VETERINARY SERVICES FOR HOUSEHOLD PETS

Appendix F: Supporting evidence for Section 8: Competition between FOPs

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CMA
Competition & Markets Authority

Website: www.gov.uk/cma

Members of the Competition and Markets Authority who conducted this inquiry

Martin Coleman *(Chair of the Group)*

Susan Hankey

Robin Cohen

Humphrey Battcock

Keith Richards

Chief Executive of the Competition and Markets Authority

Sarah Cardell

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 Some numbers have been replaced by a range.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

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1. Factors considered when choosing a FOP

1.1 This appendix sets out some further evidence regarding part A, section 8 (Competition between FOPs).

1.2 As set out at in part A, section 8,[1] pet owners may consider a range of factors when choosing a FOP, and the evidence we have seen indicates that the relative importance of these factors differs significantly depending on the characteristics of the pet owner and the context of the choice they are making. In summary, we find that the most important factor for pet owners is location, followed by word of mouth and personal recommendations. A wide range of other factors are given varying weight by different pet owners, including prices, service range and quality, online reviews, opening hours and appointment availability, staff, practice ownership, and parking and/or public transport.

1.3 The point at which pet owners decide to choose a FOP can vary. Some pet owners choose a new FOP when they first get a pet or move home. 35% of respondents to our pet owners survey reported choosing their vet practice in advance of their pet needing any particular treatment. Many other pet owners choose a FOP when they require a routine or non-emergency treatment, including a vaccination, neutering or general health check (53% of respondents to our pet owners survey), while a smaller proportion of pet owners choose a FOP when they require urgent treatment (8% of respondents).[2]

Location

1.4 On the basis of the following evidence, for almost all pet owners, choice of FOP occurs on a local basis and is limited to those providers that are easily accessible.

1.5 As a starting point, we note that as set out in our Analysis of local concentration working paper, the catchment area drive time for 80% of customers ranged from 17 to 20 minutes in urban and small-town areas, 25 to 29 minutes in rural areas, and 30 to 45 minutes in very rural areas. As discussed in that working paper, LVG internal documents look at the presence of competitors and local demographics within a distance of 12 to 40 minutes and/or 5 to 15 miles of a focal site.

1.6 Location was the most common factor that pet owners reported considering in our pet owners survey when choosing a FOP (68% of respondents) and was the most commonly listed main reason for respondents that listed multiple reasons (34% of

[1] Part A, section 8: 'When choosing a FOP, pet owners often consider location and recommendations and are less likely to place weight on prices and other factors'.
[2] Pet owners survey, Q12. This question was only asked of respondents who had been with their current FOP for less than 10 years.

such respondents).[3] Respondents at LVG practices were significantly more likely to list location as a reason, or the main reason, for choosing their FOP.[4] Otherwise, responses remained broadly similar across various pet owner characteristics, including those with different types of animals, those on different incomes and those living in rural vs urban locations.[5]

1.7 Submissions received also indicate that location is the most important factor in pet owners' choice of FOP[6, 7] and other consumer research we have reviewed consistently found location as the main driver of pet owner decision making, including our qualitative research with pet owners,[8] consumer research from Which? in 2023.[9] [10]

Recommendations

1.8 After location, respondents to our pet owners survey most commonly reported considering recommendations, for example from friends and family, when choosing a FOP. 44% of respondents listed this as something they considered and 23% listed it as their main reason. Respondents who used independent practices reported that they were significantly more likely to consider personal recommendations than those that attended LVG practices (51% of respondents at independent practices reported considering recommendations and 27% listed it as their main reason for choosing a FOP, compared to 40% and 20% of respondents at LVG practices). Otherwise, responses remained broadly similar across different pet owner characteristics, including those with different types of animals, those on different incomes and those living in rural vs urban locations.[11]

1.9 Other evidence also indicates that pet owners rely on recommendations when choosing a FOP, including our qualitative research with pet owners, in which a large proportion of pet owners took recommendations into account.[12] For example,

[3] Pet owners survey, Q13 and Q14. These questions were only asked of respondents who had been with their current FOP for less than 10 years.
[4] Pet owners survey, Q13 and Q14. Those that attended LVG practices were significantly more likely to list location as a reason (70% to 65%) or the main reason (36% to 30%) for choosing their FOP.
[5] Pet owners survey, Q13 and Q14. Out of these characteristics, the only significant difference reported was that respondents with only cats were significantly more likely than respondents with only dogs to list location as the main reason for choosing their FOP (39% to 30%).
[6] For example, LVG responses to RFI1 Q8 and Independent responses to RFI1 Q5 [✂] [✂]; [✂].
[7] For example, an LVG [[✂]] marketing doc focuses on [✂]; [✂]: KPIs including SEO for searches including 'vet near me'.
[8] Qualitative consumer research with pet owners, p4.
[9] Consumer harm in veterinary services - Which? Policy and insight, which found location to be the most important reason for choosing a practice (70% of respondents, with next highest factor 34%).
[10] For example, LVG responses to RFI3 Q23 and 28. [[✂]; [✂].
[11] Pet owners survey, Q13 and Q14. Out of these characteristics, the only significant difference reported was that respondents with only dogs were significantly more likely than respondents with only cats to list recommendations as the main reason for choosing their FOP (26% to 17%).
[12] Qualitative consumer research with pet owners, p4.

IVC submitted that personal word-of-mouth recommendations were an important driver of customer choice of FOP,[13] and an [✂].[14]

1.10 In our qualitative vet research, most veterinary surgeons reported that they did not do very much proactive marketing. Instead, many veterinary professionals reported their practice relying on word of mouth to increase custom. This was the case across LVGs, small groups and independent practices.[15]

1.11 In our roundtable with vets who had recently set up practices, most attendees stated they did not invest much in paid marketing as they relied on social media and word of mouth, and that Google reviews were important in attracting clients to their businesses.[16] The marketing carried out by an attendee at our Edinburgh roundtable when they opened their business included leaflets, Facebook ads and local dog shows.[17]

Practice ownership

1.12 We have observed a variety of views on the importance of practice ownership (that is, whether it is an independent or LVG practice). As noted above, 21% of respondents to our pet owners survey reported considering practice ownership when choosing a FOP. Of these respondents, 68% preferred independent practices, with the remaining 32% preferring LVG practices.[18] For those that preferred independent practices, the top reasons given were individual vet continuity (56%), individually tailored service (50%), overall quality of service (46%) and trust in their vets' advice (40%).[19] By comparison, for those that preferred LVG practices, the top reasons given were appointment availability (55%), the range of services available (42%) and prices (21%).[20]

1.13 The relevance of practice ownership was also noted in our qualitative research with veterinary professionals, with some vets at independent practices saying that their independent status was a key selling point for pet owners.[21] Similarly, at our roundtable with those who had recently set up practices, some attendees felt their reputation as independents helped them attract clients.[22]

1.14 [✂].[23] [✂].[24] Of the six LVGs, Medivet and Pets at Home use centralised branding that makes it clear their practices are part of a large group, as we discuss in part

[13] IVC IS Response, p5.
[14] LVG response to RFI3, Q26. [✂]
[15] Qualitative research with veterinary professionals, pp 95-96.
[16] Summary of vets who recently set up a practice roundtable discussion, p 2.
[17] Summary of Edinburgh roundtable discussions, pp 4-5.
[18] Pet owners survey, Q13.
[19] Pet owners survey, Q22. More than one answer could be given, so percentages sum to more than 100%.
[20] Pet owners survey, Q23. More than one answer could be given, so percentages sum to more than 100%.
[21] Qualitative research with veterinary professionals, pp 96-97.
[22] Summary of vets who recently set up a practice roundtable discussion, pp 2-3.
[23] For example, LVG response to RFI1, Q8 [✂].
[24] LVG response to RFI1, Q52 [✂].

A, section 8 (Competition between FOPs). However, we note that internal documents indicate that at least some LVGs make decisions to brand their business in a way which does not identify the corporate owner.

Other factors

1.15 After location and recommendations, the factors that pet owners consider appear to vary widely depending on pet owner characteristics and the context in which they are choosing a FOP. Reasons listed in our pet owners survey are set out in Table 1.1 below. Table 1.1 presents results based on two groups of respondents: those that have been with their FOP for less than 10 years, and those that have been with their FOP for less than two years. Overall, results do not differ significantly between these two groups.[25]

Table 1.1: Reasons reported for choice of FOP

	*Percentage of respondents that listed factor as **a** reason*		*Percentage of respondents that listed factor as **the main** reason*	
Base	*Have been with FOP for less than **10** years*	*Have been with FOP for less than **2** years*	*Have been with FOP for less than **10** years*	*Have been with FOP for less than **2** years*
Location	68%	63%	34%	32%
Recommendations (from friends, family, etc)	44%	40%	23%	22%
Impression of the practice, staff or website	29%	29%	6%	5%
Prices	25% (20% for vaccination and medicines; 15% for consultation)	30% (22% for vaccination and medicines; 18% for consultation)	7% (5% for vaccinations and medicines; 2% for consultation)	6% (4% and 2%)
Appointment availability	28%	28%	4%	6%
Services offered	26%	29%	4%	5%
Opening hours	26%	28%	3%	4%
Parking and transport	25%	22%	2%	2%
Practice ownership	21%, including 14% that preferred independent and 7% that preferred LVG ownership	20%, including 14% that preferred independent and 6% that preferred LVG ownership	5%, including 4% that preferred independent and 1% that preferred LVG ownership	6%, including 5% that preferred independent and 1% that preferred LVG ownership
Online reviews	19%	24%	4%	5%

[25] In response to our working papers, Linnaeus and CVS submitted that asking customers about past behaviour up to 10 years ago is likely to result in recall bias, and Linnaeus submitted that the choices respondents made up to 10 years ago are less likely to be relevant to the current market given the changes in FOP ownership structure and care over the last 10 years. Linnaeus response to working papers, Annex 2, pp 3-4; CVS response to working papers, Annex 1, p 2. Noting these submissions, we have also considered response rates based on only those respondents that reported choosing a FOP in the past two years. However, notwithstanding potential recall biases and changes in market structure, we consider that responses made about choices made more than two years ago are still relevant to inform our understanding of the market. We have therefore considered and presented response rates based on both groups of respondents.

A special offer	4%	6%	1%	2%
Other	6%	8%	6%	6%

Source: Pet owners survey, Q13†, Q14‡
† Pet owners survey, Q13 'Still thinking about your current vet practice, thinking back to when you registered with them, why did you? Please select all that you considered when making your decision'.
‡ Pet owners survey, Q14 asked of all *those who gave multiple responses at Q13: 'And what was the main reason?'.*

1.16 Compared to respondents who did not choose a FOP in an urgent situation, respondents that reported choosing a FOP for 'urgent or emergency treatment' were significantly more likely to report considering appointment availability as a reason (36% to 27%) or their main reason (13% to 4%) for choosing a FOP. On the other hand, they were significantly less likely than respondents who did not choose a FOP in an urgent situation to report considering other factors such as location, prices of vaccinations and medicines and recommendations.[26] Overall, those respondents who chose a FOP in an urgent situation reported considering fewer factors than others (listing an average of 3.3 factors in total, compared to 3.8 for those who did not choose a FOP in an urgent situation).[27]

1.17 Other customer research was broadly consistent with the findings from our pet owners survey. Our qualitative research with pet owners and research with market participants indicated that, besides location and recommendations, customers considered online reviews, accessibility and appointment availability.[28] Our qualitative consumer research on remedies found that the most frequently mentioned factors were location and access, reviews and recommendations and prices/value. Less cited factors included ownership and services and facilities.[29] We also reviewed LVG internal documents and note that they supported this finding.[30]

1.18 Submissions and documents from both independents and LVGs also indicated that, besides location and recommendations, pet owners consider factors such as cost, quality of clinical care, convenience (for example parking and appointment availability), communication and local reputation.[31]

[26] Pet owners survey, Q13 and Q14. Location: 57% to 70% considered it as a reason. Prices of vaccinations and medicines: 11% to 22% considered it as a reason. Recommendations: 36% to 47% considered it as a reason and 15% to 26% as their main reason.
[27] Pet owners survey, Q13 and Q14.
[28] Qualitative consumer research with pet owners, pp 4-5; Which? consumer harm in veterinary services, 22/12/23.
[29] Qualitative research with consumers, Research report by Blue Marble for the CMA, December 2025, published 16 December 2025, pp.22-23.
[30] For example: LVG response to RFI3, Q23 [✂]; LVG response to RFI3, Q15 [✂]; LVG response to RFI3, Q22 [✂]; LVG response to RFI3, Q26 [✂].
[31] LVG responses to RFI1, Q8 [✂];[✂];[✂];[✂];[✂]; Independent responses to RFI Q5 [✂];[✂];[✂][✂].

2. Analysis from CVS and [✂]regarding net promoter score (NPS) rates

2.1 As set out in part A, section 8,[32] we received evidence from CVS and [✂] in response to our working papers that assessed whether NPS was correlated with customer switching (CVS) and other performance metrics ([✂]).

2.2 Both CVS and [✂] submitted that their (individual) analysis confirms the importance of customer perceptions of quality. In particular, CVS submitted that its analysis indicates that customers will act on their perception of quality,[33] and that the increase in range of treatment options and quality over recent years has been driven by a demand from customers for these services and improvements.[34] [✂] told us that while it does not see NPS as a valuable external differentiator, it uses NPS internally to identify where quality improvements are needed.[35]

2.3 Overall, our view is that CVS and [✂]'s analysis indicate there may be a correlation between NPS and (a) customer switching, (b) [✂] and (c) annual number of visits to the vet. We consider this supports the view that customers care about quality, and that some customers may act on their own perceptions of quality when choosing vet services or considering whether to switch FOPs. However, we still have some concerns with NPS as a measure of quality, and do not consider that it accurately reflects clinical quality standards such as, for example, increases in the range and quality of treatments being offered.

CVS' analysis

2.4 CVS' analysis compares NPS rates (which are routinely collected from its customers) with switching rates between 2021 and 2025.

2.5 CVS uses requests for medical records from non-CVS practices as a proxy for switching. This includes switching for non-competitive reasons (such as pet owners moving home). CVS was able to identify and remove some switches for non-competitive reasons, but due to data availability this was only around [✂]% of switches (compared to around 40% of switches in our pet owners survey).[36]

2.6 Based on CVS' data, approximately [✂]% of pet owners switched each year and requested medical record transfers, with this rate dropping to [✂]% of patients after removing switches for clearly non-competitive reasons.

[32] Part A, section 8: Net Promotor Score.
[33] CVS response to the February 2025 Working Papers, Annex 4, page 7.
[34] CVS response to the February 2025 Working Papers, Annex 4, page 2.
[35] [✂].
[36] CVS response to February 2025 working papers, Annex 4, p8.

2.7 CVS' analysis finds that NPS is negatively correlated to the proportion of pet owners that switch, although the relationship is noisy, as set out in Figure 2.1. CVS' NPS is computed such that it has a range between -100 and 100.[37]

Figure 2.1: [✂]

[✂]

Source: [✂].

2.8 CVS' analysis attempts to produce a more robust analysis by controlling for differences between sites and over time using a two-way fixed effects estimator. Based on this, it finds that a [✂]-point increase in NPS leads to a [✂] percentage point decrease in the proportion of pet owners that switch. It finds similar results after excluding outliers and dropping switchers identified as being for non-competitive reasons, for example moving home.[38] CVS submitted that this [✂] percentage point decrease per [✂]-point increase in NPS is significant in terms of magnitude compared to total switching rates.[39]

2.9 However, we consider that this estimator is likely to be biased due to a staggered treatment problem. The estimator used by CVS implicitly compares changes in switching rates between practices with different changes in the net promoter score. This is only valid if the impact of a change in the net promoter score on the switching rate is the same across practices and over time. This appears to be particularly problematic in the analysis submitted by CVS because all practices record changes in the NPS across all time periods. In response to the PDR, CVS submitted that this staggered treatment bias is mitigated by the fact that its analysis is a standard "within" estimator rather than a difference-in-differences analysis (specifically, its analysis is a two-way fixed effects regression where the treatment (NPS) is a continuous variable that varies both across time and across FOPs.[40]

2.10 Overall, our view is that CVS' analysis indicates there may be a correlation between a practice's NPS score and customer switching.

2.11 We also note that the results of CVS' analysis do not indicate that quality shortcomings give rise to a significant customer response, given very low levels of total reported switching.[41] Even a significant increase in NPS, for example an

[37] Net scores are derived from an individual respondents' response to the question: 'How likely (on a scale of 0-10) are you to recommend [Business Unit] to a friend or colleague?' NPS is then derived from net scores, with 'promoters' rating 9 to 10 and 'detractors' rating 0 to 6. Specifically, CVS' NPS is computed as follows: NPS = [[total promoters – total detractors] / total responses] x 100.
[38] To mitigate issues around inconsistent reporting, the analysis focusses primarily on changes over time within practices (using fixed effects), where data is more likely to be comparable.
[39] CVS response to the February 2025 Working Papers, 21 March 2025, Annex 4, p7. HouseStyle.
[40] CVS response to the PDR, Appendix to Annex 1, p2.
[41] In response to the PDR, CVS submitted that a [✂] percentage point decrease in switching in response to a [✂]-point increase in NPS is 'highly economically significant' when compared to the mean switching rate across FOPs of [✂]%,

increase of 30 points, only decreases the switching rate by [✂]%. On that basis, we consider that these results do not indicate that consumers have a significant propensity to switch FOPs on the basis of quality.

2.12 Finally, we note that there could be a selection effect, where customers responding to a net score survey are the most engaged customers, and hence the most likely to switch if they are dissatisfied.

[✂] analysis

2.13 [✂] analysis compares 'net score' rates (which are used to derive NPS, and are collected by [✂] from pet owners following their first consultation and during visits for vaccinations) with [✂]per pet owner and number of visits per pet owner between January 2020 and May 2022.[42]

2.14 [✂] analysis finds that:

(a) A one-point increase in net score (which ranges between 0 and 10) was correlated with an increase in [✂] per pet owner of around [✂] – which is around [✂]% of pet owners' total [✂] (£[✂]).

(b) A [✂]-point increase in net score was correlated with [✂] additional yearly FOP visit per pet owner. In addition, the percentage of 'lost' clients (defined as clients who had no yearly visits in the 7 to 365 days after responding to the net score survey) was [✂].

2.15 Overall, our view is that [✂] analysis indicates there may be a correlation between net scores and [✂], and between net scores and number of visits to the vet. However, as with CVS' analysis, we still have more general concerns with NPS as a measure of quality, and do not consider that it accurately reflects clinical quality standards such as, for example, increases in the range and quality of treatments being offered.

2.16 In addition, we note that [✂] asks customers about satisfaction after their first consultation or at a vaccination, at which point it may be difficult to evaluate anything other than basic aspects of customer service. We also note that, as for CVS' analysis, there could be a selection effect where customers responding to a net score survey are the most engaged customers, and hence the most likely to attend the vet fewer times or spend less money if they are dissatisfied.

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implying that a [✂]-point increase in NPS reduces switching by [✂]%. We accept that as a proportion of the small overall switching rate, a [✂] percentage point increase is significant. However, we still consider that *overall*, these results do not indicate that consumers have a significant propensity to switch FOPs on the basis of quality. CVS response to the PDR, Appendix to Annex 1, p2.

[42] [✂].

3. Evidence relevant to marketing quality of services

3.1 As set out in part A, section 8,[43] evidence suggests that the nature of marketing by LVGs is largely determined by whether it is carried out at a local, regional or national level. National level marketing tends to be more systematic while local can be more ad hoc. Evidence indicates that this is also true of marketing on the basis of quality.

3.2 LVG submissions indicated that Pets at Home is the only LVG that invests in predominantly national brand marketing, the latest of which[44] led on a quality message.[45] This includes:

(a) quarterly marketing campaigns (which can be opted into by practices within the group);

(b) marketing based on search or pay per click; and

(c) ad hoc marketing due to a number of factors, such as the need to drive new client registrations, the opening of a competitor site in a local area, or the desire to be involved in local community events.

3.3 Pets at Home provided six examples of local marketing around the extension/relocation of practices and new practices. Two of these included detailed explanations of quality improvements.[46] However, an internal document dated March 2024 noted that some practice owners reported that [✂].[47]

3.4 Other LVGs submitted that their marketing originated from individual practices (except CVS,[48] which submitted that its marketing was carried out on both a regional and local basis).

(a) IVC submitted that at the local level, individual practices were responsible for marketing their individual quality proposition – although IVC may support local practices in advertising their quality proposition by providing locally-branded marketing materials.[49]

(b) VetPartners submitted that its practices 'have a large degree of autonomy, and this would include autonomy over marketing strategies'. This decentralised approach to marketing includes, for example, in-practice noticeboards, social media, practice websites, local newspaper articles, customer emails and leaflet drops or direct mail. VetPartners also submitted

[43] Part A, section 8: 'FOPs' marketing and disclosure of information about the clinical quality of their services is limited'.
[44] That is, the latest of which we have been made aware.
[45] Pets At Home response to RFI17, Q32, paragraph 32.1.
[46] Pets At Home response to RFI17, Q32, Annex 009 RFI17.
[47] Pets At Home, March 2024.
[48] CVS response to RFI17, Q32, paragraph 97.
[49] IVC response to RFI17, Q32, paragraph 32.4.

that it supported practices to improve their marketing efforts, including by issuing around 250 press releases since January 2022.[50]

(c) Medivet submitted that marketing was generally carried out on a local basis (with some recent social media and consumer PR campaigns being carried out on a national basis).[51]

3.5 Linnaeus' submitted that its quality proposition was advertised locally by each practice, with the marketing, public relations and advertising being focused on the relevant local community.[52]

3.6 The lack of evidence on the support LVGs offer to local practices on marketing their quality is in contrast to the documentary evidence of the role certain LVGs have in directing and supporting price rises across their local practices.[53]

3.7 Examples provided of marketing on the basis of quality were typically focused on renovations/relocations or investments in new equipment at particular sites or on staff qualifications and training. For example:

(a) CVS submitted marketing articles regarding relocation which sometimes referenced new facilities/services.[54]

(b) Linnaeus provided press releases on renovations and investments at three sites, four of which were patient case studies, three of which related to awards and accreditations, and two of which marketed years of experience/service of staff.[55]

(c) Among other materials, IVC submitted two social media posts, one about the dental treatment of a particular patient (including dental X-rays) and another with a video walk-through of a new practice site and two practice websites one with a 'Client Charter' and the other showcasing various awards.[56]

(d) Medivet submitted a brochure on a 24-hour hospital at Woodstock promoting a new CT imaging suite and outpatient CT diagnostic service.[57]

(e) VetPartners submitted three examples of local marketing initiatives. The most detailed was regarding [✂], whose marketing consisted of a 'word cloud' in reception, a practice noticeboard, Facebook/Instagram posts, an open day, free new pet checks and a summary of online reviews. VetPartners also

[50] VetPartners response to RFI17, Q32, paragraph 32.1-32.3.
[51] Medivet response to RFI17, Q32, Medivet putback response.
[52] Linnaeus response to RFI17, Q32, paragraph 32.1.
[53] This documentary evidence relating to LVG price rises is set out in Appendix E: Other supporting evidence on market outcomes, Internal document evidence on price rises.
[54] CVS response to RFI17, Q32, paragraph 100, footnote 13.
[55] Linnaeus response to RFI17, Q32, paragraph 32.4.
[56] IVC response to RFI17, Q32, Bath Vet Group Client Charter; White Cross Vets.
[57] Medivet response to RFI17, Q32, Appendix 32.

submitted an example of a marketing leaflet highlighting the range of services offered by a local practice, as well as various examples of news releases regarding specific clinical cases and highlighting the extensive transformation of two practices.[58]

[58] Vet Partners response to RFI17, Q32, paragraph 32.2.

4. Switching rate estimates

4.1 As set out in part A, section 8,[59] we have assessed two primary sources of evidence to estimate switching rates: our pet owners survey and data from insurers.[60]

4.2 In our pet owners survey, we observed the following:

(a) 3% of respondents said that they switched practices in the past year for reasons relating to the competitive offerings of FOPs,[61] which we refer to as proactive switching. This excludes a further 2% of respondents that switched due to moving home or because their previous FOP had closed down, which we refer to as reactive switching.

(b) 6% of all respondents said that they had proactively switched practices in the past two years, rising to 13% in the past five years and 18% in the past ten years. 25% of respondents to our pet owners survey said that they had been with their current practice for more than ten years.[62] These rates were very similar for insured and non-insured customers.[63]

(c) Reported switching rates in the past ten years were lower for newer pet owners, with 13% of respondents that had been a pet owner for less than 10 years reporting proactive switching since getting their pet.[64]

4.3 In response to our working papers, Pets at Home's economic advisors (NERA) conducted an analysis of the insurer datasets we used to assess pricing trends, which suggests a higher FOP switching rate than the rate observed in our pet owners survey.[65]

(a) NERA's analysis identifies the most frequently visited FOP in any given year for each pet in the insurance datasets and compares this to the most frequently visited FOP in the previous year. If they are not the same FOP, NERA counts this as the customer switching FOPs. In cases where there is more than one FOP with the highest number of visits in a year for a given

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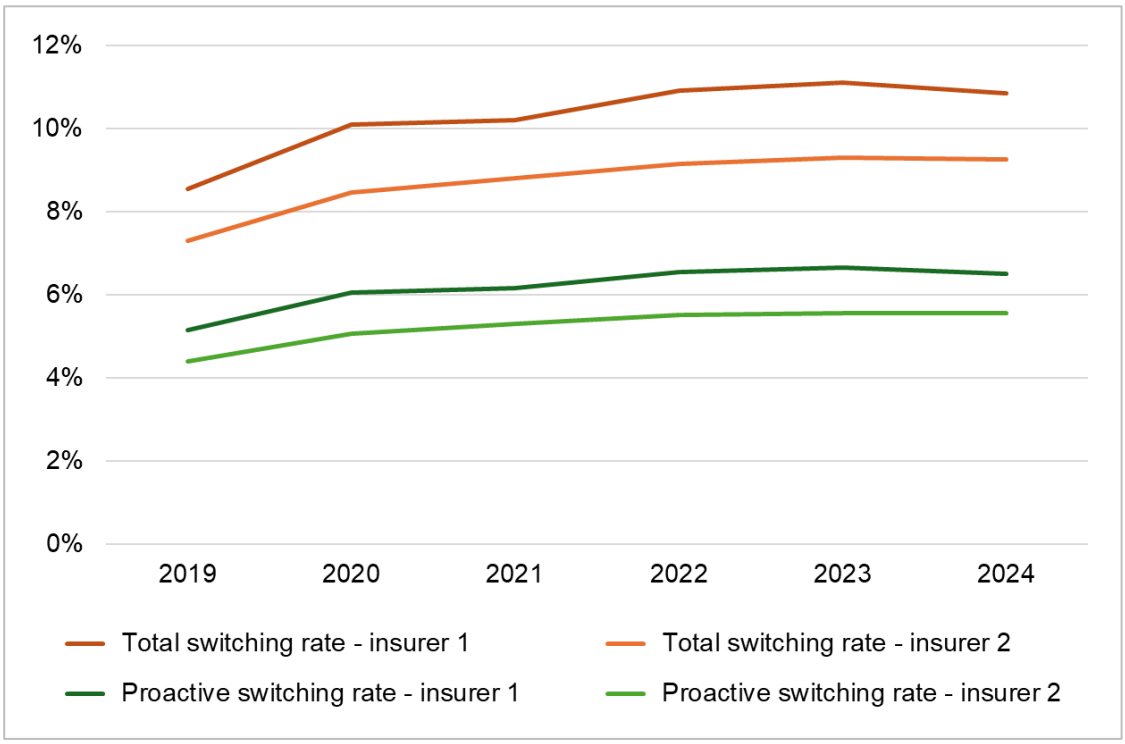
[59] Part A, section 8: Current rates of switching and reasons for switching.
[60] We note that [✂] also provided a proxy for customer switching based on [✂]. We have not given significant weight to these estimates because [✂].
[61] Pet owners survey, Q12A and Q33.
[62] Pet owners survey, Q11. 41% of respondents reported joining their practice in the past ten years and not switching. 13% reported *reactively* switching practices in the past ten years. 3% reported joining their practice in the past ten years and could not recall whether they had switched from another practice.
[63] Exact rates for currently insured respondents and respondents that had not been insured in the past three years were 3.1% and 3.2% respectively. Among insured respondents, proactive switching rates were 3.1% in the past 12 months, 6.1% in the past two years, 12.9% in the past five years and 18.5% in the past ten years. Among respondents that had not been insured for the last three years, equivalent switching rates were very similar at 3.2%, 6.9%, 13.3% and 18.3% respectively.
[64] Pet owners survey, Q12A and Q33. 72% reported that they had not switched practices, 4% could not recall whether they had switched and 11% reported switching because they moved home or because their previous vet had closed down.
[65] Pets at Home response to working papers, p58.

pet, NERA calculates a lower bound switching rate by counting all such FOPs as the most frequently visited FOP in that year. To calculate an upper bound switching rate, NERA only considers the FOP with the latest treatment start date as the most frequently visited FOP in that year.[66] The first two rates in Figure 4.1 present the average of these upper and lower bound estimates, using each of the two insurer datasets.

(b) NERA's analysis does not distinguish between proactive and reactive switching. In our survey, approximately 40% of total switching was reactive (because the pet owner moved home or their previous FOP closed down), with this rate being broadly consistent between pet owners that switched in different years[67] and among pet owners with or without insurance.[68] The second two rates in Figure 4.1 present an estimate of proactive switching that we have obtained by subtracting 40% from NERA's total estimated switching rate.

Figure 4.1: Switching rates from data submitted by two insurers [insurer 1] and insurer 2] – 2019 to 2024



CMA analysis and Pets at Home response to working papers, confidential Appendix, p3.

4.4 We note three further points in relation to this analysis:

[66] Pets at Home response to working papers, confidential annex, p2.
[67] In our pet owners survey (Q33), reactive switching constituted 38% of switches in the past year, 43% of switches between 1-2 years ago, 43% of switches between 2-5 years ago, and 41% of switches between 5-10 years ago.
[68] In our pet owners survey (Q33), reactive switching constituted 40% of switches among those respondents that said they were insured currently or in the past three years, and 43% of switches among those respondents that said they had not been insured in the past three years.

(a) First, we consider that the switches counted are likely to include some customers that did not genuinely switch FOPs. Because the classification of practices between FOPs and referral centres is not perfectly accurate in the insurer data, some 'switches' could in fact be referrals to a specialist vet, to another FOP that offers different services, or to a referral centre. This may include LVG FOPs referring customers to other FOPs owned by the same LVG, for example for a scan or for OOH treatment. By itself, this indicates that NERA's estimates may *overstate* actual switching rates.

(b) Second, NERA's switching rates only measure switching within each insurer's data. Actual switchers would not be counted if they switched or cancelled their insurance in a given year and also switched FOPs in that year. Therefore, NERA submitted that these switching rates likely understate the true level of FOP switching.[69]

(c) Third, NERA's analysis only considers insured pet owners, who might engage differently to non-insured pet owners regarding their choice of FOP. However, we note that switching rates in our pet owners survey did not differ based on insurance coverage, as noted above.

4.5 Together, we consider that these factors give rise to some uncertainty in the switching rates estimated from insurer data, which the switching rate from the pet owners survey does not face. On the other hand, the switching rate from insurer data is conducted on a very large sample of pet owners over a long period of time, whereas our pet owners survey was a point-in-time analysis conducted on a robust but significantly smaller sample of around 1,750 pet owners.

4.6 On this basis, we have given weight to both estimates and consider that actual proactive switching rates are likely to be between around 3% to 6% annually.

[69] Pets at Home response to working papers, confidential annex, p2.

5. Switching rate benchmarks

5.1 As set out in part A, section 8,[70] we have considered how rates of switching compare to benchmarks in other industries.

5.2 In our working paper, How people purchase veterinary services, we considered how the rate of switching FOPs compares to potential benchmarks, while noting that different circumstances in other sectors may lead to different consumer switching rates. We observed that switching rates were higher for other common household expenses such as insurance, broadband, mobile, energy, banking and more.[71]

5.3 In response to our working papers, LVGs submitted that switching rates in the veterinary sector are not comparable to these other household sectors.[72] Instead, LVGs submitted that:

(a) The relatively lower switching rates in the veterinary sector are likely more consistent with those for human healthcare, which similarly involve trust-based long-term relationships.[73]

(b) Unlike veterinary services, many other household purchases are purchased on a periodic basis, providing frequent opportunities for switching. They also do not have a personal or emotional element, are not in 'credence' markets and do not operate on a local basis.[74]

(c) Switching rates in the veterinary sector are comparable to other trust-based sectors such as lawyers, financial advisors, accountants, private childcare and therapists.[75]

5.4 Noting these submissions, we observe that the switching rates between FOPs are (a) lower than switching rates in common household utilities, but (b) comparable to switching rates in other trust-based sectors. However, our view that it is very difficult to compare the low switching rates between FOPs with switching rates in other industries, given that customers of other services may face different switching barriers and may obtain more or less value from remaining loyal to their existing provider or from switching providers.

[70] Part A, section 8: Current rates of switching and reasons for switching.
[71] Paragraph 5.69 of our working paper, How people purchase veterinary services.
[72] VetPartners response to the CMA's working paper on How people purchase veterinary services, p 4, Medivet response to working papers, p 42, Linnaeus response to working papers, p 32, IVC response to working papers, p 21.
[73] VetPartners response to the CMA's working paper on How people purchase veterinary services, p 4.
[74] Medivet response to working papers, p 42.
[75] IVC response to working papers, p 21. [✂].

6. Evidence relevant to the correlation between insurance coverage and spend

6.1 As set out in part A, section 8,[76] we saw evidence from LVGs that insurance coverage is likely to be correlated with higher spending. For example:

(a) A third-party assessment of European vet services markets from 2018 submitted by an investor in an LVG [✂] notes that, [✂].[77]

(b) An LVG [✂] document identifies increasing insurance uptake as a growth opportunity, as those with insurance are more valuable. The document highlights that, by improving insurance penetration, the LVG [✂] can 'help client[s'] ability to pay and increase the level of care' delivered. Most of the LVG's clients ([✂]) were identified as not covered by insurance, which was identified as a 'volume risk' for the organisation.[78] A market analysis document submitted by an investor in an LVG [✂] also identified an increased penetration of pet insurance as a facilitating factor in higher spend on vet services.[79]

(c) Another LVG [✂] document identifies that a pet owner covered by insurance is [✂] times, or around £[✂], more valuable per year than an uninsured one.[80]

(d) A document submitted by an investor in an LVG [✂] identifies [✂].[81]

6.2 More general academic evidence, albeit not from the UK or specifically in relation to the veterinary service industry, suggests that there is a strong positive correlation between health insurance coverage and medical spending in credence goods markets.[82]

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[76] Part A, section 8: The role of insurance in veterinary services.
[77] LVG Investor response to RFI3, Q3 [✂].
[78] LVG response to RFI3, Q15 [✂].
[79] LVG Investor response to RFI3, Q2, Q3 [✂].
[80] LVG response to RFI3, Q15, [✂].
[81] LVG Investor response to RFI3, Q6 [✂].
[82] These results come from studies across a range of countries including the US, China and Japan, from a range of human healthcare contexts, including prescription, emergency services and general healthcare services, and involving various age groups.
Anderson, M., Dobkin, C., & Gross, T. (2012). The effect of health insurance coverage on the use of medical services. American Economic Journal: Economic Policy, 4(1), 1-27.
Anderson, M. L., Dobkin, C., & Gross, T. (2014). The effect of health insurance on emergency department visits: Evidence from an age-based eligibility threshold. *Review of Economics and Statistics*, *96*(1), 189-195.
Card, D., Dobkin, C., & Maestas, N. (2008). The impact of nearly universal insurance coverage on health care utilization: evidence from Medicare. *American Economic Review*, *98*(5), 2242-2258.
Card, D., Dobkin, C., & Maestas, N. (2009). Does Medicare save lives? *The quarterly journal of economics*, *124*(2), 597-636.
Clemens, J., & Gottlieb, J. D. (2014). Do physicians' financial incentives affect medical treatment and patient health? *American Economic Review*, *104*(4), 1320-1349.

6.3 An academic synthesis of this body of evidence proposes that the increase in medical spending due to insurance coverage may be attributable to at least two of four explanations, these being (i) adverse selection where individuals with a higher risk of needing care are more likely to purchase insurance; (ii) moral hazard where insured patients ask for more services, or more expensive services; (iii) agency version moral hazard where doctors prescribe more or more expensive services to insured patients; and (iv) second-degree moral hazard where doctors prescribe more or more expensive services to insured patients because they have financial incentives to do so and anticipate less resistance from insured patients.[83]

6.4 There is evidence of second-degree moral hazard from human healthcare.[84] There is similar evidence of insurance creating second-degree moral hazard from other credence goods settings such as computer repair services[85] and taxi ride services.[86]

Iizuka, T. (2007). Experts' agency problems: evidence from the prescription drug market in Japan. *The Rand journal of economics*, *38*(3), 844-862.
Iizuka, T. (2012). Physician agency and adoption of generic pharmaceuticals. *American Economic Review*, *102*(6), 2826-2858.
Lundin, D. (2000). Moral hazard in physician prescription behavior. Journal of health economics, 19(5), 639-662.
Wagstaff, A., & Lindelow, M. (2008). Can insurance increase financial risk? The curious case of health insurance in China. *Journal of health economics*, *27*(4), 990-1005.
Wagstaff, A., Lindelow, M., Jun, G., Ling, X., & Juncheng, Q. (2009). Extending health insurance to the rural population: an impact evaluation of China's new cooperative medical scheme. *Journal of health economics*, *28*(1), 1-19.

[83] Kerschbamer, R., & Sutter, M. (2017). The economics of credence goods–a survey of recent lab and field experiments. CESifo Economic Studies, 63(1), 1-23.

[84] For example, in a field experiment in China, academics studied doctors' prescribing decisions using controlled hospital visits with randomised patient insurance and doctor incentive status – patients were presented as insured or uninsured to doctors from whom the prescribed medication would be bought or not. The study found that doctors wrote 43% more expensive prescriptions to insured patients when they expected to obtain a proportion of the patient's drug expenditure. Lu, F. (2014). Insurance coverage and agency problems in doctor prescriptions: evidence from a field experiment in China. Journal of Development Economics, 106, 156-167.

[85] Kerschbamer, R., Neururer, D., & Sutter, M. (2016). Insurance coverage of customers induces dishonesty of sellers in markets for credence goods. Proceedings of the National Academy of Sciences, 113(27), 7454-7458.

[86] Balafoutas, L., Kerschbamer, R., & Sutter, M. (2017). Second-degree moral hazard in a real-world credence goods market. The Economic Journal, 127(599), 1-18.