FRESHFIELDS

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MEDIVET GROUP LIMITED'S RESPONSE TO THE COMPETITION AND MARKETS AUTHORITY'S WORKING PAPERS PUBLISHED ON 6 FEBRUARY 2025 IN CONNECTION WITH THE MARKET INVESTIGATION INTO VETERINARY SERVICES FOR HOUSEHOLD PETS

21 March 2025

1. Executive summary

1.1 Medivet welcomes the opportunity to respond to the CMA's five Working Papers[1] published on 6 February 2025 (together, the ***WPs***). Medivet sets out in this document its consolidated response to the WPs. Medivet also sets out its perspectives on the next stages of the CMA's Market Investigation Reference (***MIR***) and what it sees as the most appropriate outcomes to swiftly and effectively conclude the process for the overall benefit of the market, vets, pet owners and pets.

1.2 At the outset, Medivet summarises its overall position in response to the WPs; and provides its view on the overarching factors that have contributed to the development of the UK market for the supply of veterinary services and how Medivet operates in that market.

The market and how Medivet operates

1.3 The market has developed significantly in recent years, in particular driven by the following factors (covered in detail at section 2 below):

(a) increased humanisation and medicalisation;

(b) professionalisation and corporatisation;

(c) macro-economic trends, for example around the 'cost of living crisis'; and

(d) the MIR.

1.4 The key aspects of Medivet's business are:

(a) Medivet is a First Opinion Practices (***FOP***) focused business (accounting for c. [redacted] of the Medivet group's FY2024 UK turnover). It is minimally vertically integrated – with only three referral centres and one laboratory diagnostics business. It does not have its own crematoria or online pharmacy businesses.

(b) Medivet is fully transparent about ownership, with clear Medivet branding across all services, communications, customer digital experience and brick-and-mortar sites.

(c) Medivet is a vet-led organisation that strongly believes in its Branch Partnership (***BP***) model, and includes vets at every level of the business.

(d) Medivet delivers exceptional care which is "contextualised" to the customer and pet – i.e. care that acknowledges that there are

[1] "How people purchase veterinary services" working paper (**How People Purchase WP**); "Business models, provision of veterinary advice and consumer choice" working paper (**Business Models WP**); "Competition in the supply of veterinary medicines" working paper (**Medicines WP**); "Regulatory framework for veterinary professionals and veterinary services" working paper (**Regulatory WP**); and "Analysis of local competition" working paper (**Local Concentration WP**).

different ways to approach diagnosis and treatment, depending on the circumstances of the individual pet and owner, and the context in which the care is delivered. This is underpinned by a strong clinical governance structure.

Medivet's perspectives on the CMA's emerging views

1.5 Medivet's perspectives on the CMA's emerging views are set out in this document under four key themes, as follows:

(a) Choosing services (covered in detail at section 3 below), in relation to which:

(i) Medivet agrees with the CMA that the market would benefit from greater transparency on prices of veterinary services, treatment options, quality and ownership – and Medivet provides concrete examples of how it is already a leader in the market on transparency.

(ii) Medivet does not, however, consider that the CMA's emerging views adequately reflect the following:

(A) changing market dynamics, in particular the increasing price sensitivity of UK pet owners (driven by the 'cost of living crisis'), how the market is responding, and the benefits of corporatisation to pets and customers;

(B) drivers of demand for any increased intensity of treatments, such as the link between trends of humanisation/medicalisation and increased uptake of veterinary treatments, or the peace of mind and cost-spreading benefits driving uptake of health plans – all of which undermine the CMA's potential concerns around overtreatment (which remains unsupported by empirical evidence); or

(C) the range of competitive levers at play, including on quality, reputation and price, and the beneficial use of KPIs as organisational management tools that Medivet uses to drive better clinical outcomes and resource-allocation, rather than as incentives or sanctions in pursuit of profit.

(b) Choosing providers (covered in detail at section 4 below), in relation to which:

(i) Medivet does not consider that the CMA's methodology for assessing local catchments is sufficiently robust to enable a proper local competition analysis – and Medivet's own analysis of Medivet focal areas identifies serious gaps that

materially undermine the conclusions that the CMA's analysis reaches.

(ii) Medivet considers that the CMA's view on switching relies on inappropriate comparisons with unrelated markets and is not supported by the results of the CMA's own vet users survey (***Vet Users Survey***)[2].

(iii) Medivet considers that the CMA's emerging views do not adequately consider the clinical and consumer benefits that vertical integration can offer – ranging from cost efficiencies that can be passed through to consumers, greater continuity of care across a treatment journey and pet lifespan, quicker and more seamless handovers, and enhanced quality and monitoring. Whilst Medivet is itself only minimally vertically integrated, Medivet recognises the potential for these benefits, provided transparency of ownership of adjacent services is increased and pet owners retain the ability to choose or decline in-group referrals and recommendations.

(iv) The results of the Vet Users Survey often contradict the CMA's thinking and instead demonstrate that, on the whole, customers can and do compare and switch service providers or, even when satisfied not to switch, still feel comfortable to do so.

(c) Pricing, in relation to which:

(i) In respect of FOP service pricing (covered in detail in section 5):

(A) Medivet does not consider that the CMA's methodology or data source for assessing FOP service price rises are sufficiently robust – therefore undermining the CMA's emerging view that price increases are excessive and that LVGs are more expensive than independents; and

(B) the results of the Vet Users Survey contradict the CMA's thinking and instead do not provide evidence to suggest consumers specifically choose independent practices over LVGs based on cost, nor that there are significant price differences between LVGs and independent practices.

(ii) In respect of medicine pricing (covered in detail in section), Medivet notes that its prices have risen in line with purchasing costs, and Medivet incurs substantial operational costs in connection with retailing medicines at its FOPs (including costs for vets and their time, stock space, unavoidable levels

[2] See the final report of CMA's Vet Users Survey (January 2025).

of wastage and ordinary brick-and-mortar overheads) that are not incurred by online competitors. Medivet also does not consider that the WPs have yet shown the existence of an adverse effect on competition (***AEC***) or identified the related drivers – in particular due to:

(A) shortcomings in the CMA's empirical analyses (including demonstrably incomplete or flawed analysis, and weak data assumptions and methodological approaches);

(B) a lack of an appropriate benchmark, given that the CMA does not clearly define or justify its choice of a competitive benchmark for veterinary medicine prices; and

(C) the relevant market dynamics (including the range of factors pet owners consider when purchasing from their FOP – such as value, quality, and convenience), the availability of choice, and increasing competitive pressures from online pharmacies (unencumbered by the same overheads of FOPs) not being adequately considered.

(d) The regulatory framework (covered in detail in section 7), in relation to which:

(i) Medivet believes that the current regulatory framework, with the veterinary surgeon at its core, is appropriate and does sufficiently take into account consumer aspects.

(ii) Medivet nevertheless agrees with the CMA that there is room for improvement within the current regulatory framework. The appropriate bodies to take the lead on any regulatory reforms are the Royal College of Veterinary Surgeons (***RCVS***), the Department for Environment, Food & Rural Affairs (***DEFRA***) and the British Veterinary Association (***BVA***).

(iii) Medivet believes many of the CMA's potential concerns can be effectively and expeditiously addressed within the current regulatory framework and without legislative change, in particular upweighting the existing Practice Standards Scheme (***PSS***) and Veterinary Client Mediation Service (***VCMS***) schemes.

(iv) Medivet believes that the current 'under care'-requirement, regulation of limited service providers and mobile vets, the cascade regulation and classification of medicine are important to maintain a high level of clinical care and animal welfare, and should not be changed.

(v) Contrary to the CMA's view, Medivet considers that current regulatory restrictions on the purchasing of wholesale medicines by veterinary practices act as a barrier to veterinary businesses accessing medicines at competitive prices and therefore limits their ability to set retail prices more competitively.

1.6 Medivet provides further feedback:

(a) At Annex 1, on technical elements of the CMA's emerging views in relation to local concentration.

(b) At Annex 2, on technical elements of the CMA's emerging views in relation to medicine pricing.

(c) At Annex 3, on implications of the Vet Users Survey results.

1.7 Where relevant to its response, Medivet provides direct feedback and corrections on the accuracy of statements and citations made in the WPs with reference to Medivet's RFI responses and internal documents. Otherwise, to the extent the WPs' statements and citations with reference to Medivet's RFI responses and internal documents remain inaccurate and misrepresentative (as Medivet had submitted to the CMA in Medivet's putback responses) but are not expressly addressed in this response to the WPs, Medivet nevertheless restates its putback submissions on accuracy, and rejects those inaccurate statements and citations.

Medivet's recommendations for the outcomes and next steps of the MIR

1.8 Medivet is keen to assist the CMA to reach a swift and effective conclusion to the MIR in a way that positions the veterinary services market to promote informed consumer choices and value for money, support the delivery of exceptional care and the best clinical outcomes for pets, and establish the stability needed to encourage innovation and growth across the competitive spectrum.

1.9 Medivet also reiterates its submission in response to the CMA's Issues Statement[3] that it is keen to already engage with the CMA on recommendations to resolve any potential concerns in advance of the MIR's timetable, and, aligned with the CMA's focus on pace, would be supportive of the CMA concluding the MIR as expeditiously as possible.

1.10 In Medivet's view, there are two key guiding principles that the CMA should bear in mind to achieve these outcomes:

(a) Any remedies that the CMA recommends should be market-wide, in order to effectively address any CMA concerns and ensure a consistent and long-lasting impact.

[3] See Medivet's response here Medivet_.pdf.

(b) While Medivet welcomes modernisation of the Veterinary Surgeons Act 1966, enacting new legislation would be a lengthy and complex process. Medivet therefore considers that, in order to already support pet owners' ability to choose and differentiate veterinary services and providers, consumer interest are better served by the CMA focusing on enhancing elements within the current regulatory framework which can bring about a swift and effective conclusion to the MIR.

1.11 Set against these principles, Medivet recommends that any remedies should be focused on increasing market transparency and enhancing the existing regulatory framework.

Increasing market transparency

1.12 Greater transparency can empower consumers to make more informed choices, whether between providers, product and services, or alternative businesses, and Medivet welcomes efforts to enhance transparency in veterinary services. If the market were to adopt similar levels of transparency in line with Medivet's current approach, Medivet considers that this would already address some of the CMA's potential concerns.

1.13 Accordingly, Medivet recommends that:

(a) All vet practices become fully transparent on ownership in the way that Medivet is already. All vet practices should make their ownership clear across all services, communications, customer digital experience and brick-and-mortar sites. This includes transparency in relation to referrals or recommendations given by vets to vertically integrated adjacent businesses within a corporate group.

(b) Clients should never be restricted from switching practices (as is the case today).

(c) All vet practices should publish / make available (both online and in clinic) the prices of a common list of frequently used or "entry point" services, including prescription fees.

(d) As part of the informed consent process, clients should receive a written cost estimate of a treatment and medicines (wherever clinically possible), and should be notified if there are reasonable grounds to believe actual cost will exceed the estimate by a certain amount (noting that unforeseen costs may arise).

(e) The opportunity for clients to ask for a written prescription and availability of alternative channels for purchasing prescription medicines should be communicated in clinic, and any prescription and dispensing fees should be clearly itemised in invoices.

Enhancing the existing regulatory framework

1.14 Medivet's observations on the regulatory framework and the need for reform are as follows:

(a) Medivet strongly believes that the veterinary surgeon should remain at the core of regulation. It is therefore right and appropriate that the vet is the focus of regulation and ensures continued high clinical standards. Non-vet owners do not, and are not able to, instruct or influence vets in relation to their professional behaviours in respect of the RCVS Code or impede their clinical autonomy which is based on what is best for both the pet and owner.

(b) Further, many of the CMA's potential concerns can be effectively addressed within the current regulatory framework and without legislative change, such as upweighting the existing PSS and VCMS schemes and increasing greater industry awareness of them.

(i) PSS is an industry standard and indicator of various quality differentiators – core certification reflects the minimum regulatory requirements placed on vets and practices, while higher accreditation levels and awards reflect higher standards of clinical care. Accordingly, Medivet strongly believes that improvement to the PSS scheme is the best way of effectively regulating businesses quickly, simply and in a way that can benefit consumer choice and decision-making.

(ii) As regards the VCMS scheme, Medivet considers that this is an effective complaints mechanism but supports measures to increase its visibility and therefore its effectiveness.

(iii) Relatedly, Medivet would be supportive of industry-wide improvements to complaints handling and record-keeping; and updating Continuing Professional Development (CPD) requirements to include training on contextualised care.

1.15 In addition, Medivet considers there are regulatory reforms that the UK veterinary sector would benefit from – as set out below. However, Medivet acknowledges that these would likely require new or materially reformed legislation, which would require substantially more time and consultation to progress and ultimately enact, and should therefore be considered outside the confines of the MIR.

(a) Easing the requirements placed on foreign qualified vets, which should return to pre-Brexit requirements to help address industry-wide skills and staffing shortages.

(b) Legislative or regulatory measures which support both the protection of the "Veterinary Nurse" title, and the broadening of scope of permitted roles of the Veterinary Nurse.

(c) Easing the regulatory restrictions that currently prescribe a very limited list of wholesalers from whom veterinary practices are allowed to purchase medicines. Veterinary practices should be allowed to purchase from other retailers, such as online pharmacies.

2. The UK market for the supply of veterinary services

2.1 Numerous trends, dynamics and changes in competitive conditions have materially impacted veterinary services in recent years. These are highly relevant to the CMA's investigation:

(a) humanisation of pets and medicalisation/professionalisation driving demand for greater treatment intensity;

(b) market entry and innovation;

(c) macro-economics driving veterinary cost increases and pet owner price sensitivity; and

(d) the CMA's market investigation itself.

Humanisation and medicalisation/professionalisation driving demand for greater treatment intensity

2.2 Pet owners are increasingly viewing pets as family members and therefore prioritising pet health. While the CMA is sceptical of any link between such trends and the increase in pet owner demand for veterinary services,[4] Medivet sees clear real-world links in the course of its business, with its clients across all UK demographics increasingly viewing their pets as part of their family and prioritise pet care and wellbeing.[5] Clients expect a wider range of, and more advanced, treatments to be available than those historically offered. Contrary to the CMA's scepticism, this link is supported by third-party literature[6] and the results of the Vet Users Survey.

(a) 78% of respondents to the Vet Users Survey deemed their pets' health equally or more important than that of their family.[7]

(b) 76% of respondents either always or often prioritised spending on pet care, and the majority within those respondents even deprioritise other important household expenses in favour of paying for pet care.[8]

2.3 Advances in clinical technologies and pet care products, as well as increased pet owner education about pet health, have extended pet life expectancy and lifespan.[9] Ageing, and longer-living, pets require increased veterinary care.

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4 See paragraph 4.16 of How People Purchase WP (CMA, 6 February 2025).

5 Medivet refutes the CMA's serious mischaracterisation of an internal document as '*strategic*' analysis to suggest that humanisation was an opportunity in relation to secondary revenue opportunities. See paragraph 4.14(a) of How People Purchase WP.

6 See for example, Pet Humanisation: What is it and Does it Influence Purchasing Behaviour?, Journal of Dairy & Veterinary Sciences, 22 March 2018; and Pet Humanisation and Related Grief: Development and Validation of a Structured Questionnaire Instrument to Evaluate Grief in People Who Have Lost a Companion Dog - PMC, Animals, 7 November 2019.

7 Figure 134 of Vet Users Survey.

8 Figure 135 of Vet Users Survey.

9 See Reuters article "Your Money: As pets live longer, they may need long-term health care" (13 September 2016) (https://www.reuters.com/article/markets/wealth/your-money-as-pets-live-longer-they-may-need-long-term-health-care-idUSKCN11J25C/).

2.4 The ageing demographic of Medivet's pet base is illustrated in [redacted][10]

[redacted]

[redacted]

2.5 Studies also show that, at the same time, rates of pet obesity are increasing, putting pets at greater risk of conditions requiring increasingly intensive veterinary treatment.[11] Medivet has also seen increased demand for treatments as particular breeds of dog and cat with inherent life-long associated health risks (particularly pedigrees) become more popular pets.

2.6 Widely understood advancements in human healthcare (in relation to the complexity and degree of treatments available) means that consumers now expect a similar level of treatment to be available for their pets. Medivet vets regularly experience customers asking for a specific service or treatment to a diagnosis where they are aware of a human equivalent.

2.7 Professionalisation is natural for a maturing market – and contributes to a market-wide increase in quality and care standards in line with pet owner expectation. This has occurred during a 20-year period of corporate investment in the sector (in clinics, equipment, staff remuneration, staff training, etc). Such investment has been instrumental in bringing about the clinical advances across the market, in response to growing pet owner demand for better pet health outcomes. By way of illustration, investment by CVC funds in Medivet since 2021 has facilitated:

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[10] Figure produced using Medivet internal data.

[11] Such as diabetes, heart disease, respiratory distress and high blood pressure. See RSPCA web page "Pet obesity" (https://www.rspca.org.uk/adviceandwelfare/pets/general/obesity); and UK Pet Food obesity report (2024) (https://www.ukpetfood.org/spotlight-on-obesity/new-uk-pet-food-obesity-report-2024.html).

(a) The addition of c. 1,200 new vets and 48 new Branch Partners, supported by over £[redacted] of capital expenditure investment, including in relation to clinic refurbishment (under the 'Pride in Clinics' programme), clinical equipment and technology across its estate, including ultrasound, X-ray, and dental X-ray equipment, etc.[12]

(b) Significantly improved centralised support functions and systems, e.g. Medivet's practice management system, Freedom PMS (***Freedom***).

(c) Accelerated digitisation to support accessibility and meet growing demand for digitised services such as online appointment bookings and online price lists.

(d) Infrastructure upgrades for newly acquired clinics to ensure they meet PSS accreditation standards.

Market entry and innovation

2.8 As the CMA has identified, 745 new brick-and-mortar vet practices opened in the 10-year period 2014-2024,[13] indicating that the market has been able to evolve given the low entry barriers that have allowed vet businesses to start up and grow.

2.9 In addition, the market has experienced the introduction of entirely new business models, demonstrating that market players and new entrants have been able to compete on the basis of innovation and technological developments. This includes telehealth – the provision of certain veterinary services via video-link, instant messaging, telephone or other remote means. Besides the use of technology, veterinary services can also be offered outside of the traditional brick-and-mortar practice model, including through mobile veterinary services as well as more targeted offerings from limited service providers (**LSPs**).

<u>The growing role of telehealth providers</u>

2.10 Telehealth providers are a growing competitive force in the market. While the CMA's pet owner survey indicated that 7% of respondents used telehealth services in the past two years,[14] this does not reflect the market-wide shift in competitive dynamics and innovation that telehealth has started to give rise to.

2.11 Telehealth providers have significantly fewer overheads than in-person healthcare at FOPs, lowering their barriers to entry. As a result, the market has experienced rapid entry of telehealth players. Telehealth providers are

[12] [redacted]

[13] See paragraph 3.11(d) of the CMA Working Papers Overview.

[14] See paragraph 5.9 of How People Purchase WP.

limited by the regulatory requirement that they must be able to physically examine the pet before prescribing medicine (see paragraph 7.26). However, they are able to provide consumers with guidance in cases that do not require a physical examination or the prescription of medication.

2.12 In addition, Medivet is also seeing independent vet practices partnering with telehealth providers[15] to meet the growing demand for hybrid veterinary services (i.e., in-person and online). Traditional veterinary practices across the UK are increasingly looking to broaden digital services and remote treatment offerings, in turn leading to pet owners growing more comfortable with online and remote delivery of veterinary services – which then facilitates the increasing use of telehealth providers. This is occurring while UK consumers are in general becoming increasingly comfortable with sourcing professional and healthcare services online.[16]

2.13 [redacted]

2.14 Medivet expects that the growing familiarity with, and prevalence of, online and remote delivery channels will lead to the playing field being increasingly levelled for telehealth providers to compete with brick-and-mortar clinics, in a way not currently recognised in the CMA's working papers.

Growing competition from LSPs, mobile vets and other business models

2.15 As the CMA points out in its Business Models WP, the veterinary market has seen a 'degree of innovation,' including FOPs offering new models, telemedicine and mobile veterinary services, which act as a growing constraint on traditional veterinary service providers.[17]

2.16 LSPs offer single services to their clients, such as vaccination and neutering. As the CMA points to in the Regulatory WP, recent changes to Guidance have resulted in LSPs only having to provide OOH coverage for the services they offer.[18] Medivet therefore expects their role to increase further going forward.

2.17 Medivet is also experiencing an increase in providers of mobile veterinary service providers which would not be classified as FOPs, but which provide

[15] For example, Vidivet – see its website https://vidivet.com/vet/, which shows the list of vet clinic that have partnered with Vidivet.

[16] See for example a qualitative study on online consultation systems (July 2024) (Patient experiences of an online consultation system: a qualitative study in English primary care post-COVID-19 | British Journal of General Practice) and BJGP article on increasing popularity of online appointments (December 2023) (Are video/online appointments becoming more popular among patients? – BJGP Life).

[17] See paragraph 1.2(h) of Business Models WP.

[18] See paragraph 6.111 of Regulatory WP.

veterinary services in competition with traditional FOP clinics. Similarly, there is a growing number of service providers offering subscription-based models, including, as the CMA identifies in its How People Purchase WP,[19] Creature Comforts, Snoots, Pickles and Garden Vets.[20] Medivet expects these to grow in number and popularity to cater to the preferences of a growing younger (predominantly 'Gen-Z') demographic of pet owners.[21]

Macro-economics driving veterinary cost increases and pet owner price sensitivity

2.18 Separate from market trends, recent wider macro-economic conditions have had a substantial impact on veterinary costs. Contributing factors include Brexit, Russia's invasion of Ukraine, persistently high inflation and staff and skills shortages.

2.19 The CMA will already be familiar with the details of these and other relevant macro-economic factors from previous submissions from Medivet and other industry stakeholders. Medivet will not use this response to repeat those points and would draw the CMA's attention to the joint consultation response submitted to the CMA by the BVA, 3 November 2023.[22] The multiple macro-economic factors described therein continue, in Medivet's view, to push veterinary costs up.

2.20 Whilst increasing veterinary costs, macro-economic conditions have also led to reductions in pet owner spending power – as UK consumers come to terms with the so-called 'cost of living crisis'.[23] As UK consumers, Medivet expects that these challenging conditions are directly impacting pet owners' sensitivity to veterinary prices.[24].

The CMA's MIR is already making an impact

2.21 Notwithstanding the ongoing cost challenges facing the market, Medivet has observed that the CMA's MIR is already having a positive impact on the market. In particular:

(a) Medivet has seen that certain price information is now published online by some other LVGs. Medivet has also observed increased spending in marketing through bidding for search engine key terms and increased promotional trials by competitors.

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19 See footnote 106 of How People Purchase WP.

20 See Creature Comforts Vets, Snoots | Unlimited Primary Vet Care in London for £33/Month, Home | Pickles Vets | London, and PetCare - Garden Vets at Keele for further information.

21 As corroborated by third party literature. See, for example, Gen Z and Millennials: Shaping the subscription economy - Savanta.

22 See Focus area 1 in BVA joint submission (3 November 2023) (https://www.bva.co.uk/media/5459/submission-to-cma-oct-2023.pdf).

23 See "Rising cost of living in the UK" (11 July 2024) (Daniel Harari, Brigid Francis-Devine, Paul Bolton, Matthew Keep) (https://researchbriefings.files.parliament.uk/documents/CBP-9428/CBP-9428.pdf).

24 See paragraph 3.9 for Medivet's own experience of customer price sensitivity.

(b) Insofar as an impact on Medivet specifically, Medivet has continued to roll-out transparent pricing in clinics and online, transparently publishing prices for its most common treatments for all clinics and out of hours (***OOH***) consultations for its 24-hour clinics.

(c) Further, Medivet has carried out a number of pricing trials focused on reducing prices, including lowering OOH appointment prices by [redacted]% for all clinics that offer this service, which resulted in a [redacted]% year-on-year increase in the number of appointments made[25]. This change occurred despite a lack of active marketing of the price reduction and this, in Medivet's view, is illustrative of the increasing price sensitivity of customers.

2.22 However, Medivet remains concerned that the MIR has also resulted in several unintended consequences which are having a negative impact on the industry.

(a) For example, veterinary professionals have been placed under significant added stress and hostility since the MIR commenced; and the BVA has expressed that vet teams have received "really unpleasant, often abusive behaviour",[26] which resonates with Medivet's own experience.

(b) In addition, the MIR has added to an extended period of uncertainty for the sector as a whole, arising since the CMA's interventions on various veterinary M&A activity from 2021 and continuing with the CMA's market review in 2023. The effects have been felt at all levels – impacting businesses' ability to reach and execute important strategic decisions in relation to investment into the UK; affecting staff morale, disincentivising entry into the veterinary profession, and putting additional pressure on a workforce already experiencing shortages.

(c) Medivet is proud to be fully transparent on branding across its business so that Medivet customers and potential customers are aware of whom they are dealing with. However, since the start of the MIR Medivet has experienced instances of customers switching away due to negative sentiment towards LVGs and corporate ownership, before customers have been given the opportunity to consider the full and final outcome of the MIR. Medivet is therefore seriously concerned that, due to its longstanding approach to transparency on branding and ownership, significantly above the level of all of the other LVGs, Medivet has already been disproportionately prejudiced – and punished – by the MIR. Medivet notes that unbranded local clinics of other LVGs will likely have avoided such prejudicial

[25] There is one exception for a clinic which is not yet on Medivet's practice management system, Freedom.

[26] See BVA response at BVA article (12 March 2024) (BVA responds to Competition and Markets Authority's review of the veterinary sector).

treatment, purely by remaining non-transparent about their ownership.

2.23 Consistent with the Government's growth agenda, Medivet would welcome a swift conclusion and resolution to the MIR to enable the market as a whole to focus on investment and growth, which have been stalled by the ongoing uncertainty that has arisen since the beginning of the MIR. Medivet looks forward to working with and helping the CMA in this regard.

3. Choosing services

3.1 In this section, Medivet provides its responses to the CMA's emerging view in relation to:

(a) Choice in regular FOP services (at paragraph 3.2-3.29);

(b) Choice in referrals and adjacent services (at paragraph 3.31-3.44); and

(c) Choice in health plans (at paragraphs 3.46-3.51).

Choice in regular FOP services

Transparency of pricing, options, quality and ownership

3.2 Medivet understands that the CMA's emerging view is that:

(a) Consumers face difficulties in making informed choices about the services they buy.

(b) There appears to be limited information available to pet owners about price, options available, quality of services and (in some cases) ownership of vet businesses.

(c) Consumers may be offered more complex, higher cost services without being given the option of simpler, lower cost alternatives that may be equivalent or better for animal welfare and which some consumers may prefer.

3.3 Despite these views, the CMA has not put forward any material evidence that customers are unable to compare prices or options.

3.4 To the contrary, the results of the Vet Users Survey demonstrate that:

(a) Nearly 90% of pet owners typically make decisions in advance of routine treatments, rather than under the pressure of arranging emergency treatments.[27]

[27] See Figure 15 of Vet Users Survey. 53% of pet owners made a decision about which practice to choose when it was time for a routine/non-emergency treatment. 35% chose it in advance of needing any treatment.

(b) Approximately three quarters of price-conscious pet owners can and actively do compare prices, whereas only 3% of all respondents wanted to compare prices but felt unable to do so.[28]

(c) When asked about the relationship with their vet practice, 83% of respondents understood the options presented by the vet and could make informed decisions.[29]

3.5 These survey results resonate with Medivet's real-world experience that customers do have multiple options available to them, and in the vast majority of cases are aware of them. This requires Medivet to compete with other local veterinary clinics on treatment options, appointment availability, quality and reputation and price, and to be transparent with pet owners on all these levers, in order to compete.

3.6 Indeed, Medivet is a leader in the market in transparency.

(a) Medivet is already transparent on pricing. It publishes: (i) clinic level price-lists for the most common items for dogs and cats[30] (noting that those items also align with the CMA findings regarding the most common veterinary spend items); and (ii) OOH consultation fees.[31] Further, Medivet's "informed consent" policy requires Medivet vets to provide the pet owner with an upfront estimate for treatment work following a consultation,[32] and to seek re-approval from pet owners if a treatment price exceeds the written estimate.

(b) The "informed consent" policy and protocols also require vets to provide a range of reasonable options, where relevant, in advance of proceeding with treatments, surgeries and diagnostics, which is also an obligation under the RCVS Code – with which all Medivet vets are required to comply. Indeed, Medivet has protocols, policies, training and a whistleblower regime in place that support compliance with the RCVS Code.[33] The fact that Medivet's clinicians provide multiple treatment options in practice is supported by its internal data:

(i) [redacted]

[28] See Table 9 and Figure 24 of Vet Users Survey. Medivet also notes that the CMA's original research from March 2024 demonstrated that 80% of customers received price estimates prior to tests, and 90% prior to surgery.

[29] See Q36 of Vet Users Survey.

[30] See, e.g. "Our Prices" on Medivet Greenwich's web page (https://www.medivetgroup.com/vet-practices/greenwich/).

[31] Decisions to display prices are determined centrally, and local clinics can also advertise locally other items not on the centrally determined list. Medivet encourages clients to call for indicative pricing for anticipated services prior to visiting. Medivet also has over 18,000 items on its price list and so it is not considered practical to attempt to display all of these to customers.

[32] As already explained to the CMA in Medivet's response to RFI 1, Q 14, obtaining informed consent is an integral part of the RCVS Code of professional conduct, which veterinary surgeons are personally obliged to follow. In order to gain informed consent for any procedure, the client must sign a consent form. Medivet's policy is to include a written estimate, ensuring clients are fully informed in advance of the expected price of services.

[33] See, in particular, RCVS Code provision 2.2(b): "ensure that a range of reasonable treatment options are offered and explained, including prognoses and possible side effects".

[redacted][34]

(ii) [redacted]

(c) Medivet has consistently been transparent on ownership. Given that Medivet operates all its services, communications and online presence under a single brand (and has internal policies and guidelines to ensure this), it has always been abundantly clear to both existing and potential customers when they are engaging with Medivet services. This is confirmed by the fact that most respondents to the Vet Users Survey who were customers at Medivet clinics were aware of their clinic's ownership (76%), which contrasts with only a minority of customers of most other LVGs (ranging between 9% and 26%).

3.7 The fact that Medivet actively seeks to compete on all these levers (including treatment options, appointment availability, quality and reputation and price) is reflected in the consistently positive client feedback, Trustpilot and Net Promoter Score (***NPS***) scores Medivet receives.[36] In Medivet's view, if the market were to adopt similar levels of transparency, it would enable pet owners to make more informed choices and already address the CMA's potential concerns.

Increases in treatment intensity

3.8 Medivet understands that the CMA's emerging view is that:

(a) Consumers appear to place relatively little weight on price when making decisions about treatment.

(b) There is increased treatment intensity, which the CMA believes may be incentivised by key performance indicators (***KPIs***), LVG strategy, and non-vets influencing vet decision-making.

Price sensitivity

3.9 As described at paragraph 2.20 above, UK pet owners are increasingly price sensitive with respect to veterinary treatments due to the ongoing 'cost of

[34] [redacted]

[35] Based on Medivet internal data from February 2024 to January 2025. Medivet notes that this figure accounts for multiple estimates: if, for example, a pet owner is given four different estimates for treatment and accepts one, all four are deemed accepted/converted.

[36] Medivet is consistently ranked positively by customers, maintaining a 4.6-star Trustpilot score. See https://uk.trustpilot.com/review/www.medivet.co.uk?page=136. See paragraph 3.24 below for more on Trustpilot and other quality metrics that Medivet measures.

living crisis'. The CMA's findings on price sensitivity are outdated and do not take this, or the veterinary market's responses, into account. In particular:

(a) Medivet notes that there are numerous pricing trials in flight across the sector – including innovative options such as fixed price procedures, free add-on dental checks, and subscription models offering unlimited consultations.[37]

(b) [redacted] than the marginal decrease in overall pet ownership in the UK,[38] [redacted].

3.10 There is inadequate recognition in the CMA's findings that, despite increasing price sensitivity among pet owners, there is persistent demand for the "best care" not just the cheapest, as healthcare is not purchased on a "cheaper is better" basis, and pet owners continue to prioritise pets' health and wellbeing (confirmed in the Vet Users Survey). To meet demand, professionalisation/corporate investment have focused on innovating on quality and range of treatments. There have been tangible quality improvements to veterinary treatments over the past 20 years.[39] As a result, pet owners can now choose previously unavailable or more advanced treatments that more effectively and efficiently improve their pets' health and wellbeing. The effect of this innovation has been to expand the range of treatment options, not to foreclose access to simpler or cheaper alternatives. Pet owners retain the ability to choose the treatment option that best suits them, in particular due to the 'contextualised care' approach promoted by the RCVS and followed by Medivet in practice.

Demand for treatments

3.11 The WPs have so far not acknowledged the pet-owner demand drivers behind seeking treatments or any increase in treatment intensity; or how the industry is responding to the increases in demand:

(a) Contrary to the CMA's statement that there is no link between humanisation and increased pet care/veterinary spend, Medivet's real-world experience is that increased treatment intensity is a direct

[37] See, for example fixed price procedures (https://www.bathvetreferrals.co.uk/referring-vets/news/march-2024/fixed-price-procedures-now-available), dental checks as an added free service (https://www.pets1stvets.co.uk/about-us/offers/free-dental-health-check), and subscription models allowed for unlimited consults (https://www.pethealthclub.com/uk/our-plans).

[38] This has been corroborated by third party studies. See, for example, the 2024 PDSA Animal Wellbeing Report which, in collaboration with YouGov, found that 'there have been no significant changes in dog or cat ownership in the last 12 months' and that 'Overall, 51% of UK adults own a pet of any type, a slight decrease from 2023, when 53% did' (p.8).

[39] See also paragraph 2.7 for examples of the clinic-level improvements that CVC funds' investment in Medivet has given rise to.

consequence of the trends of pet humanisation and medicalisation. As pet owners become more educated on the health and veterinary needs of their pets, and more aware of advances in human medicine, Medivet vets hear regularly from clients that they are prioritising spend on treatments and pet health above other expenses – as also demonstrated by third-party research[40] and the Vet Users Survey (see paragraph 2.2 above).

(b) Increased treatment intensity does not amount to overtreatment, and the CMA has not identified or demonstrated that overtreatment occurs. Rather, Medivet would expect that any increased treatment intensity is reflective of increased quality of service and improvements to animal health and welfare. Medivet's "contextualised care" approach and associated training safeguard against overtreatment. Overtreatment is contrary to the best interest of the patient, and would be a direct breach of RCVS Code. All Medivet vets take seriously their obligations under the RCVS Code, not least since serious breaches can result in suspension or removal from the register of veterinary surgeons, which can be career-ending.[41] Medivet has in place organisational checks and balances to ensure that the obligations of the RCVS Code are complied with, as described at paragraph 3.22 below.

KPIs, incentives and strategy

3.12 The CMA's emerging views in respect of KPIs and LVG strategy driving increased treatment intensity are based on piecemeal anecdotes and, by the CMA's own admission, not underpinned by empirical evidence.[42] Medivet does not use KPIs as performance targets or sanctions. In contrast, Medivet uses KPIs as an important means of maintaining clinical quality, identifying training needs and for the efficient allocation of resources.

3.13 No weight should be placed on the extremely limited anecdotal evidence the CMA has been able to gather in considering any link between KPIs and increased treatment intensity[43]. The examples in the qualitative research report are few in number and framed as referring to "some vets" or "a few vets," without quantifying the evidence or indicating any widespread conduct. Relying on research that lacks empirical evidence or rigorous statistical analysis risks reaching generalised and inaccurate conclusions. To the extent anecdotal evidence is relevant, Medivet would note that the

[40] See NOAH press release, "Owners still prioritise pets despite financial squeeze, but some are struggling" (7 March 2023) (https://www.noah.co.uk/press-releases/owners-still-prioritise-pets-despite-financial-squeeze-but-some-are-struggling/).

[41] As already explained to the CMA in Medivet's response to RFI 11, Q 10, RCVS Code provision 2.2b requires vets to offer owners a range of reasonable options, with further discussion on prognosis and possible side effects. In addition, Medivet's standard employment agreement for its vets and nurses requires compliance with the relevant provisions of the RCVS Code. The RCVS Code also obliges vets to make decisions by considering the circumstances of the owner alongside firstly considering animal health and welfare as priority. Compliance with these obligations prevents overtreatment.

[42] See Revealing Reality Qualitative Research with Veterinary Professionals Research Report (January 2025).

[43] See Revealing Reality Qualitative Research with Veterinary Professionals Research Report (January 2025).

CMA's qualitative research indicates that many vets felt an obligation to provide all treatment options[44] – which undermines potential concerns both around a lack of transparency and treatment intensity increasing supposedly absent demand.

3.14 Even if the CMA were to find supporting empirical evidence (which the CMA concedes it is yet to find[45]), this would not apply to Medivet since Medivet uses KPIs as a tool to monitor important elements of clinical performance – and not to reward or sanction vet performance. Medivet is pleased to note the CMA's acknowledgement that KPIs used in this way are a necessary tool of good management.[46] Medivet sets and monitors KPIs to ensure that clinical guidance is followed in practice, and to support the efficient allocation of resources across Medivet's estate (and, indeed, even not-for-profit organisations such as the National Health Service and charities utilise KPIs for similar reasons). Medivet considers there is a clear purposive distinction between KPIs (which Medivet puts in place for the purposes described above) on one hand, and performance targets or sanctions that may impair vets' clinical autonomy on the other (which Medivet does not have).

3.15 The Business Models WP describes a lack of KPIs relating to the provision to pet owners of sufficient information and recommendations.[47] However, Medivet notes that there are significant substantive issues and practical limitations to introducing these.

(a) Pet owners rely on their vet's expertise to advise and offer the most appropriate treatment or treatment options. In cases where a wide range of information or alternative recommendations is not necessary or even clinically appropriate, setting KPIs that measure information and recommendations metrics would not serve to improve the delivery of such treatments, and offering multiple alternatives may, in those circumstances, in fact be counterproductive (adding doubt to otherwise straightforward advice).

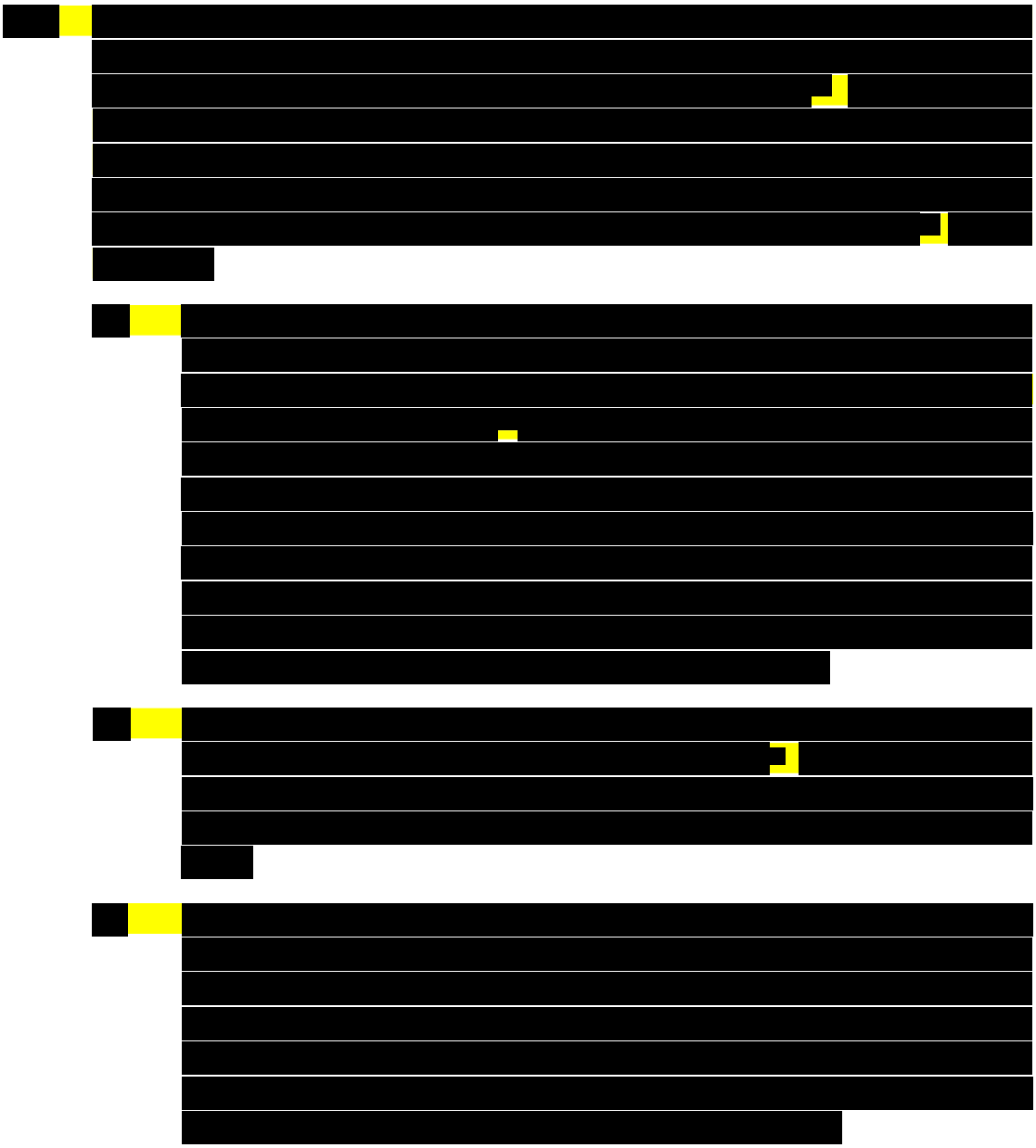
(b) In addition to failing to promote positive clinical outcomes, Medivet also considers that it would in practice be difficult to accurately measure such KPIs, given the large element of discretion involved in the delivery of veterinary advice. However, as noted in paragraph 3.6(b) above, based on internal Medivet data already available, [redacted]

[44] Ibid. paragraph 6.2.3.

[45] See paragraph 2.61 of Business Models WP.

[46] Ibid, paragraph 2.108.

[47] Ibid, paragraph 2.104.



3.17 To the extent there is any inherent tension between revenue/incentives and clinical recommendations, Medivet submits that it is: (i) unavoidable in a for-profit business (which, the CMA acknowledges in the Overview WP[52], the veterinary sector requires); and (ii) safeguarded against by Medivet's compliance processes. These include strict enforcement of RCVS Code adherence and clinical governance/auditing measures (as described further

48 See paragraphs [redacted] of Business Models WP, and paragraph [redacted] of How People Purchase WP.

49 See, for example, Medivet's responses to question 54 of RFI1, question 2 of RFI2, question 31 of RFI3 and questions 11 and 15 of RFI7.

50 [redacted]

51 [redacted]

52 See paragraph 1.8 of Overview WP.

in paragraph 3.20). Medivet notes this inherent tension is likely more prominent in independently-owned clinics than LVGs, given that:

(a) within independently-owned clinics, the same individual(s) acts as veterinary surgeon, sole business owner, price-setter and prescriber, therefore receiving the entirety of any financial benefit from increasing treatments; and

(b) unlike, for example Medivet, independently-owned clinics will not have established corporate clinical audit procedures functioning as checks and balance safeguards against the misuse of individual discretion.

Insured vs. uninsured pets

3.18 [redacted].[53] From Medivet's perspective, any such correlation is likely attributable to the fact that pet owners who have voluntarily opted to take up pet insurance do not bear the same levels of cost for treatment as those without pet insurance, meaning that affordability concerns are less common. Avoiding such concerns forms part of the reason pet insurance is recommended for better clinical outcomes, protection from unforeseen expenses, and to mitigate financial concerns (which is supported by the CMA's own finding that 81% of pet owners with insurance bought it to avoid unexpected costs[54]).

3.19 Medivet does not – in any way – vary its veterinary care according to whether a pet is insured or uninsured (including Medivet's provision of advice in relation to different treatments). In any event, the RCVS Code acts as a safeguard as not providing the owner with all available and possible treatment options would be a clear breach of its provisions (see paragraphs 3.6(b) and 3.11(b) for further detail). Medivet notes that the CMA "*is not clear whether there is a causal relationship between insurance and expenditure*",[55] and would urge the CMA to be cautious with any causation-correlation findings.

Medivet's vet-led approach

3.20 Medivet's vet-led approach ensures that vets are involved in the decision-making at all levels of the business, helping prioritise Medivet's "contextualised care" approach. As explained at Medivet's hearing with the CMA on 11 March 2025 (the ***Hearing***), veterinary professionals are represented throughout Medivet's organisation, including at the shareholder and senior management level. This reflects Medivet's approach to ensure its leadership understand the clinical and professional aspects of the

[53] See paragraphs [redacted] and [redacted] of How People Purchase WP.

[54] See p. 86 of Vet Users Survey.

[55] See paragraph 5.160 of How People Purchase WP.

business and maintain these as the highest priority. Medivet also appoints a Senior Appointed Veterinary Surgeon, as required by the RCVS who sits independently of the executive and board functions and ensures that the professional behaviour and clinical autonomy of clinicians is not eroded by any external factors, such as the commercial performance of the business.

3.21 Medivet's BP model, which contributed to c. [redacted]% of Medivet's 2024 overall clinic revenue, allows veterinary professionals to invest in the ownership and control of their clinic through acquiring a (usually significant) minority interest alongside Medivet. This allows vets to pass-on much of the administrative and non-clinical operations to Medivet, freeing up their time and capacity to devote to clinical care. The BP model gives vets influence over both clinical and non-clinical strategy and decision making for their clinic. The model has already been [redacted]. Given Branch Partners are practising vets, this model acts as a further safeguard against corporate incentivisation of overtreatment (which, as noted already, would be a breach of the RCVS Code).

3.22 Medivet also ensures that vets are part of its clinical governance structure (see Figure 2 below), which includes roles and bodies such as Senior Appointed Veterinary Surgeon (SAVS), Clinical Board, various quality, ethics and welfare Committees, and a Divisional Veterinary Director to audit and uphold clinical standards. This structure of senior and advisory vets supports the practising vets to consistently deliver exceptional clinical care in compliance with the RCVS Code obligations. There are also regional and subject-specific layers of clinical governance structure below this.

[redacted]

[redacted]

Choice and quality

3.23 Medivet understands that the CMA is also interested in how Medivet measures quality, including:

(a) The metrics Medivet uses and why.

(b) How Medivet assesses the outcomes of the measures to increase quality (including in the context of acquiring new clinics).

(c) Methods Medivet uses to ensure the appropriate price/quality combination.

3.24 Measuring quality in a healthcare market such as veterinary services is inherently challenging, as the factors that customers use to assess quality – and the relative weight they place on each – vary considerably between customers. Metrics used in the human healthcare space, such as longevity, are not appropriate (e.g. since euthanasia can in some cases be the owner's preferred outcome). However, as explained in Medivet's response to the CMA's RFI 11, Question 11 and at the Hearing, Medivet does consider there are a number of practical ways to monitor and measure quality.

3.25 Medivet measures the overall quality of its service by systematically tracking individual clinics' Trustpilot and NPS, placing high importance on these because:

(a) Trustpilot scores are at clinic level – and so it is possible for Medivet to review scores and feedback on specific clinics and even specific staff members, if named in the feedback.

(b) Trustpilot feedback is external, objective and independently maintained, and therefore not influenced by Medivet in terms of questions framework or choice-nudging.

(c) Trustpilot displays direct customer feedback, which captures various metrics of quality and customer satisfaction, as well as free-form qualitative feedback.

(d) NPS can be broken down into different "sentiments", allowing Medivet to track its ratings across very specific categories relating to the type of service provided (e.g. "primary care", "emergency care" and "vaccines"), the member of staff providing the service (e.g. "vet" and "nurse"), and pet owner experiences in relation to that service (e.g. "affordability/value", "wait time", and "competence").

3.26 Medivet strives to ensure that it maintains consistently high customer ratings (as described at paragraph 3.7 above, Medivet maintains an average 4.6-star Trustpilot rating). Medivet reviews NPS by sentiment, paying particular attention to affordability / value.

3.27 While Medivet has not acquired a clinic since 2023, when acquiring clinics Medivet invested significantly to bring these to Medivet's estate-wide quality standards,[56] in particular implementing:

(a) Consumer-facing actions, including introducing online booking, refurbishing the clinic and installing Medivet branding to materials and uniforms, increasing marketing budgets, providing access to the Medivet hub-and-spoke network and the Medivet Health Plan (***MHP***), and integration onto Freedom which supports several business administrative functions, e.g. diary management to facilitate the smooth running of clinics.

(b) Colleague-facing actions, including access to Medivet's annual pay awards, enhancing employee benefits through full eligibility for Medivet maternity and paternity policies, and providing access to Medivet's professional networks and training opportunities from the first day of their Medivet employment; and access to greater clinical and operational support networks (including via Divisional Operation Directors (***DODs***), Regional Operations Directors (***RODs***) and

[56] [redacted]

Divisional Veterinary Directors (***DVDs***), and access to Medivet's support centre).

(c) Quality and regulation improvements, including investing in clinical equipment, PSS implementation, cybersecurity infrastructure, UK GDPR compliance and health and safety accreditations.

(d) Clinical improvements, including integration into Medivet's clinical governance structure, investment in new equipment and training, and the opportunity for DVDs to review and audit clinical measures (via Medivet's practice management system) which is helpful in assessing quality.

3.28 Improvements in quality after acquisition can be observed and measured across these categories, primarily by the increased uptake of the newly established range of services. Medivet also enrols new practices onto the PSS scheme as soon as possible.

3.29 Medivet also uses complaints, significant clinical events and near misses as metrics to measure clinical and client care quality.[57] These are tracked and logged internally on Freedom PMS, and/or externally by Medivet's indemnity insurer, the Veterinary Defence Society (***VDS***) and the VetSafe monitoring platform.[58] The data is accessible to Medivet for quality analysis and clinical and client care learnings – and Medivet reviews and analyses the complaints data regularly to monitor the progress of complaints and identify themes and trends that may need specific intervention to avoid problematic behaviours recurring.

3.30 Medivet also has divisional and national Quality Improvement committees who conduct regional and national audits. Interventions at group level typically take the form of educational campaigns, policy and protocol updates and/or sharing of best practice learnings – and, if appropriate on rare occasions, formal investigation in line with Medivet's disciplinary procedures. Medivet also participates in national industry-wide audits and benchmarking programmes.

Choice in referrals and adjacent services

3.31 Medivet understands that the CMA's emerging view is that:

(a) There may be limited consumer choice of services such as referral centres for more advanced diagnostics and treatment where referral recommendations made by vet practices may deny consumers the full range of options.

(b) Many local vet practices have little choice of supplier when they outsource their obligations to provide OOH services.

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[57] The CMA will already be aware of how Medivet collects, and uses, data on complaints from Medivet's response to the CMA's RFI 11, Q5.

[58] Discussed in more detail at paragraph 7.19.

(c) Pet owners might not engage effectively and might lack awareness of their options when a pet dies and may be overpaying for cremations.

3.32 Medivet sets out its perspective on each of these in turn.

Referral centres

3.33 As already explained at paragraph 1.4 above, Medivet is FOP-focused. FOP services comprise c. [redacted]% of Medivet's FY24 revenue and are the core of Medivet's offering. Accordingly, unlike other of the LVGs, Medivet's business strategy is not affected by the distractions of adjacent business divisions whose commercial drivers may not fully align with FOP-focused veterinary care.[59] As a result, Medivet simply does not currently have the business model or referral capacity to be able to prioritise intragroup referral recommendations to pet owners in a way that denies them a full range of options.

3.34 In any case, as already mentioned, Medivet operates all its services and communications transparently under a single brand – including in relation to its three referral centres. Accordingly, any referrals within the Medivet estate are fully transparent, given Medivet's ownership and consistent branding is abundantly clear – and therefore complies with the RCVS obligation when referring cases to declare to pet owners any links to the referral practice, including common group ownership[60].

3.35 To the extent Medivet vets make referral recommendations, they do so in their independent clinical capacity with the clinical needs of the pet and circumstances of the pet owner in mind. Medivet offers no commercial benefits or incentives to vets in relation to referral recommendations[61]. As explained to the CMA in Medivet's response to RFI 11, Question 7(d), Medivet supports vets in making referral recommendations via its [redacted].

3.36 In any case, Medivet notes that the Vet Users Survey data demonstrated that the majority (64%) of consumers felt they could decline a referral after knowing the price.[62] As already noted at paragraphs 3.6(a) and 3.6(b)

[59] While Medivet does offer referrals and diagnostics, these amount to only a *de minimis* c. [redacted]% of Medivet's revenue and are limited to only three referral sites and one diagnostic site.

[60] See provision 1.7 of 1. Referrals and second opinions - Professionals: "*When referring cases, veterinary surgeons should explain any links to the referral practice that could be considered a conflict of interest to the client, including where the practice being referred to is owned by the same group.*"

[61] [redacted]

[62] See Q60 of Vet Users Survey.

above, Medivet vets are required to obtain pet owners' informed consent (with written fee estimates, where appropriate) before proceeding with treatment options – which may include the option of a referral. Further, Medivet encourages pet owners to call in for indicative pricing for anticipated services prior to visiting, which they frequently do.[63] This indicates to Medivet that, if market-wide transparency in relation to referral pricing and options (and referral centre ownership) was to increase in line with where Medivet is already, then the majority of consumers will have the ability to critically assess options and decline referrals if they so choose.

3.37 Medivet's hub-and-spoke model of transfers is entirely distinct from referrals. As a result, hub-and-spoke transfers do not give rise to the types of potential concern that the CMA's emerging views express in relation to referrals.[64]

3.38 While Medivet has minimal vertically integration, it recognises its potential pro-consumer efficiencies and clinical benefits. As the CMA describes, veterinary services are a 'credence' service,[65] where pet owners place significant trust in the professional expertise of their vet. This vital trust element becomes even more valuable to pet owners and pet health outcomes when coupled with a long-lasting and continuous relationship with a single vet or practice. Indeed, the CMA's own survey highlighted that 25% of respondents have been with their veterinary practice for 10 years or more, further highlighting the value placed on continuity of care. Provided the market increases its transparency to enable fully informed choices and preserves pet owners' freedom to choose or decline a referral recommendation, Medivet sees significant benefits to continuity of care throughout both a treatment journey and pet's lifespan.

OOH services

3.39 Where available, Medivet's hub-and-spoke model allows Medivet to offer pet owners OOH services as part of their FOP care, at Medivet's 24-hour hub clinics. This is one of many key patient and pet owner upsides of being with Medivet in relevant clinics – there is no gap in either transparency or continuity of care when pets require OOH care.

3.40 Given: (i) Medivet's hubs (as with all its clinics) are operated under the Medivet branding; and (ii) each hub's OOH consultation fees are publicly

63 See Medivet's response to RFI 1 Question 12.

64 Medivet's hub-and-spoke model of transfers facilitates transfers of patient's cases between Medivet's FOP clinics to enable regular patients of smaller 'spoke' clinics to take advantage of the increased range and availability of facilities and treatments at other larger Medivet spokes or hubs. This allows more efficient geographic distribution of staff, facilities and technologies across Medivet's estate. Transfers are distinct from 'referrals' since transferring vets are not 'gatekeepers' whose recommendation or referral is required in order to access the care. Additionally, in a referral the new vet assumes full clinical responsibility for the pet, whereas in an internal transfer the original vet retains some responsibility for it. Pet owners being transferred would be fully able to independently visit hubs to receive the same treatment, even absent a transfer. [redacted]

65 See paragraph 4.4 of How People Purchase WP.

available on Medivet's website,[66] neither Medivet customers nor Medivet vets who source OOH services from Medivet are put into the challenging situation of trying to source OOH care from non-transparent third-party providers. See paragraphs 4.18 to 4.21 below for further details on OOH services.

Crematoria

3.41 The MIR has so far failed to find evidence for pet owner demand for a breadth of crematorium service choices when a pet dies, or that services are priced too high.

3.42 At the outset, Medivet reminds the CMA that Medivet does not operate any crematoria business and therefore the CMA's emerging views in relation to the transparency of crematoria ownership do not apply to Medivet.

3.43 In Medivet's experience, bereaved pet owners do not always want numerous options for crematoria services. This was reflected in the Vet Users Survey, in which 38% of respondents submitted that they did not want the option to compare, indicative of a large proportion of pet owners being satisfied with their vet dealing with a cremation. By comparison, only 5% of respondents cited emotional upset and only 2% cited lack of awareness of options as the reasons for not comparing providers – which indicates that the proportion of pet owners who did not feel capable of making a choice is overall very low. In the experience of Medivet clinicians, owners are often extremely distressed following the loss of a beloved pet, and will expect an offering of cremation as part of the service provided by the vet. Medivet will often offer owners with an option to store a body whilst they consider the available options to them in relation to disposal – be that at Medivet's offered crematoria or elsewhere, meaning that, in line with the Vet Users Survey results, owners are not having to make a decision at a time of particular emotional upset.

3.44 The CMA suggests that the margins being earned on the provisions of cremation services may be potentially excessive.[67] However, insofar as Medivet's approach to end-of-life pet care – which prioritises compassion and sensitivity, this fails to take account of the following:

(a) The significant costs incurred by Medivet related to supporting clients with outsourced cremation which need to be factored into the overall price of the service, including:

(i) staff time discussing cremation options and ensuring that an owner's wishes are properly respected (e.g. ensuring the right vessels are provided and the pet's name is spelled correctly);

[66] See for example, the website of Medivet's Kensington clinic (Medivet 24 Hour Kensington | Kensington Vet | Medivet).

[67] For the avoidance of doubt, [redacted]

(ii) handling and body preparation;

(iii) storage of the body until cremation takes place;

(iv) organising for transport and any other specific owner requirements (and see paragraph 3.44(b) below in relation to the significantly increased cost of this service and point v) that Medivet incurs in connection with individual cremations);

(v) receipt of ashes and transfer of ashes to the owner in the case of individual or private cremations; and

(vi) contribution to common costs of the clinic and business.[68]

(b) The work required for individual cremations is significantly more time-consuming for Medivet staff (and therefore costly) than for communal cremations. Individual cremations involve a much more tailored service with many more 'touch points' with the pet owner, meaning Medivet staff often spend significant time listening to, confirming and carrying out, special requests (e.g. the taking of paw prints or hair clippings to act as a memento). Any errors made are likely to cause material distress to the pet owner, meaning sufficient time and care must be dedicated. Medivet veterinary teams pride themselves on delivering this final service with the utmost of care and compassion for both the animal and owner involved. Whilst it is a challenging and emotional time for everyone involved, veterinary surgeons also acknowledge that the impact of this last responsibility will often impress greater on the owner than any other- and so failings in providing exceptional care may result in the loss of a future client or serious reputational impact.

(c) Medivet reviews its crematoria prices against crematorium walk-in prices. However, walk-in prices will depend on a number of factors, such as location, size of animal and services offered (e.g. pick up from home, communal or individual cremation, bereavement support). Additionally, the service provided by (and therefore the cost involved for) Medivet is very different to that provided by walk-in providers. These many variables make it difficult for Medivet to benchmark fully.

(d) Medivet's rebates on crematoria services are based on volume on a group-wide basis (i.e. individual clinics do not receive commission/the financial benefit of the rebate). In any case, such rebates are very small in the context of Medivet's overall business.[69]

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[68] See Q9 of RFI7 Response.

[69] The CMA will already be familiar with Medivet's group-level rebate arrangements from Medivet's response to RFI 7, Q24. [redacted] – which is entirely *de minimis* on a group-wide level.

3.45 Medivet also notes that the CMA's emerging views do not appropriately consider cremations as part of the overall way FOPs compete to supply veterinary treatments. When a pet owner seeks veterinary care, they typically receive a service made up of individually priced products, which may include a combination of consultation, diagnosis, treatment (such as surgery), medication and/or cremation services. Competition between FOPs occurs at the level of overall treatment prices and service quality, rather than solely on the price of cremation services, which is just one component of the veterinary services considered by pet owners.

Choice in health plans

Uptake of pet health plans and routine treatments

3.46 Medivet understands that the CMA's emerging view is that:

(a) There is a drive within LVGs to encourage uptake of pet health plans.

(b) Routine treatments are not significantly improving health outcomes or reducing veterinary care spend, while strategies of vet practices, including in relation to pet care plans, appear to influence and encourage increased spending on routine treatments.

3.47 So far, the MIR has not properly acknowledged the demand drivers for pet health plans and more routine treatments, and the findings do not support its thinking:

(a) Medivet does not recognise the CMA's emerging view that routine treatments do not improve health outcomes. Medical literature (both animal and human) points consistently to screening, early diagnostics and preventative care driving better health outcomes [70]. Regular treatments and patient checkups between facilitate health outcomes by increasing opportunities to monitor, identify and treat developing health issues. The CMA has failed to present any evidence to support its contrary view. Indeed, Medivet estimates that the mortality rate of pets not on the MHP is [redacted]%, compared to [redacted]% for pets on the MHP, over a given three-year period,[71] indicating that the MHP contributes to healthier and longer living pets.

(b) As already explained at paragraph 2.2 above onward, humanisation and medicalisation are driving increased demand for veterinary services, which naturally leads to the development of health plans to meet pet owner demand.[72] Medivet invested in and designed the MHP

[70] See e.g., The Importance of Preventative Care for Pets: A Guide for Pet Owners | Academic International Journal of Veterinary Medicine, Dog owners and preventative healthcare: knowledge level, interest, and impact on perceptions of veterinarians' trustworthiness and empathy in: Journal of the American Veterinary Medical Association Volume 263 Issue 3 (2025) and UK Vet Companion Animal - The importance of preventative healthcare: what 10 years of research from the Centre for Evidence-based Veterinary Medicine reveals

[71] Based on internal Medivet data, as Medivet tracks the mortality of the pets it treats.

[72] Medivet contests the CMA's inaccurate reference [redacted]

to meet the needs of its customers (offering different tiers) and based on its business offering. The main services included in the MHP have remained unchanged since 2014, based on clinical guidance and options to keep pets healthy and support the delivery of exceptional care – e.g. the MHP includes two health assessments per year and annual booster vaccinations, which are clinically recommended to avoid development of untreated diseases,[73] which can cause rapid deterioration within a six-month time frame, and to support continuity of care.[74]

(c) Contrary to the CMA's thinking, demand for health plans is not solely a cost-efficiency exercise whereby pet owners hope to make a cost saving compared to buying piecemeal veterinary services. In Medivet's experience, pet owners' key demand drivers are: (i) improved pet healthcare outcomes; (ii) greater peace of mind around preventative treatments and early issue-spotting; and (iii) an ability to spread the cost of necessary pet healthcare. These elements of demand each carry value – and neither the Vet Users Survey research nor the CMA's emerging thinking have captured the full picture.[75]

3.48 The CMA's emerging view around the cost of pet health plans and not reducing veterinary care spend are not reflected in the Vet Users Survey results:

(a) Despite the CMA's view that routine treatments and health plans do not reduce spend, the Vet Users Survey demonstrated that, to the contrary, less than 3% of health plan subscribers cancelled a plan for lack of value for money – implying either that the treatments/plans do reduce spend or otherwise the amount spent was worth the money (likely for the benefits described above).

(b) Medivet also notes that, due to the retrospective framing of the Vet Users Survey questions, the conclusions are necessarily an incomplete financial picture about reducing spend, since it is impossible to predict whether pet owners who took the risk of not seeking routine or preventative treatment would in future need to consider higher priced / more costly non-routine treatments that routine treatment might otherwise have avoided.

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[73] See 2024 guidelines for the vaccination of dogs and cats – compiled by the Vaccination Guidelines Group (VGG) of the World Small Animal Veterinary Association (WSAVA) and Twice a year for life! | American Veterinary Medical Association.

[74] Medivet refutes the CMA's mischaracterisation of [redacted].

[75] Contrary to the CMA's reference to [redacted].

3.49 Medivet's MHP strategy is to encourage pet owners not only with regard to uptake of the product, but also with regard to fully utilising all its available benefits, for clinical and consumer-benefit reasons.

(a) In line with vet users' feedback, Medivet considers that any increase in health plan uptake by LVG customers is driven by pet owner demand that LVGs are more likely to be able to meet (e.g., the administrative burdens of setting up and administering a health plan, the ability to offer a wider range of plan services and benefits, and being better able to model the sustainable cost of a health plan). Medivet also considers that any increased uptake of the MHP is driven by the benefits and cost savings it enables. Joining the MHP represents an average annual saving of £225 vs. the cost of the same products/services purchased directly, not including Medivet's offer of additional 10-15% savings on other services. Medivet consistently sees successful uptake of benefits by MHP clients, i.e. [redacted] uptake for vaccines and [redacted] uptake for flea and worm treatments[58] and encourages more uptake through an active customer communications plan.

(b) Despite the financial and clinical benefits of the MHP, Medivet does see active churn (see [redacted] below). This indicates that switching is prevalent, in particular since there are no joining or exit penalty fees.[76]

[76] MHP members who pay annually and wish to leave the plan midway through a subscription year are refunded any remaining money after deducting the cost of any treatments received in the period between joining date or anniversary of joining (as applicable) and the cancellation date. Pay-monthly MHP members who wish to leave settle either the outstanding amount for treatment received in the period between the joining date or anniversary of joining (as applicable) and the cancellation date (including all discounts received up to the cancellation date), or all outstanding payments for the remainder of the year (whichever is lower).

[redacted]

(c) For the avoidance of doubt, while Medivet encourages clinical staff to promote uptake of the MHP, it does so because of the clear clinical benefits to pet health (see paragraph 3.(a)). Medivet has not established any continuous or material incentives or set targets for clinical staff in respect of their promotion of MHP uptake.[redacted] This minimises the risk of the plans being recommended by clinical staff purely to increase sales, and contradicts CMA's view around LVGs driving health plan uptake for commercial reasons.

(d) The MHP is designed to generate overall savings through all lifespan stages – and not only at the early-stage and late-stage phases of a pet's life when traditionally more frequent/intense treatments may be expected (which would represent a "U-shaped" demand curve over time). In particular:

(i) The MHP covers annual booster vaccinations; complete flea, tick and worm protection; six-monthly check-ups; and urine

77 [redacted]

screenings – all of which are recommended at all stages of pet lifespan.

(ii) Many dog and cat breeds (particularly pedigrees) that have gained popularity as pets in recent times have inherent, life-long associated health risks which significantly flatten the traditional "U-shaped" demand curve because treatments are required through all life stages.[78] The popularity of such breeds, coupled with a surge in demand for them during the COVID 19 lockdowns, has also encouraged unscrupulous breeding practices that fail to mitigate for inherited conditions, which further compound such health issues.

(iii) The MHP discounts on vet care and medication (10%); dental procedures (15%); and some pet food brands (10%) are available for the duration of sign-up.[79]

(e) In any case, given there are no exit penalties or joining fees associated with the MHP, Medivet does not consider there to be any value downside to pet owners taking up the MHP.[80] Therefore (although not Medivet's recommendation for pet health reasons) there is nothing stopping a pet owner from only taking up the MHP during the years of a pet's life they expect to be more treatment-heavy.

3.50 The CMA has not articulated any clear concern around the transparency of health plans. In contrast, the CMA notes that health plans are "well presented" and often display price. Medivet is a leader in this regard. The MHP is fully transparent in demonstrating the value to customers. For example:

(a) Medivet's website shows the key component treatments contained in the plan, their prices under the plan and the average MHP savings made compared to the sum of the MHP's parts.

(b) Medivet sends regular reminders to MHP members alerting them to any included services which they have not yet taken up, and other plan benefits. As part of a good preventative healthcare offering, clinic staff will use client interactions as an opportunity to remind clients of any outstanding or overdue treatments.

(c) Prior to joining the MHP, clients are explained the benefits of joining (e.g. that regular flea and worm treatment limits health issues).

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[78] See https://www.rspca.org.uk/adviceandwelfare/pets/dogs/puppy/pedigreedogs/health, in which the RSPCA notes that, e.g., in relation to 'brachycephalic' dogs (many of which suffer from serious health issues), "*popularity and ownership of these dogs had grown drastically, fuelled in part by their increased use in advertising and the media.*"

[79] If the animal is in need of a single large procedure in its lifetime, the savings may even outweigh the value of the owner's MHP investment.

[80] See footnote 76 for refunds/settlement arrangements on early exit of the MHP.

3.51 Medivet does not consider that making different providers' pet health plans easier to compare should be the responsibility of the providers themselves. Medivet is particularly concerned that, if such a requirement were imposed, it could lead to harmful outcomes for pet owners and pets.

(a) As noted above, Medivet designed the MHP to provide the best overall package of treatments and preventative care – and priced it to offer savings compared to purchasing treatments piecemeal. The design of the MHP also factors in Medivet's FOP-focused business and hub-and-spoke system for efficient allocation of staff, equipment and technology to best deliver the MHP. Medivet's MHP offering also accommodates a range of clinical options, allowing clinicians to contextualise the MHP around the patient and client factors presented. Medivet cannot comment on how any of its competitors' health plans have been designed – and indeed would expect competitors to design and operate their health plans according to their own capabilities, business models and independently sourced clinical guidance.

(b) Medivet uses the design of the MHP as a key competitive lever. It would be a fetter upon normal commercial and competitive ability to somehow require providers of pet health plans to adapt aspects of their plans to better facilitate comparisons. Such a requirement would lead to providers of pet health plans aligning on a uniform pet health plan design that fails to reflect their individual capabilities, resulting in them becoming disincentivised to innovate on quality and assortment.

(c) Further, Medivet is not aware of any consumer goods and services market (including the example well-functioning markets that the CMA cites in the WPs) where market players themselves are responsible for facilitating comparisons of products with competitors. Rather, comparisons are typically facilitated by independent third-party comparison websites or marketplaces.

4. Choosing providers

4.1 In this section, Medivet provides its responses to the CMA's emerging thinking in relation to:

(a) Choice and ability to switch FOPs (including in relation to local concentration, switching and price competition) (at paragraphs 4.3-4.14);

(b) Consumer choice of referral centres (at paragraphs 4.15-4.17); and

(c) Vet choice of out of hours services providers (at paragraphs 4.18-4.21).

4.2 Medivet understands that the CMA's emerging view is that:

(a) Around 6% of local areas are served by only one or two FOPs.

(b) Consumers appear to place relatively little weight on price when choosing a veterinary practice; and often do not shop around or switch providers even when they might get lower prices, or a service better suited to their circumstances, elsewhere.

(c) There is limited consumer choice of referral centres due to the limited availability of such facilities.

(d) There is limited local vet practice choice of local suppliers of OOH services.

Choice and ability to switch FOPs

Local concentration

4.3 In its Local Concentration WP, the CMA itself acknowledges that its approach to analysing the extent of local competition for FOPs suffers one critical flaw.[81] This stems from the CMA using fasciae count as its concentration metric, but its methodology for estimating fasciae relies on an incomplete dataset that fails to capture relevant independent veterinary sites:

(a) The CMA's analysis of local competitive conditions for FOPs is based on 3,704 'confirmed practices' providing commercial FOP services for small animals (identified using RCVS practice data and direct confirmation from each practice).[82]

(b) The CMA notes that its analysis captures complete LVGs site lists,[83] but only 1,433 of 2,401 independent chains and single-site practices.[84] This means that at least 968 independent sites were excluded from the CMA's analysis.[85]

(c) As a result, the CMA's list of 3,704 confirmed FOP sites is incomplete, distorting its local competition analysis and inflating the number of areas flagged for potential competition concerns based on the CMA's screening filter of four or fewer fasciae in a catchment area.

4.4 Medivet has reviewed the CMA's list of RCVS unconfirmed sites within the catchment areas of Medivet's focal sites with four or fewer competing fasciae

81 See paragraphs 2.16 and 2.17 of Local Concentration WP.

82 See paragraph 2.16 of Local Concentration WP.

83 See Table 2.1, footnote 2 of Local Concentration WP.

84 See Table 2.1 of Local Concentration WP.

85 The CMA notes that it has in total 2,605 unconfirmed sites. This includes 1,025 from RCVS (968 of which are independents) and 1,580 from the insurance data (see paragraph 2.14 of Local Concentration WP). Medivet has only considered the RCVS unconfirmed independents in its analysis.

and identified which of these were open and serve small pets.[86] This resulted in material differences with the CMA's findings, as shown in the table below:

[redacted]

Possible Area Type	Number of Medivet multi-ownership areas	
	CMA's analysis (based on incomplete list of sites)	Medivet's analyses (based on complete list of sites)
[redacted]		

4.5 Annex 1 sets out in detail the fasciae changes in each of the local areas in the table above.

4.6 Using the CMA's screening filter of four or fewer fasciae in a catchment area, Medivet's analysis shows only a total of [redacted] multi-ownership Medivet areas with potential competition concerns.

4.7 Medivet summarises why there are no competition concerns in the [redacted] multi-ownership areas with [redacted] where Medivet is the focal site in paragraphs 4.10 to 4.12 below.

4.8 For the [redacted] multi-ownership areas with [redacted] where Medivet is the focal site, Medivet submits that there is no good basis on which the CMA should consider local areas with four fasciae as relevant for assessing competition concerns:

(a) As the CMA itself indicates, in previous comparable cases where fascia counting was used to assess local competition concerns (for example, the groceries market investigation)[88], the focus has been

[86] Medivet focused its analysis on the local areas in which Medivet owns multiple sites in the focal site's catchment area. This is because Medivet understands these to be the areas in which the CMA might see potential for the presence of another competitor and therefore potentially insufficient competition.

[87] Medivet notes that [redacted]

[88] See p. 3 of Groceries Market Investigation (2008): "The OFT should provide advice to the LPA on whether a particular retailer has passed or failed a 'competition test'. Applications would pass the test if within the area bounded by a 10-minute drive-time of the development site: the grocery retailer that would operate the new store was a new entrant to that area; or the total number of fascias in that area was four or more; or the total number of fascias in that area was three or fewer and the relevant grocery retailer would operate less than 60 per cent of groceries sales area (including the new store)." The report can be accessed on https://assets.publishing.service.gov.uk/media/55194b9c40f0b61404000330/14-08.pdf.

on local markets with **fewer** than four fasciae. Other cases where the CMA focused on markets with fewer than four fasciae include the *Cineworld/Empire Cinemas* merger decision[89] and the *McColl/Co-op* merger decision.[90]

(b) A requirement for at least five fasciae in a local area would also be broadly inconsistent with, and more conservative than, the approach previously adopted by the CMA in merger cases, where a 30% market share was used on the basis of an FTE metric. A finding that four fasciae was insufficient for effective competition implies that a 25% market share may be excessive, albeit on the basis of a different market share metric.

4.9 As the CMA has provided no justification to depart from its previous decisional practice, Annex 1 does not address local competition dynamics in the [redacted] multi-ownership areas with [redacted] in detail.

Multi-ownership areas with [redacted]

4.10 Medivet submits that the presence of only [redacted] in an area does not, on its own, indicate ineffective competition. A thorough assessment of local competitive dynamics is needed to evaluate any potential concerns. The CMA has not considered site- and local area-specific competitive dynamics that eliminate any potential competition concerns, nor factors that inherently limit the number of competitors these areas can sustain. In particular, the Medivet sites in the [redacted] areas where there are three fasciae experience at least one of the following site- and local area-specific competitive dynamics:

(a) Serve as satellite sites or have a satellite site in the same local area.

(b) Face meaningful competition from recent new entry in the catchment area.

(c) Face meaningful competition from fasciae just outside the catchment area, where Medivet knows consumers are willing to travel.

(d) Are situated in local authority districts with limited demand that are classified as rural by the ONS[91] (even if not classified as non-urban by the CMA).

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89 See paragraph 51 of Cineworld/Empire Cinemas merger decision (2016): "The CMA believes that, as at least four different competing fascia of similar size and offering will remain in this local area post-Merger, there will be sufficient competitive constraint remaining such that no realistic prospect of an SLC arises as a result of the Merger." The full text decision can be accessed on https://assets.publishing.service.gov.uk/media/586cd7d640f0b60e4a0000e8/cineworld-empire-full-text-decision.pdf.

90 See paragraph 47 of McColl/Co-op decision (2016): "An overlap store fails this filter if there are fewer than three fascia competing with the merged entity post-Merger within a 5-minute drive time and/or 1 mile radius." The full text decision can be accessed on https://assets.publishing.service.gov.uk/media/5889d23ee5274a7a68000022/mccolls-coop-full-text-decision.pdf

91 Based on ONS Rural Urban Classification of Local Authority District Areas (LADs) for England and Wales (2024), which can be accessed on

(e) Are loss-making or of lower profitability.

4.11 Furthermore, as the CMA's findings show, barriers to entry and expansion in FOP services are low.[92] New entrants can and do enter easily and grow, competing with established sites. Medivet shares this view,[93] noting that the persistent threat of entry, alongside competition from existing sites, acts as a strong competitive constraint.[94]

4.12 As a result, there is no evidence that the number of fasciae in these local areas is not at competitive levels and that adding fasciae would even be feasible or impact competition. For example, in sites which already exhibit low levels of profitability, further entry is liable to increase financial concerns and may jeopardise viability. Annex 1 provides detail on the competitive dynamics in each of the [redacted] multi-ownership areas with [redacted] where Medivet is the focal site.

Lack of switching/price competition

4.13 The CMA's emerging view around a lack of switching or price competition has not been supported by the Vet Users Survey evidence. Furthermore, the CMA's emerging thinking rests on selective evidence and attempts to draw parallels with unrelated markets incapable of comparison. By contrast, Medivet's real-world experience shows that regular client churn and pet owner price sensitivity are commercial realities that Medivet reacts to on a daily basis:

(a) Contrary to the CMA's view, the Vet Users Survey results show that vet users can and do switch between veterinary practices, and do not feel restricted from doing so:

(i) 85% of respondents felt able to switch vet practices if they wanted to, and 64% considered it to be either easy or very easy to do.[95]

(ii) 66% of respondents that did not consider multiple vet practices nevertheless felt they had a choice but were happy with their decision.[96]

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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'.

92 In the Overview WP, the CMA notes that new vet practices are able to start up and grow and that there were 745 new vet practices established between 2014 and 2024.

93 Medivet provided an example of [redacted]. Note as well Medivet's response to the Issues statement in paragraph 27 stating that any well-regarded local vet can establish their own practice and win customers.

94 The CMA has, in previous cases, noted the importance of competitive constraints derived from potential competition, and their role in compelling incumbents to compete aggressively.

95 See Q29 and Q30 of Vet Users Survey.

96 See Q17 of Vet Users Survey.

(iii) Vet users consider that location and recommendation are key considerations when choosing a veterinary clinic, and less than 10% of consumers felt they did not have choice. These statistics correlate with the CMA findings that ~1% of the population only have the choice of one FOP.[97]

(b) The CMA's attempt to construct a comparison with other household expenses markets deemed to be "well-functioning" is inappropriate on substantive grounds, based on a selective timeframe benchmark, and incapable of delivering any meaningful comparison.

(i) The CMA's attempt to draw a comparison between veterinary services switching rates and those for retail insurance, broadband, energy and Pay-tv are substantively inappropriate given the completely different consumer drivers and product characteristics. The most obvious differences are:

(A) Retail insurance products, broadband, mobile, energy, Pay-tv are all purchased by a defined period of service with regular milestone switching opportunities at the expiry or rollover of the term. Importantly, those defined periods are either monthly or otherwise annual – meaning there are frequent opportunities for customers to consider switching either within a single year or at least annually. By contrast, outside of health plans, veterinary services are not purchased on a yearly basis, nor do they necessarily have periodic payments or switching milestones.

(B) None of the products have a personal or emotional element requiring the consumer to factor in the health or safety of a beloved family member. There is therefore no emotional element connected with a decision to switch.

(C) The products are not in so-called "credence" markets and so switching does not risk any loss of trust, expertise, or continuity of care downside.

(D) The services have no "local catchment" geographic element, and so switching takes place in the context of national markets – which are not suitable as a comparison to veterinary services, which predominantly are brick-and-mortar service provided on a local catchment basis.

[97] Medivet refutes the CMA's materially inaccurate characterisation that [redacted]

(ii) The CMA uses a one-year timeframe to assess switching of veterinary practices. This timeframe is patently too short to be meaningful given the relative infrequency of typical veterinary service usage. Indeed, even the CMA uses a two-year, rather than one-year, timeframe as the shortest timeframe when measuring frequency of vet visits,[98] no doubt given that the one-year rates are simply too low to be meaningful. The fact that one-year is inappropriately short is also reflected by the fact that, when the timeframe is extended to two, five and 10 years, switching rates becomes far more comparable to the markets that CMA deems to be "well-functioning". It is simply a practical fact that the infrequency of veterinary visits within a one-year timeframe does not give rise to any need to consider switching. It is therefore unfortunate that the CMA's switching analysis relies on an inappropriately short timeframe – particularly when acknowledged elsewhere in the WPs as being too short to be relevant.

(c) Medivet has experience of real-world client switching. For example, Medivet's [redacted].

4.14 Notwithstanding the fact that switching clearly does occur, Medivet believes that this switching is only made meaningful when a pet owner is aware of a clinic's ultimate ownership. It is for this reason that Medivet operates a consistently uniform branded model and is fully supportive of the CMA encouraging greater brand transparency.

Consumer choice of referral centres

4.15 Medivet notes that the Local Concentration WP did not identify any Medivet referral centres as the focal site of a monopoly or duopoly catchment area where another Medivet referral centre is present. This confirms the absence of competition concerns in areas where Medivet is present.

4.16 Further, Medivet notes that its three referral centres form a *de minimis* part of its business, accounting for c. [redacted]% of FY24 revenue.

4.17 As such, this response does not contain any further comment on consumer choice of referral centres or on the market dynamics of these services. Medivet reserves its position to make comments on this at a later stage.

[98] See paragraph 3.2 of How People Purchase WP (February 2025) and Q8 of Vet Users Survey measuring frequency of vet visits.

[99] Such competitors include a veterinary tech startup, Creature Comfort, and others including Wolfe Vets.

Vet choice of OOH services

4.18 Medivet also submits that the CMA's local concentration analysis of OOH services demonstrates no competition issues in the provision of such services.

4.19 The analysis identified no Medivet OOH site as the focal site of a monopoly catchment area where Medivet owns an additional site, and only [redacted] Medivet site as the focal site of a duopoly catchment area where Medivet owns an additional site ([redacted]).

4.20 As stated in regard to the choice of FOP services, the presence of a certain number of fasciae in a given area, such as two fasciae in this case, is not, in itself, sufficient to conclude that competition is ineffective. In relation to [redacted] catchment area defined by the CMA, there appear to be site-and-local area specific competitive dynamics justifying the presence of only two competitors:

(a) It is located in a rural area of [redacted], with low population density area, which limits the demand for FOP clinics and, in turn, OOH services.

(b) In Medivet's experience, vet practices in this region are spread across a wider geographic area as pet owners are generally willing to travel further.

(c) As a result, the CMA's analysis ignores meaningful competitors in nearby areas. For instance, expanding Medivet's [redacted] catchment area by only an additional 10% drivetime (equivalent to less than three minutes) would bring the [redacted] site, another provider of offsite OOH services, into the catchment area. It is likely that FOPs in the area would also consider this OOH provider when making their choice of site for OOH provision due to the very small increase in drive times.

4.21 This means that Medivet's [redacted] catchment area includes at least three fasciae, which, according to the CMA's Local Concentration WP, exceeds the threshold for areas requiring further investigation for local competition concerns. The CMA should therefore disregard Medivet's [redacted] site from its local concentration analysis for OOH services.

5. FOP service pricing

5.1 In this section, Medivet sets outs its responses to the CMA's emerging thinking on FOP service pricing (in particular that the LVGs (including Medivet) are more expensive than independents).

5.2 Medivet understands that the CMA's emerging view is that:

(a) There has been a long period of sustained price rises for the delivery of vet services, higher than both the rate of inflation and increases in vet salaries.

(b) Prices for FOP services at LVGs are more expensive than those at independent FOPs.

The CMA relies on flawed analysis to suggest that price increases are excessive and that LVGs are more expensive than independents

5.3 In its Overview WP, the CMA states that vet businesses have high retail prices for veterinary medicines, which have increased significantly in recent years.[100] In paragraphs 6.16-6.50 Medivet sets out why the CMA cannot derive any conclusions on levels of competition based on assessment of prices and mark-ups in medicines without reference to a suitable counterfactual.

5.4 In the Business Models WP, the CMA relies on Figure 2.2 to suggest that LVGs usually generate higher average revenue per pet than independent practices. The CMA implies that this difference is primarily attributed to the pricing strategies of LVGs, which tend to set higher prices for services and treatments than independent practices. However, this comparison is misleading and cannot be used to conclude that prices at Medivet are above those of independents. This is because:

(a) As acknowledged by the CMA in the Business Models WP,[101] the CMA's analysis does not control for differences in how treatment data is categorised and stored between competitors.

(b) Further, the CMA comparison does not control for differences in the regional distribution of practices. This will disproportionately affect Medivet since Medivet's practices are primarily located in London and the South East, where prices are generally higher as a result of a higher labour and property costs.[102]

5.5 The results of the Vet Users Survey do not support the CMA's emerging views:

(a) 33% of respondents who chose an independent practice cited price as a key factor, compared to 21% of those who chose an LVG. These differences are not significant, especially given sample size limitations. The CMA can therefore not derive any meaningful conclusions on FOP prices and consumer choices of LVGs and independent practices.

[100] See Paragraph 1.10(e) of Overview WP.

[101] See paragraph 2.46 of Business Models WP.

[102] Medivet points the CMA to [redacted]

(b) Moreover, the survey shows that price is not the primary consideration when selecting a FOP practice, with only 18% of respondents identifying price as their main reason for choice.

5.6 Therefore, there is no evidence to suggest that consumers choose independent practices over LVGs based on cost, nor is there any indication of significant price differences between LVGs and independent practices.

5.7 Lastly, Medivet considers that the main evidence the CMA relies on to claim that price increases are excessive and that LVGs are more expensive than independents is the analysis presented by the CMA on its WP '*The impact of corporate acquisitions on treatment costs*' (***Econometrics WP***). In the Econometrics WP, the CMA states that:

(a) Claim values, first-year treatment costs, and unit prices are statistically significantly higher for LVGs than independent clinics.

(b) Corporate acquisitions of an independent clinic result in a statistically significant increase in claim values and unit prices.

5.8 As set out in Medivet's response to the Econometrics WP, the CMA has not derived reliable conclusions. Medivet has very serious concerns with the underlying insurer data used by the CMA and the methodology of its analysis. In summary:

(a) The CMA's insurer data lacks the necessary granularity to reflect the actual variety of treatment provided, leading to an unrealistically wide range of claim values and unit prices in the data. This makes the data unusable, and even the best statistical analysis cannot resolve this. The presence of outliers in the data further shows that the data has not been adequately cleaned.

(b) The CMA also makes methodological errors and omissions that further undermine its findings:

(i) When controlling for regional price variations, 24-hour centres, and [redacted], the effect of Medivet ownership on claim values is [redacted]. Similar controls also [redacted] the effect of Medivet's ownership on unit prices. Moreover, the CMA's methodology does not, and cannot with its insurer data, control for differences in the quality of the treatment provided.

(ii) In estimating the causal effect of a Medivet acquisition of an independent clinic, the CMA does not account for the effect of integrating newly acquired clinics into [redacted]. The CMA also does not consider changes in the quality of treatment provided, as well as changes to the cost

structure and levels of investment in the newly acquired clinics.

(c) Given the fundamentally flawed nature of this analysis, the Econometrics WP analysis or conclusions cannot be relied on to support arguments made in the WPs published on 6 February 2025. This includes the CMA's analysis in the Medicines WP, which Medivet discusses in detail in section 6 and Annex 2.

[redacted]

6. Medicines pricing

6.1 In this section, Medivet provides its responses to the CMA's emerging thinking in relation to:

(a) Medicine prices and mark-ups (at paragraphs 6.2-6.13);

(b) Benchmarking for the prices of veterinary medicines in a well-functioning market (at paragraphs 6.14-6.50); and

(c) Shortcomings in the empirical evidence presented by the CMA (at paragraphs 6.51 to 6.61).

Medicine prices and mark-ups

6.2 Medivet understands that the CMA's emerging views in the Medicines WP include:

(a) Vets set high retail prices for veterinary medicines, which have increased significantly in recent years. In some cases, vet businesses apply large mark-ups to their purchase costs of medicines.

(b) Customers might be overpaying for veterinary medicines and associated fees and therefore, competition may not be working well.

103 [redacted]

(c) Customers are unable to compare prices of veterinary medicines and associated fees across FOPs when choosing FOPs.

(d) Customers are not aware of the third-party retailer options available for purchasing veterinary medicines.

(e) FOPs' behaviour makes it more difficult for pet owners to use third-party retailers.

Overview: the CMA fails to show the existence of an AEC in the provision for veterinary medicines and identify the related drivers

6.3 The CMA's framework aims to determine AEC by benchmarking current market conditions in the provision of veterinary medicines against those of a counterfactual well-functioning market (***WFM***).[104] It then attempts to identify the drivers of any findings that the market for the provision of veterinary medicines may not be working well.

6.4 However:

(a) the approach taken by the CMA does not allow it to confirm these concerns;

(b) the evidence does not suggest that competition for the provision of veterinary medicines is not working well; and,

(c) the drivers of the alleged AEC identified by the CMA are not supported by the evidence.

6.5 Firstly, as explained in paragraphs 6.14-6.50 below, the CMA does not clearly define or justify its choice of the appropriate competitive benchmark for veterinary medicine prices and is, therefore, unable to accurately identify any AEC.

6.6 This is because:

(a) The CMA does not provide the required economic justifications why the different benchmarks considered in its analysis are an accurate representation of outcomes which would be seen in a WFM.

(b) The CMA does not identify a single relevant benchmark, but instead considers multiple benchmarks, without expressing which it considers more relevant or whether those benchmarks are consistent with one another. Where there is inconsistency between benchmarks, the CMA should assess the reasons for these inconsistencies and their impact on the relevance of the benchmarks.

6.7 Specifically, the CMA suggests that in a WFM it would be the case that:

[104] See paragraphs 3.5-3.7 of CMA Overview WP.

(a) The level of margins on the provision of veterinary medicines earned by LVG-owned FOPs should align with those of independent FOPs.[105]

(b) The level of prices for the provision of veterinary medicines at FOPs should align with those of online retailers.[106]

(c) The evolution of prices for the provision of veterinary medicines at FOPs should follow the evolution of prices of other services in the wider economy, measured by the consumer price index for services.[107]

6.8 However, as explained further below:

(a) the margins on the provision of veterinary medicines of independent FOPs are not an appropriate benchmark, as they cannot be considered separately from margins earned in the other complementary services offered by FOPs, which, for clinical and convenience reasons, are usually bought together (see also paragraphs 6.16-6.19). Moreover, the CMA has not presented a like-for-like comparison enabling a robust conclusion on differences in margin;

(b) the prices for veterinary medicines sold by online retailers are not an appropriate benchmark, as they relate to the provision of products of different quality with substantially lower costs of provision and overheads than brick-and-mortar veterinary practice (see also paragraphs 6.33-6.48), such that prices for medicines from FOPs and from online retailers would be expected to be substantially different even in a WFM; and

(c) there is no reason for the prices for the provision of veterinary medicines by FOPs to follow the consumer price index for services rather than the costs underpinning the provision of those medicines. There is no economic principle which would imply that the costs of all goods and services in an economy should move in line with one another, or that failure to do so offers any insight into market power (see also paragraphs 6.49-6.50).

6.9 The CMA has also not attempted to verify the consistency of these various benchmarks. For example, it has not attempted to verify if the prices of veterinary medicines sold by independent FOPs or online pharmacies even approximately followed the consumer price index. If they did not do so, then at least one of these benchmarks must be inappropriate.

6.10 Secondly, as explained in paragraphs 6.51-6.57 below, even if such benchmarks were appropriate, the preliminary findings of the CMA are

[105] See paragraph 3.26, 3.29 of Medicines WP.

[106] See paragraph 3.39 of Medicines WP.

[107] See paragraph 3.13, 3.14, 3.42(a) of Medicines WP.

based on empirical analyses which are either incomplete or flawed and do not allow the CMA to robustly conclude that there has been an AEC.

6.11 Thirdly, as explained in paragraphs 6.62-6.79 below, the CMA has not identified specific features of the market which are supported by the evidence and could explain the alleged higher prices and margins.

6.12 Even if the CMA were to conclude that prices and margins in the provision of veterinary medicines at LGV-owned FOPs were above its chosen benchmarks, the CMA has failed to establish:

(a) a clear link between any alleged AEC and the source of such effect;

(b) the specific market conditions enabling any AEC to occur; or

(c) that these conditions would not exist in a WFM counterfactual.

6.13 For example:

(a) There is strong evidence that customers prefer the quality of service offered by their vets. To the extent that this includes the provision of veterinary medicines, and customers are willing to pay for such higher quality, the CMA would have needed to show that its findings are not primarily driven by consumer preferences in favour of high quality leading to higher prices, and that in a WFM those preferences would have been different.

(b) If consumers perceive buying medicines from their vet, rather than an online pharmacy, to offer a higher quality of service,[108] then this would drive willingness to pay for medicines at a vet above those at online pharmacies. This in turn means that online prices would be an inappropriate benchmark, as they would not compare like with like.

The CMA fails to set an appropriate benchmark for the prices of veterinary medicines in a well-functioning market

6.14 The CMA's evidence for an AEC relies particularly on comparisons of medicine prices and margins for LVGs with those of independent FOPs and online pharmacies. The CMA also relies on a comparison of the evolution of prices between veterinary medicines at FOPs and prices of services in the wider economy.

6.15 However, these comparisons are flawed for the reasons set out below.

<u>FOPs compete to provide veterinary treatments, of which medicine provision is only one component</u>

6.16 The CMA argues that the margins earned on the provision of veterinary medicines by LVG-owned FOPs are higher than the margins earned by

[108] For example, because the medicine can be administered in person by a vet or received by the client immediately at the point of care rather than after a delay in ordering

independent FOPs, to suggest that the prices of those services at LVG-owned FOPs is inconsistent with a WFM.[109]

6.17 However, this fails to account for the way FOPs compete to provide veterinary treatments.

(a) Medication is the final step of a diagnostic process, resulting in a natural integration between consultation, treatment, and medicine provision.[110]

(b) When a pet owner seeks veterinary care, they are typically billed for a number of services, which may include consultation, diagnosis, treatment (such as surgery), and medication.

(c) One of the features of products which are strong complements to each other is that the prices set between them are to a large extent arbitrary as it is the joint price which matters. A pet owner who attends a vet knowing that they will need a prescription (for example, for an ongoing chronic condition), and who would not purchase from an online pharmacy, will only rationally care about the joint price of the consultation and medicine, as the split between the two separable products is of no relevance.

6.18 Competition between FOPs therefore occurs at the level of overall treatment prices and service quality rather than solely on the price of medicines, which are just one component of the veterinary services considered by pet owners.

6.19 This is confirmed by the Vet Users Survey results, which indicates that when comparing FOP prices, pet owners do not focus solely on medication costs. Instead, they rationally evaluate a variety of services: 72% inquiring about vaccination costs; 63% about routine consultations; 38% about neutering; and 21% about emergency consultations,[111] reflecting that they will need a range of services over the lifetime of their pet.

Joint and common costs may efficiently be recovered in a range of ways

6.20 There are a range of costs incurred by a veterinary practice which are joint or common across the various products offered. These include the property costs of the practice (which are common across all of the products offered by that practice); the energy costs of the practice (common across all of the products offered by that practice); and the wage costs of vets (common across all of the products which require time from that vet).

[109] See paragraphs 3.26 and 3.29 of Medicines WP.

[110] Indeed, the first dose of prescription medication cannot be given without some consultation having taken place in some form as a course of prescription medicine cannot be given by anyone other than a veterinary surgeon who has the case under their care. Although not vice versa – prescription medicines cannot be purchased without a consultation, but consultations can (and often are) purchased without a medicine being prescribed.

[111] See Table 9 of Vet Users Survey.

6.21 The pricing of medicines reflects the need for all products offered by a vet practice to contribute to the joint-and-common costs of providing the various products offered.

(a) There is no reason to assume that analysing the price of a single component, such as medicines or associated fees, provides a meaningful basis for assessing the competitive dynamics of the market.

(b) In fact, there is no economic reason for the same level of margins to apply to the different components of the veterinary treatment, nor to expect proportionate recovery of operating costs across all of the services offered.[112]

6.22 This issue was considered at length in the recent Competition Appeal Tribunal judgment in *Le Patourel v BT*. In that judgment the CAT set out that:

> "*Where common costs are shared across multiple outputs, this gives rise to an intrinsic interdependence between the profitability of those activities, and at least a degree of flexibility in the way in which those common costs might be recovered across the different products*…"[113]

6.23 The CAT then set out that it would permit BT to recover 40% of its common costs from the products that were the subject of the litigation, notwithstanding that they only represented 18% of BT revenues, reflecting the "*principle that firms in competitive conditions should enjoy a considerable degree of flexibility in how [common] costs are recovered*".[114]

6.24 The CMA has not articulated why this approach, which implies quite different mark-ups across different products offered by a firm, is inappropriate when considering the pricing of medicines.

(a) Online retailers, which the CMA considers a prospective benchmark, do not have the same set of common costs as FOP veterinary clinics, and therefore do not need to recover them.

(b) Comparing mark-ups over direct costs between medicines and other services within a FOP clinic would represent an inappropriate benchmark, as common costs can be efficiently recovered in different proportions across the range of FOP products.

Medivet's pricing strategy is welfare-enhancing

6.25 Medivet's pricing strategy, which involves recovering a greater proportion of joint and common costs (fixed costs representing [redacted]% of total revenue

[112] The recent CAT ruling in *Le Patourel vs BT* confirms that it is entirely legal for companies to engage in differential cost recovery. See CAT, *Le Patourel vs BT*, paragraphs: 112, 512, 897 et seq, 907; available at https://www.catribunal.org.uk/sites/cat/files/202412/13817721%20Justin%20Le%20Patourel%20v%20BT%20Group%20PLC%20-%20Judgment%20%2019%20Dec%202024.pdf

[113] See recital 112 of *Le Patourel v BT*.

[114] See recital 907 of *Le Patourel v BT*.

in FY24)[115] from medicines than from initial consultations, is beneficial to consumers and to pet health outcomes, and as such is consumer welfare-enhancing.

6.26 The current price structure is designed to keep front of house treatments affordable, improving access to essential veterinary care. To sustain this, lower margins on front of house treatments must be offset by higher margins elsewhere, including through medicine sales. This differential cost recovery has already been highlighted to the CMA in a joint submission from multiple veterinary associations, which noted:

> "*The growth of online pharmacies, (…) has made it increasingly important that vets charge appropriately for their professional services, which historically were subsidised by medicine sales*".[116]

Overall, this enhances consumer welfare, as higher margins are set for products with lower elasticity of demand, in line with Ramsey pricing principles[117] (see below).

6.27 To maintain the profitability of the veterinary sector, any reduction in medicine prices would likely require higher prices for other front of house services. These could, in turn, reduce the number of these consultations, reducing animal welfare and harming patients.[118]

CMA's analysis lacks consideration of differences in price elasticity

6.28 The CMA has not undertaken analysis of the relative price elasticity of demand of consultations and of medicines, but if (as Medivet considers) demand for consultations is more elastic than for medicines, under a competitive benchmark there would be higher price cost margins on the inelastic products.

6.29 As the CAT noted in *Le Patourel v BT*: *"Ramsey pricing… predicts that margins for individual products will vary in inverse proportion to the demand elasticity for each item… competitive market outcomes can exhibit a variety of price-cost margins*."[119]

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[115] Medivet's considers three key cost components "fixed": (i) staff on payroll, (ii) locum coverage required to maintain consistent service levels, and (iii) operating expenses such as rent, utilities, service charges, IT, telephony and insurance. In FY2024, these fixed costs represented 43% of total revenue, highlighting the significant proportion of revenue that must be generated simply to cover these essential costs. See Medivet's response to Q24(a) of RFI 7.

[116] See Joint submission of British Veterinary Association (VA), the British Small Veterinary Association (BSAVA), the Society of Practising Veterinary Surgeons (SPVS), the British Veterinary Nursing Association (BVNA) and the Veterinary Management Group (VMG) to the Competition and Markets Authority review of the provision of veterinary services for household pets in the UK, paragraph 14; available at https://www.bva.co.uk/media/5459/submission-to-cma-oct-2023.pdf.

[117] Ramsey pricing is a strategy often used by regulated firms to allocate costs efficiently by setting higher mark-ups on products with inelastic demand and lower mark-ups on those with elastic demand. This approach helps recover fixed costs while minimising economic distortions and maintaining consumer access.

[118] For completeness, while, in theory, decreasing the prices on veterinary medicines could also lead to an increase in the volume of medicines serviced at FOPs, this would not be clinically appropriate in most cases.

[119] See recitals 689-690 of *Le Patourel v BT*.

6.30 It has generally been found that Ramsey pricing is consumer welfare enhancing, by enabling recovery of common costs while minimising the loss of demand due to prices exceeding their marginal cost. The Medicines WP presents no evidence that margins on medicines do not represent a form of Ramsey pricing; indeed, the concept of Ramsey pricing is not mentioned in the Medicines WP.[120]

6.31 The CMA cannot therefore conclude from a comparison of margins on the provision of veterinary services across FOPs on the existence of any AEC, without considering the overall price structure of the different services provided by FOPs.

6.32 Any finding that the level of medicines pricing would be lower in a WFM must take into account that prices for other services would be higher, and take into account the consumer welfare impacts of both of these effects.[121]

Online pharmacies have a lower cost base and provide a lower quality service

6.33 The CMA's emerging view is that the prices of veterinary medicines sold by online retailers are often considerably lower than those at FOPs, implying that FOP pricing is in excess of that which would be seen in a WFM. However, this fails to account for structural differences in the level of service provision and related costs of such provision between FOPs and online pharmacies.

6.34 FOPs provide a higher level of care, convenience, and veterinary oversight, which many pet owners value. The higher quality of services offered by FOPs comes with higher costs of providing those services than those incurred by online pharmacies.

6.35 As such, it is not appropriate to compare margins earned by FOPs and online retailers without controlling for the different cost bases of FOPs and online pharmacies, and the lower level of quality provided by online pharmacies.

The level of service provided by FOPs is materially higher than that offered by online pharmacies

6.36 FOPs are able to provide a higher level of service associated with the provision of veterinary medicines than online pharmacies. Pet owners place considerable value on the aspects of quality for which FOPs are superior. There are multiple aspects of the higher quality offered by FOPs compared to online pharmacies.

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[120] This is particularly important in the current case. Setting a higher consultation fee may lead to owners incurring higher costs overall. For example, a higher consultation fee may deter owners from consulting with their vets until the animal's condition had deteriorated. This then may lead to higher charges for non-consultation products, due to the animal presenting to the vet when their injury or disease was further progressed.

[121] The exception would be if all vet market participants – independents as well as LVGs – were found to be excessively profitable. Medivet notes that the CMA has not yet published any analysis of the profitability of the veterinary sector.

6.37 First, FOPs provide immediate availability of medicines:

(a) Unlike online retailers, FOPs maintain broad in-clinic stock at all times to ensure medicines are available on demand. Medivet also manages its supply chain to guarantee steady availability of drugs. For example, Medivet [redacted].

(b) Medivet's standard is for FOPs to obtain medication in less than 24 hours. To ensure this, [redacted]. In contrast, the expected delivery times from online pharmacies are three to five working days.[122]

6.38 Second, FOPs provide personalised care related to medicine provision, and therefore a higher quality of service. For example, FOPs provide additional personalised support to the pet owner in terms of general information about the medication, dosing, use and dispensing.

6.39 Third, online pharmacies cannot administer medication in the same way that FOPs do (and as many pet owners prefer):

(a) Consumer demand has been moving away from pills and towards injectable products. This reflects that injectables work more quickly than other administration methods, as they are placed directly into the bloodstream or affected area; and that there is a greater level of compliance with injections than with other administration methods, as there is no need for an owner to convince a reluctant animal to take a pill, and no burden to carefully time the provision of doses of treatments. This greater level of compliance is associated with improved patient outcomes.

(b) Injectables cannot be administered by online pharmacies. Unless a pet owner purchasing injectables online is confident enough to inject their own pet (many of whom are not), they would need to buy the injectable online, wait for its delivery, and then take it to the vet for administering. This time delay means that, where injectables will lead to improved patient outcomes, provision of the injectable by a FOP will offer a preferable service to most pet owners than that provided by an online pharmacy.

6.40 Fourth, FOPs ensure continuity of care between veterinary medicine provision and other veterinary treatments. In a FOP, the same veterinary professional assesses, diagnoses, and prescribes medication within the same setting. Continuity of care can have significant benefits for patients in all healthcare settings and provides a level of reassurance to pet owners

[122] This is particularly important for acute conditions, where the patient may deteriorate during the delay in treatment being commenced; and in pain relief medicines, where many owners may be reluctant to save money at the cost of leaving their pet in pain for an extended period of time.

that online pharmacies cannot offer (see paragraphs 1.5(b) and 3.38 above).

6.41 Fifth, the CMA has not taken into consideration that pet owners place a high value on convenience and patient outcomes when purchasing veterinary medicines, consistent with pet owners perceiving the quality offered by purchasing medicines from their FOP to be superior to that available from online pharmacies. The evidence shows that for many pet owners, these are more important criteria than price, which seems to be the primary focus of the CMA in its assessment:

(a) The Vet Users Survey analysis shows that among pet owners who bought medicines from their FOP, 50% cited convenience as their primary reason for doing so.

(b) Furthermore, pet owners identified trust in the quality of medicine from the FOP and need to purchase them quickly as key reasons to purchase medicines directly at FOPs.[123]

FOPs face higher direct and indirect costs for offering medicines than online retailers

6.42 Almost every model of price setting by a company demonstrates that the cost of providing a product is a core driver of prices. As such, comparisons between different providers of a given product only make sense if either:

(a) the underlying costs of providing the product are the same across those two providers; or

(b) cost differences are due to inefficiency on the part of the more expensive provider.

6.43 In this case, FOPs have higher costs of provision for a number of reasons unrelated to any inefficiency, making it inappropriate to draw comparisons between FOPs and online pharmacies.

6.44 Immediate availability of service implies higher service provision costs:

(a) Providing medicines at short notice requires higher expenses for inventory management, storage facilities, and staff time, while also increasing the risk of wastage of drugs which are not used before their expiry.

(b) In particular, injectable medications have a limited shelf life after the first dose is taken and is associated with higher wastage.[124] Medivet data for its 10 most commonly used injectable medicines suggests that wastage levels range [redacted]

[123] See Table 19 of Vet Users Survey.

[124] For example, Apovomin 5ml costs £[redacted]. A 10kg dog needs just 0.2ml, leaving 4.8ml unused. With a 28-day shelf life, any surplus, worth £[redacted], must be discarded if not used. Disposal follows strict controlled drug protocols, requiring a denaturing kit and authorisation from another vet or the police, adding further waste costs.

[redacted].[125] This wastage represents a direct cost to the business, as unused medication cannot be resold and must be discarded; the process of disposing of unused controlled medicines can itself be costly.

(c) In contrast, the Medicines WP notes that online providers tend to focus on a narrower range of the most heavily used medicines.[126] This has the effect of lowering the costs of stockholding, which decreases working capital requirements.

6.45 Personalised, more convenient and continuous care at FOPs implies higher overheads. There are a number of costs which are faced by FOPs when prescribing and dispensing drugs which are either not faced by online pharmacies, or incurred at a much lower level than for FOPs:

(a) Staff costs: unlike online retailers, FOPs must employ highly skilled veterinary professionals,[127] nurses, and administrative staff to provide in-person consultations, dispense medication, and offer medical advice.

(b) Premises costs: FOPs operate from physical clinics, often located at key locations, which incur high fixed costs through rent, facility maintenance, and utility costs. Costs are also incurred in keeping medication secure and stored appropriately (i.e., at correct temperature) at every site.

(c) Economies of scale: online pharmacies can spread fixed costs over a larger number of individual sales compared to any single FOP clinic. By contrast, because FOPs serve pet owners looking for continuity of care at their clinics, they are limited in their sales of veterinary medicines, and do not benefit from the same level of economies of scale.

6.46 In addition, regulatory requirements applicable to FOPs imply that they incur higher costs than online retailers. FOPs face restrictions when sourcing medicines that do not apply to online pharmacies. Under RCVS obligations, they must purchase exclusively from licensed wholesalers to ensure the quality of medicines, often at higher prices, even after rebates and discounts, than those available to online retailers. This can and does result in online pharmacies selling some drugs [redacted][128]

[125] Medivet's internal procurement and sales data allow for an analysis of this issue by comparing the quantities purchased and sold. This volume discrepancy serves as a proxy for wastage. The average is calculated as a simple unweighted average.

[126] See paragraph 2.84 of Medicines WP.

[127] For completeness, online pharmacies are required to employ veterinary staff, but not to the same extent as FOPs.

[128] For example (all prices excluding VAT): **(i) Epiphen Solution for Dogs (30ml)**, a POM-V antiepileptic drug, are sold for £14.95 without VAT at Animated, while Medivet's current net net purchase cost for the solution is £[redacted] (see https://www.animed.co.uk/epiphen-solution-for-dogs-30ml (last accessed on 18 March 2025)) **(ii) Zodon Oral Solution for Cats and Dogs (20ml)**, a drug used to treat wounds, is sold for £8.51 without VAT at Animated. Medivet's current net net purchase cost for the solution is £[redacted] (see https://www.animed.co.uk/zodon-25-mg-ml-oral-solution-for-cats-and-dogs-20ml (last accessed on 18 March 2025))

6.47 As a result of the lower quality of service offered by online pharmacies, and the reduced regulatory requirements which they face, online pharmacies have structural cost advantages that cannot be replicated by FOP clinics. These cost advantages are in both the incremental cost of medicines, and joint and common costs related to the significantly higher costs of operating FOPs which have to be recovered across the set of products offered at each FOP.

6.48 Given these differences, a simple comparison of the pricing models between FOPs and online pharmacies, as set out in the Medicines WP, is inappropriate. The difference in underlying costs is such that it would be surprising if there were not substantial price differences between online pharmacies and FOP medicine prices.

<u>The CMA provides no reason why prices of veterinary medicines should change in line with inflation</u>

6.49 The evolution of prices for the provision of veterinary services will be determined by the evolution of costs and demand conditions affecting the provision of those services. There is no reason *a priori* to assume that the evolution of those costs and demand conditions would have been similar to those affecting other service markets.

(a) There are several specific factors impacting the FOP market such as the strong increase in the demand for veterinary services after the pandemic or the constraints faced in obtaining qualified staff, particularly following Brexit. As such, it appears unlikely that in a WFM price changes for veterinary services – including veterinary medicines – would have been in line with inflation.

(b) The Medicines WP provides no rationale why prices of veterinary medicines would have changed in line with inflation in a WFM. In particular, there has been no control for the cost of the underlying medicines, nor for other costs facing FOPs such as labour costs and energy costs.

(c) In addition, the CMA has presented no argument in economic theory why it represents a market failure if prices of any particular goods or service do not move in line with inflation. It is entirely normal for the prices of different products to evolve in very different ways – it is for this reason that the ONS carefully constructs appropriately weighted baskets of representative products to derive its estimates of inflation. If the prices of all products moved in parallel with one another, this would not be required.

6.50 In the absence of a clear justification why the prices for the provision of veterinary medicines would have followed that of services - which is unlikely – the CMA cannot rely on the comparisons with evolution of the CPI to draw any conclusions on an AEC.

The empirical evidence presented by the CMA does not support the existence of an AEC, once important shortcomings are considered

6.51 Beyond the failure to clearly define the appropriate benchmark for WFM (discussed above), the CMA also relies on questionable data assumptions and methodological approaches to conclude that the prices of veterinary medicines are inappropriately high.

6.52 The following section outlines these issues in relation to the five core pieces of evidence cited in the Medicines WP. Annex 2 provides further detail.

Methodological issues in the comparison of margins between LVG-owned and independent FOPs

6.53 The Medicines WP claims that LVG-owned FOPs apply mark-ups of 300-400% on purchase costs, compared to 100% for independent FOPs.[129]

6.54 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 on veterinary medicines this comparison will by construction find that LVG prices are excessive.

(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 (for which it suggests that they do not belong to buying groups).[130] This selection exacerbates any differences in mark-ups between LVG-owned FOPs and independent FOPs, such that the results cannot be relied on by the CMA to conclude on the existence of a material higher mark-up by LVG-owned FOPs relative to other FOPs.

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

6.55 The CMA argues that acquisitions of independent FOPs by LVGs led to an [redacted]% increase in unit prices for medicines within the acquired practice.[131]

6.56 Regarding this result, Medivet raises similar concerns as those raised regarding the CMA Econometrics WP analysis, which are explained in more detail in Annex 2 as well as sections 3.1 and 4.2 in Medivet's response to the Econometrics WP.

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

[130] 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%)."

[131] See paragraphs 2(b), 3.15 – 3.19 of Medicines WP.

6.57 Medivet considers the approach taken by the CMA to estimate the causal effect of corporate acquisitions on treatment costs deeply flawed and not fit for purpose.

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

6.58 The CMA estimates 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.[132]

6.59 This comparison is not valid, as explained above. Furthermore, the CMA's estimates ignore the cost and quality drivers of the prices of Medivet's veterinary medicines.

(a) The CMA finds lower average price increases of veterinary medicines supplied by Medivet ([redacted]) compared to the average price increase across LVGs [redacted].

(b) The average increase in the veterinary medicines supplied by Medivet can be largely explained by the increase in the purchase costs of those medicines.

(c) 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 10 years ago. Increases in range imply higher holding costs for medicines, while increasing complexity is correlated with higher unit costs.

Additional services and fees reflect market dynamics

6.60 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.[133]

6.61 The CMA does not clearly indicate the basis of this analysis. However:

(a) A proper evaluation would require assessing the overall pricing and profitability of the complete veterinary service offered, as dispensing, medicines, and consultation charges are jointly incurred by customers (see paragraph 6.8(a) above).

(b) The CMA's analysis overlooks the fact that different fee structures are a natural reflection of market dynamics, reflecting the labour, training, and professional liability associated with dispensing and administering veterinary medicines in line with relevant regulation.

[132] See paragraphs 2(a), 3.12 – 3.19, 3.22 (a), 3.42 (a) of Medicines WP.

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

Response to the CMA's suggested drivers distorting the market

6.62 The CMA claims that "competition may not be working well for pet owners" and attributes this to two key drivers:

(a) difficulties they face accessing and comparing prices of veterinary medicines and associated fees when choosing a FOP; and

(b) a lack of awareness of the options available to them and the conduct of FOPs which raises barriers for pet owners looking to use third-party retailers.

6.63 The following sections provide a detailed critique of these claims, highlighting the lack of robust evidence and questioning the assumptions upon which the CMA's conclusions are based.

Pet owners consider multiple factors beyond price

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

6.65 This can be seen from the results of the Vet Users Survey, set out in Annex 3, which shows that convenience and quality of care are much more important than price to consumers of veterinary services.

CMA finds pet owners have access to multiple FOPs and are aware of their choices

Pet owners have access to multiple FOPs

6.66 Pet owners have choice, as shown by the local concentration analysis, which finds that [redacted]% of areas where Medivet operates have four or more competing providers (see paragraph 4.4).

6.67 The CMA has also acknowledged low barriers to entry and that some pet owners switch to online providers. As described in paragraphs 2.8 to 2.17, there is increasing competitive pressure from new market entrants.

6.68 It is therefore unlikely that the issues identified by the CMA stem from a lack of competition in the market.

Pet owners are aware of their choices

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

6.70 However, as set out in detail in Annex 3, the Vet Users Survey data contradicts this hypothesis – rather, consumers were aware that they could purchase medications elsewhere. Many pet owners buy repeat medicines

through online retailers, and few customers believe they have insufficient knowledge to choose between practices.

Limitations of full price transparency for veterinary medicines

6.71 The CMA's potential concerns on a lack of price transparency are less relevant to Medivet, given its strategy on price transparency. Medivet's website displays the prices for its 10 most common cost items (such as for a standard vet appointment, annual vaccination booster, castration etc), as well as and OOH and in clinic-costs.

6.72 However, Medivet notes that providing a full list of prices for all treatments and medications would be both impractical and of limited benefit to consumers – given the vast range of treatments and procedures available, many of which vary in cost depending on the specific condition, pet size, and required medication/dosage required, a comprehensive price list would be excessively long and complex. Such a list would create confusion rather than clarity.

6.73 More importantly, pet owners cannot predict in advance which treatments their pet will require. As a result, publishing an exhaustive price list would not provide meaningful insight for consumers (and could even risk misleading them about the expected cost of treatment, as final prices often depend on clinical judgement and individual pet needs).

6.74 Publishing mark-up percentages would offer limited value to consumers and raise several concerns:

(a) Publishing mark-up percentages were based on actual purchase cost could expose FOPs' marginal supply costs, creating competitive risks and undermining commercial confidentiality. Publishing mark-up percentages based on list prices would create incentives on all market participants to increase list prices while also increasing rebates, leaving *net net* prices unchanged, but lowering stated margins which are revealed to consumers.

(b) In any event, it is unclear how revealing the difference between the cost of goods and their selling price provides consumers with meaningful insights to help them decide which veterinary care to consider. Consumers primarily base their decisions on the overall price of treatment and the quality of care, not on mark-ups for individual items.

(c) As mentioned in the paragraphs above, pet owners cannot predict which treatments their pets will require without a professional diagnosis. Publishing mark-up percentages - like full price lists - fails to address this challenge and provides no meaningful guidance to consumers.

(d) Mark-ups over direct costs offer limited insight into profitability or whether any prices are excessive, as it does not reflect indirect costs

of provision. For example, coffee shops have been cited as having a profit margin of 95% on coffees,[134] which would translate into a 1900% mark-up on the basis used by the CMA. This does not indicate a lack of competition or excessive profitability in the highly competitive market for coffees but reflects that most of the costs are fixed or are joint costs such as property, staff and electricity.

6.75 Notwithstanding these issues, Medivet is committed to supporting enhanced pricing transparency for veterinary medicines and associated fees. This may include:

(a) providing consistent price lists for "entry point" services (both online and in clinic), akin to the 10 most common cost items currently available on Medivet's website;[135]

(b) offering customers written estimates (included in consent forms) for treatment and medicines, and notifying the client promptly (and recording in the clinical history) if there are reasonable grounds to believe the actual cost of treatment will exceed the written estimate by a certain amount, with clear justifications (noting that unforeseen costs may arise);

(c) clearly itemising prescription and dispensing fees on invoices alongside medication costs, with a detailed explanation of what each fee covers, and ensuring clients have the opportunity to ask for a written prescription and are informed of alternative channels for purchasing prescription medicines.

Competitive pressures from online pharmacies

6.76 Pet owners are increasingly aware of their choices, as reflected in the growing role of online retailers in the supply of veterinary medicines. This trend is evident in two key statistics:

6.77 First, as shown in Figure 4 below, the number of prescriptions issued at Medivet locations (on a like-for-like basis) has [redacted]

[134] See https://www.sage.com/en-gb/blog/how-much-profit-coffee-shops-annually/

[135] Medivet considers publishing uniform price lists for certain "entry point" services is likely to be more effective than the publication of "most frequently offered" services, as has been proposed by the BVA (see https://www.bva.co.uk/news-and-blog/news-article/new-bva-guidance-helps-profession-address-cma-concerns-on-transparency-and-client-choice/).

[redacted]

6.78 Relatedly, Medivet has experienced [redacted] indicating customers obtaining medications from online pharmacies instead of FOPs. Chronic medicines are generally easier to switch to online purchasing than acute medicines.

6.79 Second, as shown in Figure 5 below, the number of registered online pharmacies has expanded from 12 in 2012 to approximately 44 in 2024 demonstrating that the market is large enough to sustain and attract new entrants on an ongoing basis.

[redacted]

7. Regulatory framework

7.1 In this section, Medivet provides its responses to the CMA's emerging view in relation to:

(a) Regulation of veterinary surgeons and vet practices (at paragraphs 7.2-7.22);

(b) Veterinary nurses (at paragraphs 7.23-7.25); and

(c) Regulation of the supply of veterinary medicines and the provision of veterinary care (at paragraphs 7.26-7.40).

Regulation of veterinary surgeons and vet practices

Need for regulatory reform

7.2 The CMA's emerging view is that the regulatory framework does not help drive competitive processes and good consumer outcomes by not giving enough weight to consumer matters.

7.3 Medivet's overarching observations on the regulatory regime and the need for reform are as follows:

7.4 First, Medivet strongly believes that the veterinary surgeon should remain at the core of regulation:

(a) The provision of clinical care to animals is first and foremost the role of the veterinary surgeon. It is therefore right and appropriate that the vet is the focus of regulation and ensures continued high clinical standards. Non-vet owners are not, as described above in paragraph 1.14(a), able to instruct or influence vets in relation to their professional behaviours in respect of the RCVS Code or impede their clinical autonomy which is based on what is best for both the pet and owner

(b) While the CMA has not provided evidence that vets experience actual business pressure, the regulatory focus on the vet further provides the right counterbalance to any (perceived) corporate pressure on vets. Vets are personally responsible for care under the regulations, and risk disciplinary action for acting on business pressure that conflict with their clinical duties and cause harm to a patient. Further, if employed vets were to experience inappropriate business pressure in their workplace, they would simply leave. Given the high levels of demand created by an overall shortage of vets, it would not be difficult for them to find new employment.

(c) All vet businesses have a Senior Appointed Veterinary Surgeon at both practice- and group-level who is ultimately responsible for the clinical aspects of the business, and is accountable for clinical decisions, ensuring professional and clinical autonomy are not jeopardised by commercial interests.

7.5 Second, Medivet broadly supports the initiatives for regulatory reform in the sector. The 1966 Veterinary Surgeons Act is in need of modernisation, and Medivet looks forward to continuing to work with the RCVS, DEFRA and BVA on the specifics of any future reform. In Medivet's view, this process must, however, be owned by the RCVS, DEFRA and the BVA. Such reforms would likely require new or materially reformed legislation, which would require substantially more time and consultation to progress and ultimately enact, and should therefore be considered outside of the MIR. This would also apply to expanding the role of veterinary nurses and protecting their title, discussed from paragraph 7.23 below and easing the wholesale restrictions on the sale of medicines, discussed from paragraph 7.35 below.

7.6 Third, enacting new primary legislation would be a lengthy process, and it will take several years before consumers might see any benefits. As already noted at paragraph 2.22 above, the sector is suffering from the uncertainty arising from the CMA's investigation, and prolonged uncertainty would be damaging to vets, the profession and consumers.

7.7 Medivet believes that the sector and consumers are best served by a swift solution with targeted regulatory improvements within the existing regime. Many of the potential concerns the CMA has expressed can be addressed within the existing regulatory regime, such as upweighting the existing PSS and VCMS schemes.

7.8 Fourth, it is important to take into account that the RCVS Code does already cover elements of consumer protection, including aspects of how vets offer choice, appropriate care and the handling of complaints.[136]

Monitoring and enforcement

7.9 Medivet understands that the CMA's emerging view is that there is inadequate monitoring and enforcement of compliance with the VSA and RCVS Code:

(a) The RCVS has limited visibility over conduct and outcomes within the veterinary sector, whether these relate to clinical standards or consumer outcomes.

(b) The RCVS seems to lack a full regulatory toolkit enabling it to take effective action against a range of misconduct, including in relation to consumer protection matters.

(c) Many cases involving failure to comply with the consumer-facing requirements of the RCVS Code are excluded from the scope of formal action.

[136] See, in particular, provision 2.2(b) of RCVS Code: "ensure that a range of reasonable treatment options are offered and explained, including prognoses and possible side effects".

7.10 Medivet wants to emphasise that the RCVS already has efficient enforcement powers, including over the consumer aspects of the RCVS Code.

(a) There are cases where a breach of the consumer aspects of the RCVS Code by itself will constitute serious professional misconduct, such as unnecessary overtreatment that causes harm to the animal. Indeed, Medivet has in one instance reported to the RCVS a case of a vet employed by Medivet performing unnecessary surgeries, which led to the vet being struck off.[137]

(b) Where a breach of the consumer aspects of the RCVS Code does not meet the threshold of serious professional misconduct in isolation, such breaches can nevertheless form part of a wider course of conduct that, when taken together, could constitute serious professional misconduct, e.g., where an animal is euthanised as a result of an owner not being offered alternative treatment options, or an animal suffers complications under the care of a veterinary surgeon at a FOP when referral to a specialist was not offered. Such cases would be treated more seriously because they also involve the provision of insufficient information to consumers.

7.11 However, Medivet recognises that many breaches of the consumer aspects of the RCVS Code may not frequently meet the threshold of serious professional misconduct, and accordingly there is scope for increased RCVS monitoring and enforcement of such aspects. Medivet believes that the most efficient way to increase the RCVS's monitoring and enforcement powers is through strengthening: (i) the PSS, which would increase RCVS's remit over vet practices; and (ii) the VCMS, which would give consumers easier access to third-party mediation in cases of complaint.

Regulation of vet businesses and the PSS

7.12 Medivet understands the CMA's emerging view is that the RCVS is not currently able to monitor or control the conduct of vet businesses, and questions whether the PSS would be an effective tool to address this gap.

7.13 Medivet strongly believes that improvement to the PSS system is the best and most practical way of regulating businesses quickly, simply and in a way that can benefit consumers in their decision making. The RCVS designed the PSS as a client-facing scheme and Medivet believes in the transparency it promotes.

(a) PSS is an industry standard already adhered to by most vets and practices, despite being voluntary. As the CMA points to in the Regulatory WP, c. 70% of vet practices are PSS accredited.

(b) Core PSS certification reflects the minimum requirements placed on vets and practices under the RCVS Code, HSE and VMD

[137] See https://www.kentonline.co.uk/faversham/news/vet-struck-off-for-unnecessary-surgery-on-dogs-262616/.

requirements. As the RCVS describes on its webpage "*Meeting Core Standards is a legal requirement for all UK veterinary practices, whether or not they're part of the PSS.*"[138] Accordingly, all practices should easily be able to achieve Core accreditation,[139] and Medivet therefore questions any suggestions from independents that PSS accreditation is burdensome.

(c) The PSS efficiently consolidates 'under one roof' several regulatory initiatives which would otherwise need to be handled separately, i.e. VMD and HSE inspections, thereby saving time and money for vets and clinics.

(d) The cost of PSS accreditation is not particularly high, with an application fee of £79, an initial assessment fee of £646 and an annual fee of £582 for main/standalone practices or £157 for branch practices.

7.14 The PSS accreditation system does not only reflect a minimum quality standard, but can also be used as a quality indicator to differentiate vet clinics, thereby enabling pet owners to choose a veterinary practice based on quality:

(a) While Core accreditation reflects the minimum requirements placed on vets and practices under the RCVS Code, HSE and VMD requirements, the higher accreditation levels reflect that the practice offers higher standards of (clinical) care, and are awarded based on various factors, including service provision, available equipment, facilities, clinician skill level, and training and governance standards.

(b) PSS also provides PSS awards for practices that demonstrate they excel in specialist areas, such as Client Service, Emergency and Critical Care Service, Team and Professional Responsibility, and Environmental Sustainability awards.

7.15 Together with NPS and Trustpilot scores, see paragraph 3.24, PSS accreditation and awards – when properly communicated – can give customers a good understanding of the different qualities of service offered at a clinic. Customers are able to use the PSS accreditation to evaluate quality in a similar way to the Kitemark certification.

7.16 Medivet agrees with the CMA that increased public visibility would increase the effectiveness of the PSS. PSS accreditation and awards, and what this entails, should be better communicated to customers. Medivet therefore supports measures to increase customer awareness, with a display of their accreditation status in clinic and online. This would not compel clinics to be

[138] See PSS accreditation levels - Professionals.

[139] c. 94% of Medivet clinics have minimum Core accreditation. All Medivet clinics will be enrolled into the scheme and those outstanding are clinics where significant building or other works mean that inspection is pending.

accredited - but if they are not accredited, they would be required to indicate this.

Customer complaints

7.17 Medivet understands that the CMA's emerging view is that, firstly, in-house complaint handling policies and processes may not be entirely effective, and secondly, that VCMS's effectiveness is limited.

7.18 Medivet emphasises that its customers are largely satisfied with its services – as evidenced by Medivet's Trustpilot and NPS scores and feedback, and that complaints represent less than approximately [redacted]% of client interactions in a given year.

7.19 Medivet believes that the RCVS requirements on in-house complaints handling are efficient and sufficient, and that there are industry-wide solutions available for tracking of complaints.

(a) As set out in Medivet's response to RFI 11, Question 5, Medivet has a comprehensive complaints policy. The complaints process is made visible to consumers on Medivet's webpage. When customers are not satisfied with the response, they are made aware of the option to escalate the case to the RCVS and VCMS.

(b) The RCVS Code does contain obligations related to redress and complaints which effectively require vets to respond to complaints and criticism. Medivet would however, support any clarifications from the RCVS on how complaints should be handled and monitored by practices.

(c) As explained at paragraph 3.29 above, Medivet records complaints on a complaint tracking system. Significant clinical complaints, near misses and incidents are reported on the VetSafe platform, which is run by the VDS. VetSafe is a voluntary scheme that is open to everyone in the industry. VDS can assist veterinary service providers with complaints handling, such as advice, guidance monitoring and tracking. VDS provides Medivet with monthly reports which Medivet reviews as a means of assessing themes and trends in relation to e.g. complaints received, or patient safety issues logged. As it is open to all veterinary businesses, the VetSafe platform also allows for benchmarking against the industry and can therefore be used to identify industry-wide needs for improvements. Medivet would welcome greater industry awareness and use of VetSafe.

7.20 The RCVS and VCMS offer effective third-party complaints mechanisms, but Medivet agrees that there is room for increasing the role and awareness of the VCMS:

(a) Medivet considers that the VCMS, while little used, is an effective complaints resolution mechanism. Medivet's policy is to always participate in VCMS mediation, with limited exceptions (e.g. violent

or threatening customers) and solve cases through mediation. Medivet would support making VCMS participation mandatory.

(b) Medivet agrees with the CMA that the VCMS's effectiveness is limited by its current lack of visibility and would therefore support measures to increase this.

7.21 While the RCVS may not systematically capture substantive learnings from complaints handled by the VCMS, there are several industry-wide initiatives for auditing and reporting, such as the VetSafe platform, the national audit for small animal neutering and canine cruciate registry. These facilitate good industry benchmarks and support delivery of evidence-based medicine.

Access to the profession

7.22 Medivet agrees with the CMA that the requirements to enter the profession and practise as a vet are too restrictive and that this contributes to a shortage of vets. Medivet supports easing the requirements for foreign qualified vets, which should return to pre-Brexit requirements. Medivet also supports limited licensure for clinicians with disabilities, enabling more individuals to practice.

Veterinary nurses

7.23 Medivet agrees with the CMA that increased use of veterinary nurses would be beneficial to the sector, including ease staffing pressure and allow for a broader array of (cheaper) services to the consumers. Medivet welcomes any measures which may support both the protection of the "Veterinary Nurse" title, and the broadening of scope of permitted roles of the Veterinary Nurse (currently denoted by Schedule 3).

7.24 Updating the Schedule 3 Guidance, which is already underway, will help towards this goal.

7.25 In order to fully utilise veterinary nurses, legislative change is required. As the CMA has correctly pointed out, it is important that the title of "Veterinary Nurse" is protected. Under the current regulations, all tasks that veterinary nurses can do without being under direct supervision by a veterinary surgeon, can also be done by, for example, farmers.

Regulation of the supply of veterinary medicines and the provision of veterinary care

'Clinical assessment/under care'

7.26 Medivet understands that the CMA's emerging view is that there are limited opportunities for a vet to prescribe medicine without a physical examination under the current RCVS Guidance.

7.27 Medivet agrees with this view, as physical examination is important to ensure continued animal welfare and public health. It is a core principle of clinical care that vets physically examine the animal. In most cases, the vet

must be able to physically examine the animal to appropriately assess and diagnose it. Medivet is concerned that loosening the 'under care' requirements would make it less likely that consumers will actually gain access to the vet, which would be detrimental to both the consumer and animal welfare. Medivet therefore considers it important that the recently passed 'under care'-regulation is adhered to, and that this is not changed in the future.

7.28 This also applies to the prescription of parasiticides - there would be risks involved with allowing them to be prescribed without a physical examination by a vet, in particular the risk of an incorrect dosage (customer routinely underestimate the weight of their pet) and environmental risks (such as risk of resistance and discharge to water).

LSPs and mobile vets

7.29 Medivet understands that the CMA's emerging view is that continued restrictions on LSPs could be hindering competition by restricting innovation and new entry, in particular the OOH requirement. The CMA is further requesting input on the requirements on mobile veterinary service providers that they must be linked to a registered physical premises where the unit is normally stored, and that they must offer or arrange in-person emergency care out of hours.

7.30 The CMA has not presented any evidence as to why the requirements on LSPs and mobile vets are hindering innovation. To the contrary, Medivet firmly believes that loosening the requirements would risk reducing the service level of vets in the sector, as it would allow service providers to cherry-pick the most lucrative services while traditional full-service vets would have to cover the costs associated with providing equipment and increased staffing to facilitate a fuller range of services.

7.31 In addition, Medivet believes these requirements, and in particular the OOH requirement, are essential for the continued high level of clinical care essential to ensure animal welfare.

Cascade restriction

7.32 Medivet understands that the CMA's emerging view is that the Cascade restriction may be acting as a barrier to entry or expansion for products which otherwise might serve the needs of consumers at a lower price than the authorised medicine which the Cascade restriction requires vets to prescribe, in particular where cheaper human medicine is considered effective. This may lead to animals going untreated due to the high costs of prescription-only veterinary medicines (**POM**), where cheaper products were available.

7.33 In Medivet's view, the question of loosening the Cascade restriction is not easily answered. On the one hand, there is no doubt that loosening the Cascade restriction in some instances could give pet owners increased

access to cheaper human medicines. On the other hand, the Cascade restriction plays an important role in ensuring increased animal welfare.

(a) Firstly, it ensures that safe medicines, that have been tested and developed for animals, are used.

(b) Secondly, the Cascade restriction is important to ensure the continued innovation of animal medicine by pharmaceutical companies.

7.34 Medivet is further concerned that a loosening of the Cascade restriction to allow vets to take into account the financial situation of the customers, would place vets in difficult ethical dilemmas where they would have to determine what a pet owner can afford.

Wholesale restrictions on the sale of medicines

7.35 Medivet understands that the CMA's emerging view is that the wholesale restriction – which under the Veterinary Medicine Regulations 2013 (**VMR**) prevents FOPs from buying POM from retailers including from online pharmacies, even if those outlets may offer medicines at lower cost than wholesale channels - is unlikely to be a primary barrier to FOPs accessing wholesale supplies of POM at competitive prices.

7.36 Contrary to the CMA's emerging view, Medivet considers that the regulatory restrictions act as a barrier to veterinary businesses accessing wholesale supplies of POM at competitive prices and can limit their ability to price retail medicine competitively. Medivet regularly sees online pharmacies selling medicines at a price lower than Medivet's purchasing cost. Allowing veterinary businesses to purchase medicines directly from other retailers such as online pharmacies would increase purchasing options which potentially could reduce costs. Medivet would likely consider acquiring POM from retailer should this become an alternative.

7.37 Medivet has not identified any material risks involved with veterinary practices acquiring POM from an online pharmacy, compared to an online pharmacy delivering medicines to a consumer. Medivet would therefore welcome any regulatory change that allows veterinary businesses to purchase medicines directly from other retailers.

Classification of medicines

7.38 Medivet understands that the CMA's emerging view is that some POMs may be retaining their 'high' classification for longer than necessary, due in part to the way re-classification is driven by the market authorisation. This may make it more difficult – and expensive – than necessary for consumers to access these products.

7.39 Medivet disagrees that medicines are retaining a higher classification than is necessary. In Medivet's view, the current classification rules work well for the sector. By changing the classification, the requirement that only vets

can prescribe (most) medications would be removed, thereby risking easier access to medicines that can be abused, risk that medicines will end up being sold outside regulated channels and less control with potential side effects.

7.40 The potential for reclassification would primarily be relevant for parasiticides. However, even for parasiticides, there would be risks involved with lowering the classification so that they could be prescribed or dispensed without consulting a vet – as described above in paragraph 7.28, there are risks to pet health arising from potential incorrect dosage, and also environmental risks.

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