The Corporate Scalpel: Private Equity and the Consolidation of UK Healthcare

By Payal Panchal.

What is Context? "The Silent Buyout on the High Street"

While public debate centres on NHS waiting lists and staffing shortages, a quieter structural shift is reshaping UK primary care. Over the past decade accelerating after 2020 thousands of independent dental practices and GP surgeries have been acquired by private equity (PE) backed groups.

Firms such as The Carlyle Group (backer of MyDentist) and consolidators like PortmanDentex and Rodericks Dental have executed aggressive "buy-and-build" strategies across the UK.

What was once a profession dominated by owner operators is increasingly controlled by corporate platforms managing hundreds of sites.

As of February 2026, the Competition and Markets Authority (CMA) has begun examining whether local market consolidation in dentistry and primary care is reducing competition and distorting patient choice.

Healthcare, traditionally framed as vocation, is now under valuation pressure.

What's Happening? The Bolt-On Era of Healthcare.

The consolidation model is structurally simple:

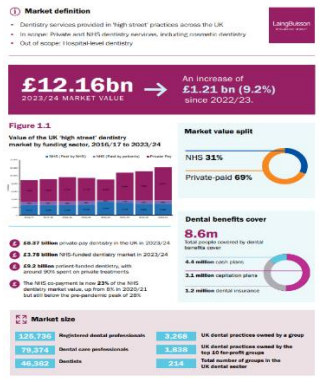
- Acquire a "platform" practice.
- Add bolt on practices within geographic proximity.

- Centralise back-office operations.
- Improve EBITDA.
- Exit within 3–7 years.

This financial engineering has undeniably professionalised parts of the sector procurement efficiencies, HR centralisation, digitalisation, and branding.

But 2025–2026 presents a new challenge

A. The Margin Shift:



Many PE-backed practices are increasingly prioritising higher-margin private cosmetic treatments over lower-margin NHS contracts. Whitening, implants, and aesthetic dentistry generate materially stronger returns than standard NHS banded treatments.

For GP practices, the introduction of digital triage systems and productivity targets has sparked debate about throughput pressure.

The shift raises a fundamental question: Is access to care being quietly repriced?

B. The Debt Burden

As interest rates stabilised at higher levels in 2025–2026, leveraged buyout models face new strain. Debt acquired during low-rate periods now carries heavier servicing costs.

Some PE-backed healthcare groups are responding with:

- Staff restructuring
- Reduced appointment times
- Centralised procurement mandates
- Tighter performance metrics

Critics argue this risks weakening the patient clinician relationship replacing long-term continuity with throughput optimisation.

“Buy-and-Build Model in UK Dentistry: Platform → Bolt-On → Consolidation → Exit”

Critical Analysis: The Commercial and Future Impact & The Legal and Compliance Impact.

A. Commercial Impacts:

a. The EBITDA Trap

Private equity performance is measured through EBITDA growth and exit multiples. When applied to healthcare, this metric-driven lens creates tension.

Increased valuation often depends on:

- Higher revenue per chair
- Greater patient volume
- Optimised treatment mix

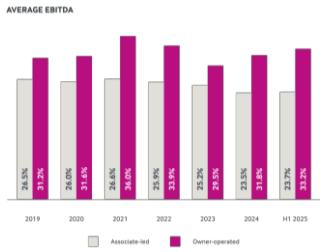
ANALYSIS OF EBITDA MULTIPLES 2024 - H1 2025

	Owner-operated (Average)	Range	Associate-led (Average)	Range
Private (90%+)	3.7	1.8 - 5.1	7.6	6 - 9.5
Mixed, Private-led (50%-90%)	3.5	2 - 4.1	6.5	6.3 - 7.4
Mixed, NHS-led (50%-90%)	3.5	1.5 - 4.8	7.1	6.1 - 7.9
NHS (90%+)	3.7	1.5 - 5.5	7.0	6.4 - 9.1
AVERAGE / RANGE	3.4	1.5 - 5.6	7.4	6 - 9.5

But healthcare is not software. A GP surgery cannot infinitely scale patient throughput without affecting service quality.

The "EBITDA trap" emerges when profitability becomes the primary success metric in a system historically guided by professional ethics and continuity of care.

b. Market Power at Local Level



Unlike national supermarket mergers, healthcare consolidation operates hyper-locally. A town may have only three dental practices. If two are owned by the same group, competitive pressure diminishes materially. Under UK competition law, even small geographic concentrations can trigger concern if consumer switching is limited.

The CMA's 2025/26 Annual Plan explicitly signals a focus on "livelihood sectors" industries central to daily life. Primary healthcare squarely fits that category.

"Local Market Concentration: Independent vs PE Owned Practices (Town-Level Model)"

B. Critical Analysis: Legal and Compliance Impact

a. Restrictive Covenants and the Restraint of Trade Doctrine

To protect goodwill, PE-backed platforms frequently include restrictive covenants in clinician contracts. These often prevent departing dentists or GPs from:

- Practising within a defined geographic radius
- Soliciting former patients
- Establishing competing clinics

UK courts assess such clauses under the doctrine of restraint of trade. They must be:

- Legitimate in protecting business interests, and
- Reasonable in scope, duration, and geography.

In 2026, litigation involving dentists challenging non-compete clauses has reportedly increased. Courts are scrutinising whether restrictions serve legitimate commercial protection or unfairly suppress professional mobility.

Healthcare's public interest dimension may influence judicial tolerance for aggressive restrictions.

b. Regulatory Overlap: Competition Meets Public Health

This consolidation also intersects with NHS contractual governance. In February 2026, NHS England updated aspects of the GP Contract for 2026/27, including data governance and private provider access to NHS systems.

As corporate platforms expand, regulators face a dual concern:

- Competition distortion at local level
- Alignment with NHS public service obligations

The legal tension lies between free-market consolidation and public-service accountability.

“Legal Pressure Points: Competition Law + Restraint of Trade + NHS Contract Governance”

C. Future Impact: Healthcare as a Financial Asset Class

Private equity investment in healthcare is unlikely to reverse. Demographic demand, fragmented ownership, and predictable cash flows remain attractive.

However, three risks loom:

- Increased CMA intervention in local mergers
- Judicial narrowing of non-compete enforceability
- Political scrutiny over NHS to private margin shifts

If regulatory friction intensifies, PE firms may need to adapt exit strategies, lengthen holding periods, or reduce leverage assumptions. Healthcare may remain investable but not frictionless.

Conclusion: The Architecture of Power

The corporate scalpel is precise, efficient, and financially disciplined. But healthcare is not merely a balance sheet asset.

The consolidation of UK primary care reflects a broader shift: essential public services are increasingly structured through private capital logic.

The question is not whether private equity can improve operational efficiency. It is whether efficiency can coexist with equitable access and professional autonomy. As the CMA sharpens its review and courts revisit restrictive covenants, 2026 may mark the point where valuation metrics collide directly with vocation. And in that collision, the future structure of UK healthcare will be defined**.**

Glossary of Commercial Terms

- Private Equity (PE) – Investment firms that acquire companies, improve performance, and sell them at a higher valuation.
- Bolt-On Acquisition – Purchase of smaller firms by a larger "platform" company to increase market share and operational scale.
- EBITDA – Earnings Before Interest, Taxes, Depreciation and Amortisation; a measure of operating profitability.
- Restrictive Covenant – A contractual clause limiting a former employee's competitive activities after departure.
- Non-Compete Clause – A restrictive covenant preventing a professional from working in or starting a competing business within a specified period or area.

Sources

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