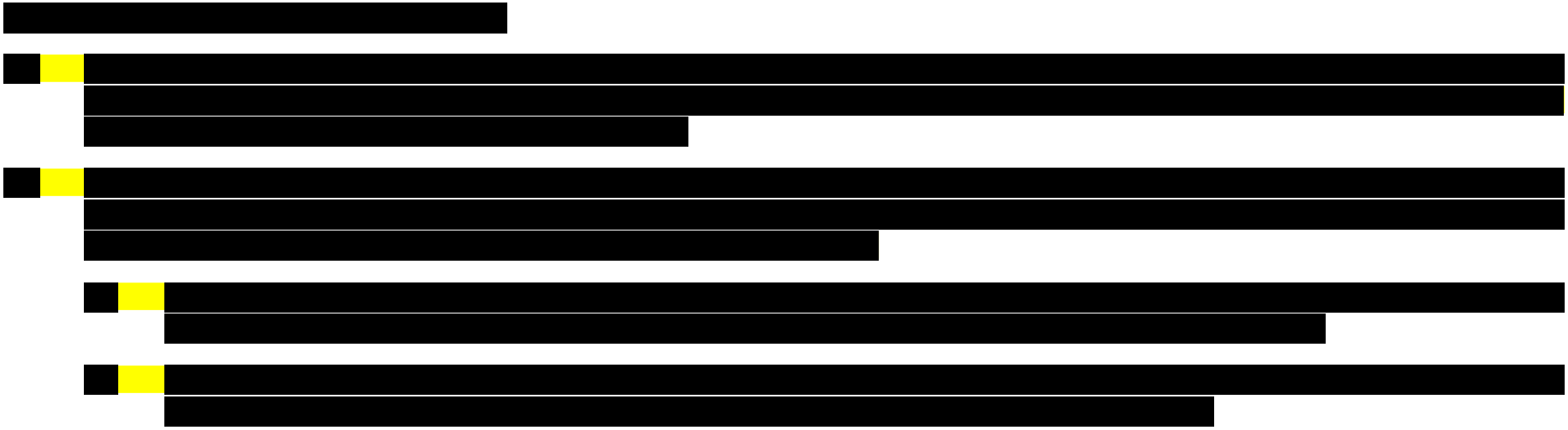
ANNEX 1 – Local Concentration

1. This annex presents the impact of incorporating RCVS unconfirmed independent sites into the CMA's local concentration analysis within catchment areas of Medivet's focal sites where Medivet owns at least one additional site (multi-ownership areas). Medivet's analysis focuses on areas flagged by the CMA for potential competition concerns based on the four-or-fewer fasciae screening filter. The results are detailed by local area type in the remainder of this annex.



Medivet focal site	Sites in focal site catchment area identified by CMA	Additional independent sites identified
[redacted]		

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Medivet focal site	Sites in focal site catchment area identified by CMA	Additional independent sites identified
[redacted]		

Medivet focal site	Sites in focal site catchment area identified by CMA	Additional independent sites identified
[redacted]		

Medivet focal site	Sites in focal site catchment area identified by CMA	Additional independent sites identified
[redacted]		

[redacted]

Medivet focal site	Sites in focal site catchment area identified by CMA	Additional independent sites identified
[redacted]		

Medivet focal site	Sites in focal site catchment area identified by CMA	Additional independent sites identified
[redacted]		

Medivet focal site	Sites in focal site catchment area identified by CMA	Additional independent sites identified
[redacted]		

Medivet focal site	Sites in focal site catchment area identified by CMA	Additional independent sites identified
[redacted]		

Medivet focal site	Sites in focal site catchment area identified by CMA	Additional independent sites identified
[redacted]		

Medivet focal site	Sites in focal site catchment area identified by CMA	Additional independent sites identified
[redacted]		

Medivet focal site	Sites in focal site catchment area identified by CMA	Additional independent sites identified
[redacted]		

Medivet focal site	Sites in focal site catchment area identified by CMA	Additional independent sites identified
[redacted]		

Site- and local area-specific competitive dynamics for Medivet areas remaining as potential competition concerns after accounting for unconfirmed sites

1.9 As set out in section 4 of Medivet's main response, [redacted] multi-ownership areas with [redacted] where Medivet is the focal site remain as part of catchment areas of potential concern. The presence of only [redacted] in a given area is not, in itself, sufficient to conclude that competition is ineffective or that regulatory intervention is warranted. The CMA has not considered in its analysis site- and local area-specific competitive dynamics that eliminate any potential competition concerns, nor factors that inherently limit the number of competitors able to sustainably operate in these areas. In particular, the Medivet sites in these [redacted] areas experience at least some of the following site- and local area-specific competitive dynamics:

[redacted]

[2] Based on ONS Rural Urban Classification of Local Authority District Areas (LADs) for England and Wales (2024), which can be accessed on https://geoportal.statistics.gov.uk/maps/3b274939bfb84a97867ce0531973c243/explore. Rural LADs refer to areas classified as one of the following: 'Majority rural: Majority further from a major town or city'; 'Majority rural: Majority nearer to a major town or city'; 'Intermediate rural: Majority further from a major town or city'; or 'Intermediate rural: Majority nearer to a major town or city'.

1.10 The table below sets out in detail which of these site- and local area-specific competitive dynamics apply to each of the [redacted] Medivet sites that remain as focal sites of catchment areas of potential concern.

Medivet focal site	Satellite site or has a satellite site in catchment area	Meaningful competition from recent new entry in the catchment area	Meaningful competition from fasciae up to 10% drivetime outside the catchment area	Situated in rural local authority districts (ONS classification) with limited demand	Loss-making or lower profitability
[redacted]					

Medivet focal site	Satellite site or has a satellite site in catchment area	Meaningful competition from recent new entry in the catchment area	Meaningful competition from fasciae up to 10% drivetime outside the catchment area	Situated in rural local authority districts (ONS classification) with limited demand	Loss-making or lower profitability
[redacted]					

3 [redacted].

Medivet focal site	Satellite site or has a satellite site in catchment area	Meaningful competition from recent new entry in the catchment area	Meaningful competition from fasciae up to 10% drivetime outside the catchment area	Situated in rural local authority districts (ONS classification) with limited demand	Loss-making or lower profitability
[redacted]					

4 [redacted]

Annex 2 – Medivet's Critique of the CMA's Empirical Approach in the Medicines WP

1.1 This annex provides Medivet's more detailed critique of two aspects of the CMA's methodology in the Medicines WP:

(a) The CMA fails to clearly define the appropriate benchmark for WFM.

(b) The findings of the Medicines WP rely on questionable data assumptions and methodological approaches to conclude that the prices of veterinary medicines are inappropriately high.

<u>Methodological issues in the comparison of margins between LVG-owned and independent FOPs</u>

1.2 The Medicines WP claims that LVG-owned FOPs apply mark-ups of 300-400% on purchase costs, compared to 100% for independent FOPs.[6]

1.3 However, the Medicines WP's findings are based on an inappropriate and biased comparison between products. Specifically:

(a) The comparison of the CMA is not like-for-like. It compares margins on *net net prices* earned by LVG-owned FOPs against margins on *list prices* earned by independent FOPs. Given that there are substantial discounts and rebates in this market – which are earned by independents as well as LVGs – this comparison will by construction find that LVG prices are excessive. A like-for-like comparison instead would find the margins of LVGs and independents are broadly similar.

(b) The CMA relies on a selective data sample. It compares the margins earned by only two (out of six) LVGs against the margins of a subset of independent FOPs not belonging to buying groups[7] – while any differences in margins would have been lower if the CMA had relied on data which included all LVGs and all independent FOPs, particularly since the majority of independent FOPs are members of buying groups.

1.4 These issues – which are explained below in more detail - are in addition to the conceptual flaw outlined earlier, namely, the CMA's narrow focus on medicine prices and mark-ups rather than on the price of the bundle of products purchased by customers.

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[6] See paragraphs 2 (c), 3.20 – 3.29, 3.30 – 3.36 of Medicines WP,.

[7] See paragraph 3.33 of Medicines WP: "(…) the 'true' mark-ups on the purchase costs of […] can be expected to be significantly higher than the estimates obtained from independent FOPs set out above (which indicates that prices for medicines can be around twice their purchase costs – this is equivalent to a mark-up on purchase costs of 100%)."

Inconsistent calculation of mark-ups

1.5 The CMA's comparison of independent and LVG-owned FOPs relies on inconsistent mark-up metrics, leading to a biased assessment of relative margins between the two groups. The metrics employed for each group are conceptually distinct, and do not enable accurate like-for-like comparisons. As a result, the analysis is biased towards the conclusion that LVG-owned clinics exhibit higher prices and margins.

1.6 A meaningful comparison requires the mark-up metrics across both groups to be consistent. However and as shown in Figure 1 below, in this case it appears that the CMA has constructed a flawed comparison by evaluating:

(a) the **mark-up on purchase costs** (that is, the mark-up after both discounts and rebates) **for LVGs**, with

(b) the **mark-up on manufacturer list price** (that is, the price before discounts and rebates) **for independent FOPs**.

Figure 11 Comparison of LVGs and Independent Margins as estimated by the CMA

Source: Based on CMA, Medicines WP.

1.7 This inconsistency distorts the findings of the Medicines WP. A more consistent comparison of FOPs on the basis of mark ups on manufacturer list prices shows broadly similar levels of margins across LVG owned FOPs and independent FOPs. The CMA itself notes that mark-ups on manufacturer list price for LVG-owned FOPs range from 50%-200% [redacted], while those for independent FOPs range between 30% and 100%.

1.8 Furthermore, the CMA acknowledges that "the negotiating power of some buying groups is comparable to some LVGs."[8] If the CMA were to compare margins consistently on a net price basis between LVG owned FOPs and independent FOPs which are part of buying groups, it would reach similar

[8] See paragraph 6.30 of Medicines WP.

conclusions to those obtained from the consistent comparison of margins on list prices, given their similar negotiating power – and therefore rebates – and similar mark-ups on list prices.

1.9 Consequently, there is no basis for the CMA to conclude that the mark-ups of independent are materially different from those of LVG-owned FOPs. To the extent that the CMA wishes to rely on independent FOP margins as a benchmark for a WFM, they would therefore indicate that the current market for veterinary medicines is well-functioning.

CMA's estimate considers only two of six LVGs

1.10 The CMA's mark-up analysis is based only on *two of six LVGs* [redacted], and excludes data from other LVGs (see para. 3.24 of the Medicines WP).

1.11 Paragraph 3.23 of the Medicines WP sets out the rebates of not only these two LVGs, but those of three of the other four LVGs. The two LVGs which the CMA has used for its end-to-end analysis of mark-ups on total purchase costs are those with the highest rebates, at [redacted] and [redacted] respectively, while the rebates of the other three LVGs are [redacted] and [redacted].

1.12 The CMA has neither justified why this selective approach is appropriate nor why the conclusions from this selective approach can be applied to other LVGs. The CMA's data shows that mark-ups on purchasing costs for other LVGs range between [redacted] which is approximately [redacted] lower than the Medicine WP's claimed range of 300-400%. As such, the choice of these two LVGs materially distorts the conclusions presented in the Medicine WP.

Understated mark-up estimates for independents as the impact of buying groups is not considered

1.13 The CMA notes that the 100% mark-up for independent FOPs in its preliminary analysis is likely to be understated, and as such may be closer to the LVGs' mark-ups.

1.14 This is because the CMA seemingly has not included FOPs that are part of a buying group in its mark-up assessment for independent FOPs. When accounting for these groups, mark-ups for independent FOPs likely align more closely with those of LVGs.

1.15 The CMA acknowledges this, but fails to consider the implications for its assessment: *"the 'true' mark-ups on the purchase costs of […] can be expected to be significantly higher than the estimates obtained from independent FOPs set out above (which indicates that prices for medicines can be around twice their purchase costs – this is equivalent to a mark-up on purchase costs of 100%)."*[9]

[9] See paragraph 3.33 of Medicines WP.

Weak assumptions underlying the CMA's findings on retail price increases post LVG acquisitions

1.16 The CMA argues that acquisitions of independent FOPs by LVGs lead to an [redacted] increase in unit prices for medicines within the acquired practice.[10]

1.17 However, as presented by Medivet in the response to the Econometrics WP, there are several inconsistencies in the CMA's analysis. Specifically:

(a) the CMA's findings are based on flawed and unreliable data; and

(b) the CMA's findings require that the retail prices of acquired FOPs evolved similarly to those of non-acquired FOPs. However, the CMA has not yet been able to verify this.

1.18 The reasons behind these inconsistencies are reiterated in more detail below.

Data quality issues

1.19 As set out in section 3.1 of Medivet's response to the CMA's Econometrics WP, The CMA's analysis and findings are based on flawed and unreliable data, making its conclusions questionable. The primary issue is the poor data quality, which lacks granularity and contains numerous data entry errors, outliers and inconsistencies.

1.20 Given the poor data quality, the CMA has not taken the necessary steps to appropriately clean the data to adequately control for treatment mix effects. As explained in Medivet's response, robust analysis would require relying on the [redacted] dataset procedure or treatment variable (e.g. "VCII_ITEM_DER_CAT_A") and at the very least, removing the outliers within the CMA's chosen aggregated treatment category.

1.21 Because these steps were not taken, the CMA's difference-in-difference analysis is unreliable. Its findings may be driven not by actual pricing trends but by changes in pack size, formulation, or data entry practices.

1.22 The CMA using data at an inadequate aggregation leads, for example, to the following issues:

[redacted]

[10] See paragraphs 2(b) and 3.15 – 3.19 of Medicines WP.

[redacted]

1.23 Other LVGs share Medivet's concerns with the quality and the poor treatment of the data used in the CMA analysis. They find that the significance of the CMA's observed retail price increases diminishes considerably once methodological issues are accounted for:

[redacted]

Failure to validate the parallel trends assumption

1.24 As set out in section 4.2 of Medivet's response to the CMA's Econometrics WP, the CMA has not presented sufficient evidence that the parallel trends assumption holds, undermining the validity of its difference-in-differences methodology. This means that the estimated impact of acquisitions are likely biased and invalid.

[redacted]

11 [redacted]

1.25 The CMA's difference-in-differences approach relies on the assumption that in the absence of acquisitions, retail prices for both acquired and independent practices would have evolved in the same way.

1.26 Medivet notes that the existence of pre-acquisition parallel trends is not in itself sufficient to prove that the parallel trends would have continued in the absence of acquisitions. It is best practice to perform further tests, including comparing the group characteristics of acquired independent clinics with those of non-acquired clinics, to assess the likelihood that the 'parallel trends' assumption would have remained valid in the post-acquisition period.

1.27 As shown in Figure 3 of Medivet's response to the Econometrics WP, the average claim value and first-year treatment cost for clinics acquired by Medivet in the pre-acquisition years were consistently higher than for clinics that remained independent in almost every year between 2014 and 2022, suggesting the presence of unobserved factors that need to be taken into account to ensure the validity of the 'parallel trends' assumption.

1.28 The CMA should therefore test for differences in group characteristics between acquired independent clinics and those that remained independent (such as time-varying geographic factors) more generally. On this basis, the CMA should then consider whether additional controls should be included in the difference-in-differences analysis to ensure the validity of the parallel trends assumption.

Price increases beyond a general cost index do not indicate an AEC

1.29 The CMA asserts that veterinary medicine prices have increased by 60-70% [redacted] across LVGs between 2014 and 2024, significantly exceeding the 35% rise in the CPI for services.[14]

1.30 However, this observation alone is insufficient to establish weak competition, for three key reasons.

1.31 **First**, the CMA finds lower average price increases of veterinary medicines supplied by Medivet.

(a) While the CMA finds a price increase for veterinary medicines of [redacted] 60-70% across LVGs[15], a review of the CMA's own data and methodology suggests that the average price increase for Medivet's veterinary medicines is actually just [redacted].

(b) This is a difference of [redacted] below the rate suggested by the CMA for LVGs overall.

[14] See paras. 2(a), 3.12 – 3.19, 3.22 (a) and 3.42 (a) of Medicines WP.
[15] See paragraphs 2(a), 3.13 and 3.42 (a) of Medicines WP.

1.32 **Second**, the average increase in the veterinary medicines supplied by Medivet can be largely explained by the increase in the purchase costs of those medicines.

(a) An analysis of Medivet's manufacturer list price increases from 2018 to 2024 (earlier data is unavailable) shows that Medivet's unit costs rose by [redacted] per pack over this period.

(b) As can be seen in the [redacted] below, this significantly exceeds service inflation, the CMA's chosen comparator, which increased by just 31% over the same period. The trend in manufacturer list prices closely mirrors Medivet's rising purchasing costs.

1.33 This implies that service CPI is an inappropriate WFM counterfactual for veterinary medicine prices. In a WFM, prices would be broadly cost reflective; as such it would be expected that prices would rise in line with unit costs.

1.34 The CMA has set out no reason why, in a WFM, FOPs would not pass on the cost of medicines into their retail pricing; high levels of pass-on are generally an indication of competitive, well-functioning markets.

[redacted]

1.35 **Third**, the CMA comparison of average prices ignores that the range of veterinary medicines supplied by Medivet today is much larger and more sophisticated than the range of veterinary medicines supplied ten years ago,

such that the average price increase estimated by the CMA substantially reflects the mix of medicines supplied, rather than changes in the price of any single medicine over time.

1.36 Over the last ten years there has been a shift in the product mix towards more innovative, pet-specific treatments, including changes in drug formulation or the method of administration (e.g., injectable versus tablet form). Such advancements have tended to result in higher prices, reflecting improved efficacy, enhanced patient outcomes, or greater convenience, but have also led to higher prices. Specifically:

(a) The number of licensed veterinary medicines has more than doubled from 1,486 in 2015 to 3,031 in 2024, reflecting advances in treatment options. This indicates the shift from human generics to veterinary-licensed medicines, which tend to be substantially more expensive due to the additional R&D, regulatory approval, and market-specific production costs. For instance, Mirtazapine, previously used in its human generic form as an appetite stimulant for cats, it is now available as the veterinary-licensed Mirataz, which is two to three times more expensive.

(b) The growing use of injectable treatments is exemplified by the shift in arthritis care for dogs. Traditionally managed with oral non-steroidal anti-inflammatory drugs (e.g., Metacam), arthritis is now increasingly treated with injectable monoclonal antibodies (e.g., Librela). The injectable offers greater compliance (one injection lasts 28 days versus daily pills) and fewer side effects, making it the clinically preferred choice despite the higher cost.

1.37 The above resulted in a material change in the mix of veterinary medicines that Medivet supplied to pet owners over the last ten years, resulting in a more effective treatment but also in the supply of more sophisticated and costly medicines.

1.38 The CMA cannot therefore conclude from a simple comparison of average prices of medicines over time that pet owners are overpaying for those medicines without accounting for the impact of this improved quality in treatment on the costs to serve.

Additional services and fees reflect market dynamics

1.39 The CMA asserts that FOPs generate profits not only from selling medicines but also from earning additional revenues associated with the retail of veterinary services, such as dispensing and administration fees, which may contribute to profitability differences between LVGs and independent FOPs[16].

[16] See paragraphs 2(d), 3.24 – 3.25 and 4.29 of Medicines WP.

1.40 The CMA does not clearly indicate the basis of this analysis. However, based on the points raised by the CMA on additional fees the CMA's conclusion is flawed for several reasons.

Dispensing and administration fees are part of a broader service offering

1.41 Assessing individual treatment services, such as administration and dispensing fees, in isolation is not meaningful.

1.42 A proper evaluation would require assessing the overall pricing and profitability of the complete veterinary service offered, as dispensing and administration fees can only be incurred as part of a bundle with consultation fees.

1.43 Yet the CMA's analysis fails to recognise that dispensing and administration fees are only one component of a broader veterinary service (and medicine) offering and therefore a comparison of vet medicine fees only is not meaningful, as FOPs do not compete on these fees alone (nor on the supply of vet medicines alone, as stated above).

1.44 These fees generate revenue that contributes to recovering fully allocated costs, including fixed costs, as well as partially allocated costs. While the structure of fees varies across different services, on average, prices are set to ensure cost recovery. Further, variations in prices reflect differences in perceived quality and pet owners' willingness to pay for each specific service. This is a feature of the current veterinary services market and should be expected in a WFM. Medivet notes that independent FOPs also charge dispensing fees.

Fees reflect genuine cost drivers

1.45 The CMA's analysis overlooks the fact that different fee structures are a natural reflection of market dynamics within the veterinary sector. These fees reflect the labour, training, and professional liability associated with dispensing and administering veterinary medicines in line with relevant regulation. For example:

(a) **Dispensing fees**: These account for expertise and the time required to prepare a written prescription, labels and packaging for medication that is dispensed to pet owners.

(b) **Administration fees**: When a vet administers medication within a practice, this involves not only the medicine itself but also the professional liability associated with dispensing the medicine.

1.46 Some of the CMA's findings regarding the pricing of dispensing and administration fees contradict Medivet's internal pricing data. For example, the CMA states some injection fees exceed £[redacted]

[redacted][17]. However, Medivet's maximum recorded standard injection fee in 2024 based on Medivet's RFI2 Q6 submission is £[redacted] and the average fee is just £[redacted].[18] It is therefore unclear how the CMA reached its conclusions on this point.

[17] See paragraph 2.75(d) of Medicines WP.
[18] See Medivet's response to RFI2 Q6 [redacted].

Annex 3 – Implications of CMA Vet Users Survey

1.1 This annex summarises the key Vet Users Survey findings that are referenced in the main body of Medivet's response to the WPs.

Pet owners consider multiple factors beyond price

1.2 The CMA's claims that competition is reduced for pet owners, given that they tend to overpay for its medicines.

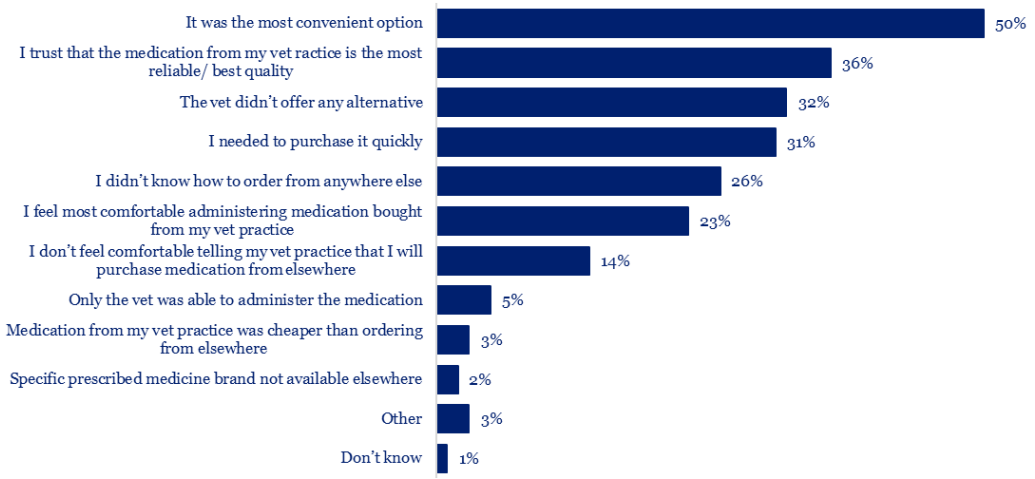
1.3 However, this claim overlooks that price is just one factor in consumer decision-making and fails to consider that price differences may reflect the value, quality, and convenience that pet owners perceive in purchasing from their FOP.

1.4 The Vet Users Survey results support this broader view.[19]

(a) When asked about their reasons for purchasing medication from their vet, 50% of respondents cited convenience, while 36% mentioned trust in the quality of care and reliability of the medications provided.

(b) In contrast, only 3% identified price as the primary reason for purchasing from a vet instead of a third-party retailer.

Figure 3 3 Reasons for buying medicine from FOP



Source: CMA Vet Users Survey, Q99

1.5 These findings align with broader economic principles observed in healthcare markets, where price is often not the dominant competitive factor. Instead,

[19] See Table 19 of Vet Users Survey.

consumers prioritise ease of access, continuity of care, and professional expertise when making decisions.

(a) If pet owners choose to purchase medicines from their FOP rather than a third-party retailer, this should not be assumed to indicate a lack of competition.

(b) Rather, it reflects a rational preference for minimising effort, ensuring treatment consistency, and valuing the professional judgment of their veterinarian. This was also confirmed by an article published by 'Veterinary Evidence' which presents UK survey evidence indicating that price was the ninth most important choice factor, with location and range of services scoring more highly.[20]

1.6 By framing the findings in a consumer behaviour framework, it becomes clear that the CMA's focus on price-focused competition is not the sole driver of market outcomes in veterinary services. A more detailed view, accounting for non-price factors such as convenience and trust, is essential in assessing market dynamics accurately.

<u>CMA finds pet owners have access to multiple FOPs and are aware of their choices</u>

1.7 The CMA also contends that pet owners are unaware of their options when purchasing veterinary medicines, particularly with regard to third-party retailers.

1.8 However, the Vet Users Survey contradicts this assertion:

(a) 57% of pet owners were aware that they could purchase medication elsewhere of which more than a third were informed of this by their own practice (see Figure 4 below).

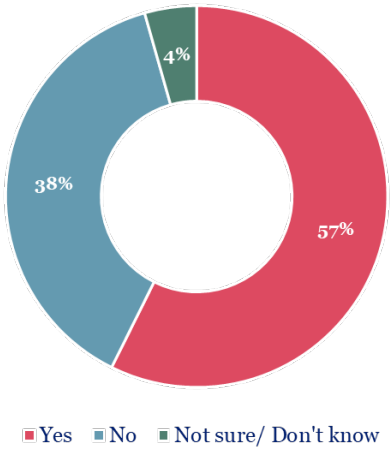
(b) 26% of pet owners buy their repeat medication through online retailers (see Figure 5 below).

(c) Only 3% of those who felt they had no choice of practices attributed it to a lack of information or knowledge, indicating that awareness is not the primary barrier to comparison.[21]

[20] See *How and why you should segment veterinary markets*, Small Animal Sector Market Segments section; available here: https://veterinaryevidence.org/index.php/ve/article/download/289/511?inline=1

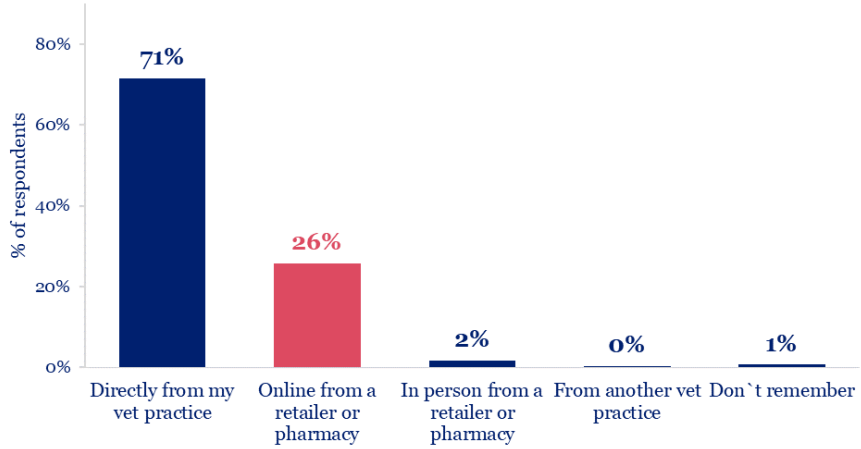
[21] See Figure 19of Vet Users Survey.

Figure 44 Do pet owners know that they can purchase medications from elsewhere?



Source: CMA Vet Users Survey, Q89

Figure 5 Usual source for repeat medication purchase



Source: CMA Vet Users Survey, Q96

1.9 Moreover, the CMA claims that pet owners have difficulties to access and compare prices of veterinary medicines and associated fees when choosing a FOP. However, this conclusion contradicts the findings of the Vet Users Survey:

(a) Among pet owners who considered price when selecting a FOP, 50% specifically looked at the cost of flea and worm medicines.[22]

(b) 82% of pricing information available to consumers was sourced through the vet practice (either on the website, or by phoning them, or through in-person visit). This percentage was significantly higher for LVGs compared to independents (81% vs 69%).[23]

[22] See Table 9of Vet Users Survey.
[23] See Table 8 and Figure 23 of Vet Users Survey.