to the CMA's information requests: [✂].
[33] Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations – section 6.1.1.
[34] Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations – section 6.1.1.
[35] [✂] generally set prices centrally for individual practices and treatments, although local practices can request adjustments or appeals. One dental group has a fairly fixed percentage uplift across all sites ([✂]). Most large dental groups set prices at group level separately for each practice and there is some scope for practices to object or change those prices ([✂]). Responses to the CMA's information requests: [✂].
[36] Large dental groups that set prices at the practice level include [✂]. Responses to the CMA's information requests: [✂].

to the discretion they have around the treatments they recommend, which will also determine the price paid).

(a) The Revealing Reality research found that although prices were largely decided by practice owners, managers, or dental groups, many dental professionals across practice types described having discretion to adjust charges on a case-by-case basis. Dental professionals reported considering various factors when adjusting the prices of treatment, including the complexity of the treatment, materials required, as well as the time the treatment would take. These prices could go up or down, depending on the case the dentist was treating.[37]

(b) Of those groups that indicated that they give local practices more discretion to set prices locally, a minority indicated that this involves clinicians making the final pricing decision or having some discretion within centrally defined frameworks or guidelines.[38]

Barriers to entry and expansion

A.25 Barriers are factors that prevent or otherwise impair a firm's entry or expansion in a market. Such barriers can give incumbents, and/or larger firms, an advantage and reduce competition in a market. They may also impede the ability and incentive to innovate and thereby reduce the application of new ideas that improve efficiency or enhance quality.

A.26 In order to explore the main barriers to entry and expansion in the private dentistry market, we asked dental groups to provide qualitative views on the barriers they consider applicable, and independents to score different barriers on a scale of 1-5 based on level of significance.[39] Table A.2 below shows the key barriers identified by groups and independents and the average significance scores the independents gave.[40]

[37] Revealing Reality (2026) Qualitative Research with Dental Professionals Delivering Private Dental Services Across the UK Nations – section 6.1.2.
[38] Some groups emphasise the ability of clinicians to make the final pricing decision on the care required ([✂]). [✂] and [✂] give practices and clinicians greater discretion to set prices locally, within centrally defined frameworks or guidelines ([✂]). [✂] and [✂], said that they adjusted prices for the expertise of the clinician. Responses to the CMA's information requests: [✂].
[39] Independents were asked to select, from a prescribed list of barriers, which they consider are currently applicable and give a significance score. Independents could also cite other barriers that were not prescribed using free-text options.
[40] Other barriers were also cited by some dental firms but less commonly, for example access to NHS contracts and high operating costs and access to finance. Access to finance was almost exclusively identified by only Independents, as aside from the 139 out of 147 Independents, only one large dental group also identified it.

Table A.2: Overview of key barriers identified and the average significance scores from independents

Barriers	*Number of dental firms to cite barrier*		*Average significance scores from independents*
	Groups	*Independents*	
Workforce challenges	25 of 26	143 of 145	4.3 out of 5
Regulatory complexity and burden	16 of 26	138 of 145	4.1 out of 5
Attracting private demand	22 of 26	139 of 145	3.4 out of 5
Upfront investment costs	22 of 26	N/A[1]	N/A[1]
Access to suitable premises	7 of 26	135 of 145	3.2 out of 5

Notes:
[1]Upfront investment costs was not a pre-set option in the questionnaire that independents responded to and only one firm raised it independently. This also means the average significance score would have been based on a single response.

A.27 We discuss each of the key barriers in greater detail below. Within the section on workforce challenges, we also discuss regulatory barriers and contractual arrangements constraining the NHS dentistry workforce and firms' NHS offering's expansion more generally.

Workforce challenges

A.28 We asked dental firms what they consider are the key barriers to entry and expansion in the private dentistry sector in the UK, and why. The challenge of finding workforce was identified as a key barrier to entry and expansion by almost all dental firms,[41] including dental groups of all sizes and independents across all four UK nations.[42] Independents rated workforce challenges as a highly significant barrier to entry and expansion, with an average significance score of 4.3 out of 5. Some large dental groups also noted that workforce challenges are the single most significant barrier.[43]

A.29 When explaining why workforce challenges are a key barrier to entry and expansion, some of the key points identified by dental groups included:

(a) Just over half of large dental groups and one small to mid-size dental group noted there are shortages in the number of dental professionals in the UK.[44] For example, one large dental group noted there is a shortage of approximately 3,000 dentists in the UK.[45] One large dental group noted clinician shortages particularly act as a barrier to entry for groups rather than independents, as a qualified dentist can be a founder and open their own practice with themself as the primary clinician.[46] In addition, just over half of large dental groups and two small to mid-size dental groups also noted shortages also apply to nurses and other clinical professionals, for example

[41] [✂]. Responses to the CMA's information requests: [✂]. Responses to the CMA's Independents' questionnaire published 13 July 2026, [✂].
[42] [✂]. Responses to the CMA's information requests: [✂].
[43] Responses to the CMA's information requests: [✂].
[44] Responses to the CMA's information requests: [✂].
[45] [✂] response dated [✂].
[46] [✂] response dated [✂].

hygienists.[47] One group noted that it did not think there would be so-called 'dental deserts' if the workforce was sufficiently big.[48,49]

(b) One of the four largest dental groups noted dentists have rising expectations around remuneration – which can be a financial challenge to practices recruiting.[50] A small minority of large dental groups noted that dentists tend to not want to build their own patient list from scratch and prefer practices that can offer them an established one.[51] In addition, two of the four largest dental groups and one small to mid-size dental group noted that rises in the national minimum wage have made it more difficult to recruit dental care professionals, such as nurses, who are often paid at levels similar to minimum wage – as employment in other sectors becomes relatively more attractive.[52]

(c) A small minority of large dental groups noted there is a limited supply of dentists, as well as hygienists and therapists, that perform NHS Dentistry,[53] and falling numbers of dentists willing to perform NHS Dentistry.[54,55] Two groups noted that dissatisfaction with NHS contract terms and the opportunity for better remuneration and working conditions doing private dentistry as the key reasons for the shift.[56] This particularly impacts mixed practices that need to meet NHS contract quotas. Further, one of the four largest dental groups noted that issues with the process for dentists to get an NHS Performer Number (a requirement to deliver NHS Dentistry as self-employed dentists), such as a lengthy and bureaucratic application process and

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[47] Responses to the CMA's information requests: [✂].
[48] Note of meeting with groups, dated 8 July 2026.
[49] A 2025 internal document from one of the four largest dental groups noted that in 2021 the UK had a lower average density of dentists compared to EU countries – for example the UK has 6.4 dentists per 10,000 population, compared to an average of 8.3 per 10,000 for EU countries. Also, the document notes the shortage of dentists in the UK has been growing approximately 36% per year since 2016. [✂] response dated [✂]. In addition, several large dental groups considered that competition with other dental firms is more intense for clinicians than it is for attracting patients – reflecting how impactful workforce shortages are. Responses to the CMA's information requests: [✂].
[50] [✂] response dated [✂].
[51] Responses to the CMA's information requests: [✂]. Note of meeting with groups, dated [✂].
[52] Responses to the CMA's information requests: [✂].
[53] Responses to the CMA's information requests: [✂].
[54] Responses to the CMA's information requests: [✂]. Other evidence also helps explain why dentists may be shifting away from delivering NHS dentistry. Internal document evidence from two large dental groups point to better remuneration opportunities from delivering private dentistry as a reason many clinicians are shifting away from NHS delivery. [✂] response dated [✂]. [✂] response dated [✂]. Further, a study by MINDSET on burnout and depression in the UK dental workforce, based on a 2023 survey, concluded that dentists with a high NHS commitment (75-99%) were experiencing significantly higher levels of emotional exhaustion and depressive symptomology and lower levels of personal accomplishment. MINDSET, Burnout and depression in the UK dental workforce: findings from a cross-sectional survey, page 1. In addition, the GDC's Dentist working patterns inferential analysis found that the longer a dentist has been on the GDC register, the less likely they are to be providing some amount of NHS dentistry – indicating the shift away from NHS dentistry is not uniform across experience levels. GDC, Dentist working patterns inferential analysis, page 23.
[55] 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 dated [✂]. 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 dated [✂].
[56] [✂] response dated [✂]. [✂] response dated [✂].

requirements for mentoring, deters dentists from delivering NHS Dentistry and instead towards delivering only private dentistry.[57]

A.30 Large dental groups provided further insight as to the root causes of dentist shortages in the UK. Specifically:

(a) A minority of large dental groups noted there are not enough training places in the UK for dentists to become qualified.[58] For example, two of the four largest dental groups cited data from the Office for Students which shows there are approximately 10,000 applicants competing for around 1,100-1,200 undergraduate dental school spaces.[59] Further, one large dental group noted that dental schools have been increasingly offering more spaces to overseas students – many of whom then leave the UK to practise back in their home country.[60]

(b) Half of large dental groups noted there are constraints on the number of qualified dentists from overseas that can move to the UK and become registered to practice here – primarily via the Overseas Registration Examination (ORE) or Licence in Dental Surgery Exam (LDS).[61] For example, one of the four largest dental groups noted that, as of April 2026, there are over 6,000 dentists in the waiting list to do the ORE – run by the GDC.[62] Two of the four largest dental groups noted that although the number of ORE and LDS places are set to increase to approximately 1,500 and 1,800 respectively between now and 2028 – which should lead to increases in the number of dentists available in the UK – it would still take a number of years thereafter for the supply and demand of dentists to rebalance.[63] Two large dental groups and one small to mid-size dental group raised an additional point that changes to the Skilled Worker visa – introduced in June 2025 – removed dental nurses from sponsorship eligibility, and that the self-employed associate model is incompatible with the visa, as it mandates employment requires a guaranteed salary – thereby preventing sponsored overseas dentists working as self-employed staff.[64]

(c) Just over half of large dental groups noted self-employed clinicians either do not want to work full-time hours or are reducing their hours over time.[65] This means that although the number of practising dentists in the UK may not change or indeed could increase, the total full-time equivalent (FTE) – ie the

[57] [✂] response dated [✂].
[58] Responses to the CMA's information requests: [✂].
[59] [✂] response dated [✂]. [✂] response dated [✂].
[60] [✂] response dated [✂].
[61] Responses to the CMA's information requests: [✂].
[62] [✂] response dated [✂].
[63] [✂] response dated [✂]. [✂] response dated [✂].
[64] Responses to the CMA's information requests: [✂].
[65] Responses to the CMA's information requests: [✂]. One of the four largest dental groups also noted that it finds its longest running vacancies are those with the highest hour requirements. [✂] response dated [✂].

total available clinical hours – would reduce.[66] Further, a small minority of large dental groups noted self-employed clinicians may also split their time across multiple practices.[67] A minority of large dental groups explained dentists are choosing to work less hours to practice better work-life balance, as working in the sector carries high stress.[68]

(d) Two of the four largest dental groups noted that litigation risk from treatments delivered – where patients are not happy with the treatment received – may also influence clinicians' willingness to practise.[69] In addition, one of the four largest dental groups noted that due to the significant increase in the volume of dental negligence claims over recent years, the cost of indemnity insurance for both clinicians and firms has increased.[70]

A.31 Several groups and a few Independents explained that workforce challenges vary by location. Specifically:

(a) Responses from large dental groups identified that the areas that experience the greatest recruitment and retention challenges include parts of Scotland and Wales, and rural and coastal areas of England. Challenges also tend to be greater in areas of higher socio-economic deprivation.[71] One of the four largest dental groups and an independent also identified recruitment challenges in Northern Ireland.[72] Additionally, two dental groups noted that shortages of dentists in more rural areas seems to be due to lifestyle choices – ie some dentists do not want to live in rural areas.[73] Two large dental groups explained that Wales and Scotland have smaller pools of recently qualified dentists.[74]

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[66] Two of the four largest dental groups cited data from the GDC that shows 44% of dentists now work 30 or fewer hours per week – directly contributing to a fragmented, part-time vacancy profile in its group. [✂] response dated [✂]. [✂] response dated [✂]. Additionally, an internal strategy document from one of the four largest dental groups cites data which shows between 2021 and 2030, the total supply of clinician hours will be limited, given modest growth in the number of dentists and reductions in working hours. [✂] response dated [✂].
[67] Responses to the CMA's information requests: [✂]. An internal strategy document from one of the four largest dental groups cites data for 2024/25 that shows 39% of dentists work across multiple practices. [✂] response dated [✂].
[68] Responses to the CMA's information requests: [✂]. One of the four largest dental groups cited data from two surveys of dental professionals – a 2023 survey conducted by the British Dental Association (BDA) and a 2025 survey conducted by Dental Protection. For the former survey, it cited that 61% of respondents ranked 'high' on an emotional exhaustion scale, while in the latter survey, it cited that 63% of respondents stated they are frequently burnt out and exhausted. [✂] response dated [✂].
[69] Responses to the CMA's information requests: [✂].
[70] [✂] response dated [✂].
[71] Responses to the CMA's information requests: [✂]. In addition, one of the four largest dental groups has found that among the four UK nations, England has had the shortest period needed on average to recruit dentists, while Scotland, Wales and Northern Ireland have substantially longer average times (in that order). [✂] response dated [✂].
[72] [✂] response dated [✂]. Regarding Northern Ireland specifically, one Independent noted that although the number of dentists in Northern Ireland has increased, there are still severe difficulties recruiting dentists in the areas bordering the Republic of Ireland, as there has been an increase in the number of dentists based in Northern Ireland that choose to work across the border. [✂] submission to the CMA, [✂].
[73] Note of meeting with groups, dated [✂]. In addition, an Independent also noted many younger dentists only want to work in cities, which impacts recruitment in rural areas. Note of meeting with Independent dental firms, dated [✂].
[74] Responses to CMA's information requests: [✂].

(b) One of the four largest dental groups noted there are some parts of the UK with no local dental qualification provision,[75] while two other groups noted that dentists tend to practice broadly near where they trained – so the distribution of the workforce is dependent on the proximity to dental schools.[76]

(c) One large dental group noted that for dentists with enhanced skills (eg specialists), shortages are almost absolute outside major urban centres.[77] In addition, one of the four largest dental groups noted that specialist dentists are often more established in their careers and locations, which reduces mobility of that workforce.[78]

(d) A small minority of large dental groups noted that regional disparities in the NHS rates for 'Unit of Dental Activity' (UDA) create regional variation in the level of difficulty attracting dentists.[79] For example, one large dental group noted that it is more difficult to attract dentists in areas where the NHS UDA rates are lower,[80] and another noted that some UK regions have increased the NHS UDA rates – which has had the effect of drawing more dentists to those areas – as they can earn more for delivering the same treatments relative to other areas with lower UDA rates.[81]

Barriers constraining NHS dentistry

A.32 To practice NHS dentistry, dental professionals must be registered with the GDC and join the relevant NHS Performer List (DPL or Health Board list).[82] All dentists wishing to join the DPL in England must show they have either (i) completed UK Dental Foundation Training; (ii) are exempt as they have practised in a European Union country and were registered there; or (iii) have to demonstrate equivalence to foundation training via the competence assessment route. The equivalence route may involve supervised practice and mentoring.[83]

A.33 Some dental groups told us that applications can take several months and differing requirements across the UK nations can create additional complexity and delay.[84] Variations in mentoring requirements, funding arrangements, eligibility criteria and

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[75] [✂] response dated [✂].
[76] [✂] response dated [✂]. Note of meeting with groups, dated [✂].
[77] [✂] response dated [✂].
[78] [✂] response dated [✂].
[79] [✂] response dated [✂]. [✂] response dated [✂]. Note of meeting with [✂].
[80] Note of meeting with [✂].
[81] [✂] response dated [✂].
[82] Performer Lists are maintained by Primary Care Support England (PCSE) in England on behalf of NHS England, the NHS Wales Shared Services Partnership (NWSSP) in Wales, the 14 territorial Health Boards in Scotland, and HSC Business Services Organisation (BSO) in Northern Ireland. See NHS England 'NHS England » Policy for managing applications to join the England performers lists' for an example of what is required in England, accessed 19/11/26.
[83] Primary Care Support England, 'Overseas Dentists | PCSE' accessed 19/11/26.
[84] [✂] response dated [✂]; Association of Dental Groups response to the CMA's statement of scope, q10B; Portman Dentex's response to the CMA's statement of scope, q10B; Note of a roundtable with Dental Groups.

mentor responsibilities can create complexity, constrain recruitment and limit the number of professionals able to deliver NHS care, and that shortages of suitably qualified mentors create restrictions on the number of practices able to accommodate trainees.[85]

A.34 Existing mentoring arrangements may discourage experienced clinicians from becoming mentors. Large dental groups questioned some mentor eligibility requirements and highlighted concerns regarding responsibilities, liability, funding and recognition of the time commitment involved.[86] One of the four largest dental groups also told us that the time required for mentees to complete relevant requirements can be lengthy, suggesting the process can take up to 18 months.[87]

A.35 In relation to specific nations, one of the four largest dental groups told us that mentor training requirements in Wales, including the requirement to attend a centrally delivered course offered annually, may contribute to slower recruitment into NHS dentistry in Wales, particularly in rural areas.[88]

A.36 For businesses seeking to expand their NHS dentistry offering, beyond these workforce challenges, there can also be contractual challenges (where relevant). For example, one of the four largest dental groups indicated that, for practices seeking to expand their NHS offering, it could be challenging where there was a lack of new commissioning for NHS activity.[89]

A.37 In England, differing UDA rates can also distort market incentives around entry and expansion of NHS services. Internal documents from one of the four largest dental groups indicate that, unless improvements to profitability can be made for practices with UDA rates less than [£[✂]], it would consider ending those contracts. On the other hand, for practices with UDA rates above [£[✂]], contracts would be maintained and protected, with potential to explore growing the contracts (provided not at the expense of private work, for example).[90]

A.38 We have heard from industry commentators that there is a 'competitive rate' for dentists delivering UDAs across England of [£[✂] or £[✂]] which can impact where professionals choose to practise.[91] In particular, because the value of a UDA is fixed by a contract's funding allocation and activity target, practices with

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[85] [✂] response dated [✂]; [✂] response dated [✂]; [✂] response dated [✂].
[86] [✂] response dated [✂];
[✂] response dated [✂]. The lead dentist is usually responsible for the patient, although dental hygienists, dental therapists, and clinical dental technicians sometimes operate independently under direct access provisions. See GDC Guidance on Scope of Practice. GDC Standard 6.3.1 provides: 'You can delegate the responsibility for a task but not the accountability. This means that, although you can ask someone to carry out a task for you, you could still be held accountable if something goes wrong'.
[87] [✂] response dated [✂].
[88] Note of meeting with [✂] dated [✂].
[89] Note of meeting with [✂] dated [✂].
[90] [✂] response dated [✂].
[91] Note of meeting with [✂].

lower UDA rates may be less able to offer competitive rates to dentists – which could distort distribution of the supply of NHS services.

Regulatory complexity and burden

A.39 We asked dental firms what they consider are the key barriers to entry and expansion in the private dentistry sector in the UK, and why. Most dental firms[92] cited regulatory complexity and burden as a key barrier to entry and expansion,[93] with an average significance score from independents of 4.1 out of 5.

A.40 When explaining why regulatory complexity and burden is a barrier to entry and expansion, some of the key points identified by dental groups included:

(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.[94] One of the four largest dental groups noted that the registration and approval processes can be slow – which have the effect of delaying entry or expansion.[95]

(b) Extensive compliance requirements, including health and safety standards and regulations such as the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.[96]

(c) Mixed practices are more operationally complex than dental practices that exclusively deliver private treatments, since those practices need to additionally deal with NHS contract terms and commissioning bodies.[97]

A.41 Several firms made points that regulatory complexity and burden affect larger dental firms to a greater extent. Specifically:

(a) One of the four largest dental groups and a dental payment plan provider noted that the differing regulatory regimes and standards across the four UK nations particularly increased administrative complexity for larger firms that operate across multiple nations.[98]

[92] [✂]. Responses to the CMA's information requests: [✂]. Responses to the CMA's Independents' questionnaire published 13 July 2026 [✂].
[93] A significant proportion of dental firms also cited regulatory burden and complexity as a key challenge and issue to their ongoing provision of dentistry services. [✂]. Responses to the CMA's information requests: [✂].
[94] Responses to the CMA's information requests: [✂].
[95] [✂] response dated [✂].
[96] Responses to the CMA's information requests: [✂].
[97] [✂] response dated [✂].
[98] [✂] response dated [✂]. [✂] Statement of Scope consultation response dated [✂].

(b) One large dental group noted that multi-site groups have greater compliance requirements with the CQC, for example as each of their practices are required to have registered managers.[99]

(c) One large dental group noted that corporate bodies providing dentistry are required to have at least 50% of their directorship as GDC-registrants.[100]

A.42 Whereas one large dental group noted the compliance infrastructure (such as audit systems, clinical governance leads, bi-annual key lines of enquiry assessments) that is needed to maintain ongoing compliance with the different regulations and standards noted earlier, is substantial, and is the same for Independents as well as large dental groups, therefore disproportionately affecting smaller firms.[101]

A.43 Aside from the above points that note regulatory complexity and burden differs geographically, one of the four largest dental groups noted regulatory frameworks are largely consistent across Great Britain, while Northern Ireland has more differences.[102]

Attracting private demand

A.44 We asked dental firms what they consider are the key barriers to entry and expansion in the private dentistry sector in the UK, and why. The vast majority of dental firms[103] cited attracting private demand as a key barrier to entry and expansion in the private dentistry market,[104] with the average significance score from Independents of 3.4 out of 5.

A.45 When explaining why attracting private demand is a barrier to entry and expansion, some of the key points identified by dental groups included:

(a) Half of large dental groups and one small to mid-size dental group noted that demand for private dentistry is closely linked to the availability and accessibility of NHS Dentistry[105] – with areas that have higher availability of NHS seeing lower demand for private dentistry. Two large dental groups and one small to mid-size dental group noted that demand for private dentistry is also linked to patients' willingness to pay – which is impacted by wider economic uncertainty and rising cost of living.[106]

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[99] [✂] response dated [✂].
[100] [✂] response dated [✂].
[101] [✂] response dated [✂].
[102] [✂] response dated [✂].
[103] [✂]. Responses to the CMA's information requests: [✂]. Responses to the CMA's Independents' questionnaire published 13/07/26 [✂].
[104] A significant proportion of dental firms also cited attracting private demand as a key challenge and issue to their ongoing provision of dentistry services. [✂]. Responses to the CMA's information requests: [✂].
[105] Responses to the CMA's information requests: [✂].
[106] Responses to the CMA's information requests: [✂].

(b) A quarter of large dental groups and less than half of small to mid-size dental groups noted a practice's ability to attract new private patients is dependent on their ability to promote their services and treatments,[107] with another large dental group noting that new entrants need marketing investment to establish credibility.[108]

(c) In addition to points about competition with other dental practices in their local area, one large dental group and one small to mid-size dental group noted that attracting private demand also involves competing with providers overseas – for example in Turkey – often referred to as 'dental tourism'.[109]

A.46 Several groups explained that attracting private demand varies by location. Specifically:

(a) As noted above, with the link between level of NHS dentistry and demand for private dentistry, just under half of large dental groups and one small to mid-size dental group noted that demand for private dentistry is stronger in areas with weaker NHS dentistry – for example there is limited access or NHS waiting times are long.[110]

(b) The groups submissions indicate that the areas where it is harder to attract private demand include the Midlands, North of England, Wales and Scotland.[111]

(c) One of the four largest dental groups noted there are regional variances due to levels of workforce and price variations.[112]

(d) One large dental group noted competition for private patients in city-centre areas is consistent throughout the UK, although competition specifically against group firms is higher in urban areas – in particular in England – where it notes groups have a greater presence.[113]

Upfront investment costs

A.47 We asked dental firms what they consider are the key barriers to entry and expansion in the private dentistry sector in the UK, and why. The vast majority of groups[114] cited upfront investment costs as a key barrier to entry and expansion.

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[107] Responses to the CMA's information requests: [✂].
[108] [✂] response dated [✂].
[109] [✂] response dated [✂]. [✂] response dated [✂].
[110] Responses to the CMA's information requests: [✂].
[111] Responses to the CMA's information requests: [✂].
[112] [✂] response dated [✂].
[113] [✂] response dated [✂].
[114] [✂]. Responses to the CMA's information requests: [✂]. Response to the CMA's Independents' questionnaire published 13 July 2026, [✂].

A.48 When explaining why upfront investment costs are a barrier to entry and expansion, a majority of large dental groups and almost all small to mid-size dental groups explained that dental practices require significant upfront capital investment, for example to purchase and fit clinical equipment and digital systems.[115] One of the four largest dental groups further noted that material and labour costs for construction and dental practice fit-out have risen significantly since Covid-19, and BCIS forecasts building costs to rise a further 14% over the next five years.[116] One large dental group noted that dentistry premise fit-out costs are modest by healthcare standards and are easily financed by individual dentists with bank finance, asset financing, founder-led groups or institutional buyers.[117] One large dental group and one small to mid-size dental group also noted that private patients expect high-quality, modern, aesthetically pleasing premises – which influences the level of spend required.[118]

A.49 Several groups explained that upfront investment costs vary by location. Less than half of large dental groups noted that costs are highest in London and the South East in England,[119] and a small minority of large dental groups noted the costs are lowest for example in northern England and Wales.[120] Whereas, less than a fifth of large dental groups noted costs are broadly consistent across the UK regions.[121]

Access to suitable premises

A.50 We asked dental firms what they consider are the key barriers to entry and expansion in the private dentistry sector in the UK, and why. Most dental firms[122] cited access to suitable premises as a barrier to entry and expansion, with the average significance score from independents of 3.2 out of 5.

A.51 There were mixed views from dental groups on the strength of the barrier. Those that considered it impactful made the following points:

(a) One of the four largest dental groups explained that dental firms compete with other types of firms for premises similarly targeting high-footfall locations, such as food & beverage and retail operators – which reduces availability and increases costs.[123]

[115] Responses to the CMA's information requests: [✂].
[116] [✂] response dated [✂].
[117] [✂] response dated [✂].
[118] [✂] response dated [✂]. [✂] response dated [✂].
[119] Responses to the CMA's information requests: [✂].
[120] Responses to the CMA's information requests: [✂].
[121] Responses to the CMA's information requests: [✂].
[122] [✂]. Responses to the CMA's information requests: [✂]. Responses to the CMA's Independents' questionnaire published 13/07/26, [✂].
[123] [✂] response dated [✂].

(b) Two large dental groups and less than a third of small to mid-size dental groups noted that suitable premises are expensive and difficult to secure.[124]

(c) Two large dental groups noted premises require specific layouts and need to comply with different clinical, regulatory and accessibility standards – which is both time and resource intensive to find and refurbish (if necessary) – and can require planning approvals.[125]

A.52 Conversely, the points made by dental groups that did not consider the barrier impactful included:

(a) One large dental group noted there are no specialist building requirements, so a range of spaces can be sufficient, for example residential conversions.[126] Similarly, one large dental group stated that premises are readily available.[127]

(b) One large dental group noted that many existing practices have surplus chair capacity that they rent to new entrants – for example on a daily basis similarly to renting office spaces – which removes this barrier.[128]

A.53 Views were also mixed as to whether the significance of the barrier varied by location. Two large dental groups noted urban areas face higher property costs and competition for space[129] – for instance one large dental group cited London as the most expensive[130] - while rural or less densely populated areas may have greater availability but equally require greater refurbishment investment to meet required standards.[131] In addition, one large dental group noted the North West and much of the Midlands in England as areas with greater availability of premises and at lower cost.[132] On the other hand, one of the four largest dental groups noted the barrier is broadly consistent across the UK, although it also notes the intensity of competition for premises varies by urban vs rural locations and the specific retail conditions in particular areas.[133]

[124] Responses to the CMA's information requests: [✂].
[125] [✂] response dated [✂]. [✂] response dated [✂].
[126] [✂] response dated [✂].
[127] [✂] response dated [✂].
[128] [✂] response dated [✂].
[129] [✂] response dated [✂]. [✂] response dated [✂].
[130] [✂] response dated [✂].
[131] [✂] response dated [✂].
[132] [✂] response dated [✂].
[133] [✂] response dated [✂].

Capacity utilisation

A.54 We asked dental groups to provide data on utilisation for the last five years (for example, number of appointment slots used divided by number of available appointments).[134]

A.55 Almost all of the large and small to mid-size dental groups that responded had average utilisation levels of over 80% and for the vast majority, it was over 85%.[135]

A.56 We note that dental groups will take differing approaches to measuring utilisation (if they measure it at all). However, the large dental groups that responded to our information requests mostly indicated that utilisation measures are typically closely linked to the number of available clinician hours (eg diary utilisation), though a minority indicated they consider chair utilisation. We note that if a dentist works less than full-time but is working all their contracted hours, this would be counted as full utilisation in the data if the firm considers diary utilisation.

[134] We defined utilisation as 'the proportion of available clinical capacity that is used to deliver dental care over a given period').
[135] As the small to mid-size dental group data came from a relatively small proportion of the small to mid-size dental groups in the market, the results should be considered as indicative. Some respondents specified that the calculation excludes lunch, not working and holiday blocks. Some also specified that these figures include 'no show' patients. Responses to the CMA's information requests: [✂].