BUSINESS MODELS, PROVISION OF VETERINARY ADVICE AND CONSUMER CHOICE

Vets Market Investigation Working Paper

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CMA
Competition & Markets Authority

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The Competition and Markets Authority has excluded from this published version of the final report information which the inquiry group considers should be excluded having regard to the three considerations set out in section 244 of the Enterprise Act 2002 (specified information: considerations relevant to disclosure). The omissions are indicated by [✂]. Some numbers have been replaced by a range. These are shown in square brackets. Non-sensitive wording is also indicated in square brackets.

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Appendix

A. Treatment analysis: Data sources and methodology
B. Analysis of an LVG's [✂] acquisition modelling

Summary

1. First opinion practices (**FOPs**) offer general veterinary care and are a first port of call for people seeking treatment for their pets. The vast majority of veterinary services in the UK are provided by businesses on a commercial basis by a mix of players: single site independents, small and medium chains and large veterinary groups (**LVGs**), most of which have hundreds of individual sites. To varying extents, some of these LVGs are vertically integrated and offer related services through referral centres, diagnostic labs, online pharmacies and animal crematoria.

2. Meeting the needs of pet-owners and the welfare of their animals depends on those businesses being incentivised to open and expand vet practices, improve quality and innovate. Incentives are provided by the opportunity to make a reasonable return on investment and an appropriate level of profits.

3. This sector has changed considerably over the past 10 years. Significant developments include: new business models and structures; increases in the number of pets and pet-owners; changes to the number of vets; advances in the range and quality of diagnostics and treatments, and developing expectations about the care of animals. We would expect a competitive market to respond to these changes in ways which could impact costs, prices and other aspects of animal care. The principal legislation for regulating veterinary services is almost 60 years old (Veterinary Surgeons Act 1966[1]) and does not reflect the way the sector currently operates; in particular, it contains no provision to regulate vet businesses as well as individual professionals.

4. This working paper considers the interaction between the way in which consumers purchase veterinary services (the 'demand side') and the incentives faced by vet businesses and their employees when selling services, taking into account any regulatory constraints.

5. We consider the practices and behaviour of veterinary businesses. What we say about veterinary professionals relates to the pressures they may be under as employees in, or owners of, vet businesses and should not be taken to be an adverse reflection on the professional conduct or integrity of individual vets and vet nurses, the vast majority of whom show high levels of dedication to the animals under their care and the animals' owners. Evidence indicates that pet owners display high levels of trust in veterinary experts and their advice, with almost all

[1] Veterinary Surgeons Act 1966.

respondents to our pet owners survey agreeing that their vet focuses on the highest standard of care.[2]

6. We explore whether the incentives for vet businesses and their employees work differently depending on the business model, including any differences between independent practices and LVGs. [✂]

7. Our emerging view, at this stage in our investigation, is that competition between FOPs may not be working as effectively as we might expect in a well-functioning market for the following reasons:

   (a) there may be a lack of competitive and regulatory pressure to constrain prices and ensure that suitable recommendations and sufficient information are given to pet owners on treating their pets (that is, recommendations that reflect the circumstances and preferences of the pet owner);

   (b) as a result, vet businesses' legitimate incentives to make and maximise profits may not operate in a way that delivers the best outcomes for consumers, and, if this were the case, the costs of FOP services for consumers may be higher than we would expect in well-functioning market; and [✂].

   (c) there are some differences between outcomes at FOPs (prices, treatment costs and spend per pet)

8. As to competition in the supply of referrals services, we have the following observations:

   (a) we have limited evidence, at this stage in our investigation, on whether consumer detriment is arising that is specific to FOPs at vertically integrated groups favouring their own referral services, that is any consumer detriment specific to self-preferencing; and

   (b) there is some evidence that might suggest a broader potential concern that all types of FOP (whether vertically integrated or not) do not give enough pet owners sufficient information about a range of referral options, which could result in weaker competition in the supply of referral services than we might expect if the market was working well.

[2] Pet owners survey, Q36r1 'My vet focuses on the highest standard of care for my pet's health'. 60% completely agree, 27% somewhat agree.

Higher prices, treatment costs and treatment intensity in FOP services

9. In relation to prices and treatment costs at FOPs, there is evidence[3] that treatment costs and unit prices at LVG and independent FOPs increased substantially between 2015 and 2023. Our analysis of that evidence is that first-year treatment costs[4] increased by [70-80]% [✂] in that period, and the unit price of treatments[5] by [60-70]% [✂]. It appears that these increases are not wholly explained by changes in salaries of veterinary staff, which have not increased to the same extent. We note, however, that our analysis of these price increases does not reflect whether services have improved in quality, and only covers services for which insurance claims were made, which excludes common items such as vaccinations. Certain LVGs have indicated that they disagree with this analysis and these submissions will be taken into further consideration in a subsequent paper which sets out our analysis in more detail.

10. The increases in costs and prices across all practices are above the rates of inflation that applied at the relevant times (the Office for National Statistics (**ONS**) Consumer Price Index (**CPI**) for services grew by 35% between January 2015 and December 2023, compared to the [70-80]% [✂] and [60-70]% [✂] increases we observe in first-year treatment costs and unit prices).

11. It appears to us that the ability of vet businesses to sustain price increases may be explained by the way pet owners respond to the services and prices offered to them, combined with limitations in the effectiveness of regulation.

12. In terms of the consumer response, the evidence we have assessed so far suggests there is likely to be a weak response to price increases, meaning that vet businesses may be able to raise prices without pet owners switching away or deciding not to purchase the relevant services. This is covered in more detail in our working paper on **How people purchase veterinary services** that sets out the following:

    (a) Many pet owners appear to have limited awareness of, and sensitivity to, price. The most important factors in their choice of FOP seem to be location, word of mouth and personal recommendations, and over half of pet owners do not find out about prices ahead of registering with their FOP.[6]

[3] We have conducted analysis on data provided by two insurance companies of amounts charged for veterinary care from 2014-2024. This analysis has been shared with the LVGs and their advisers for comment. We will publish our methodology and results in due course, taking into account any representations from the LVGs. The figures used in this working paper therefore represent interim or indicative figures subject to those representations.
[4] First-year treatments costs are the total costs to pet owners for diagnosing and treating a condition over a 12-month period.
[5] Unit price refers to the price recorded in pet insurance claims data for a given diagnostic or treatment (including medicines).
[6] Pet owners survey, combination of Q17 (where those that considered prices are assumed to have found pricing information before registering) and Q15 (where those that didn't say they considered prices as a factor when choosing a FOP reported whether they nevertheless found pricing information before registering).

(b) It may be difficult for pet owners to estimate and compare prices and quality based on the information available to them. Most FOPs do not appear to advertise any prices,[7] and those prices that are available are for only a limited number of services such as vaccinations, depending largely on individual FOP's policies. While FOPs often provide a range of information about their services, their clinical quality and other quality indicators such as staff, facilities and amenities, these are not based on any universal form of standardised and comparable metrics. There is also little information about ownership of FOPs in those four of the six LVGs that retain the original branding on acquiring an independent practice.

(c) Switching rates between FOPs are low (3% annually for reasons relating to the competitive offerings of FOPs as opposed to, for example, moving home), and of the overall low proportion of pet owners who do switch only a small fraction do so to get cheaper prices.[8]

(d) Most pet owners consider their pet's healthcare to be at least as important as that of their family members,[9] and say that pet care costs should either always or often be prioritised over other important household expenses.[10]

(e) Some LVGs, and the private equity owners of three LVGs, are aware that pet owners are unlikely to respond to higher prices (for example, by switching to a competitor or deciding not to buy services).

13. For those LVGs who have acquired practices,[11] we are currently developing further analysis to understand whether increases in costs and prices have been higher at those practices.

14. [✂]

15. [✂]

16. [✂]

17. [✂]

18. [✂][12]

[7] Our research in March 2024 of approximately half of all vet practice websites including both LVGs and independently owned vets indicated that 84% did not advertise any pricing information. See Final report of the consultation, p.30.
[8] Pet owners survey. Q33, in response to which only 13% of those who had switched indicated that this was because they wanted cheaper prices.
[9] Pet owners survey, Q134, in response to which 78% said this.
[10] Pet owners survey, Q134a, in response to which 42% said 'always' and 34% 'often'.
[11] All LVGs other than Pets at Home.
[12] [✂]

19. A particular limitation on the effectiveness of regulation, described in more detail in our working paper on the **Regulatory framework for veterinary professionals and veterinary services** appears to be that it applies to individual vets but not to vet businesses. The majority of FOPs (around 60%) are now owned by LVGs which employ non-vets in a range of managerial and business roles, and have shareholders or owners who are not vets. Other smaller vet businesses are also sometimes owned by non-vets or employ managers who are not vets.

20. The changes in ownership and management structures mean there is a range of actors – corporate bodies and individuals – not subject to direct regulation, who are taking or influencing business decisions. Without regulatory constraint, those actors may place greater weight on profitability concerns when making those decisions. We are considering whether these limitations in the regulatory framework could be leading to higher treatment costs at certain vet businesses.

21. [✂]

22. Other limitations on the effectiveness of the regulatory framework may also be relevant. As set out in our working paper on the **Regulatory framework,** neither the parts of that framework which apply to individual vets nor the voluntary Practice Standards Scheme to which vet businesses may subscribe appear to be sufficiently effective in assuring that consumers always receive adequate and timely information on price, quality and treatment options to enable them to make informed decisions.

23. The picture appears to be less clear in relation to treatment intensity (that is, offering more extensive treatment options rather than simpler ones which may have similar, or not significantly inferior, outcomes for the pet). While we have not found empirical evidence of overall increases in treatment intensity over time [✂].

Consumer choice and competition in referral services and the effects of vertical integration

24. In relation to competition in referral services, at this stage in our investigation, we have limited evidence on whether consumer detriment is arising that is specific to FOPs at vertically integrated groups favouring their own referral services, that is any consumer detriment specific to self-preferencing. At this stage, the evidence we have on self-preferencing is mostly limited to suggesting that there may be an ability and incentive to self-preference in a way that could be detrimental to consumers and competition.

25. Vet businesses' normal incentives to make and maximise profits can include incentives to acquire referral services. Those incentives can produce good

outcomes for consumers where the operation of the services is subject to competitive constraints from consumers who are able to make informed choices between them. There can be benefits of referrals being carried out within the same group in terms of continuity of the care given to pets and efficiencies which are passed on to consumers in the form of lower prices. We are not concerned where in-group referrals deliver these benefits or where in-group referrals meet pet owners' needs (including on price) just as well as external referral providers.

26. Where concerns can arise is when the competitive constraints are not as strong as we would expect in a well-functioning market. That may be the case where sufficient options and suitable recommendations are not being presented to pet owners. These concerns are likely to be compounded as we identify in our working papers on **How people purchase veterinary services** and on the **Regulatory framework for veterinary professionals and veterinary services**, due to possible weaknesses in the way pet owners respond to the services and prices they are offered or limitations in the effectiveness of regulation.

27. In those circumstances, the effect could be that some in-group referrals are influenced by the commercial considerations of a vertically integrated provider when the pet owner might have made a different choice that better suited their needs and preferences had they been offered greater choice or a more suitable recommendation. For example, a pet owner may have preferred to use a referral centre closer to their home, or one that was less expensive. These kinds of in-group referrals can be seen as detrimental self-preferencing by providers.

28. Detrimental self-preferencing also has the potential to contribute to weak competition between referral services and higher prices of these services than we might expect in a well-functioning market. It can mean that referral centres that are integrated with FOPs need not compete as aggressively for consumers as they would otherwise.

29. We have examined the vertically integrated LVGs' incentives and abilities, identifying those which indicate the potential either for efficiencies arising from referrals staying within-group, or for more harmful self-preferencing which might result in consumers having fewer choices and paying higher prices. We identify the potential for the latter in some evidence we have seen that some integrated groups are, to differing extents, seeking to use their FOPs to direct consumers to their own referral centres, hospitals and hubs for more complex and specialised treatments. For example, we have seen evidence that:

    (a) self-preferencing in referrals is an important motivator in LVGs' acquisition strategies (albeit to varying extents depending on the relevant LVG);

    (b) some integrated groups set targets around the percentage of referrals that are referred in-group; and

(c) some vets and vet nurses are sometimes encouraged to refer in-group.

30. However, we have not seen evidence, at this stage, to assess whether this potential has been realised and led to harmful effects. One important indicator could be the level of profitability of referral centres in vertically integrated groups. We intend to assess that but have not yet done so.

31. Another indicator of harm from detrimental self-preferencing would be evidence of non-vertically integrated FOPs being foreclosed from accessing vertically integrated referral centres for their customers, and of non-vertically integrated referral centres being disadvantaged in terms of being able to access customers who are referred from a range of FOPs. At this stage of our investigation, we have not seen significant evidence that either of these types of foreclosure is occurring.

32. Our assessment is not limited to whether there are vertical effects arising from detrimental self-preferencing. A broader potential concern that we are assessing is whether pet owners at all types of FOP (whether vertically integrated or not) are being given sufficient information about the range of referral options available and a recommendation that best suits their needs. We are concerned that this may not be the case in some pet owners' experiences, with the possible result that there could be weak competition in the supply of referral services. The evidence available related to assessing this potential concern includes:

(a) in our pet owner survey, 62% of respondents to our pet owners survey that were referred to another practice said they did not do any research when they were recommended a referral;[13] and

(b) responses to this survey also show that there is a lack of transparency about the potential costs of a referral treatment, and about the ownership of referral centres.

33. The Royal College of Veterinary Surgeons (**RCVS**) supporting guidance on its regulatory professional Code of Conduct (**Supporting Guidance**) says that vets should have regard to all relevant factors when considering referring, including the ability and experience of the referral vet, location, urgency, and the circumstances and financial situation of the owner. In light of the evidence we have seen so far, it is not clear to us how effectively this guidance is observed and whether regulation is providing an effective constraint on the way vet businesses are operating.

34. We intend, where we can, to explore what further empirical analysis to undertake on the degree of self-preferencing, and to assess its effects on treatment intensity, pricing and quality of care.

[13] Pet owners survey, Q67.

Structure of this paper and next steps

35. This paper is structured as follows:

    (a) We first note some relevant developments in the veterinary sector and set out an overview of the vet businesses in this market, and the services they sell.

    (b) We consider the evidence on whether weak competition coupled with changing business models may be leading to higher prices, treatment costs and treatment intensity in FOP services. As part of this, we consider:

        (i) Analysis of trends and market outcomes including on prices, overall treatment cost and treatment intensity, [✂].

        (ii) Our assessment of competition between FOPs on price; and

        (iii) Our assessment of competition in relation to treatment intensity and veterinary advice.

    (c) We consider the evidence on consumer choice and competition in referral services and the effect of vertical integration, including:

        (i) whether consumers are receiving sufficient information and suitable recommendations from their FOPs on their referral options; and

        (ii) whether vertically integrated groups are directing pet owners to their own referral services, and whether this self-preferencing is weakening competition in referral services. As part of this, we consider the ability and incentive to self-preference in a detrimental way, and the effect of this type of self-preferencing.

36. We invite comments on our analysis to date and the further work parties consider that we should undertake. We also welcome any further evidence that parties can provide to inform our assessment. At the end of this paper, we briefly set out our plan for a remedies working paper and explain how to respond to this working paper.

1. Context and industry background

1.1 This section sets out some context and industry background relevant to the aspects of competition we consider in the sections below. We first describe some relevant trends, and then set out information on the businesses providing veterinary services, including giving an overview of the activities of the LVGs, and information on FOPs, referral services and diagnostic testing.

Developments in the sector

1.2 Throughout our market investigation and our earlier market review, we have gathered views on relevant characteristics of and developments in the veterinary services market. In subsequent sections, we consider the evidence on some of these trends, and how they might affect competition and consumers in the market.

(a) There has been a general trend of rising prices in the industry (we discuss this further in the following section).[14] We observe that there has also been a rise in input and operational costs, including staff costs, though it appears that prices have risen faster than staff costs.[15]

(b) There has been a trend of acquisition by five of the six LVGs (CVS, IVC, Linnaeus, Medivet and VetPartners) and expansion by Pets at Home since around 2000.[16] This has led to a sector with fewer independent FOPs and a few large firms. While concentration has also increased, the supply of FOP services is generally not locally concentrated, as set out further in our working paper **Analysis of local concentration**.

(c) Related to this, there has been a trend of vertical integration, with several of the LVGs acquiring related services (such as referral centres, crematoria, laboratories and other providers).

(d) We understand that the COVID-19 pandemic caused a rapid increase in UK household pet ownership, though this may have fallen since then.[17] Some estimates indicate that the proportion of UK households owning a pet increased from 41% in 2019/20 to 60% in 2023/24,[18] and other estimates show that 51% of UK adults owned a pet in 2024.[19]

(e) Retention of staff and staff shortages (both of vets and vet nurses) are reported to be widespread issues in the vet industry, experienced by both the

[14] See paragraphs 2.1 to 2.71.
[15] LVG Responses to RFI 1, Question 1. [✂]
[16] As noted above, in 2013, around 10% of vet practices belonged to large groups, but that share is now almost 60%.
[17] For example, PDSA estimates that there were 21.1 million pets (cats, dogs and rabbits) in 2020, rising to 23.1 million in 2023, but then falling to 22.2 million in 2024. UK pet populations of dogs, cats and rabbits - PDSA
[18] Paw-some new pet population data released by UK Pet Food | UK Pet Food and Historical Pet Data | UK Pet Food
[19] UK pet populations of dogs, cats and rabbits - PDSA

LVGs and independents, with many noting Brexit and COVID-19 as exacerbating factors.[20,21]

(f) As with human medicine, technological improvements and advances in animal medicine have meant that an increasingly advanced range of techniques and treatments can be offered. In the case of pets, this means that some conditions can be treated when, in the past, the only option would have been euthanasia.

(g) We observe that pet owners are increasingly 'humanising' their pets. In our survey of pet owners, 78% of pet owners considered that their pet's healthcare was at least as important as the healthcare of a family member, and this humanisation is a driver of pet healthcare spending.[22] This is considered further in our working paper on **How people purchase veterinary services**.

(h) There has been some degree of innovation in the market, leading to different services and types of businesses. This includes FOPs offering subscription-based models,[23] telemedicine, or mobile veterinary services.

(i) Veterinary surgeons (but not vet businesses) are regulated by the RCVS. However, the legislation governing the sector dates from 1966 and has not kept up with changes to the industry. This is considered further in our working paper on the **Regulatory framework for veterinary professionals and veterinary services**.

Vet businesses in the market

1.3 The veterinary market is made up of a mix of players offering a range of services to pet owners. These include providers offering first opinion care, referral centre services, diagnostic laboratories, cremation services and out-of-hours (**OOH**) services as well as selling medicines and a range of other related services. In this section we focus on first opinion practices and referral centres, but also include some information on diagnostic laboratories. Cremation services are covered in our working paper on **How people purchase veterinary services**, and the supply

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[20] Summary of Edinburgh roundtable discussions p.1. Summary of Manchester roundtable discussions p. 2. Summary of Swansea roundtable discussions p. 2. Small/medium chains response to RFI1 Q1 [✂]: all but 1 mentioned staff shortages as a challenge, many highlighted recruitment and retention as the key challenge they face. Single site independents response to RFI1 [✂] Q1: all but 2 respondents highlighted recruitment and retention as a challenge.
[21] All 6 LVGs and 24 of the 27 independents we asked named staffing as one of the main challenges they faced, many of them naming it the key challenge faced. [LVG] response to RFI1 Q1. [✂]. [LVG] response to RFI1 Q1 [✂]. [LVG] Response to RFI1 Q1 [✂]. [LVG] response to RFI1 Q1 [✂]. [LVG] response to RFI1 Q1 [✂]. [LVG] Response to RFI1 Q1 [✂]. [CMA analysis of Small and medium chains RFI] [✂] Q1: all but 1 mentioned staff shortages as a challenge, many highlighted recruitment and retention as the key challenge they face. [CMA analysis of single site independents RFI] [✂] Q1: all but 2 respondents highlighted recruitment and retention as a challenge.
[22] Pet owners survey, Q134 and Q134a.
[23] Note of call with [✂].

of medicines is covered in our working paper on **Competition in the supply of veterinary medicines.**

1.4 There has been a trend of increasing corporate ownership over the past decade. In 2013, around 10% of vet practices belonged to LVGs, but that share is now around 60% and has grown principally through acquisition of independently owned practices.

1.5 As set out in our working paper **Analysis of local concentration** we understand that there are at least 3,804 sites providing first opinion care and referral services in the UK, as of December 2024.[24] As noted above, around 60% of these practices are owned by six LVGs[25], while the remaining practices are either independently owned (for example, as part of a small or medium chain, or a single practice site) or part of a registered charity.

Overview of the LVGs

1.6 The LVGs are not homogeneous in structure, and vary in terms of size, ownership model and the number and type of related veterinary services they own:

(a) **IVC** has the highest share of FOPs in the UK (904 practices as of May 2024). IVC's ultimate parent company is Islay New Group Holding SA, which, in turn, is owned by private equity group EQT and others.[26] As well as its FOP business, IVC owns 24 referral centres,[27] 65 veterinary hospitals, a dedicated OOH service called Vets Now (including some hospitals offering referral services), diagnostic laboratories, pet crematoria, a pet care plan business through Pet Health Club, and an online pharmacy business for animal medication named Pet Drugs Online.[28]

(b) **Pets at Home** has 447 FOPs,[29] including trading entities Companion Care (Services Limited) and Vets4Pets.[30] It is publicly listed and mainly operates a 50/50 joint venture model for its vet practices.[31] It stated that practice owners

[24] Number of total sites was obtained by adding the number of confirmed FOP practices (3,704) with the number of confirmed referral-only sites (99) (see our working paper **Analysis of local concentration,** pp. 57). We currently have a total of 2,605 additional unconfirmed and duplicative independent sites which we are in the process of identifying. See our working paper **Analysis of local concentration** section 'Unconfirmed and duplicate sites'.
[25] In the case of Pets at Home, these are mostly run as joint ventures, as discussed below.
[26] IVC response to RFI1 question 2. Islay is incorporated in Luxembourg with registration number B252223.
[27] IVC RFI1 Response, Question 4. [✂]. IVC's website indicates that it currently has 87 practices (including referral centres/hospitals) in the UK that offer referral services for small animals.
https://www.ivcevidensiareferrals.com/referralclinics
[28] IVC's RFI1 Response, [✂]
[29] Pets at Home RFI1 Response, Question 4. [✂]
[30] Pets at Home response to RFI1 question 2 and 4.
[31] In this Joint Venture model, Pets at Home owns 50% of the practice's shares, and the other 50% are owned by practice owner (usually a vet but can also be a veterinary nurse or a practice manager). In exchange for a management fee, Pets at Home provides each practice with a range of support services such as marketing or accountancy. There are also a smaller number of group managed practices where Pets at Home owns 100% of the shares, although Pets at Home submitted that t these practices are usually in the process of finding practice owners. [✂] Pets at home response to RFI3, question 4, p.3

at individual practices are run as joint ventures (**JVs**) that retain clinical and operational autonomy, and take decisions with regards to investment, recruitment and pricing.[32] JV practice owners pay a management fee to PAH for using the brand and for a range of support functions, including IT, accounting, and HR. Pets at Home has five FOPs that are accredited by the RCVS as animal hospitals, telehealth services, and a retail business providing pet-related products in addition to its FOP business.[33] Its retail business stores often have its vet services business Vets4Pets located within them.

(c) **CVS** has 386 FOPs in the UK.[34] It is a publicly listed business. CVS owns nine referral centres, 40 veterinary hospitals, two diagnostic laboratories, a dedicated OOH business called MiNightVet, pet crematoria, an online pharmacy for animal medication named Animed Direct and food suppliers.[35]

(d) **VetPartners** has 380 FOPs.[36] It is (indirectly) majority owned by funds managed by BC Partners, a private equity company.[37] VetPartners owns three referral centres, 28 veterinary hospitals, a pet crematoria and clinical waste disposal called Pet Cremation Services (PCS), two online pharmacies for animal medication called 365Vet and Vet UK, and two veterinary nursing schools.[38]

(e) **Medivet** has 369 FOPs.[39] It is owned by funds managed by CVC Capital Partners private equity company.[40] Medivet owns three referral centres, 21 veterinary hospitals and a diagnostic laboratory business.[41] Medivet operates a branch partnership model in a minority [✂] of its practices, where each month clinic profits and costs are split between the Branch Partner (namely the vet in charge of the site) and Medivet based on the percentage of equity owned.[42]

(f) **Linnaeus** has the smallest share of FOPs of the six LVGs (183 practices). It has 20 referral centres (including 18 referral-only centres, the largest number of dedicated referral centres for the LVGs) and 19 of its FOP practices are RCVS accredited hospitals. Linnaeus is a privately owned business, owned

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[32] Pets At Home response to RFI3 [✂], see question 4, p.3. Pets At Home "[✂]" slide 14. Pets At Home website: "Practice Ownership with Vets for Pets" [33] Pets atHome RFI1 Response, Q33. [✂] While these practices do offer more "advanced" treatments, they operate primarily as FOPs and do not employ "specialists".
[33] Pets atHome RFI1 Response, Q33. [✂] While these practices do offer more "advanced" treatments, they operate primarily as FOPs and do not employ "specialists".
[34] CVS RFI1 Response, Question 4.
[35] CVS RFI1 Response, Q33. [✂]
[36] VetPartners RFI2 Response [✂]
[37] VetPartners response to RFI1 questions 2 and 3.
[38] VetPartners RFI1 response, Question 33, [✂]
[39] Medivet RFI1 Response, Question 4. [✂]
[40] Medivet RFI1 Response, Question 2.
[41] Medivet RFI1 Response, Q33. [✂]
[42] Information obtained from Medivet's website, last accessed 23 December 2024. https://www.medivetgroup.com/about-medivet/become-a-branch-partner/. [✂] out of the [✂] practices owned by Medivet are listed as partnerships.

by parent company Mars Incorporated (**Mars**). Mars owns three diagnostic laboratories (branded under the name Antech) in the United Kingdom.[43] Mars also sells pet-related services through the manufacturing and supplying of pet food under multiple brands (such as Pedigree).[44]

1.7 As is evident from the above, most of the corporate groups are vertically integrated, albeit to differing extents, and have ownership of, or a stake in, providers of related veterinary products and services. CVS and IVC appear to be more vertically integrated than the other LVGs while Pets at Home does not own any related businesses and services. This is summarised in the table below.

Table 1.1 LVGs' related businesses and services, 2024

	CVS	IVC	Linnaeus	Medivet	Pets at Home	VetPartners
Referral-only centres	✓	✓	✓	✓		✓
Specific out-of-hours business *	✓	✓				
Diagnostic laboratory	✓		✓**	✓		***
Crematoria[45]	✓	✓				✓
Online pharmacy[46]	✓	✓				✓

Sources: CVS, IVC, Linnaeus, Medivet, Pets at Home, Vet Partners
** A specific out-of-hours business is a provider that focuses on out-of-hours veterinary care, including providing services to other FOPs to allow them to meet their obligations to make OOH available.*
*** Mars, Linnaeus's parent company, owns Antech Diagnostics*
**** VetPartners has a diagnostic laboratory, but it submitted that as [✂] of its diagnostic laboratory revenue comes from small animal testing, it should be excluded from the list of diagnostic laboratories.[47]*

1.8 The vast majority of LVGs' revenues are from their small animal practices (Table 1.2 below). All of these LVGs offer first opinion care for pets, and in some cases, this is offered alongside referral services. LVGs generally earn significantly less revenue from their other services.

Table 1.2: LVG recent year revenues (£ million)

Revenues from services (£ million)	*An LVG [✂]*	*An LVG [✂]*	*An LVG [✂]*	*An LVG [✂]*	*An LVG [✂]*	*An LVG [✂]*	*All LVGs*
For year ended	[✂]	[✂]	[✂]	[✂]	[✂]	[✂]	
Small animal practices (FOPs, including those that also offer referral service)	[300-400] [✂]	[200-300] [✂]	[800-900] [✂]	[200-400] [✂]	[200-300] [✂]	[500-600] [✂]	[2,600-2,700] [✂]
Mixed practices	-	[100-200] [✂]	[200-300] [✂]	-	-	-	[300-400] [✂]
Farm/equine practices	[50-100] [✂]	[50-100] [✂]	[10-20] [✂]				[100-200] [✂]

[43] Linnaeus RFI1 Response, Q33. [✂]
[44] Linnaeus RFI1 Response, Q51. [✂]
[45] Further details on cremation services can be found in our working paper on **How people purchase veterinary services**.
[46] Further details on online pharmacies and medication can be found in our working paper on **Competition in the supply of veterinary medicines**.
[47] VetPartners response to CMA draft diagnostics RFI. [✂]

RCVS-specialist led referral centres	[20-50] [✂]	[0-5] [✂]	[20-50] [✂]	[10-20] [✂]	[100-200] [✂]	-	[200-300] [✂]
Standalone OOH operations[48]	-	-	[100-200] [✂]	-	-	-	[100-200] [✂]
Laboratory services	[20-50] [✂]	[0-5] [✂][49]	-	[0-5] [✂]	[0-5] [✂]	-	[20-50] [✂]
Online pharmacy	[10-20] [✂]	[20-50] [✂]	[50-100] [✂]	-	-	-	[100-200] [✂]
Crematoria services	[10-20] [✂]	[10-20] [✂]	[20-50] [✂]	-	-	-	[50-100] [✂]
Total of services / goods in scope of market investigation[50]	*[400-500]* [✂]	*[300-400]* [✂]	*[1,100-1,200]* [✂]	*[300-400]* [✂]	*[400-500]* [✂]	*[500-600]* [✂]	*[3,200-3,300]* [✂]

Source: CMA analysis of LVG RFI6 responses

First opinion practices

1.9 FOPs are general vet practices and vary considerably in their size and offering. Some FOPs are small practices run by one or several vets, with one or just a few sites, whereas others are large practices with many dozens of staff and several sites. FOPs also differ in the range of services they offer from the basic levels of care to diagnostics and treatments involving advanced equipment or Specialists who work in (or visit) the practice. Some FOPs are owned by vets (who may also be working in the practice), while others are owned by businesses which may put in place practice managers who are not registered vets.

1.10 IVC, Linnaeus and Vet Partners do not operate under uniform branding for their FOPs – rather, they retain the name and branding of independently owned practices or small chains when they acquire them. CVS recently started adopting uniform 'Vet Collection' branding across practices online, but this does not appear to be used across its physical practices. Medivet and Pets at Home have operated under uniform branding for a significant period of time.

1.11 Smaller groups and independents account for the rest of the market and there is also variety here, ranging from single site practices to chains with multiple practices. The largest independent chain, [✂], operates 35 practices.[51] There are some charitable providers of veterinary services, but we do not consider these further in this working paper, as they are not commercial FOPs and they only serve particular consumer groups (and hence are not an alternative provider for most consumers).

[48] Most LVGs were unable to disaggregate the various clinical services provided within clinics. For all but [✂] separated figures on OOH revenues could not be provided. Instead, the revenue figures for small animal practices include some OOH revenues.
[49] As explained in the table above, [✂] of this figure is from small animal testing.
[50] Totals do not include mixed practices, but small animal revenues from mixed practices are in scope of the market investigation. Totals will therefore be higher in actuality.
[51] Small medium chain response to RFI1 [✂]

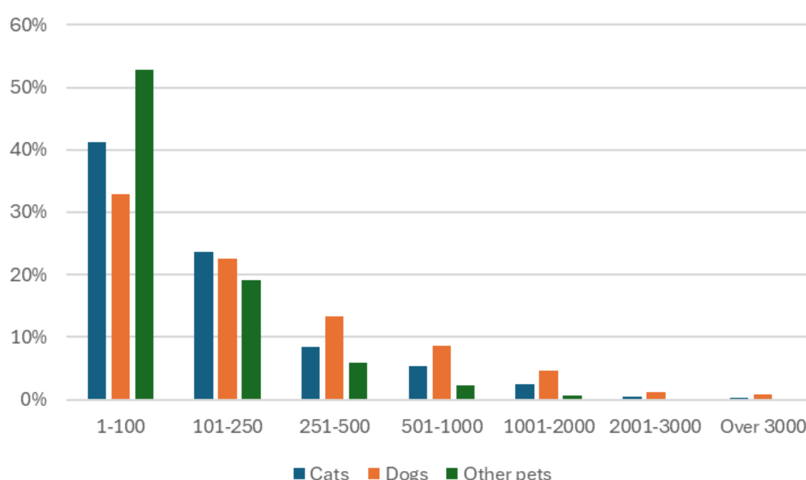
Table 1.3: Number of Small Animal FOPs, 2024

Ownership	*Number of FOPs*[52]	*Share (%)*
IVC	900	24
Pets at Home	447	12
CVS	386	10
VetPartners	380	10
Medivet	369	10
Linnaeus	183	5
Independents	1056[53]	28
Total	3721	100

Source: RFI4 data submissions and responses to putback from IVC, CVS, Linnaeus, Medivet, Pets at Home and VetPartners. Data on the number of independent FOPs was obtained by contacting individual practices. See our working paper ***Analysis of local concentration.***
As the number of FOPs for independents is likely to be an underestimate, the shares presented for the LVGs are an upper bound, and the shares presented for independents is a lower bound.

1.12 Data on the revenues earned from different pets in 2023 from the LVGs and a sample of independent practices from [✂] indicates how pet owners' spend on their pets can vary significantly (Figure 1.1). This analysis is based on spend outside of pet care plans (based on our survey of pet owners, 37% of pet owners subscribe to a pet care plan).[54] Our analysis of this data indicates that over half of pet owners spent less than £250 at FOPs for their pets in 2023. We note that including spend on pet care plans would increase these figures for those pet owners with pet care plans. Around or less than 6% of pet owners spent over £1000 at FOPs.[55] Dog owners overall spent the most money, and owners of pets other than cats and dogs spent the least.

Figure 1.1: Pets in revenue brackets across FOPs, 2023



[52] We note that the number of LVG FOPs in the table differs from those set out in our working paper **Analysis of local concentration.** This is because different data sources have been used.
[53] See our working paper **Analysis of local concentration**. This number represents the number of independent FOPs that are 'confirmed practices' (such as practices that responded to our information request and confirmed they are a FOP). We attained a response rate of 79% to our information request, so this figure is likely an underestimate.
[54] Pet owners survey, Q108.
[55] 3% of cat owners spent over £1000 on their pet in 2023, and this figure was 6% for dog owners, and 1% for owners of household pets other than cats and dogs.

Source: CMA analysis of LVG and [✂] data. Further information on this data and the analysis we did can be found in Appendix A.

Referral services

1.13 Some providers offer referral services, where a pet owner will receive a referral from their FOP to go to another qualified or specialist vet, sometimes in a different site. Referral services may include, for example, specialist imaging, dentistry or complicated surgery, and vets offering referral services may have particular specialisms (and access to equipment) that the FOP vet may not have.

1.14 A Specialist vet, as defined by the RCVS, will have at least a postgraduate diploma level qualification.[56] Specialist vets can work in a number of different types of practice. They may work in different sites offering referral services (described in more detail below), or FOPs may employ peripatetic Specialist vets who travel to different practices to deliver services within those practices.

1.15 Referral services may be offered at a range of different sites: dedicated referral-only centres (which do not provide FOP services), hospitals (sites meeting RCVS hospital standards which include having 24-hour staff and the ability to treat complex cases) and FOPs. Some LVGs operate hub and spoke models where hubs can be referral centres, hospitals or FOPs offering specialist services which receive referrals from surrounding FOPs (spokes). A practice does not have to have specific accreditation to offer referral services and indeed many FOPs also offer these services, subject to having sufficiently qualified vets and the necessary equipment to provide them. The range of referral services offered at FOPs and hospitals therefore can vary significantly.

1.16 All of the LVGs offer referral services of some capacity, although we understand Pets at Home does not have any practices where referrals make up [✂] of the work; Pets at Home sold its referral centres to Linnaeus in 2020).[57]

1.17 The table below shows the split in 2024 between practices that offer only referral services (referral-only centres) and those that also offer first opinion care but where referrals make up the majority of the practice's work. There are many more sites offering some levels of referral services (for example as a small part of their offering at the site), which are not included in the table below.

[56] https://www.rcvs.org.uk/lifelong-learning/professional-accreditation/specialists-status/?&&type=rfst&set=true#cookie-widget
[57] Pets at Home RFI2 Response, Question 2.

Table 1.4: Number of sites providing a majority of referral services in the UK, 2024

Ownership	*Referral-only centres*	*Additional sites where referrals make up a substantial part of the work*	*Total referral-led sites*	*Share of referral-led sites (%)*	*RCVS accredited hospitals*[58]	*Total referral-led sites and RCVS accredited hospitals*
Linnaeus	18	2	20	< [✂][10-20]	19	39
IVC	[✂] [10-20]	[✂] [0-10]	[✂] [20-30]	< [✂][20-30]	[✂] [40-50]	[✂] [70-80]
CVS	5	4	9	< [✂] [0-10]	40	49
Medivet	3	0	3	< [✂] [0-10]	21	24
VetPartners	2	1	3	< [✂] [0-10]	28	31
Pets at Home	0	0	0	0	5	5
Independent	51	Unknown	>51	> [✂] [40-50]	56	>107
Total	[✂][90-100][59]	> [✂] [10-20]	> [✂] [110-120]	100	[✂] [210-220]	> [✂] [320-330]

Source: RFI9 data provided by IVC, CVS, Linnaeus, Vet Partners and Medivet; RFI4 data provided by Pets at Home; putback responses from these parties. Data on the number of independent referral centres was obtained by contacting individual referral centres and supplementing with RCVS data where we did not get a response.

Diagnostic testing

1.18 Diagnostic testing is any testing with the aim of identifying a disease or condition or checking general indicators of overall health. This may include, but is not limited to, analysis of blood, tissue, urine or stool as well as a range of scans and imaging tests (such as ultrasounds, x-rays, MRI scans and CT scans).

1.19 Diagnostic testing might be done at the FOP, if the necessary equipment and expertise is available,[60] or the animal could be referred to a specialist provider in a different location following sampling (or a peripatetic Specialist vet if the FOP has the equipment but not the expertise). Specialist providers are usually private laboratories or universities which conduct the analysis and send the results back to the original clinic for the vet to interpret and discuss the results with the pet owner.

1.20 All the LVGs engage in within-FOP diagnostic testing and imaging, although to varying degrees. CVS, Medivet and Linnaeus (through its parent company Mars) also have links to their own diagnostic testing laboratories, as shown in the table below which sets out the number of diagnostic laboratories in the UK in 2024.

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[58] Numbers do not include the referral centres listed in the second and third columns, some of which are RCVS hospital accredited.

[59] We note that the total number of referral-only centres here differs from the figure discussed in our working paper **Analysis of local concentration** (99 referral-only centres). This is due to differing data sources being used. If the same data source is used as in our **Analysis of local concentration**, the share of LVG referral-only sites would increase slightly, driven by an increase in the count of sites for [✂] and [✂].

[60] Tests which are often conducted within FOPs include blood tests to determine blood-glucose or lactate levels, Schirmer's tear test or basic urine tests to determine hormonal or kidney issues.

Table 1.5: Number of diagnostic laboratories in the UK, 2024

Ownership	*Number of diagnostic laboratories*	*Share (%)*
CVS	2	<7
Medivet	1	<3
Linnaeus (Antech Diagnostics)	2	<7
Independents[61]	>25	>83
Total	>30	100

Source: LVG RFI10 responses, putback responses and CMA desk research

[61] We note that we reached out to independent diagnostic laboratories that we were able to find through desk research, but that the true number of independent diagnostic labs may be higher than this.

2. Higher prices, treatment costs and treatment intensity in FOP services

Introduction

2.1 There are concerns among pet owners around the increasing overall cost of veterinary care. These higher costs could be driven by higher prices for like-for-like services, or by selling a greater proportion of higher cost services when there is a range of clinically appropriate options to treat the pet (which we term increased treatment intensity).

2.2 In this section we assess how much the costs to consumers of vet care have increased, and to what extent these increasing costs may be due to the lack of competitive pressure that consumers are putting on business and/or limitations on the effectiveness of regulation.

2.3 This section is structured as follows:

(a) **Analysis of evidence on trends and market outcomes:** We analyse evidence which indicates that the costs of veterinary care for pet owners have increased, [✂]. We explain how price rises may have contributed to these greater costs but note that there is more limited evidence of increases in treatment intensity.

(b) **Assessment of competition on price**: We assess whether price increases of veterinary services may be due to a weak consumer response to these price increases. We also assess charging practices in the sector.

(c) **Assessment of competition in relation to treatment intensity and veterinary advice:**

(i) We assess the evidence on whether pet owners are likely to follow their vet's advice on treatment.

(ii) We consider what factors might influence how vets present treatment options to pet owners, including regulatory constraints, commercial pressures (including key performance indicators (**KPIs**)) and pet owners' level of experience or confidence in assessing what might be the best care in the context.

(iii) We consider the evidence on how treatment options are presented to pet owners, including how they report their experience and what vets and vet businesses have told us.

Analysis of evidence on trends and market outcomes: prices and treatment intensity

2.4 In this section, we consider the evidence we have seen to date on increases in prices, overall treatment costs and treatment intensity and possible reasons for these differences.

2.5 Throughout our assessment, where possible, we compare LVGs with independent vet businesses to explore whether there is evidence of differences between them. Given the increased importance of LVGs in the sector, and the strong presence of non-vets (who are not subject to statutory sectoral regulation) in management and ownership roles in LVGs, we consider that it is important to test for these differences, though we note that that some smaller practices also have non-vets in management roles.

2.6 Many consumers – and indeed vets as well – have told us that costs for pet owners have risen in recent years. Costs could have increased due to price rises or vet businesses selling a higher proportion of more expensive services. We assess the evidence on price rises, [✂].

2.7 We are aware that that there is a significant number of treatments for animals which would not have been available 10 to 15 years ago. It is now possible for consumers to purchase a wide range of increasingly complex treatments and diagnostic tests for their pets. We consider the evidence on whether treatment intensity has been increasing and whether this varies between different types of vet businesses.

The cost of veterinary care for pet owners has increased

2.8 We have assessed trends in the total costs incurred by pet owners for diagnosing and treating a condition over the 12-month period following their first contact with a vet (**first-year treatment costs**) and trends in average unit prices of the diagnostics and treatments involved using data from two pet insurers.[62] We first set out the evidence on these trends and then compare these trends to inflation (using the CPI) and salaries of vet professionals. We note that we have received some submissions from the LVGs on our analysis, which we have not been able to review in detail ahead of the publication of this paper. Certain LVGs have indicated that they disagree with this analysis, including identifying possible methodological errors and noting that there are significant market trends (including rising costs and increased service quality) which provide key context for the findings. Their

[62] We intend to publish our methodology for this analysis in due course. We have shared it with the LVGs and their advisers and will consider their comments before we publish it.

submissions will be taken into further consideration before we publish a further paper which sets out our analysis in more detail.

2.9 Our analysis of data from one pet insurer ([✂]) indicates that first year treatment costs to pet owners at FOPs (both LVGs and independents) increased by [70-80]% [✂] between 2015 and 2023.

2.10 The increase in first-year treatment costs could be driven by an increase in the unit price of the specific diagnostics and treatments involved (the **price effect**), an increase in the number or complexity of these clinical options (the **treatment intensity effect**), or both. Our analysis of the unit prices (to which we had access from another insurer, ([✂]) show that on average unit prices at FOPs (both LVGs and independents) grew by [60-70]% [✂] between 2015 and 2023.

2.11 This analysis is subject to three important limitations. First, it does not include conditions and treatments that are not covered by pet insurance, such as vaccinations and other types of preventive care. Second, to mitigate the effect of changes in coverage over time, this analysis focuses on the categories of conditions and treatments that are most frequently observed in the data. Third, this analysis does not control for any changes in the type or quality of the treatments applied. This limitation applies to our analysis of first-year treatment costs, but also to some degree to our analysis of unit prices. This is because we are only able to analyse trends in average unit prices for the categories of treatments used by the insurer to categorise the items invoiced by vets, and within a given category (eg rhinoscopy) there might be a degree of substitution from simple to more complicated versions of a treatment over time. Nevertheless, we think that this analysis provides a reliable estimate of increases in treatment costs and average unit prices for the most common categories of conditions and treatments covered by pet insurance. It is, though, like all our analysis in our working papers, provisional and subject to change as interested parties respond and our investigation continues.

2.12 At this stage in our analysis, we cannot use this insurance data to assess any trends in treatment intensity. Due to the data sets used coming from different insurers, it is not possible to infer that the seven percentage-point greater increase in total costs compared to the increase in unit prices is explained by increases in treatment intensity.

2.13 The [60-70]% [✂] increase in unit prices at FOPs is significantly greater than the general inflation for services during this period. The CPI for services grew by 35% between January 2015 and December 2023.[63]

[63] Source: ONS, CPI Index: services.

2.14 The [60-70]% [✂] increase in unit prices at FOPs is also significantly greater than the increase in salaries of vet professionals and so changes in unit costs of veterinary professionals do not appear to explain the extent of the price increases in the sector.

2.15 Between 2015 and 2023 annual full-time pay increased by 20% for vets and 34% for vet nurses. When including all staff (full-time and part-time), annual pay increased by 34% for vets and 33% for vet nurses, although these changes may reflect changes in working hours of part-time staff rather than changes in unit costs (hourly pay) of veterinary professionals. These salary estimates are based on data from the ONS Annual Survey of Hours and Earnings on mean gross salaries (that is before tax) and does not include earnings from bonuses and performance related pay.[64]

[✂]

2.16 [✂]

(a) [✂]

(b) [✂]

2.17 [✂]

2.18 [✂]

2.19 [✂]

2.20 [✂].

2.21 [✂].[65] [✂]. [66] [✂]

2.22 [✂].

2.23 [✂][67] [✂].

2.24 [✂]

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[64] ONS Annual Survey of Hours and Earnings, Table 14.
[65] See section 9.34 of the Supporting guidance to RCVS Code of Professional Conduct for Veterinary Surgeons (available here: Practice information, fees and animal insurance).
[66] [✂] LVG response to RFI 11 Question 8, paragraph 31, [✂] LVG response to RFI 11 Question 8 [✂]; LVG response to RFI 11 Question 8 [✂]; LVG answer to RFI 11 Question 8, [✂]; LVG response to RFI 11 Question 8 [✂]; LVG response to RFI 11 Question 8, [✂].
[67] Pet owners survey, Q112.

Evidence from internal documents on pricing strategies

2.25 There is some evidence from internal documents that some LVGs may recommend prices to their practices (even if the pricing is set by the local practice), and that these recommendations involve increasing prices. For example:

(a) An LVG [✂] 2022 pricing document considers the current price for various treatments at a clinic of the LVG ([✂]) and has a column with the 'Recommended Price'.[68] In most instances, the recommended price has been accepted, with a weighted average recommended price increase of 10-20% across all treatments. [✂]% of treatments did not change price, [✂]% of treatments decreased in price, and the remaining [✂] increased in price. Of the treatments where a price increase was recommended, the average price increase was 20-30%.

(b) An LVG [✂] 2022 service fee pricing document, created in response to a question from the CMA in the context of a CMA merger investigation detailed the weighted average fee increase being applied to practices from April 2019 to October 2021. The response also included further details on the drivers behind price increases and the significant ongoing cost pressures. The average yearly fee increases were calculated as 8.6% in 2019, 9.0% in 2020 and 10.3% in 2021 Over these three years, the overall increases were higher in London, but in some years they were lower.[69]

2.26 We note many of the price increases referred to in the documents above are above inflation (for context CPI inflation was 2.5% in 2018, 1.87% in 2019, 0.91% in 2020, 2.65% in 2021, and 9.1% in 2022).[70]

2.27 We reviewed some internal documents from some LVGs suggesting that prices have increased and that there were pet owner concerns about high prices. For example:

(a) An LVG [✂] internal document discusses average transaction values (ATV). As of September 2021, the report notes that ATV has improved a little in September (£4 higher (+5%)) but still with weaker year on year growth, which have been increasing year on year. On a two-year basis, the average transaction value was up 17% from September 2019 to September 2021. The report also notes the impact of the COVID-19 restrictions during this period, including that client numbers had increased in the previous six

[68] LVG response to RFI4, [✂]
[69] LVG response to RFI3, [✂]
[70] CPI ANNUAL RATE 00: ALL ITEMS 2015=100 - Office for National Statistics

months to September 2021, driven by reactivation of clients whose pets' treatments were delayed as a result of the COVID-19 restrictions.[71]

(b) An LVG [✂] clinical operations document considers handling of complaints by pet owners, showing that, of the approximately [✂]% of FTE vets at this LVG that had a Stage 2 complaint raised against them in the year, the third largest number of complaints ([✂]% in 2021/2022) were about clinical fees, with the largest subcategory of complaint within this being 'fees - excessive', which increased from [✂]% of complaints in this category in 2020-2021 to [✂]% in 2021-2022.[72]

Evidence from third parties on price trends

2.28 We received some submissions from third parties that prices were increasing more (or were generally higher) for the LVGs than for independents. How much weight we can place on such submissions depends on whether they are supported by evidence and the strength of this evidence.

2.29 An insurance company [✂] submitted some data which indicates the increase of average costs (measured by comparing the average cost of invoice items from one year to the next – referred to as 'inflation' in the document) by the LVGs as well as some independent practices.[73] This evidence indicates that in 2023, increases have been the most significant among the LVGs, with two LVGs [✂], [✂] showing the largest rises, although there have been significant increases at two independent vet groups ([✂], and [✂]). The average cost per item of independent vets is also cheaper than for the LVGs listed (with the exception of independent referral centres, which do not offer FOP care). [✂]

Figure 2.1: Item costs as submitted to [✂]

[✂]

Source: [✂] internal documents

2.30 A specialist [✂] operating out of different corporate and independent FOP practices noted a large difference between the markups added by corporates and independents for his services.[74] In particular, he submitted: '[t]he consultation fee is marked-up by 57% and 60% by the corporate host practices and 34% and 43% by the independents; the additional fee is marked-up by 68% and 87% by the corporate host practices and 27% and 54% by the independents'. He additionally submitted '[s]edation and anaesthesia fees are set by the host practice – the corporate practices charge more than the independent host practices despite little

[71] LVG response to RFI3, slide 12, [✂]
[72] LVG response to RFI3 [✂]
[73] [✂] submission, January 2024, slide 3.
[74] Referral centre response to RFI1, Question 16, pp. 6-7. [✂]

or no difference in personnel, drugs or monitoring equipment (in regard to the latter, corporate practice monitoring equipment is often of poor quality and/or functionality). The corporate practices also charge additional fees for anaesthetic drugs (the independents include them in the fixed, usually lower cost of the anaesthetic)'.

2.31 An independent vet submitted that it tracked the prices of competitors, including the LVGs, and found that their increases had been 'frequent and much higher than our usual price increases. Have reluctantly increased our prices so not falling too far behind competitors (although still significantly less than corporates)'.[75]

2.32 A submission made to us independently by an individual formerly employed at an LVG [✂] stated that the investors of the LVG viewed it as a 'cash cow' which could be squeezed to extract excess profits. The submission stated that investors would habitually publish arbitrary single price increase target figures to be applied across all items regardless of the underlying cost of the service or product being provided.[76]

2.33 In the section above we cite a document from this LVG which recommends [✂].

Evidence from qualitative research on pricing

2.34 Most vets and vet nurses who participated in our qualitative research referred to recent rising prices in the sector. Reasons given included inflation, the rising cost of supplies, however many attributed the increases in prices to the growing prevalence of corporate ownership in the UK.[77]

2.35 Many of the vets and vet nurses at LVGs reported regular price increases across various treatments and services, and some indicated that these regular price increases were part of company-wide policies.[78] Many vets and vet nurses working at practices that had recently been acquired by LVGs reported that rising prices for pet owners were the most significant change resulting from the takeover.[79] [✂]. The vets and vet nurses noted the challenge of communicating the price increases to pet owners.[80] A few said that these price increases occurred alongside no noticeable improvements in the perceived quality of care provided.[81]

[75] Independent response to RFI1, Question 1, p.1. [✂].
[76] An individual formerly employed by an LVG [✂].
[77] Qualitative research with veterinary professionals, p. 85-86.
[78] Qualitative research with veterinary professionals, p. 87.
[79] Qualitative research with veterinary professionals, p. 88.
[80] Qualitative research with veterinary professionals, p. 88.
[81] Qualitative research with veterinary professionals, p. 89.

2.36 An independent practice vet stated: ‘I had worked in a previous practice that got taken over by an LVG [✂] and I personally saw that the high prices were putting clients off having procedures done’.[82]

2.37 Many vets and vet nurses expressed concerns about the influence of LVGs on the veterinary sector, often highlighting the impact on affordability for pet owners as a primary issue:[83]

> I think my main worry is where we're going and since most of the veterinary practice is now owned by the small number of groups… and most of it is private equity and their business model is to own practices for four or five years to increase the turnover … that's their sole mechanism and the way they seem to have done that is just by jacking prices up constantly. I do think that it's had a major impact on affordability for clients and I think that it's beginning to get to the point where people can't have treatments, they're having to have euthanasia for procedures that would have been treated. *Veterinary surgeon, Independent practice, previously LVG* [✂] *practice*

2.38 Many vets and vet nurses raised concerns over rising prices across the sector.[84] Aside from the difficulty of communicating these to pet owners, many vets were concerned about the impact of rising prices on animal welfare.[85] A few explicitly mentioned increased euthanasia rates, which they felt was due to financial constraints and therefore ability to afford treatments that avoid euthanasia.[86] For example:

> I am facing everyday owners that want to do the best for their pets, but they cannot afford it … honestly, I am constantly advising owners to buy insurance because I have seen so many cases that are treatable and they cannot afford it and you have to euthanise the patient*. Veterinary surgeon, LVG* [✂] *practice*

Evidence on whether vet businesses consistently charge for services

2.39 We observe that LVGs prioritise consistently charging for services provided, whereas independent vets may be more flexible in charging, in a way that might be detrimental to the financial health of their business. This differing approach may have the effect of increasing the cost of treating a pet at an LVG compared to an independent practice.

[82] Independent response to RFI1, October 2024, Question 5. [✂]
[83] Qualitative research with veterinary professionals, p. 93.
[84] Qualitative research with veterinary professionals, p. 87-94.
[85] Qualitative research with veterinary professionals, p. 92.
[86] Qualitative research with veterinary professionals, p. 92.

2.40 Internal documents from private equity owners referred to 'charging optimisation' (or words to that effect), meaning consistently charging for services provided, as an important mechanism for improving profitability.[87] For example, one document [✂] considered that expanding a 'charging optimisation and compliance initiative' was a way to deliver above-market organic growth and margin expansion.[88] We have seen references to this in many of the LVG internal documents which we have reviewed as well.[89]

2.41 In our qualitative research, many vets at independent practices reported flexibility when charging pet owners. They discussed feeling able to waive certain fees if they felt it was appropriate, for example not charging for a very short follow up consult.[90]

2.42 Less flexibility when charging clients was reported by vets who were working, or had worked, at LVGs. The vets reported that practice computer systems or protocols prompted them to comply with diagnostic guidance or charge for services in certain ways. For example, the system would not allow them to charge for one service without also charging for another which the business recommended was sold in combination. In some cases, it would prevent the removal of charges or not allow the vet to proceed to the next screen without adding a charge.[91]

2.43 There were also examples of vets working at LVGs describing that the 'friction' of not adhering to the practice guidelines (for example needing to explain why they did not charge for something) had changed their behaviour and meant that in the future they would be more likely to comply with corporate guidelines.[92] One attendee at the Manchester roundtable indicated that they knew of a corporate practice where if an expected treatment or service was missing from a bill, the vets would receive an email from corporate management asking why it was missing.[93]

2.44 A number of vets at LVGs, especially more senior staff, reported not following the established protocols or guidance around charging, for example manipulating charging to make it cheaper for pet owners, or not charging for things that they did not agree with, despite pressure to charge from management or performance monitoring.[94]

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[87] For example, Private Equity-LVG investor response to RFI1 [✂]
[88] Private Equity- LVG investor response to RFI1 [✂]. The presentation further explained that 'charging optimisation' included: (i) rebalancing revenue from sales of drugs towards treatments and services; (ii) greater compliance with pricing structures and 'driving cultural shift towards full pricing for the services provided (with some degree of freedom)'; (iii) ensuring prices reflected new technologies; and (iv) aligning prices to the market.
[89] See, for example, LVG response to RFI3 [✂], LVG response to RFI3 [✂]
[90] Qualitative research with veterinary professionals, p. 68.
[91] Qualitative research with veterinary professionals, p. 38-40.
[92] Qualitative research with veterinary professionals, p. 72.
[93] Summary of roundtable in Manchester, paragraph 14. Summary of roundtable discussion held in Manchester on 28 August 2024
[94] Qualitative research with veterinary professionals, p. 69-71.

Analysis of revenues and number of treatments per pet

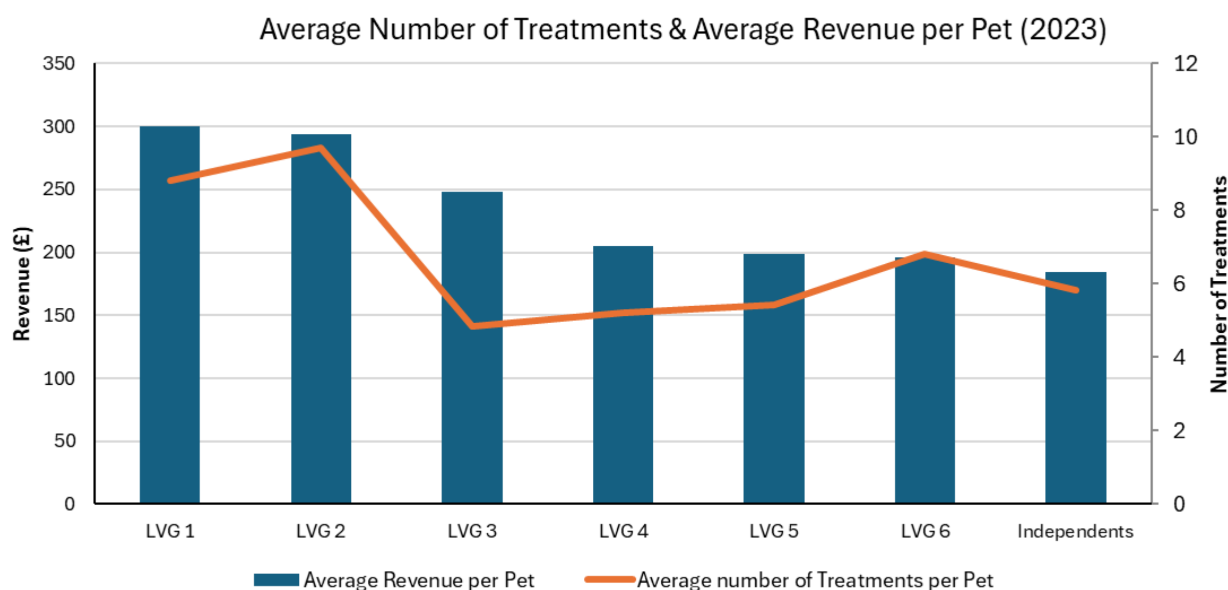
2.45 This section sets out some analysis of revenues and number of treatments based on data of the LVGs' FOPs and data on 120 independent FOPs provided by [✂]. This data is set out in more detail in Appendix A. While the data from [✂] is not representative of all independent FOPs, it provides an indication of how a set of independent FOPs compares to the FOPs belonging to LVGs. [✂] indicated that the independent FOPs it advises and collects data from may be more likely to be 'better performing' practices. One possible inference is that the [✂] dataset is more likely to include independents that are similar to LVGs and so our analysis below may underestimate any differences between LVGs and the wider population of independents.

2.46 Using this data and excluding pet care plans, we estimated the average number of treatments and revenue per pet, per annum at FOPs in 2023 for each of the LVGs and our set of independent FOPs (Figure 2.2).[95] Each individual service provided, as itemised on the bill, during a visit to an FOP in 2023 is considered as an individual treatment. It is worth noting that services may be grouped differently within and across corporates on the bill, which might affect interpretation. Further details of our methodology for these estimates are set out in Appendix A.

2.47 An LVG [✂] and another LVG [✂] appear to have the highest number of treatments per pet on average (8 to 10) and the highest average annual revenue per pet (around £300). Other vet businesses had a much lower average number of treatments per pet, ranging from around five for some LVG [✂] and our set of independents to just under seven for an LVG [✂]. Other vet businesses also had much lower average revenues per pet, ranging from £180 for the independents to almost £250 for an LVG [✂].

[95] All mentions of average revenue per pet and average number of treatments per pet are to be understood as meaning per pet per annum.

Figure 2.2: Average revenue per pet and average number of treatments per pet in 2023



Source: CMA analysis of LVG RFI8 and [✂] data

2.48 There may be some differences in behaviour between vet businesses which may affect how the average revenue and number of treatments per pet compares between these different vet businesses (LVGs and our set of independents). Some vet businesses may have the capability to do more advanced treatments within their FOPs, whereas others may rely more on referring to other types of practices (potentially both internally and externally, where relevant). We are seeking to understand further whether there are certain vet businesses where this ability to do more advanced treatments within FOPs is more likely to apply than others.

2.49 We also analysed the proportion of pets (split by cat, dog and other) falling into various revenue brackets in 2023 for FOPs across the LVGs and supplemented this with information from [✂] on independents. We focused on pets that had generated revenues for the FOPs (omitting those with £0 spend). The results are presented in the figures below which show that the majority of pets treated at LVGs and our set of independents fell into revenue brackets that were below £250 across 2023.

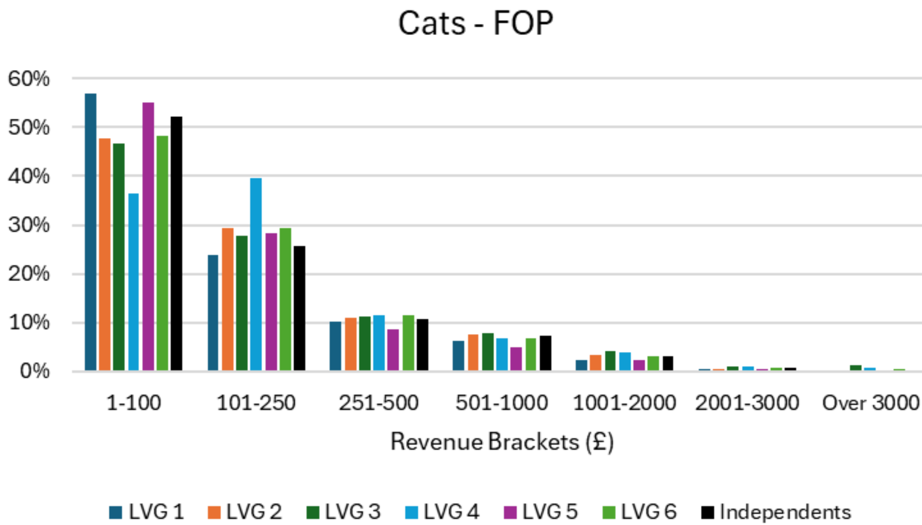
2.50 Note that these figures exclude revenue generated from pet care plans.[96] Including pet care plans would increase revenues generated for pets covered by pet care plans and may involve some pets moving from lower revenue brackets into higher ones. This is likely to affect revenues at the LVGs more than independents because our consumer research found that a consumer whose usual vet practice is part of an LVG is more likely to have a pet care plan than a

[96] See answers to question 3 and 4 of LVG RFI11. Pet care plan revenues cannot be traced back to individual pets and are thus excluded and/or pets that only received treatments as part of their pet care plan in 2023 are placed in the '0' revenue bracket, and are excluded from these charts.

consumer whose usual practice is independent (42% compared to 29% respectively).[97]

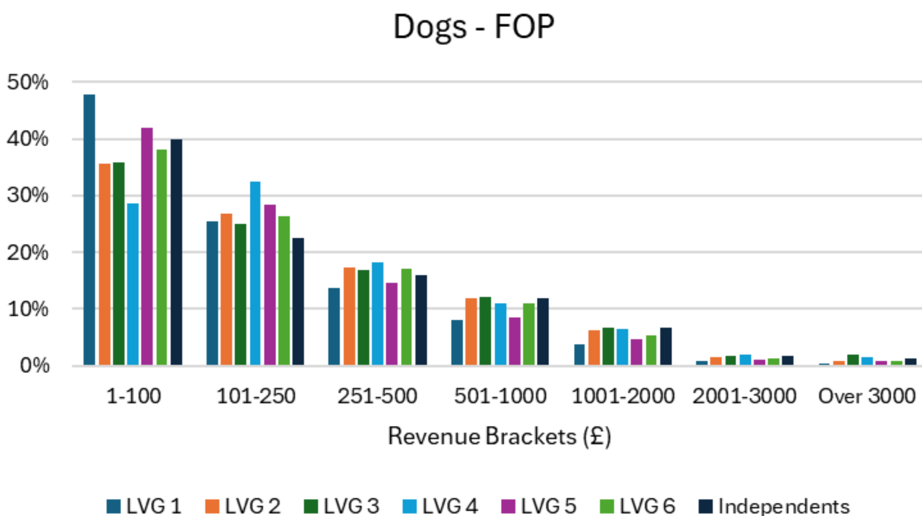
2.51 Based on the figures below, there does not generally appear to be a substantial difference between the LVGs and independents.

Figure 2.3: Proportion of cats falling into different revenue brackets in 2023 for FOPs



Source: CMA analysis of RFI11 responses to Question 3, and [✂] data

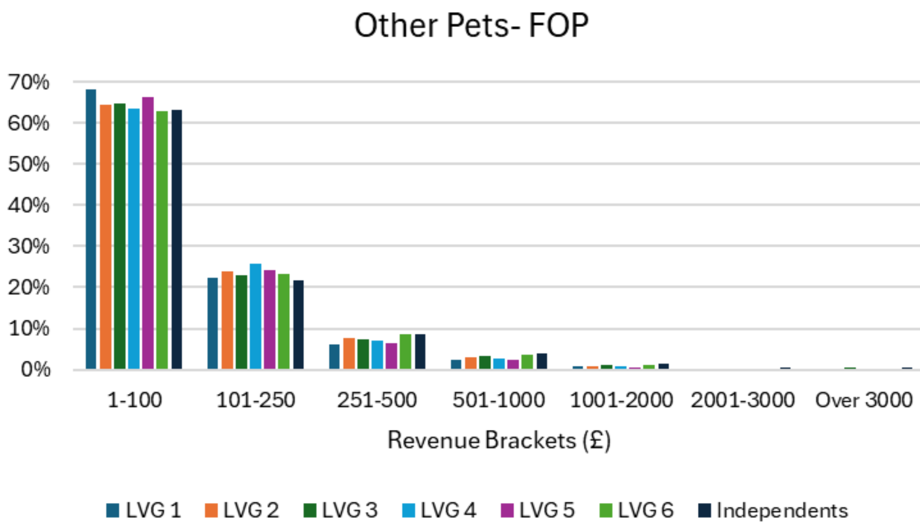
Figure 2.4: Proportion of dogs falling into different revenue brackets in 2023 for FOPs



Source: CMA analysis of RFI11 responses to Question 3, and [✂] data

[97] Pet owners survey, Q108. 42% of respondents whose usual practice was identified as an LVG had pet care plans, compared with 29% of those whose usual practice was independent. This difference is statistically significant.

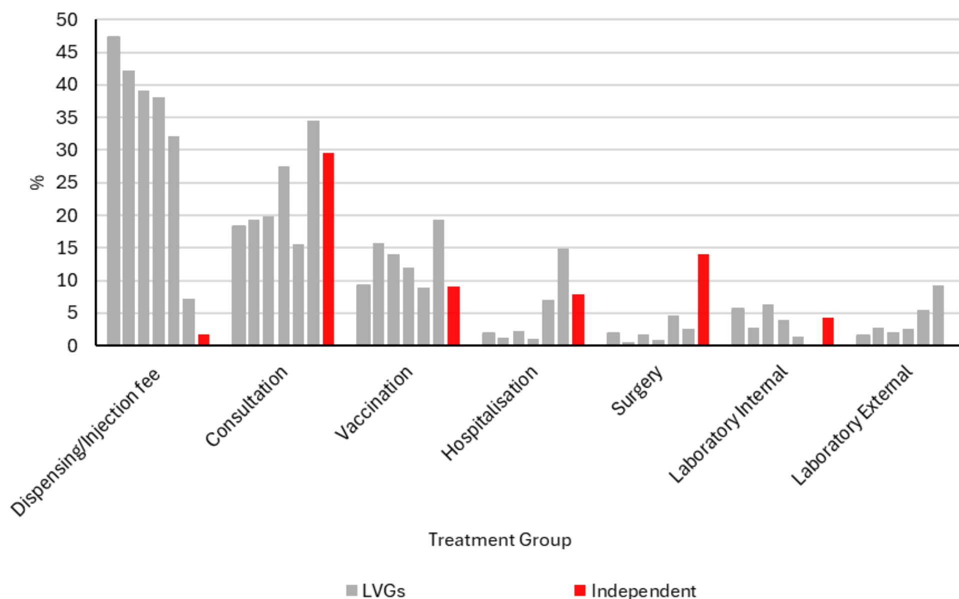
Figure 2.5: Proportion of other pets falling into revenue brackets in 2023 for FOPs

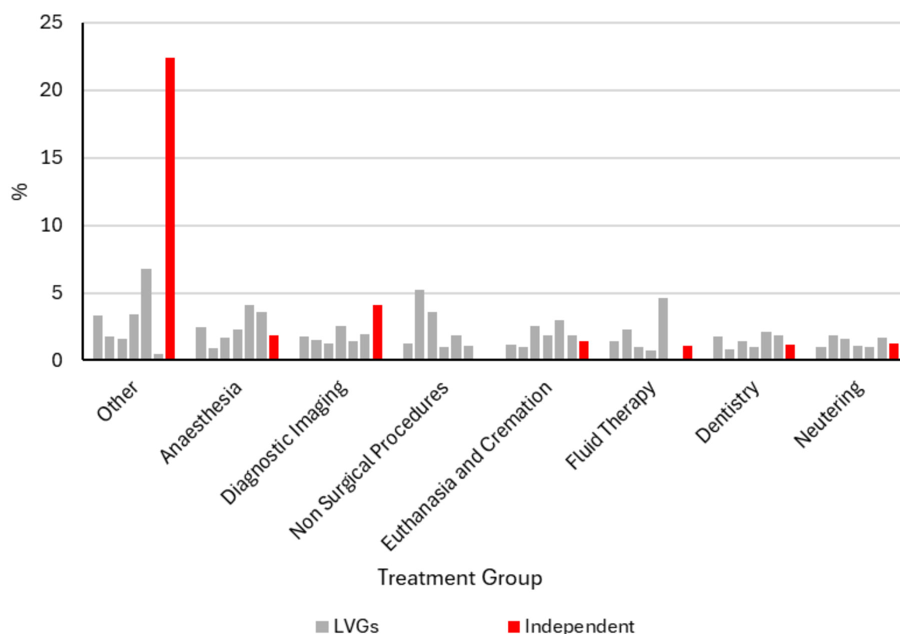


Source: CMA analysis of RFI11 responses from LVGs to Question 3, and [✂] data

2.52 We used data on FOPs from LVGs and the set of independents from [✂] to assess whether there were any differences in how much of particular types of service LVGs and independents offered at their FOPs. Figure 2.6 below shows the results of this analysis with results from our set of independents highlighted in red. For the reasons given below we have not made inferences from this analysis on the extent to which treatment intensity differs between LVGs and independents.

Figure 2.6: Independent vets and Large Veterinary Groups: Treatment Groups by Percentage of Total Number





Source: CMA Analysis of Corporate RFI8 responses and [✂] data

2.53 One difference identified by this analysis is in the provision of surgery (and associated treatments), which represents around 15% of total number of clinical services for independents, but only up to 8% for LVGs. Such differences in surgeries does not necessarily indicate that vets at independent FOPs are more likely to recommend surgeries. Another potential explanation is that vets at independent and LVG FOPs may have a similar propensity to recommend surgeries, but that independent FOPs may be more likely to conduct the surgical treatment in-house at their FOPs, whereas vets at LVG FOPs may be more likely to refer surgeries to be undertaken at a dedicated specialist or veterinary hospital (which are not included in this dataset).

2.54 The use of other types of clinical service appears to be broadly similar at LVGs compared to our set of independents. Other possible differences may arise due to differences in how the data has been recorded by LVGs and independents (for example injections, mix between internal and external diagnostic testing, and services in the other category) and where this may be the case we have not made comparisons between LVGs and independents.

We have limited empirical evidence at this stage as to whether increases in treatment intensity are contributing to the trend of increasing veterinary care costs

2.55 LVGs submitted that treatment intensity had not increased in the period 2016 to 2024, whereas we received submissions from other parties that treatment intensity had increased more for large groups than independents. We therefore need to consider the weight of evidence supporting these competing claims in our assessment.

2.56 Evidence received from LVGs included empirical analysis. For example, an LVG [✄] provided analysis on the usage of MRI machines in referral centres post-acquisition by [✄] as a proxy for 'advanced treatments'.[98] It stated that, if our theory was correct, one would expect to see a significant increase in the use of advanced treatments after the practice was acquired by [✄]. It provided information on four referral centres, for which it said there was no significant change in the years following acquisition for two of the sites, a decrease in usage for one site and an increase in usage for another. It [✄] submitted that for the site which saw an increase in MRI usage, this was due to a relocation to a larger site and an increase in size of the Neurology team.[99]

2.57 Evidence from other parties was more anecdotal. For example, a group of independently owned vet practices [✄], told us that 'gold-plating' treatments by large groups is leading to potential overtreatment and higher costs for consumers.[100] This included examples of more complex treatments and medications being prescribed by vets in large groups, compared to independents. The group [✄] explained that this could happen due to inexperienced vets overtreating a problem, compared with more experienced vets. Another example was given of a low-cost alternative option not being provided to a consumer until they rang and asked about it.

2.58 It may be possible for some parties to provide more evidence to support their submissions, and we are considering exploring this further with them.

2.59 Our qualitative research included some concerns from vets about increasing treatment intensity. For example, one vet expressed concerns about what they considered an industry-wide trend towards over vaccination or administering preventative treatments that might not be strictly necessary. They felt that pet care plans often normalised these services, even when some animals might not require them, with the implication of increasing prices for basic care for pet owners.[101]

2.60 At this stage in our investigation, we have not found empirical evidence of any overall trends in treatment intensity. [✄].

2.61 So far, we have found limited empirical evidence on increasing treatment intensity. We note that all of the LVGs track a variety of clinical and financial KPIs (as would be expected), some of which appear to be aimed at increasing treatment intensity, and vets working at LVGs have told us that they sometimes experience pressure as a result of these targets. We have also seen evidence from the private equity investors in some LVGs which indicates that they have explicitly expressed intentions to increase treatment intensity. We discuss this evidence in the section

[98] LVG submission [✄].
[99] LVG submission [✄].
[100] Note of call with [✄], pp. 3-4.
[101] Qualitative research with veterinary professionals, p. 100.

on **Assessment of competition in relation to treatment intensity and veterinary advice**.

Assessment of competition on price

2.62 In this section we consider the evidence that there may be a weak consumer response to changes in price. Our current view is that consumers appear unlikely to respond to price increases (or make decisions on choice of FOP and veterinary care which are principally based on price considerations), and therefore there could be limited competitive pressure on vet businesses to keep prices low.

Higher prices of veterinary services may be in part due to a weak consumer response to price increases

2.63 Our working paper on **How people purchase veterinary services** sets out several factors which suggest that there may be a weak consumer response to price differences between competitors. These are set out in more detail in that paper and include:

(a) Evidence from a range of sources indicates that pricing information regarding treatment options may not be provided to or understood by pet owners on a consistent basis in a way that supports informed decision making.

(b) Evidence from our pet owners survey indicates that most pet owners are loyal to their current practice, and only 3% of respondents said that they switched practices in the past year for reasons relating to the competitive offering of FOPs.[102] 4% reported switching in the past 10 years in response to price. Even fewer, at around 1% of total survey respondents, reported switching FOPs in the past 12 months in response to price.[103] This is alongside the general trend of rising prices mentioned above.

(c) We observe that pet owners are humanising their pets and that this humanisation is a driver of pet healthcare spending. For example, most pet owners said that pet care costs should either always (42%) or often (34%) be prioritised over other important household expenses.[104]

(d) There may be barriers to switching FOP, such as wanting to build up a relationship with a particular vet, or the difficulty in seeking a second opinion when treatment is underway (including the cost of a new consultation and the need to move the pet to a different location).

[102] Pet owners survey, Q12A and Q33. To isolate respondents that moved because of the competitive offerings of FOPs, we removed respondents that switched FOPs because they moved home, or because their previous FOP closed down.
[103] Pet owners survey, Q33.
[104] Pet owners survey, Q134a.

2.64 If competition were working well, we would expect consumers to respond if the relative prices between different FOPs changed (where such changes did not reflect any changes in quality). We note that pet owners may be likely to experience benefits from staying with their existing FOP, given that people value continuity of care and an ongoing relationship with their FOP and individual vet. It is not necessary for all pet owners to switch FOPs in these circumstances, but effective price competition does depend on a sufficiently strong consumer response.

(a) As set out above, there has not been a significant consumer response [✂]. Evidence from our pet owner survey indicates that 3% of respondents said that they switched practices in the past years for reasons relating to the competitive offering of FOPs.[105]

(b) Around 40% of respondents reported finding out pricing information before registering with their FOP,[106] and 51% of respondents to our pet owner survey said that they only considered one practice.[107] In a well-functioning market more pet owners would be expected to compare prices or be aware of key overall price differences.

(c) This evidence on limited switching and price comparisons despite significant price increases indicates that there is a lack of competitive pressure on the prices of FOPs.

2.65 [✂]. We also note that there is some evidence, set out in our working paper on **How people purchase veterinary services**, suggesting that consumers do not generally prefer LVGs over independents. This includes:

(a) Views on the importance of practice ownership (namely whether it is an independent or LVG practice) from our pet owner survey. 21% of respondents reported considering practice ownership when choosing a FOP. Of these respondents, 68% preferred independent practices, with the remaining 32% preferring LVG practices.[108] For those that preferred independent practices, the top reasons given were individual vet continuity (56%), individually tailored service (50%), overall quality of service (46%) and trust in their vets' advice (40%).[109]

[105] Pet owners survey, Q12A and Q33. To isolate respondents that moved because of the competitive offerings of FOPs, we removed respondents that switched FOPs because they moved home, or because their previous FOP closed down.
[106] Pet owners survey, combination of Q17 (where those that said they considered prices as a factor when choosing a FOP were asked how they found pricing information before registering) and Q15 (where those that did not say they considered prices as a factor when choosing a FOP reported whether they nevertheless found pricing information before registering). 54% reported that they did not find out prices, and 6% could not recall.
[107] Pet owners survey, Q12b. This question was only asked of respondents who had been with their current FOP for less than 10 years. The remaining 6% of respondents could not recall.
[108] Pet owners survey, Q13.
[109] Pet owners survey, Q22. More than one answer could be given, so percentages sum to more than 100%.

(b) Respondents who had switched practices were more likely to say that they did so because they wanted to move to an independent practice (8%) compared to wanting to move to an LVG practice (1%).[110]

(c) Internal documents indicate that at least some LVGs make decisions about marketing and branding that reflect and target customer preferences for independent practices.

2.66 [✂]

2.67 Even if price increases did reflect changing quality, with better quality practices charging higher prices, we would expect that in a well-functioning market, consumers would be aware of this and compare higher priced higher quality practices with lower priced lower quality (but still meeting minimum standards) practices. As noted above (paragraph 2.63), the limited comparisons by consumers based on price suggests that broader comparisons that consider both price and quality are also limited.

2.68 While we need to assess further the extent to which price rises are closely linked to changes in quality, we have not seen internal documents from vet businesses suggesting that price increases are closely linked to changes in quality. Moreover, there is evidence that changes in quality is not the sole factor that explains these price rises. We have seen evidence that some vet businesses believe that there is likely to be a weak consumer response to higher prices and that raising prices is likely to be profitable. There are some internal documents from the LVGs and private equity owners of some LVGs which include reference to econometric analysis carried out internally to calculate how price sensitive their consumers are. Evidence from these documents suggests that overall price elasticity is low, meaning that few consumers will switch away or purchase less in response to high prices (or price rises). The documents also highlight ‘back of house’ treatments for which this finding is stronger. We understand ‘back of house’ treatments are diagnostics and procedures performed outside of the appointment time with the pet owner, such as when the pet is admitted to the clinic, and may include both routine and non-routine treatments. For example:

(a) An LVG [✂] document explains that ‘price elasticity is not that high in this sector’, and that ‘[back of house] items are clearly less price sensitive than the [front of house] items’.[111]

(b) An LVG [✂] pricing plan document prepared independently by external consultants ([✂]) states that an ‘[e]lasticity study of historic data found demand for fees and drugs to be inelastic. […] indicating the revenue

[110] Pet owners survey, Q33.
[111] LVG response to RFI3 [✂]

accretive effect of price increases, especially for treatments. Analysis provided evidence to weight price increases towards Back of House treatments where elasticity was lower'.[112] The same document explains that the '[p]rice experiment confirmed that strategy of price optimisation and price harmonisation allows prices to be increased with minimal volume loss'.[113]

(c) An investment committee update for a private equity firm [✄] from [✄] stated that 'charging optimization will continue to be a major value creation opportunity given low price elasticities exist in all markets'.[114] The presentation estimated that the impact on like-for-like pricing was around [0-10]% [✄] and that, across the LVG Group [✄], charging optimisation had the potential to increase EBITDA by £[0-50] [✄] million year-on-year.[115]

2.69 [✄]

Emerging view on price competition

2.70 It seems to us that there is likely to be a weak consumer response to price increases, and that vet businesses may be able to increase prices to levels above what we would expect in a well-functioning market, without constraints from pet owners switching to competitors. Given how important pets are for many people,[116] the weak consumer response may also mean that pet owners are unlikely to restrict their purchases of vet services in response to rising prices. We note that rising prices may also bring animal welfare considerations where pet owners are unable to access and afford sufficient veterinary care.

2.71 We found that the cost of veterinary care for pet owners has increased overall: data from one pet insurer indicates that the unit price of treatments increased by [60-70]% [✄] between 2015 and 2023. [✄]. The evidence indicates that part, but not all, of these prices increases are due to a weak consumer response to prices.

Assessment of competition in relation to treatment intensity and veterinary advice

2.72 Where pet owners are generally given sufficient information and suitable recommendations by their vet which reflects a pet owner's circumstances and preferences, any increase in the take-up of higher cost clinical options or increases in treatment intensity are unlikely to be a cause for concern. On the other hand, if the options presented to pet owners are limited, are not sufficiently

[112] LVG response to RFI3 [✄]
[113] LVG response to RFI3 [✄]
[114] Private Equity- LVG investor response to RFI1 [✄]
[115] Private Equity- LVG investor response to RFI1 [✄]
[116] As explained previously, in our survey, most pet owners (78%) reported considering their pet's healthcare at least as important as the healthcare of a family member. Pet owners survey, Q134.

explained or presented in a timely fashion, or there is any indication that a vet has not properly assessed the pet owner's preferences and circumstances, there is a concern that, in circumstances where there are multiple clinically appropriate options, some pet owners may opt for higher cost clinical options when they would otherwise have chosen a lower cost alternative.

2.73 At this stage in our investigation the evidence on treatment intensity is more limited than the evidence we have on prices. It is difficult to measure treatment intensity, and therefore assess whether it has increased. Any increases in treatment intensity could also largely reflect a greater desire by pet owners to spend more on their pets' health in response to the increased availability of complex or more advanced treatments, which would not be a competition concern.

2.74 Assessing whether there is a competition concern in relation to treatment intensity is therefore more complex than it is for prices. One way of assessing competition concerns in relation to treatment intensity is to take a risk-based approach, to assess whether there are features of the market, including business conduct and/or regulatory gaps, that increase the risk of there being a competition concern in relation to treatment intensity.

2.75 Given the submissions we received on treatment intensity increasing (described in paras 2.55 to 2.71 above), we have reason to undertake an assessment of whether there is an increase in the risk of there being a competition concern in relation to treatment intensity. These submissions are supported, to some extent, by the indicative evidence above that some LVGs appear to treat pets more often, and generate more revenue per pet, than other vet businesses.

2.76 In this section, we consider to what extent commercial incentives of vet businesses can affect vets' recommendations and, by implication, the services that consumers purchase. To do this, we assess two key factors that are relevant for assessing the risk of competition concerns in relation to treatment intensity:

(a) Whether pet owners rely on and follow the advice of their vets.

(b) Whether vets sufficiently inform pet owners about the range of clinical options.

2.77 We first summarise the evidence which suggests that pet owners are likely to follow the advice of their vets when choosing treatments, and unlikely to switch FOPs based on the quality of advice that they are given.

2.78 We then explore factors which influence the recommendations that vets make to pet owners about treatments, including animal welfare considerations, regulatory constraints, and business practices and pressures. We also present the evidence we have gathered (from vets, vet businesses and pet owners) on how treatments are presented to pet owners.

Pet owners are likely to follow the advice of their vet when choosing treatments and are unlikely to switch FOP based on the quality of the advice they are given

2.79 We set out in our working paper on **How people purchase veterinary services** that there is a range of factors which make it likely that pet owners will rely on and follow the recommendation of their vet. These include:

(a) For some types of vet services, it is difficult for pet owners to know what their pet's health needs are, or to evaluate the quality of service received, even retrospectively. There is therefore an information asymmetry between pet owners and veterinary professionals, and pet owners must rely on veterinary professionals as trained experts to recommend what services a pet needs and then to provide those services.

(b) There may be a range of emotional or behavioural factors that affect consumer decision making when receiving veterinary care. This includes wanting to do the best for their pet, or some vet visits being critical and involving quick or life-threatening decisions with associated increased levels of stress and anxiety.

(c) Most respondents to our consumer research stated that they did not conduct their own research on alternatives to the treatment they were recommended by their vet, mostly because they reported trusting the vet's decision.[117]

2.80 We consider, therefore, that pet owners are very likely to follow the guidance and recommendation of their vets in choosing which tests or treatments to purchase. Where there is a range of clinically appropriate options that a pet owner could decide between, it appears to us that vets – if they wished to – could influence pet owners to a large degree to accept certain treatments over others, for example by only presenting a limited list of options or through how they present the choice of options.

2.81 What information a vet gives to a pet owner and whether the vet's advice is appropriate are related to each other. For example, a vet's recommendation may be inappropriate if they have not explained to the pet owner the differences in prices of the available, appropriate clinical options. This leads to the risk that the vet recommends a more expensive option when the pet owner would have preferred a lower cost option. This can still be harmful for the pet owner even if they might be able to afford the more expensive option.

2.82 The evidence we have on how pet owners behave indicates that the advice pet owners receive from vets, including how much vets inform them about a range of

[117] Pet owners survey Q53. "No, because I did not realise I could" (5%), "No because I trusted the vet to make the right decision for my pet" (61%), and "No, because I was unable to do so" (11%). Remaining responses: don't know / can't remember (8%).

options to diagnose and treat their pets, is likely to have a limited effect on which FOP a pet owner uses. So, even if there are limitations to the advice a pet owner is given, for example if they are not told about lower cost options, the evidence indicates that pet owners may be more likely to follow this advice than switch FOP.

Vets are conscientious professionals working within a regulated sector, but also in a commercial context

2.83 Veterinary services are provided by highly qualified, regulated professionals, most of whom see their work as a vocation. They have taken an oath to do the best for the animals under their care. In our many conversations with vets over the course of this investigation so far, we have observed veterinary professionals' strong motivation to do the best for the animals they treat.

2.84 Vets operate under the regulation of the RCVS. In order to practise their profession, they must register with the RCVS, take an oath to protect animal welfare and follow the RCVS's professional Code of Conduct (**RCVS Code**). Vets who are found guilty of serious professional misconduct can be removed or suspended from the register. The Code and its Supporting Guidance contain some provisions for consumer protection, such as: the need to present adequate price information; the need for advice to be impartial (and not influenced by financial considerations of the vet business), and requirements around obtaining informed consent by giving pet owners the opportunity to consider a range of reasonable treatment options. Not every breach of the Code or its Supporting Guidance will constitute serious professional misconduct. We discuss these provisions in more detail in our working paper on the **Regulatory framework** including how the RCVS has very limited powers to monitor outcomes for consumers and cannot sanction breaches of the Code by individual vets except for very serious concerns, and how this is likely to reduce the effectiveness of the consumer provisions in the Code.

2.85 Vets not only work as individuals in a regulated context, but also in the context of a practice selling commercial services to consumers.[118] Vet businesses are commercial operations and it is important that they make sufficient returns for there to be an adequate supply of veterinary care available to support animal welfare and meet the needs of pets and their owners.

2.86 Around 60% of FOPs in the UK are now owned by LVGs, in which there are many people in management roles, as well as shareholders or private equity owners,

[118] Charity veterinary providers are out of scope for this investigation.

who are not vets.[119] Some smaller chains or single practices also have owners or managers who are not vets.

2.87 Owners and managers in small and large vet business make many decisions which affect the environment in which the vets they employ sell services to consumers. They take business decisions which influence the quality of service provided, through recruitment and staffing decisions, and investment choices. They may influence the level of additional training that vets can undertake, either in clinical matters or other aspects such as how to have good conversations with pet owners. They either make, or influence, pricing decisions. As we set out above, owners and/or managers often set KPIs based on measures that are important to the business, and help them monitor how the business is operating (as would be expected).

2.88 However, as we discuss in our working paper on the **Regulatory framework**, individuals engaged in veterinary business management who are not themselves registered vets are not bound by the Code and while vet practices may subscribe to the voluntary PSS, there is no statutory oversight of vet businesses to encourage compliance.

2.89 [✂], it may be the case that large vet businesses in which non-vets are likely to have significant influence on operational decisions might give greater weight to profitability concerns in their everyday operational activities than businesses owned (and managed) by vets.[120]

2.90 This could be for a number of reasons, including: because non-vets are not subject to the professional Code; because managers in LVGs may not be close to the community in which the FOP operates, and more distant from 'on the ground' interactions with consumers and their needs; or because non-vet managers may be more strongly motivated (financially or otherwise) by successful financial performance of the business than vets, who may also be driven by a vocation to care for animals.

2.91 Vets may also be influenced by the relationships that they (desire to) build with pet owners and their knowledge or perception of the pet owner's circumstances, which may affect how assiduously they charge for all of the services given.

2.92 LVGs – or the managers within them – might be more adept at assessing operational, financial and investment needs and pursuing a profit maximisation (including cost minimisation) strategy than vets who own their businesses. Such managers might have superior skills or tools to assess and implement business

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[119] As set out in paragraph 1.6, three of the LVGs are owned by private equity groups, two are publicly listed companies, and one is a privately owned US company.

[120] As explained in paragraph 1.6, we note that Pets at Home has practice owners in individual practices, which are run as joint ventures (JVs) that retain clinical and operational autonomy, and take decisions with regards to investment, recruitment and pricing. Practice owners are often, but not always, vets.

decisions to the extent that their prior experience or education may have been in business strategy (or related activities) rather than clinical veterinary care. Larger businesses may also have sufficient scale to drive efficiencies across their portfolio. As noted above, such skills are important, vet businesses must remain viable in order to support a thriving vet care sector and the pursuit of profits can result in efficiency gains. However, we would be concerned if weak competition meant that there was no pressure on businesses to improve quality or pass efficiency savings onto consumers, or that consumer choice was reduced.

2.93 While veterinary businesses may be owned or managed by non-vets, the day-to-day interactions between the practice and pet owners is through the actions and decisions of individual vets and other veterinary professionals. Individual vets have regulatory and professional responsibilities. They also have obligations to their employers who, as explained above, may not have such regulatory responsibilities. We now set out our evidence to date on the actions vet businesses may take to influence the behaviour of vets that they employ and how effective this might be, including setting and following up on KPIs, financial incentives, training in presenting options, and guidance presented to vets.

2.94 This is based primarily on internal documents from the LVGs (as they represent around 60% of the market and it has been easier to gather information from them than from the hundreds of small independent practices), but we have included some information on independent practices where we have this, including our qualitative research with veterinary professionals which covered a full range of vet businesses.

There is evidence that vets in some practices are financially compensated in relation to the profitability of the overall business or their individual practice, which may impact the recommendations given by vets

2.95 We have considered the LVGs' submissions and internal documents on whether there are financial incentives linked to providing a greater number of treatments (or more expensive treatments) to pet owners, or improved group performance. We have similarly considered submissions and internal documents from independent chains and single site practices where available.

2.96 There is evidence that vets employed at some LVGs are financially rewarded based on group performance, sometimes at a practice level and sometimes at an individual level, though in some cases the financial rewards appear to be relatively low. These measures relate to the overall financial health of the business or the individual practice. We consider that some of the specific KPIs in place (discussed below) may be more relevant for considerations of whether vets may feel pressure to sell a mix of treatments that is different to what they might recommend if the KPIs and targets were not in place.

2.97 Based on the evidence we have seen from LVG internal documents and contracts:

(a) One LVG [✂] has a bonus scheme relating to turnover.[121] This LVG has bonus schemes in place based on individual and group financial performance, including a [✂] contribution scheme, [✂] scheme, and Leadership bonus scheme. For example, the [✂] scheme means that '[i]f a [✂] earns above the clinic's budgeted contribution they will earn an additional amount above their salary. [✂] above contribution gets [✂] more salary. Up to a maximum of [✂]'.[122]

(b) One LVG [✂] submitted that (outside of a few legacy arrangements) it does not offer any incentives to the vets or nurses working at the practices by reference to revenues, profit or specific treatments, but it operates a 'profit share arrangement for some practices that is based on outperformance of the budget (which is set by the practice management team with support from the [business development director]). If a practice exceeds its budgeted EBITDA, then 10% of any EBITDA delivery above the budgeted level is available to share with the practice team'.[123] The LVG also submitted that a number of practices at the time of acquisition had bonus arrangements, and some of these legacy arrangements have remained in place and others have been phased out, mostly, related to employee turnover.[124]

(c) One LVG [✂] has an internal reporting measure which measures the investigation and treatment of clinical conditions, and is associated with high quality clinical 'work-up' (as explained above); for example, one document referenced a total £ [✂] bonus paid across all practices, and to the Net Promoter Score (the same document referenced a total £ [✂] bonus paid across practices).[125] It also has a bonus scheme related to the Net Promoter Score (a measure of consumer satisfaction).

(d) One LVG [✂] has two legacy incentive schemes in place for acquired practices,[126] and had a bonus for dental treatments (where practices receive £ [✂] if they have the best 'conversion' rate, namely successfully recommending a dental procedure to pet owners).[127]

(e) One LVG [✂] provided some examples of standard contracts with [✂] with 'discretionary pay bonuses of up to a percentage of basic salary based upon [✂] and [✂].[128]

[121] LVG response to RFI3, Question 31, p.3 [✂]
[122] LVG response to RFI3, Question 31, p.3. [✂]
[123] LVG response to RFI2, Question 5, paragraph 5.8 [✂]
[124] LVG response to RFI2, Question 5, paragraph 5.9. [✂]
[125] LVG response to RFI3, [✂]
[126] LVG response to RFI3, Question 32, p. 13.
[127] LVG response to RFI3, [✂]
[128] LVG response to RFI3, [✂]; LVG response to RFI3, [✂].

(f) One LVG [✂] submitted that its veterinary surgeons and nurses [✂] are generally not paid bonuses or other incentives linked to practice revenue, profits or treatments sold.[129] However, it said that it could not exclude the possibility that there may be some local arrangements at its practices which provide bonuses and/or incentives, and provided a few examples of bonus arrangements in place in individual practices.

2.98 We received some submissions and internal documents in the form of contracts from 20 small and medium independent chains.[130] Many of these chains told us they did not have any bonus schemes, performance appraisal targets or other incentive schemes linked to treatments sold or the financial performance of the practice. Some independent chains had similar financial incentives to those of the LVGs, with the notable incentives including: some chains have bonuses linked to individual performance based on treatments and services sold, a few chains have bonuses linked to group performance, one chain had contractual financial incentives based on group performance for the Head of Services,[131] and three chains have bonuses (including of £10 or under) for pet care plan signups.

2.99 We received some submissions and internal documents in the form of contracts from ten single site independent practices.[132] All of these practices told us that they did not have any bonus schemes, performance appraisal targets or other incentive schemes linked to treatments sold or the financial performance of the practice. We reviewed the submissions and employment contracts provided by these individual practices and note that none of the provided contracts included any bonuses or other financial incentives related to the number of treatments sold, or the financial performance of the practice.

KPIs and targets which might be aimed at increasing treatment intensity, alongside other goals

2.100 Submissions from the LVGs and their internal documents indicate that they have KPIs across a number of measures, setting targets based on these for individual vets and vet practices within their group. This is standard business practice, and is consistent across the LVGs, although we observe that some LVGs appear to do this to a greater extent than others. In a section below (paragraphs 2.123 to 2.125), we also set out evidence on KPIs and targets from the documents of private equity owners of LVGs, which have explicitly expressed intentions to

[129] LVG response to RFI3 Response, Question 31, paragraph 31.1. [✂]
[130] We reached out to a sample of small and medium chains, spread across the UK. We contacted all chains with five or more practices for which we were able to find contact details, and a sample of chains with between two and four practices. Beyond ensuring spread across the UK, the sample was selected randomly. We note that 'chain' may include practices that operate multiple branches (rather than only separate clinics).
[131] Small medium chain response to RFI1, paragraph 5.1. [✂]
[132] We reached out to a sample of single site independent practices and received ten responses. Beyond ensuring spread across the UK, the sample was selected randomly.

increase revenue in a variety of ways, including through increasing treatment intensity.

2.101 We have summarised some relevant KPIs tracked by the LVGs in Table 2.1 below, split by clinical, client and financial metrics. We note that the LVGs may also track other KPIs than those set out below (such as staffing levels).

2.102 These KPIs (and associated targets) cover a wide range of metrics, from ones that focus on public health concerns (controlling antibiotic usage) to measuring consumer satisfaction (monitoring the net promoter score). Most LVGs have KPIs around financial metrics (such as P&L, and average transaction value), as well as KPIs around achieving a specific number of treatments or ratios of treatments to consultations (such as diagnostics, dentistry, ophthalmology, initial versus repeat consultations), and the uptake of pet care plans.

Table 2.1: Summary of key performance indicators tracked by the LVGs[133]

	Key Performance Indicator	*An LVG [✂]*	*An LVG [✂]*	*An LVG [✂]*	*An LVG [✂]*	*An LVG [✂]*	*An LVG [✂]*
Clinical	Number of consultations (by vet and practice)	x	x	x		x	
	Ratio of first consultations to follow-up consultations (C1:C2) (by vet, practice and/or region)	x	x	x	x		
	Ratio of back of house to front of house[134] treatments			x			
	Number of vaccinations (by practice)	x		x		x	
	Number of diagnostic procedures (including as a percentage of consultations) (by practice)	x	x	x		x	
	Number of specific treatments (for example x-ray and ultrasound usage) (by practice)	x	x	x		x	x
	Number of dental treatments (by practice)	x		x		x	
	Number of surgical treatments (such as neutering) (by practice and/or regionally)	x	x			x	x
	Antibiotic usage (with aim to reduce) (by practice and/or nationally)	x	x	x		x	
Client	Net Promoter Score (by practice)	x	x	x	x	x	
	Number of pet care plan signups (by practice and vet)	x	x	x	x	x	x
	Number of active clients (by vet and/or practice)	x	x	x	x	x	
	Number of new clients (by practice)	x	x		x	x	x
Financial	P&L (various metrics) (by practice)	x	x	x	x	x	x

133 LVG response to RFI3, Question 27, paragraphs 27 to 36. LVG response to RFI3, [✂].
LVG response to RFI2, Question 38, paragraphs 38.1 to 38.7 [✂]
LVG response to RFI2, Question 33, pages 9 to 10. [✂] LVG response to RFI11 Q11, pages 10-11, para 11.1-11.4. [✂]
LVG RFI2 Response, Question 13, page 1 [✂]. LVG response to RFI11 Q11, page 14-15. [✂]
LVG response to RFI2, [✂] LVG response to RFI2, [✂]. LVG response to RFI2, Question 34, paragraphs 34.1 to 34.7. [✂] LVG response to RFI3, [✂]

134 [✂] explained that in the 'front of house' environment, it looks at the volume and distribution of consultations. It considers 'back of house' clinical work to be treatment which does not generally take place in a consulting room, such as surgical procedures, diagnostic testing and hospitalisation. [✂] LVG response to RFI11, Question 11.

	Number of transactions/visits (by vet and/or practice)	x		x	x	x	x
	Average transaction value (by vet, practice, regionally and/or nationally)	x	x	x	x	x	x
	Turnover (by vet and/or practice)		x		x	x	
	Net revenue per visit (by vet and/or practice)			x			
	Sales/transactions including per client (by practice and/or vet)	x		x	x	x	

Source: CMA analysis of LVG RFI responses and internal documents, putback responses.

2.103 In addition to this evidence from internal documents, participants in our qualitative research with vets reported being monitored, either on an individual level or a practice level, on the following metrics:[135] number of consultations per vet, revenue generation per consultation, diagnostic work up rate, percentage of follow up appointments, vaccination rates, percentage of animals with pet care plans, percentage of preferred drugs used, percentage of preferred laboratories used, turnover, and consumer satisfaction. We consider the impact this may have on vets below.

2.104 Based on the evidence above, there appears to be a lack of KPIs and monitoring of vets relating to whether vets are providing sufficient information and suitable recommendations to pet owners on the available diagnostic and treatment options. There are KPIs on the net promoter score (consumers' perception of the service they have received). However, we have not seen evidence of KPIs on whether written pricing information is provided to consumers, for example, or whether a range of testing or treatment options is explained, where appropriate.

2.105 In our review of internal documents from the LVGs, we have seen some documents which set out targets which are framed around improving clinical standards.[136] These targets may also have the effect of increasing treatment intensity. For example, one LVG [✂] has a series of [✂] projects and requires the practices within its group to implement at least one of these.[137] Documents explain how practices might improve the clinical care offered to animals, usually by pursuing an increase in (and setting targets for) the proportion of pets who take up the services included and setting KPIs for this (although there are no implications should a practice not achieve this).[138,139] These documents which set out ways to improve clinical standards often go hand in hand with, or may be driven by, a focus on improving financial outcomes. The same LVG [✂] also produces and monitors an internal reporting measure which it defined as being associated with high quality 'work-up' (diagnosis and targeted treatment) of cases, which monitors

[135] Qualitative research with veterinary professionals, p. 61-62.
[136] LVG response to RFI3, [✂], LVG response to RFI3, [✂].
[137] LVG response to RFI3, [✂]
[138] For example: See LVG response to RFI3, [✂]; LVG response to RFI3, [✂]; LVG response to RFI3, [✂]; LVG response to RFI3, [✂]; LVG response to RFI3, [✂].
[139] These include: lameness workup, ultrasound, endoscopy, ear cytology, fine needle aspiration, ophthalmology, hypertension, radiology and radiography and dental radiography.

the level of care given when investigating and treating clinical conditions.[140] Some documents explore case studies of a FOP which was highly successful in increasing its internal reporting measure and had a corresponding significant increase in margin.[141]

2.106 We received information from 20 small and medium sized independent chains on whether they actively set and track treatment KPIs by practice or vet. Approximately half indicated that they set and track some KPIs, with the most frequently mentioned KPIs being similar to those tracked by the LVGs (as would be expected), and include average transaction value, proportion of clients on pet care plans, income by client or pet, turnover by vet and number of specific treatments (such as surgeries, consultations, diagnostic tests, dental procedures).[142,143,144] Some of these businesses told us that they track additional targets, such as revenue and profitability per vet, ratio of initial to follow-up consultations, sales per pet, consumer churn or average invoice value.

2.107 It appears that all LVG vet practices and some independents offer pet care plans. All the LVGs have targets for the coverage of pet care plans among their consumers, and some have minor financial rewards (such as Christmas bonuses) for practices which reach these targets [✂], [✂], [✂].[145] Evidence from our sample of 20 small and medium sized independent vet chains suggests that some (five of 20)[146] independent chains also have targets for selling pet care plans.

2.108 It is generally good management to set and monitor KPIs. It is helpful to have KPIs around clinical matters, for example to ensure that the right procedures are followed, and for financial measures to understand how the business is operating and to support and encourage business efficiency. This could help ensure good outcomes for consumers. However, it could be concerning if the mix of KPIs (for example a focus on targets around the revenue per consumer or number of surgeries performed) had the effect of unduly influencing vets to be less likely to provide advice on the lower cost treatment options to consumers, where appropriate for their pets. This concern is more significant where there are no, or limited, KPIs relating to the effectiveness of customer support and there are weaknesses in the demand side.

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[140] [✂] The LVG defines the [✂] as 'a fairly crude measure of how well the LVG's [✂] practices are investigating and treating clinical conditions in their patients', that 'tracks what percentage of the LVG's [✂] total revenue is generated from services that would be undertaken as part of the investigation and subsequent treatment of a patient's condition'. LVG response to RFI3 [✂]. LVG response to RFI3, [✂].
[141] LVG response to RFI3, [✂]
[142] Small medium chain response to RFI1, Question 8, 23 July 2024. [✂]
[143] Small medium chain response to RFI1, Question 8, 19 July 2024. [✂]
[144] Small medium chain response to RFI1, Question 8, 15 July 2024, p. 25. [✂]
[145] LVG response to RFI2, Question 6, paragraph 6.3. [✂] Qualitative research with veterinary professionals, p. 98-100. LVG response to RFI3, [✂]. LVG response to RFI3 [✂].
[146] Small medium chain response to RFI1 Q8, p. 23. [✂]; Small medium chain response to RFI1 Q8, p.6. [✂] Small medium chain response to RFI1 Q8, p.5. [✂]; Small medium chain response to RFI1 Q8, p.25; Small medium chain response to RFI1 Q8, p.4. [✂].

2.109 We would like to understand more about how these KPI targets work towards business goals of ensuring sufficient levels of profitability without overly influencing vets to prioritise offering (or encouraging the uptake of) the more complex and expensive treatment and diagnosis options, where there might be other clinically suitable treatment options, which consumers may prefer.

Vet businesses monitor the achievement of KPIs in detail (including those which relate to treatments) through setting and following up on targets

2.110 There is evidence that LVGs monitor KPIs against set targets which might drive increases in treatment intensity (as well as those which could improve customer service, animal welfare or efficiency) and show intention to engage with vets or practices which are not meeting some of these. The evidence presented below indicates that KPIs would be monitored and 'followed up' if not met. We would like to understand more about how KPIs are communicated to vets and individual practices, and what mechanisms may be in place to incentivise their being met (such as communications in different forms to ask why targets had not been met, or suggestions as to improvements). We set out the evidence we have gathered so far.

2.111 We have seen some evidence from internal documents on how KPIs are tracked and discussed internally at head office level, including a wish to speak to and work with practices to improve them. For example:

(a) A document from one LVG [✂] notes of one of its practices that, '[an internal reporting measure] […] is still not in an acceptable position. [..] During these [Senior Wellness sessions] there will be a focus on bonding with clients, whilst also encouraging them towards further diagnostic investigation where appropriate'.[147] A business performance document states: 'Perform more in-house work ups' and 'Ensure clinical team are using in house laboratory, dental machine and ultrasound scanner'.[148] Another [✂] document states '[n]eed to see significant shift in clinical w/u [work-up], recommendations and charging […] [c]hange phrasing "I recommend" not "I advise" or "options are"'.[149] A business health document lists an action as '[p]erform more in-house work ups. Ensure clinical team are utilising in-house laboratory, dental machine and ultrasound scanner'.[150]

(b) An internal document from an LVG [✂] considers the objectives for groups of practices, including objectives, such as 'Increase dentals to [✂]' with the listed actions '[i]n house dental incentive to drive recommendations', 'dental culture piece with team to drive early interventions/every patient has an oral

[147] LVG response to RFI3, [✂]
[148] LVG response to RFI3, [✂]
[149] LVG response to RFI3, [✂]
[150] LVG response to RFI3, [✂]

exam', 'follow up on nonconverted recommendations', and '[a]dditional training for the team'.[151] Another tab considers endoscopy, and states '[p]rovide more training for in house teams and drive internal use of these products. Aim for increase [✂] CT scans per week'.[152]

(c) An internal document from an LVG [✂] compares two practices, one of which is described as 'average' but is failing on a variety of factors including average spend per consumer (average spend of £[✂]), and another one which is described as 'above average' and is succeeding on a variety of factors (including on average spend, which is £ [✂]).[153]

(d) An internal document from an LVG [✂] practice discussion detailed a number of actions, one of which was submitted as 'continued focus on increasing in customer visits per months/consults revisits'.[154] Another internal practice meeting log discusses various items related to the practices' operations and areas of improvement and states that among many other things, '[i]n-house lab work needs to increase. [✂] to encourage the team to use it more'.[155]

(e) A document from an LVG [✂] discusses that '[small animal] focus needs is on [an internal reporting measure] growth (through a combination of clinical excellent projects and practice support and intervention)'.[156] Another [✂] document discusses that 'meeting with [..] leaders to promote engagement in regard to the impact of billing accuracy to the practice, valuing your time as Vets and providing an insight into how the surgical prices were decided'.[157]

Some vets told us that they were aware of KPIs and in some cases felt pressure to meet targets around treatment types

2.112 All LVGs told us that they do not incentivise or otherwise influence their vets on the treatments offered.[158] Some individual vets have told us – either as part of our qualitative research or through direct contact – that they have felt pressure to deliver on KPIs and targets.

2.113 As we noted above, different KPIs work towards different aims, including attempts to consider public health concerns, improve business efficiency or improve

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[151] LVG response to RFI3, [✂]
[152] LVG response to RFI3, [✂]
[153] LVG response to RFI3, [✂]
[154] LVG response to RFI3, [✂]
[155] LVG response to RFI3, [✂]
[156] LVG response to RFI3, [✂]
[157] LVG response to RFI3, [✂]
[158] For example: LVG response to RFI3, Question 31, paragraph 30, p. 8. [✂]; LVG response to RFI3, Question 32, paragraph 32.2, p. 9. [✂]; LVG response to RFI3, Question 32, p. 13. [✂]; LVG response to RFI3, Question 32, p. 3. [✂]; LVG response to RFI3, Question 32, paragraph 32.4. [✂]; LVG response to RFI3, Question 31, para 31.1, p. 24. [✂].

customer service. However, we are particularly interested to establish whether the setting and monitoring of certain KPIs might put pressure on vets to change how they recommend treatments to pet owners in a way which could reduce choice for consumers.

2.114 In our qualitative research, many vets who worked (or had worked) at LVGs reported being set targets, either for numbers of certain procedures (as an individual vet) or financial targets at a practice level, such as turnover and profitability. Performance monitoring was reported by most of the vets working in LVGs, though to differing extents.[159] Those working at independent practices reported being monitored on performance metrics much more rarely, though where vets were aware of this, this included the revenue of each veterinary professional being recorded, and one vet reported closely monitoring one of their employee's billing due to suspected undercharging.[160]

2.115 In our qualitative research, most vets working at [✂] said they were questioned on targets and that management highlighted if the targets were not being met, for example:

> There was a constant pressure to meet sales targets… Practice manager would tell us whether we were meeting targets or not. Everybody was very target aware and target driven. They'd probably be monthly [review meetings]. You would know monthly how you were performing and what was expected. I was constantly aware of where we were. I mean, bearing in mind that they probably confided a bit more in me because I knew the ins and outs of it [due to previously owning a practice]. Anyway, I gather that everybody was constantly aware of meeting targets and whether we were doing enough work… Monthly turnover was usually the main target[161] *Veterinary surgeon, Independent practice, previously LVG* [✂] *practice*

2.116 The type of management practices at [✂] highlighted in our qualitative research with vets are likely to lead to pressure on vets to meet these targets (and some vets directly referred to such pressure). This sort of pressure was reported by some vets at other LVGs but by no vets working at independent practices.[162] A number of vets described actively seeking employment in independent practices to avoid the performance pressure in their previous roles at LVGs.[163]

[159] Qualitative research with veterinary professionals, p. 61.
[160] Qualitative research with veterinary professionals, p. 62.
[161] Qualitative research with veterinary professionals, p. 65.
[162] Qualitative research with veterinary professionals, p. 65.
[163] Qualitative research with veterinary professionals, p. 63.

2.117 Our qualitative research reported that methods used to monitor performance included billing audits and real-time tracking.[164] Based on our review, financial incentives were not provided to meet KPIs, beyond some reports from a few vets working at LVGs of trivial financial incentives including bonuses, vouchers and prizes based on performance.[165]

2.118 Few vets in our qualitative research reported that performance monitoring and financial incentives had influenced their clinical decisions.[166] A few vets (including a locum) working at LVGs described feeling that targets might affect their own or others' decision making. As an example:[167]

> I think some people have been in that position where they have felt more pressured and that has forced them out of the corporates, but as a practice I think we try to stay to our roots and not be too influenced by that, but there is a concern that if they started to incentivise things more it would be easy to start to be influenced by those sorts of things *Veterinary surgeon, at an LVG* [✂] *practice*

2.119 In our qualitative research, a number of veterinary surgeons at LVGs reported deviating from practice-level targets. More experienced vets and those in senior roles were more likely to report ignoring those group protocols which might influence how they recommended frequency of treatments or set prices for those treatments. Some senior vets felt they could easily disregard protocols and charging pressures due to having fewer concerns over job security.[168] A few junior vets reported disregarding corporate guidance with the support of senior colleagues.[169] There were also examples of vets in management positions feeling it was not necessary to communicate practice-level targets or business goals to clinical teams to avoid adding further pressure to teams and allow them to focus on clinical work.[170]

2.120 No vets at any independents in our qualitative research referred to commercial pressures or targets affecting clinical decisions at their practices.

2.121 We have also received some direct submissions from individuals on the actions taken by LVG vet employers to influence vets, for example by setting targets on various treatments.

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[164] Qualitative research with veterinary professionals, p. 66.
[165] For example, at one LVG [✂] practice everyone received a £[60-80] voucher for being the practice with the highest proportion of follow up appointments compared to others in the area. Qualitative research with veterinary professionals, p 67
[166] Qualitative research with veterinary professionals, p. 71.
[167] Qualitative research with veterinary professionals, p. 72.
[168] Qualitative research with veterinary professionals, p. 69.
[169] Qualitative research with veterinary professionals, p. 70.
[170] Qualitative research with veterinary professionals, p. 64.

2.122 RCVS submitted a redacted letter it had received raising the following issues about an LVG employer:[171]

> My employer is imposing 'targets' to be achieved which include the number of diagnostic investigations per consultation and number of procedures per consultation. In both instances they are requiring an increase in these ratios. As an experienced veterinary surgeon, I am comfortable with the clinical decisions I make and whether further investigations are required to confirm a diagnosis made on clinical grounds. I feel the same way about clinical decisions as to whether procedures (generally I would say this would be whether to proceed to surgery) are necessary. I see these 'targets' are pushing me to make decisions which are not in the best interest of either the patient or owner. This does not sit well with the declaration we all make on admission to the RCVS. It also challenges the key Principles of Practice in the guide to Professional Conduct, notably Honesty and Integrity, Independence and Impartiality and also Client trust. I would say that, albeit indirectly, this is an Incentive contrary to section 1.8 of the Guide to Professional Conduct.
>
> [✂] these 'targets' are dictated by [✂] managers [that] are [not] member[s] of The College nor have clinical backgrounds. As I have said above, I am not alone on this, particularly as my employer controls a large number of Practices [✂].

Assessment of the intentions and considerations of the investors in some LVGs

2.123 We reviewed internal documents from the private equity investors of [✂], [✂] and [✂], prepared in order to evaluate the purchase of these businesses. These documents indicate that, as is expected for investors of this sort, the investors each aimed to maximise profit and quality of the business (through revenue growth for instance) over the period of their fund's investment, with a view to selling the business (or stakes in the business) after around four years.[172] Similarly, and as we would expect, internal documents indicate that the potential to increase revenue was a key part of the acquisition rationale and an important 'lever' for private equity firms to increase profitability and realise returns on exit.

2.124 The documents considered that revenue enhancement could be delivered in a number of ways: increased volume of sales, increased spend per pet, increased quality, higher treatment intensity, higher prices or charging more effectively for

[171] RCVS RFI Response, Question 8. [✂]
[172] Private Equity- LVG investor response to RFI1, [✂]; Private Equity- LVG response to RFI1, [✂]; Private Equity-LVG investor response to RFI1, [✂].

services sold. The documents variously note opportunities to increase revenue through all these means.[173] Several of the documents note that the availability of more sophisticated services and the 'humanisation of pets' are likely to contribute to pet owners' willingness to spend more.[174,175,176]

2.125 From this evidence, it appears to us that the private equity firms may have seen an opportunity to increase revenues by increasing treatment intensity. [✂]. From our review of their internal documents, we have not yet found evidence of private equity firms taking into account any regulatory or competitive pressures when setting their strategy, that could otherwise limit the extent to which treatment intensity could be increased. We welcome submissions on how private equity firms may be taking into account regulatory and competitive pressures.

Some vet businesses position themselves as higher quality providers

2.126 We have seen some evidence that some of the LVGs [[✂][177], [✂][178], [✂][179], [✂][180]] aim to position themselves as high quality providers in the market. For example, in an initial meeting, [✂] said it wanted to build a brand associated with quality, such as the 'Waitrose' of vets where it can be seen as the place to go for 'really high quality'.[181] We discuss at paragraphs 2.153 to 2.155 below that LVG internal documents also show several references to their suggested treatment approach being to offer the 'best clinical care' (or words to similar effect), though some documents also highlight the importance of offering contextualised care, or presenting a range of options.

2.127 We also note that some smaller chains or independent businesses present themselves as offering treatments that are more comprehensive or complex and have invested in equipment to provide these. For example, one of the independent vet practices we visited on our site visits positioned itself in this way. In addition, we are aware of advice for start-up vet businesses that they should decide what sort of care they want to provide (such as 'gold standard' or more basic) and find like-minded colleagues with whom to practise.[182]

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173 Private Equity- LVG investor response to RFI1, [✂]; Private Equity- LVG investor response to RFI1 [✂] Private Equity- LVG investor response to RFI1 [✂]; Private Equity- LVG investor response to RFI1, [✂]; Private Equity- LVG investor response to RFI1, [✂]; Private Equity- LVG investor response to RFI1, [✂] and Private Equity – LVG investor response to RFI1 [✂].
174 Private Equity- LVG investor response to RFI1 [✂]
175 Private Equity- LVG investor response to RFI [✂]
176 Private Equity- LVG investor response to RFI1 [✂]
177 LVG response to RFI3, [✂]
178 LVG response to RFI3 [✂]
179 LVG response to RFI3, [✂].
180 Transcript of meeting with [✂] 10 October 2023, p. 7, line 4. [✂]
181 Transcript of meeting with [✂] 2 October 2023, p. 30, lines 4 to 7. [✂]
182 Session at the London Vet Show on 14 November 2024 on Setting up for success: creating your dream business plan.

2.128 We consider that it could be positive for competition if vet businesses position themselves in different ways within the market and the consumer is offered a range of different approaches to veterinary care. However, there is evidence that pet owners do not fully appreciate the difference between alternative vet practices, and may not realise that they might not be offered the more 'basic' options in certain FOPs, in a way that would be clear to them when choosing between supermarkets with different price/quality positioning.[183] In these circumstances, positioning the business as a high quality provider, to the exclusion of lower cost options (if this is what is occurring), could represent a reduction in choice for consumers. Some attendees in our roundtable discussion with charities also stated that increasingly sophisticated treatments were not always the best approach for overall animal welfare.[184]

2.129 We might be concerned if this approach of offering the 'best clinical care' meant that pet owners were not also offered appropriate but less complex or high-cost options (where they exist) and were not sufficiently informed of the differences between them in terms of price and clinical outcomes. However, even then, and as we have noted in our working paper on **How people purchase veterinary services**, there may be reasons – such as potential feelings of guilt when deciding on behalf of a pet – that make it difficult for consumers to choose a lower cost option after they have been presented with an option that appears to be more comprehensive or 'best practice'.

Vet businesses sometimes provide clinical guidance but vets did not generally see these as particularly restrictive

2.130 We asked five of the LVGs if they provide any clinical guidance or protocols to vet practices in relation to carrying out treatments.[185] Clinical guidance or protocols can be useful for ensuring a consistent approach to using best practice and ensuring efficient working. Four of the groups responded that they did provide such guidance and submitted some examples. Treatment guidance provided by these LVGs varied significantly in terms of prescriptiveness and detail, although three of the LVGs ([✂], [✂] and [✂]) submitted that these documents were for guidance purposes only and that the clinical freedom of the vet remained.[186]

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[183] In our survey of pet owners, we found that the majority (66%) of respondents that did not consider multiple practices when first choosing a FOP felt they did have a choice. Pet owners survey, Q12c. These pet owners selected a wide range of reasons for their lack of comparison, including 'I was happy with my choice' (50%), 'I didn't think there would be much difference between practices' (18%) and 'I thought most practices charged very similar prices' (14%). 15% of respondents said that they just did not think about comparing options. Pet owners survey, Q12e. More than one answer could be given, so percentages add up to more than 100%.
[184] Summary of roundtable with charities, paragraph 7. Summary of roundtable discussion held with senior veterinary professionals who currently work in the charity sector via MS Teams to on 19 September 2024
[185] Information on treatment protocols was obtained from all LVGs except for Medivet during the Market Review stage (and confirmed through statutory powers during the market investigation).
[186] LVG response to RFI2 Q32, p. 9, [✂]. LVG response to RFI2 Q6, p. 6. [✂]. LVG response to RFI2 Q6, p. 8, [✂].

Guidance documents submitted by one LVG [✂] began with the statement 'This document is intended for guidance only'.[187]

2.131 Our qualitative research with vets and vet nurses also found some instances of vets in LVGs, [✂], reporting that they needed to follow certain guidelines, recommendations or procedures when ordering and administering diagnostics, which sometimes restricted their flexibility in decision-making. However, many vets at LVGs described having some or full clinical autonomy over ordering or administering diagnostics.[188]

2.132 Some vets and other professionals in roundtables indicated the existence of treatment protocols, guidance or other messaging in LVGs that might influence vet behaviour. During the roundtable with senior vets at charities, one attendee said that, in their experience, the large corporate groups had very rigid protocols that vets must follow and linked that to an increase in over treatment.[189] During the roundtable with senior staff at veterinary schools, one attendee said that the practice type and their associated guidelines would shape how a vet worked and what level of treatment options were presented to consumers.[190] Another participant noted that each practice would have its own guidelines which would shape how the vet operated. The same participant said that large corporate groups, for example, had certain protocols to be followed, as would other organisations.[191] During the Manchester roundtable, one attendee provided examples of experiencing limitations on clinical decisions in providing medicines which were not on the preferred product lists when working in a corporately owned practice.[192]

2.133 During the roundtable with vets working at LVGs, one attendee noted that their LVG had guidelines on how to approach treating certain conditions, but this was agreed locally, within the FOP.[193]

2.134 A few vets in roundtables indicated an ability to push back on any influence from their employer. During the roundtable with vets working in the LVGs, two attendees noted reluctance to work to protocols, and that if a protocol directed the

[187] For example, LVG response to RFI2, [✂].
[188] Qualitative research with veterinary professionals, p. 38-40.
[189] Summary of roundtable with charities, paragraph 7. Summary of roundtable discussion held with senior veterinary professionals who currently work in the charity sector via MS Teams to on 19 September 2024
[190] Summary of roundtable with academics, paragraph 11. Summary of roundtable discussion held with senior representatives of veterinary schools via MS Teams on 16 September 2024.
[191] Summary of roundtable with academics, paragraph 11. Summary of roundtable discussion held with senior representatives of veterinary schools via MS Teams on 16 September 2024.
[192] Summary of Manchester roundtable, paragraph 10. Summary of roundtable discussion held in Manchester on 28 August 2024
[193] Summary of roundtable with vets in LVGs, paragraph 13. Summary of roundtable discussion held with veterinary surgeons who work in practices owned by one of the six large corporate groups via MS Teams on 5 November 2024

vet to do something contrary to the best interest of the pet or its owner or professional obligations, they would not follow it.[194]

2.135 We also asked the sample of small and medium independent veterinary chains that provided us with information if they provide any clinical guidance or protocols to vet practices in relation to carrying out treatments. As with the LVGs, treatment guidance was common: 12 of the 17 small and medium independent chains which responded to this question stated that they provided treatment guidance to their vets. The most common treatment guidance provided by independent chains were for routine treatments such as neutering, parasite treatments and vaccination. Many of the guidance documents submitted by independent chains contained details of the chain's recommended medication and medication dosage for specific treatments.

2.136 We asked the sample of single site independent practices if they provide any clinical guidance or protocols to vets in relation to carrying out treatments. Three out of the ten single site independent FOPs who responded to this question submitted that they provided treatment guidance to vets, with some others highlighting that their practices were too small to necessitate sharing guidance.

Evidence suggests that vets have different approaches to outlining options for pet owners – sometimes consumers are given a range of options but sometimes vets focus on the most comprehensive approach

2.137 We first present evidence on what options pet owners were presented with, and then set out what vets have told us about how they make recommendations to pet owners.

Evidence from our survey of pet owners indicates that some pet owners are not presented with different clinical options, though most respondents reported feeling well-informed

2.138 In response to our pet owners survey, most respondents reported feeling well informed by their vet in relation to the clinical options provided to them:

(a) 84% agreed that their vet took the time to clearly explain various treatment options[195] and 84% of participants felt they understood the options when presented them by their vet and were able to make an informed decision.[196]

[194] Summary of roundtable with vets in LVGs, paragraph 13. Summary of roundtable discussion held with veterinary surgeons who work in practices owned by one of the six large corporate groups via MS Teams on 5 November 2024
[195] Pet owners survey, Q36r4.
[196] Pet owner survey, Q36r5. "Somewhat agree" (25%), "Completely agree" (58%).

(b) 79% of respondents said that they were satisfied with the information and advice received from their vet in their most recent visit for non-routine treatment.[197]

2.139 While most pet owners reported feeling well-informed, responses to our pet owners survey indicated that some pet owners were not presented with different clinical options, or that there may have been issues with the information and advice provided by their vet.

(a) In their most recent visit for non-routine treatment, 47% of respondents said that their vet gave them only one option for treating their pet.[198]

(b) In their most recent visit for a diagnostic test, 30% said that prior to this test no other options were provided or they did not think other options were applicable.[199]

(c) In their most recent visit for non-routine treatments, 43% of respondents said that their vet did not provide alternative treatment options. 42% of respondents said that they did receive alternative options.[200]

(d) In response to a question on what information the vet gave them during a discussion of diagnosis and treatment options relating to their most recent visit for non-routine treatment, 44% said they were not given a range of options.[201] A range of options might include both more complex and more simple options, as well as doing nothing. 14% said that they were not given information on the potential outcomes (eg likelihood of success, risks of side effects, any implication for you on aftercare). 49% said that they were not given information on the prices of each treatment/diagnostic option.[202]

(e) In their most recent visit for non-routine treatment, 13% of respondents said they were unsatisfied with the information and advice they received, compared to 79% that were satisfied.[203]

(f) Among those who visited the vet for a diagnostic test, 35% said they were unsatisfied with the information and advice they received, compared to 56% that were satisfied.[204]

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[197] Significantly more customers of independent vets (86%) were satisfied with the information they received on their last visit than customers of LVGs (77%). Pet owners survey, Q55br1.
[198] Pet owners survey, Q52b.
[199] Pet owners survey, Q77.
[200] Pet owners survey, Q52b. The remaining respondents said that they needed a second consultation (4%), could not remember whether they were given options (4%) or gave another answer (7%).
[201] Pet owners survey, Q52cr2.
[202] Pet owners survey, Q52c.
[203] Pet owners survey, Q55br1.
[204] Pet owners survey, Q85br1.

(g) We asked pet owners about the extent to which they agreed or disagreed with whether their vet considers their personal circumstances when deciding which treatment options to offer them. 47% said they agreed, compared to 20% that said they disagreed (the remainder said neither, do not know or not applicable). [205]

2.140 We have assessed whether there were any statistically significant differences in the survey results between pet owners at LVGs and those at independents across all types of visits to FOPs (that is, for both routine and non-routine treatments). While there were no statistically significant differences between pet owners at LVGs and independents that reported being given only one clinical option, there were statistically significant differences in other survey results:

(a) Pet owners were less likely to be satisfied with the information and advice they received in their most recent visit to the vet (across all types of visit to a FOP) if they used an LVG (77% satisfied) compared to an independent (86% satisfied).[206]

(b) Pet owners were more likely to disagree that their vet considers their personal circumstances when deciding which treatment option to offer them (across all types of visit to a FOP) if they used an LVG (24% disagreed) compared to an independent (14% disagreed).[207]

(c) Pet owners were less likely to agree that they could challenge their vet's advice if they used an LVG (66% agreed) compared to an independent (74% agreed).[208] This may be connected to the fact that pet owners were less likely to agree that they had a strong ongoing relationship with their individual vet if they used an LVG (30% agreed) compared to an independent (43% agreed).[209]

2.141 In some cases, there may only be one clinical option that a vet can offer a pet owner. This factor may have an impact on these specific pet owner survey results and the significant proportion (47%) of pet owners who said that they were only being presented with one option during their most recent visit for non-routine treatment.[210] However, there is a potential concern that a significant proportion of pet owners are not being given enough information to make informed decisions. Some pet owners may also not be as informed as they perceive themselves to be.

[205] Pet owners survey, Q36r3.
[206] Pet owners survey, Q55br1.
[207] Pet owners survey, Q36r3.
[208] Pet owners survey, Q36r6.
[209] Pet owners survey, Q57r1.
[210] Pet owners survey, Q52b.

Many vets aim to provide 'contextualised' care, but some find it challenging to achieve in practice and may feel the need to present all options, including the most comprehensive ones

2.142 'Contextualised care', is a relatively new term for something that many vets have always done, namely taking into account the circumstances of the pet and its owner when considering which is the most appropriate treatment, including the animal's age and general health, and the pet owner's financial situation and ability to bring the animal to the vet or care for it at home during the treatment. Contextualised care does not necessarily mean recommending the cheapest treatment, as an owner may be able and willing to pay for the more comprehensive care available, and it does not always focus on financial considerations: it could, for example, mean adjusting to the needs of a pet which is aggressive or distressed when visiting the vet.

2.143 There appear to be differences in the profession as to whether contextualised care means a vet should evaluate what might be best to recommend in the circumstances and present a single personalised option to the pet owner, whether this means that a full range of options should be presented (to allow the pet owner to choose the best option) or whether the outcome should be arrived at through an open discussion between vet and pet owner.[211]

2.144 Participants at our roundtable with senior staff from the vet schools told us that contextualised care is now taught in some universities to some extent (as opposed to only a 'gold standard' care).[212] We observe that historically this may not have been the case, and perhaps giving it a name has helped it become an area of focus.[213]

2.145 However, vets have also told us that there is sometimes a gap between gold standard as taught in vet school and the day-to-day experience of treating pets, and that it is vital to address the contextual factors when practising as a vet, but that newly qualified vets are not always prepared for this.[214]

2.146 Some newly qualified vets indicated in a roundtable discussion that they struggle to manage contextualised care, for example because often consumers wanted to get the best treatment but they could not always afford it, and felt guilty about choosing a cheaper option.[215] An attendee at our vet nurses roundtable said that

[211] See some of the evidence presented below on how vets present options (and which options) and also the discussion on contextualised care at BVA Congress at the London Vet Show on 14 and 15 November 2024.
[212] Summary of roundtable discussion with academics, paragraph 9. Summary of roundtable discussion held with senior representatives of veterinary schools via MS Teams on 16 September 2024
[213] This view was put forward at the session on contextualised care run by the Veterinary Humanities Group (who invented the term) and the BVA Congress at the London Vet Show on 14 November 2024.
[214] A view put forward, for example, at the sessions on contextualised care at the BVA Congress at the London Vet Show on 14 and 15 November 2024.
[215] Summary of roundtable discussion with newly qualified vets, paragraph 9, p. 2. Summary of vet student and new graduates roundtable discussions.

there was some fear around offering contextualised care in case the treatment did not work.[216] Some less experienced vets told us that they might be less confident in judging what treatment to recommend based on an examination only or a more limited range of tests.[217]

2.147 The majority of veterinary professionals interviewed in our qualitative research indicated that, in at least some cases, they adapted care based on a combination of both the pet owner's, and the pet's, circumstances.[218] Many vets in our qualitative research reported that although they took pet and pet owner circumstances into consideration, they felt a professional responsibility to offer all treatment options – including the most complex ones – to pet owners, as they could not make a judgment about what pet owners might choose to pay for.[219] As a result, they reported striving not to exclude any treatment options. This was mentioned across independent practices, small group practices and LVGs.

2.148 We note that evidence from the internal documents of LVGs indicates that some LVGs provide guidance to their vets on offering contextualised care indicating there may be some encouragement given to vets to offer contextualised care. We note that this was infrequent, compared to the monitoring and tracking of KPI targets (which might be expected, given these are ongoing monitoring tools).

2.149 Some vets in roundtables told us that they would start by offering the most comprehensive available diagnostic and treatments to consumers, and revise the recommendation if the pet owner raised cost concerns, in the belief that this would be more likely to secure the appropriate clinical outcome for the animal.[220]

2.150 Some attendees in the Manchester roundtable told us that vets at independent practices had more clinical freedom and so were better able to deliver contextualised care than vets in corporately owned practices. This view was shared by a few of the vets in this discussion.[221]

2.151 Some vets in our qualitative research acknowledged that there was often a tension when offering veterinary care between animal welfare, affordability for the pet owner, and in some cases, the financial goals of the business.[222]

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[216] Summary of roundtable with veterinary nurses, paragraph 28. Summary of roundtable discussion held with Registered Veterinary Nurses via MS Teams on 23 September 2024

[217] Summary of roundtable with newly qualified vets, paragraph 8. Summary of roundtable discussion held with newly qualified vets via MS Teams on 19 September 2024. Summary of roundtable with academics, paragraph 12. Summary of roundtable discussion held with senior representatives of veterinary schools via MS Teams on 16 September 2024.

[218] Qualitative research with veterinary professionals, p. 14.

[219] Qualitative research with veterinary professionals, p. 16.

[220] Summary of roundtable with newly qualified vets, paragraph 8. Summary of roundtable discussion held with newly qualified vets via MS Teams on 19 September 2024

[221] Summary of roundtable in Manchester, paragraph 14. Summary of roundtable discussion held in Manchester on 28 August 2024

[222] Qualitative research with veterinary professionals, p. 13.

2.152 Some vets working in LVGs reported less flexibility around what diagnostics to order. This was linked to their software having built-in options and packages that did not allow them to take off charges for certain steps or elements of diagnostic testing that they did not use. If the vet wanted to use a diagnostic test that was not encoded for in the computer system, they had to escalate the matter to their manager for a code to be created and the order to be placed.[223]

There is some evidence from internal documents that vets are encouraged to focus on the more comprehensive options

2.153 The internal documents from LVGs which we have reviewed to date have mixed evidence on the range or number of options vet businesses recommend their vets offer to pet owners, with several indicating that vets should prioritise offering the 'best clinical care', but some indicating contextualised care should be offered, or a range of options should be presented.

2.154 We have seen several references in the internal documents of the LVGs to their suggested treatment approach being to offer the 'best clinical care' (or words to similar effect), meaning the most clinically effective, safe or robust treatment method (but not necessarily the preferred treatment once contextual factors are considered).[224] This may mean that pet owners first get told about the 'best clinical option' and only subsequently get told other treatment options which may also be clinically appropriate.

(a) For example, an LVG [✂] training document for staff titled 'Recommendation culture' discusses how treatment options should be presented to pet owners, and concludes by stating 'Focus on the best clinical care first, recommend the thing you think is best for that patient', and 'If the client doesn't want to proceed at that price then discuss other options that may be available'. The document also acknowledges that 'We need to give all the information for clients to make their decision'.[225]

(b) In further support of this, an LVG [✂] clinical operations document considers complaint handling, which showed that, of the approximately [✂]% of FTE vets working at this LVG that had a Stage 2 complaint raised against them in the year, the majority ([✂]%) of complaints were about standard of care, with the largest subcategory of complaint within this being 'failed to explain options', which increased from [✂]% of complaints in 2020-2021 to [✂]% in 2021-2022.[226]

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[223] Qualitative research with veterinary professionals, p. 39.
[224] LVG response to RFI3, [✂]. LVG response to RFI3 [✂]. LVG response to RFI3, [✂]. LVG response to RFI3 [✂]. LVG response to RFI3 [✂]. LVG response to RFI 3 [✂]. LVG response to RFI3 [✂].LVG response to RFI3, [✂]. LVG response to RFI3 [✂].
[225] LVG response to RFI3, [✂].
[226] LVG response to RFI3, [✂]

2.155 We note that some LVG documents highlight that contextualised care should be offered. We also found a few examples of LVG internal docs suggesting vets should present multiple options to pet owners (including doing nothing). Some examples of LVG internal documents include:

(a) An LVG [✂] document discusses industry updates, stating 'We are the first and still only veterinary group to publish a clinical governance framework which includes the concept of contextualised care. […] Contextualised care does not mean cheap care, but appropriate care in light of the client's and their pet's individual requirements.'[227]

(b) An LVG [✂] internal document states that '[w]e want to provide quality, contextualised care to every pet that needs us', with additional comments saying '[i]ncluding providing investigation only options, encourage use of clinical judgement and avoidance of overtesting'.[228]

The approach taken to care in the charitable sector

2.156 Although vet services supplied by the charitable sector are not within scope for our market investigation, we briefly consider their approach to providing care. We understand that veterinary charities operate very differently from LVGs and independents. In particular, an animal charity [✂] explained that many charities are strategically placed in areas of high deprivation, offering services to those eligible for free or at a low cost.[229] It [✂] explained that it has a defined scope of services, and will take a pragmatic approach to any diagnostics, aiming to utilise their limited funds to help as many animals as possible by providing an acceptable level of welfare to many pets (rather than exceptional care to a few pets). In particular, we understand that this charity and other charities may use evidence-based treatment protocols or otherwise give guidance to their clinical staff on the most cost effective clinically appropriate way to diagnose or treat a pet for a range of diseases and conditions. The charity [✂] submitted that it performs clinical audits to monitor adherence to, and clinical outcomes from individual protocols.[230]

Emerging view on the extent to which weak competition is contributing to business incentives to increase treatment intensity and to reduce the range of options that vets present to pet owners

2.157 In a well-functioning market vet businesses would have incentives to ensure that pet owners are given sufficient information and suitable recommendations by their

[227] LVG response to RFI3 Question 16, slide 11. [✂]
[228] LVG response to RFI3, Question 16, slide 11. [✂]
[229] Transcript of call with [✂], October 2023, p. 2. [✂]
[230] For example, [✂] does not offer MRI or CT scans, but [✂] hospitals have x-ray, ECG, endoscopy and blood pressure testing. There are also in-house tests. Clients are able to be referred to private veterinary practices for further tests and treatment if required.

vet on the options for diagnosing and treating their pet. This would mean that pet owners, with support from their vet, can make informed decisions on these clinical options resulting in good outcomes for pet owners. As noted previously, any increase in treatment intensity under these circumstances would not be a competition concern.

2.158 Incentives of vet businesses to ensure that pet owners are given sufficient information and suitable recommendations could arise from a combination of regulatory and competitive pressure:

(a) Appropriate regulatory rules and guidance monitored and enforced effectively would influence the actions of vets and vet businesses to ensure good outcomes for pet owners.

(b) Effective competition would involve vet businesses competing for customers by ensuring that their vets give suitable recommendations and sufficient information to help their customers make informed decisions on what diagnostic tests and treatments options to use. A vet business failing to do so would risk a significant number of customers switching to other competitors.

2.159 We consider these in turn.

2.160 Where it is difficult for consumers to evaluate the quality of the service provided (even in retrospect) as it is with many vet services, regulation is required to protect the consumer interest. Regulation in the veterinary sector focuses on ensuring a minimum level of education and training, and removing any vets found guilty of gross professional misconduct.

2.161 There is evidence that, to some extent, regulation encourages vets to offer appropriate advice and information to pet owners. As noted above, the Code and Supporting Guidance include provisions aimed at producing good outcomes for consumers. However, the RCVS, as the sector regulator, has very limited ability to monitor outcomes and take action when these provisions are not being complied with. Moreover, vet businesses are not subject to regulation and there are no consequences for vet businesses (and non-vets within the business) when the vets they employ do not give sufficient information and suitable recommendations to pet owners. While the RCVS' Practice Standards Scheme (**PSS**) does contain some information requirements for practices, the scheme is voluntary and there are no adverse consequences for members if they do not comply with the rules (beyond expulsion from the scheme). Further, assessment for accreditation under PSS takes place only once every four years, with 'spot checks' for compliance within that period very rare in practice.[231]

[231] See Section 4 of the Regulation working paper, *Regulation of veterinary businesses.*

2.162 We are therefore concerned that regulation is not incentivising (or requiring) vet businesses to provide veterinary care in the way we would expect in a well-functioning market. It may not result in vets giving consumers sufficient and timely information and good recommendations that help them make informed choices. We consider this in more detail in our working paper on the **Regulatory framework**.

2.163 Competitive pressure also does not appear to be sufficiently strong to incentivise vet businesses to compete for consumers by ensuring that their vets give suitable recommendations and sufficient information to consumers. As set out in our working paper on **How people purchase veterinary services**, how consumers behave indicates that the advice pet owners receive from FOPs, including how much vets inform them about a range of options to diagnose and treat their pets, is likely to have a limited effect on which FOP a pet owner uses.

2.164 We continue to investigate how far regulatory or competitive pressure is providing appropriate incentives to vet businesses and their vets, and we continue to consider the following potential concerns:

(a) Vets may not consistently give sufficient information and suitable recommendations to pet owners;

(b) Vets may focus on offering higher quality and higher cost treatments, potentially at the expense of lower cost clinically justified alternatives, when there is a range of appropriate treatments for the animal in their care; and

(c) As a result, this could be leading to increases in treatment intensity that do not properly reflect pet owners' preferences. That is, increases in treatment intensity may not reflect the diagnostics and treatment options pet owners would have chosen if they had been given more information and more suitable recommendations.

2.165 Our concerns are supported by some of the business practices that we have set out in the previous sections. This includes:

(a) Setting KPIs and monitoring vets in a way that could increase treatment intensity (for example based on number of diagnostic procedures or number of specific treatments) but there are limited, if any, KPIs and monitoring based on whether vets are giving sufficient information and suitable recommendations to pet owners. While KPIs are good business practice and can help ensure good outcomes for consumers, there is a concern that a specific set of KPI targets may be having the effect of unduly influencing vets to be less likely to present the lower cost treatment options to consumers, where appropriate for their pets.

(b) Business strategies that suggest a treatment approach based on offering the 'best clinical care' rather than a treatment approach based on understanding the pet owner's circumstances and preferences (although we also found some internal documents highlighting that such contextualised care should be offered).

2.166 The evidence about these business practices comes primarily from the LVGs. Independents are subject to the same regulatory regimes and competitive pressures as LVGs and could respond to them in similar ways. We have found some areas of similarity, for example independent chains in particular might set similar KPIs that could increase treatment intensity, although we have seen less evidence of this in independent single site practices so far. These independents do not have the same scale and sophistication as LVGs to adopt some of these business practices. Owners of vet practices who are themselves vets are directly regulated under the RCVS Code and Supporting Guidance, and may feel more forcibly its pressure to provide sufficient information and suitable recommendations to pet owners.

3. Consumer choice and competition in referral services and the effects of vertical integration

Introduction

3.1 In the previous section we explained how consumers rely on the information and advice from vets at their FOP when making decisions on treating their pet. In some cases, an appropriate treatment option may include referring a pet to a Specialist vet, for example at a referral centre. The services provided at referral centres can vary significantly in terms of the nature of treatments they offer and the specialisms they focus on such that they are not all substitutable for each other. Given consumers' reliance on their FOP vet, how effectively consumers shop around for referral services depends on the information and advice that FOP vets give consumers. Such shopping around by consumers, with support from their FOP vet, is important for effective competition in the supply of referral services.

3.2 In this section, we assess how effective competition is in the supply of referral services with a focus on:

(a) whether vertical integration between FOPs and suppliers of referral services impacts the information and recommendations given by FOP vets; and

(b) whether consumers, at all types of FOP, are receiving sufficient information and suitable recommendations from their FOP vets on their referral options.

3.3 We focus on the choice by pet owners of referral services offered by referral centres, hospitals and FOP hubs, including any effect of vertical integration of these services with FOPs. We consider this aspect of competition because pet owners frequently have a choice of which referral service to use, and the choice pet owners make is guided by the advice of the vet at their FOP. Competition in referral services is heavily influenced by the advice vets give, and the choices pet owners make based on this advice.

3.4 Given the complexity and specialised knowledge involved, the referral services with which we are concerned are liable to be amongst the most expensive services which pet owners buy from vets. It is important that competition works effectively so that pet owners do not pay too much for them.

3.5 As well as vertical integration between FOP and referrals service, some vet businesses also include laboratories that do diagnostic testing, pharmacies, out of hours (OOH) centres and crematoria.

3.6 We have not focused on the use of diagnostic labs by vertically integrated groups as pet owners do not generally make choices about diagnostic labs. Diagnostic labs are a business-to-business (**B2B**) service and a given FOP typically has a

contract with a laboratory (or laboratories). As a result, competition between diagnostic labs is based on the choices of vet businesses rather than pet owners. However, we do include some evidence on laboratories where we discuss possible foreclosure. We consider the impact of vertically integrated pharmacies in our working paper on **Competition in the supply of veterinary medicines** and do not discuss it here.

3.7 We consider the sale of cremation services (including by vertically integrated groups) in our working paper on **How people purchase veterinary services**. As with diagnostic labs, it appears that FOPs generally have a contract with a provider of cremation services, which they sell on to their customers.

3.8 OOH provision has a B2B aspect in that every FOP must either offer OOH services itself for its customers or have a contract in place with an alternative provider to which it will direct its customers. There is some limited consumer choice when selecting an OOH provider as a pet owner could opt for an OOH service other than that with which their FOP has contracted. We consider OOH provision in our working paper on **How people purchase veterinary services**, where we explain that pet owners typically use the OOH service offered by their FOP and do not often shop around for OOH providers.

Framework and overview of our assessment

3.9 Our framework for assessing competition in referrals includes assessing the impact of vertical integration between FOPs and referral centres. We assess to what extent vet businesses are focusing on referring to their own referral centres (self-preferencing), instead of focusing on offering a range of options, sufficient information on these options and the most suitable recommendations to pet owners. We refer to self-preferencing in this way as ‘detrimental self-preferencing’.

3.10 Our assessment is structured as follows:

(a) We first explore vertically integrated vet businesses’ incentives, including their incentives to favour their own referral services (self-preferencing) and their incentives to ensure that vets and pet owners consider a range of other referral options.

(b) We next consider these businesses’ ability to self-preference, looking at:

(i) whether they encourage their vets to do so; and

(ii) whether consumers are likely to accept the referral service offered or recommended by their vets.

(c) We then assess the evidence on any effects that might arise from self-preferencing including how this may affect competition in referral services. We set out the evidence to date on:

   (i) the information and referral options given to pet owners;

   (ii) the overall treatment cost; and

   (iii) competitor or customer foreclosure.

3.11 By competitor foreclosure we mean a situation in which non-vertically integrated FOPs are unable to find referral centres for their consumers in circumstances when referral centres in their local area only accept in-group referrals. By customer foreclosure we mean a situation in which non-vertically integrated referral centres are unable to access consumers because nearby FOPs are vertically integrated with referral services and direct customers (through self-preferencing) to their own referral services.

3.12 Part of our assessment is not limited to vertical effects (that is, effects relating to detrimental self-preferencing). As noted in the introduction, we also assess a related, but wider, potential concern about whether, irrespective of the degree of vertical integration between FOPs and referral services, consumers are receiving sufficient information and suitable recommendations from their FOP vets on their referral options. We assess this broader potential concern as part of our assessment of effects (step (c) at paragraph 3.10above).

3.13 In our assessment, we take account of the fact that individual vets – though not the businesses which employ them, or non-vets within a business structure – are regulated by the RCVS and operate under a professional Code of Conduct.

3.14 Our assessment of whether FOPs are giving consumers sufficient information and suitable recommendations about their referral options is relevant for our broader assessment on the effectiveness of competition and regulation in the supply of FOP services. The quality of this information and these recommendations depends on the competitive and regulatory pressure to which FOPs are subject.

3.15 Our assessment suggests that consumers may not be given sufficient information about their referral options at all types of FOP (irrespective of their degree of vertical integration with referral services). As we set out below (from paragraph 3.72) when considering outcomes for consumers, there is some evidence to suggest that FOPs could be giving consumers more information to help them compare the expected costs of different referral options and, in doing so, further understanding the pet owner's circumstances and preferences before making a recommendation. This evidence suggests that competition and regulation in the supply of FOP services may not be working as well as it could be, which in turn

may have consequences for how effective competition is in the supply of referral services.

3.16 We note that, at this stage in our investigation, we have limited empirical evidence on whether there is self-preferencing in practice and limited evidence on whether consumer detriment is arising that is specific to self-preferencing of vertically integrated groups. At this stage, the evidence we have on self-preferencing is mostly limited to suggesting that there may be an ability and incentive to self-preference in a way that could be detrimental to consumers and competition. We are considering what further analysis to undertake to assess the degree of self-preferencing, and the extent of any potential consumer detriment arising from any self-preferencing

3.17 We are considering how to assess outcomes of competition in referral services more broadly, for example whether there are significant differences in the prices of similar referral services. This more general 'outcomes analysis' would not be limited to assessing the effects of vertical integration and self-preferencing.

3.18 We are interested to understand further the benefits of vertical integration between FOPs and referral services. This may include how vertical integration might facilitate greater continuity of care for pets, and any efficiencies that may be passed on to pet owners. In this context, and with sufficient information given to consumers, an increase in referrals to Specialists that work within the same group as the consumer's FOP may be a positive outcome. There may be cases where there are no material differences between the available referral options and where a FOP self-preferencing its own referral services does not lead to consumer detriment.

Incentive: To what extent do vertically integrated groups focus on self-preferencing when making referrals, instead of providing options including third parties?

3.19 The commercial incentives of vertically integrated groups are likely to be to prioritise in-group referrals to centres providing specialist diagnostic or treatment services as this generates revenues that would otherwise be diverted to a competitor. A pet owner made aware of the various options might make a different choice from the in-group provider if it better suited their needs, for example, using a referral centre closer to their home or one that was less expensive. Limiting or directing the choices of pet owners might be considered to be detrimental self-preferencing and could dampen competition in referral services.

3.20 A business's incentives to sell more of the services it provides are what we expect of profit maximising companies. Where those incentives exist in a well-functioning

market, they can result in businesses engaging in vigorous rivalry to win and retain customers, with prices at a competitive level.

3.21 In a well-functioning market, we might expect those incentives – to retain customers within a vertically integrated group – to exist. However, we might also expect the incentives to be counterbalanced in the first instance by well informed and responsive consumers who seek out the provider that best suits their needs, which may include an alternative provider. This would facilitate competition between providers over price or quality. We are aware that a feature of this market is that the consumer response is likely to be weak as set out in our working paper on **How people purchase veterinary services**, and that sector specific regulation aims to address this feature of the market by protecting consumers and promoting consumer choice.

3.22 The extent to which a vet business has incentives to pursue a strategy of detrimental self-preferencing (as described at paragraph 3.9 above) is likely to depend on both the effectiveness of the regulatory measures in place and how pet owners respond to the advice given by vets at their FOPs:

(a) If informed pet owners are likely to respond negatively to detrimental self-preferencing by switching FOP, for example because they are unsatisfied with the range of referral options put to them, there may not be commercial incentives to adopt such a strategy;

(b) Or there may be a risk of significant regulatory intervention from adopting a strategy of detrimental self-preferencing. Under these circumstances, there may be commercial incentives to ensure that pet owners are sufficiently informed of a range of referral options alongside explaining the benefits of using the integrated group's own services.

3.23 If, instead, pet owners generally follow the recommendation of their vet on what referral service to use, even if this recommendation is limited and based on only one option, and there is no regulatory intervention in response to this strategy, there may be commercial incentives for an integrated group to engage in detrimental self-preferencing. The group retains consumers at its FOPs while increasing the sales of its referral services with no or limited regulatory consequences.

3.24 We have therefore examined evidence from a variety of sources, to see what it may tell us about the vertically integrated vet businesses' incentives and whether they tend towards detrimental self-preferencing. That is, evidence:

(a) in internal documents about the rationale for acquiring relevant vet businesses;

(b) relating to the profitability of the referral services vertically integrated groups provide;

(c) in internal documents about presenting referral options to pet owners and how vet businesses measure and react to FOPs' performance with regard to referrals;

(d) about the response from pet owners to vertically integrated vet businesses prioritising in-group referrals; and

(e) from and about non-vertically integrated vet businesses.

3.25 Much of this evidence is also relevant to our assessment of the ability to pursue a strategy of detrimental self-preferencing, which we consider further after our assessment of incentives.

Acquisition strategies indicate that self-preferencing referrals was an important motivator

3.26 We reviewed internal documents of the private equity investors in [✂], [✂] and [✂] that were prepared in order to evaluate the purchase of these businesses and to consider subsequent strategic priorities. These documents show that the private equity firms considered that FOPs act as gateways to other veterinary services and could be used to direct patient flow to group-owned sites, and that this was an important motivation in the acquisitions. For example:

(a) The private equity owner of one of the LVGs [✂] noted in an [✂] document from [✂] that the LVG [✂] owned more than [✂] sites [✂] and that around [✂] of these sites were hospitals or specialist referral centres. It stated that '[the] rest of the sites are primarily FOPs which are strategically very important [✂] and provide significant opportunity in referral and specialised care' and that '80-85%' of this potential referral and specialised care is currently estimated to be outside the group.[232] It added that growth in referral and specialised care could be achieved by 'harmonising referral processes [✂] in areas where [the LVG] [✂] already has [referral and specialised care] capabilities'.[233]

(b) The private equity owner of one of the LVGs [✂] stated that it planned to build referral centres 'to capture a higher proportion of more complex and profitable specialist procedures'.[234] An external adviser, engaged by the private equity owner of one of the LVGs in the context of a sale's process [✂] expressed the view that the LVG's [✂] 'hub and spoke model creates

[232] Private Equity-LVG investor response to RFI1 [✂]
[233] Private Equity- LVG investor response to RFI1 [✂]
[234] Private Equity- LVG investor response to RFI1 [✂]

relationship stickiness by enabling referrals for specialist services to remain within the [✄] network'.[235]

(c) A private equity investor in one of the LVGs [✄] stated that: 'referral revenue [is] captured in [first opinion practices] to incentivise branches to refer internally within the [LVG] [✄] network'.[236] It stated that its [✄] allowed the LVG [✄] to 'capture a greater share of client wallet including higher margin referral revenue' and that there remained scope for further growth of referral services by integrating additional FOPs into the LVG network.[237]

3.27 Our review of two other LVGs' [[✄] and [✄]] internal documents, prepared in connection with their acquisitions of FOPs and referral centres, indicates a similar intention to redirect follow-on services to sites within the LVG's own group:

(a) An LVG [✄] acquisition document consistently highlighted opportunities to re-direct the provision of a range of related services [[✄]] to [✄]sites owned by the LVG following acquisition. The documents that we have reviewed show that this is a key part of the LVG's [[✄]] rationale for continuing to make add-on acquisitions in the sector. We highlight some specific examples from the documents we have reviewed below but note this is a common theme for all of this LVG's [[✄]] acquisitions we have reviewed (a total of [✄] in the last five years):

(i) In 2020, [✄] stated that, after its acquisition of [✄], [✄] wanted to increase the number of referral and OOH cases sent by the practice to a [✄]-owned site and that laboratory and crematorium work would be transferred to [✄].][238]

(ii) In 2021, [✄] stated that it planned to redirect around 15 orthopaedic referrals per annum to its own sites, following the acquisition of [✄].[239]

(iii) In 2022, [✄] noted an "opportunity to achieve significant referral synergies" after acquiring [✄].[240] It stated that amongst other potential synergies, the acquisition would allow it to re-direct referral cases to a [✄]-owned site and estimated that this would create synergies of around £[✄] per annum.[241]

(iv) In 2023, the LVG [✄] stated that its acquisition of [✄] would create additional referral opportunities for its network.[242] Its financial due

[235] Private Equity- LVG investor response to RFI1 [✄].
[236] Private Equity- LVG investor response to RFI1 [✄]
[237] Private Equity- LVG investor response to RFI1 [✄]
[238] LVG response to RFI3 [✄]
[239]LVG response to RFI3 [✄]
[240] LVG response to RFI3 [✄]
[241] LVG response to RFI3 [✄]
[242] LVG response to RFI3 [✄]

diligence provider identified that the practice used a site owned by another LVG [✂] for OOH provision and recommended that 'this service is transferred across to a [✂]-owned provider at the earliest opportunity'.[243]

(b) An LVG [✂] acquisition document similarly highlighted opportunities to direct pet owners to referral centres owned by the LVG. As with another LVG [✂], we highlight some specific examples from the documents we have reviewed and note this is a common theme for all of the LVG [✂] acquisitions we have reviewed ([✂]in the last five years):

(i) In 2019, the LVG [✂] acquired [✂]. In considering the interaction with referrals following the acquisition, the LVG [✂] noted [✂] created opportunities for referral synergies. It identified that [✂] owned [✂] sites which were less than 20 miles from the LVG's [✂] referral centre and anticipated an additional [✂] in EBITDA each year could be generated by increasing referral cases to its own site.[244]

(ii) In 2020, the LVG [✂] acquired [✂]. In considering the interaction with referrals, it noted that the majority of external referrals were made to a [✂] competitor of the LVG and that increasing referrals to a [✂] site owned by the LVG could add around £ [✂] in EBITDA each year for the Group.[245]

(iii) In 2021, the LVG [✂] acquired [✂]. In considering the interaction with referrals, the LVG [✂] stated that the acquisition presented an opportunity to redirect referral cases to its own sites and that doing so would improve the profit margin earned by the group.[246]

3.28 Pets at Home appears to be in a different position. It has told us that it sold its referral division in 2021[247] because it concluded that its JV practice structure undermined the strategic logic for being vertically integrated (the JV practices being free to use or not Pets at Home's referral division).[248]

3.29 The above evidence from acquisition strategies supports the view that vertically integrated groups have an incentive to self-preference for referrals and that this provides a motivation for acquiring FOPs. Although self-preferencing itself is not problematic, there is a potential concern that detrimental self-preferencing could occur if a within-group referral is made when an alternative option might have

[243] LVG response to RFI3, [✂].
[244] LVG response to RFI3, [✂].
[245] LVG response to RFI3, [✂].
[246] LVG response to RFI3, [✂].
[247] Although it does still own five accredited veterinary hospitals.
[248] Pets at Home Issues Statement Response, paragraph 9(b). Pets_at_Home__PAH_.pdf

better met the needs of the pet owner, either in terms of quality of care, price or location for example.

Assessment of financial incentives to self-refer within LVG financial models

3.30 Our assessment of the incentives that vertically integrated groups may have to self-refer is reinforced by our preliminary analysis of the financial models relating to some of their acquisitions. This financial analysis by itself indicates that, without the revenue synergies from related services (including referral services), some acquisitions may have an Internal Rate of Return (**IRR**) below the cost of capital.[249] The evidence we set out below also points to the expected ability of vertically integrated LVGs to self-refer, given that they anticipate a successful strategy of keeping referral income within the group. We say more about this from paragraphs 3.47 below.

3.31 We have analysed the financial models we obtained from [✂], which were prepared to assess the attractiveness of acquisition targets. In these documents [✂] considers net present value (**NPV**) and IRR to evaluate acquisition opportunities. Typically, an acquisition would be expected to proceed where the IRR generated by the investment exceeds the cost of capital (resulting in a positive NPV and therefore creating value for shareholders). Where the IRR is below the cost of capital, the project is not expected to yield a sufficient return, and a business would typically reject the investment opportunity.

3.32 [✂] financial models included detailed forecasts of the future cashflows it expected to generate from target sites. These forecasts were produced with considerable granularity and included synergies from [✂].

3.33 This breakdown allowed us to carry out some preliminary financial analysis to inform our understanding of the strength of the incentives to refer in-group: by removing the cashflows associated with in-group referrals and observing the effect on the IRR of a given acquisition, we were able to test the extent to which the agreed purchase price was reliant on such referrals.

3.34 Our analysis is described more fully in Appendix B. It suggests that, without the ability to refer patients to in-group services, around a third of [✂] acquisitions in the last five years would have had an estimated IRR below the cost of capital at the agreed purchase price. This points to strong incentives to refer in-group:

[249] We note that, in the absence of referral synergies, there are other 'levers' through which the acquiring firm might achieve an IRR above the cost of capital at realised purchase prices. This could include higher prices for some services or additional cost control measures. We note there are a number of instances where inflationary price increases appear to have been built into the financial models, but where there were opportunities to increase practice turnover per vet above the level of inflation, these were noted: see LVG response to RFI3, [✂] slides 18-19 and 21-22; LVG response to RFI3 [✂], slides 18-19 and 23; LVG response to RFI3, [✂], slides 19 and 23.

without this ability, a significant proportion of [✂] completed acquisitions would likely not be profitable (at least not at the prices paid).[250]

3.35 We have also identified a number of the LVGs' internal documents which are informative of the profitability of referral services. While the LVGs – with the exception of [✂] – do not disaggregate between FOPs and referral centres for the purposes of internal financial reporting,[251] some of the due diligence reports carried out for the private equity firms included separate analyses of the profitability of specialised hospitals and referral centres.

3.36 For example, an analyst [✂] carried out an analysis of the profitability of each of the hospitals and referral centres owned by an LVG [✂], [✂]. This analysis showed that these sites had, on average, generated an EBITDA margin of 22% in 2018, 23% in 2019, 25% in 2020 and 28% in 2021.[252] Another LVG's [✂] internal reporting, meanwhile, shows that it earned similar margins across its estate of referral centres: an EBITDA margin of [10-20]% [✂] in 2020,[253] [20-30]% [✂] in 2021,[254] [20-30]% [✂] in 2022,[255] and [10-20]% [✂] in 2023.[256]

3.37 Our analysis of financial information received from three LVGs [[✂], [✂] and [✂]] – which do not disaggregate between FOPs and referral centres in the ordinary course of business – suggests EBITDA margins in a similar range, albeit with lower margins in the most recent years. Our preliminary analysis suggests EBITDA margins as follows:

(a) For an LVG's [✂] referrals centres, an average of 14% in 2021, 11% in 2022 and 4% in 2023.[257]

(b) For an LVG's [✂] referral centres operating division, an average operating margin of [[✂]] in 2021, [[✂]] in 2022 and [[✂]] in 2023.[258]

(c) For an LVG's [✂] (as defined by the CMA), referral centres, an average of 28% in 2022, 18% in 2023 and 9% in 2024.[259]

3.38 These figures indicate that referral services have historically made a positive contribution to group-level profitability (albeit declining in recent years). Moreover, the LVGs told us that the majority of the costs associated with referral services are

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[250] We have not carried out the same analysis for the other LVGs given the available information. The documents provided by other LVGs in their evaluation of acquisition opportunities showed that they generally considered earnings multiples, and did not carry out future revenue modelling at a similar level of granularity to [✂].
[251] As described in the Approach to profitability and financial analysis working paper, paragraph 4.37.
[252] Private Equity- LVG investor response to RFI1, [✂].
[253] LVG response to RFI2, [✂].
[254] LVG response to RFI2 [✂].
[255] LVG response to RFI2, [✂].
[256] CMA analysis of [✂] LVG response to RFI6.
[257] CMA analysis of [✂] LVG response to RFI6.
[258] CMA analysis of [✂] LVG response to RFI6.
[259] CMA analysis of [✂] LVG response to RFI6.

fixed in the short run, such that additional volume improves the financial performance of a referral centre, by making a greater contribution to the clinic's fixed cost base.[260] (and the group, where referred cases cannot otherwise be handled by the referring FOP).

3.39 An LVG [✂], for example, told us that between 80% and 90% of total costs for referral centres are fixed (comprising mainly staff salaries, equipment costs and rent).[261] This means that a substantial amount of fixed costs must be covered each month (through selling treatments/services) and that, once those costs are recovered, a very significant proportion of revenue translates directly to profit.

3.40 The high degree of operating leverage[262] within referral services was well recognised by the LVGs: An LVG [✂] and another LVG [✂] told us that high fixed costs meant that volumes had a 'significant effect on total profitability',[263] and another LVG [✂] told us that volumes (or caseload) had a 'more acute bearing' on the financial performance of its referral centres compared to FOP practices because of a higher fixed cost base for referral-only centres and also the volume tends to be 'lumpier' compared to FOP practices (the caseload is typically lower volume and higher value for referral services).[264]

3.41 This evidence of a direct – and strong – relationship between increased utilisation of staff and equipment and profitability also informs our current view that vertically integrated groups are likely to have strong commercial incentives for in-group referrals.

A weak consumer response and a lack of regulatory pressure means the incentive to self-preference for referrals may not be counterbalanced

3.42 We have considered to what extent the incentive to refer within-group might be counterbalanced by other factors. We have reviewed internal documents from vertically integrated vet businesses and their investors for any evidence of concerns that prioritising in-group referrals would risk consumers switching away from any of the vertically integrated vet businesses for example because consumers felt they were not being given sufficient options or the option that best suited their needs. We have not seen any evidence of such concerns, which may suggest that vertically integrated suppliers are confident that their referral centres are at least as good as other available options. However, this does not take account of the possibility that an alternative option might better meet the needs of

[260] LVG response to RFI7, question 24, paragraphs 97 and 98; LVG response to RFI7, question 24, paragraphs 24.5 ; LVG response to RFI7, question 24, paragraph 24.2; LVG response to RFI7, question 24, p. 8; LVG response to RFI7, question 24, paragraphs 24.10 to 24.12.
[261] LVG response to RFI7, question 24, paragraph 98.
[262] Operating leverage refers to the proportion of fixed costs to variable costs in a company's cost structure. A company with high fixed costs, relative to variable costs, is said to have high operating leverage.
[263] LVG response to RFI7, question 24, paragraph 24.2; LVG response to RFI7, question 24, paragraph 24.11.
[264]LVG response to RFI7, question 24, paragraph 24.6.

the pet owner based on the pet owner's circumstances (for example location, or financial situation) and preferences. The lack of evidence of concern about switching may also suggest that concern about customer switching is not operating as a counterbalancing factor on self-preferencing.

3.43 This would be consistent with our emerging views about the 'demand-side' evidence that pet owners trust and rely on the advice of their vet even when many are not given a range of referral options. That evidence and those concerns are described in more detail in our working paper on **How people purchase veterinary services, and** include the following:

(a) The evidence from our pet owners survey, cited in paragraphs 5.170 to 5.206 of the working paper on **How people purchase veterinary services**, in which:

(i) a pet owner's trust in their vet was found to be a key driver of referral centre choice (along with some other less commonly mentioned factors);[265] and

(ii) 62% of those respondents that were recommended a referral to another practice said they were not given a choice of referral centre.[266]

(b) An LVG [✄] 2022 consumer research document found that 77% of those consumers surveyed said that their choice of referral centre location was heavily reliant on the vet's advice.[267]

(c) An LVG [✄] 2022 marketing strategy document for its referral centre, [✄], noted that 'clients are heavily influenced by their referring vet with little knowledge of referral centres and what options are available or where their pet can be treated'.[268]

3.44 The professional integrity of vets and the RCVS Code that sets out how treatment should be offered might also counterbalance the ability or incentive to refer within-group. We have not seen evidence that regulatory intervention was a concern for vertically integrated groups in relation to increasing self-preferencing for referrals, this is something we would like to explore further.

3.45 The lack of evidence of vet businesses taking into account these competitive and regulatory factors with respect to self-preferencing may indicate that the incentives

[265] Pet owners survey, Q69. When asked why they accepted their vet's referral recommendation, most respondents (63%) said that they accepted this recommendation because they trusted the vet. 39% of respondents said that they did so because they 'had no reason not to', while a smaller group (20%) said that they confirmed the recommendation with their own research. 7% of respondents said that they accepted this recommendation because they did not know how to get a second opinion, and 7% of respondents said that they did so because they did not feel confident challenging the recommendation.
[266] Pet owners survey, Q66.
[267] LVG response to RFI3, [✄].
[268] LVG response to RFI3, [✄].

the vertically integrated vet businesses have to prioritise in-group referrals are not counterbalanced in these ways. This could lead to consumers not being offered a range of choices, sufficient information about these options and recommendations that reflect their circumstances and preferences. That is, there may be incentives to pursue a strategy of self-preferencing even when it might be potentially detrimental to consumers. To assess this potential concern further we are considering whether it is possible to collect further evidence on the extent to which there is a group of pet owners that would be better off, or at least no worse off, from vets increasing the rate of in-group referrals.

Our emerging view on incentives to self-preference

3.46 Our emerging view is that vertically integrated groups may have incentives towards detrimental self-preferencing in referral services. This type of self-preferencing has the potential to weaken competition between referral services and may result in veterinary treatment that is influenced by commercial considerations rather than being solely based on ensuring good outcomes for pet owners and their pets. As noted in the introduction however, we have not so far identified material directly showing that, as a result of vertical integration, consumers are being offered insufficient choice of referral services and that this is dampening competition between providers of those services and causing harm. This is discussed further below under 'Effects of vertical integration and competition in referral services' from paragraph 3.71.

Ability: Do vertically integrated groups have the ability to influence consumer options and choices in relation to referrals?

3.47 The role of vet businesses (and vets) in shaping consumer choice is described in our working paper on **How people purchase veterinary services** and summarised above in paragraphs 2.79 to 2.82. Our emerging views as set out above also apply in relation to the making of referrals because we think both vet businesses (and the vets within them) and consumers behave in similar ways for referrals as they do for the provision of FOP services.

3.48 In this section, we highlight some additional relevant factors on the ability of vet businesses (and the vets within them) to influence pet owners considering or requiring referrals to related services, including:

(a) The ability of vertically integrated vet employers to influence the vets they employ. This includes looking at the factors that influence how vets offer referrals for related services, and the actions vertically integrated vet employers may take to influence vets.

(b) The ability of vets to influence pet owner choice for referrals. We review relevant demand-side features considered in our paper on **How people purchase veterinary services**. This includes looking at whether pet owners rely on vet professionals for advice and access to referrals, and a range of emotional and behavioural factors that affect pet owner decision making.

Ability of vet businesses to influence how vets offer referrals

3.49 We set out some relevant regulatory and commercial factors that affect how vets offer general veterinary services from paragraph 2.83. It seems to us that these factors are also likely to apply when vets recommend referrals. That is, vets are influenced by their professional integrity and regulatory obligations to provide impartial advice and adequate information to pet owners, but it might also be the case that vet businesses attempt to influence how vets behave.

3.50 As noted above, vets are registered with the RCVS and should adhere to its Code. Under the Code, vets must make animal health and welfare their first consideration when attending to animals, keep within their area of competence and refer cases responsibly.[269] The RCVS's guidance on the Code in reference to referrals says vets should:

(a) have regard to all relevant factors when considering referring, including the ability and experience of the referral vet, location, urgency, and the circumstances and financial situation of the owner;

(b) record the reasons for their referral decisions and be able to justify them;

(c) if they consider a real or perceived conflict of interest arises from any referral-based incentives, inform their clients; and

(d) inform pet owners of any links to a referral centre that could be considered a conflict of interest, including where the centre is owned by the same group.[270]

3.51 As discussed further in our working paper on the **Regulatory framework** the RCVS has limited powers to monitor whether vets are complying with these provisions of the Code and supporting guidance and is unable to take enforcement action except in the most serious cases of professional misconduct, which in most cases does not cover matters that go to consumer protection and the promotion of competition (such as conduct covered by the requirements listed).[271] Moreover, while individual vets, who make recommendations to pet owners, are governed by this Code, vet businesses (and any managers who are non-vets) are not

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[269] RCVS Code, paragraphs 1.1 and 1.2. Code of Professional Conduct for Veterinary Surgeons.
[270] RCVS guidance on Referrals and second opinions - Professionals and Consumer rights and freedom of choice - Professionals.
[271] See section 2 of the Regulatory framework working paper, at paragraphs 2.47- 2.73.

regulated. As such, the RCVS cannot impose any sanctions on businesses whose vets do not comply with these elements of the Code (or businesses who put pressure on their vets to refer pets for treatment in a way which may breach these requirements of the Code).

Internal documents indicate an ability to influence vets' referral advice including though monitoring the number and proportion of in-group referrals

3.52 The existence of tracking and monitoring of the level of self-preferencing in referrals may place pressure on vets who work for large integrated groups to recommend a supplier of related services within the same group, and to downplay or not mention alternative options. This may prevent some pet owners from finding out about referral options for related services that better suit them (for example based on location, availability of appointments, price, or anything else).

3.53 In response to our information requests, [✂] LVGs groups said that they did not have any incentives in place for FOPs or vets in relation to in-group referrals,[272] and did not have any policies around which referral centres vets may refer to.[273]

3.54 Based on the review of internal documents provided by the LVGs, it appears to us that vets have clinical freedom to refer to the most appropriate vet/location. That is, we have not seen explicit prohibitions on them doing so or formal restrictions on which referral centre they can suggest.

3.55 However, we have seen evidence that all LVGs track the extent of outside-group versus in-group referrals, and often have targets for practices around the number or proportion of in-group referrals, or appear to guide that an in-group referral centre should be used.[274] As discussed above (paragraphs 2.112 to 2.122), vets at some LVGs have reported feeling pressure to meet certain KPIs and targets. We consider this as it specifically relates to referrals, below. While this is consistent across all vertically integrated groups for the related services they own, it appears to affect vets working at some groups to a greater extent than others. We have also seen evidence that employers may follow up with vets who do not follow these referral policies or preferences, meaning that these targets are

[272] CVS Issues Statement Response, p. 6. CVS.pdf; LVG response to RFI3 Response, paragraph 32.2. [✂]; IVC Issues Statement Response, paragraph 5.9. IVC_Evidensia.pdf; Linnaeus Issues Statement Response, paragraph 4.9. Linnaeus.pdf;
LVG response to RFI9 Response, Question 22, p. 30 [✂]
LVG response to RFI9 Response, [✂]
[273] LVG response to RFI9, Question 14, paragraph 28, [✂]; LVG response to RFI9, Question 14, paragraph 14.4 '[✂]. LVG RFI9, Question 14, paragraph 14.1, [✂] LVG response to RFI9, Question 14, [✂]; LVG response to RFI9, paragraph 16.1. [✂].
[274] For example: LVG response to RFI1, [✂]; LVG response to RFI3, [✂]; LVG response to RFI3 [✂]; LVG response to RFI3, [✂]; LVG response to RFI3, [✂]; LVG response to RFI3, [✂]; LVG response to RFI3 [✂]; LVG response to RFI3, [✂]; LVG response to RFI3, [✂]; LVG response to RFI3, '[✂]; LVG response to RFI3, [✂]; LVG response to RFI3, [✂]. We note Pets at Home submitted it does not track nor has targets around the number or proportion of in-group versus outside-group referrals.

actively monitored as part of business practice.[275] This evidence appears to be consistent with vertically integrated vet businesses being able to influence referrals towards self-preferencing. As noted above, we are considering this in the context of whether these targets might promote self-preferencing to the detriment of consumers.

3.56 Some of the evidence from large group internal documents tracking referrals, including within-group versus outside-group referrals, is summarised below.

(a) An LVG [✂] has [✂] referral centres[276] and [✂] veterinary hospitals[277]. The LVG's [✂] documents indicate an effort to keep referrals within-group, for example discussing how employees can support 'company initiatives, making referrals to the LVG's [✂] referral centres or using our [✂] clinicians where appropriate, using our labs, and by introducing clients to our other services such as [✂], [✂], and our [✂]'.[278] Other documents also track the number of within-group versus external referrals,[279] and business performance documents state 'Referrals – think in house first'.[280]

(b) An LVG [✂] had, as of May 2024, [✂] referral centres[281] and [✂] veterinary hospitals[282]. It told us that the referral decision is driven by clinical consideration. Where all other factors are equal, in-group referrals are encouraged on the basis that the LVG [✂] believes that its clinics are amongst the best available.[283] The evidence that we have reviewed to date appears to be consistent with the LVG [✂] having a policy of encouraging and prioritising in-group referrals. [✂].[284] The LVG [✂] also appears to have a [[✂]] referenced in its internal documents,[285] [✂]. We note that another LVG's [✂] internal documents suggest that [its competitor LVG] [✂] has a strong reputation of referring within-group, with the LVG's [✂] internal strategy and review documents mentioning '[the competitor's] [✂] policy of

[275] Qualitative research with veterinary professionals, p. 50. Quote from a vet nurse at an LVG [[✂]]. LVG response to RFI3 [✂].
[276] LVG Response to RFI9 Q1, [✂]. [✂] has [✂] referral-only centres and [✂]
[277] Source: Data collected from FOPs, ArcGIS and CMA analysis set out in our working paper **Analysis of local concentration**.
[278] LVG response to RFI1, [✂].
[279] LVG response to RFI3, [✂].
[280] LVG response to RFI3, [✂].
[281] LVG response to RFI9 Q1. [✂]. [✂] has [✂] referral-only centres under the supervision of its referrals operation division and [✂] additional sites where referral work makes up a substantial part of the work.
[282] Source: Data collected from FOPs, ArcGIS and CMA analysis set out in our working paper **Analysis of local concentration**
[283] LVG response to RFI1, paragraph 40.2.
[284] For example: LVG response to RFI3, [✂]; LVG response to RFI3, [✂]; LVG response to RFI3, slides 5-6. [✂]; LVG response to RFI3, [✂]; LVG response to RFI3 [✂]; LVG response to RFI3 [✂]; LVG response to RFI3, [✂]; LVG response to RFI3, [✂]; LVG response to RFI3 '[✂]; LVG response to RFI3, [✂].
[285] For example:LVG response to RFI3, Question 16. [✂]; LVG response to RFI3 Question 28. [✂].

internal referrals only',[286] 'and [✂] directing PC [primary care] to refer to their own hospitals!'.[287]

(c) An LVG has [✂] referral centres[288] and [✂] veterinary hospitals[289]. Its documents reference some desire to ensure that its FOPs are referring within-group, including considering the opportunities from acquiring FOP practices close to its referral centres[290] (although, when looking at its referral centres, [✂] appears to focus less on referrals from its own group compared to referrals from competitors).[291]

(d) An LVG [✂] has [✂] referral centres,[292] and operates a hub-and-spoke model with [✂] veterinary hospital hubs.[293] The LVG [✂] documents show some evidence on prioritising in-group referrals to referral centres and hubs, for example one document describing the rationale for acquisition of a referral centre cites high referral rates from the LVG [✂] FOPs as a consideration,[294] and another document setting out preferred referral centres for external OOH operators in a [✂] FOP of the LVG lists only one [✂]-owned referral centre.[295]

(e) An LVG [✂] has [✂] referral centres[296] and [✂] veterinary hospitals.[297] [✂] documents show some evidence on prioritising in-group referrals to referral centres and hubs. This document, prepared in the context of a potential acquisition of a practice states 'there is an opportunity to send referral cases […] and out of hours work to either [✂] hospital [✂] situated less than 20 miles away or [✂] referral centre [✂] […]. The Target currently send this work to another LVG's specialist [✂], a [✂]-owned [✂],[298] and another document discusses how encouraging FOP vets to refer to a referral site would give 'huge organic growth potential'.[299]

(f) **Pets at Home** is less vertically integrated than the other LVGs, although some Pets at Home FOPs have advanced diagnostic, surgical and medical

[286] LVG response to RFI3, [✂].
[287] LVG response to RFI3, [✂].
[288] LVG response to RFI9 Q1. [✂]
[289] Source: Data collected from FOPs, ArcGIS and CMA analysis set out in our working paper **Analysis of local concentration**
[290] LVG response to RFI3 [✂]; LVG response to RFI3, [✂]; LVG response to RFI3, [✂]; LVG response to RFI3, [✂].
[291] LVG response to RFI3, [✂].
[292] LVG response to RFI9 Q1, [✂] operate 4 referral-only sites.
[293] Source: Data collected from FOPs, ArcGIS and CMA analysis set out in our working paper **Analysis of local concentration**.
[294] LVG response to RFI3, [✂].
[295] LVG response to RFI3, [✂].
[296] LVG response to RFI9 [✂] submitted that it has [✂] referral-only sites.
[297] Source: Data collected from FOPs, ArcGIS and CMA analysis set out in our working paper **Analysis of local concentration.**
[298] LVG response to RFI3, Q36, [✂].
[299] LVG response to RFI3, Q28, [✂].

capabilities.[300] Consistent with Pets at Home limited activities in referral services, we have seen limited evidence of mentions of where referrals should be sent to in internal documents.[301,302]

3.57 In addition to the evidence from internal documents, an LVG [✂] submitted the following, which indicates an ability to influence vets' referral advice through financial benefit/incentive for FOPs when referring within-group. Such financial benefits/incentives also have potential clinical benefits in terms of continuity of care:

> To compensate the LVG [✂] clinics for any work they continue to provide when they refer cases to one of the LVG's [✂] [✂] Referral Centres, a clinic may be able to claim up to [✂] of the veterinary fees paid by a client to an LVG [✂] Referral Centre. The option to do this depends on the degree of involvement of the originating veterinary surgeon in the case. If a vet completely signs over the care to the referral clinician and has no involvement whatsoever in the care, the originating site is unable to claim.
>
> The fee increases to [✂] when the clinic that refers the case remains significantly involved in the case, for instance in the case of outpatient imaging (such as CT or MRI) because they would be involved in building a care plan based on the scan results, discussing the case with the Referral clinicians and communicating to clients. In such scenarios, clinicians from the first opinion practice are often using the equipment at the referral centres, as opposed to the time and knowledge of the specialist clinicians.[303]

3.58 We have seen no evidence so far from our review of the large vertically integrated groups' internal documents that they are monitoring the extent to which vets are giving information to pet owners on how a range of referral centres compare on price, quality or other metrics, as well as making suitable recommendations on these options. Neither have we seen evidence of guidance to vets about the information that should be offered to pet owners when considering a referral.

3.59 Viewed as a whole, this body of evidence suggests there are means by which vertically integrated vet businesses are able to influence vets to recommend referrals to be made to within-group sites. This is consistent with evidence from

[300] Source: Data collected from FOPs, ArcGIS and CMA analysis set out in our working paper **Analysis of local concentration.**

[301] We found one document which sets out a pipeline project around 'veterinary internal referrals' of an acquired practice. LVG response to RFI3, [✂].

[302] We note we found a [✂] document which considers a potential acquisition also states that '[a]bility to influence ref[erral] patterns often over-stated (clinical/relationship based decisions)', however the document also discusses crematoria and labs, stating as a positive 'keeps margin in-house'. LVG response to RFI3, [✂].

[303] LVG response to RFI1, Question 42, pp.17-18. [✂]

the previous section that integrated groups may have incentives to self-preference in a detrimental way.

Evidence from qualitative research indicates that vets are sometimes encouraged to refer within-group

3.60 Evidence from our qualitative research with vets and vet nurses demonstrates that some vets reported being encouraged to use referral centres owned by the LVG that owns their FOP. Others said that ownership was one of a range of factors they considered in making referrals, and that a pet owner's specific request to use a particular clinic was always accommodated.[304]

3.61 A number of veterinary surgeons working in vertically integrated LVGs reported that they were encouraged to refer to group-owned referral centres, though there were differences between the LVGs, with vets working at some LVGs reporting it more than those working at others. The reported ways in which this was encouraged ranged from word of mouth and lists being provided, to IT systems designed to streamline the referral process:[305]

> There's a referral shortcut [on the IT system] but it only works for [✂] [LVG owned referral centres], if you see what I mean. So they say, 'here, use this useful shortcut on your system'. But, when you actually go through the process, your options are not all the places that are actually available, it's the [same LVG name] places.
> *Veterinary surgeon* [✂] *LVG practice*

3.62 Other submissions to us also indicate that vets may be encouraged to refer within-group, though we are cautious about how much weight to place on these compared to LVG internal documents or our independent qualitative research. We received some submissions from third parties indicating that vertically integrated groups may attempt to constrain the providers which their FOP vets can recommend, and these vets may only be able to make a referral to a third-party referral centre if a pet owner explicitly requests this.[306] For example:

(a) A referral centre submitted that it only receives referrals from neighbouring LVG [✂] practices when the LVG's consumers specifically request to be referred there, or for LVG [✂] staff pet, whereas a different neighbouring LVG [✂] practice refers many cases.[307] We note that based on the location

304 Qualitative research with veterinary professionals, p. 50-51.
305 Qualitative research with veterinary professionals, p. 52. Quote from a vet at an LVG [✂].
306 In addition to the submissions described below, we received the following responses to our Issues Statement which provided some additional relevant information: [✂] Issues Statement Response, p. 3-4, [✂]. [✂] Issues Statement Response, p. 4-5. [✂]
307 Referral centre response to RFI1, p.5. [✂]

of this referral centre, referrals to the LVG [✂] would take considerably longer and require additional transportation costs.

(b) Another referral centre submitted that it does not receive many (if any) referrals from LVGs such as [✂], and that if it does, the referral has usually been requested by the pet owner, who wanted a referral closer to where they live.[308]

(c) An independent vet who had previously held a senior position at an LVG [✂] stated that when LVGs are referring a consumer to another clinic, referral options may be reduced for commercial reasons, for example pushing for referrals to vets with a revenue sharing agreement.[309] This vet also said that the referrals are sometimes to non-Specialists, and the difference in training and accreditation is not made clear. The vet emphasised that this push for narrowed referrals comes mostly from non-veterinary management within the LVGs, rather than from vets.

3.63 Submissions were made independently to us by individual vets about vertically integrated LVGs advising their vets to refer in-group, even when other referral options existed which may have been preferred by pet owners (for example, because they were closer or cheaper for the same quality of care). In particular:

(a) One vet stated that there are minuted national meetings where staff were advised not to refer outside of the group even if better care was available elsewhere at lower price. Clinical director approval was required in order to make referrals to practices outside the group. [310]

(b) Another individual told us that pets may be transported by ambulance from some branches to different LVG [✂] branches when other veterinary options were available much closer. The person told us that this happens, for example, with painful surgeries and imaging work and was concerned that the LVG [✂] prioritised profit over animal welfare.[311]

3.64 The LVG [✂] example is consistent with the financial incentives the LVG [✂] offers to its FOPs for keeping referrals within the LVG [✂] group (see paragraph 3.57 above). These submissions, too, are consistent with an ability of vertically integrated groups to self-preference, in some cases in a potentially detrimental way.

[308] [✂] Issues Statement Response, August 2024, paragraphs 14 and 15. [✂]
[309] [✂] Individual vet submission, page, [✂].
[310] An individual formerly employed by an LVG
[311] An individual employed by an LVG [✂]

3.65 The evidence above from our qualitative research and submissions we received on the ability of vertically integrated groups to self-preference (including in a potentially detrimental way) is also indicative of an incentive to do so.

The ability of vets to influence consumer choice for referrals

3.66 Based on the evidence we have seen so far, vets play a vital role in influencing consumer choice for referrals given the reliance on the FOP vet for these referrals. We set out some key emerging findings below, and additional information and underlying evidence on the demand side can be found in more detail in our paper on **How People Purchase Veterinary Services**.

Pet owners rely on veterinary professionals for advice and access to referrals

3.67 Pet owners needing a referral to be seen by a specialist (for example, in a referral centre) will need to first go to a FOP to obtain a referral (and in most cases cannot access a specialist directly). This gives the practice (and vet) a point-of-sale advantage and means the options they present to the pet owner will directly influence what referral a consumer gets, in other words the FOP has a ‘gatekeeper role’ in terms of access to referral services.

A range of factors appears to limit how effective consumer decision making is at facilitating competition in the supply of referral services

3.68 We set out in our working paper on **How People Purchase Veterinary Services** that there may be a range of emotional and behavioural factors as well as asymmetries of information that affect pet owners’ decision making when purchasing veterinary care. We consider that these factors also apply to accessing referrals and may limit competition in the supply of these services. The factors which we highlighted in that working paper which are particularly relevant for referrals include:

(a) Some referrals might be more urgent, give rise to higher financial costs, or have greater animal welfare implications. For example, a pet may need a referral for a complex surgery or need to be seen by a specialist. These situations are likely to be more emotional, have a higher degree of urgency, and be more dependent on trust in the vet than other more routine treatments.

(b) Reliance on the FOP vet may be limiting pet owners’ willingness and ability to consider alternative referral options. Evidence from our pet owners survey indicates that most pet owners do not shop around when recommended a referral by their FOP vet. For example, of those respondents that were recommended a referral to another practice, 35% said they did their own

research on the treatments offered and/or looked for alternatives, and only 12% said they found an alternative to use. The majority (62%) of these respondents said they did not do any research.[312]

(c) As seen throughout the pet owner journey, evidence indicates that vet recommendations are very influential in referral practice choice. In addition, pet owners' confidence and ability to assess clinical quality was sometimes identified as a barrier to shopping around. As we noted in the paper on **How people purchase veterinary services**, complex veterinary treatments could be characterised as 'credence goods' due to the information asymmetry between pet owners and vets and the difficulty consumers may have in assessing quality, even in retrospect.

3.69 Taking this evidence in the round, as for the discussion on increased treatment intensity above, it appears that there may be a weak consumer response when it comes to accessing referrals to related services. Pet owners are likely to be reliant on their FOP vet for advice and access to referrals, and so can be significantly influenced by their vet when choosing a referral option.

Our emerging view on ability to self-preference

3.70 Our emerging view is that, as well as the incentives to do so, vertically integrated groups have some ability to self-preference in a potentially detrimental way. We have looked at both the ability of vertically integrated vet employers to influence the vets they employ, and the ability of vets to influence pet owner choice for referrals. In reaching this view we have considered the role of regulation, which does not apply to non-vet business owners and may have only limited impact on vets due to the lack of monitoring and weak enforcement of the consumer-facing provisions of the Code. We also considered the tracking and monitoring of internal referrals by vet businesses, alongside the follow up and, in the case of one LVG, financial incentives offered for within-group referrals. We have also seen from our qualitative research that some vets reported being encouraged to refer within-group. Evidence from our pet owner survey indicates that pet owners rely heavily on the advice of their vet when selecting a referral centre.

Outcomes of competition including effects of vertical integration

3.71 In a market investigation we will normally consider outcomes of the competitive process such as prices, innovation, range, quality and profitability. This is because outcomes of the competitive process can provide evidence about the functioning of a market.[313]

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[312] Pet owners survey, Q67.
[313] CC3, paragraph 103.

3.72 Evaluating these outcomes helps us determine whether there is an adverse effect on competition and, if so, the extent to which consumers may be harmed by it, that is the degree and nature of 'consumer detriment'.[314] In particular, considering whether market outcomes are in line with what we may expect in a well-functioning market[315] is informative of whether competition is working well.

3.73 In this section we consider three potential effects of the increasing extent of vertical integration (growing due to FOP acquisitions by vertically integrated LVGs) in the vet market between FOPs and more specialist care provision among the LVGs:

(a) Vertically integrated groups self-preferencing and limiting choices to pet owners when making referrals;

(b) Vertically integrated groups increasing the rate of referrals to referral centres (rather than pets being treated in the original FOP) and this leading to higher treatment costs; and

(c) Vertically integrated groups foreclosing their competitors, for example self-preferencing of vertically integrated groups foreclosing independent referral centres from access to enough consumers.

3.74 Key to any concerns in relation to these three effects is whether vets are giving sufficient information and suitable recommendations to pet owners on the available referral options or other alternatives. As noted above, when this is not the case, self-preferencing is more likely to be detrimental to consumers. Similarly, there is a greater risk of foreclosing independent referral centres if pet owners are not sufficiently informed about using them.

3.75 Part of our assessment is not limited to vertical effects. In this section we also assess a broader potential concern about whether, irrespective of the degree of vertical integration between FOPs and referral services, consumers are receiving sufficient information and suitable recommendations from their FOP vets on their referral options.

3.76 One example of possible consumer harm from failing to give pet owners enough information on their referral options is pet owners (and their pets) travelling substantially further for their referrals when they would have preferred to avoid

[314] CC3, paragraph 104.
[315] The CMA uses a well-functioning market as a benchmark in market investigations. A well-functioning market is one that displays the beneficial aspects of competition, rather than an idealised, perfectly competitive market. Generally the well-functioning market is the market envisioned without the features that may be restricting or distorting competition, but there may sometimes be reasons to depart
from that general concept, for example, if features are intrinsic to the market but nevertheless have anticompetitive effects (as in the case of a natural monopoly) or if the nature of competition in the market is defined by arrangements put in place by Government. See CC3, paragraphs 30 and 320.

doing so. Another could be that they are referred to a centre which has a longer waiting list than an alternative.

3.77 Another possible concern from not giving pet owners enough information is that the prices and profits of referral services might be too high due to lack of competition between providers of these services. In relation to profits, we note the evidence at paragraphs 3.30 to 3.41 on the profitability of referral services. At this stage in our investigation, we do not have further evidence on profitability.

3.78 This section is structured as follows:

(a) evidence on information and the referral options given to pet owners at all types of FOP, and whether there are any differences by type of FOP;

(b) evidence on self-preferencing in vertically integrated groups;

(c) effect of increased referral rates of integrated groups on overall treatment costs;

(d) evidence of the approach to referrals of FOPs that are not vertically integrated;

(e) potential risk of competitor or customer foreclosure due to vertical integration; and

(f) our current view on overall effect on competition in the supply of referral services.

Evidence on information and the referral options given to pet owners

3.79 Below we set out:

(a) evidence from our pet owners survey on i) price transparency, ii) ownership information, iii) non-price information and iv) referral options given to pet owners;

(b) LVGs' submissions on their approach to referrals; and

(c) evidence from vets and vet nurses on how FOPs present referral options to pet owners based on our qualitative research and roundtables.

3.80 These sections draw on the relevant evidence from our working paper on **How people purchase veterinary services**.

3.81 We conclude the section with our emerging view on the information about referral options given to pet owners and what this may mean for competition.

Our pet owners survey suggests there is a lack of transparency about pricing and on ownership of referral centres

3.82 We note that there appears to be a lack of price transparency for referrals. In our pet owner survey, many of those respondents who were recommended a referral to another practice (44%) did not receive information from their FOP about the likely price of a consultation at this other practice.[316]

3.83 We also note that information regarding ownership of referral practices may not always be understood by pet owners. 42% of those respondents who said they went to a referral practice which was different from their FOP reported that they did not know the ownership of the referral practice.[317] While the remaining respondents said they were aware of the ownership of their referral practice, we note in this connection that a considerable number of respondents were incorrect about the ownership of their FOP practice (53% of those at an LVG did not know that their vet was part of an LVG),[318] so it is plausible that this also extends to referral practices.[319]

Our pet owners survey shows that most pet owners are given relevant non-price information by their FOP

3.84 Responses to our pet owners survey indicate that most pet owners are given relevant non-price information by their FOP vet to help them make the correct decisions regarding their pet's referral. However, it appears that this is not always the case. For instance, 10% of pet owners reported not receiving information on the potential outcome of the referral (including likelihood of success, side effects, and aftercare implications) and 22% reported not being provided with an estimate of how quickly they could be seen.[320]

Our pet owners survey suggests pet owners are not always offered a choice of referral options and often accept their vets' recommendations

3.85 Evidence from our pet owners survey suggests options of referral centres are not always provided by the referring vet. In our pet owners survey, 62% of those respondents that were recommended a referral to another practice said they were not given a choice of referral centre.[321] 33% of respondents said they were given options to choose from – of these, a minority (11% of overall respondents) were recommended one option in particular.[322] Of those respondents that were recommended a referral within their own FOP, 56% said they were not given a

[316] Pet owners survey, Q63r2. Consultation price: 38% yes, 44% no, 13% do not remember, 5% N/A.
[317] Pet owners survey, Q74.
[318] Pet owners survey, Q34.
[319] Pet owners survey, p.38.
[320] Pet owners survey, Q63r1 and Q63r6.
[321] Pet owners survey, Q66.
[322] Pet owners survey, Q66.

choice of alternative providers, while 24% said that they were given a choice.[323] There were no significant differences between independents and LVGs.

3.86 In most cases pet owners accepted their vet's recommendation because they trusted the vet, with this being the case for 63% of pet owners that were recommended a referral, with no significant difference based on whether they were referred to a vet within the same practice or one outside it.[324]

Evidence from LVGs is that that their vets consider a range of options when referring consumers

3.87 In Section 2 above we noted the mixed evidence from LVGs on the range of options vet businesses recommend their vets offer to pet owners. Several indicated that 'best clinical care' should be prioritised, and some indicated that contextualised care should be offered, or a range of options should be presented.[325]

3.88 In respect of referrals, the LVGs submitted that their vets considered a range of factors, including availability, price, and the highest quality clinical care. Half of the LVGs [[✂], [✂], [✂]] emphasised that their vets would only refer a pet owner after discussing and agreeing with them on the most suitable referral centre.[326] The other LVGs [[✂], [✂], [✂]] submitted that individual practices within their group make their own decisions as to how and where they refer pet owners, and follow the RCVS Code in doing so.[327,328] As noted above (paragraphs 3.53 and 3.54) LVGs submitted that they did not have any policies around which referral centres vets may refer to.[329]

Evidence from non-vertically integrated independent vet practices indicates that they consider a range of factors and present a range of options when making referrals

3.89 We asked a sample of single site independent practices, and small and medium independent vet businesses that are not vertically integrated, what they take into consideration when making a referral. Overall, they responded that the most important factors were estimated costs, availability (especially in emergencies) and travel distance from the FOP. Other factors, such as the preference of the pet owner, the appropriateness of the centre in terms of clinical skill and facilities and

[323] Pet owners survey, Q66.
[324] Pet Owners survey, Q69.
[325] See paragraphs 2.137 to 2.155.
[326] LVG response to RFI1 Q40-41. LVG response to RFI1 Q40-41; LVG response to RFI1 Q40-41.
[327] LVG response to RFI1 Q40-41; LVG response to RFI1 Q40-41; LVG response to RFI1 Q40-41.
[328] Further information can be found in our working paper on **How people purchase veterinary services**.
[329] LVG response to RFI9, Question 14, paragraph 28, [✂]'; LVG response to RFI9, Question 14, paragraph 14.4 [✂] LVG response to RFI9, Question 14, paragraph 14.1, [✂]'; LVG response to RFI9, Question 8, p.13. LVG response to RFI1 Q40-41. LVG response to RFI9, paragraph 16.1. [✂]

the personal relationship of the centre with the referring vet were also considered. Most of the practices described presenting the pet owner with options when it came to referrals and emphasised that the final decision was the pet owner's choice.

Vets and vet nurses indicated that they provide a range of options to pet owners

3.90 Our qualitative research found that vets generally decided whether to offer a referral during consultations with pet owners when they felt a case required escalation. This decision was influenced by the scope of care a vet could personally provide, as well as the resources available within their clinic.[330] It also found that a number of vets reported that they provided pet owners with multiple referral options, but this was not consistent across those interviewed.[331] Vets also noted that referral options varied largely depending on location, and in some regions, or for complex cases, there was a limited number of referral options.[332]

3.91 The qualitative research indicates that factors influencing vet recommendations for referral providers included clinical specialism, location and convenience to the pet owner, price, details within insurance policies about specific referral requirements, and the availability of timely appointments.

3.92 Vets reported that their primary consideration when determining choice of a referral provider was typically what would best serve both the pet and the pet owner, using their clinical judgment while also taking account of the pet owner's preferences/affordability, and availability/waiting times. The vets also noted that some insurance policies specified where referrals could be made.[333]

3.93 In some cases, vets working at LVGs reported that they also had to consider management pressures to refer to specific clinics or specialist hospitals.[334] A number of vets at some LVGs reported that they were encouraged to refer to group-owned referral centres:

(a) Most vets working at an LVG [✂] practices reported being encouraged to refer to hospitals or referral centres owned by the same group.[335]

(b) There were also examples of vets at a variety of LVG groups [[✂],✂],[✂], [✂]], and one small group, being encouraged to refer to hospitals and

[330] Qualitative research with veterinary professionals, p. 42.
[331] Qualitative research with veterinary professionals, p. 54.
[332] Qualitative research with veterinary professionals, p. 47-48.
[333] Qualitative research with veterinary professionals, p. 46-50.
[334] Qualitative research with veterinary professionals, p. 51.
[335] Qualitative research with veterinary professionals, p. 46.

referral centres owned by the same group, although it was less consistently reported than those interviewed working at some LVG [✄] practices.[336]

3.94 The approach used to encourage vets to refer within-group ranged from word of mouth, newsletters, staff meetings, providing lists, to IT systems designed to streamline the referral process.[337]

3.95 However, many vets considered the ownership of the referral clinic as just one of many factors as described above when making referrals. Vets said they were not necessarily restricted from referring to clinics outside of the LGV.[338] Most vets did not express concern about being encouraged to refer cases to specific practices. While some noted that the preferred provider was the one they would typically choose anyway, others emphasised that they felt free to refer cases to alternative centres if they believed it was in the best interest of the pet or owner, as described above.

3.96 Additionally, some vets highlighted that there were no consequences for them in choosing not to follow referral guidance. However, one of the vets working as a locum described how they thought that the practice would be less likely to ask you back for more shifts if you did not refer pets to the group's preferred provider.[339]

3.97 Two attendees at one of our roundtables described how it was generally difficult for their employers to control where referrals were made, even if there were preferred referral centres as vets tended to be 'independently minded'. Another attendee noted that the clarity and transparency of referrals were not just an issue for practices owned by LVGs, as they knew of independent practices which had omitted communication of some referral options so they could keep the treatment within the practice.[340]

Our emerging view on information about referral options given to pet owners

3.98 Based on our review of evidence so far which is quite mixed, it appears to us that some pet owners may not be receiving or engaging with sufficient information to inform their choice of referral provider. This concern relates to all FOPs, not only those that are vertically integrated. This may result in pet owners not effectively considering that they have a choice of referral practices, leading to weak competition in referral services, for example, on price. We note that we have not at this stage identified any significant differences between LVGs, which are more

[336] Qualitative research with veterinary professionals, p. 50.
[337] Qualitative research with veterinary professionals, p. 50-51.
[338] Qualitative research with veterinary professionals, p. 51.
[339] Qualitative research with veterinary professionals, p. 52-53.
[340] Summary of Manchester roundtable discussions, paragraph 15.

likely to be vertically integrated, and independents in terms of the provision of sufficient information to pet owners.

Evidence on self-preferencing: rates of in-group referrals by vertically integrated groups indicates that around half of referrals are within-group

3.99 We received some information on the referral patterns for the LVGs, namely about the proportion of referrals going from a group's FOPs to a referral centre that is also owned by the group. Some LVGs submitted that they were unable to provide this information.

3.100 For those LVGs which were able to provide information, around half (or just over) of referrals from their FOPs were to within-group practices or referral centres. In particular:

(a) An LVG [✂] submitted that '[i]n the 12 months to September 2023, 42.5% of referrals made from our first opinion practices and recorded on our practice management system were referred to third party (non-[✂]) practices. Of the cases seen by the LVG [✂] referral hospitals in the same period, 32.1% were referred by the LVG [✂] first opinion practices'.[341]

(b) An LVG [✂] submitted that it did not have information on referral services providers at the local level readily available but submitted that 'over [50%] of the LVG [✂] FOP customer spend on Referral Services flows to third party Referral Centres'.[342] This indicates that less than [✂] % of referral spend was within-group to the LVG practices. The LVG submitted that '[t]he referral decision is driven by clinical considerations and not ownership considerations, and as such the centre most suited to the client's needs which is likely to give the best patient outcome will be sought. In some cases, the LVG [✂] vets may over time have come to know (and hence trust) the LVG [✂] specialists more and so have a tendency to refer intra group.'[343] It submitted further that it 'considers that [its] referral centres are amongst the best available so that where (and only where) all other considerations are considered equal, the LVG [✂] encourages surgeons to refer to an within-group [✂] centre, though no financial incentives are provided. Customers are informed that they have a choice as to which referral centre they select'.[344]

(c) Another LVG [✂] did not provide referral information. However, a pet insurance company [✂] provided a one-off report it created for the LVG [✂] to 'highlight the distribution of referrals from the LVG's [✂] First Opinion

[341][✂] LVG response to RFI1, p. 23. [✂]
[342] [✂] LVG response to RFI9, Question 15, paragraph 15.2. [✂]
[343] [✂] LVG response to RFI1, p. 17. [✂]
[344] [✂] LVG response to RFI1, p. 17. [✂]

practices'.[345] The information provided shows the volume and value of the pet insurer [✂] customer referrals from the LVG [✂] First Opinion Practice and where that referral ended up in 2022.[346] Aggregated across the referral centres used, we estimate that 57% of the pet insurer's [✂] clients using LVG [✂] FOPs ended up at the LVG's [✂] referral centres in 2022.[347]

3.101 The high rate of within-group referrals for some groups could be due to self-preferencing or other factors. These other factors include the group having a high share of referral centres and high share of FOPs in a similar area, or a group having acquired FOPs that are located near their referral centres.

3.102 Analysis submitted by an LVG [✂] suggests that self-preferencing is taking place to some extent. This analysis plotted the concentration of the LVG's [✂] FOPs in a local area against the share of referrals the LVG [✂] referral centres received.[348] The LVG [✂] submitted that, absent any self-preferencing behaviour, one would expect an LVG [✂] referral centre to receive referrals from the LVG [✂] FOPs roughly in proportion with the FOPs' share of supply in the respective referral centre's catchment. We note that, based on the figure presented below, as the LVG's [✂] FOP share increases (i.e. as you move towards the right on the horizontal axis) some of the data points are above the diagonal line (which shows when the share of referrals equals the share of FOPs within a catchment). The LVG's [✂] view is that this is purely driven by outliers and that excluding these outliers, the distance above the line is not statistically significant from zero given the variance in the relationship (the distance above the line is on average 1.6 percentage points once 25% of sites, which the LVG [✂] considers to be outliers, are excluded).[349] It is not clear to the CMA why these observations would be outliers however. This appears to suggest the LVG [✂] is doing more within-Group referral work than proportional to its share of FOPs.

Figure 3.1 [✂]

[✂]

Source: [✂] submission

3.103 Trends in within group referral rates can also give an indication of the extent to which self-preferencing is contributing to the high rate of within group referrals. An increasing trend in within group referrals could suggest that the degree of self-preferencing is increasing over time and contributing to the high rate of within group referrals. Our evidence on this trend is currently limited to an LVG [✂] and

[345] [✂] RFI response, November 2024, p. 3. [✂]
[346] [✂] RFI response, [✂]; LVG, [✂]
[347] Our analysis of information [✂] internal document.
[348] [✂] analysis, Figure 1, August 2024. [✂]
[349] The LVG [✂] argues these outliers are due to additional location specific factors that account for the higher proportion of FOP referrals rather than any systematic policy to self-refer, such as the referral centre being particularly close to a FOP of the LVG or having a strong relationship with a FOP that pre-dates the acquisition for example.

we intend to assess whether an increasing trend in within group referrals applies more widely across the sector.

3.104 A pet insurance company [✂] submitted data tracking an LVG [✂] referrals from its FOPs from 2019 to 2024 YTD. The insurer submitted that this data report was developed at the request of the LVG [✂], to 'support helping them understand the pattern of referrals from their Primary First Opinion practices and more specifically whether these went to [a referral centre of the LVG] or to a referral centre outside of [the LVG]'.[350] We present the summarised information requested from the pet insurance company [✂] below.[351] This shows that over the past five years, the LVG [✂] has increased the within-group referral revenue as a proportion of total referral spend each year from 28.6% in 2019 to 41% in 2024.[352]

Table 3.1 Proportion of [✂][✂]

Year	[✂] *LVG to LVG Referral Count*	[✂] *LVG to LVG Referral Spend*	[✂] *LVG to LVG Spend (%)*	[✂] *LVG to non-LVG Referral Count*	[✂] *LVG to non-LVG Referral Spend*	[✂] *LVG to non-LVG Spend (%)*
2019	[2,000 -3,000]	[£2-3m]	[20-30%]	[4,000-5,000]	[£5-6m]	[70-80%]
2020	[1,000-2,000]	[£1-2m]	[30-40%]	[2,000-3,000]	[£3-4m]	[60-70%]
2021	[1,000-2,000]	[£1-2m]	[30-40%]	[2,000-3,000]	[£3-4m]	[60-70%]
2022	[1,000-2,000]	[£1-2m]	[30-40%]	[2,000-3,000]	[£3-4m]	[60-70%]
2023	[1,000-2,000]	[£2-3m]	[40-50%]	[1,000-2,000]	[£2-3m]	[50-60%]
YTD 2024	[1,000-2,000]	[£1-2m]	[40-50%]	[1,000-2,000]	[£2-3m]	[50-60%]

Source: [✂] Internal Document.

3.105 We intend to explore whether it is possible to replicate the analysis above on within group referral trends for other LVGs. We are also considering how we can exclude any other factors that may affect this trend, for example an LVG newly acquiring a referral centre, or acquiring FOPs that are located close to its referral centres.

3.106 Evidence from our qualitative research with vets reported above (see from paragraph 3.60) could suggest that other LVGs are also increasing within group referrals, as does the monitoring of within group referrals by LVGs. The evidence from internal documents from two LVGs [✂] about the rationale for recent acquisitions also indicates an intention to increase within group referrals.

Increased referral rates of integrated groups may be increasing overall treatment costs

3.107 We received some limited evidence that vertical integration may be increasing the rate of referral and that this is leading to increased costs to pet owners. As noted above, a possible concern is that these increased referral rates are driven by vertical integration rather than well-informed consumers choosing higher cost

[350] [✂] RFI Response, November 2024, p. 2. [✂].
[351] [✂] Internal Document, November 2024 [✂].
[352] [✂] Internal Document, November 2024 [✂].

referral options. Our understanding is that an equivalent treatment can cost significantly more at a specialist referral centre than when provided in the FOP.

3.108 We received some submissions which state that increased referrals have led to increased treatment costs. For example, [✂] submitted that insurers have observed an increase in vet referrals which may result in a duplication of costs for consumers because, for example, repeat diagnostics may be ordered by the referral clinic. The party also noted that it had observed changes in invoicing with more services being added as extra charges, for example interpretation of laboratory results or post-operation consultation had been added which were previously included in diagnostics or surgery costs, and without a reduction in those diagnostics or surgery costs. The CMA has not seen any underlying analysis of this evidence, however.[353]

3.109 A small number of vets in our qualitative research reported instances at LVGs where vets were encouraged to refer cases to referral centres within their LVG, even when they believed it was not clinically necessary due to available expertise within the practice. This included situations where an in-house surgeon was capable of performing the surgery.[354] All examples of this were based on the experience of vets at LVGs, in either their current or former roles.[355]

3.110 One such example was a vet who had previously worked at an independent practice, which was sold to an LVG [✂]. During the period working at the practice, the vet expressed frustration with the new management's encouragement to make referrals that the vet did not believe were necessary. Despite holding Advanced Practitioner status and feeling fully competent to perform certain surgeries, the vet was directed to refer cases to the company's dedicated orthopaedic referral centre. The vet reported finding this both professionally limiting and financially burdensome for consumers. In the example the vet gave, it would have cost pet owners £3,400 for the treatment if done in practice, and £4,800 if done at the clinic.[356]

> When I worked in corporates … you could only refer to their referral clinic. … They might not want the operation done in-house because if it got referred to [the LVG], they'd be more profitable. …[357] *Veterinary surgeon, Independent, previously [✂] practice*

3.111 There were also cases in which vets offered referrals to Specialists outside the FOP, even where the procedure or treatment could be provided in-house, because

[353] [✂] submission in response to the CMA's review of the veterinary sector, October 2023, p. 2. [✂]
[354] Qualitative research with veterinary professionals, p. 45.
[355] Qualitative research with veterinary professionals, p. 45.
[356] Qualitative research with veterinary professionals, p. 45.
[357] Qualitative research with veterinary professionals, p. 45.

they felt it was important to present all options to pet owners, including a higher-level expertise.[358]

Referrals by non-vertically integrated practices

3.112 We received evidence that some FOPs which are not vertically integrated may carry out some more complex treatments within the FOP instead of referring to an external practice/referral centre. A range of reasons were given for this, including that the FOP had the expertise to manage cases internally, referrals would have been prohibitively costly for the pet owner, and in order to keep revenues within the practice, for example:

(a) In our qualitative research with vets, a few vets interviewed at independents reported rarely making referrals to vets outside the practice, as they had a high enough level of expertise within the clinic to manage most cases internally. The only examples of this in vets working at LVG practices came from those at hospitals that provided first opinion care.[359]

(b) Our qualitative research also found that a few veterinary surgeons from independents provided examples of offering treatment or procedures within the FOP rather than referring, as the price of referral was deemed too high by the pet owner.[360]

(c) In the Manchester roundtable, one attendee said that clarity and transparency of referrals were not just a corporately owned issue, as they knew independent practices which had omitted communication of some referral options so they could keep the treatment within the practice.[361]

(d) An LVG [✂] listed the competitive pressures its [✂] referral centres faced, noting the following: ‘Advanced Practitioners in FOPs performing more complex surgeries also leads to a change in the caseload for [✂] specialists. […] the LVG [✂] notes that the nature of the casework between specialist veterinary surgeons and Advanced Practitioners has historically differed, where specialists performed a greater number of technical and highly challenging procedures (e.g. complex fracture repairs and spinal surgery) and Advanced Practitioners perform more routine procedures (e.g. TPLOs and TTAs)’.[362] The LVG [✂] additionally submitted that ‘[s]trategies adopted by certain third-party veterinary groups to keep referrals within the same

[358] Qualitative research with veterinary professionals, p. 46.
[359] Qualitative research with veterinary professionals, p. 43.
[360] Qualitative research with veterinary professionals, p. 44.
[361] Summary of roundtable discussion held in Manchester, paragraph 15
[362] [✂] LVG response to RFI9, Question 10, paragraph 20. [✂]

group (leading to a reduction in cases referred to LVG [✂] Referral Centres)' is a competitive pressure.[363]

3.113 We consider that is important, where applicable, to ensure that pet owners are aware of the options to treat a pet within a FOP and at a referral centre, and for the pet owner to understand the differences in cost involved in each option where the treatment offered is the same (albeit it would be carried out by a different vet). Where there is a significant difference in costs, it is particularly important that they are told about these differences.

Potential risk of competitor or customer foreclosure

3.114 In this section we consider the risk of competitor and customer foreclosure that could, in principle, arise when there is self-preferencing. As noted in the introduction, as well as foreclosure of referral centres, we also consider foreclosure of diagnostic labs. Foreclosure could arise in the following ways:

(a) Self-preferencing by vertically integrated vet providers could potentially lead to the foreclosure of competing non-vertically integrated diagnostic labs and referral centres. That is, independent referral centres and diagnostic labs may find it more difficult to supply their services to FOPs (and their customers) given the increasing numbers of FOPs being part of vertically integrated groups; and

(b) Independent FOPs could also be foreclosed if they find it more difficult to secure referrals. This could occur if the referral centres that are owned within integrated groups have weaker incentives to serve consumers of these FOPs.

3.115 We present below the limited evidence we have received so far on the risk of foreclosure of independent referral centres, independent laboratories and FOPs.

Any risk of foreclosure of non-vertically integrated referral centres and diagnostic labs does not appear to be a widespread risk

3.116 Some independent referral centres submitted that corporate acquisitions of FOPs and subsequent self-preferencing have led to a reduced workload for the independent referral centre, as well as reduced access to treatment at local referral centres by the customers of vertically integrated practices. However, the number of independent referral centres informing us of such concerns is limited. At this stage, we have not received any evidence of independent referral centres

[363] [✂] LVG response to RFI9, paragraph 20. [✂]

closing due to reduced workload arising from increasing within Group referrals at integrated groups.

(a) An independent referral centre submitted that it does not see referrals from a large group's FOPs, as this group focuses on referring within group, whereas a different neighbouring LVG's FOPs [✂] refer many cases.[364] We note that this referral centre is based on an island where no other referral centres are based, therefore customers of the LVG FOPs are travelling substantially further for their referrals and incurring the cost of the ferry to the mainland, as well as adding to the stress and discomfort of the ill or injured pet being transported a long distance, including time being left on its own below deck.

(b) An independent chain submitted that: 'As all our local referral centres are corporate owned, they prioritise appointments for [clients of] their own [FOPs] and will only see our clients if they can fit them around their own'.[365]

3.117 Some independent laboratories submitted that vertically integrated LVGs which had acquired FOPs had been sending fewer samples for testing (and using their own laboratories instead). Only one independent laboratory indicated that this was affecting its ability to provide a competitive offering.

(a) One independent laboratory submitted that 'Corporate groups having their own laboratory offering has significantly reduced the available market for independent laboratories to service within the Household Pet market […] One side effect of this is that, due to reduced volumes in areas where large corporate groups are present that we do not serve, we are unable to provide courier services for independent practices as doing so for a small number of customers would be cost prohibitive. This means that we are increasingly unable to provide a competitive offering to our independent customers.'[366] It additionally submitted 'Corporate groups [are] acquiring independent practices and requiring or encouraging them to use their preferred laboratories or the corporate group's own laboratory',[367] and '[w]e cannot compete with [two LVGs] [✂] for access to their referral work as their practices are instructed to use their own laboratory. [An LVG] [✂] allow their practices to use other laboratories, but they are encouraged to use their own in-house offering'.[368]

(b) One independent laboratory submitted that: 'a number of FOPs that used to generate significant revenues now submit only rarely. Against that there is testing that only [independent laboratory] are able to provide or where we are

[364] [✂] Independent response to RFI1, p. 5 [✂]
[365] [✂] Independent response to RFI1, Question 14. [✂]
[366] [✂] Independent Diagnostic Laboratory response to RFI1, Question 5. [✂]
[367] [✂] Independent Diagnostic Laboratory response to RFI1, Question 7.
[368] [✂] Independent Diagnostic Laboratory response to RFI1, Question 11.

one of a small number of providers and laboratories such as [independent laboratories] [✂] send samples to us for testing in those cases'.[369]

There is no significant concern of non-vertically integrated FOPs being foreclosed from accessing referral centres

3.118 We have not seen evidence from independent FOPs that suggests that they, or their customers, are finding it difficult to access referral centres. Vertically integrated referral centres would be likely to have incentives to serve a wide range of customers given the high fixed costs of referral centres as noted above by two LVGs [✂].[370] We know that a significant proportion of the customers of vertically integrated referral centres are from FOPs outside of the referral centre's group:

(a) At an LVG [✂], the proportion of referral revenues generated from non-[✂] sites has increased consistently over time from [50-60]% [✂] in FY2020 to [60-70] [✂]% in FY2024.[371]

(b) At an LVG [✂], in FY2023, the share of referral revenue from non-[✂] sites to the LVG's [✂] dedicated referral centres that record the referring FOP was [50-80]%, which has been relatively stable over time. For the LVG's referral centres that also offer FOP services, the average share of referral revenue from non-[✂] sites was [50-80]%.[372]

(c) [✂] submitted data on its referral centres, which showed that the share of revenue from the non-[✂] FOPs have been around 90% since 2020.[373]

(d) For another LVG [✂], referrals from non-[✂] FOPs accounted for more than 50% [✂] of revenues in FY2023 and more than 50% [✂] in FY2024.[374]

(e) At another LVG [✂], referrals from non-[✂] FOPs accounted for 97% to 84% of the referral revenues at each of its referral centres, (except for one site within a multisite practice, with pre-existing links to other sites within the practice before acquisition by the LVG, from where it continues to receives the bulk of its referrals, such that the percentage of referrals from non-[✂] FOPs was 15%).[375]

[369] [✂] Independent Diagnostic Laboratory response to RFI1, Question 7[✂]
[370] See paragraph 3.110
[371] [✂] LVG response to RFI9, Question 14, paragraph 28 and Table 6. [✂]
[372] [✂] LVG response to RFI9, Question 14, paragraph 14.3. [✂]
[373] LVG submission [✂], [✂] report, August 2024 pp. 5-6. [✂]
[374] [✂] LVG response to RFI9, Question 14, p. 23, footnote [✂]
[375] [✂] LVG response to RFI9, Question 14, pp. 19-21. [✂]

Our emerging view on effects of competition in referral services and vertical integration

3.119 Our emerging view is that some vertically integrated groups may be favouring their own referrals services in way that has the potential to be detrimental for consumers and competition in the supply of referral services. At this stage, however, we have not found direct evidence of such detriment arising that is specific to self-preferencing.

3.120 The potential for detriment may be a broader issue than self-preferencing by vertically integrated groups as there is evidence that some pet owners at all types of FOP, whether vertically integrated or not, are not being given sufficient information about a range of referral options. A potential concern is that this may result in worse outcomes for pet owners and lead to weak competition in the supply of referral services.

3.121 When there is vertical integration between FOPs and referral centres, there is also a possible concern that this could result in the foreclosure of non-vertically integrated FOPs or referral centres. At this stage in our investigation, the available evidence suggests that the risk of such foreclosure is not a widespread or significant concern. The available evidence also suggests that the risk of foreclosure of diagnostic labs is not a widespread or significant concern.

Our emerging view on competition in the supply of referral services and the effects of vertical integration

3.122 In relation to competition in referral services, at this stage in our investigation, we have limited evidence on whether consumer detriment is arising that is specific to FOPs at vertically integrated groups favouring their own referral services, that is any consumer detriment specific to self-preferencing. At this stage, the evidence we have on self-preferencing is mostly limited to suggesting that there may be an ability and incentive to self-preference in a way that could be detrimental to consumers and competition.

3.123 Providers’ normal incentives to make and maximise profits can include incentives to acquire referral services. Those incentives can produce good outcomes for consumers where the operation of the services is subject to competitive constraints from consumers who are able to make informed choices between them. There can be benefits of referrals being carried out within the same group in terms of continuity of the care given to pets and efficiencies which may be passed on to consumers in the form of lower prices. We are not concerned where in-group referrals deliver these benefits or where in-group referrals meet pet owners’ needs (including on price) just as well as external referral providers.

3.124 Where concerns can arise is where the competitive constraints are not as strong as we would expect in a well-functioning market. That may be the case where sufficient options and suitable recommendations are not being presented to pet owners. These concerns are likely to be compounded as we identify in our working papers on **How people purchase veterinary services** and on the **Regulatory framework for veterinary professionals and veterinary services**, due to possible weaknesses in the way pet owners respond to the services and prices they are offered or limitations in the effectiveness of regulation.

3.125 In those circumstances, the effect could be that some in-group referrals are influenced by the commercial considerations of a vertically integrated provider when the pet owner might have made a different choice that better suited their needs and preferences had they been offered greater choice or a more suitable recommendation. For example, a pet owner may have preferred to use a referral centre closer to their home, or one that was less expensive. These kinds of in-group referrals can be seen as detrimental self-preferencing by providers.

3.126 Detrimental self-preferencing also has the potential to contribute to weak competition between referral services and higher prices of these services than we might expect in a well-functioning market. It can mean that referral centres that are integrated with FOPs need not compete as aggressively for consumers as they would otherwise.

3.127 We have examined the vertically integrated LVGs' incentives and abilities, identifying those which indicate the potential either for the kinds of efficiencies described above or for more harmful self-preferencing which might result in consumers having fewer choices and paying higher prices. We identify the potential for the latter in some evidence we have seen that some integrated groups are, to differing extents, seeking to use their FOPs to direct consumers to their own referral centres, hospitals and hubs for more complex and specialised treatments. For example, we have seen evidence that:

(a) self-preferencing in referrals is an important motivator in LVGs' acquisition strategies (albeit to varying extents depending on the relevant LVG);

(b) some integrated groups set targets around the percentage of referrals that are referred in-group; and

(c) some vets and vet nurses are sometimes encouraged to refer in-group.

3.128 However, we have not seen evidence, at this stage, to assess whether this potential has been realised and led to harmful effects. One important indicator could be the level of profitability of referral centres in vertically integrated groups. We intend to assess that but have not yet done so.

3.129 Another indicator would be evidence of non-vertically integrated FOPs being foreclosed from accessing vertically integrated referral centres for their customers, and of non-vertically integrated referral centres being disadvantaged in terms of being able to access customers who are referred from a range of FOPs. At this stage of our investigation we have not seen significant evidence that either of these types of foreclosure are occurring.

3.130 Our assessment is not limited to whether there are vertical effects arising from detrimental self-preferencing. A broader potential concern that we are assessing is whether pet owners at all types of FOP (whether vertically integrated or not) are being given sufficient information about the range of referral options available and a recommendation that best suits their needs. We are concerned that this may not be the case in some pet owners' experiences, with the possible result that there could be weak competition in the supply of referral services. The evidence available related to assessing this potential concern includes:

(a) in our pet owner survey, 62% of respondents who were recommended a referral to another practice said they were not given a choice of referral centre; and

(b) responses to this survey also show that there is a lack of transparency about the potential costs of a referral treatment, and about the ownership of referral centres.

3.131 The RCVS guidance on its regulatory professional code of conduct (**Code**) says that vets should have regard to all relevant factors when considering referring, including the ability and experience of the referral vet, location, urgency, and the circumstances and financial situation of the owner. In light of the evidence we have seen so far, it is not clear to us how effectively this guidance is observed and whether regulation is providing an effective constraint on the way vet businesses are operating.

3.132 We intend, where we can, to explore what further empirical analysis to undertake on the degree of self-preferencing, and to assess its effects on treatment intensity, pricing and quality of care.

4. Consideration of Remedies

4.1 Should we identify an AEC, we are required to consider which, if any, action we should take to mitigate or remedy this, whether through direct action ourselves or recommendations to others.[376]

4.2 On 9 July 2024 we set out in our Issues Statement potential remedies we were considering and invited views on those early remedy proposals. We have considered submissions that were made to us in response to the Issues Statement and are at the early stages of further developing our thinking on possible remedies, and/or a possible remedies package. We intend to publish a working paper in Spring 2025, setting out our emerging views on possible remedies and inviting written comments.

[376] FN Enterprise Act 2002, section 134(4).

5. Responding to this working paper

5.1 Any submissions must be provided no later than **5:00pm on Thursday 27th February 2025** by emailing: **VetsMI@cma.gov.uk**.

5.2 We intend to publish all responses from businesses and other organisations on our case page except those marked as confidential. Please clearly highlight any confidential information in your submission and provide a non-confidential version of your submission for publication.

5.3 We may decide to publish anonymised submissions from individuals on our case page. Please clearly mark your submission as confidential if you do not want it to be published and let us know if you would prefer not to be named.

5.4 We will redact, summarise, or aggregate information in published reports where this is appropriate to ensure transparency whilst protecting legitimate consumer or business interest. While the information you provide will primarily be used for the purposes of this market investigation, where appropriate, we may also use information provided as part of this consultation in relation to the CMA's other functions. For example, we may share your information with another enforcement agency (such as local Trading Standards Services) or with another regulator for them to consider whether action is necessary.

5.5 Personal data received in the course of this consultation will be processed in accordance with our obligations under the UK GDPR, the Data Protection Act 2018, and other legislation designed to protect individual privacy.

6. APPENDIX A: Treatment Analysis: Data Sources and Methodology

6.1 In this Appendix we describe some data received from the LVGs and from [✂] on independents (including limitations of the data), and the methodology used to clean and analyse the data (including caveats) presented in our working paper on **Business models, provision of veterinary advice and consumer choice**.

Data description and limitations

Large Veterinary Groups

6.2 We collected data from the LVGs for each of their FOPs on the following: every individual treatment offered at least once in 2023 (financial year), the total number of times the treatment was billed in FY2023 and the revenues generated from each treatment in FY2023. The data also includes a snapshot of the price of each treatment for a specified date in early December 2023. Treatments include any services provided for diagnosing or treating a Household Pet, including any routine treatments and aftercare offered. Treatments do not include medicines or any items or consumables which do not require a consultation, health check or prescription first.

Data limitations

6.3 There are a number of key data limitations of the treatment information provided it is worth noting, which might affect analysis:

(a) Although the corporate groups were required to standardise treatment names in use across FOP sites, many different treatment names are used across FOP sites owned by the same LVG, so standardisation was limited in practice.

(b) The use of treatment names varies within as well as between LVGs. This can be due to varying extents of treatment bundling (providing multiple procedures under one treatment code). For example, some FOPs will bill all procedures conducted in a consultation as one ‘Consultation’ whereas other will bill a charge for a consultation in addition to the charges of individual treatments.

(c) Due to the volume of individual treatments in use across FOP sites, the LVGs were unable to provide the CMA with descriptions of all treatments in use. We have therefore made some assumptions on what constitute treatments based on the treatment names alone.

(d) The CMA requested that the data exclude consumables, but due to treatment bundling some fees may still include consumable items.

6.4 The LVGs were unable to provide information on all of their FOPs:

(a) Historic data on FOPs owned by an LVG [✂] is limited (for the periods prior to their acquisition by the LVG). Within the time available, the LVG was able to provide data for the [✂] FOP sites using its [✂], representing around [✂] of the LVG's [✂] FOPs with a small animal focus.[377] [✂] submitted the following on the impact this would have on the overall representativeness of the data:

(i) The included sites are largely geographically representative, except for coverage of London, Southeast England, South West England and Northern Ireland.

(ii) The included sites are representative of the LVG's [✂] small to medium-sized FOP sites but limited in terms of representation of its [✂] multisite practices, specifically those with an annual turnover of more than £20 million, more than 50 FTE staff and/or more than 10 sites. There are three [✂] practices which fall under this 'larger muti-site practices' category.[378]

(b) An LVG [✂] was only able to provide data for the 80% of its [✂] (groups of practices operating under the same brand) that operate unified treatment coding.[379]

(c) Data provided by an LVG [✂] excludes 22 recent acquisition sites (which account for less than [✂]% of [✂]'s total FOP sites).[380]

(d) Data provided by an LVG [✂] excludes [✂] UK FOP practices that are not on its [✂] PMS for the full calendar year 2023 to date at the time of the information snapshot (12 December 2023). These sites account for approximately 8% of UK FOP sites owned by the LVG [✂].[381]

(e) Data submitted by an LVG [✂] excludes some sites that it was not able to provide full year data on.[382] It did not specify the number of sites this applied to, but we estimate that we have data for approximately 73% (or [✂] out of [✂]) of its FOP sites.

[377] [✂] LVG response to RFI8 p. 2. [✂]
[378] [✂] LVG response to RFI8, pp. 2-3.
[379] [✂] LVG response to RFI8, paragraph 1.2
[380] [✂] LVG response to RFI8, p. 2. [✂]
[381] [✂] LVG response to RFI8 paragraph 1.5; CMA analysis of data submitted by [✂]
[382] [✂] LVG response to RFI8, p.1.

6.5 The LVGs submitted that there may be some limitations about the data accuracy of the information that was provided. In particular:

(a) For its FOP sites which also provide referral services, an LVG [✂] submitted that it was likely that some revenues from referral work are included in the data, due to inconsistent use of treatment codes, and that the revenue figures provided should be taken as the upper-bound of the true value of revenue from first opinion services. It noted that this applied especially to its FOP practices performing only a small amount of referral service work (or with a small amount of visiting specialists) will be less likely to record referral treatments accurately, and the extent of any overstatement of first opinion services revenue could be larger.[383]

(b) An LVG [✂] was unable to provide snapshot pricing data on a single day in early December 2023 for all treatments billed in 2023. It therefore instead provided the sale price charged in the last instance of the treatment sold before the 8th of December 2023.[384]

(c) An LVG [✂] was unable to provide snapshot pricing data for all treatments billed in 2023. It instead provided the modal price for each treatment billed in 2023.[385]

(d) Two LVGs [✂] provided total revenues by FOP site rather than per treatment per site. Therefore, for these veterinary groups, a proxy of treatment revenues was calculated by multiplying total volumes sold in 2023 with the December 2023 snapshot prices in the case of [✂], and the 2023 modal price in the case of [✂].[386]

[✂] Independent practices

6.6 [✂] is a consultancy business advising independent veterinary practices who need help developing their business or work-out their exit strategy when they are in the process of being acquired by an LVG. As part of their services, they collect two years of their client's Practice Management System's data to gather insights on their financial performance and pricing strategy.[387] We requested access to some data [✂] holds on independent practices in order to make comparisons with the data we received from the LVGs.

6.7 Data for independent FOPs in 2023 obtained from [✂] covered around 320 sites and contained over 13 million individual observations, including information on the

[383] [✂] LVG response to RFI8 pp. 4-5. [✂]
[384] [✂] LVG response to RFI8 pp. 2-3.
[385] [✂] LVG response to RFI8, paragraph 1.3.
[386] [✂] LVG response to RFI8 [✂]; [✂] LVG response to RFI8 [✂]
[387] [✂] Teach-In Note, p. 1. [✂] website accessed 22.01.2025.

practices, daily transactions for each practice, and pet information for each transaction.

Data limitations

6.8 [✂] submitted that there were likely to be several important limitations of their data, with the main one being that the independent practices covered in their dataset may not be fully representative of independent practices overall and suggested that the independents in their sample might be 'better than average' in terms of financial performance.[388] This may have implications on the treatment mix and pricing data in the sample, namely that the selection of independent FOPs may likely to be skewed towards higher price points and more expensive treatments than the average independent practice.

6.9 This data, although similar in nature to that submitted by the LVGs, was not presented under the same format. The methodological caveats that arise from these differences relevant to our analysis are:

(a) The data included some sales other than those relevant for small animal FOP services. We manually removed out-of-scope information such as sales information concerning Farm Animals, medicines and information not obtained from the LVGs (for example disposal of medical waste).

(b) We used strings (sequences of characters) to group observations into the same treatment groups we used for the LVGs, as described in paragraph 6.3(a). For instance, any iteration of the string 'consult' would be allocated to the 'Consultations' category. We have standardised these with the grouping used for LVGs to the extent possible. However, this may mean that if the naming conventions between the [✂] and LVG data differ, some category groupings may include too many or too few observations (if [✂] used wider or narrower naming conventions than LVGs respectively).

(c) Finally, in two instances, the observations provided or summarised were visibly erroneous (in particular, very large figures) and biasing the results. To alleviate this concern, we excluded the top and bottom 1% of observations in datasets where there were outliers, however these exclusions do not affect the 2023 results in the working paper.

Analysis methodology

6.10 We conducted the following analysis in our working paper on **Business models, provision of veterinary advice and consumer choice**:

[388] [✂] Teach-In Note, p. 1.

(a) The number of, and revenues from, treatment groupings sold in FOPs in 2023

(b) The average number of treatments and average revenue per active pet in 2023 for FOPs

(c) The proportion of each of cats, dogs and other household pets falling into revenue brackets in 2023

The number of and revenues from treatment groupings sold in FOPs in 2023

6.11 We used the information collected from LVGs and from [✂] on independents described in paragraph 2.45 to conduct this analysis. We used this data to summarise and group treatments into broad treatment categories, making comparisons between the LVGs and independents.

6.12 In conducting the analysis, treatment groupings used by the LVGs and independent FOPs were matched to create consolidated treatment groups. This matching process was not exact and involved some assumptions on which procedures related to which treatments based on their stated names.

6.13 We note that for some of the below treatment groupings (such as Consultation and Non-Surgical Procedures), many vet businesses would not use such categorisations and would list individual treatments separately. However, these treatments have been combined for the purposes of our analysis.

6.14 Generally,[389] for the treatment groupings specified in the graphs in Figure 2.6 (see Section 2 above), treatment groupings refer to the following:

(a) Dispensing and Injection fees refer to any fees charged for the dispensing of medication (excluding the charge for the medication itself), prescription fees or fees charged for administering injections.[390]

(b) Consultation refers to the fee charged for a consultation, as well as any routine treatments commonly carried out within a consultation (for example nail clipping, ear cleaning, microchipping etc).

(c) Vaccination refers to the fee charged for administering any kind of vaccination and often includes the fee charged for an accompanying health check.

[389] As noted, inconsistencies in data reporting both within FOPs of the same group and between FOPs of different groups mean that treatment categories are not entirely consistent.
[390] Note that data submitted by [✂] does not include a treatment group for dispensing and injection fees, nor an individual treatment name for either of these procedures. We assume that this is instead billed as part of the consultation fee.

(d) Hospitalisation refers to the fee charged for the care of a pet requiring monitoring within the FOP. This fee is usually charged per time period, for example per 12 or 24 hours.

(e) Other refers to fees for house visits, grooming, administration, rehabilitation, certificates, acupuncture, homeopathy, hydrotherapy, physiotherapy and other miscellaneous treatments.

(f) Laboratory External refers to the fee charged for diagnostic tests provided by external laboratory providers (for example Idexx, Axiom etc).

(g) Laboratory Internal refers to the fee charged for diagnostic tests provided in-house.

(h) Non-Surgical Procedures refers to treatment conducted outside of an operating theatre, for example bandage application, emptying anal sacs.

(i) Anaesthesia refers to the fee charged for inducing and maintaining any kind of anaesthetic.

(j) Surgery refers to the charge for any treatments involving an incision into the pet in some way.

(k) Euthanasia and Crematoria refers to any fees charged relating to the euthanasia and/or cremation of a pet.

(l) Diagnostic Imaging refers to fees charged for treatments such as x-ray (excluding dental x-ray), ultrasound and CT/MRI scans which are used to produce images of the internal structure of an animal's body.

(m) Fluid Therapy refers to the set up and maintenance fees charged for administering fluids, for example blood transfusions and intravenous fluid set up/maintenance.

(n) Dentistry refers to any fees charged for dental procedures, including dental x-rays.

(o) Neutering refers to the fee charged for spay and castration procedures.

6.15 There were some potential differences in the information gathered by [✂] compared to the LVGs which might affect this analysis, the most notable being that some treatment groupings either were not present or were present only to a limited extent compared to the LVGs. On the other hand, there were many treatments that were put in the 'Other' category for [✂] data.

The average number of treatments and average revenue per active pet in 2023 for FOPs

6.16 We used the information collected from LVGs from [✂] on independents described in paragraph 2.45 to conduct this analysis.

6.17 The information received from LVGs was at a higher level of aggregation than that of the [✂] data. Therefore, in order to make a meaningful comparison between the two datasets, the following steps were taken to align the [✂] data to the LVG data:

(a) The [✂] data on treatment price and quantity was grouped by FOP site. These figures were then divided by the number of pets that received a treatment in this FOP site in 2023. For both LVG and [✂] data, the top and bottom 1% of practices by number of pets were excluded from the analysis, to remove any obvious inconsistencies (i.e. practices showing no or a negative number of pets, or an obviously excessive number of pets).

(b) For both LVG and [✂] data, each FOP site's quantity and revenue figures were then weighted by the number of pets that received a treatment in this practice in 2023. As a result, practices with a higher number of pets are weighed more heavily in the average number of treatments per practice and average revenue per practice figures, for better representativeness.

The proportion of each of cats, dogs and other household pets falling into revenue brackets in 2023

6.18 We received information from the LVGs on the proportion of each of cats, dogs and other household pets falling into revenue brackets in their 2023 financial year. We used this information for the LVGs, excluding pets that did not generate any revenues in 2023 and revenues generated from pet care plans, which were not attributable to any individual pet.[391] FOPs were weighted equally.

6.19 We used the information received from [✂] and summarised this to be in the same format as what we received from the LVGs, similarly excluding pets that did not generate revenues in 2023. This involved separating data from dogs, cats and all other animals, computing the sum of all treatments for each individual animal, and then counting the number of animal fitting in each of the categories in Figure 2.5.

[391] See LVG response to RFI11 [✂], paragraph 3.2 and LVG response to RFI11 [✂] paragraph 4.3.

7. APPENDIX B: Analysis of an LVG's [✂] acquisition modelling

Introduction

7.1 In this Appendix we:

(a) Describe the financial modelling carried out by [✂] in support of the acquisitions it has pursued over the last five years; and

(b) Present the sensitivities that we have implemented, in which we test the effect of removing cashflows from in-group referrals on the expected internal rate of return (IRR) from completed acquisitions.

[✂]'s internal financial modelling

7.2 In this sub-section, we set out a brief overview of the models provided by [✂].

[✂] models

7.3 We requested that [✂] provide:

(a) Details of all acquisitions made covering any of the Relevant Activities since 1 January 2019; and

(b) Relevant internal documents, including any investment appraisals or other financial models associated with its acquisitions.[392]

7.4 In response, [✂] told us that it had completed [✂] relevant acquisitions since 2019 and provided the financial models used in assessing the value of each acquisition.[393]

7.5 Our review of [✂]'s financial models shows that:

(a) [✂] assesses potential acquisitions on a discounted cashflow (DCF) basis, calculating the expected net present value (NPV) and IRR from acquisitions of new sites.

(b) Its models typically consist of two forecasting periods: an explicit forecast period and an implicit forecast period. The explicit forecast period includes detailed assumptions about [✂].

[392] [✂] LVG response to RFI3, dated 14 June 2024, Q36 [✂].
[393] [✂] LVG response to RFI3, dated 14 June 2024, Annex 36 [✂].

(c) the implicit forecast period uses [✂] to project future cashflows from that point.

7.6 We note in particular that the explicit forecast period in [✂]'s DCF models included detailed forecasts of the future cashflows it expected to generate from target sites and that these forecasts included synergies from [✂].

7.7 This breakdown allowed us to carry out preliminary financial analysis which can be used to inform our understanding of the strength of the incentives to refer in-group. Specifically, it allows us to modify [✂]'s models to remove the cashflows associated with in-group referrals and to observe how this affects the NPV/IRR of a given acquisition (such as to observe the NPV/IRR in the absence of the cashflows from in-group referrals).

7.8 We then compare the 'modified IRR' against the cost of capital included in [✂]'s model for each acquisition, noting the following:

(a) Investment projects that earn an IRR that exceeds the cost of capital will have a positive NPV and add to shareholder wealth.

(b) Investments that earn less than the cost of capital make shareholders worse off and should not be pursued.[394]

Modifications to [✂]'s modelling

7.9 In this sub-section, we present the modifications to [✂]'s DCF models that we implemented to assess the strength of the incentives to refer in-group.

Our analysis: approach

7.10 For illustrative purposes, we show in this Appendix the modifications that we made to the [✂] model in respect of one particular acquisition, [✂]. We performed the same analysis in respect of the other [✂] acquisitions completed by [✂] since 2019.

7.11 An extract from [✂]'s DCF analysis for [✂]is shown in Figure 5.1 below. Figure 5.1 shows the projected cashflows over [✂] years of ownership.[395]

Figure 7.1 [✂] Financial model extract, [Name of acquired practice] [✂]

[✂]

Source: [✂], Response to RFI3, question 36, Appendix 36.48.

[394] See for example Brealey, Myers and Allen, Principles of Corporate Finance, tenth edition, p. 747.
[395] [✂].

7.12 Figure 7.1 shows that [✂] projected core EBITDA for the practice before [✂]. It shows that [✂] anticipated an IRR of [✂]% and an NPV of £[✂] from its acquisition of [✂]. The cost of capital used in the model for [✂] was [✂]%.[396]

7.13 To inform our understanding of the strength of the incentives to refer in-group, we modified [✂]'s model to remove the cashflows associated with in-group referrals and observed the effect on the IRR. [✂]. The results of this analysis are shown in Figure 7.2 below:[397]

Figure 7.2 [✂] Financial model extract, [✂] (CMA modifications)

[✂]

Source: [✂], Response to RFI3, question 36, Appendix 36.48 and CMA analysis.

7.14 Figure 7.2 shows that, absent these revenue synergies, the projected IRR for [✂] would be [✂]. That is, a return below the cost of capital ([✂]%) and an investment proposition which would yield a negative NPV of approximately £[✂].

Our analysis: results

7.15 As [✂] carried out similar financial modelling in respect of all acquisitions completed in the last five years, we have been able to carry out the same analysis described above for the remaining [✂] acquisitions completed in that time.

7.16 Table 7.1 below shows the results of our analysis for all of [✂]'s acquisitions. It shows:

(a) The date of acquisition;

(b) The cost of capital used in each financial model;

(c) The base case IRR modelled by [✂];

(d) The modified IRR calculated by the CMA (which assumes no vertical integration); and

(e) The differential between (b) and (d).

[396] [✂], LVG response to RFI3, question 36, [✂]
[397] Note this assumes no referral fees are received by [✂].

Table 7.1 Outcomes from modifications to [✂] DCF models (all acquisitions since 2019)

Name of target	Date acquired	Cost of capital	IRR base case [✂]	Modified IRR (CMA)	Differential (Modified IRR vs cost of capital)
[✂]	[✂]	[✂]	[✂]	[✂]	[✂]
[✂]	[✂]	[✂]	[✂]	[✂]	[✂]
…	…	…	…	…	…

Source: [✂], Response to RFI3, question 36 and CMA analysis.

7.17 From Table 7.1, it can be seen that, without the ability to direct patient flow, a third of [✂]'s recently completed acquisitions would have an expected IRR below the cost of capital at the realised purchase prices.

7.18 For completeness, we also show the projected NPV of each acquisition inclusive and exclusive of [✂]'s referral synergies in Table 7.2 below:

Table 7.2: Projected NPV of [✂] acquisitions since 2019, including and excluding referral synergies

Name of target	*Date acquired*	*NPV*	*NPV (without referral synergies)*
[✂]	[✂]	[✂]	[✂]
[✂]	[✂]	[✂]	[✂]
…	…	…	…

Source: [✂], Response to RFI3, question 36 and CMA analysis.