IVC response to CMA Working Papers published on 6 February 2025 - APPROACH

1. By way of response to the CMA working papers published on 6 February 2025, IVC Evidensia submits the following presentation, together with the Annexes and underlying data packs referenced at the end of the slide deck (see slide 90A).
2. The original version of this slide deck, shown using a green colour scheme, was presented to the CMA at the IVC Evidensia hearing on 3 March 2025 (and sent to the CMA on 28 February 2025). This version (dated 21 March 2025) is supplemented by annotations, shown using a blue colour scheme. Annotated and new slides are also identified by a blue box in their top right corner.
3. The annotations in this deck address key issues raised (and information requested) by the CMA at the hearing, and the most salient emerging views and evidence contained in the CMA working papers. They reiterate key evidence showing that: (a) competition in the vet sector (from LVGs and independents) is robust across a range of factors, including price and quality; (b) higher prices are driven by higher costs and increased quality; and (c) corporate ownership has brought substantial benefits to vet clinics' staff, patients, and clients – despite an often challenging macro-environment.
4. IVC recommends that this annotated deck be read alongside the IVC hearing transcript, given the important additional context provided by the IVC speakers' presentation and responses to the CMA's questions.
5. IVC summarises below its key reflections (addressed in more detail in the annotations for each working paper) on three priority themes discussed at the hearing: (A) quality; (B) veterinary medicines; and (C) regulation.

NEW SLIDE

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IVC response to CMA Working Papers published on 6 February 2025 – PRIORITY THEMES

(1) Quality

- Quality is an important part of 'care reassurance', which clients consider when choosing FOPs. But quality can mean lots of different things in veterinary care (e.g. clinical outcomes, service quality, facilities, equipment, client satisfaction), and there is no 'one measure' to capture all of these.
- IVC closely monitors, and makes available externally, several measures that reflect quality (e.g. Positive Pawprint report, PSS certification, Google Business reviews etc.).
- These measures show that IVC maintains high quality standards, which are reflected in high customer satisfaction.
- **IVC would welcome - and is ready to contribute to building - a robust, meaningful, and practical industry-wide measure to enhance quality transparency for clients.**

(2) Medicines

- IVC in-clinic medicine prices reflect medicines' necessary contribution to IVC clinics' overall cost base and profitability, and the added value offered to clients by dispensing and administering on-site. Clinics must always remain price-competitive - across treatment and medicines – to win and retain clients.
- Medicines are complementary goods to treatments, which in part drives the cross-subsidy historically observed across the market. A market-wide reduction in medicine pricing will lead to a rebalancing towards higher treatment prices via economic mechanisms driven by the continued growth of online (already well in train, and prompting a competitive response from IVC) - and/or via CMA transparency remedies.
- IVC private label is not intended to, and does not have the effect of, creating barriers to switching. These provide: (A) cost savings, which are passed on to clients, and (B) clear sustainability and security of supply benefits - but clients can and do identify and purchase branded alternatives.
- **However, IVC is willing to contribute to the development of meaningful, practical industry-wide measures that further enhance transparency for clients on medicines prices and branded alternatives to private label products.**

(3) Regulation

- **IVC is supportive of regulatory reform to address the key issues identified in the WP:**
  - **RCVS remit** – extension beyond the regulation of veterinary surgeons, in a framework that is pragmatic, clear and principle-based (including by making the PSS mandatory).
  - **Staffing challenges** – to be eased by: (A) reducing regulatory limits on para-professionals, especially veterinary nurses, to enable them to carry out a wider range of delegated clinical tasks; and (B) Government intervention to lift restrictions on hiring from the EU.
  - **Monitoring and enforcement powers** – through better resourcing of RCVS's regulatory functions and appropriate RCVS governance reform to increase its efficacy.
  - **Consumer redress and complaints** – IVC has an effective in-house complaints process which provides quick resolution to clients; supportive of early pathways for escalations through an effective third-party mediation scheme where needed.

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IVC Response to CMA Working Papers published on 6 February 2025 – NEXT STEPS

1. Per its reflections on priority themes, IVC recognises that industry-wide challenges remain, and is committed to working collaboratively with the CMA Panel and case team to find meaningful and workable industry-wide solutions, as soon as possible – for the benefit of pet owners, patients, veterinary professionals, and the industry.

2. However, remedies should be proportionate and limited (in time and scope) to what is necessary to achieve this – and should provide legal certainty to the veterinary sector, to avoid discouraging investment.

3. IVC considers that the LVGs' remedies proposal submitted to the CMA during the Market Study addresses the majority of these challenges, but recognises there is more to do (see slide 0B) – with a particular focus on developing a robust and accessible quality transparency framework, to help customers better understand the value of vet services offered by different providers, and choose the right proposition for their and their pet's circumstances. IVC looks forward to engaging further with the CMA on these topics.

4. [REDACTED]

IVC Evidensia – CMA Hearing

3 MARCH 2025

[REDACTED]

IVC EVIDENSIA

Today's speakers

[REDACTED]

What we will cover today

1. **Opening statement**
2. **How people purchase veterinary services (WP1)**
3. **Business models, veterinary advice and consumer choice (WP2)**
4. **Analysis of local competition factors (WP3)**
5. **Regulatory framework for veterinary professionals and veterinary services (WP4)**
6. **Competition in the supply of veterinary medicines (WP5)**
7. **Econometrics (WP6)**
8. **Profitability (WP7)**
9. **Closing statement**
10. **Questions**

IVC Evidensia - CMA Hearing

Opening statement

3 MARCH 2025

[REDACTED]

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Background

IVC recognises work and engagement of inquiry group and case team. Also understands some of the factors which prompted MIR...

- Emotive market (and correspondingly high consumer engagement).
- Rapid evolution in provision of care (as per site visit presentation) – higher expectations of vet care and innovative technology.
- Change in ownership structure with growth of corporate groups.
- Price rises in context of "*cost of living*" crisis.
- Concern among vets that industry falling behind the times in certain respects (regulation, training, working practices).

…but working papers have inaccurately presented some findings as LVGs v independents (and wrongly treat LVGs as homogenous mass).

- In truth, market does not operate that way – IVC faces strong competition from both independents and LVGs.
- Implicit presumption that ownership by LVGs is less likely to be consistent with consumer benefits e.g.:
  - Analysis of upselling - not clear why WPs limit this to LVGs ([REDACTED]).
  - [REDACTED]
- [REDACTED]

Myths around corporate ownership not supported by evidence

Number of "myths" around corporate ownership as set out in CMA Issues Statement are not supported by evidence (as shown in CMA working papers).

(1) High concentration "*in part driven by sector consolidation*" (see slides on working paper 3 - 'Local Concentration')

- CMA finds (1) few areas of high concentration; and (2) low barriers to entry and evidence of factual entry.
- Reality is IVC FOPs face strong competition from both LVGs and independents- with significant new entry (facilitated by outsourced OOH often provided by LVG).

(2) "Upselling" by LVGs (see slides on working paper 2 – 'Business Models')

- Not evidenced and no detriment in practice.
- Not clear why WPs limit this to LVGs ([REDACTED]).

(3) Anti-competitive "self-preferencing" by LVGs (see slides on working paper 2 - 'Business Models')

- Not evidenced and no detriment in practice.

N.B.: Clinical autonomy is fundamental to how we operate:

- Key to building **trust with pet owner** (at the heart of how we compete).
- **Key for vets** – vets fiercely protective of their clinical autonomy and judgment (would not tolerate any interference – [REDACTED]).

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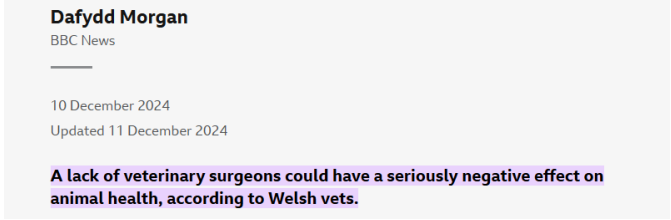
WPs' evidence on price rises is incomplete and anyway not due to weak competition

IVC prices have been driven by higher costs - in particular, pay and benefits (in face of vet shortages and challenges on retention).

- Very substantial increase of [REDACTED] in total clinic staff costs over 2015 – 2023.
- IVC expects that [REDACTED].
- See further slides on working paper 6 - 'Econometrics'.

IVC notes ongoing CMA econometric work - key that this is robust.

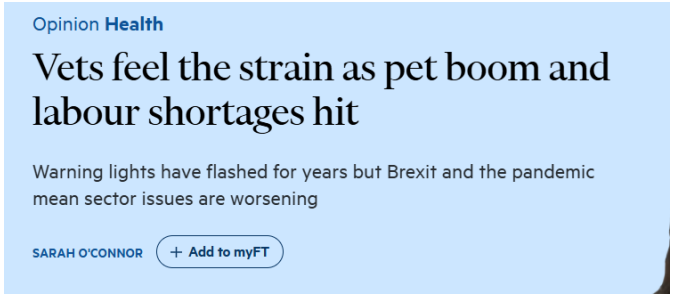
- We have provided strong evidence to challenge initial findings.
- IVC looks forward to engaging further – see slides on working paper 6 - 'Econometrics'.



Dafydd Morgan
BBC News

10 December 2024
Updated 11 December 2024

A lack of veterinary surgeons could have a seriously negative effect on animal health, according to Welsh vets.



Opinion **Health**

Vets feel the strain as pet boom and labour shortages hit

Warning lights have flashed for years but Brexit and the pandemic mean sector issues are worsening

SARAH O'CONNOR + Add to myFT

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Plugging the skills gap in veterinary practice

Written by: Stephanie Malone Published on: 5 Dec 2023

Category: Veterinary view

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Estimating economic profit in this industry is extremely challenging

Working paper now delayed until May: CMA needs to allow adequate time – without delay to the Provisional Findings - to reflect responses to the working papers before PFs.

IVC welcomes CMA's recognition of the challenges of measuring economic profitability (see slides on working paper 7 – 'Profitability') - it is critical that the CMA develops robust methodology to address these.

- **Tangible assets** – not recorded at replacement cost.
- **Intangible assets** – significant and hard to measure.

IVC looks forward to engaging further…

…but given the challenges, if the CMA is unable to develop a robust profitability analysis, **it cannot place weight on this in its assessment of the market.**

Reality is that corporate ownership brings substantial benefits which should be recognised by the CMA

- Regretful that the WPs position analysis as LVGs vs independents.
- In any event, corporate ownership has brought benefits for pets, owners and the workforce (competing alongside independents).
- Working papers currently underplay benefits (see slides on working paper 2 – ‘Business Models’).
- And overplay concerns – including the way in which they present evidence through the prism of LVGs vs independents e.g.:
  - Risks/incentives to upsell (as above).
  - [REDACTED]

CMA also needs to assess further the nature of competition in FOP

CMA agrees that pet owners display high levels of trust in veterinary experts and their advice.

Mutually beneficial (continuity of care) – similar to human health

This is what drives lower levels of switching – but clients who are unhappy can (and do) easily switch. A 3% switching rate implies that [REDACTED] switch away every year.

Nature of rivalry between FOPs – FOPs need to be competitive on retail offer to win and retain clients (see also slides in working paper 2 - 'Business Models').

- **To win clients**: strong competition for new clients (including 'switchers') – including on price (as well as quality) which can be reflected through other metrics (reviews/recommendations).
- **To retain clients**: trust is easily lost (and switching can easily happen) if pet owners think that they are not getting value for money or a good quality of service.

Reality is that client satisfaction (with IVC at least) is very high

[REDACTED]

[REDACTED IMAGE]

NPS – selected consumer facing businesses


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On medicines, we recognise prices in-clinic are out of line with online prices – to subsidise treatment prices

- [REDACTED] (see slides on working paper 5 – 'Medicines'):
  - Clear evidence of **upward trend in online sales** for (repeat) prescription veterinary medicines.

- **There are significant implications for the FOP business model (for LVGs and independents):**
  - Relies on **cross-subsidy from meds to treatments and consults**.

IVC recognises the sector (incl. independents) could do more on transparency – noting that this would further accelerate existing trend (and further challenge the business model).

CMA investigation must be concluded in an expedited manner

IVC recognises CMA effort to date to conclude MIR sensitively – but impact on sector has been very significant.

- Investigation has been running for over 17 months - leading to ongoing uncertainty and intense scrutiny.
- Impact on vet professionals : pervasive and negative media fuelled by investigation has hit morale, and increased anxiety, etc.

But CMA must avoid extending timetable.

- Critical that investigation is now brought to a swift conclusion: key to sector (investment), staff morale (impacted by unhelpful coverage) and consumers (earlier implementation of remedies).
- [REDACTED]

IVC is ready to play a leading part on industry solutions

IVC is not suggesting there isn't room for improvement, in particular in relation to:

- **Better information for consumers; and**
- **More effective regulation.**

IVC wants to be part of the solution - building on Phase 1 proposals. We look forward to engaging further after the remedies working paper.

IVC Evidensia - CMA Hearing

(1) How people purchase veterinary services (demand)

3 MARCH 2025

[REDACTED]

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Overview

- **Choice of FOP** – Clients can shop around effectively.
- **Switching FOPs and nature of competition in FOP** – Lower switching rates not indicative of weak competition. And clients wanting to switch find it easy to do so.
- **Role of pet care plans (PCPs)** – Measurable actual benefits to pet owner (savings) and pet (healthier).
- **Choice of treatments** – Vets clearly communicate choice of non-routine treatments.
- **Role of insurance** – Does not affect options presented to pet owner (only ability for pet owner to choose certain options).
- **Choice of referral specialist** – Pet owners provided with relevant information.
- **Out-of-hours (OOH)** – Working papers fail to recognise nature of the competitive constraint.
- **Euthanasia and cremation services** – Sufficient information provided to pet owners.

IVC recognises that the sector could do more on price transparency and transparency of ownership – building on Phase 1 proposals.

Choice of FOP – Clients can shop around effectively

Many clients do 'shop around' and all can make well informed decisions.

Working paper indicates:

(1) Of those who could recall, **44%** of pet owners surveyed by CMA said that they **considered more than one practice** when choosing a FOP (WP1, 6(a)).

(2) Of those that considered just one practice:

- Only **15%** said that they **did not think about comparing** options (WP1, 5.7(b)).
- When comparing options (the remaining 85%) pet owners considered **a range of factors** including quality of **service and price** in their choice, drawing on both **recommendations** and **online reviews** (WP1, 5.7(b)).

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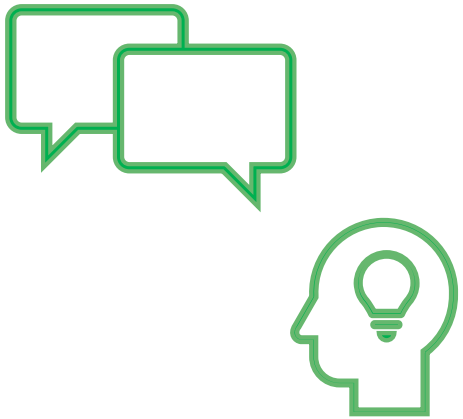
Choice of FOP – Pet owners consider a range of factors (in addition to location), in particular care ‘reassurance’ and price / cost

(1) Care reassurance is an important factor for pet owners.

Owners want to be confident that their pet (and sometimes they themselves) would be well cared for and so **seek out social proof**, i.e. care ‘reassurance’ – factoring in range of trust, service, quality (as well as price) dimensions.

This explains importance of **recommendations and online reviews** to lesser degree (and the social proof element of this).

Pet owners are also influenced by **‘first impressions’ of the practice** (i.e. website, a call, a visit). Pet owners often looking to confirm their choice and recommendations by getting a ‘feel’ for the practice first hand.



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NEW SLIDE

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Choice of FOP – Pet owners consider a range of factors (in addition to location), in particular care 'reassurance' and price / cost

Quality is an important part of 'care reassurance' - which clients consider when choosing FOPs.

'Quality' can mean different things in veterinary care, including:

- Clinical outcomes (e.g. successful treatment, rates of complication, infections);
- Service quality metrics and client experience (e.g. appointment availability, clinical staff empathy/understanding);
- Practice facilities, appearance, and equipment;
- Overall standards as per RCVS PSS accreditation; or
- Client satisfaction, or practice reputation (via word of mouth and client experience), which would likely reflect all of the above.

Although there is no 'one measure' to capture all of the above (and 'clinical quality' is difficult to measure), IVC closely monitors several measures that reflect quality.

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Choice of FOP – Pet owners consider a range of factors (in addition to location), in particular care 'reassurance' and price / cost

Externally-available IVC quality measures:

- Professional Standards Scheme (PSS) accreditation – nearly 92% of IVC clinics are accredited, with the remaining 8% awaiting accreditation.
- All IVC clinics have a Google Business Profile account where they are actively encouraged to generate client reviews, ensuring other pet owners have access to open and honest feedback on the Google reviews tab - average score (out of 5 stars) is a comparable metric.
- Positive Pawprint report on sustainability, published annually online, based on three pillars (People, Planet and Patients), and underpinned by KPIs and targets to measure IVC's progress.
- Personal word-of-mouth recommendations and social proof.

Internally-monitored IVC quality measures:

- All clients are sent a survey to gather Net Promoter Score (NPS) feedback post-consultation, and IVC receives c. 45,000 responses per month ([REDACTED]). Overall client satisfaction is objectively high (81%) compared to other consumer-facing sectors.
- [REDACTED]
- [REDACTED]
- [REDACTED]
- Significant investment in quality improvements – IVC invests heavily in improved quality in each practice (e.g. equipment/facilities, staff pay and benefits) and wider group benefits (e.g. group clinical resources, R&D papers to improve quality of care, improved client experience). See slide 32A on the benefits of corporatisation, in the section on WP2.

- Client complaints – [REDACTED]- see IVC_00000008, IVC_00000017 and IVC_00000018 submitted in Q20, RFI3.
- Clients can raise issues with their vets and escalate to Practice Managers or Clinical Directors – or send claims directly to the RCVS or the VCMS.
- Vets Now and Vetspeed also operate their own complaints arrangements – see IVC_00000009, IVC_00000010, and IVC_00000012-IVC_00000016 submitted in Q20 RFI3.
- [REDACTED]

However, IVC would welcome - and is ready to contribute to building - a robust, meaningful, and practical industry-wide measure to enhance quality transparency for clients.

Choice of FOP – Pet owners consider a range of factors (in addition to location) – in particular care 'reassurance' and price / cost

(2) Price / cost is an important factor for many pet owners.

This is consistent with CMA findings - **price ranked similarly to service and quality** (appointment availability, services offered, opening hours, parking and transport) and **only slightly higher than "online reviews"** (WP1, Table 5.1).

Use of **word of mouth, recommendations and online reviews** also reflect price and quality.

Consistent with **IVC client insight** (see IVC response to Q8 RFI 9), which suggests price is an important factor in choice of practice- alongside e.g. location and proximity, service levels (including opening hours, look and feel of premises, and whether the receptionist is friendly), and vet reputation.

40% of respondents to CMA survey reported finding out price information before registering with their FOP - of those that considered pricing before choosing, 44% reported finding it easy to compare price information (WP1, 5.36(a)) (5.36(d)).

[REDACTED]* of IVC lapsed vaccination clients have moved to a different vet practice – with over [REDACTED]† doing so for price/cost reasons

*[REDACTED]

†[REDACTED]

IVC recognises the sector could do more on price transparency and transparency of ownership – building on Phase 1 remedy proposals.

Nature of competition in FOP – Lower switching rates instead reflect high levels of trust in veterinary professionals

Pet owners display high levels of trust in veterinary experts and their advice – this is what drives lower levels of switching. Working papers find:

- "[*Almost all pet owners agree*] *that their vet focuses on the highest standard of care for their pet*" (WP1, 5.124(a)).
- *"Pet owners highly value the trust and relationship that comes from remaining with a particular FOP practice, or with a particular veterinary professional"* (WP1, 5.66).
- 3% of pet owner switched in last year for "competitive reasons" (i.e. price, service) (WP1, 5.58) – [REDACTED].

Trust is a strong predictor of client loyalty. And reverse is true where trust is lost.

- Loss aversion from leaving a 'good' FOP that a client is happy with will be considerable (i.e. factoring in pet wellbeing / health).

Switching is <u>not</u> difficult for clients wanting to do so. FOPs need to be competitive to:

- **Retain clients** – trust is easily lost (and switching can easily happen) if pet owners think they are not getting good advice, value for money, or a good quality of service.
- **Win new clients** who are actively searching for a FOP (including 'switchers').

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Nature of competition in FOP – Lower switching rates not indicative of weak competition

Working papers suggest **switching rates** lower "*than we might expect in a well-functioning market*" (WP1, 6(b)), but CMA recognises that **utilities / insurance are poor benchmarks** to compare against vets.

[REDACTED IMAGE]

- Query **what is the right benchmark**, considering: (1) trust-based nature of vet relationships; and (2) frequency of vet visits (i.e. < 3 times per year on average).
- [REDACTED]
- Clients wanting to switch are readily able to do so.

Switching rates are comparable to other trust-based sectors - contrary to the WP's view that switching rates are lower than should be expected in a well-functioning market.

Further detail on the underlying survey data and questions is provided in Annex 2.

ANNOTATED SLIDE

Role of Pet Care Plans - benefits to pet owner and pet

Pet Health Club encourages good preventative healthcare.

- CMA qualitative vet research: "Most veterinary professionals felt that pet healthcare plans were cost-effective for pet owners, with some highlighting that the plans also improved clinical outcomes for animals"(14.3.1).
- No reliable evidence found by CMA "*pet care plans may be normalising the over-vaccination or over administration of preventative treatments that might not be strictly necessary*" (WP1, 5.111) - only qualitative commentary from one single vet.

Transparent and brings clear cost savings - [REDACTED] of PHC dog plan clients made savings last year.

- Clear information on pricing and plan benefits available online.
- Spreads the cost of pet healthcare over time to reduce the likelihood / impact of larger lump sum liabilities - i.e. by reducing the likelihood and / or severity of preventable health conditions which require significant care.

Easy to cancel and not a barrier to switching FOPs.

Benefits to the practice: more predictable revenues and ability to communicate preventative healthcare.

Vets clearly communicate choice of non-routine treatments

- Sound business practice and requirement under RCVS code for vets to communicate treatment options to clients.
- But must also recognise role of the vet (and owner's trust in the vet).
- Options selected by vet in accordance with 'contextualised care' (see working paper 2).
- CMA pet owners survey shows that vets clearly communicate treatment options.
  - **84%** of owners agreed that their vet takes the time to clearly explain various treatment options (WP1, 5.124(a)).
  - **84%** of owners felt they understood the options when presented to them by their vet and were able to make an informed decision (WP1, 5.125(a)).
  - **79%** of owners said that they were satisfied with the information and advice received from their vet (WP1, 5.152(b)).
  - **71%** of owners felt that they had the capability to challenge their vet's treatment advice if necessary (WP1, 5.125(a)).
  - **43%** of respondents said their vet did not provide alternative treatment options for non-routine treatments – but there are good clinical reasons for this (inc. when no treatment is required) (WP1, 5.153(a)).
  - **62%** of respondents who received a referral to another practice recalled that their FOP gave them treatment options – indicating that vets do provide options when they exist (especially for more complex cases) (WP1, 5.185(a)).

Vets clearly communicate pricing information for non-routine treatments

- This is reflected in IVC policy.
  - IVC policy to provide an explanation to clients of the **reasons** for each alternative recommended treatment plan, with an estimate of cost.
  - IVC policy to keep all clients **informed of estimated costs** to ensure client satisfaction.
- Also requirement under RCVS code for vets to communicate pricing information to clients.
- And supported by CMA qualitative vet research findings.
  - Vets often communicate prices as part of a conversation seeking consent to proceed with the treatment (WP1, 5.139(a)).
  - Over 40% of client respondents visiting for a non-routine appointment received price information in advance (WP1, 5.142(a)). [REDACTED].
  - Over 75% of client respondents that received a price estimate stated that the actual price paid was the same or less (Pet Owners Survey, Q53b).

Insurance – does not affect options presented to pet owner (only ability for pet owner to choose certain options)

CMA pet owners survey: **insurance does not impact information provided or take-up of non-routine treatments** (WP1, 5.165).

IVC does not recognise suggestion in working papers that there is "*some evidence that whether a pet owner has insurance may affect the options that are provided by individual vets*" (WP1, 5.169).

- **Insurance does not impact vet's initial assessment or treatment options** outlined to a pet owner (and often vet is not aware if pet is covered).
- However, insurance **can increase the set of options a pet owner is able and willing to consider** (given affordability considerations, as part of contextualised care).

ANNOTATED SLIDE

Referrals – Owners provided with relevant information

Owners provided with relevant information on referrals – this is evidenced by CMA pet owners survey…

- (1) Most pet owners provided with **alternative treatment options to referral** (WP1, 5.185).
- (2) Pet owners generally provided with sufficient information regarding **referral treatment risks, outcomes, and practicalities** – e.g. on pet owner's most recent visit, **80%** satisfied with the information or advice they received (WP1, 5.198).

… and CMA qualitive vet research.

- (1) **Vets consider several factors on choice of specialist,** including clinical specialism, trust (based on previous referral experience), location and convenience, and price for the pet owner (WP1, 5.188).
- (2) Owners not always provided with a choice of specialist – but may not be relevant.

No basis for CMA concern that pricing information "delivered inconsistently sometimes due to a lack of awareness among referring vets" (5.194).

- (1) CMA qualitative vet research: **prices usually communicated alongside referral options** (WP1, 5.197(b)).
- (2) Pet owners **can seek prices from specialist providers**.
- (3) CMA pet owners survey: **79% pet owners perceived themselves to be well-informed** about their choice of referral practice (WP1, 5.198).

No evidence of "self-preference" - and certainly no evidence of detrimental outcomes in practice (see working paper 2)

- e.g. currently over [REDACTED] of IVC FOP customer spend on Referral Services goes to non-IVC Referral Centres.

It is also IVC practice to identify ownership links in a referrals context.

OOH - Nature of the competitive constraint

Most clients tend to use their FOP or its affiliated provider – this is consistent with OOH being outsourced.

This does not mean that there is insufficient competitive constraint on OOH services.

- **B2B constraint** – if pet owners are not happy with the price and/or service provided by an OOH provider, this reflects badly on the FOP clinic (and undermines the pet owner's trust in the vet). The **FOP would then look to change provider** or bring the service back **in-house.**

[REDACTED]

- **B2C constraint:**
  - **For Vets Now,** nearly [REDACTED] **of caseload is B2C** (i.e. pet owners that have a FOP not partnered with Vets Now).
  - **Option not to use OOH at all** - only [REDACTED] of calls to Vets Now call centre or the clinic end up in a visit to a Vets Now clinic.

  N.B. Vets Now does not charge for this 'triage' service, irrespective of whether the caller is a client of a VN partner practice or not.
- Few OOH providers in some areas a **feature of the market** (i.e. limited demand; challenging supply side) – see working paper on local concentration.

Also worth noting evidence from the CMA quantitative pet owners survey:

- **69% of respondents** reported **receiving pricing information** before agreeing to them (Q89).

Euthanasia and cremation services – Sufficient information provided to pet owners

- Most clients value the role their vet practice plays in making arrangements - and are not looking for a choice.
  - **This is consistent with evidence provided to the CMA** by third parties, including by independent FOPs and Dogs Trust.
- Use of VetSpeed / CPC ensures a consistently high level of care and service at competitive prices.
  - We invest in high standards on **client experience, health and safety, and sustainability**.
- Where consumers want a choice of provider, this is supported.
  - Working papers recognise **FOPs provide flexibility on timings** – IVC does not require decision on same day as euthanasia (which itself may be planned). Not unusual for FOP to hold pet for significant time post-euthanasia to allow time for decision (WP1, 5.258).
  - Where owner asks to use another provider, this **choice is fully supported** by the FOP (consistent with CMA qualitative vet research, p.59). 20% of clients chose cremation services not through their FOP / OOH (relying on word-of-mouth recommendations, online search, or other methods) (WP1, 5.261).
- Vets sensitively raise options and sign-post price / cost.
  - CMA review of evidence confirms pet owners generally provided with a choice of cremation services.
  - [REDACTED] vets tend to provide post-euthanasia options to pet owners and signpost costs. Vets are more likely to (sensitively) outline the broad options and relative costs, as they are aware pet owners struggle to process information (because of the emotional distress) (page 11).
  - CMA quantitative pet owners survey shows 52% of respondents recalled **receiving price information** on cremation services, and 47% recalled receiving **information on different cremation options** (Q105) – [REDACTED].
- Clinic "mark-ups" for cremations reflect value of services provided.
  - Profitability **should not be assessed separately** for individual treatments (including cremation services).
  - Price to client **covers more than cremation itself** (e.g. support, handling, and storing pet).
  - Mark-up higher on **individual vs communal cremations** – because these are more complex and time consuming for FOP to process, also e.g. include collection of the ashes.

NEW SLIDE

IVC EVIDENSIA

Cremation services – Comparison of client journeys for individual vs communal cremation

Individual cremation	Communal cremation
The vet discusses cremation options with the client prior to the euthanasia consultation and/or immediately post-euthanasia - to establish client preference and inform of cost, process, and timings.	
If required, the clinic manages and stores the body until a client decision is made (clear identification and security is essential).	
If required by the client, the clinic takes, supplies, and manages logistics of 'keepsake' tokens, such as locks of hair, or pawprints. For particular urns, practice staff would request this from the cremation provider.	
The clinic communicates with the cremation team and arranges logistics of separate processing to communal cremation. Body is stored and managed separately, via a rigorous and labour-intensive tracking process, to ensure nothing is misallocated, e.g. using: ○ Separate, assigned body bag. ○ Identification tag. ○ Separate tracking in clinical records.	
The cremation service provider prepares individual sympathy card and cremation certificate.	
Separate cremation.	Communal cremation.
The cremation service provider packages individual ashes in the chosen vessel (includes supply of various caskets, urns, and other 'keepsake' containers).	Communal ashes are disposed / scattered by the cremation service provider - typically in an area of remembrance at the cremation facility.
The clinic receives and records individual ashes.	
The clinic receives and records the individual waste transfer documentation.	
The clinic arranges collection of ashes at a mutually convenient time with the client, in line with previously agreed communication requirements.	
The clinic receives the client and delivers the ashes.	
If required, the clinic provides post-euthanasia support and/or bereavement advice.	

The respective client journeys illustrate the increased complexity and client value-add of individual cremations (which leads to higher clinic 'mark-ups').

- Significant increase in clinical time and FOP service complexity for individual cremation vs communal cremation.
- Options for same-day, attended, or drop-off services (which may add additional layers of responsibility for the clinic) - and ongoing client reassurance is often required throughout.
- **N.B. price is consistent regardless of number of visits and consultations with the client - regardless of how long it takes for the client to confirm wishes for their pet.**

NEW SLIDE

IVC EVIDENSIA

Further observations on IVC-specific evidence in WP1

Switching (FOPs)

- [REDACTED]
  - [REDACTED]
- Indeed, slide 21 and the (recent) [REDACTED] data analysis in Annexes 2-4 indicates that switching in the veterinary sector is today comparable to other trust-based sectors.
- [REDACTED]

Pet Care Plans (cost vs value)

- The evidence provided on slide 22 makes clear that IVC's own, most recent data shows that [REDACTED]% of PHC dog plan clients made savings last year (>£100 on average). PHC customers' savings are as against the cost of 'pay as you go' in-clinic, which IVC considers to be the correct counterfactual, particularly as PHC offers a bundle of benefits – many of which clients cannot buy online. For example, PHC's convenient 'one-stop shop' proposition includes: vaccines; health checks; nail clips; anal gland expression; urine tests; discounts on neutering, dental and other treatments; a free microchip etc.
- [REDACTED]
- PHC members are more likely to take up preventative health care - and will have access to discounts. More generally PHC members tend to be more engaged owners, so more likely to visit the vet.
- Ultimately, reaching more pets (and clients) with preventative healthcare benefits everyone - through healthier pets and cost savings to the client. [REDACTED].

Questions

IVC EVIDENSIA

IVC Evidensia - CMA Hearing

(2) Business models, provision of veterinary advice and consumer choice

3 MARCH 2025

[REDACTED]

IVC EVIDENSIA

Role of corporate ownership

WPs need to provide a balanced view on impact of corporate ownership; WPs are focused on hypothetical risks which are not evidence whilst ignoring or undervaluing the benefits of corporate ownership

WPs identify the following risks with LVGs:

[REDACTED]	**…but…**	[REDACTED]
Local concentration	**…but…**	No adverse finding as per WP3
Impact on choice of treatment (“**upselling**”) – addressed below	**…but…**	- Not clear why WP limits this to LVGs ([REDACTED]) - No evidence of upselling or detriment in practice
Impact on choice of **specialist** (“**self-preferencing**”) – addressed below	**…but…**	No evidence of anti-competitive self-preferencing in practice.

IVC EVIDENSIA

ANNOTATED SLIDE

IVC EVIDENSIA

Benefits of corporate ownership

Corporate ownership has driven innovation across the market and offered solutions to many of the problems faced by the industry

WPs acknowledge the potential for efficiencies brought about by corporatisation.

*"Such managers might have **superior skills** or **tools to assess and implement business 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 portfolios."* (WP2, 2.92 (emphasis added))

Reality is corporate ownership provides substantial benefits to each of (a) pets; (b) owners; and (c) veterinary professionals. Please refer to slide 32A for further detail on the benefits of corporatisation.

- **Quality improvements**: e.g. PSS, group clinical support and resources, group support for client experience, client digital experience, training (incl. graduate training programmes providing a better entry to the profession as well as continuing professional development through career pathways; see para 2 response to CMA Consultation and slide 10 of the CMA Site Visit presentation).
- Higher investment into premises and modern equipment: e.g. approximately £20m in **equipment including for diagnostics** in FY23 and a £10m investment for a new state of the art referral hospital in Blaise (see para 6 of IVC's "no basis for concern" submission and slide 7 of the CMA Teach In).
- Support from central functions: e.g. HR (e.g. support to navigate new and more complex employment laws) or support for animal welfare cases and research and data sharing (e.g. development of evidence-based frameworks for care to support clinical freedom and contextualised care - see para 2 response to the CMA consultation).
- Employee benefits: e.g. annual spend on **salaries and benefits** has increased by £50m since July 2022; alternative and expanded career pathways for vets and nurses; maternity, paternity and sick pay; DEI support (see Q11, 12 RFI 7 and Q34 RFI2).
- Other: e.g. charitable and sustainability initiatives: e.g. over £4.1m in the **Care Fund**, which has supported 4,500 families with cost of vet treatments since 2021 to date (see Q21 RFI 7 and para 5 of IS response, updated for 2024 figures); provision of strategic support for c. 1,000 UK animal welfare charities, donating care worth over £800,000; local community grants to 75 colleague-nominated charities during 2024; non-accidental injury support available to all clients and pets.

Corporatisation has also significantly contributed to and accelerated the timeline for positive change across the industry (cont'd)

IVC has been key in supporting research and work around emerging diseases, being able to rely on the experience of multiple specialists holding positions on IVC's Clinical Boards – a knowledge sharing system which would have taken much longer (or indeed may not have been possible at all) to coordinate between disparate practices/specialists.

IVC has provided considerable support to vets in the understanding of new regulations (e.g. on the guidance of "under care") which will be critical for the development of a new Vet Surgeons Act. LVGs are also in the unique position to share large data sets and key knowledge (as already shared with VetCompass or SAVSNET*), to further evidence-based veterinary medicine – the collection of which would be a lot more difficult / slower otherwise.

IVC has supported local authorities and state organisations such as the police in dealing with emerging threats (e.g. by providing controlled drugs to counter dangerous dogs in threat to public situations, support to authorities in avian influenza outbreaks, etc.).

IVC has significantly contributed to the development and implementation of emerging AI, clinical technology (e.g. SignalPET which helps vet professionals interpret x-rays) and compliance software such as electronically controlled drugs registers.

IVC's scale has enabled it to have an impact in the field of sustainability, where it has focussed on initiatives such as: reduction in carbon emissions by up to 30% through investment in tin heating and lighting initiatives; £300,000 investment in lower flow anaesthesia; volatile agent re-capture; recycling of blister packs (1.5 million in 2024) and non-hazardous waste (49% recycled in 2024); 41% reduction in antibiotics outpatient prescriptions since 2022; 88% reduction in farm use of Category B antibiotics (critically important for human medicine) since 2022.

*VetsCompass is a nationwide research programme run by the Royal Veterinary College. VetCompass' aim is to collect as much data as possible from actual pets seen in veterinary practices to enable them to gain a better understanding of illnesses and conditions suffered by companion animals. and SAVSNET (Small Animal Veterinary Surveillance Network) harnesses electronic health and environmental data for rapid and actionable research and surveillance.

Upselling - overview

WP concern: "*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*" (WP2, 2.165(b))

But CMA needs to be mindful of:

1. **Clinical autonomy**: vets' clinical and practical expertise is <u>never</u> compromised

2. **Contextualised care**: the approach of our vets is to provide the <u>right level of care</u> to <u>that patient</u> and client at <u>that point in time</u>

3. **Role of KPIs and incentives:**
   - Not clear why these are only a concern for LVGs ([REDACTED])
   - Do not undermine clinical autonomy / contextualised care

4. **No evidence of adverse increase in treatment intensity in practice**
   - Question how the CMA would be able to determine what level of treatment intensity is appropriate?

IVC EVIDENSIA

Upselling – Clinical autonomy

- **Fundamental to our ways of working**
  - Key to building trust with pet owner
  - Key to vets - any attempt to interfere would lead vets to leave
- IVC clinical teams have **full clinical independence** (consistent with professional obligations to act impartially without regard to incentives)
- **No clinical protocols** (cf health and safety) – only non-binding guidance / frameworks reflecting the latest practice and evidence (welcomed by vets)

ANNOTATED SLIDE

Upselling – Contextualised care

IVC expects all its vets to provide the right level of care for that patient and client at that point in time

➢ **No tension with providing high quality care**

- "High quality" does not mean offering expensive treatments when not needed; on the contrary, it means using advanced technology and expertise to deliver the optimal outcome for the pet / owner (Contrary to WP 2 (2.126-2.129))

- Consistent with internal documents:
  - ❑ As submitted to CMA, our documents refer to "*highest standard of clinical care*" – in the context of our investment in clinics and staff to deliver high standards of care for pet owners ([REDACTED])
  - ❑ [REDACTED]

IVC EVIDENSIA

ANNOTATED SLIDE

Upselling – KPIs and incentives do not undermine clinical autonomy / contextualised care

1. Not clear why WP focuses on incentives for LVGs – [REDACTED]

2. IVC KPIs and incentives do not cut across clinical autonomy and the provision of contextualised care

KPIs

- Use of KPIs in line with best clinical and business practice (including the NHS) as it allows for audit and improvement (see significant reduction in antibiotics usage) – as recognised in WPs
- Only the [REDACTED]
- Close monitoring of NPS scorecard – which for IVC shows high level of client service satisfaction (81%)

Incentives

- Use of incentives consistent with best business practice
- No practice incentives linked to sales of particular treatments (other than vaccinations where it is justified for e.g. prevention of zoonotic diseases)
- No practice incentives based on IVC group UK performance
- All vets incentivised to grow reputation / trust – not consistent with upselling

Upselling – No evidence of upselling in practice

No empirical evidence

"We have not found empirical evidence of any overall trends in treatment intensity" (WP2, 2.60)

CMA quantitative analysis in WP comparing LVGs and a sample of independents:

- Average **number of treatments per pet is lower for** IVC ([REDACTED]) than for independents (6) (WP2, Fig 2.2)
- **Similar revenue distribution** of pets between LVGs and independents (WP2, Fig 2.3)
- **Differences in treatment category mix** between LVGs and independents **does not suggest LVG upselling** – [REDACTED]

Additional IVC data

- **Diagnostics: Small** [REDACTED]) and **declining % patients** (down [REDACTED] in last 3 years) receiving diagnostic procedures
- **Referrals: c.[REDACTED]% of IVC's active patients received a referral in the 12 months up to Jan 2025** – equivalent to c. [REDACTED] referral / vet FTE per month
- **Referrals: [REDACTED]% drop in IVC referral case load, and [REDACTED]% drop in conversion rate** from consultation to procedure between 2023 and 2024

Not supported by qualitative research

WP: " *few vets in our qualitative research reported that performance monitoring and financial incentives had influenced their clinical decisions*" (WP2, 2.118)
[REDACTED]: no evidence of vets *"erring on testing as the default choice*" (p.7); instead, evidence of a heavily "*pet-focused*", highly *"pragmatic and cost-conscious"* approach (p.14)

IVC EVIDENSIA

Self-preferencing – Overview

WP concerns not warranted given:

1. IVC's focus on **clinical autonomy** (as above)
2. **No ability / incentive** to self-prefer
3. **No evidence** of self-preference or detriment in practice

Self-preferencing – no ability or incentive for IVC to engage in self-preferencing

Clinical autonomy
(recognised by CMA)

When an IVC vet refers a pet owner to one of our referral centres, it is because they believe it is the best option for that client in those specific circumstances:

- **Consistent with WP review of internal documents supports this**: "*it appears to us that vets have clinical freedom to refer to the most appropriate vet/location*" (WP2, 3.54).
- **Substantial referrals ex group**: over [REDACTED] of IVC FOP client spend on Referral Services goes to non-IVC Referral Centres.
- **No KPIs/incentives linked to in-group referrals** (recognised by CMA – with one (non IVC) exception).
  - [REDACTED]
  - [REDACTED]

All vets are incentivised to grow reputation / trust – not consistent with self-preferencing

IVC clients are informed that they have a choice as to which referral centre they select and any ownership links are flagged to them in advanced

Self-preferencing – no evidence in practice – qualitative research

WP finds no reliable evidence of self-preferencing:
"we have not found direct evidence of such detriment arising that is specific to self-preferencing" (WP2, 3.119)

- High / increasing rates of in-group referrals not indicative of self-preferencing; instead, they are consistent with build-up of vet / specialist relationship

Qualitative research

- **CMA evidence from <u>vets / nurses</u> not conclusive**
  - Vets indicated that they provided a range of options (WP2, 3.90).
  - Main factor for vets in decision on where to refer was clinical specialism (*Qual research*, p.47).
  - Where multiple options exist, one of the most common considerations was availability and waiting times for treatment (*Qual research*, p.48).
  - Many vets working at LVG practices considered the ownership status of referral clinics as just one of many factors (*Qual research*, p. 51).
  - Most vets did not express concerns about being encouraged to refer to group owned centres.
- **[REDACTED]** a wide range of contextual and owner-driven factors shape the final decision (including: proximity, availability, cost).

Self-preferencing – no evidence in practice – quantitative research and corporate strategy

Quantitative research

- ➢ **CMA evidence from <u>pet owner survey</u> not conclusive**
- ❑ LVG clients **no more likely to be recommended a referral:** 17% of all pet owners reported receiving a referral in last 2 years. No statistically significant difference between LVGs and Independents (Accent, Q58)
- ❑ LVG vets **no less likely to outline alternative treatment options** to a referral: 62% of respondents that received a referral said their FOP gave them other options for treatment. No statistically significant difference between LVGs and Independents (WP1, 5.185)
- ❑ LVG vets **no less likely to provide multiple referral options:** 34% of respondents that reported receiving a referral were given multiple referral options. No statistically significant difference between LVG and independent clients (Accent, Q66)

LVG models

- ➢ **LVG financial models are not evidence of strategy to self-refer**
- ❑ Recognise clear incentive for IVC referral centres to win clients from **<u>all</u>** FOPs (not only IVC)
- ❑ But does not translate to incentive on IVC FOP vet to self-prefer (and would not do so to detriment of consumer)
- ❑ [REDACTED] of IVC Referral Centre revenue comes from referrals from non-IVC FOPs

Self-preferencing – no evidence of detrimental outcomes in practice

According to the WP:

Potential benefits from intra-group referrals:

- ❑ In-group referrals benefit (a) IVC group; (b) vets; and (c) consumers: "*continuity of care and efficiencies which may be passed on to consumers in the form of lower prices*" (WP2, 3.123)

No conclusive evidence of consumer detriment arising from any self-preferencing practices (WP2, 3.119)

No concerns where in-group referrals meet pet owners' needs (including on price) just as well as external referral providers (WP2, 3.123) – as is the case

No evidence of foreclosure of competing specialists (WP2, 3.129)

NEW SLIDE

Observations on IVC-specific evidence in WP2

Pricing / price optimisation

[REDACTED]

[REDACTED]

NEW SLIDE

Observations on IVC-specific evidence in WP2

KPIs & Incentives	➢ [REDACTED] • **KPIs and targets**: these are merely a helpful indicator of what areas practices are doing well on and where there might be an opportunity to improve. There are no financial incentives offered to vets/practices for hitting any particular KPIs (other than vaccinations where it is justified). Use of KPIs is in line with best clinical and business practice (including the NHS) as it is part of IVC's quality improvement support, in which audit/measurement is important – as recognised in WP2 (see 2.108) and slide 37 above. For instance, measuring antibiotics use has enabled IVC to support initiatives to reduce antibiotics use (e.g. infection prevention and control initiatives, and supporting use of diagnostics), which can also provide better patient outcomes. • **[REDACTED]**
Self-Preferencing	➢ [REDACTED] • **[REDACTED]** • Further, as explained above: (i) Currently over [REDACTED] of IVC FOP customer spend on Referral Services goes to non-IVC Referral Centres; and (ii) High referral rates not evidence of self-preferencing: specialists within the IVC group also invest in getting to know IVC FOP vets (who do the referrals).

Questions

IVC EVIDENSIA

IVC Evidensia - CMA Hearing

(3) Analysis of local competition dynamics

3 MARCH 2025

[REDACTED]

IVC EVIDENSIA

Local Concentration Overview

The WP's findings are consistent with effective competition:

FOP:

- Majority of local areas are served by multiple competing FOPs.
- Low barriers to entry: clear evidence from the CMAs of hundreds of new FOPs successfully entering the market.

OOH:

- Fewer providers driven by OOH economics: lower demand and higher cost to serve (and staffing constraints), and the need for minimum efficient scale.
- Higher concentration in OOH inevitable given fewer OOH 3rd party providers vs FOP

Referral:

- Few local areas with high concentration.
- There will inevitably be fewer referral centres vs FOP reflecting specialised nature of services and less demand.

Even if there are a limited number of areas with relatively few competitors, the WP has presented no evidence that this is leading to AEC, or any customer detriment whatsoever

ANNOTATED SLIDE

FOP – WPs analysis shows strong competition and low concentration in the vast majority of areas

Only 14% (524 sites) have 3 or fewer fascia, and just 6% (232 sites) have 2 or fewer fascia in the CMA's analysis.

Few competitors likely to be driven by insufficient demand (and/or supply) in many areas - in 209 / 524 of the low competition FOP sites identified by the CMA, the operators present have just 1 site each.

- Sites in concentrated areas are disproportionately in **geographically remote / low population** areas:
  - The average population density where the 14% of sites are located is 2/3 the UK average (excl. NI & London).
  - WP finds *"the majority of monopoly areas appear to be in coastal areas or on islands".*

- Supply factors also play a role – it is harder to staff sites in rural areas.

Only a very small minority (8%) of FOP sites are in areas with 3 or fewer fascia where at least one veterinary group has more than one site

Please see [REDACTED]

IVC EVIDENSIA

ANNOTATED SLIDE

FOP – No reason to believe areas with fewer competitors are likely to be of concern

Only 8% of sites (315) are identified by the WP of being a potential concern, but there are multiple factors that the WP's preliminary analysis does not consider sufficiently:

WP is underestimating the true level of competition

- Currently **conservatively excluding 2,605 unconfirmed independent practices.**
- Likely to be **competitors just outside of the 80% catchment which exert competitive pressur**e in real life.
  - Extending the CMA's drivetimes on average by just 3.6 mins **reduces the number of sites with 3 or fewer fascia by over a half** (from 315 to 179)

Please see [REDACTED]

WP has found low barriers to entry in FOP

- The **threat of entry is a constraint** on existing operators

No CMA evidence of AEC or customer detriment in these local areas

ANNOTATED SLIDE

FOP - Low barriers to Entry in the FOP market

WPs have found "*new vet practices are able to start up and grow*"- demonstrating **low barriers to entry and expansion** (Overview of WPs, 1.9)

WP analysis shows **at least 745 new FOP entrants in the last 10 years:**

Almost **90% of FOP sites had an opening in their catchment in the last 10 years**

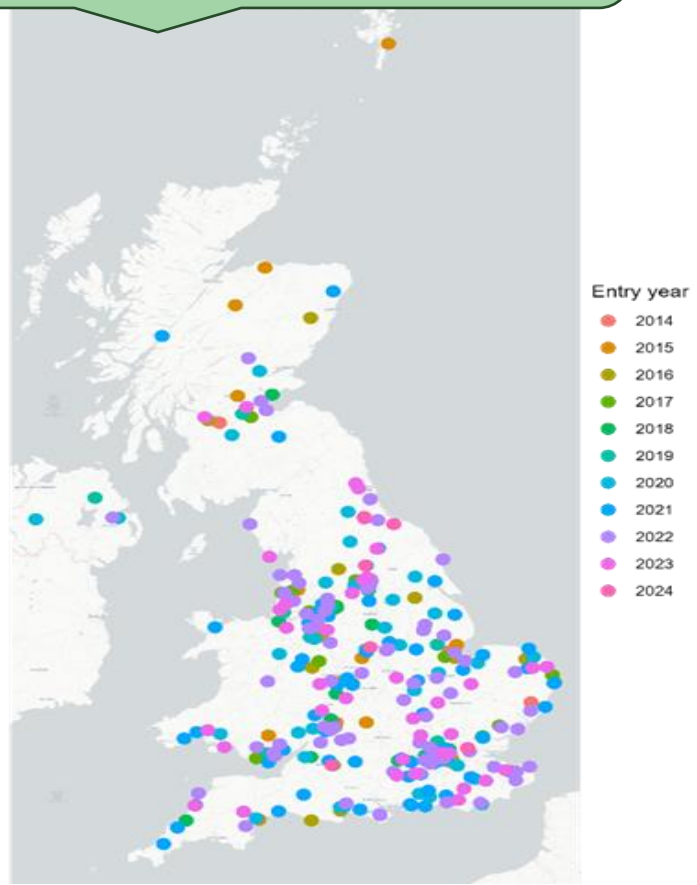
The FOP market is constantly **evolving**:

- Almost 350 sites previously meeting the CMA's "concentrated" definition in fact experienced at least one entry (from the 745) at some point over the last 10 years, that resulted in them no longer meeting the concentrated definition in 2025.

- Of the 745 entries since 2014, 36% were opened by LVGs.
- [REDACTED] of the independent sites opened since 2014 were acquired by IVC.

[REDACTED]

Map of non-IVC entries by year *(based on IVC data of 295 entry events)*



IVC EVIDENSIA

OOH – High concentration in some local areas reflects challenging economics of the OOH market and minimum efficient scale

WP has found 44% (158) of OOH sites are either a monopoly or a duopoly. Relatively few OOH providers reflects challenging OOH economics and minimum efficient scale:

Lower demand given emergency nature of service

Low vet 'productivity' (i.e cases per hour)

Different treatment mix vs FOP - (i.e emergency critical care vs routine treatments)

Higher cost to serve – high staff costs (inc. recruitment & retention)

As with FOP, there are recruitment challenges in **rural / coastal areas** - more **acute for OOH given unsociable hours** required for 24/7 care

This results in "pooling" of OOH provision across FOPs:

- Ensures OOH services can be provided sustainably
- Reduces barriers to entry for FOPs
  - Dedicated OOH providers (such as Vets Now) can act as an "enabler" for independents to open or to continue where the above challenging economics means they struggle to self-staff 24/7.

NEW SLIDE

OOH - Vets Now does see proactive switching [REDACTED]

Some of the most common feedback for FOPs proactively switching to other OOH providers are:

(1) Own OOH provision

[REDACTED]

(2) Location of Vets Now clinics

[REDACTED]

(3) Dissatisfaction with OOH service

[REDACTED]

Some moves are driven by pet owners themselves choosing other OOH providers

[REDACTED]

OOH – Exploring the 'low competition' sites identified by the CMA highlights multiple factors to consider

16% of OOH sites across the UK (57 / 356) are identified by CMA as multi-site monopolies or duopolies

1. **WP's analysis underestimates OOH competition as it ignores the in-house OOH model.** All FOPs have outside option of **self-provision** (on more limited basis, e.g. on-call vets vs dedicated team), and many choose this.
2. **Data issues in the WP's analysis are overstating the number of 'low competition' areas.** [REDACTED] of [REDACTED] IVC OOH sites identified as 'low competition' are either duplicates, do not offer OOH to third parties anymore or are actually single-site monopolies/duopolies.
3. **Many of the multi-site monopolies and duopolies are complementary and serve distinct populations**
   - IVC OOH sites flagged by the CMA shows that approx. [REDACTED] serve distinct populations and are based in separate towns, overlapping only at the margins.
   - It would not make commercial sense to have multiple Vets Now sites serving the same population, but the WP's analysis implies that [REDACTED] of [REDACTED] Vets Now sites in 'low competition' areas operate with another Vets Now site in their catchment.
4. **Many of these flagged 'low competition' areas cannot support more OOH operators due to insufficient demand**
   - These sites face **lower demand than the overall OOH market** on average.
   - The remaining [REDACTED] IVC OOH operators in 'low competition' areas appear to have a smaller than average number of FOPs in catchment versus for the full set of OOH operators, indicating these are low demand areas.

[REDACTED]

[REDACTED]

NEW SLIDE

OOH – Vets Now link to IVC is not a barrier to other 3rd party OOH providers

3rd party OOH providers can compete for a substantial portion of the FOP market, and Vets Now's link to IVC is not a barrier to entry/expansion in outsourced OOHs

Vets Now does benefit from its relationship with IVC FOP clinics, in that this provides it with a 'base load' of demand which helps the viability of Vets Now sites.

- NB. IVC FOP clinics have discretion on how they provide OOH, but they are encouraged to use Vets Now where it meets their needs and those of their clients.

However, it is not the case that this is a barrier to entry or expansion for other 3rd party OOH providers.

- Nationally, IVC has a [REDACTED] share of FOPs *(WP2, Table 1.3)*
- IVC analysis shows that on average locally, IVC FOPs account for [REDACTED] of Vets Now case load and revenue

This means 3rd party OOH providers have a large addressable market to target.

Referrals – No evidence of undue concentration

WP has found the vast majority (80%) of referral only sites have 5 or more fascia

CMA also needs to recognise 'blurred' market definition for referrals, and constraint from FOPs

When CMA includes FOPs that offer referral services in its analysis, the CMA finds **no concentrated areas.**

WP wrongly excludes constraint of FOPs that do not offer referral services – these **may be able to provide an alternative treatment option** to a pet owner.

Shown by CMA survey: *"over 50% of pet owners that received a referral reported that their vet provided alternative options"* (Q61) - likely to be an **underestimate as excludes pet owners received a referral option but opted for treatment from their FOP.**

Referrals – Where there are fewer providers, will reflect the challenging economics

- **Like OOH, referrals present challenging economics.**
  - **Lower demand** given specialised nature of service.
  - Specialist skills and equipment on supply side (which are higher cost)

- **In rarer disciplines (e.g neurology) the number of viable sites is limited UK-wide (given constraints in the numbers of vets with the relevant specialist training), let alone locally.**

- **Caution against extending the analysis by specialties:**
  - Credible analysis would require much more detailed (and consistent) data collection from LVGs and independents, requiring **expert vet input**.
  - High **supply-side substitutability** – often no more than hiring vet with relevant specialism.
  - Any concentration would likely reflect the economics of referral services – rather than "high market shares".

As per discussion in the IVC Hearing, any analysis attempted by specialty would quickly become outdated:
- The referrals offer of a practice is heavily dependent on the availability of specialist skills.
- If these specialist vets were to move, a practice could mistakenly be deemed as a referral centre for a specialty whilst no longer offering that specialty.

Questions

IVC EVIDENSIA

IVC Evidensia - CMA Hearing

(4) Regulatory framework for veterinary professionals and veterinary services

3 MARCH 2025

[REDACTED]

IVC EVIDENSIA

IVC recognises the need for regulatory reform in certain areas building on LVG proposals at Phase 1 – as also identified in WP4

1. The remit of the RCVS regulatory regime: expanding the regime beyond the regulation of vets

2. Staffing challenges

3. Efficacy of RCVS's monitoring and enforcement powers

4. Improvements in consumer redress and complaints management mechanisms

5. Effect of VMD's regulatory restrictions on medicines

ANNOTATED SLIDE

The remit of the RCVS regulatory regime: the lack of practice regulation

- RCVS Code and Principles currently apply only to individual vets

- **IVC is supportive of an extension of the RCVS as a regulator to cover practices** (as well as individual vets); could be achieved by:

  - **Enhancing the PSS**:
    i. applies to practices, but currently voluntary – switch to compel membership and compliance and bolster with greater role for consumer protection as part of PSS accreditation (nearly 92% of IVC clinics are accredited, with 8% booked in waiting on accreditation).

  - **New regulation** to allow RCVS monitor and control vet practices – building on LVG proposals at Phase 1.

- Any reform / extension should be <u>principle-based</u> given complexity and variety of clinical realities in practices

<u>Extension of the RCVS remit: the appropriate entity to regulate if given adequate powers and resources to do so</u>

- IVC believes RCVS-led regulation can be achieved in a pragmatic, clear and principle-based manner, e.g. through:
  i. Clear identification of responsibility;
  ii. Appropriate indemnity provisions (which currently only extend to the RCVS member);
  iii. The formulation of appropriate sanctions, and a clear process for their application.
- Given the need for a solution that works across the industry, a review of job descriptions and formalising role responsibilities across the profession may be needed as a precursor to the legislative change extending the application of the RCVS rules and Code.

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Clinical autonomy and the application of the RCVS Code

- **WP concern**: the lack of practice regulation "*risks creating a conflict for individual vets between what they would like to do and what may feel encouraged (or required) to do by their employer or through corporate incentives*"(WP4, 4.8(a))

- We do not see any risk of such conflict due to the primacy of clinical autonomy across our network (as recognised by CMA in WPs).
    - IVC clinicians are under no pressure to depart from their clinical judgment and compliance with the RCVS Code
    - See WP2: KPIs and incentives do not undermine clinical autonomy / contextualised care

ANNOTATED SLIDE

Staffing challenges and potential changes for improvements

Veterinary workforce external challenges

Regulatory changes:

Under Care
Veterinary Medicines Regulations
XL Bully legislation

Changing expectations of pet owners influenced by social media and news agendas

Changing nature of pet health

Structural changes of modernisation

Covid effect

Brexit challenge - reduced numbers of registrants to the RCVS:

- >**2/3** drop in 2 years
- Fell by **68**% from **1132** in 2019 to just **364** in 2021
- Impact on workforce numbers and Brexit related changes such as Pet Health Certification

Potential Changes

- Update the Veterinary Surgeons Act, in line with recommendations by the British Veterinary Association, to:
  - Allow veterinary nurses and para-professionals to carry out a wider range of clinical tasks
  - Protect 'Registered Veterinary Nurse' title to ensure patient safety.
- Provide clear guidance on the interpretation of Schedule 3 of the VSA as regards the tasks that can be safely delegated to veterinary nurses.

Increase access to veterinary training and funding to expand number of university places

Ease the restrictions on hiring vets from the EU (e.g. impractical salary visa requirements for qualified vets and interns) while efforts to increase UK-trained vets take effect

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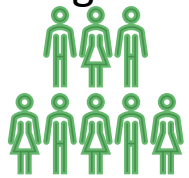
ANNOTATED SLIDE

Efficacy of RCVS's monitoring and enforcement powers

IVC supportive of enhanced monitoring and enforcement powers for RCVS – building on LVG proposals at Phase 1: including through:



Better resourcing of the RCVS's regulatory functions
to allow enhanced monitoring and enforcement

Self-auditing and reporting
whereby clinics have obligations to self-audit and report compliance with the Code on an annual basis

More targeted and proportionate types of sanctions
with better outcomes for consumers

RCVS's governance: reform of the regulatory remit to be accompanied by reform to the RCVS' governance to bolster its function as a regulator. As proposed by the British Veterinary Association (in its Policy position on RCVS governance), IVC is supportive of a clearer distinction between RCVS's Royal College and its regulatory functions (with better funding/resourcing of the latter). Additional considerations for increasing RCVS's efficacy:

- External scrutiny of the RCVS against similar standards to the Professional Standards Authority;
- Protocols defining timelines for investigations and disciplinary hearings;
- Greater implementation of RCVS's regulatory powers to take action against non-vets and non-vet businesses performing acts of veterinary surgery to support the profession and show confidence to the public.

ANNOTATED SLIDE

Improvements in consumer redress and complaints management mechanisms

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Issue needs to be assessed against background of very high client satisfaction (at least for IVC)

RCVS SETTING VETERINARY STANDARDS

Recognise RCVS is limited to considering gross misconduct - which does not give closure for many of the complaints

How IVC sees the three-pronged approach outlined in the WP

Effective in-house complaints process:

- Agree the "quickest, cheapest and least resource-intensive means of resolution" (WP 4, 5.8)
- Majority of IVC complaints are dealt with at practice level in a timely and effective manner, driving high client satisfaction NPS for IVC (**81%**)
- See IVC's client complaints handling procedure and "**Speak Up**" policy and "**Integrity Line**" website (whistleblowing)
- Consider bolstering in-house processes further by making appropriate consumer redress and complaints elements an integral part of a mandatory PSS system (at veterinary group level).

Third-party schemes (e.g. mediation services):

- VCMS is a viable alternative for escalated complaints:
  - **82%** resolution rate and high levels of satisfaction
  - **93%** of veterinary practices
  - **97%** of clients indicated they would use the VCMS again
- Any system needs to be proportionate and pragmatic for vets as well as pet owners
- VCMS engagement could be improved significantly by providing for earlier pathways and "normalising" it as an effective resolution mechanism for escalations, including potentially by mandating entry to the mediation process once a complaint has been escalated.

Court system:

- Last resort solution

Effect of VMD's regulatory restrictions on medicines

Cascade

- **Safe medicine and safe practice as utmost concerns:**
  - Medicines are not benign, and all have side effects
  - Use of a human medicine in animals may not be safe practice unless confirmed by approved medical trials and marketing authorisation
- **Cascade provides clear guidance for vets** – onus should not be on them to take a view on untested medicinal prescribing.
  - Vets should not be making decisions on affordability in individual cases
- **Loosening Cascade rules further would also reduce the incentive for pharma companies to invest in R&D** for veterinary medicines – leading to reduced innovation and fewer veterinary meds entering the market (WP4, 6.32(b))
  - Market for veterinary meds is just 2-3% of the market value of its human counterpart

Wholesale supply restriction

- IVC would not see an issue with online retailers being allowed to sell to FOPs
- IVC would expect it to be very rare for online prices to be below wholesale price to independents in practice
- Independents are already able to join buying groups to enjoy similar discounts/rebates as LVGs

Questions

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IVC Evidensia - CMA Hearing

(5) Veterinary medicines

3 MARCH 2025

[REDACTED]

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Overview

[REDACTED]	- [REDACTED] - FOPs compete on **total package,** including treatment services. CMA cannot look at medicines' profitability or competition in isolation. **- Quality** is also relevant to medicines in-clinic.
No evidence of above cost price rises	- WPs' **analysis of medicine 'unit prices' is flawed** and gives a misleading picture of price trends. - IVC's own data shows **mark-ups have remained constant**.
When comparing prices for medicines, CMA needs to recognise costs and benefits	- Significant **benefits** to consumers purchasing in-clinic. - Significant **additional costs** to dispensing and stocking medicines.
Differential to online [REDACTED]	- **Highly competitive** online segment. - Consumers **able to compare prices**. - Clear evidence of **upward trend in online sales** for (repeat) prescription veterinary medicines. - **Implications for FOP business model** (for LVGs and independents), which relies on cross-subsidy from medicines to treatments and consults.

IVC recognises the sector (including independents) could do more on transparency – noting this would further accelerate existing trend, and further challenge the business model.

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Mark-ups

[REDACTED]	FOPs compete on the total package – including medicines and treatments	Quality is also relevant to the dispensing of medicines
- [REDACTED]	- CMA cannot look at mark-ups, profitability, and competition in veterinary medicines in isolation. - For example, a pet receiving treatment for repeated vomiting may require consultation and examination, diagnostic tests, injections, and follow-on supervision and aftercare.	- There may be variations in quality across providers, e.g. availability; vet and reception support; investment in premises. - IVC invests in high-quality care and outstanding client service at its clinics, across treatments and medicines.

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No evidence of above cost price increases

Misleading to suggest manufacturers' list prices are "retail price suggested by manufacturers" (WP5, 3.7(a)) - not RRPs but **wholesale cost prices** before discounts.

WPs' analysis of medicine 'unit prices' is flawed - it does not compare like-for-like and gives a misleading picture of price trends. For example:

- **Quantity of drugs sold is not accounted for**, e.g. a purchase of 180 bottles of Metacam 180ml is treated as equivalent to a purchase of 1/3 of a bottle.
- Drug categories group together a range of **incomparable drugs**, e.g. a sachet of a probiotic supplement to dog food is grouped together with a common injection for chronic dermatitis, and a sedation drug for surgery.

No evidence of above cost price rises:

- IVC pricing data shows that **mark-ups on list price at IVC have remained roughly constant between 2018 and 2023.**
- This suggests that the price increase found by the CMA is largely driven by an **increase in manufacturer's list prices** and/or **changes in the mix** of medicines prescribed.
- **IVC's margins on 'net-net' prices of medicines sold in its FOP clinics have also remained constant -** at around [REDACTED] between 2018 and 2024 ([REDACTED]). [REDACTED]*
- Importantly, **these 'mark-ups' reflect also: (i) the cross-subsidy** between meds and treatments (see further slides 71A-C below); (ii) and the **additional client value and costs** of dispensing in clinic (see next slide).

*Note that net-net mark-ups for 2021 to 2023 can be calculated from RFI6.

Comparing prices in-clinic vs online

Online markets offer highly competitive prices for clients – but driven by a very different business model compared to 'bricks and mortar' practices. Price differentials (in-clinic vs online) explained by:

(1) In-clinic benefits to consumers - and consumer willingness to pay for these, e.g.:

- Speed and convenience
- Access to advice – at the time of dispense and subsequently
- Help administering drug

Consistent with CMA pet owner survey (Table 15 / Q99)

(2) Additional costs of dispensing in clinic, e.g.:

- Higher wastage
- Providing advice and support
- Reporting on adverse events

(3) Cross-subsidy from medicines to treatments - all vets (LVG and independents) have tended to undervalue their time and charge unrealistically low fees for treatment prices, and looked to make up some of the shortfall through higher medicine prices.

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Consumers can and do compare prices

(1) Most consumers aware they have a choice - especially when it becomes more relevant, i.e. on repeat prescription.

CMA quantitative client survey: 57% of clients (rising to 73% of clients that purchase repeat medications) are aware that they could ask their vet for a prescription and then buy the medication elsewhere (Accent, Q91 and Q92).

(2) Vets in practice play an important role in raising consumer awareness of alternative channels.

CMA qualitative vet research: "many veterinary surgeons did discuss prescriptions" (8.2.3); CMA pet owner survey showed 35% of pet owners learned about prescriptions from their vet (Accent, Q91).

[REDACTED]: it is common for vets to discuss these options with pet owners, especially where purchasing repeat medicines (p.9).

(3) Evidence shows consumers can and do compare prices.

CMA "review of LVG internal documents showed evidence of LVG policies to present [medicines] prices clearly when they were being provided to pet owners in the consulting room, or for specific treatment plans." (WP5, 4.12).

CMA quantitative pet owner survey: 30% of pet owners have compared the price of their pet medication – rising to nearly 45% for pet owners buying repeat medicines (Q98).

IVC recognises vet sector could do more, building on Phase 1 remedy proposals – but CMA needs to have regard to impact on business model (for LVGs and independents).

ANNOTATED SLIDE

IVC EVIDENSIA

No other barriers to switching (1/2)

(1) No barriers to switching created by prescription fees.

- **Level of prescription fees:**
  - Reflective of cost and comparable to private human healthcare.
  - Not such as to undermine savings from purchasing online - see evidence presented by IVC in response to Issues Statement (5.58).

- **Duration / validity of prescriptions:**
  - Working paper recognises no evidence of prescription duration or scope (e.g. quantities) being limited by vets to promote FOP commercial interests to the detriment of consumer optionality (5.82).

(2) No barriers to switching created by vets' choice of medicines.

- **Clinical autonomy and professional judgment** of vets determine recommendations for medicines.

- Includes use of **injectables**, e.g. for greater efficacy (also recognised by CMA), safety, and convenience - especially as more advanced injectables have launched in last 3-4 years.

- Significant benefits of **IVC private label**, including reliability of supply, quality, and lower price (aim for [REDACTED] saving vs branded in-clinic).
  - But IVC vets can and do offer guidance on branded alternatives.
  - No evidence of IVC private label limiting consumer use of alternative channels – e.g. prescription rates for 2 largest selling private label [REDACTED] remained flat 6 months after launch.

[REDACTED]

NEW SLIDE

IVC EVIDENSIA

No other barriers to switching (2/2)

(3) IVC private label is not intended to, and does not have the effect of, creating barriers to switching.

- **More advantageous supply terms** can typically be achieved when negotiating for private label vs branded medicines supply (e.g. due to predictability of order volumes):
  - Cost savings, passed on to clients:
    - [REDACTED]
    - Cost savings benefit customers [REDACTED].
  - Clear sustainability and security of supply benefits:
    - As an illustrative example, Arthrocam is manufactured in Ireland (by Chanelle Pharmaceuticals), reducing transport emissions to the UK by 80% vs Metacam (manufactured in Mexico by Boehringer Ingelheim).
    - IVC has worked with Chanelle to: (1) return unused Arthrocam dog syringes for recycling; and (2) reduce the size of the packaging – to reduce waste.
    - [REDACTED]
    - By near-shoring production to Ireland, IVC has also mitigated security of supply risks, especially in light of supply chain disruptions during the Covid pandemic, and a potential future increase in global trade barriers.
    - N.B. comparable benefits apply for other IVC private label medicines.
- **Clients can and do identify and purchase branded alternatives**:
  - E.g. for all 4 IVC private label medicines launched in 2024, IVC advised clinics to keep branded equivalents visible on written dispense forms, showing IVC's commitment to providing choice to clients. N.B. active ingredients / APIs are also displayed on IVC private label medicines – even if most customers do not typically use these to cross-shop medicines (whether between private label and branded, or between branded alternatives).
  - IVC also circulated a leaflet to clinics (to be provided to pet owners when dispensing IVC private label drug Incovet) making clear that Incovet is equivalent to branded drug Propalin – see Annex 24.2 to IVC's response to RFI 11.
  - IVC vets can and do offer guidance on branded alternatives for all IVC private label medicines.

However, IVC is willing to explore developing meaningful, practical industry-wide measures to give clients improved transparency on branded alternatives to private / own label products, without undermining their benefits.

Price balance between treatments vs meds does not discriminate against older pets

Veterinary medicines are used throughout the life of a pet.

- A significant proportion of younger animals also need medicines – [REDACTED] of total medicine sales (by value, dogs and cats only) at IVC FOPs in FY24 were for animals younger than 8 years at the time of treatment.
- The same medicines may be used by pets at different life stages - if suffering from the same or similar conditions. For example, antiparasitics (which have a total annual sales value at IVC FOPs (incl. value for PHC members) of [REDACTED]- higher than both long-term and acute medicines) are required for animals across the age spectrum. The price of these medicines is not set by reference to age – the same price applies to all pets.
- For patients having the same acute condition, the per patient spend is broadly similar, regardless of age. For example, the average sales value of acute medicines dispensed at IVC FOPs for patients at 49 – 60 months old is [REDACTED], whereas for patients at 157 – 168 months old it is [REDACTED] (calculated as total annual revenue for the age cohort divided by number of patients in the age cohort).

IVC must remain price-competitive throughout the lifespan of any pet (across medicines and treatments) given that price is an important parameter of competition, and clients can and do switch (FOPs and medicine retailers).

- The pet's owner may switch FOPs during the pet's life (e.g. if moving house or where trust in the vet is diminished) – see the WP 1 slides above on switching.
- The constraint from online channels for medicines is increasing and expected to grow further – see the slides below.
- Therefore, it is not viable to "back-load" profitability for a pet by relying on in-clinic medicine sales later in life, and IVC does not set or analyse its commercial strategy or performance in this way.

Clear evidence of strong upward trend in online sales for prescription veterinary medicines

Clear upward trend in clients seeking prescriptions for common chronic medications (IVC response to Q19 RFI11).

[REDACTED IMAGE]

Notes:
[REDACTED]

Proportion of clients receiving prescriptions for the four most common chronic medicines has steadily increased in recent years, reaching [REDACTED] in July 2024.

Consistent with the CMA research: 26% of buyers of repeat medicines do so online (Accent, figure 93).

Increases to 43% for those that pay for a repeat prescription between every 3 months to 12 months (Accent, Q92/93/96).

Furthermore:

- 57% of pet owners who have been prescribed medicines in the past 2 years are aware they can get a prescription online – this share increases to 73% for those with a repeat prescription (Accent analysis, Q91 and 92).
- 30% of pet owners compare medicines prices - this share increases to 44% for those with a repeat prescription (Accent analysis, Q98 and Q92).

IVC EVIDENSIA

Internal IVC documents clearly show that the growing competitive constraint of online has prompted a competitive response from IVC - this pressure will grow as more clients switch online

[REDACTED]

[REDACTED]

[REDACTED IMAGE]

[REDACTED]

[REDACTED IMAGE]

[REDACTED]

[REDACTED IMAGE]

[REDACTED]

[REDACTED IMAGE]

[REDACTED]

[REDACTED]

[REDACTED]

Implications for the business model (LVGs and independents)

Working paper recognises, but fails to put adequate weight on:

- Historic industry-wide pricing practices subsidising treatments with revenues from medicines.
- The importance of revenues generated from medicines for the sustainability of all FOPs, including independent FOPs.

Increased downward pressure on medicines pricing will inevitably lead to a rebalancing towards treatment prices.

NEW SLIDE

IVC EVIDENSIA

Rebalancing between medicine and treatment prices: the economic mechanisms (1/2)

Medicines are complementary goods to treatments, which in part drives the cross-subsidy historically across the market

FOPs offer both treatments (i.e. consults, surgeries) and medicines and will normally provide some combination to treat a patient.

Medicines are complementary goods to treatments

- There is a negative cross-price elasticity between the price of treatments and quantity of medicines sold.
- An increase in the sale of treatments (especially consults) leads to greater demand for medicines (but not necessarily vice versa and not to the same degree).

FOPs will set the prices of medicines and treatments jointly to maximise profits

- As such, it is optimal for FOPs to price lower on treatments which are drivers of (1) clinic choice; and (2) 'footfall' / visits; and price higher on medicines.
- A hypothetical 'treatment service - only' FOP market would have a much higher profit maximising price for treatments.

The end result is the market situation today and historically: cross-subsidy from medicines to treatments.

NEW SLIDE

IVC EVIDENSIA

Rebalancing between medicine and treatment prices: the economic mechanisms (2/2)

A market-wide reduction in medicine pricing will lead to a rebalancing towards higher treatment prices, via the following economic mechanisms. This re-balancing could be driven by either the continued growth of online and/or via CMA transparency remedies.

1) Lower medicine cash margins

- A reduction in medicine prices (and medicine cash margins more generally) driven by increased competition will initially lead to a reduction in profits.
- Without price adjustments to treatments, this will make FOPs economically unprofitable on the basis that there are no excess profits across the market today.
- This will lead to combination of market exit, and/or an increase in treatment prices to help restore competitive profit levels (the exact outcome depending on how responsive pet owners are to treatment price increase, and the ability of FOPs to manage the transition).
- [REDACTED]

2) Weaker complements from 'fragmentation' of the FOP offer

- The growth of online – and more shopping around for medicines in general – means pet owners are becoming less reliant on purchasing medicines alongside treatments from their FOP.
- This will weaken the relationship between treatment prices and medicine sales in FOPs - making medicines a *weaker* complement to treatments.
- As a result, the optimum price equilibrium across the market will be higher treatment and lower in-clinic medicine prices vs today.

[REDACTED]

NEW SLIDE

IVC EVIDENSIA

Rebalancing between medicine and treatment prices: international regulatory comparators have limited value in the UK

It is not meaningful to compare medicines pricing models in the UK vs other countries (e.g. Spain), as market conditions (historic and current) diverge significantly. Regulation should take account of these differences.

- For example, contrary to the CMA's suggestion at the IVC hearing, there has been no recent regulatory 'cliff-edge' change in Spain prohibiting vet practices from selling medicines in-clinic and shifting retail transactions online.
    - In fact, clinics have never been allowed to sell medicines in Spain, other than where dispensing was a part of the course of treatment applied in-clinic to the patient – and Spanish commercial models have evolved accordingly (very differently to the UK).
    - Recent regulatory changes over the last ~2 years have aimed to: (i) reinforce these restrictions (in particular for dispensing of chronic medicines); and (ii) limit use of anti-biotics - which have arguably resulted in incremental behavioural changes in the sector but were not far-reaching 'cliff-edge' regulatory changes to clinics' business models.
- When not comparing like-for-like market conditions, regulatory policy is not readily transferable across jurisdictions.
- Disproportionate interventions may carry significant unintended consequences, and their effects would be even more acute if the transition (imposed by regulation) is abrupt and more difficult to manage for market participants (than under economic mechanisms described above).

IVC is willing to contribute to the development of meaningful, practical industry-wide measures that further enhance transparency on medicines prices for clients – in a way that carefully manages the impact on industry stakeholders and minimises unintended consequences

IVC EVIDENSIA

LVG ownership of online retailer (PDOL) does not reduce competition for medicines

Online medicines channel is highly competitive.

- Significant number of competitors online.
- High degree of price transparency.
- Clients are highly price sensitive (having elected not to purchase in clinic) – [REDACTED]
- Low brand loyalty - most new clients arrive at the site via paid search online and organic search.
- High levels of shopping around and switching - only c. [REDACTED] of new clients make a second purchase within a year.

PDOL sales reliant on price competitiveness – with other online retailers, as well as FOPs.

- [REDACTED]
- CMA working paper recognises that LVG-owned online pharmacies have lower prices than FOPs, which "*suggests that they do have an incentive to compete with FOPs*" (WP5, 5.42).

WP found buying groups are working effectively, and support smaller players in obtaining good purchasing terms

WP finds that the negotiating power of some buying groups is comparable to LVGs – and some buying groups have purchase volumes greater than some LVGs (WP5, 6.30).

As a result, buying groups allow independent FOPs and third-party retailers to increase their negotiating power with manufacturers and obtain good procurement terms (WP5, 6.28).

However, the WP also suggests that the negotiating power of buying groups has declined in recent years - but does not put forward any empirical evidence to substantiate this (WP5, 6.32).

Even if LVGs have a higher share of the market than in the past, it does not follow that all buying groups have lower volumes and therefore have a weaker negotiating power:

- **Participation in buying groups may have increased over time** – or could do, given not all independents are part of one.
- **Some of the smaller buying groups may be sub-scale**. There are large differences in the size of buying groups – ranging from £1m to £145m.
- **One of the LVGs is part of a buying group** – so it follows that members of this buying group may also benefit from shared purchase volumes.
- **There are other factors affecting a buying groups negotiating power** (e.g. use of preferred products).

Differences in procurement costs between LVGs and buying groups (or independents more generally) is not an AEC in itself.

NEW SLIDE

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Further observations on IVC-specific evidence in relation to WP 5

IVC must remain price competitive on medicines

- [REDACTED]
- [REDACTED]
- Ultimately, as explained in response to WP 1 above, pet owners are price-sensitive and do change practice in response to uncompetitive (treatment and medicine) prices at their veterinary clinic. IVC's in-clinic proposition must therefore remain price competitive – with other FOPs and, increasingly, online medicine retailers (see slide 72 above) – having regard also to medicines' necessary contribution to IVC clinics' cost base and profitability, and the added value offered to clients by dispensing and administering on-site. This is IVC's commercial strategy in the medicines space.

Questions

IVC EVIDENSIA

IVC Evidensia - CMA Hearing

(6) Treatment Costs (Econometrics)

3 MARCH 2025

[REDACTED]

IVC EVIDENSIA

Treatment cost trends - Overview

Sector-wide increases in treatment costs

WP finds substantial sector-wide increase in treatment costs over the last decade

- 70-80% increase in first-year treatment costs between 2015 and 2023 across the sector;
- 60-70% increase in "unit price" of treatments.

Treatment costs have risen over time due to:

- **Increasing input costs across the veterinary sector, in particular, pay/benefits (in face of vet shortages)**
  - IVC has led the way in investing in staff pay/benefits in response to recruitment/retention challenges ([REDACTED])
- **Change in treatment mix driven by:**
  - Advances in veterinary medicine and treatments available
  - Demand from pet owners for more sophisticated treatment options

[REDACTED]

[REDACTED]

ANNOTATED SLIDE

Sector-wide: IVC price rises driven by higher input costs – in particular, investment in pay/benefits given sector-wide vet shortages

The WP presents ONS vet salary data as a proxy for costs – which is partial and misleading…

Issues with ONS data on vet and nurse salaries:

- **Small sample size** for vets – approx. 65 vets in 2023 data. ONS recognises that salaries may be +/- 10 % in any year.
- **Not reliable for time series analysis:** ONS states *"care should be taken"* when looking at changes over time, in part as data does not adjust for compositional changes (e.g. staff experience, qualifications).
- **Average vet/nurse salary gives incomplete view of staff costs:** it does not account for costs relating to locum costs; maternity/paternity cover, pension contributions, training and other benefits etc.

According to ONS data, vet salaries *declined* 2015-2019 – which is clearly incorrect

… looking at IVC data shows increases in clinic staff costs *exceeded* increases in treatment costs over the period

[REDACTED IMAGE]

- Volume data is not systematically available historically, but other data shows that for the set of clinics present from 2015-2023, revenue increased by [REDACTED], which is less than the staff cost increase shown above. **This indicates that increases in prices have not outstripped underlying costs**.
- For a small set of clinics for which volume data is available, the number of transactions and number of unique pets increased by [REDACTED] respectively between 2015-2023 – cost increases have therefore not been predominantly volume driven.

Sector-wide: The CMA's data does not allow it to properly explore the changes in treatment mix over time, and the impact on treatment costs

- **Over the c. 10 year time period of the CMA's analysis there have been material advances in veterinary medicines, and changes in demand and pet owner preferences.** In other words, the make-up of typical veterinary invoice today will look very different to 10 years ago.
- **Taking a handful of illustrative examples:**
  - **Local anaesthetics:** not commonly used in 2015 but are now more commonly used as part of an anaesthetic plan to manage pain but this requires more skill and training to administer.
  - **Laparoscopic spay**: a less invasive method of surgery with potentially quicker recovery time, decrease in post operative pain and fewer post operative complications, but requires more skill and specialist equipment to administer.
  - **Cruciate repair:** lateral suture technique is an older procedure less suitable for larger dogs. More advanced alternatives have higher success rates, but require specialised surgical skills, equipment and often expensive implants.
- The CMA recognises that an increase in treatment costs could be driven by:
  - **A price effect**: an increase in the unit price of the treatments administered (the price effect); or
  - **A 'treatment mix' effect**: an increase in the number or complexity of the treatments administered
- However, the CMA's data – even the so-called 'unit price' dataset - does not allow it to systematically explore changes in treatment mix over time and estimate the relative contribution to increased sector-wide treatment costs.

IVC data demonstrates this change in treatment mix, with more advanced treatments becoming increasingly common

Looking at two of the treatments mentioned on the previous slide - laparoscopic spay and non-lateral suture – shows the increased use of more complex treatments which are also more costly.

Laparoscopic spay

The cost of a **standard spay** can range from **c.£200 to £700.**
A **laparoscopic spay** can range from **c.£500 to c.£1,200**

Year	Total bitch spays	% of which are laparoscopic
2020	[REDACTED]	6%
2021	[REDACTED]	6%
2022	[REDACTED]	10%
2023	[REDACTED]	11%
2024	[REDACTED]	13%

Non-lateral suture

The cost of a **lateral suture** can range from **c.£1,900 to c.£3,000.**
A **non-lateral suture** can range from **c.£3,200 to c.£5,000**

Year	Total cruciate repair	% of which are non-lateral
2020	[REDACTED]	56%
2021	[REDACTED]	65%
2022	[REDACTED]	68%
2023	[REDACTED]	76%
2024	[REDACTED]	78%

** i.e. Non-lateral suture: all alternative methods of cruciate repair that is not lateral suture*

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[REDACTED]

1 [REDACTED]

- [REDACTED]

2 [REDACTED]

- [REDACTED]

3 [REDACTED]

- [REDACTED]

[REDACTED]

[REDACTED]

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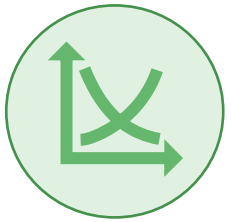
[REDACTED]



[REDACTED]

[REDACTED]

[REDACTED]

NEW SLIDE

IVC EVIDENSIA

[REDACTED]: IVC's investment in the quality of care and service of its practices starts soon after acquisition

Practice standards	• Upon joining the group, IVC aims for all practices to reach the level to pass the RCVS PSS within a year. Over 90% of IVC practices are RCVS accredited vs 70% across the market.*
Group clinical support	• All IVC staff get access to group clinical support and resources, included access to IVC clinical network, clinical boards and a quality improvement team.
Client experience	• IVC provides practical support and best practice guidance on delivering exceptional client service, including advice, tips and practical check lists.
Client digital experience	• IVC improves the digital client experience of newly acquired practices with range of convenient features, such as online appointment booking and digital appointment reminders.
Facilities & equipment	• Investment in facilities/equipment of newly acquired practices. IVC invested £20m in equipment including for diagnostics in FY23 across the business.
Staff pay & benefits	• Market-leading investment in clinical staff pay & benefits to help with recruitment and retention – increased by £50m per year in 2022.
Staff training	• IVC invests £8m+ per year in staff training, inc. L&D programme and graduate training programme.

Note: see IVC's narrative response to the CMA's econometrics WP for further detail

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* The remaining IVC practices are booked in waiting on accreditation from the RCVS.

Questions

IVC EVIDENSIA

IVC Evidensia - CMA Hearing

(7) Profitability

3 MARCH 2025

[REDACTED]

IVC EVIDENSIA

Economic profitability very difficult to accurately measure in veterinary sector

- CMA plans to share its *Working Paper on financial analysis and profitability* in early May.
- IVC welcomes CMA's recognition in its *Approach Working Paper* of the challenges of measuring economic profitability. Profitability analysis is extremely sensitive to assumptions and small measurement errors.
- Key challenge is that **accounting data does not give meaningful estimates of economic profitability ([REDACTED]).**
- Data limitations in the veterinary sector are fundamental and result in large goodwill value on balance sheet.
  - **Tangible assets** – not recorded at replacement cost.
  - **Intangible assets** – significant in vet sector and hard to measure.
- **This means the CMA needs to essentially 'start from scratch' in its asset valuation**– which necessarily relies on assumption-driven approach.
- **Given the challenges, if the CMA is unable to develop robust profitability analysis, it cannot place weight on this in its assessment of the market.**

Tangible assets – not recorded at replacement cost

- CMA has recognised that net book value may not reflect replacement cost / value to business.

Clear evidence of this:

- **Asset register is incomplete.**
  - Historically, asset register not always updated post-acquisition and acquired asset registers often incomplete.
  - Pilot asset verification exercise showed:
    - **[REDACTED] of in-use assets not recorded** on asset register.
  - Asset register shows [REDACTED] **clinics [REDACTED] live assets**.
- **Accounting life is shorter than useful economic life.**
  - Depreciation and Amortisation Policy depreciates owned equipment assets over max lifetime of five years.
    - Useful life for some assets (scanners, kennels) known to be 10+ years.
    - Pilot verification showed **[REDACTED] of assets in use were 5+ years old**
    - Asset register shows **[REDACTED]** of assets **have NBV of <£1**.

[REDACTED IMAGE]

Intangible assets - significant in vet sector and hard to measure

- Intangible assets take years to build, hence corporate strategy of growth through acquisition.
- Intangible asset value is currently captured in goodwill within balance sheet.

Main intangible assets are:

Client relationships

Vet practice reputation / brand

Intellectual capital

IT systems and software

All of these intangible assets meet CMA intangibles criteria:

Require an investment to obtain future earnings

Incur costs which are in addition to those arising from the running of the business

Are separable assets

NEW SLIDE

The intangible assets of a vet practice are separable from the individual practice owner – even if they played a key role in building the assets

The intangible value of a practice - which is in part captured in goodwill – **is separable from the reputation of an individual owner of a vet practice.**

- Owner-vets do invest significant time in building the intangible value of their vet practice, including the practice reputation and client base, when they initially set up a practice.
- However, much of this intangible asset value is separable from the individual owner-vet. A vet practice reputation is a function of multiple factors – client experience over time; performance of the team; practice management / leadership etc.
- If the intangible asset value was not separable from the owner-vet, then there would be limited incentive for LVGs to acquire vet practices – much of their investment would be at risk from a 'key person dependency'. [REDACTED]
- IVC's historic M&A strategy has been to focus on acquiring practices with strong local reputations, and well performing teams. [REDACTED]
- [REDACTED]

Approach to revaluing assets

Current view

- CMA has indicated it is considering alternative approaches to tangible asset valuation.
- **Robust alternative measures are essential** to get to a meaningful assessment of profitability.

Tangible assets

- IVC has proposed a **proof of concept rebuild approach** for revaluing tangible assets.
- Relies on actual costs, avoids unnecessary complexity, and addresses issue of missing assets, unlike second-hand market and insurance approach.
- However, this is **still very sensitive to data used**, e.g. requires parties to have robust square foot data, relies on input data accurately reflecting how costs have changed over time period in question.

Intangible assets

- Inherently **difficult to measure** and has a **significant impact on assessment** of economic profitability.
- Estimating the **start-up losses** incurred is a good proxy for the investment in developing the intangible assets required for a vet business.
- [REDACTED] **Genuine standalone start-up clinics** would need to be used for this exercise to provide meaningful results.

Measurement issues have a significant impact on assessment of profitability

[REDACTED IMAGE]

Correcting for tangible asset valuation and using alternative valuations for intangible assets [REDACTED].

Demonstrates how essential accurate measurement of capital employed is. CMA needs to have certainty on this if intending to use profitability analysis in its assessment of the market.

Questions

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Closing statement

3 MARCH 2025

[REDACTED]

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[REDACTED]

[REDACTED]