ANNEX 1

SECTION A

Linnaeus – Specific comments on the CMA's Demand Working Paper

Row	Paragraph(s)	Linnaeus comments
Section 4 – Factors impacting pet owners' decision making		
1.	4.8	**Weak evidence base -** in order to support its claim that "*pet owners' trust in their veterinary providers can generate more sales…*" the CMA relies upon a handful of documents from one LVG and an academic study which considers a client base in the US and Canada. However, the CMA provides no evidence of this with regard to any UK market to support this assertion. It is not appropriate for the CMA to make such allegations without any robust evidence, given the significant scope to undermine pet owners' confidence in the care they receive from vets – to the detriment of pet owners and veterinary service providers.
2.	4.10	**No directly applicable evidence –** the CMA's only evidence regarding a potential conflict of interest where vets (or their employers) have a financial incentive in relation to clinical recommendations, relates to human healthcare. Linnaeus strongly rejects the implication – which is entirely unsupported by any evidence that relates to Linnaeus, or indeed to the UK veterinary services market – that Linnaeus vets may be swayed by financial interests to make inappropriate recommendations to pet owners.
3.	4.16, 4.17 and 5.126	**Speculation with limited or no evidence -** the CMA speculates that pet owners might choose more complex treatments due to recommendations made by vet practices and not request such treatments in the absence of such suggestions. There is an implication behind this assertion that such an outcome would be in some way adverse to pet owners. Firstly, even if this dynamic were to occur in practice, it would not necessarily represent evidence of an adverse effect on competition. If pet owners were to become more informed on treatment options as a result of a consultation with their vet (an outcome which may not be surprising or in any way concerning), and were then to exercise their judgment to accept an appropriate course of treatment of which they were previously unaware

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		(in full consideration of the relevant alternatives), this would be evidence of the market for veterinary services working well, not poorly. Secondly, as the CMA itself notes, there is no empirical evidence that this is the case and the CMA should not engage in unjustified speculation of this nature – especially given the feedback received during the roundtables held by the CMA, for example that there has been somewhat of a cultural shift among pet owners towards being more informed about their animal's health and the available treatments (paragraph 4.15).
Section 5 – How pet owners make decisions		
4.	5.27(a)	**Assertion that mischaracterises Linnaeus' branding intentions –** the CMA notes that internal documents indicate that at least some LVGs make decisions about marketing and branding that reflect "*and target*" customer preferences for independent practices. However, the CMA has mischaracterised **[Redacted - Confidential]**
5.	5.67(a)	**Assertion based on a minority of respondents** – a minority (9%) of respondents to the CMA's survey that said they would find switching difficult or not possible were asked why they said that (Questions 30 and 31 of the CMA's survey). The CMA's survey makes the point that 29% of this minority of respondents who said they would find switching difficult or impossible, considered it would be difficult to switch medical records between vet practices. This assertion relates to a very small percentage of pet owners and obscures the fact that the vast majority of respondents consider switching to be possible and easy. Further, Linnaeus notes that this is not correct – medical records are easily requested and transferred, in accordance with RCVS obligations to do so.[1] This is also demonstrated by the other results from the CMA's survey which found that 88% of customers either switched vet practice in the last 10 years, or did not switch but thought they would be able to switch if they wanted to – the transfer of clinical records is not a barrier to switching.
6.	5.69	**Comparison to other industries that are not relevant to the vet sector –** the CMA compares switching rates of customers using veterinary services to retail banking, mobile network, energy, and car insurance providers. There is limited crossover between the veterinary sector and those industries – these comparisons cannot provide meaningful insight into the way in which veterinary medicine operates, and the key relationships

[1] Paragraph 13.14 states "Under RCVS guidelines, at the request of a client, veterinary surgeons and veterinary nurses must provide copies of any relevant clinical and client records."

Row	Paragraph(s)	Linnaeus comments
		built between customers and their chosen vet. As such, it is not appropriate for these industries to be used as a comparator of switching rates to determine whether the market is functioning well. Further, see Section 4.10 of Linnaeus' main response and Section 2.3.3 of Annex 2 which explains that given the high levels of satisfaction in veterinary professionals, it is unsurprising that switching rates are low.
7.	5.134-142(d)	**Price transparency –** the CMA suggests there is evidence that protocols and policies aimed at supporting the provision of price information are not being sufficiently communicated or followed, and that information provided can confuse or overwhelm clients. **[Redacted - Confidential]** In practice, Linnaeus' vets will talk the customer through the available options following an initial examination and as part of this process, Linnaeus provides its customers with a price estimate for the diagnostic test(s) and/or treatment. These estimates are tailored to the test(s) and/or treatment plan that has been discussed and agreed with the pet owner, and testing/treatment will only begin once the vet has reached an agreement as to a pet owners preferred course of action. i. This estimate will typically be made in writing and included on the consent form. ii. The exception to this is emergency situations where decisions need to be made quickly for the welfare of the pet. Linnaeus disseminates guidance to its clinics setting out the way in which estimates should be provided to pet owners. See document **[Redacted - Confidential]** as submitted to the CMA in response to question 26 of RFI 3 (Tranche 6). The CMA fails to consider the clear implication from Linnaeus' internal documents that this is an area where Linnaeus is actively pursuing strong performance by monitoring the quality and accuracy of estimates provided by its practices, and takes corrective steps to improve estimates where required.
8.	5.143	**Price transparency** – the CMA raises concerns around "bill shock" – as acknowledged by the CMA (see row above), **[Redacted - Confidential]**. This aligns with the CMA's survey finding that only a limited number of pet owners (12%) said their price was higher than quoted (see para 5.143(a)).
9.	5.151	**Treatment options** - the CMA states that in its qualitative research many vets described limiting the treatment options to those which are affordable when the vet is aware of a particular customer's financial constraints – relying on information or signals from the pet owner to understand financial circumstances. This is inconsistent with Linnaeus' approach to contextualised care – Linnaeus' policy is to provide all appropriate potential options

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		to the pet owner to enable the vet and pet owner to have a discussion as to what suits their individual financial circumstances. As explained during Linnaeus' teach-in with the CMA, Linnaeus considers it is a vet's duty to present the options to pet owners to allow them to decide which option best suits their financial and personal situation.
10.	5.203(b)	**Price transparency** – the CMA's articulation of **[Redacted - Confidential]** Linnaeus has since issued new guidance to its referral centres to avoid any misunderstanding which **[Redacted - Confidential]**
11.	5.218	**Information regarding online pharmacies** - the CMA raises research indicating that vets do not proactively raise a prescription as an option for one-off treatments because they believe it could be more expensive or because medicines need to be provided during the consultation for clinical reasons. The CMA considers that in circumstances where there is no clinical reason for a medicine to be provided by a FOP (for example, where the medicine is not urgent and it can be administered by the pet owner), the decision of whether and how to inform pet owners that they can buy medicines from elsewhere does not have clinical consequences. Linnaeus considers that there are certainly situations where it is legitimate for vets not to proactively raise the option of a prescription given the urgency with which treatment is required. At other times, where prescription is an option, Linnaeus informs pet owners that they can obtain a written prescription and purchase medication elsewhere (including by displaying clear signs to this effect in practices as required by the RCVS).
12.	5.257	**Cremation decision making** – cremation decisions can be made at the time of euthanasia of a pet, or afterwards if the pet owner would like time to consider the options and next steps. Linnaeus' policy regarding cremation discussions is guided by its approach to contextualised care – **[Redacted - Confidential]** This ultimately depends on the preference of the pet owner at the time. Some pet owners will want to make the decision at the same time as the euthanasia appointment, others would rather split these decisions up. Linnaeus does not pressure such decisions and will hold the body of the animal post-euthanasia (and in the majority of cases does not charge for this service).

SECTION B

Linnaeus – Specific comments on the CMA's Business Models Working Paper

#	Paragraph(s)	Linnaeus comments
CMA's Summary / Linnaeus' general comments		
1.	14 – 18 (and also 2.8 – 2.24, 2.35, 2.66, 2.69, 2.71)	**[Redacted - Confidential]**
2.	9 (and also 1.2(a) / 2.9 / 2.10 / 2.14 / 2.15)	**Simplistic view of prices rising faster than costs does not reflect market reality** - the CMA notes that "*treatment costs and unit prices at LVG and independent FOPs increased substantially between 2015 and 2023*" and that "*it appears that these increases are not wholly explained by changes in salaries of veterinary staff, which have not increased to the same extent*". As evidenced in greater detail in Linnaeus' main response (Sections 2 and 5), the CMA's observation **[Redacted - Confidential]**. Linnaeus' own experience suggests that the CMA's headline conclusions on increases in FOP treatment costs are overly simplistic and draw sweeping generalisations that do not apply to all market participants.
3.	18	**General reference to LVGs which should not include Linnaeus** - the CMA notes that **[Redacted - Confidential]**. It is not clear which documents are being referred to or how many of them exist (possibly those at paragraph 2.68 of the Business Models WP). In any event, to the best of its knowledge these documents do not relate to Linnaeus, and the CMA should therefore not draw a general statement such as this one which applies to Linnaeus.
4.	20 – 21 (and also 2.86 to 2.93)	**Unsupported assertion that non-vets may place greater weight on profitability concerns** – the CMA implies that non-vet managers who are not subject to the RCVS Code may be more strongly motivated by financial performance than vets. Linnaeus strongly rejects the suggestion that non-vet members of Linnaeus' management may be pushing Linnaeus' vets to prioritise commercial considerations, which may be contrary to

		their ethical obligations and the principles of contextualised care. Linnaeus management owes a duty to its employees, and would never put its vets in the position of having to compromise on their obligations.
5.	21 (and also 2.86 to 2.93)	**CMA fails to recognise the similarities between the financial incentives of LVGs and independent practices** - in relation to non-vets who are able in a position to take or influence the business decisions of practices, the CMA claims that **[Redacted - Confidential]**. As the CMA itself notes, the use of financial KPIs are "standard business practice" and "good management" (see row 21 below). Due to the focus of the Business Models WP on LVGs, the CMA has conducted this analysis without any acknowledgement that independent vet practices have owners whose earnings are directly related to the profitability of the business – and therefore that the entirely legitimate incentive to run a business successfully applies irrespective of whether a practice is an LVG or an independent. The focus that the CMA places predominantly on KPIs within certain LVGs is unwarranted.
6.	24	**Assertion with limited or no evidence** - the CMA notes that there is "*limited evidence on whether consumer detriment is arising that is specific to FOPs at vertically integrated groups favouring their own referral services*". The Business Models WP does not refer to any evidence which supports any consumer detriment – in other words, even the reference to "limited" evidence would appear to overstate the point.
7.	30	**Profitability not necessarily a reflection of harmful effects** - the CMA notes that it intends to assess whether the level of profitability in vertically integrated groups could be an important indicator that self-preferencing potential has been realised and led to harmful effects. It does not follow that any finding in relation to the profitability levels of referral centres would be an indicator of the harmful effects of self-preferencing. A number of factors may impact profitability, and these are not necessarily related to the presence of any self-preferencing (e.g. a high degree of efficiencies arising from vertical integration).
Section 2 – Higher prices, treatment costs and treatment intensity in FOP services		
8.	2.25 – 2.28	**Evidence from internal documents on pricing strategies limited to LVGs** - in this section, the CMA considers internal documents from some LVGs which recommend prices (and price increases) to their practices.

		There is no corresponding analysis in this section (or elsewhere) on how independent practices may be approaching price rises which may be necessary.
9.	2.29	**Evidence from third parties on price trends -** Linnaeus has not reviewed the data on average costs submitted by an insurance company in detail, and can therefore can only provide a high level view on the trends summarised in Figure 2.1 of the Business Models WP. However, Linnaeus has a number of views on this data: • First, the CMA's statement that **[Redacted - Confidential]**. • Second, the table includes a mix of both FOP and Referral practices for each LVG group. **[Redacted - Confidential]**. • Third, whilst Linnaeus has not analysed the underlying data, it is likely that there are other potential factors that are influencing the results, particularly the mix of treatments and changes in quality over time, neither of which have been controlled for. • Finally, as set out in Linnaeus' main response, **[Redacted - Confidential]**.
10.	2.31 to 2.33	**Over-reliance on anecdotal evidence on industry-wide pricing trends** - the CMA refers to the views of a specialist operating out of different FOP practices, an individual vet working at independent vets' practices and a person who was formerly employed by an LVG as evidence of the pricing trends at LVGs. The CMA appears to be giving significant weight to anecdotal evidence given by individual vets, some of whom may have an anti-corporate bias. Clearly the CMA should not take into account local anecdotal evidence from a small number of individuals when reaching its conclusions on industry-wide pricing trends.
11.	2.39 - 2.44	**Over-reliance on anecdotal evidence and inappropriate inference** - the CMA notes that "*LVGs prioritise consistently charging for services provided, whereas independent vets may be more flexible in charging, in a way that might be detrimental to the financial health of their business*." None of the evidence presented in these paragraphs relate to Linnaeus. Instead, the very few internal documents are all from private equity owners and other anecdotal evidence from individual vets. This is insufficient evidence to reach a market-wide finding on charging trends. In any event, it is inappropriate to criticise LVGs for charging for the services they provide. Professionalising the charging process is not evidence of competition not working well. This may in part explain price rises as businesses have moved away from historical relaxed approaches to pricing, to ensure viability of businesses in light of cost increases. This is neither a competition nor a consumer concern. **[Redacted - Confidential]**.

12.	2.45 - 2.48 (and also 2.75)	**Linnaeus comments on the limitations of the analysis of revenues and number of treatments per pet** - the Business Models WP sets out some analysis of revenues and number of treatments based on data of the LVGs' FOPs and data on 120 independent FOPs provided by **[Redacted - Confidential]**. Linnaeus does not have access to the other LVG and **[Redacted - Confidential]** data, and therefore can only provide high level comments on the analysis conducted by the CMA, set out below: • First, the **analysis of number of treatments per pet** does not seem to be meaningful as it does not appear to use a standardised measure to count the number of treatments across vet groups. As the Business Models WP states, a 'treatment' is considered to be each individual service provided as itemised on the bill. This means that different services may be grouped differently across vet groups or that the naming conventions between **[Redacted - Confidential]** and the LVG data differ. This is acknowledged by the CMA in paragraph 2.46. The fact that there are significant differences is consistent with the CMA's evidence in Figure 2.6, which shows substantial differences in the number of "dispensing/injection fees" and "Other" treatments between LVGs and independents. Specifically, it suggests that the **[Redacted - Confidential]** data for independents do not treat "dispensing/injection fees" as a separate treatment in the bill and this may be bundled with other treatments/services or in the "Other" category. Given the lack of standardised list of treatments across vet groups, Linnaeus does not believe it possible to draw any meaningful conclusions from the number of treatments per pet, neither as between LVGs nor across LVGs and independents. • Second, with respect to the **analysis of the revenue per pet,** Linnaeus notes that although the analysis does not appear to suffer from issues relating to how a treatment is defined (unlike the number of treatment analysis described above), it is still likely to suffer from issues relating to differences in mix of cases and quality between vet practices. For example, some FOP vets may have a more complex case mix and do a greater number of complicated treatments in-house than others. This is acknowledged by the CMA in paragraph 2.48. **[Redacted - Confidential]**
13.	2.53 – 2.54	**CMA's suggestion that LVG FOPs are more likely to refer surgeries than independent FOPs is unevidenced** - Figure 2.6 lists various treatment groups by percentage of their total number for independent vets and each of the LVGs. The CMA notes that the provision of surgery "*represents around 15% of total number of clinical services for independents, but only up to 8% for LVGs*."

		The CMA suggests one potential explanation for the difference is that "*vets at independent and LVG FOPs may have a similar propensity to recommend surgeries, but that independent FOPs be more likely to conduct the surgical treatment in-house [...] whereas vets at LVG FOPs may be more likely to refer surgeries.*" Linnaeus is unable to assess the underlying data relied on by the CMA. Nonetheless, the CMA is unjustified for speculating that LVGs have a greater propensity to refer surgical procedures rather than perform certain surgeries within FOP. The CMA's explanation is unsubstantiated and is based on a preconceived idea that LVG FOPs refer more cases than independent FOPs.
14.	2.55 – 2.61	**Inappropriate weighting of evidence** - the CMA states in its section title that it has "*limited empirical evidence at this stage as to whether increases in treatment intensity are contributing to the trend of increasing veterinary care costs*". However, the only additional evidence that the CMA references in this section to support this trend is an anecdotal submission from <u>one</u> group of independent practices and the views of one vet who participated in its qualitative research. This is <u>not</u> empirical evidence and is clearly an insufficient basis on which to draw any conclusions. The CMA concludes that it has found "*limited empirical evidence on increasing treatment intensity*", seemingly based on the existence of clinical and financial KPIs, which the CMA itself notes "*would be expected*", some anecdotal submissions from vets and some private equity internal documents. Again, this is <u>not</u> empirical evidence. The CMA has however received empirical evidence from Linnaeus which indicates that there has been no increase in treatment intensity (as also noted in Linnaeus' main response). As a result, the CMA should instead be concluding that the empirical evidence it has received indicates that there has not been an increase in treatment intensity, and therefore it is unlikely that this is contributing to increasing veterinary care costs.
15.	2.62 – 2.71	**Assessment of price competition not supported by empirical evidence** - the CMA's analysis on price competition, which leads the CMA to conclude, at paragraph 2.70, that *"there is likely to be a weak consumer response to price increases, and that vet businesses may be able to increase price levels above what we would expect in a well-functioning market, without constraints from pet owners switching to competitors"* is premised only on: (i) survey evidence which ignores key points (as explained in the row below); and (ii) a handful of documents from LVGs **[Redacted - Confidential]** and their private equity owners on assessments of consumers' price sensitivity. While the CMA has undertaken its **[Redacted - Confidential]**

16.	2.63(b) / 2.64	**Inappropriate conclusions from CMA survey results on switching** - Linnaeus refers to Section A, row 5 of this annex on why the switching rates referred to by the CMA misunderstand the dynamics around switching in this market.
17.	2.66	**CMA's analysis of unit prices for medicines ignores some fundamental considerations** - the CMA refers to its econometrics analysis, noting that **[Redacted - Confidential]**
18.	2.79(c)	**Inappropriate conclusions from CMA survey results on research on alternative treatments** - Linnaeus refers to Section 3.2 of Annex 2 regarding customer research.
19.	2.95 – 2.99	**No consideration of independents' incentives** - in this section, the CMA considers the LVGs' submissions and internal documents on whether there are financial incentives linked to providing a greater number of treatments. The CMA also received submissions and internal documents in the form of contracts from ten single site independent practices, finding that these sites do not typically use bonuses or other financial incentives related to the number of treatments sold or the financial performance of the practice. However, there is no acknowledgement in this section that independent vet practices typically have owners whose earnings are directly related to the profitability of the business. This does not mean that independent practices have incentives to act in a way which runs counter to their regulatory obligations, but rather that this fundamental dynamic of being motivated to improve financial performance is not unique to LVGs.
20.	**[Redacted - Confidential]**	**[Redacted - Confidential]**
21.	2.100 et seq.	**Adverse inferences are implied on use and monitoring of KPIs, despite acknowledgement that these are good business practice** - the CMA acknowledges that KPIs are "standard business practice" and, indeed, at paragraph 2.108 notes that "*it is generally good management to set and monitor KPIs*". Despite this, it then goes on to draw unsubstantiated negative inferences (e.g. at paragraph 2.165) that the use of KPIs, and the monitoring of such KPIs, *"may have the effect of unduly influencing vets to be less likely to present the lower cost treatment options to consumers, where appropriate for their pets"*. This is speculation on the part of the CMA, and not borne out by any evidence presented in the Business Models WP.
22.	**[Redacted - Confidential]**	**[Redacted - Confidential]**

23.	2.114	**Inappropriate inference from anecdotal description on different approaches at LVGs v independents** - the CMA notes that in its qualitative research, *"those working at independent practices reported being monitored on performance metrics much more rarely"*. This is anecdotal only and does not amount to evidence of Linnaeus (or any other LVG) exerting pressure on vets to make inappropriate recommendations. No inferences should therefore be drawn.
24.	2.118	**Qualitative research points to the absence of concerns on incentives and KPIs** - the CMA notes that "few vets" reported that performance monitoring and financial incentives had influenced their decisions. Although the Business Models WP gives no further detail on this point, the qualitative research therefore indicates that vets were not influenced to change their approach to patient care by virtue of KPIs and incentives. If, therefore, the CMA intends to assign probative value to its qualitative research, it should recognise more prominently that the research denies the existence of concerns in this area.
25.	2.126 - 2.129	**The CMA conflates a focus on quality with the removal of 'basic' options** - as noted in Linnaeus' main response, the CMA suggests that the focus of some practices on offering 'best clinical care' may mean the exclusion of lower cost options, which could represent a reduction in choice for consumers. This is not correct: • Being a high-quality practice does not mean that pet owners will necessarily experience any differences in terms of care pathways available to them – it means that practices have talented vets, observe high clinical standards and provide high levels of customer service. • Being able to offer more advanced options does not mean that "basic" options are not offered to pet owners. Vets discuss options with pet owners on a case-by-case basis, in line with the principles of contextualised care. The choice of treatment is always with the pet owner and depends on the circumstances of each case.
26.	2.130	**Clinical guidance ensures a consistent approach to best practice and should not give rise to concerns** - Linnaeus agrees with the CMA's statements that the use of any clinical guidance and protocols *"can be useful for ensuring a consistent approach to using best practice and ensuring efficient working"* and that *"vets did not generally see these as particularly restrictive"*. The use of clinical guidance should not give rise to any concerns, in particular, it should not feed into the CMA's potential concern relating to increases in treatment intensity (as described in paragraph 2.164).
27.	2.138 / 2.139 / 2.141	**CMA presents survey results selectively** - the vast majority (84%) of survey respondents for non-routine treatments agreed that their vet took time to clearly explain various treatment options and felt they understood the options when presented them by their vet and were able to make an informed decision.

		The CMA moves on to dismiss this, noting that *"while most pet owners reported feeling well-informed, responses to our pet owners survey indicated that some pet owners were not presented with different clinical options or that there may have been issues with the information and advice provided with the vet"*. This statement is tendentious, and appears to be an attempt to deny the most obvious conclusion from this survey result (that consumers feel well informed because they are well informed) based on an unjustified pre-disposition to find a concern. This aspect of the CMA's emerging thinking seems to be based on the result that 47% of pet owners said they were only presented with one option during their most recent visit for non-routine treatment. This is not sufficient to suggest pet owners are wrong to believe that they are well informed. In many circumstances it is not appropriate or possible for a vet to provide a pet owner with multiple options, and the CMA makes no attempt to analyse whether the 47% figure is in line with what would be expected in a market where all vets were providing care in a contextualised manner. The CMA also notes that only 13% were unsatisfied with the information and advice received in their most recent visit for non-routine treatment, which further supports the view that contextualised care is broadly functioning well across the market. The CMA's subjective take on the survey is also evident at paragraph 141 which notes that "*some pet owners may also not be as informed as they perceive themselves to be*". This is entirely speculative and ignores clear evidence to the contrary.
28.	2.140	**The survey data that the CMA relies upon is not indicative of a failure to provide an appropriate range of options** - the CMA's survey asked respondents whether vets considered their personal circumstances when deciding which treatment options to offer them. Linnaeus notes that responses to this question do not suggest that customers were not given an appropriate range of options: • many pet owners may have only used standard services (e.g. neutering, standard vaccinations, microchipping etc), for which personal circumstances are unlikely to impact on the advice and treatment offered; • there may well be instances where vets did not "consider" pet owners' circumstances, but nonetheless presented all available options, allowing the pet owners to decide which is best based on their own personal circumstances; and

		• a pet owner would not necessarily be aware that their vet had considered their personal circumstances (e.g. the vet may not have presented certain options that were clearly outside of the pet owner's price range or would not have been covered by their pet insurance policy).
29.	2.153 – 2.155	**Contextualised care and best clinical care are not mutually exclusive – CMA taints Linnaeus with the internal documents of others** - the CMA states that the documents they have reviewed to date *"have mixed evidence on the range or number of options vet businesses recommend their vets offer to pet owners, with several indicating that vets should prioritise offering the 'best clinical care', but some indicating contextualised care should be offered, or a range of options should be presented."* The CMA alleges that they have seen *"several references in internal documents of the LVGs to their suggested approach being to offer the 'best clinical care' [...] but not necessarily the preferred treatment once contextual factors are considered."* The CMA seems to be suggesting that contextualised care and best clinical care are mutually exclusive. This is not the case – at least in so far as Linnaeus is concerned. As long as pet owners are put in the position of being able to take an informed decision, there is nothing concerning with offering the option which provides the best clinical care – even if it is first in a list of several options. The CMA cites **[Redacted - Confidential]**
30.	2.166	**Speculation on incentives of independent owners** - the CMA speculates that *"owners of vet practices who are themselves vets are directly regulated under the RCVS Code and Supporting Guidance, and may feel more forcibly its pressure to provide sufficient information and suitable recommendations to pet owners."* This is speculation, which is not supported by any evidence. The direct assertion made by the CMA that LVGs run by non-vet managers may not feel pressured to allow their vets to follow ethical obligations is entirely unjustified and is likely to be very harmful to LVGs. Linnaeus management owes a duty to its employees, and would never put its vets in the position of having to compromise on their obligations. Additionally, Linnaeus has embedded medically-qualified members in its executive / management teams (including a Chief Medical Officer), who participate in key commercial decisions alongside non-vets. See further Section 5.23 of Linnaeus' main response.

Section 3 – Consumer choice and competition in referral services and the effects of vertical integration		
31.	**[Redacted - Confidential]**	**[Redacted - Confidential]**
32.	3.55	**General conclusion regarding LVGs which is not correct for Linnaeus** - the CMA states it has "*seen evidence that all LVGs track the extent of outside-group versus in-group referrals, and often have targets for practices around the number or proportion of in-group referrals, or appear to guide that an in-group referral centre should be used*". However, Linnaeus does not track outbound referrals from its FOPs, monitor or set targets for the number or proportion of in-group referrals, or have any policy of pushing its FOPs to refer in-group. With regards to this statement, the CMA lists a number of documents related to other LVGs **[Redacted - Confidential]**
33.	3.62(b)	**Inappropriate inference from anecdotal findings on intra-group referrals** - the CMA refers to a number of submissions made by independent referral centres who do not see many referrals from LVGs, as evidence that LVGs may be encouraged to refer within-group. For example, the CMA states that a *"referral centre submitted that it does not receive many (if any) referrals from LVGs such as* **[Redacted - Confidential]***, and that if it does, the referral has usually been requested by the pet owner, who wanted a referral closer to where they live".* This is <u>not evidence</u> **[Redacted - Confidential]** a policy of encouraging its FOPs to refer within-group, and Linnaeus has submitted clear empirical evidence to the contrary. There may be many reasons why an FOP may rarely refer cases to a particular referral centre, including that the referral centre's pricing is not competitive, it is lower quality than other local referral centres, it is not the most conveniently located for the pet-owner and/or that the FOP has had previous poor experiences with that centre. Moreover, the submission cited by the CMA appears to indicate that customers were made aware of the option to choose the referral centre in question and some chose to use it due to geographic proximity. The CMA cannot properly rely on such vague and unsupported submissions by competitor referral centres as the basis for any degree of concern about the level of competition in the market.

34.	3.85 and 3.98	**It is often not appropriate or possible to provide multiple referral options** - the CMA references its consumer survey finding that 62% of respondents that were recommended a referral to another practice were not given a choice of centres, which ultimately leads the CMA to state its emerging view that a lack of information "*may result in pet owners not effectively considering that they have a choice of referral practices, leading to weak competition in referral services*". This view fails to account for the fact that in many cases there may be one option that is clearly the most appropriate option for the pet owner (in terms of quality of the relevant referral vets in the relevant specialty, location, price and compatibility with the pet owner's insurance policy), considering the principles of contextualised care. In such circumstances, it is entirely reasonable that vets may not provide multiple options. The CMA makes no attempt to assess what proportion of pet owners would be informed of multiple referral centre options in a market where all vets were providing care in a contextualised manner. It is therefore wrong for the CMA to suggest that the 62% figure is evidence that the market is not working well.
35.	**[Redacted - Confidential]**	**[Redacted - Confidential]**
36.	3.101	**CMA fails to note a number of explanations for high proportion of within-group referrals** - the CMA notes that the high rate of within-group referrals could be due to self-preferencing "or other factors" and lists three other factors. The CMA neglects to note the many other legitimate factors for high rates of within-group referrals that are not attributed to self-preferencing. For example, it may just be the quality of the referral centres that means that they receive more referrals. Linnaeus considers its referral centres to be market leading for quality and therefore it is not surprising if its referral centres receive a high rate of referrals from FOPs, including Linnaeus-owned FOPs. This should not cause any competition concerns, provided clinical freedom is maintained and vets remain able to recommend what they consider to be the best option for the pet and pet owner.
37.	3.102	**CMA has incorrectly interpreted CRA's analysis on self-preferencing** - the CMA has stated that the analysis submitted by CRA suggests that self-preferencing is taking place to some extent. The CMA has misunderstood CRA's analysis as the data does not show this. See Section 5.30 of Linnaeus' main response and CRA's economic submission on self-preferencing and higher cost treatment, Appendix C.

38.	3.105 / Table 3.1	**Any analysis of intra-group referrals should take into account the pre-acquisition behaviour of acquired FOP** - the CMA notes that it intends to explore whether it is possible to replicate the analysis on within group referral trends in Table 3.1 for other LVGs. In this regard, Linnaeus notes: • While Linnaeus was not able to review the underlying methodology / data relating to the analysis in Table 3.1, it seems that the analysis which is presented at Table 3.1 does not hold constant for referral centre shares over time. As an LVG's referral centre share increases in an area (e.g. due to an acquisition or expansion), naturally one would expect the proportion of outbound within-group referrals for that LVG to increase. A further issue could also be the mix of FOPs acquired and their distance to the referral centre – the closer acquired FOPs are to the group's referral centre, the higher the proportion will be (as also acknowledge by the CMA in paragraph 3.105). • The CMA should also consider whether an LVG acquired any FOPs which already referred a significant number of referrals to the LVG's referral centre(s). In this scenario, these referrals would not be considered to be potential self-preferencing pre-acquisition, but would be post-acquisition, despite the fact that there is no change in behaviour from the FOP.
39.	3.119 - 3.121	**CMA recognises that there is no evidence of foreclosure effect** - the CMA admits that the evidence it has reviewed to date suggests that the risk of foreclosure of non-vertically integrated FOPs or referral centres and diagnostic labs "is not a widespread or significant concern." This is unsurprising given that the UK veterinary services market is a fiercely competitive market. As discussed in Section 3 of Linnaeus' main response, Linnaeus' referral centres compete vigorously to maintain their reputation among pet owners and referring vets are vital gatekeepers for referral work. Given Linnaeus has a limited primary care estate and its referral centres rely on third-party primary care practices to be commercially viable, offering a lesser quality of service or otherwise attempting to foreclose third-party primary care practices would make no commercial sense – in addition to being inconsistent with Linnaeus' values in the first place. Third-party primary care practices make up the vast majority of Linnaeus' referral centres' work which receive cases from a broad spectrum of practices.
40.	3.128	**Profitability levels not necessarily an indicator of self-preferencing** - the CMA has suggested using the profitability of referral centres in vertically integrated groups as an indicator to assess whether self-preferencing might result in consumers having fewer choices and paying high prices. There are numerous factors that may feed into profitability of referral centres, many of which may not be influenced by the existence or otherwise of self-preferencing (e.g., treatment prices, cost base of the referral centre, levels of demand etc). Moreover, in the absence of any evidence of self-preferencing within Linnaeus, and in the absence of evidence of any detriment

		to consumers, any conclusion that the CMA may ultimately make about levels of profitability will not be capable of amounting to evidence that self-preferencing is in fact occurring.

SECTION C

Linnaeus – Specific comments on the CMA's Medicines Working Paper

Row	Paragraph(s)	Linnaeus comments
CMA's Summary		
1.	2(b) (and also 3.15-3.16; 3.42(b))	**[Redacted - Confidential]**
2.	2(c) (and also 3.24; 3.42(c))	**Misleading comparison of mark-ups data between LVG-owned and independent FOPs –** the CMA states its estimate that LVGs charge effective mark-ups of 300-400% on the purchase costs of medicines (which takes account of rebates and discounts received), alongside a figure of 100% for independent FOPs, which does not take account of rebates and discounts received. Based on these figures, the CMA states that LVG FOPs' retail prices are "*between four and five times their purchase costs*", whereas independent FOPs' retail prices are "*around twice their purchase costs*". This is entirely misleading as it compares two different metrics (effective mark-up for LVG FOPs vs. mark-up on list price for independents FOPs). Contradicting its general conclusion, the CMA states at para. 3.30 that the evidence it gathered indicates that mark-ups applied to list prices by independents are "*broadly similar*" to those applied by LVG-owned FOPs. Further, the CMA also finds that buying groups (which most independent FOPs are members of, see paragraph 6.28) obtain discounts and rebates that are "*broadly comparable to those obtained by most LVGs*" (paragraph 6.92). On the basis of the evidence that the CMA has gathered, it therefore seems that the effective mark-ups of LVG-owned and independent FOPs may often be broadly similar. There is a serious risk that the CMA's misuse of statistics in this instance may cause materially adverse consumer sentiment and consequent commercial harm to LVGs generally and Linnaeus in particular. It is crucial that the CMA is clear that it is not comparing like-for-like in providing these figures, and preferably that it does not present analysis in this misleading way. Instead, if the CMA has concluded that it understands both the mark-ups on list price and effective mark-ups to be broadly similar between LVG-owned and independent FOPs, this should be the conclusion to this part of its analysis.

		The CMA's average effective mark-up for LVG-owned FOPs materially overstates Linnaeus' effective mark-up – the CMA's statement that LVGs charge effective mark-ups of 300-400% on the purchase costs of medicines materially overstates the effective mark-up that Linnaeus applies. Linnaeus receives an average combined discount and rebate of **[Redacted - Confidential]**% and applies an average mark-up of **[Redacted - Confidential]**% on the list price of medicines. This equates to an effective mark-up of c. **[Redacted - Confidential]**% - **[Redacted - Confidential]**. The CMA's conclusion is therefore either inaccurate or a further example of the CMA inappropriately applying a conclusion that relates to other LVGs to Linnaeus as well.
3.	9(c)	**Unsubstantiated suggestion that dispensing and prescription fees may not reflect costs** – the CMA states that its emerging view is that dispensing and prescription fees "*may not reflect the incremental costs of dispensing medication or providing a written prescription*". However, the CMA has yet not conducted any analysis in this respect and therefore this assertion is unsubstantiated. Linnaeus set out analysis of its prescription fee at paragraph 6.5 of its response to the CMA's Issues Statement, that makes clear that its prescription fee is proportionately in line with or cheaper than its average price for a 15-minute initial consultation appointment, and therefore it is not the case that prescription fees are high, relative to the work involved.
Section 3 - Outcomes of competition		
4.	3.13	**CMA's analysis of unit prices for medicines ignores some fundamental considerations** - the CMA notes that it has carried out analysis in relation to the unit prices for medicines which showed a [60-70%] increase in average unit medicine costs over 2014 to 2024 (which the CMA notes is significantly greater than the measures of inflation over the same period). In this regard, Linnaeus refers to Section B, row 17 of this annex.
5.	3.19	**Higher quality of service at LVG-owned FOPs** - as set out in Linnaeus' response to the CMA's Econometrics WP, the CMA's conclusions must take account of quality improvements which may arise when LVGs acquire clinics, and the increased costs which LVGs must absorb to maintain high-quality service offering. Further, medicines prices contribute to the wider costs of Linnaeus providing high quality veterinary care, as set out in further detail in Linnaeus' main response.
6.	3.26 / 3.27	**Impact of incremental costs of supply** – the CMA states with regards to the incremental costs of FOPs retailing medicines that "*the evidence currently available to us does not suggest these other costs are likely to*

		be responsible for what appears to be the premium pricing of veterinary medicines and related fees". This claim is unsubstantiated as the CMA has not conducted analysis on the extent of incremental costs on FOPs in retailing medicines. In addition, this fails to take account of the fact that medicines prices contribute to the wider costs of FOPs providing quality veterinary care, as discussed in Linnaeus' main response. It is therefore not necessarily the case that any margin above medicines' purchase costs and incremental costs equates to pure profit for FOPs. Further, with regards to "*related fees*", see row 3 above.
7.	3.38(c) / (d)	**Misleading comparison of FOP and online pharmacy pricing** – the CMA excludes the fee charged by FOPs for providing a written prescription fee when comparing prices between FOPs and online pharmacies. The prescription fee must be included as an element of the cost to consumers for using online pharmacies when comparing these prices. A prescription fee is a legitimate charge reflecting the expertise, time and cost involved in preparing the prescription. When purchasing medicines at a vet clinic, the prescription fee is included in the overall price to the consumer. Prescribing medicines is a high-risk service that must be carried out by a suitably qualified professional. When written prescriptions are included, the gap between FOP and online pharmacy prices narrows significantly in many cases.
8.	3.39 (and also 5.2)	**Cost base and service incomparable between FOPs and online pharmacies** - the cost base and service proposition of FOPs and online pharmacies are not comparable. In terms of cost base, Linnaeus (and other veterinary businesses) have considerable cost disadvantages compared to online operators, including higher staffing and delivery costs, less efficient storage options (due to the smaller scale of individual clinics) and irregular take up of medicines. In terms of service, in addition to the convenience of buying medicines directly from their local FOP, Linnaeus' own experience is that many customers see value in buying medicines from their local FOP as they can rely on the practice to provide the exact form and quality of product that they need, instead of relying on their own ability to get the online order right.
9.	3.42(c) (and also 4.3)	**Statement that medicines sales are highly profitable, prior to conducting analysis** – the CMA states that "*the sale of veterinary medicines appears to be highly profitable for both LVG-owned and independent FOPs*". The CMA has not yet completed its analysis on profitability and thus this statement is not currently evidenced, prejudges the ongoing analysis, and fails to factor in that margins on medicines contribute to vet business' higher cost bases.
Section 4 – Competition between FOPs		

10.	4.17 / 4.19 / 4.22 / 4.41	**Prices are constrained by competition** –the CMA's finding that location primarily drives customer choice is unsurprising as it is always an important factor in local markets. However, the relevant question is rather what the drivers of choice within a given local area are. The CMA's survey does not explore this question, but one can get a proxy for this by simply ignoring location. Aside from location, recommendations are the key factor, followed by price. Price is likely to be a key component of a recommendation, as owners are unlikely to recommend a practice that they feel is bad value for money. It would therefore be wrong for the CMA to conclude that just because location and recommendations may be more important than price, then there are no competitive constraints on prices. See Sections 4.7-4.9 of Linnaeus' main response and Section 2.2 of Annex 2 for more detailed discussion.
11.	4.37 / 4.38	**Variety in prescription fees are to be expected** – the CMA observes a wide range of prescription fees and suggests that the variety may be due to a lack of competition. Variety in prescription fees is to be expected **[Redacted - Confidential]**. In Linnaeus' experience, prescription fees reflect the time spent on preparing the prescription and are proportionately in line with or cheaper than Linnaeus' average price for a 15-minute initial consultation.
Section 5 – Competition between FOPs and third-party retailers		
12.	5.8 / 5.39	**Low proportion of pet owners using online pharmacies is not the result of an ill-functioning market** – Linnaeus strongly disagrees with the CMA's assertion that low uptake of written prescriptions is a reflection of a market for veterinary medicines that is not working well. The CMA's survey did not collect data on whether pet owners would buy from FOPs or online pharmacies if aware they could buy from online pharmacies at a cheaper price. Many people prefer to buy from FOPs for convenience and trust in the practice and there is good awareness of the ability to purchase medication from third parties. See Sections 6.23-6.24 of Linnaeus' main response and Section 3.1 of Annex 2 for more detailed discussion of the consumer survey results. Furthermore, price may in some cases be cheaper when purchased from a FOP where it is a one-off and inexpensive medicine, due to the prescription fee.
13.	Table 5.1	**Misleading use of data on written prescriptions –** it is misleading for CMA to use this table to suggest it shows that the number of written prescriptions remains a low proportion of medications purchased at LVG-owned FOPs. Linnaeus is not able to identify from the data available how many products are included on each written prescription or how many repeats have been granted per prescription or item.

		The CMA uses "products dispensed" as a proxy for the number of times a product has been invoiced – this indicates the number of times a product was sold, not the total quantity of that medication sold and so the CMA is not comparing like for like. The figures may understate the proportion of medications dispensed by Linnaeus that are covered by written prescriptions, as they do not account for multiple products being included on a single prescription or that a written prescription may grant multiple repeats. As a result, the CMA's estimate of the proportion of medications dispensed that were written prescriptions is unreliable and may significantly understate the proportion of total medications dispensed by written prescriptions. (See Linnaeus' response to RFI 11). This may explain why the proportion is much lower than the consumer survey result (CMA Survey, Figure 94) which found that for over 28% of consumers their usual place to buy repeat prescriptions was from somewhere other than their own vet practice.
14.	5.17 / 5.25	**CMA's survey results on purchasing medicines elsewhere** – the CMA's survey results do not necessarily support a position that consumer awareness of the options to purchase medicines elsewhere is low. Factors such as the need to purchase medicines in the context of surgical procedures or in circumstances where it is necessary for the pet to begin taking the medication immediately are likely to distort the data. See Sections 6.23-6.24 of Linnaeus' main response and Section 3.1 of Annex 2 for more detailed discussion of the consumer survey results.
15.	5.49 / Figure 5.1 / 5.56 – 5.59	**Prescription fees are not being used as a barrier** – the CMA's survey on the reasons customers may prefer buying from FOPs supports the claim that there is a clear difference in service between FOPs and online pharmacies which rebuts the suggestion that prescription fees may be a barrier to switching to online pharmacies. See Section 6.19(c) of Linnaeus' main response.
16.	5.75 - 5.82	**Medicines made available through written prescriptions are not being intentionally restricted** – Linnaeus agrees that the evidence reviewed by the CMA indicates that the scope and length of written prescriptions is purely a clinical decision of the individual vet who must abide by their ethical and regulatory obligations. Linnaeus agrees that written prescriptions are not a barrier to using third-party retailers.
17.	5.83 - 5.96	**Injectables are not being intentionally prescribed to increase barriers** – Linnaeus strongly rejects the CMA's inference that injectable medicines may be intentionally prescribed to increase barriers to online pharmacies. Whether or not injectables are prescribed by Linnaeus clinics is purely a clinical decision of the vet, based on the needs of their patients and in discussion with the pet owner, taking account of ethical and regulatory obligations. Any suggestion that injectables would be prescribed to further commercial aims is

		entirely unfounded in relation to Linnaeus. Given the very significant impact such an allegation from a public authority would have on consumer confidence in the professionalism of vets, such an allegation should not be made in general terms at all and should only be made about specific operators if justified by compelling evidence.
18.	5.84	**CMA's survey results do not support claim that injectables are being intentionally prescribed to increase barriers** – the CMA's consumer survey makes clear that the administration of medicines is not seen as a material barrier by customers to using online pharmacies. Only 5% of respondents listed "Only the vet was able to administer the medication" as a reason why they chose to purchase medication from their current FOP (the 8th highest reason), compared to 50% who said convenience (paragraph 5.49, Figure 5.1).
19.	5.90	**CMA's reference to internal documents on injectables does not relate to Linnaeus** – the CMA states that it has seen evidence that that there is an awareness among market participants that injectables are more likely administered within a FOP and that there may be a financial incentive for FOPs to prescribe injectables over other forms of medication. None of the internal documents referenced by the CMA are Linnaeus' documents and therefore there is no basis for the CMA to extrapolate this allegation to apply to Linnaeus. As set out in row 17 above, given the very significant impact such an allegation from a public authority would have on consumer confidence in the professionalism of vets, such an allegation should not be made in general terms at all and should only be made about specific operators if justified by compelling evidence.
Section 6 - Negotiating power and its consequences for competition		
20.	6.30 and case studies 6.60 - 6.89	**Negotiating power of larger buying groups is equivalent or greater than LVGs** – it is unsurprising that the CMA has found that "larger buying groups have purchase volumes for some veterinary medicines that are equivalent to or greater than some LVGs". As discussed in Section 6.12(b), **[Redacted - Confidential]**