Appendix G: Data collection approach and methodology for margin analysis of dental firms

G.1 In this appendix, we explain our data collection methodology and analytical approach for the financial analysis of dental firms. We also provide an overview of anticipated next steps. This appendix is structured as follows:

(a) Data collection methodology;

(b) Analytical approach; and

(c) Next steps.

Data collection methodology

G.2 We collected financial information separately for dental groups and independents (**Dental firms**). We adopted different collection approaches due to the differences in financial reporting capabilities. 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. As such:

G.3 For dental groups, we developed a financial template which we required each dental group to complete.[1] This helped us to collect information on a broadly consistent basis, despite differences in accounting standards (which can create differences in the recording of some costs, eg property cost).

G.4 We gathered data from 24 dental groups. This included:

(a) The four largest dental groups, comprising 100% of the segment share.[2]

(b) Other large dental groups with 30 or more practices.[3] Our sample included 12 of these dental groups, comprising 90% of the segment share.

(c) Small to mid-size dental groups with 3-29 dental practices.[4] Our sample included eight of these dental groups, comprising around 6% segment share.

G.5 Given that we have a high percentage coverage of the segment for the four largest dental groups and the other large dental groups, we focused our analysis on the results of these firms. We have not included the financial results from the small to mid-size dental groups in this Interim Report.

---

[1] A profit and loss statement for all dental groups as well as a balance sheet for FLDGs and LDGs.
[2] According to data from Christie & Co, these groups accounted for over 1,400 practices as of September 2026.
[3] According to data from Christie & Co, these groups account for approximately 800 practices as of September 2026.
[4] According to data from Christie & Co, these groups accounted for over 1,800 practices as of September 2026.

G.6 As far as possible, we standardised definitions and reporting of income statement and balance sheet categories across dental groups. Nevertheless, differences in accounting policies, financial year-ends, and how information is recorded and maintained within dental groups' accounting systems may have affected comparability.

G.7 We asked firms to provide financial information relating to their five most recent financial years. However, we have focused on the three most recent years to avoid distortions associated with the COVID-19 period. Due to differing year-end dates, there are differences in the time periods covered in each set of data. We have presented the results of our three years of financial analysis such that the most recent year for which we have data from a firm is 'Year 3', the year prior to that is 'Year 2', and the year prior to that is 'Year 1'. In practice, this means that the 'Year 3' results include some firms for which the most recent year end is March 2026, and for others it is March 2025. We are requesting updated financial information from firms as it becomes available to support the comparability of data for our Final Report.

G.8 In addition, dental groups have acquired, divested, and merged practices, which may further affect comparability, particularly when reviewing results over time.[5]

G.9 For independents, we initially sought to obtain historical financial performance data directly from independent firms via an online survey platform which practice owners could voluntarily respond to. However, we received minimal responses.

G.10 We subsequently obtained anonymised financial data covering approximately 500 independent practices across the UK by issuing a section 174 notice to the National Association of Specialist Dental Accountants and Lawyers (**NASDAL**).[6] This notice required NASDAL to provide its information to us under the provisions of the Enterprise Act. This information was less granular than from dental groups – for example, we did not obtain depreciation and amortisation costs or tax paid, although we did obtain information on actual drawings. Given the anonymised nature this data, we note that the practices may move in and out of our sample between years.

G.11 In addition to obtaining financial data, we held discussions with two corporate finance advisers active in the dental sector, to obtain their views on market trends, acquisition activity, valuation drivers, growth strategies and investor return in the dental sector.

---

[5] There was an aggregate of around 1,800 dental practices across all dental groups five years ago increasing to around 2,200 by the latest year. Over this period, the population of dental groups has fluctuated, reflecting new entrants to the market, acquisition activity, divestment and merger of existing practices.

[6] NASDAL annually publishes Benchmarking Survey statistics which they gather from the accountant members of NASDAL. These statistics results show Associate and practices income across the UK.

Analytical approach

G.12 A comprehensive assessment of economic profitability is challenging in private dentistry. The market is highly fragmented; over two-thirds of firms are independents, typically with one to two practices run by a practicing dentist owner-operator. The type of financial information required to assess full economic profit is not readily available for many of these small operators. Comparisons between independent practices and groups also complicated by differences in ownership and remuneration models: associate dentists are typically paid a share of the revenue of treatments they provide, while owner-clinicians generally take remuneration via dividends and sometimes eventual sale of the business. [7,8]

G.13 Additionally, firms do not allocate costs to individual treatments (NHS or private) in a comparable way. In many cases, firms were unable to split costs accurately between NHS and private services, noting that NHS and private services are delivered by the same Associates, staff, and practice assets. This means that we have not been able to assess profitability by treatment, or for the provision of private dentistry alone.

G.14 However, we can analyse profitability for similar types of providers (as we indicated we would do in our published scope). We combine NHS and private activities, rather than assessing the profitability of private dentistry alone.

G.15 Our analysis focused on earnings before interest, tax, depreciation and amortisation (**EBITDA**), a key performance metric in the sector, and earnings before tax, depreciation and amortisation (**EBTDA**).

G.16 EBITDA helps improve comparability of returns between similar types of firms. It avoids differences arising between firms due to differences in:

(a) **Amortisation and depreciation:** where firms apply different policies relating to the amortisation and depreciation of assets margins will differ, all else equal.

(b) **Interest:** firms may choose to structure their capital (ie debt and equity) in different ways which will result in differing interest costs. This will impact margins, despite not being directly tied to the provision of dental services.

(c) **Taxation:** firms may incur different taxation charges which are not directly tied to the provision of dental services.

[7] We have collected information for the last five years for dental groups and for the last six years for independents. However, due to COVID-related data quality issues, we have focused our analysis on figures for the last three years.
[8] A principal dental practice owner is a dentist who owns and runs their own dental clinic. They manage patient care, hire staff, buy equipment and handle all business costs and profits. This role mixes clinical work with business management.

G.17 By relying on the EBITDA metric, we take account of financial results prior to these differences, to improve comparability between practices.

G.18 For independents, we are aware that there will be differences in the comparability of EBITDA margin analysis, relating to property costs and labour costs:

(a) **Property costs:** 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.

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 mortgage, the property costs reflected in EBITDA are likely to be lower than for leased premises, because whereas rent is deducted[9] 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.

(b) **Labour costs:** 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. In this case, the cost of remunerating Principals would not be included in the EBITDA margin. In our analysis, we compare the EBITDA margin to an indicative margin which takes into account 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.

G.19 In this context, both property and labour costs may be understated, which in turn will overstate the EBITDA margins.

Next steps

G.20 **For independents**: we are extending our financial analysis of independent firms to ensure the analysis is representative of the market, accurately reflects all costs (eg property), and identifies drivers of high margins, including low-cost business models.

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

G.21 **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.