Samera

Consultation response

Private dental services market study: response to the CMA interim report

An accountant's view of independent practice economics, acquisition finance and the proposed remedies

Submitted to	Competition and Markets Authority
Consultation	Private dentistry market study: interim report (closes 17 December 2026)
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Samera

1. About Samera and this response

Samera is a UK accountancy and advisory firm specialising in dentistry, founded in 2002. This response is from Arun Mehra FCA, founder and CEO, and draws on that professional experience. Where we give examples, they are anonymised so that no practice can be identified.

Our work gives us a view of practice economics that few other respondents have:

- Annual accounts, tax and management information for mid-sized dental groups, independent practice owners and associates
- Financial due diligence and valuations on practice acquisitions, for buyers and sellers
- Acquisition finance and refinancing through Samera Finance
- Tax advice to hundreds of self-employed dental associates through our Associate Tax Hub
- Running one of the largest buying groups for dentists in the UK

We respond to the interim report published on 26 November 2026, and to the CMA's specific request for more input from independent practices.

> **Declaration of interests**
> Samera advises on accounting, tax, acquisitions, brokers finance and runs a dental buying group, and our clients include both independent practices and dental groups. We set out our views on that basis.

Geographic scope: our response relates to the whole of the UK, though most of our experience is with practices in England.

2. Summary of our position

> **Our central ask**
> We broadly agree that patients find it hard to compare prices and that regulation is complex. We ask the CMA to distinguish clearly between the behaviour it found at large groups and the economics of independent practices, which make up over 60% of the market.

Our six points:

1. Independent price rises have been driven mainly by cost inflation, not market power.
2. Acquisition finance creates pressure to raise prices after a deal; the CMA should examine this in its work on financing and understand the difference between the owners of dental practices. Private equity-backed groups operate very differently from independently owned practices.
3. Price controls would hit independents hardest and could accelerate the consolidation the CMA is concerned about.

4. Changing associate remuneration is harder than it looks, because of how self-employed status and tax work, which if changed could increase the costs in practice, and ultimately the fees charged by a practice.
5. Price transparency should be simple and standardised, so small practices can comply at a low cost.
6. An owner-dentist's profit includes the value of their own clinical work, so margins need normalising for this before independents and groups are compared.

3. Emerging analysis

3.1 Chapter 3: consumers' experiences of the dentistry market

We agree that patients find it hard to compare prices and judge value. Our direct evidence on patient experience is limited, so our comments here are brief.

From our work with owners, many independent practices would welcome a simple, standard way to show prices. Most do not set out to be opaque; they lack a common format and the time to build one. In addition, the services provided by a dental practice can be varied and complex, so trying to detail every outcome in a price list can be difficult for all scenarios. Our proposals on transparency are under Potential remedies below.

3.2 Chapter 4: what drives supply and pricing of private dental treatment

This is where our experience is most relevant. We see three drivers the interim report should give more weight to: cost inflation at independents, the financing of acquisitions, and how associate pay is structured.

3.2.1 Independent practices: costs, not market power

In our experience, most independent practices raised fees between 2023 and 2025 to protect margins, not to exploit weak patient price sensitivity. The CMA found large-group prices rising about 7% a year; independents faced the same cost pressures without the buying power of a group.

The main pressures we have seen on independent practice P&Ls:

- **Staff costs.** Nurse, receptionist and hygienist wages rose sharply, and the April 2025 employer NI changes added further cost. Since COVID, significant numbers of dental nurses have left the profession, pushing wages up further.
- **Materials and lab fees.** Supplier and laboratory prices rose, and independents buy without group discounts. Our buying group is growing as many independent dentists are feeling the pinch and are seeking such groups to help them reduce their costs.
- **Premises, utilities and equipment.** Energy, rent, insurance and compliance spend all increased.
- **NHS contract income.** For mixed practices, NHS income has not kept pace with costs, so private fees carry more of the overheads.

In our experience we see many independent owners raising prices reluctantly, and some later than their costs justified, because they fear losing patients. That is not the behaviour of a business with

pricing power. It's the behaviour of a business that is concerned about surviving and meeting the payroll at the end of each month.

We suggest the CMA's profitability work separates independents from groups, and looks at margin trends, not just price trends. Many of the larger groups are backed by private equity, with investment horizons of around five years, while most independents are long-term owners serving their local community. These are two very different types of owner, and the final report should treat them separately.

Anonymised examples from our work:

- **Mixed NHS/private practice, South East.** Private fees rose each year between 2023 and 2025, but staff costs rose faster, so the EBITDA margin fell over the period.
- **Fully private practice, single site.** The owner delayed a fee increase for fear of losing patients, while lab and materials costs rose. When fees were eventually increased, the rise only restored the previous margin.
- **Mostly NHS practice, Midlands.** NHS contract income did not cover rising costs. Private fees were raised to cross-subsidise NHS work, not to grow profit; overall margin was still lower in 2025 than in 2022.
- **Large private practice, South East.** Fees were raised reluctantly, and only after significant rises in staff, borrowing, supply and energy costs. Despite the increases, profit is still lower than three to four years ago.

3.2.2 How acquisition finance shapes pricing

The CMA found group documents that discuss raising prices after acquisitions. From our due diligence and finance work, this follows from how deals are structured, and the CMA should look at the mechanism, not only the documents.

Independent purchases are usually funded by high street banks, with some of the buyer's own equity. For most buyers it is the largest purchase of their lifetime, often backed by substantial personal guarantees.

Many groups, by contrast, are private equity-backed. Their investors need a return within a defined period, typically by selling the group to another investor after around five years.

A PE-backed group therefore has a much shorter window to grow EBITDA than an individual dentist who owns for the long term. In our view, this time pressure is likely to be a major reason fees in such groups rise quickly after acquisition.

How it works in practice:

1. **Price paid.** Buyers pay a multiple of EBITDA. Competitive bidding pushes multiples up. (For individuals and groups)
2. **Debt service.** Acquisitions are often debt-funded, with lender covenants tied to EBITDA. (For individuals and groups)
3. **Business plan.** To justify the price and service the debt, the plan assumes EBITDA growth after completion. (PE-backed groups have a short time horizon to grow EBITDA, so they may raise fees more readily; an owner-operated practice has no such deadline.)

4. **Levers.** The quickest levers are fee increases, higher private conversion, more treatment per patient and payment-plan sales, the same strategies the CMA found in group documents. Cost cutting can also grow EBITDA, but revenue levers are usually quicker.

The result is that the purchase price itself creates pressure to raise patient prices. This is most acute in highly leveraged, serial-acquisition models, usually backed by private equity.

In acquisitions we have reviewed for buyers, we have seen business plans that only worked if private fees rose soon after completion, on top of growth in treatment volumes. Nothing about patient demand or quality had changed; the uplift was needed to service the purchase price.

We suggest the CMA's work on ownership and financing examines acquisition multiples, leverage and post-deal pricing assumptions, and distinguishes PE-backed purchases from owner-operated practices bought with bank borrowing.

3.2.3 Associate remuneration

The CMA notes that dentists are usually paid a share of the revenue they generate, and sees a risk this encourages over-treatment. The model is widespread for reasons the CMA should understand before proposing change.

- **Self-employed status.** Most associates are self-employed, which gives them the choice of whether to take on a patient. Paying a share of gross fees, with the associate bearing lab costs and business risk, is central to that status. Salary-based pay would push many associates towards employment, with significantly higher costs for practices and more risk on the practices too.
- **Tax and NI.** Moving associates to employment would add employer NI and other employment costs, which would feed into patient prices.
- **Clinical judgement.** In our experience most associates treat appropriately. The commercial pressure that matters is where practice KPIs, targets or payment-plan sales are pushed on clinicians. In our experience of over 20 years in UK dentistry, formal sales targets are far less common in owner-operated practices than in groups.

We suggest the CMA focuses on practice-level targets and KPIs imposed on clinicians, rather than the revenue-share model itself, and assesses the cost and workforce effects of any change to associate status.

3.3 Chapter 5: regulatory framework

We agree that regulation is complex and that accountability sits too heavily on individual clinicians. Commercial decisions on pricing, targets and payment plans are often made by owners, managers or group head offices, and accountability should follow those decisions.

Compliance costs are largely fixed per site. CQC registration, NHS contract compliance and GDC requirements cost a single-site independent much the same as one site in a large group, so the burden falls proportionately harder on independents.

3.4 Chapter 6: outcomes

We agree that outcomes vary by region and that affordability is a real concern. We ask the CMA to judge outcomes on margins as well as prices: rising prices with falling margins, which is what we generally see at independents, points to cost pressure, not excess profit.

Regional recruitment problems also affect practice viability. Practices in low-supply areas struggle to hire associates, which limits capacity whatever the price.

Owner remuneration and margins. The CMA's sample of independent practices shows a three-year average EBITDA margin of about 30%, falling to an indicative 16% after deducting owners' drawings. We welcome this adjustment and suggest refining it.

An owner-dentist's EBITDA includes the value of their own clinical and management work. Drawings are not a reliable measure of that value, because they reflect personal tax planning, borrowing and family circumstances. In practice valuations, we normalise EBITDA by deducting the market cost of replacing the owner: typically what an associate would earn on the owner's clinical fees, plus a manager's salary for management time.

Applied consistently, this gives a fair comparison with groups, whose clinicians and managers are already paid as costs. We would be happy to share our normalisation approach with the CMA.

4. Potential remedies

4.1 Supply-side measures: workforce capacity

We support measures to increase workforce capacity, which we see as the most important lever for competition. For patients, more capacity means shorter waits and more choice, especially in under-served areas.

- **Faster registration of overseas-qualified dentists.** Delays in registration hold back recruitment, especially outside London and the Southeast.
- **Practical support for small practices to sponsor overseas staff.** The cost and administration of a sponsor licence is a real barrier for a single-site practice, so in practice groups recruit more easily.

Possible unintended consequence: if new capacity is easiest to access for groups with central recruitment teams, workforce measures could strengthen the largest groups. Support aimed at small practices would help avoid this.

4.2 Demand-side measures: transparency, comparison and switching

We support better price information. The CMA found a composite filling listed at between £80 and £223 in one town, and patients deserve to compare that easily. A standard list would let a patient compare practices in minutes. The CMA itself says the answer is better-focused accountability, not more regulation.

To keep compliance proportionate for independents:

- **A standard price list.** A short, fixed set of common treatments, in a common format, published on the practice website and in reception.

- **"From" prices with clear ranges.** Many treatments vary by case. Allowing a starting price plus a typical range avoids misleading single figures.
- **One central template.** A free national template would avoid each practice paying advisers to design its own.
- **Phased introduction.** Give small practices a longer lead time than groups.

We suggest transparency measures are piloted with independents before roll-out, so compliance cost and patient value can both be measured.

Possible unintended consequences: single fixed prices could push practices to quote high to cover complex cases, and a costly compliance regime would add overheads that feed back into fees. Simple "from" pricing and a central template reduce both risks.

4.3 Regulation and enforcement

We support better-focused accountability rather than more regulation. For patients, this means clearer routes to complaint and redress.

- **Accountability for owners and providers,** including corporate owners, for commercial practices that affect patients, alongside clinicians' professional duties.
- **Less duplication** between CQC, NHS commissioners and the GDC, so practices report once where possible.
- **Proportionate enforcement,** scaled to practice size and risk.

Possible unintended consequence: new provider-level duties could add fixed compliance cost that small practices struggle to absorb. A light-touch route for single-site practices would avoid this.

4.4 The role of governments, and the risk of price controls

We support governments using their role as the main purchaser of dentistry to shape the market. The most effective step would be NHS contract reform: when NHS work does not cover its costs, mixed practices raise private fees to cross-subsidise it. A sustainable NHS contract would ease pressure on private prices.

The interim report says caps on specified essential treatments could be considered if other measures, including changes to NHS contracts, prove impracticable. We support the CMA's preference for exploring other options first. If caps are considered, we urge caution: controls designed with large groups in mind would fall hardest on independents.

- **No scale to absorb costs.** A group can offset capped fees with central purchasing and shared overheads. A single-site practice cannot.
- **Faster consolidation.** Owners facing capped fees and rising costs are more likely to sell, often to the groups whose behaviour the CMA criticised. This compounds the problem: each independent that sells means less choice for patients.
- **Less investment.** Practices reinvest in equipment, premises and training from margin. A cap would delay this, and could reduce capacity in areas already short of dentists and also potentially impact the quality of care provided to patients.
- **Lending and valuations.** Banks lend against practice EBITDA. A cap would cut what owners can borrow and what practices are worth, discouraging new entrants and succession. This

could have the unintended consequence of groups getting larger and the independent dentist becoming a thing of the past.

We suggest that any price-control option is tested against its effect on independent viability and market structure before it is recommended, and that the CMA's final report models this explicitly.

5. Other views

We ask that the final report treats independents and large groups separately wherever their economics differ and tests every proposed measure against its effect on independent viability.

Independents are over 60% of practices; measures that weaken them would reduce the competition the CMA wants to see.

6. Confidentiality and contact

This response contains no confidential information and may be published in full. It reflects professional experience, not data from any identifiable practice.

We would welcome the chance to discuss these points, or to join a roundtable with independent practices.

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