

Corporates and their backers continue to eye growth in the dental market as more opportunities emerge to expand private pay. **Ty Lantz-Subtleny**, associate, and **Adam Scott**, senior partner, at Mansfield Advisors assess the potential for further consolidation in the increasingly competitive dentistry market



Keep on rolling up



Since our 2019 article comparing veterinary with the dentistry sector, the latter has continued to steadily consolidate.

The share of practices owned by large groups has increased from c.15% to c.20%, primarily through single practice and small group acquisitions by consolidators and their backers including Portman Dental (Core Equity), Rodericks Dental (CBPE Capital), and Dental Partners (August Equity) amongst other smaller players.

In a typical year, we estimate 840 out of the c.12,000 practices are acquired, most by the major corporate consolidators shown in Figure One. Covid-19 inhibited larger transactions in 2020, but the market for individual practices has rebounded to with high activity since the second half of the year.

So, what are the big trends in dentistry, and how far do we think this sector will consolidate further?

Private continues to grow its share of spend

The majority of dental care provided in the UK is still paid for through the NHS, but over the past decade, private spend has both substituted NHS treatment and expanded across services which are not covered by the NHS. In our view, there are two fundamental drivers: the more attractive unit economics for private and therefore less acceptance of NHS work by dentists, and a materially improved value proposition for private patients, including cosmetic benefits.

Most dentists provide both NHS and private treatments.

For NHS work, dentists are paid based on volume as measured by the number of Units of Dental Activity (UDAs) delivered. Individual dental practices are provided a contract with a fixed volume to be delivered. UDAs approximate the amount of work required to treat a pa-

tient as the number of UDAs are banded by type of procedure. However, a quirk in the system aimed at reducing historical overtreatment means patients who receive multiple treatments (e.g. fillings on multiple teeth, crowns etc) receive the same payment.

In contrast, dentists working privately set their own prices and charge for each individual treatment – therefore they earn significantly more per hour (see Figure Two) than NHS counterparts.

Perhaps surprisingly, the payor mix has limited impact on practice operating margins because private cases require more expensive materials and incur greater staff costs, but the quantum of earnings are greater with private.

Between FY14 and FY20, the total volume of NHS treatments steadily declined by 11%.¹

In interviews with dentists, we heard about access issues resulting in patients driving more than 50 miles to receive

FIGURE ONE
DENTISTRY – KEY PLAYERS

				
Owned by	Bupa	Jacobs Holding AG	August Equity	Universal Partners
Practices	420	73	60	84
Revenue	£388m	£42m	£52m	£55m
Private revenue share	58%	23%	c.30%	c.80–90%

				
Owned by	Palamon	Core Equity	CBPE Capital	G Square
Practices	567	155	84	30
Revenue	£601m	£117m	£55m	c.£30m (est.)
Private revenue share	20%	90%	c.80–90%	c.80%

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NHS-paid care owing to capacity limitations for dental practices. The limitation has arisen from increased burden from regulation, staffing challenges, and declining income that persuaded dentists to minimise their NHS work.

In response to Covid-19, NHS commissioners reduced the requirements for UDA contract delivery to a percentage of the contract, to account for drops in productivity owing to sanitisation and air renewal. In more efficient practices, this gave many dentists more time for private work.

On demand side, patients increasingly want straight and white teeth, and private prices are becoming affordable for many.

We spoke with several dentists and executives that cited a year-long trend of increasing demand for cosmetic procedures that, fuelled by hours of social media consumption and Zoom calls, accelerated through the pandemic.

Furthermore, unlike in NHS-funded care, better looking materials can be used in non-cosmetic private procedures. For instance, white fillings are not always covered by the NHS, but they look natural and cost as little as £20 more than an NHS co-pay.

Additionally, private prices, and NHS reimbursement, move similarly to infla-

tion while NHS patient co-pay has risen at 5% per year. The result is a competitive value proposition when considering the outcomes, shorter wait times and more convenient appointment slots.

While several tailwinds point the industry toward privately-funded care, we do not expect the UK to mimic the US or Spain, where private prevails, anytime soon without a sea-change in dentists' perceived mandate.

Dentists and dental business make their money in private care, and dentists are frustrated with the NHS, but we do not anticipate a wholesale rejection of the NHS by dentists.

However, we expect dentists to continue prioritising private patients even as UDA delivery requirements return to normal.

How does the corporate model work and how does it add value?

Individual and small group practices are typically owned by one or two principal dentists, who may hire associate dentists as independent contractors. Many associates aspire to purchase a practice from a retiring principle and benefit from a significant income bump.

In contrast, corporate dental businesses own the practices and all dentists are associates (though some partnership models do exist). In both models, associate remuneration is about 40% of NHS revenue and 40–50% of private revenue.

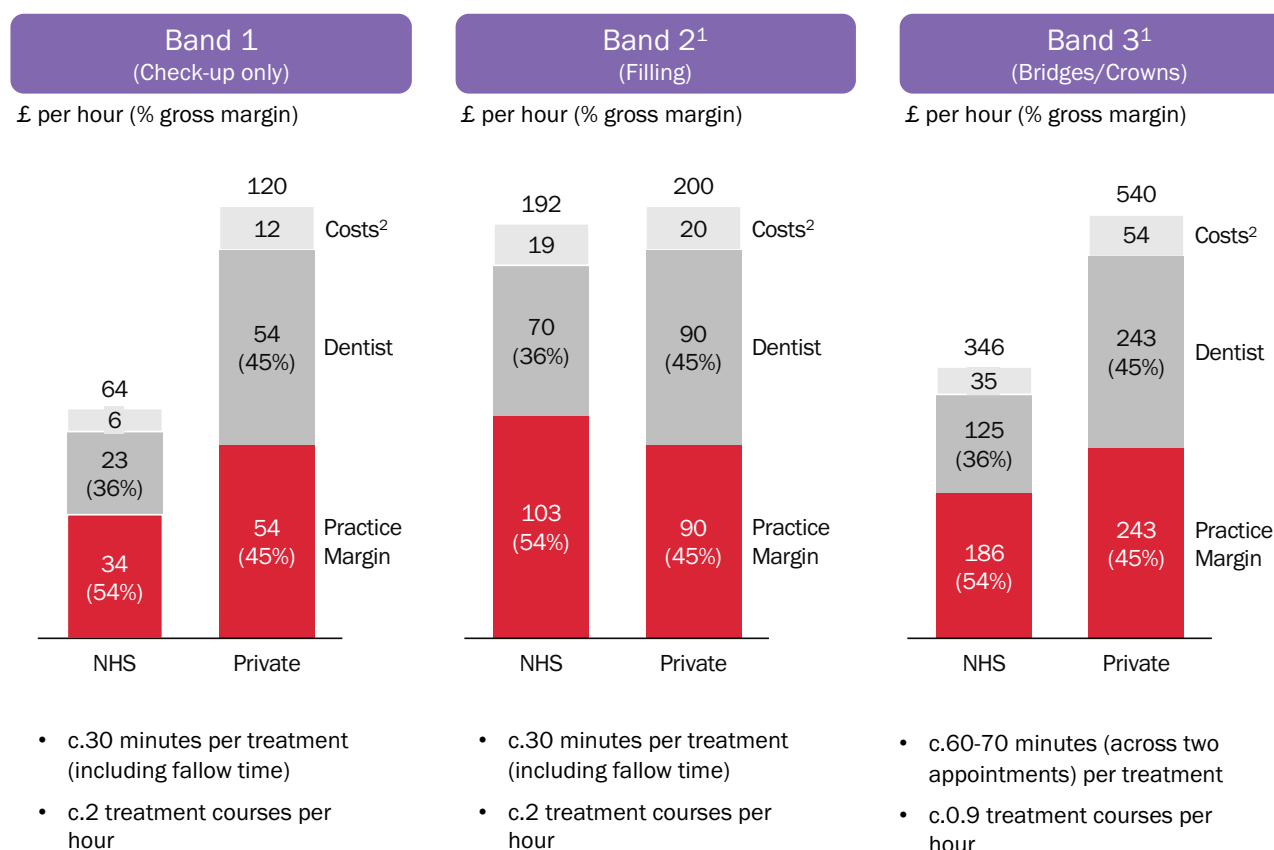
Corporates create value by consolidating back-office functions, referral synergies for specialist care, best practice sharing, and procurement synergies. However, corporates do not provide a route to ownership for associates, and they sometimes struggle to retain dentists in the long-term. Corporates address this by helping associates drive private revenue, which improves their earnings and grows the business. They provide clinical training on techniques such as clear aligners, communication and sales with support from treatment coordinators, who help patients decide on care options.

While dentists are not typically natural sellers, some excel at communicating the value of procedures such as Invisalign and consequently generate unusual income. Such practitioners may have no interest in practice ownership because they feel best suited to working with patients and are sufficiently remunerated for it.

We also see value in the dental support organisation (DSO) model employed

FIGURE TWO
DENTISTRY – VALUE PER HOUR

DENTISTS AND PRACTICES EARN MORE PER HOUR DOING PRIVATE WORK OVER NHS, SO ARE INCENTIVISED TO UPSELL TO PRIVATE



NOTES 1 NHS VALUE PER HOUR IS A 'BEST CARE' SCENARIO - FOR EXAMPLE, ASSUMED ONE FILLING FOR A BAND 2 TREATMENT COURSE. IN MANY CASES MULTIPLE TREATMENTS MAY BE DONE FOR THE SAME PRICE **2** INCLUDES MATERIALS AND LAB COSTS
SOURCE MANSFIELD ADVISORS RESEARCH AND ANALYSIS

in the US, where non-dentists cannot own dental practices in most places, and we believe it could work in the UK. In the DSO model, dental practices outsource all non-clinical aspects of the business to the DSO in exchange for a share of revenue. This enables dentists to focus on clinical work, aligns incentives between the 'corporate' DSO and dentists, and leverages returns to scale. It is also more palatable to regulators and dentists sceptical of corporate interests in healthcare.

How are the corporates positioning themselves to capitalise on private?

Since we last discussed the dental market, the two largest consolidators, Bupa and IDH/mydentist, have paused their acquisition activity to focus on integrating their locations. The groups expanding over the period - Rodericks,

Dental Partners, Dentex, and Portman - appear dissimilar since private revenue ranges from 30-90% among them. However, an analysis of their websites and messaging illustrates an all parties in-fight for private patients.

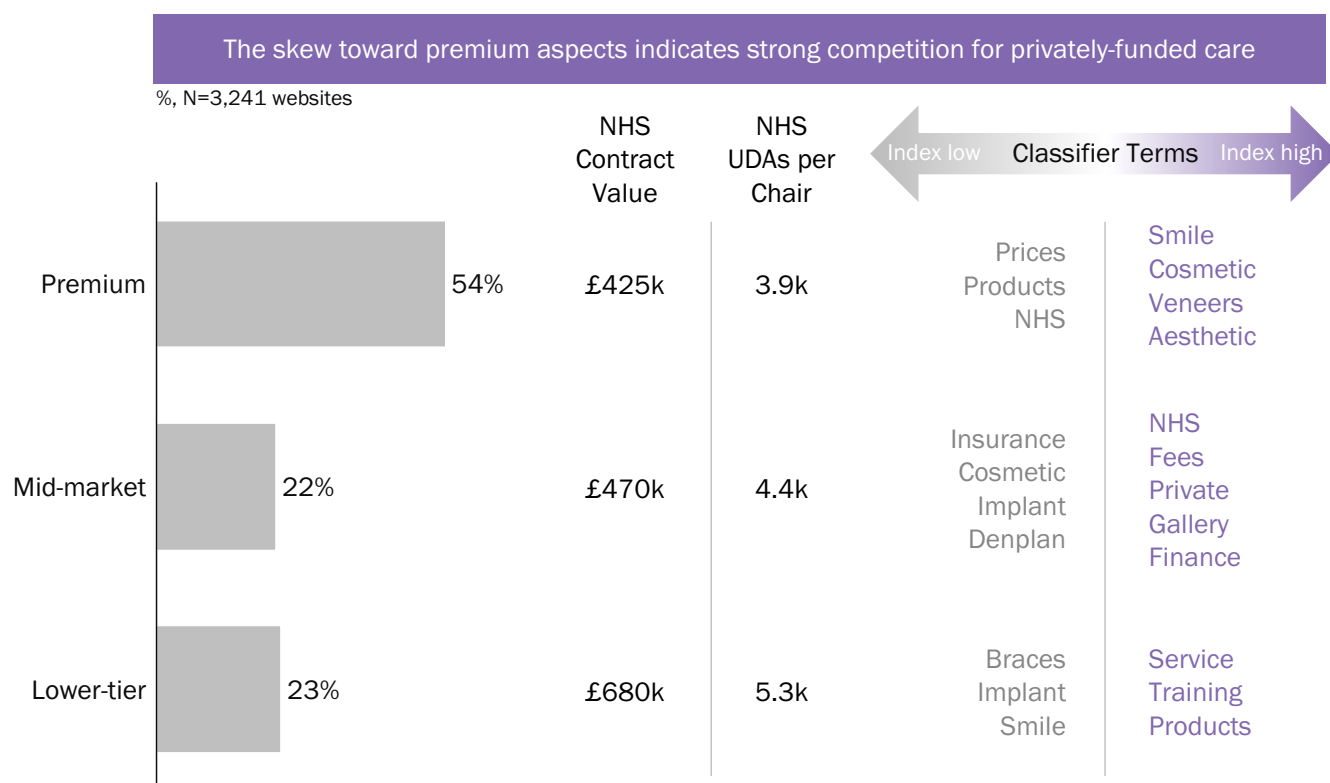
We analysed more than 11,000 UK dental business websites using a machine learning algorithm to segment them into premium, mid-market, and lower-tier clusters. We trained the algorithm with a combination of supervised learning, using keyword classifiers and examples of websites, and unsupervised learning techniques (see Figure Three). Websites for premium practices indexed high on words like cosmetic and veneers, and low on terms like NHS and were less likely to have a price list. Websites for mid-market practices indexed high on words like NHS, private price list, and financing and low on terms like cosmetic and implant. Premium practices were also more likely to have a more polished and professional website.

We found that more than half of dental practices (with a web presence) represent themselves as participating in the premium segment and all corporates are strongly marketing their private services. When matched to our own Mansfield dental database, we found that those with less reliance on NHS income and more capacity for private per surgery, were more likely to fall in the premium segment.

More surprisingly, mid-market and premium practices are similarly distributed geographically considering socioeconomic measures, which demonstrates that the addressable market for private care spans socio-economic classes. The analysis also reveals that pricing within dental groups varied and this does reflect the prosperity of the neighbourhood. The websites also revealed an emphasis on aesthetics, particularly among the premium and mid-market segments. We believe this could reflect the slow change in professional culture and may influence

FIGURE THREE DENTISTRY – WEBSITE CLASSIFICATION DISTRIBUTION

THE MAJORITY OF PRACTICE WEBSITES INDEX HIGH ON PREMIUM MARKERS



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how British dentists think about their mandate.

Despite much overlap in messaging across mid-market and premium practice websites, there is a clear delineation between truly 'premium' practices and those upselling patients from the NHS to private. For instance, Harley Street clinics and groups such as Portman and Dentex, represent the high end of the market and IDH's mydentist, Rodericks, Bupa, and Dental Partners sit firmly in the mid-market. Regardless of positioning, we believe increasing private revenue is the primary strategic initiative across both segments as evidenced by acquisitions of practices with existing and expandable private revenue.

Will the dental market continue to consolidate?

In our 2019 discussion, we compared the level and drivers of consolidation in

dentistry and veterinary care and we predicted relatively slower consolidation for dentistry owing to minimal cost synergies, greater competition for practices from associates, and cyclical in cosmetic dentistry spending.

While the cost structure of dental practices is skewed toward staffing, greater materials costs in private care improves the returns from scale for consolidators leveraging their bargaining power, but still not to the level found in veterinary.

Regarding competition for practice acquisitions, experts suggest EBITDA multiples see-sawing from 6–7x pre-pandemic to 4–5x in 2Q 2020 to 9–10x from 3Q 2020 onward. The higher valuations come from associates, many of whom were furloughed without pay during the first lockdown, hedging their future earnings through practice ownership.

While the current valuations may be high for corporate consolidators, our analysis of associate earnings suggests the inflated multiples are not sustainable

from associate interest alone and are likely transitory. In contrast to the recession following the global financial crisis, when the private dental market contracted by c.20%, the Covid-19 recession has expanded the private dental market.

Of course, investors are savvy to the uniqueness of this recession but cashflow stability trumps most and we believe the expansion of private care is sticky. Of the three moderating factors, cost synergies are improving, competition from associates will taper, and cyclical in is tempering.

The roll-up will not be as simple for dental clinics as it was for veterinary clinics, but we believe the consolidators will continue to make steady progress.

NOTES

1 NHS Digital: <https://www.nhsbsa.nhs.uk/dental-data/nhs-payments-dentists>