NON-CONFIDENTIAL VERSION

21 MARCH 2025

CMA MARKET INVESTIGATION INTO THE SUPPLY OF VETERINARY SERVICES FOR HOUSEHOLD PETS

CONSOLIDATED RESPONSE TO THE CMA'S WORKING PAPERS (OF 6 FEBRUARY 2025)

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Pets at Home Group Plc (**PAH**) welcomes the opportunity to comment on the set of Working Papers (together **WPs**) published by the Competition and Markets Authority (**CMA**) on 6 February 2025. This response (**Response**) comments on the five working papers:

- *How people purchase veterinary services* (**Demand WP**);
- *Business models, provision of veterinary advice and consumer choice* (**National WP**);
- *Competition in the supply of veterinary medicines* (**Medicines WP**) and accompanying *Appendix on the Profitability of medicines retailing – gross contribution to profits* (**Medicines Gross Contribution Appendix**);
- *Regulatory framework for veterinary professionals and veterinary services* (**Regulatory Framework WP**); and
- Analysis of local competition (**Local Competition WP**).

This Response also provides information that was requested by the Inquiry Group in relation to OOH services at the PAH main party hearing held on 5 March 2025 (in Section 3E).

This Response builds on PAH's previous submissions and RFI responses to the CMA. Unless otherwise stated, defined terms in previous submissions have the same meaning in this Response.

Please note that this Response contains confidential information/business secrets, disclosure of which might significantly harm the legitimate business interests of the PAH group for the purposes of Section 244(3)(a), Part 9 of the Enterprise Act 2002. This confidential information is marked by green highlight.

This response is structured as follows:

- **Executive Summary** outlines PAH's key comments on the CMA's WPs.
- **Section 1** sets out briefly PAH's view of local competition, market entry, and its own business model and associated efficiencies.
- **Sections 2-6** sets out PAH's comments on specific themes in the WPs, in particular:
    - **Section 2** covers Medicines;
    - **Section 3** covers Out-of-Hours (OOH) provision;
    - **Section 4** covers Cremations;
    - **Section 5** covers Pet Care Plans;
    - **Section 6** covers Future Regulation;
- **Section 7** sweeps up comments on other items in the WPs, such as FOP switching rates and risk of overtreatment.

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This Response should be read alongside:

- Confidential Annex 001, which was prepared by PAH's economic advisors, NERA, and contains comments relating to the confidential versions of the CMA's WPs and/or based on insurer data provided within the Confidentiality Ring.
- Annex 002, which shows PAH's estimate of its start-up losses.
- Annex 003, which includes OOH provider information for each PAH FOP.

Executive Summary

PAH welcomes the CMA's emerging thinking in the five WPs, and the valuable research the CMA has conducted via the Pet Owners Survey.

PAH focuses its comments primarily on the FOP part of the market in which it is active. As the National WP makes clear,[1] PAH does not have any specialist hospitals, crematoria, laboratories or online pharmacies.

PAH operates in a rapidly evolving and highly competitive FOP market. Around 50% of the FOP market, including PAH, consists of independent FOP-only operators, with the other half operated by vertically integrated Large Vet Groups (**LVGs**) (collectively the **LVG5**). PAH is differentiated from the other five LVGs and should not be grouped with these LVGs. Our business model is unique and offers significant benefits to pet owners and the veterinary teams we work with.

PAH recognises significant growth and evolution in the pet care market, in particular the humanisation of family pets, and this requires ongoing investment in talent, systems, brand and services. PAH is currently a successful and profitable FOP business, but this has not been the case in the recent past and is not guaranteed into the future.

As an operator growing organically (through opening new FOPs over the last decade, and planning to open a further [REDACTED] FOPs in the next [REDACTED]), PAH has taken significant risk and can only succeed in winning share in the FOP market by offering customers a great service at a competitive price.

The CMA's evidence shows a FOP market that is both competitive and dynamic, and PAH has won national market share in this market by adding capacity and choice in competitive local markets.

PAH's JV model combines the right long-term incentives with scale efficiencies, unlocking significant investment to deliver a competitive edge. Staying competitive will require significant ongoing investment in the evolving market.

PAH understands that the CMA may have concerns about the business models and vertical integration of the five LVGs. However, the CMA needs to balance carefully any remedies to address these concerns with not adversely impacting or overburdening the c.50% of the FOP market (including PAH and independents) that focus on FOP-only services.

PAH supports remedies that encourage organic FOP growth and promote competition in the FOP market. PAH does not support remedies that could crowd out growth of new independently-owned FOPs (including PAH FOPs) which would damage competition and potentially cause further market consolidation or entrench the LVG5. The right regulatory reform needs to deliver an outcome that is

[1] National WP, Table 1.1.

good for customers, pets and vets, by supporting a market that is good for investment, growth and employment and therefore good for competition.

Local FOP competition. The vast majority of PAH FOPs are located in local markets with healthy levels of competition. Based on the CMA's current analysis, over 80% of PAH FOPs face four or more competing fascia in their local catchment areas. However, PAH notes that there are issues and omissions in the CMA's local FOP market analysis that, once addressed, will show that over 90% of PAH FOPs face four or more competing fascia. A FOP can only survive and thrive in a competitive local market in the long term if it offers value for money. The CMA is significantly underestimating the effects of shopping around and switching in the market, as shown by both PAH's FOPs' own data, and the insurer data (in Confidential Annex 001).

Medicines. The CMA is concerned about the pricing and profits on medicines, but PAH has some significant concerns about issues in the CMA's analyses.

First, the CMA uses insurer data to say that medicine prices rose by over 60% over a nine-year period. PAH's economic advisors (NERA) set out in the Confidential Annex 001 (which PAH has not seen) an analysis that shows that correcting biases in the CMA's weighting and dropping of data over time shows that drug prices rose by significantly less than estimated by the CMA. Related to this difference, NERA notes that almost all PAH FOPs are dropped from the CMA's trends analysis due to data restrictions in the CMA's approach. Dropping so many PAH FOPs means that PAH's competitive medicine prices are not being fully reflected in the CMA's trends.

Second, medicines are intrinsically linked to the service and care that PAH FOPs offer and cannot sensibly be separated out. Where appropriate, PAH offers customers the option to take a prescription to an online dispensing service, but there remains real customer value in the convenience and immediacy of combined prescribing and dispensing. Once the real direct and indirect costs of prescribing, advising and maintaining a pharmacy are reflected, PAH believes that its net medicine margins are appropriate and its medicine prices are fair and competitive. PAH has concerns about errors in the CMA's Medicines WP Appendix estimating the gross margin contribution of medicine retailing for PAH. Once corrected, the CMA's estimated mark-up would be [REDACTED] of what is reported in the Medicines WP.

Medicines are important to pets and customers. PAH supports reform remedies that ensure clear and consistent customer choice (e.g. better signposting to online pharmacies for chronic medications, and reasonable fixed prescription pricing around £15-25). PAH does not support any remedies that focus on price controls based on simplistic "gross margin" analysis (ignoring the integrated nature and cost of managing medicines in FOPs), as these would risk adding a significant additional financial and administrative burden.

OOH. OOH Services are the equivalent of Accident and Emergency, and dedicated, contracted-out OOH provision best meets the needs of pets, owners, and FOPs. PAH recognises that delivering these OOH services cost-effectively requires locally exclusive provision to give reasonable certainty and scale across an inherently variable OOH caseload. [REDACTED].

[REDACTED] and considers that extreme caution is needed to prevent widespread withdrawals of OOH providers or OOH market collapse. Such an outcome would result in FOPs having to provide full 24/7 provision, which would apply new and additional pressure on the FOP teams, which would harm pets, owners and vets.

Cremations. PAH's vets are excellent at guiding clients through the full range of end-of-life choices for their pet, despite difficult circumstances, and customers can choose the service that is right for them and their pet. PAH FOPs incur significant integrated costs to deliver cremation services and price fairly to reflect these costs as well as competitively to reflect the local market conditions.

For FOPs, there are usually relatively few choices upstream in the cremations market. PAH is concerned that the CMA's Demand WP provides no data, description, or analysis of the upstream markets for the provision of cremation services, including the identity and number of pet cremation providers in the UK (not just those crematoria vertically integrated with LVG5s but also independent crematoria), shares of the upstream cremation market at the national level, evidence of entry and exit, the degree of concentration in the provision of cremation at the local level, or the profitability of these cremation providers etc. This information would assist in considering the dynamics of cremation provision and whether any AEC is present.

This said, PAH is currently able to contract for cremation and waste disposal services effectively across the UK. [REDACTED].

PAH supports reform remedies that ensure customers of all FOPs are given an appropriate range of choices at the end of the life of their pets. However, PAH does not support remedies that ignore the integrated cost and support provided by FOPs, as they would result in an inappropriate financial burden.

Pet Care Plans. PAH's pet care plans are a great example of how PAH transparently delivers significant value for customers. Pet care plans allow PAH to offer greater convenience, choice, and flexibility to its customers and provide significant cost savings on necessary preventative care for their pets. PAH's pet care plans are designed to focus on preventative care. This could save the customer further money in avoiding more expensive curative care. There is no evidence provided by the CMA that PAH's pet care plans cause any overtreatment. Indeed, the CMA must please be cautious in making such a statement without empirical evidence and without testing for causation.

Given the benefits customers derive from pet care plans, PAH would not support any remedies that damage or restrict the provision of pet care plans. PAH would welcome remedies that improve the comparability of plans between providers, as this would enhance competition, and allow PAH to further demonstrate the value of its plans to customers.

Regulatory Reform. PAH is a leading advocate of sensible regulatory reform in the veterinary sector to update the current outdated regulatory framework and believes that the right regulatory reform needs to deliver a balanced outcome that is positive for customers, pets and veterinary businesses and professionals, in particular by:

(i) continuing to prioritise animal welfare;

(ii) supporting the consumer interest, in particular so that pet owners have sufficient information, at the right time, to make informed purchasing decisions; and

(iii) supporting a market that is attractive for investment, growth, innovation and employment, by avoiding the imposition of unnecessary or disproportionate regulatory restrictions, burdens or costs on veterinary professionals and businesses.

It is vital that any changes to the current regulatory framework do not undermine PAH's (and others') incentives to (continue to in PAH's case) invest in growth and innovation.

In PAH's view, any regulatory reform proposals should, where possible, build on the current regulatory framework, to minimise unnecessary disruption and uncertainty. This would include retaining the RCVS as the market regulator and building on (rather than replacing) the RCVS Code and Supporting Guidance and the PSS and maintaining the VCMS in its current form.

PAH is concerned that the current emphasis of the Regulatory Framework WP is towards over-regulation, which could undermine growth, investment and innovation incentives. In particular, it is important that any new RCVS monitoring/enforcement powers should be deployed in a manner which is transparent, accountable, proportionate, consistent, targeted only at cases in which action is needed and not impose an undue compliance cost on FOPs. Further, in the interests of promoting growth and investment, there should be a bias in favour of light touch regulation and constructive engagement with stakeholders wherever possible.

Reform proposals which PAH would support include:

(i) measures to make it easier for overseas veterinary surgeons and veterinary nurses to work in the UK, including by amending the minimum salary requirements for Skilled Worker visas and improved and more regular opportunities for veterinary surgeons from overseas to obtain RCVS certification for registration;

(ii) requiring FOPs to make available online their prices for the most frequently provided services;

(iii) mandating PSS Core Standards accreditation, strengthened in certain respects, as a requirement for all FOPs in the UK;

(iv) requiring that FOPs have an effective in-house complaints handling process and strengthening the PSS Core Standards accreditation to clearly stipulate the elements that in-house complaints schemes must include;

(v) protection of the RVN title and extension of the delegation procedures in Schedule 3 VSA to enable registered veterinary nurses or student veterinary nurses (with appropriate supervision) to carry out more clinical duties;

(vi) introducing more flexibility in the Cascade, to facilitate the prescription of lower price alternatives to authorised medicines; and

(vii) a reconsideration by the RCVS of the current approach to the definitions of ‘under care’ and ‘clinical assessment’ as they relate to the prescription of POM-Vs and of the requirement for a repeat physical examination for the prescription of antibiotics, antifungals, antiparasitics or antivirals POM-Vs in cases where the initial physical examination has already taken place, to facilitate increased use of telemedicine options.

1 MARKET ENTRY, EFFICIENCIES AND THE INTEGRATED NATURE OF FOP SERVICES

1.1 In this section, PAH makes the following key points:

(a) Significant FOP market entry has taken place, with PAH driving the way.

(b) PAH FOPs are succeeding in highly competitive local markets.

(c) PAH has a unique model that delivers a competitive edge.

(d) PAH FOPs offer a range of integrated services, and it is artificial and inappropriate to segment these out. PAH does not, for example, look at medicines as a separate P&L.

(e) The CMA should continue to promote competition, investment and organic growth of independent FOPs.

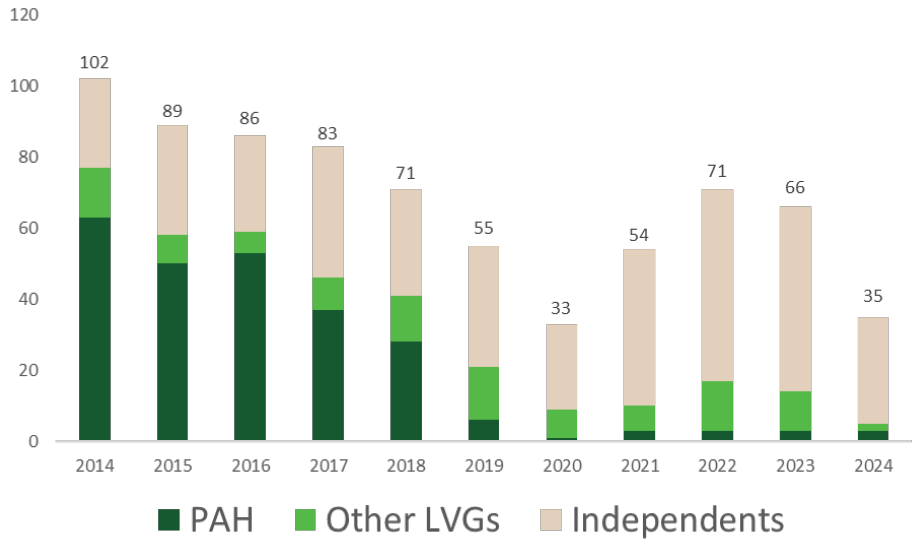
A Significant FOP Entry has Taken Place, with PAH Driving the Way

1.2 The CMA's analysis of the supply of FOP services shows a marketplace with a large number of players, a diversity of business models, surmountable entry barriers, and high levels of customer satisfaction.

1.3 The CMA has identified some 745 FOPs that have opened since 2014.[2] As shown by Figure 1 below, PAH has been the largest contributor of new organic FOPs openings since 2014 – approximately a third of all FOP openings over the period were by PAH. All of PAH's FOP openings have been done organically (as opposed to acquiring an existing FOP and its site / equipment). Therefore, PAH is adding new choice and capacity to these local markets.

[2] Local Competition WP, Figure 6.1.

Figure 1: PAH vs Other New FOP Openings since 2014



Source: Local Competition WP, Figure 6.1. PAH data.

1.4 PAH is investing to add more capacity and choice in the FOP market over the next [REDACTED], with plans to open over [REDACTED] new FOPs and to extend over [REDACTED] of its existing FOPs.

1.5 As discussed at the hearing, however, while PAH has significant experience entering new markets (with a business model that gives a competitive edge), it also understands the challenges and risks to establishing FOPs. This includes the years of start-up losses a FOP will face. Not all FOPs succeed. [REDACTED]. Therefore, success in markets is by no means guaranteed, FOPs have to continually invest to remain competitive, and what the CMA sees in the PAH are the survivors (i.e. there is a **survivorship bias** in PAH's results).

1.6 Figure 1 above shows three other important things.

1.7 *First*, while PAH has been a key driver of new entry of FOPs over the past decade, the group of 'Independent' FOPs have also contributed a lion's share of FOP entry, particularly in recent years. Why is this important? Because it means that any remedies that disproportionately affect PAH and Independents – even if a problem is caused by the LVG5s – could choke off precisely the players that are bringing new capacity to local markets.

1.8 *Second*, the CMA's pricing trends analyses over time (based on the insurer data) have significant ***selection bias***. For example, the CMA says that prices of medicines have risen by over 60% over the nine years from 2014, but this analysis relied on restricting the data to only those FOPs that were present in all nine years. The analyses specifically drop out the data of any FOPs that entered after 2014 (and so did not have nine continuous years of data). This means the CMA's price trends are omitting the effects of entrants – and it is those

entrants that may be offering lower prices to customers.[3]

1.9 *Third*, the CMA says it finds only a 3% switching rate between FOPs in the Pet Owners Survey. But, as discussed in Section 7 of this Response, PAH's own experience and the market data from insurers suggests higher rates of switching and churn in customer lists. The higher rate of switching and churn is consistent with the observed number of new FOP entrants over time, which suggests that the survey results may be an underestimate.

B PAH FOPs have succeeded in Highly Competitive Local Markets

1.10 PAH had 447 FOPs at the end of FY24, or c.12% of the CMA's 3,704 "confirmed" FOPs in the UK.

1.11 PAH's preferred model is the JV model, with over [REDACTED] ([REDACTED]%) of PAH's FOPs as JV FOPs, and just over [REDACTED] ([REDACTED]%) as Group-managed FOPs.[4]

1.12 PAH FOPs operate in highly competitive local markets, as is demonstrated by the CMA's own analysis in the **Local Competition WP**. The ability of PAH's FOPs to enter and thrive in these competitive markets is testament to their investment in growing local reputation, excellent clinical teams, and competitive prices.[5]

1.13 Indeed, PAH notes that there are certain issues and omissions in the CMA's local FOP market analysis that should be updated, as described below, which means that the CMA's current analysis understates the local competition PAH FOPs face.

1.14 Starting first with the CMA's analysis as it stands in the Local Competition WP:

(a) *First*, the CMA's analysis currently includes only 3,704 "**confirmed**" FOP sites. The CMA notes that there are approximately 2,605 'unconfirmed' and / or duplicate FOP sites that exist within the insurer data or the RCVS list, and these are currently excluded from the CMA's analysis. The CMA has said it continues to investigate these unconfirmed sites and add them to the analysis once confirmed.[6] Clearly, including even a small proportion of these unconfirmed FOP sites would materially change the CMA's overall local market conclusions. PAH has conducted some research of its own in the local markets of its FOPs and has identified over 100 active, small animal FOPs that are not currently included in the CMA's analysis. Table 1 below includes these additional sites.

(b) *Second*, with respect to PAH, after reviewing the CMA's analysis, PAH found that

[3] For example, please see the submissions made by NERA at the CMA hearing on 5 March 2025 about the Econometrics WP and the number of observations being dropped in the CMA's trends analyses.
[4] PAH consolidated response to RFI7, Table 3.
[5] For example, please see the submissions made by NERA at the CMA hearing on 5 March 2025 and in response to the Econometrics WP, which use the CMA's insurer data to show PAH's pricing relative to other players in the market.
[6] Local Competition WP, paras 2.16-2.17 and 2.49.

only 430 PAH FOPs out of its 447 total FOP sites were included in the analysis.[7] PAH queried the CMA on why these sites were excluded via email on 25 February 2025, but no response was given by the CMA.

(c) *Third*, for the 430 PAH FOP sites the CMA's analysis includes, the CMA found that most PAH FOPs are in areas with healthy competition. Based on the CMA's own analysis, **over 80% of PAH FOPs face four or more competing fascia**[8] in their local catchment areas, as shown in the first column of Table 1 below.

(d) *Fourth*, the CMA does **not** uplift the drivetime catchment areas by 1.5 times as it normally does in local market merger cases.[9] If the CMA were to widen the catchment areas in this way (as it does in merger cases), this would add even more FOP competitors within the catchment area of each focal PAH FOP site. PAH includes a column in Table 1 below adding this analysis.

1.15 The CMA says it would welcome further information on any unconfirmed FOPs in areas with four or fewer fascia.[10]

1.16 PAH conducted research to identify additional small animal FOP sites **not** included in the CMA's analysis (i.e. not included in the list of 3,704 "confirmed" sites). PAH restricted the search to **only** those catchment areas where the CMA had estimated that PAH competes with three or fewer other fascia (so approximately 80 local areas). Yet, within these 80 areas, PAH identified 123 additional active small animal FOPs that are not included in the CMA's analysis. To confirm that all these additional competing FOP sites are currently operational, PAH conducted a verification process which involved checking each site through the practice's official website and making phone calls to confirm that the locations are open to the public.[11]

1.17 Table 1 below shows the results from the CMA's analysis of FOP local competition:

Scenario 1: using only the CMA's shorter list of 3,704 "confirmed" sites – note the percentages in Scenario 1 do not change when adding in the 17 further PAH FOP sites as almost all are in the four or more fascia row;

Scenario 2: including the additional 123 active small animal FOP sites that PAH has identified; and

7 The following 17 PAH FOPs are not included in the CMA's current analysis of FOP local competition: [REDACTED].
8 Fascia means a competitor is counted only once even if it owns multiple FOPs in the catchment area.
9 The CMA calculates the drivetimes by looking at where 80% of customers to the FOP come from. The CMA would usually in local merger analyses then multiply this catchment by 1.5 to make sure: (i) it captures the full catchment area from which the FOP draws its customers, and (ii) the influence and overlap of rival FOPs that are located just outside the boundary of the 80% drivetime.
10 Local Competition WP, para 2.73.
11 Initially, PAH identified 182 additional FOP sites, that were not included in the CMA's analysis, in catchment areas where the CMA has estimated that PAH competes with three or fewer other fascia. However, out of these, 59 sites were removed from PAH's list either because the FOPs were closed, they did not provide veterinary services to small animals, or they did not exist. This led to 123 additional active small animal FOP sites.

Scenario 3: uplifting the catchment areas around PAH FOP sites by 1.5 times and including additional FOP sites in these wider catchment areas.

Table 1: Number of PAH FOPs facing one, two, three or more other fascia under different scenarios

	Scenario 1: Based on the CMA's 3,704 "confirmed" sites		Scenario 2: Adding 123 additional active competing sites		Scenario 3: Based on the CMA's 3,704 "confirmed" sites uplifting catchment areas by 1.5x	
The PAH FOP faces…	Number of PAH FOPs	%of PAH FOPs	Number of PAH FOPs	%of PAH FOPs	Number of PAH FOPs	%of PAH FOPs
One other fascia (i.e. duopoly)	6	1%	2	0.4%	0	0%
Two other fascia	30	7%	10	2%	3	0.7%
Three other fascia	43	10%	27	6%	5	1%
Four or more other fascia	351	82%	391	91%	422	98%

Source: Local Competition WP. NERA analysis.

1.18 As shown in Scenario 2, in reality, 91% of PAH FOPs are in catchment areas where there are at least four other fascia, and 97% are in areas with at least three other fascia.

1.19 Scenario 3 shows that were the CMA to use the same approach to local market definition that it uses in merger cases, multiplying the drive time catchment by 1.5 times, over 98% of PAH FOPs are in catchment areas where there are at least four other fascia.

C PAH's Unique Model Delivers Competitive Edge

1.20 PAH's JV model provides the Practice Owner with clinical autonomy and operational independence, with best practice support, scale economies, and a trusted national brand. The Practice Owner has the right incentives to invest in their practice, team and local reputation, and retains 100% of the equity value on exit or succession. PAH does not repeat how the model works in detail here, but notes that the JV model is unique and demonstrably delivers a competitive edge for PAH's Practice Owners.

1.21 It supports PAH's FOPs to have the money to invest in talent, clinical quality, and growth. As part of PAH's RFI7 response, PAH submitted a paper (**Annex 001 RFI7**) showing that PAH's JV model generates material efficiencies and delivers more value to its Practice Owners than they could achieve as independents, allowing growth and investment.

1.22 This investment and support, including protection on the downside when FOPs

underperform, helps Practice Owners overcome the significant financial hurdles that exist to grow a FOP to scale. There can be over [REDACTED] of start-up losses.

1.23 NERA estimates for the 15 most recently opened PAH FOPs, the economic value of the capital invested was, on average per FOP, c.[REDACTED] of tangible assets (fit out, equipment, capitalised leases, central support, working capital) and over c.[REDACTED] of start-up loss asset (which includes unquantified intangibles of know-how and expertise).[12] Figure 2 below shows that PAH FOPs make economic losses for [REDACTED], even when the cost of capital is set relatively low – as noted in the response to the Profitability Working Paper, the true WACC for a tiny micro-business could be significantly higher, likely over 13%.

1.24 Further detail on how PAH has estimated the economic value of the start-up loss asset is set out in a paper submitted at Annex 002 to this Response.

Figure 2: [REDACTED]

Source: PAH data, analysis undertaken by NERA

Notes: Analysis based on actual performance of FOPs over FY2020 – FY2024 [REDACTED]. Capital employed based on the cohort of 15 new FOPs.

1.25 The costs of opening and extending FOPs are increasing due to inflation and building costs, higher costs of borrowing, and higher staffing costs (e.g. increases in national insurance contributions and the national living wage).

1.26 PAH's FOP profitability needs to be contextualised given the significant start-up losses and intangible expertise are not capitalised, unlike the goodwill that results from an acquisition of a FOP by the LVG5s.

1.27 As discussed at the hearing, and shown in PAH internal documents, PAH and its JV partners plan to make over £[REDACTED] of direct investment over the next [REDACTED] (see Figure 3 below) [REDACTED]. [REDACTED].

Figure 3: [REDACTED]

Source: PAH, FY25-29 Strategy Plan, March 2024, submitted in response to RFI 3.

[12] PAH response to Profitability WP, para 2.6.

D PAH offers a range of integrated FOP services and it is artificial to separate these out

1.28 PAH FOPs compete for customers by providing a high-quality integrated FOP service, pricing competitively in local markets and investing in know-how, skills, expertise and clinical equipment to stay competitive. PAH FOPs offer a range of inherently integrated FOP services that PAH does not evaluate on a standalone basis in the ordinary course of business. For example, it is inappropriate and artificial to look at medicines as a separate business line.

1.29 Equally, medicines are intrinsically linked to the overall clinical service delivery and care that its FOPs offer and cannot be sensibly separated out. The CMA has seen PAH's management accounts for FOPs and that medicines are not broken out separately.

1.30 It is therefore artificial to attempt to separate out or calculate margins on individual services (such as medicines or cremations) for the purpose of profitability analysis due to their inextricable linkage to the overall clinical service and FOP operations.

E The CMA should continue to promote competition, investment and organic growth

1.31 Staying competitive in the FOP market required ongoing investment in an evolving market. PAH supports remedies that encourage organic FOP growth and promote competition in the FOP market. PAH does not support remedies that could crowd out growth of new independently-owned FOPs (including PAH FOPs) which would damage competition and potentially cause further market consolidation.

2 MEDICINES

A Executive Summary

2.1 The CMA is concerned that the prices for medicines dispensed by FOPs have risen by over 60% in the past decade; that FOPs set high mark-ups on medicines; and, that the incremental profit contribution for FOPs of dispensing medicines is high, with FOPs using medicines to cross-subsidise other services. While the CMA cites these points as evidence of *"weak competition in the supply of veterinary medicines,"* PAH notes that those concerns are not based on sound economic analysis and are at odds with PAH's own experience.[13]

2.2 *First*, when our economic advisors use the CMA's insurer data and correct for a bias in the weighting and dropping of data, NERA finds that the general rise in medicine prices has been below 50%, which is much lower than the increase of over 60% over a nine-year period reported by the CMA. As explained to the CMA at the hearing, the CMA's current approach drops out nearly all PAH FOPs, meaning the trends reported do not reflect PAH's competitive prices. Further, the CMA's trends analysis – in looking only at medicines reimbursed by the insurer – likely overstates the price rise by underestimating the effects of online pharmacies on drug spend. Since 2015, a growing share of customers may have accessed lower drug prices online by paying for the online prescription separately.

2.3 *Second*, looking at drug 'mark-ups' in isolation, without capturing the true costs of providing and fulfilling a pharmacy service for the FOP, obviously and artificially overstates the profitability of medicines. Further, the CMA's Appendix examining the profit contribution of medicines for PAH has several data issues that, once corrected, significantly lower the CMA's results even before capturing indirect costs. To be specific, PAH calculates that the corrected markup (as measured over purchasing cost) is [REDACTED]. Further, when expressing these figures in 'gross margin' terms, the gross margin is [REDACTED]%.[14]

2.4 *Finally*, PAH is concerned that the CMA has not set out what it means by '*cross-subsidy*' – how it will define and measure a cross-subsidy, and why this would necessarily be anticompetitive (see the PAH response to the CMA's Profitability Working Paper).[15] In PAH's view, its medicine prices are set at a reasonable and fair level, and they are not used as a separate profit centre to 'cross-subsidise' other services offered by the FOP. This said, if the CMA artificially capped drug prices, it would likely mean that the prices of other services would need to rise to allow the FOP to cover all its economic costs (such as the significant costs in running and maintaining a dispensary within each FOP) and be able to invest for the future.

Integrated Services of a FOP and Medicine Pricing

2.5 There are important interlinkages between dispensing, prescribing and other clinical

[13] Medicines WP, para 2.
[14] [REDACTED].
[15] See paragraphs 4.2-4.8 on page 23 of PAH's response to the CMA's *Approach to Profitability and Financial Analysis Working Paper* (**Profitability WP**).

services. Consumers value combining these services and so place value on purchasing medicines directly from a FOP even though some prescribed medicines can be dispensed at a third party (such as an online pharmacy). Thus, PAH sees itself as providing an '*integrated service*', as medicines dispensed in a FOP cannot be disconnected from the overall clinical service delivery. Accordingly, a FOP cannot be cleanly split into a 'medicines' arm and a 'non-medicines' arm.[16]

2.6 Given the integrated nature of FOP services, PAH believes its medicine pricing is fair, appropriate, and competitive. In the round, medicine prices need to be contextualised against the consumer benefits of purchasing medicines from a FOP, as well as all the direct and indirect costs incurred by a FOP to supply medicines.

2.7 It is difficult to estimate the incremental contribution that fully accounts for the costs of supplying medicines. In the first instance, after applying the correct rebates, PAH's Gross Markups on medications are significantly lower than suggested by the CMA.[17] In any case, by definition, Gross Margins only take into account the direct costs. In addition to direct medication cost, PAH expects there to be substantial associated costs after fully accounting for the associated clinical input (e.g., advice on safely using and administering medicines) and other indirect and direct costs (e.g., ranging from dedicated space requirement, inventory, and wastage).[18]

2.8 PAH does not believe there exists a medicines cross-subsidy in the sense that PAH does not have a strategy of incurring losses on its 'non-medicines services' to drive volumes and earn high profits from selling medicines.[19]

2.9 Nevertheless, even though PAH does not have a strategy to cross-subsidise medicines, PAH believes there is likely a *'waterbed effect'*. This means that an intervention that would significantly lower medicine prices would very likely flow on to affect the prices of 'non-medicine services'. A *waterbed effect* arises because a FOP has integrated costs and sets charges across its services to recover these costs.

Future Competition and Remedies

2.10 PAH faces strong competition to supply FOP services and believes its medicine pricing is

[16] It is also difficult to define the 'medicines segment'. Many medicines are administered as part of a treatment (e.g., injectables); some medicines are supplied as part of a broader health check with clinical input (e.g., vaccines); and in the case of preventative medicines, some medicines are typically provided as part of a Pet Care Plan (e.g., parasiticides). PAH does not have its own internal definition of Medicines or a distinct Medicines segment.

[17] Medicines (excluding parasiticides i.e., preventative flea, tick, and worm) that can be dispensed at third parties typically have the lowest rebates. We exclude parasiticides because the vast majority are sold via Pet Care Plan). Correcting for this difference in rebates leads to materially lower markups. When expressed as a markup on purchase price (as is presented by the CMA), PAH calculates that the CMA's markups are double ([REDACTED]% vs. [REDACTED]%) the true markups. For clarity, the CMA calculates a Gross Markup of [REDACTED]% for PAH in Appendix A: Profitability of medicines retailing – gross contribution to profits. The CMA also cites calculated markups of *"between 300% and 400%"* when referring to *"most large veterinary group (LVG)-owned FOPs"* on paragraph 2(c) of page 7 of its Medicines WP.

[18] Noting, in the ordinary course of business, PAH does not attempt to estimate incremental costs and revenues associated with medicines.

[19] See also Confidential Annex 001 for an analysis of PAH medicine prices relative to other FOPs based on the CMA's insurer data.

fair, appropriate, and competitive. PAH also faces strong competition from online pharmacies as consumers can and do request written prescriptions to purchase medications from online pharmacies.

2.11 Even though there exists strong (and growing) price competition from online pharmacies, PAH understands that the CMA's own Pet Owner Survey evidence suggests that not all customers are fully aware of online pharmacy options.[20] With this in mind, PAH supports the following two remedies that promote clear and consistent customer choice:

(a) **Better signposting to online pharmacies for chronic medications.** PAH vets do often advise clients about online options and PAH FOPs already have posters that clearly communicate that Pet Owners can request a written prescription. However, a measured intervention may lead to improved signposting for chronic medication (as for chronic medication, the online pharmacy option can in some circumstances be the most appropriate and cost-effective route for a customer).

(b) **A reasonable standardised prescription fee (of around £15-£25).** It is important for FOPs to charge a prescription fee to recover the clinical costs involved with prescribing. In PAH's view, a standardised prescription fee (of around £15-£25) is reasonable to allow for cost recovery without unduly affecting a customer's ability to request a prescription.

2.12 If the CMA imposes significant remedies on medicine pricing, this will likely lead to a *waterbed effect*, in which shared costs currently recovered through medicines sales will be recovered through the pricing of other services. This is a natural outcome of pricing when services are of an integrated nature.

2.13 Against this background, **PAH does not support any remedies that focus on directly controlling prices or mark-ups based on simplistic Gross Margin analysis**. Such an approach would ignore the integrated nature and cost of managing medicines in FOPs. It is also likely to introduce distortions given that the costs of providing medications can vary, e.g., due to different requirements of associated clinical input, the extent of wastage, and differing storage conditions. A price control would also risk adding a significant additional financial burden, especially on independent FOPs. Regarding transparency measures, the existence of online pharmacies already means that prices are transparent, and it is easy for Pet Owners to price compare. Any additional price transparency measures would need to carefully consider the added benefits relative to any possible distortions and costs. For instance:

(a) Additional transparency over list prices could affect manufacturers' incentives to set list prices (e.g., to set high list prices offset by higher rebates).

(b) A published price list would by necessity only contain a subset of medications

[20] For instance, see Figure 5.1 on page 81 and paragraph 13(a) on page 10 of the CMA's Medicines WP.

([REDACTED]). An overly broad list risks not being helpful. An overly narrow list risks distorting the relative prices of medications that do and do not feature on the list.

2.14 The response goes into more detail in the following parts:

(a) Section B: PAH's Gross Markups and trends in medicines prices and costs;

(b) Section C: PAH views a FOP as supplying an integrated bundle of veterinary services;

(c) Section D: Pricing of medicines and the absence of a medicines cross-subsidy; and

(d) Section E: A summary of PAH's views on possible remedies and PAH's responses to specific requests from the CMA.

2.15 Please also see the Confidential Annex 001 which uses the CMA's insurer data to look at pricing trends and how PAH's medicines prices compare to other FOPs.

B PAH's Gross Markups for Medicines and Trends in Medicine Prices and Costs

2.16 When considering the contribution of profits from medications, PAH's markups on medication sales are materially lower than the markups calculated by the CMA (which are cited as evidence of limited price competition). This is because [REDACTED].[21]

PAH's Medicine Markups are Lower than Calculated by the CMA

2.17 [REDACTED].[22] For this calculation, we exclude parasiticides (i.e., preventative flea, tick, and worm) as parasiticides are primarily provided via Pet Care Plans. [REDACTED] and, thus, the margin of PAH (and very likely other LVGs) on medications is substantially lower than the CMA calculated. [REDACTED] reduces the markup on purchase costs from around [REDACTED]% (quoted by the CMA as between 300% and 400%) to around [REDACTED]%.[23]

2.18 It is important these markups are estimated correctly as the CMA cites these markups as evidence that *"FOPs set retail prices that are substantially above their costs of supply"* and, therefore, *"The level of retail prices set by FOPs appears to be consistent with the existence of weak competition in the supply of veterinary medicines"*.[24]

2.19 Table 2 below steps though the change in Gross Markups. It shows that the weighted average rebate varies significantly across different types of pharmaceuticals. While PAH's overall weighted average rebate is [REDACTED]%, [REDACTED]. The key takeaway is that the weighted average rebate applicable to all other medicines is [REDACTED]%, which is roughly [REDACTED] lower than the overall weighted average of [REDACTED]%.

Table 2: [REDACTED]

Source: Annex 019 RFI2
Notes – From the "Sales Group" column in Annex 019 RFI2, Vaccines are defined as the following categories Vaccines – Equine/LA/SA and Parasiticides are defined as Endos – LA/SA, Ectos – Equine/LA/SA, and Combi Ecto/Endo – SA. To be clear, the vast majority of the volume is classified as Small Animal (SA), but there can be a very small volume (i.e., less than 0.01%) that is classified as non-SA.

2.20 PAH Gross Markups are considerably lower when accounting for [REDACTED] (see Figure 4 below). Correcting the rebates leads to the lower gross markup.

2.21 PAH, however, typically calculates Gross Margins rather than Gross Markups. Correcting for

[21] Medicines excluding parasiticides (i.e., preventative flea, tick, and worm). This is because the vast majority of parasiticides are sold via Pet Care Plans.
[22] As set out in the simplified medicines landscape (Figure 5 below), vaccines are sold as part of a broader health check (and are included within Pet Care Plans) and the vast majority of parasiticides are sold within and provided as part of a Pet Care Plan.
[23] [REDACTED].
[24] Medicines WP, para 2(c) on pg. 7.

rebates lowers the gross margin from [REDACTED].

Figure 4: [REDACTED]

Source – Annex 019 RFI2 for the rebate (as summarised in Figure 4 above). Q15 of RFI2 for the markup over the list price.

Notes – From the "Sales Group" column in Annex 019 RFI2, Vaccines are defined as the following categories Vaccines – Equine/LA/SA and Parasiticides are defined as Endos – LA/SA, Ectos – Equine/LA/SA, and Combi Ecto/Endo – SA. To be clear, the vast majority of the volume is classified as Small Animal (SA), but there can be a very small volume (i.e., less than 0.01%) that is classified as non-SA.

Increase in Medicine Retail Prices is Lower than Calculated by the CMA

2.22 NERA, PAH's economic advisors, have used the CMA's insurer data to correct for a bias in the weighting and dropping of data to find that the general rise in medicine prices has been much lower than the [60%-70%] as reported by the CMA. To be specific, when considering the same sample of medications but constructing a consistent basket of medications (i.e., as would be done to measure an inflation index), NERA estimates that the increase in medicine prices is well below 50%.

2.23 Further, the CMA's trends analysis – in looking only at medicines reimbursed by the insurer – likely underestimates the effects of online pharmacies on drug spend where customers may have paid for the online prescription separately.

2.24 This analysis is helpful to contextualise the CMA claims in its Medicines WP that trends in medicine retail prices *"appear to be consistent with there being weak competition in relation to veterinary medicines."* The primary reason is that the CMA measures an increase in retail prices without constructing a consistent basket of medications, which is not a measure of true inflation.

2.25 The Confidential Annex 001 sets out the analysis showing that the increase in medicine prices is significantly lower if one measures the increase using a consistent basket (e.g., as would be done for an inflation measurement).

C The Integrated Nature of Supplying Medicines

2.26 In PAH's view, a FOP provides an 'integrated service', which cannot be cleanly split into a 'medicines' arm and a 'non-medicines' arm – indeed PAH FOPs do not look at Medicines as a separate P&L as the CMA will see in the FOPs management accounts. This is because medicines dispensed in a FOP cannot be disconnected from the overall clinical service delivery.

2.27 In the first instance, it is challenging to define a segment of medicines.[25] Many medicines are inherently administered as part of a treatment/surgery (e.g., injectables). Some medications

[25] For example, PAH does not have its own internal definition of Medicines or a distinct Medicines segment.

are supplied as part of a broader health check with clinical input (e.g., vaccines) or in the case of preventative medications are typically provided as part of a Pet Care Plan (e.g., parasiticides).

2.28 Outside of these medicines, there is a subset of medicines that are prescribed following a consultation and can, in principle, be dispensed at a third party such as an online pharmacy. For these medications, there are important interlinkages between dispensing and prescribing as well as other clinical services. In general, consumers value these distinct services being provided together.

2.29 It is also very difficult to allocate costs to distinct parts of the customer journey. While PAH does not estimate incremental costs and revenues in the ordinary course of business, it expects there to be substantial associated costs after fully accounting for the associated clinical input (e.g., prescribing advice) and other indirect and direct costs (e.g., ranging from dedicated space requirements, and controlled storage to inventory management and wastage).

2.30 The remainder of this section covers:

(a) Difficulties defining the medicines segment;

(b) The integrated nature of a FOP and implications for medicines;

(c) An overview of some of the cost drivers associated with providing a pharmacy service; and,

(d) Given the integrated services of a FOP, the nature of price competition between FOPs and between FOPs and online pharmacies.

It is difficult to define the medicines segment

2.31 PAH does not have a distinct medicines segment primarily because it does not view medicines as distinct from the integrated services of a FOP. Another reason is that the boundaries of the medicines market are challenging to define and, as a result, there is no single definition that applies.

2.32 In Figure 5 below, PAH sets out the landscape of medicines. The first row illustrates that some medicines are inherently dispensed as part of a treatment and cannot be separated from the clinical component. Vaccines are one example. They are administered as part of a wider health check, which means the clinical input cannot be separated from the vaccine dose itself. The second example is medications administered as part of a treatment or

surgery (which are typically injections). [REDACTED].[26]

2.33 The second row identifies the subset of medicines for which dispensing can – in principle – be done separately from treatment. [REDACTED]. The remaining medicines are one-off medications (e.g., antibiotics) and chronic medications (e.g., to treat arthritis).

Figure 5: Simplified landscape of medicines to compare medicines administered within surgery relative to medicines for which dispensing can be done separately

Type of Medicines	Medicines with descriptions and examples		
Administered within treatment	**Vaccinations** e.g., Kennel Cough, Leptospirosis, & Canine Hepatitis. [REDACTED]	**Oral medications** e.g., oral sedative	**Injections** e.g. Anaesthetics for surgery
Dispensing can be done separately	**Parasiticides** E.g., Advocate or Milprazon. [REDACTED]	**One-off medications** E.g., Antibiotics for an ear or eye infection	**Chronic medications** e.g., for Arthritis or a Heart condition

Source: PAH illustration

*Notes: **Green text** indicates medications typically supplied via Pet Care Plan. There can be overlap between oral medications (administered in surgery) and one-off medications.*

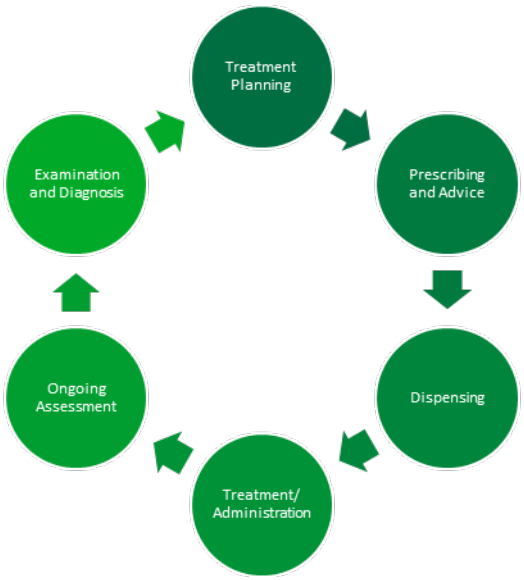
There are Important Interlinkages

2.34 There is only a subset of medicines for which dispensing can be provided by a third party. For these medicines, an integrated FOP provides many interlinked services, meaning there are customer benefits to combined prescribing, advice, and dispensing services.

2.35 Figure 6 below illustrates the customer journey. It sets out how the dispensing of medicines is inextricably connected with other clinical services. Due to the interlinkages, there are consumer benefits of combined prescribing, advice and dispensing and, as a result, customers will often choose FOP dispensing even when they are fully aware of the alternative (through signage or vet advice). The interlinkages mean it is somewhat artificial to segment the customer journey into separate parts (i.e., as represented by each labelled circle).

[26] This value is calculated using *Annex 001 RFI 11 - Data Template.xlsx*, which was provided as part of PAH's response to RFI11. Using this data, PAH calculates the % share of *"Prescribed Veterinary Medicines administered as part of the services provided to pet owners by FOPs and Veterinary Practices in your Group"* relative to all medicines, which includes *"Medicines prescriptions dispensed at the point of sale by FOPs and Veterinary Practices in your Group"*

Figure 6: An integrated FOP provides many interlinked services meaning there are customer benefits to combined prescribing, advice, and dispensing services



Benefit to Pet Owner	Explanation
Clinical input	Various aspects of the medicine usage, safety etc. only need to be explained once by the prescribing vet who the pet owner knows and trusts
Continuity of Care	Easy follow-up for clarifications, reminders, any side effects and issues
Instant provision	Instant provision of medicine which can improve the quality of care
Time and effort savings	Submitting a prescription online adds friction
Monetary savings are often small	For a typical purchase, savings from online pharmacies are often relatively small compared to a FOP's benefits of convenience, speed, and support

Source: PAH illustration

2.36 The CMA's Pet Owners Survey supports the notion that pet owners typically prefer directly buying medicines from their FOP.[27] Among the top-stated reasons, there are three broad categories.

2.37 The first category links to the benefits from the integrated nature of services.

2.38 The second category links convenience and urgency. Convenience in part may reflect the clinical input that pet owners are receiving at the point of prescription. Urgency reflects that instant provision can be particularly beneficial in many circumstances (e.g., to start a course of antibiotics immediately) but may also capture the time and effort savings from buying directly. Both categories refer to the benefits of FOPs relative to online pharmacies.

2.39 A third category relates to consumer awareness. As set out in Section E below, PAH supports remedies that ensure clear and consistent customer choice, e.g., better signposting to online pharmacies. In most instances, PAH expects customers to continue to prefer purchasing directly from their FOP given the inherent benefits of doing so.

There are Significant Direct and Indirect costs to Supplying Medicines

2.40 Through the customer journey from treatment to dispensing, FOPs provide many clinical support services along the way. In addition to costs inherent in providing these clinical services, FOPs incur significant direct and indirect costs when offering pharmacy services.

[27] Figure 5.1 on page 81 of the CMA's Medicines WP.

By definition, Gross Margins do not include these costs. Therefore, Gross Margins earned from medicine sales contribute towards covering these costs as well as the integrated costs of the FOP.

2.41 In the ordinary course of business, PAH does not track, estimate, or attempt to allocate these indirect costs related to its pharmacy service (and related clinical input). This lack of tracking is for two reasons:

(a) *First*, it is inherently difficult and artificial to separate the customer journey into distinct parts and assign costs to each part. It is also inherently challenging to charge prices for each segment. Given this limitation, costs need to be recovered in either treatment prices or medicine prices. In some sense, there is more clinical input involved in a treatment that leads to a prescription and thus cost reflective pricing would lead to costs being recovered (in part) through medicines sales rather than being fully loaded into the treatment charge.

(b) *Second*, PAH does not see a business rationale to attempt to segment its business and estimate these types of costs. This is because PAH views itself as providing an integrated service and thus does not have business lines or segments in which it would make decisions (e.g. pricing) based on incremental revenues and costs of these segments.

2.42 For these reasons, PAH does not directly estimate costs associated with pharmacy activities. With that said, PAH does believe that it incurs significant costs to offer pharmacy services, and that Gross Margins should be contextualised relative to these costs.

2.43 FOPs have a service and regulatory obligation to provide appropriate clinical care, which includes an obligation to provide an adequate stock of appropriate medicines.[28] Offering a pharmacy service in a typical FOP (to the appropriate standard) requires stocking a few hundred SKUs per FOP. These medicines need to be tailored to each FOP's caseload and the exact SKUs will be shaped by the clinical preferences of the managing vet. [REDACTED].[29]

2.44 It is possible to group costs into two broad categories. The primary cost driver relates to the integrated nature of a FOP. In the treatment journey, a Vet provides a diagnosis, prescription, and clinical advice on administering the medicine, how to monitor the animal, and any other clinical follow-up regarding the medicine. The clinical input is not charged separately and, given the integrated boundaries between treatment, prescription, advice, and dispensing, some of the cost of clinical service will be recovered through the retailing of medicines (an alternative would be to load these costs into the price of a treatment).

[28] RCVS *Practice Standards Scheme, Medicines Core Standards.*
[29] [REDACTED].

2.45 Beyond the clinical costs, there are other drivers, such as the direct and indirect costs related to providing a retailing service. Examples include:

(a) Daily ordering, deliveries and returns requiring clinical oversight;

(b) Product expiration, wastage and shrinkage;

(c) Dedicated space, refrigeration, controlled drug storage and security measures;

(d) Record keeping, inventory management and disposal;

(e) Working capital investment; and

(f) Dispensing of medicines, which requires advanced knowledge of medicines, i.e., providing the correct product in the correct amount, labelled according to strict guidelines.

PAH FOPs Face Strong Price Competition

2.46 PAH FOPs face strong price competition from two sources. In the first instance, PAH FOPs face price competition from other competing FOPs, who also compete to offer an end-to-end or integrated service that spans from treatment and prescription to dispensing and other clinical services. Additionally, FOPs face price competition from online pharmacy services, which compete to dispense medications.

2.47 Consumers will choose a FOP based on the overall service quality / price combination. As cited in the CMA's Pet Owners Survey, many of the top reasons for choosing a FOP relate to this trade-off.[30] A FOP can only develop a strong reputation if it provides a high-quality service at attractive prices. A key part of developing this reputation is – following a diagnosis that requires a prescription – selling medications at a price point that appropriately and fairly reflects the clinical service quality provided by Vets. Competition to provide an integrated bundle of FOP services leads FOPs to compete to provide medications and treatments at attractive prices.

2.48 In addition to competition between FOPs (which is more focused on the overall price and quality of the FOP) – there is competition between PAH FOPs and online pharmacies. Competition is strongest for medications in which the relative advantages from direct purchase from a FOP are relatively lower so that online pharmacies become a more attractive option. To put this into context, many medications dispensed by FOPs occur at relatively low-price points (e.g., below £25 per dispensing instance). Pet Owners can still receive large benefits from direct dispensing, while the possible cost savings from online

[30] For instance, examining some of the main reasons provided: *"Recommendations (from friends, family, etc)," "Impression of the practice, staff or website,"* and "Prices." *"Location"* is also listed as a main reason, which may be in part because Pet Owners limit their search to nearby FOPs and then choose a FOP based on their overall offering. See Demand WP, Table 5.1.

purchase may be relatively limited (although obtaining a prescription that covers requirements over a long period, e.g. several months, can increase the cost savings). In these instances, many Pet Owners may purchase directly from the FOP given the benefits of direct purchase.

2.49 Competition from online pharmacies is therefore naturally strongest when considering repeat medications (such as for chronic medications). This arises because, while the benefit of direct purchase from a FOP may be similar to relatively lower-value medications, a given percentage point of possible saving can also be greater. The CMA pet owners survey illustrates this mechanism: Pet Owners are much more likely to request a prescription for chronic medications.[31]

D How PAH FOPs Set Prices for Medicines

2.50 PAH supplies medicines as part of an integrated or end-to-end FOP service, and PAH believes its medicine pricing is fair, appropriate, and competitive. PAH does not believe there exists a medicines cross-subsidy, in the sense that PAH does not have a strategy of incurring losses on its 'non-medicines services' to drive volumes and earn high profits from selling medicines.

2.51 Nevertheless, even though PAH does not have a strategy to cross-subsidise medicines, PAH believes there is likely a *'waterbed effect'.* This means that an intervention that would lower medicine prices would very likely flow on to affect the prices of 'non-medicine services'. A *waterbed effect* arises because a FOP has integrated costs and sets charges across its services to recover these costs. Many of these shared costs are being recovered via medicines sales rather than through other services.

2.52 In the subsections below, PAH sets out:

(a) Purchasing and pricing of medicines and the process of writing external prescriptions;

(b) Given the integrated nature of a FOP, there is no cross subsidy; and

(c) The '*waterbed effect*', in which an intervention that significantly affects medicines prices might lead FOPs to recover costs through other services.

[31] CMA's Demand WP, Table 5.2.

Medicines – Purchasing, pricing, and external prescriptions

2.53 PAH has operated a dedicated supplier relations team, which negotiates to secure discounts and rebates relative to manufacturers' list prices. PAH takes advantage of its scale to achieve lower medicine purchase costs.

2.54 The supplier relations team primarily focuses on negotiating favourable pharmaceutical costs. PAH does not have own-brand products; an online pharmacy; or operate a buying group open to non-PAH FOPs (e.g., Independents). PAH does not limit FOPs to only choose from a limited range of 'preferred products', although the supplier relations team will often be able to negotiate relatively more favourable purchase costs for certain products and from certain suppliers. Naturally, JVPs are more likely to prescribe these products with favourable purchase costs due to their cost advantage. Similarly, PAH does not encourage or guide its FOPs to favour using certain medications such as injectables.

2.55 [REDACTED].

2.56 PAH provides Joint Venture Partners with suggested mark-ups for medicines. These markups reflect decades of experience on roughly what is required (on average) to deliver a reasonable overall FOP margin, given that medicines are one part of a FOP's integrated service. Relative to these suggested markups, each local Vet has the freedom to choose the medicines that they stock and prescribe and price the medicines as they wish (i.e., with reference to local FOP competition and online pharmacy competition). For example, it may be the case that a JVP receives client feedback that prices for a certain medicine are cheaper at a competing local FOP, which may lead the JVP to lower its local price relative to the suggested markup.

2.57 PAH FOPs also provide external prescriptions at a reasonable cost. In many cases, PAH vets will suggest that customers use an online pharmacy when appropriate (e.g., for chronic medicines).

2.58 Prescription fees are set locally and are typically within the range of £15-£25, which in PAH's view is a reasonable charge in the context of the clinical input surrounding a prescription. As per RCVS guidelines, Vets do not discriminate between customers who purchase medications directly and those who request a prescription to purchase elsewhere.

2.59 Providing a written prescription is a bespoke process which requires time, consideration and professional judgement. It therefore adds work relative to dispensing within the FOP. To illustrate, Figure 7 below shows that the highlighted fields are unique to each prescription and must be completed uniquely each time.

Figure 7: Highlighted Fields that must be completed by a Vet to provide a written prescription

"(1) A written prescription must include—

(a) the full name, address and contact details of the person prescribing the product, including that person's professional registration number (if available);

(b) the full name, address and contact details of the animal owner or keeper;

(c) the identification (including the species) of the animal or group of animals to be treated;

(d) the premises at which the animals are kept if this is different from the address of the owner or keeper;

(e) the issue date;

(f) the signature or electronic signature of the prescriber;

(g) the name and amount of the product prescribed;

(h) the pharmaceutical form and strength of the product;

(i) as regards veterinary medicinal products that are antibiotics which are prescribed for prophylactic purposes or metaphylactic purposes (as the case may be), a statement to that effect;

(j) the dosage regimen;

(k) any warnings necessary to ensure the proper use, including, where relevant, to ensure prudent use of antimicrobials;

(l) the words "It is an offence under the Veterinary Medicines Regulations 2013 for a person to alter a written prescription unless authorised to do so by the person who signed it";

Source: RCVS - Veterinary Medicines Regulations (Amended) 2004

No Cross-Subsidy given the Integrated Nature of a FOP

2.60 PAH does not believe it uses medicines to cross-subsidise other services. PAH views FOPs as providing an integrated service spanning preventative care, treatment, diagnosis, and prescribing and dispensing of medicines. Given this context, PAH does not view medicines as an incremental activity where there are 'add-on' or 'follow-on' revenues. PAH's view of the integrated nature of a FOP is reflected in the fact that:

(a) PAH does not have a strategy of driving volume by discounting 'non-medicines services', while earning excessively higher profits on medicines (i.e., treating 'non-medicines' services as a loss leader);

(b) When costs are correctly accounted for, PAH does not believe it incurs losses on 'non-medicines services'; and

(c) PAH does not define a separate 'medicines' segment or estimate the incremental revenues and costs of medicines.

2.61 PAH's interpretation of a cross-subsidy broadly aligns with definitions adopted previously by the CMA.[32] That is, the concern around cross-subsidies is less around the recovery of shared or common costs (and where these costs may be recovered differently between products or customer groups), but where the direct operating costs of a product cannot be recovered at

[32] Additionally, in the Overview of its Working Papers, the CMA describes a well-functioning market as a market where *"providers do not significantly cross subsidise between services and customer groups"* (emphasis added). CMA, Market Investigation into Veterinary Services, Overview of our working papers, 6 February 2025, paragraph 3.10.

the current price.[33]

2.62 For example, in its *Retail Banking* market investigation, the CMA defined cross-subsidies as occurring "*when firms sell some products or to some customers at a price below incremental costs, and fund this through higher prices on other products or customers.*"[34,35]

2.63 Gross Margins do not include all costs related to providing a service. The integrated nature of FOP services and the existence of many shared and unallocated common costs mean that a focus on Gross Margins by themselves will be particularly misleading.

2.64 For instance, variation in Gross Margins is an expected and efficient outcome in competitive markets when there are large fixed and shared costs and firms sell a portfolio of differentiated products/services, some of which may be contributing more to common costs than others. In such settings, varying Gross Margins are expected from the perspective of efficient pricing and cost recovery.

2.65 A FOP has shared costs of providing the integrated services and will consider these integrated costs when setting prices across its services to recover these costs. This can lead to differences in where cost is loaded, which will show up as differences in Gross Margins between services. This is a natural occurrence in settings where it is difficult to separate out costs between different services.

Integrated Costs mean there is a 'Waterbed Effect'

2.66 PAH does not have a strategy to cross-subsidise medicines. However, there is likely a *'waterbed effect'* that would mean that an intervention that *substantially* lowered medicine prices would likely flow through to the prices of non-medicine services.[36]

2.67 It can be true that medicines have a higher contribution to the recovery of shared costs compared to some other services. However, the integrated service means this difference is slightly illusory – the price of a treatment does not fully account for the cost involved in prescribing and overall clinical service delivery – since some of those costs are recovered through other related services (such as medicines).

2.68 An intervention that pushes down the prices of medicines is unlikely to also decrease the shared costs of the integrated service. Therefore, lower medicine prices may cause prices

[33] And even then, previously the CMA has primarily discussed cross-subsidisation in the context of the potential distributional effects on more vulnerable customer groups rather than focusing on the existence of a cross-subsidy for an individual product (see for example, the Retail Banking Market Investigation, *Final report* paragraph 6.206 and the Care Homes Market Study *Update Paper* para 6.20).

[34] CMA, Retail Banking Market Investigation, *Final report*, August 2016, paragraph 6.197. Also stating at paragraph 6.206 that *"… the fact that some customer groups may contribute more to common costs does not necessarily imply cross-subsidies*".

[35] Related is the Care Homes Market Study *Final Report*, where the CMA considered cross-subsidies between different customers, e.g., as price differentials meant that self-funded residents are meeting *"a much greater proportion of home's fixed costs"* than state-funded residents. From the discussion in the Care Homes *Update Paper*, PAH interprets that the price difference would only be an issue if the state-funded prices did not cover the direct operating costs.

[36] As less of the substantial shared and common costs of a FOP are recovered through medicines and would therefore be recovered through other services.

to rise elsewhere in the integrated service offering, as the shared costs are recovered through other services. This would occur even if PAH does not price treatments as a loss leader to drive medicine sales.

E PAH's views on future competition and remedies and responses to CMA's specific requests for views

2.69 PAH faces strong competition to supply FOP services and believes its medicine pricing is fair, appropriate, and competitive. PAH also faces strong competition from online pharmacies as customers can and do request written prescriptions to purchase medications online.

2.70 Even though there exists strong (and growing) price competition from online pharmacies, PAH understands that the CMA's pet owners survey evidence suggests not all customers are fully aware of online pharmacy options[37] (noting that all PAH FOPs do advertise this option, e.g., through signage within FOPs).

2.71 With this in mind, PAH supports improvements to access to alternative dispensing options (such as online pharmacies). PAH supports remedies that promote clear and consistent customer choice but, at the same time do not:

(a) Lead to distortions, either because they ignore the integrated nature and cost of managing medicines in FOPs, or ignore important realities connected with the supply of medicines; and/or

(b) Impose significant burdens on individual FOPs.

2.72 As explained above, if the CMA imposes significant remedies to medicine pricing, this will likely lead to a *waterbed effect*, in which clinical and other costs currently recovered through medicines sales will be recovered through the pricing of other services. This is a natural outcome of pricing when services are of an integrated nature.

2.73 Against this background, PAH supports the following remedies:

(a) **Better signposting to online pharmacies for chronic medications.** PAH FOPs already have posters that clearly communicate that Pet Owners can request a written prescription. The CMA's pet owners survey evidence suggests, however, that not all Pet Owners are fully aware of the possibility of asking for a written prescription. A measured intervention may require further signposting for chronic medication where the online pharmacy option can in some circumstances be the most appropriate or cost-effective route for a customer.

(b) **A reasonable standardised prescription fee (of around £15-25).** It is important for FOPs to charge a prescription fee to recover the clinical costs involved with

[37] For instance, see Figure 5.1 on page 81 and paragraph 13(a) on page 10 of the CMA's Medicines WP.

prescribing. On this basis, in PAH's view a standardised prescription fee (of around £15-25) is reasonable to allow for cost recovery without unduly affecting a customer's ability to request a prescription.

2.74 PAH does not support any remedies that focus on directly controlling prices or mark-ups based on simplistic Gross Magin analysis. Such an approach would ignore the integrated nature and cost of managing medicines in FOPs. It is also likely to introduce distortions given that the costs to providing medications can vary, e.g., due to associated clinical input, extent of wastage, and storage conditions. Further, a price control risks adding a significant additional financial burden, especially on independent FOPs.

2.75 The existence of online pharmacies already mean that prices are transparent, and it is easy for Pet Owners to price compare. Any additional price transparency measures would need to carefully consider the added benefits relative to any possible distortions and costs. For instance, additional transparency over list prices could affect manufacturers incentives to set list prices (e.g., to set high list prices offset by higher rebates). A published price list would by necessity only contain a subset of medications ([REDACTED]). An overly broad list risks not being helpful and an overly narrow list risks distorting the prices of medications that feature on the list compared to those that do not feature on the list. For example, the prices of listed medications may fall, which is offset by an increase in the price of unlisted medications.

2.76 In Table 3 below, PAH provides its response to the CMA's six specific requests for views in its Medicines WP (paragraph 22(a) – 22(f)).

Table 3: PAH responses to six specific requests for views from the CMA in its Medicines WP (paragraph 22(a) – 22(f))

CMA request	PAH response
***(a) Pet owners' willingness to pay higher prices for medicines in return for a higher quality of service at FOPs**, particularly those owned by LVGs.*	Discussed in Section C above.
***(b) The ownership of online pharmacies by LVGs** and whether this may limit competition between FOPs and online pharmacies as well as between online pharmacies.*	There is strong competition between online pharmacies. Entry costs are low, which means that several "independent" online pharmacies have successfully entered. PAH does not believe that 'cross-ownership' is reducing competition in online pharmacy (PAH understands that four online pharmacies are operated by three different LVGs and one additional LVG has indicated plans to open another one).
***(c) Pet owners' purchasing behaviour in relation to veterinary medicines that are more readily comparable** between FOPs and third-party retailers (such as routine or on-going medication to treat chronic conditions in pets).*	As identified by the CMA, pet owners do purchase from online pharmacies when the benefits to doing so are greater, for example, for chronic medicines. This is a natural outcome: Pet Owners are more likely to choose the online pharmacy option when the cost savings of purchasing externally outweigh the benefits from purchasing directly.
***(d) The ability and incentive of FOPs to charge high medicines prices** to pet owners who may have a preference to purchase medication from their FOP and/or face difficulties in effectively comparing veterinary medicines between FOPs and third-party retailers.*	PAH faces competition from other FOPs and online pharmacies and, therefore, needs to set competitive prices. There may be some pet owners who have stronger preferences for purchasing from a FOP (for instance, because they receive materially higher benefits from the associated clinical services provided by a FOP).
***(e) The use of injectable veterinary medicines by vets** and whether this represents a barrier that pet owners must overcome when requesting a written prescription from a FOP in order to purchase medication from third-party retailers.*	In many cases, there is no clinical substitute to an injectable medicine. In cases in which a possible substitute is available, PAH only prescribes injectables in instances in which there is a clear gain in clinical efficacy from the injectable. One reason is that an injection places more stress on the animal and so the benefits need to be weighed up accordingly. In RFI 11, PAH set out an explanation of prescribing oral medications (for arthritis) when an injectable option also exists.
***(f) The negotiating position of buying groups** and whether this has weakened in recent years as the negotiating position of LVGs has strengthened. This may be as a consequence of the increasing share of FOPs that are owned by LVGs, with LVGs now owning and operating more than 60% of FOPs in the UK, as well as the wider scope of at least some LVGs' activities (including online pharmacies and buying groups).*	PAH has limited visibility on buyer groups, but notes that the CMA writes: "*most independent FOPs and independent online pharmacies from which we gathered information as part of our investigation told us that they were members of a buying group"* (Medicines WP, para 6.28). The typical LVG accounts for less than 10% of the FOP market, so it is no surprise that buyer groups can achieve similar discounts to LVGs, e.g., the CMA writes: *"larger buying groups have purchase volumes for some veterinary medicines that are equivalent to or greater than some LVGs"* (Medicines WP, para 6.30). At least one LVG runs a buying group and thus allows Independents to benefit from its procurement services and access economies of scale.

3 OUT-OF-HOURS (OOH)

3.1 In this section, PAH makes the following key points:

(a) PAH recognises that OOH services are likely best provided via exclusive, locally outsourced contracts.

(b) [REDACTED].

(c) But please beware of any remedies that could break the OOH marketplace, as it is an essential service for pet owners and FOPs, and there would be significant problems for FOPs if OOH provision retrenched or closed because of disproportionate remedies.

A OOH services are likely best provided via exclusive, locally outsourced contracts

3.2 OOH services deal with pet emergencies, often literally as a case of life or death. So quality, locally accessible provision is hugely important to pets and their owners.

3.3 OOH services serve distinct pet, owner and vet needs. Pet owners want clear and robust directions on exactly what to do and where to go when emergencies arise, accessed via their FOP website, voicemail or direct call forwarding.[38]

3.4 Dedicated, contracted-out OOH provision has also resulted in better care from both the FOP (through better staff retention, mental health and wellbeing in the FOP) and the OOH provider (via more emergency and critical care (**ECC**) services specialisation and better facilities at the OOH site).

3.5 Locally exclusive OOH provision may be required to generate the scale and throughput necessary to respond to an inherently variable and unpredictable caseload. Local aggregation of catchment demand is understandably required given the relatively small catchment areas (as, due to emergencies, pets cannot travel long distances to OOH provision).

3.6 FOPs also value a single operational relationship with an OOH provider to: (i) prominently signpost 24/7 cover to pet owners through all relevant touchpoints; and (ii) seamlessly deal with case and patient handover in the morning.

B [REDACTED]

3.7 OOH services provision may tilt towards concentration (and market power) at the OOH

[38] The CMA's Pet Owner Survey found that 70% of consumers follow the directions of their FOP when seeking OOH care, whereas only 19% found an OOH provider '*through their own research*'.

level, as FOPs may have few OOH providers to turn to locally. The CMA notes that, "*The nature of outsourced OOH means that its provision is likely to be more highly concentrated than for FOPs*".[39]

3.8 Further, the CMA has found that the LVG5s are increasingly active in the provision of OOH services – for example, Vets Now (owned by IVC since 2019) is the largest supplier of OOH services across the UK.

3.9 [REDACTED]. Yet there seems very little analysis in the WPs by the CMA about competition, prices, or profitability in OOH markets.

3.10 [REDACTED].

3.11 [REDACTED].[40] [REDACTED].

3.12 [REDACTED].

C [REDACTED]

3.13 PAH recognises the challenging economics of OOH services and why exclusive relationships may be necessary at the local level. [REDACTED].

3.14 [REDACTED].

3.15 Based on the evidence in the CMA WPs, PAH does not consider that further intervention is required (e.g. price controls of OOH) as there is an insufficient evidence base to understand what consequences would result in OOH provisions. Extreme caution is needed to prevent widespread withdrawals of OOH providers or OOH market collapse. Such an outcome would result in FOPs having to provide full 24/7 provision, which would apply new and additional pressure on the FOP teams, and which would harm pets, owners and vets.

D PAH's comments on the CMA's OOH local competition analysis

3.16 The CMA used drivetime analysis to find that the average travel time from a FOP to its OOH provider is around 20 minutes – as shown in Table 3.2 of the CMA's Local Competition WP. The drivetimes tended to be shorter in urban areas than in rural areas.

3.17 The CMA finds in its Local Competition WP that 44% of OOH providers were in monopoly or duopoly areas.[41] The CMA notes also that around 40% of the monopoly areas had more than one OOH site provided under common ownership, so could

[39] Local Competition WP, para 3.19.
[40] See the Excel spreadsheet (column T) at Annex 003 to this Response. [REDACTED].
[41] Local Competition WP, para 3.20 and Table 3.4.

potentially have supported two competing sites (had both not been under common ownership).[42]

3.18 PAH observes that the CMA identified OOH providers in its OOH local competition analysis based on information from small animal FOPs on who their OOH supplier is and their address. PAH notes that the CMA's analysis dropped out the PAH FOPs because no postcodes were available for the OOH provider for each PAH FOP. PAH has compiled for each of its 447 FOPs, information on who their OOH supplier is and their postcode and provides this at Annex 003 to this Response.[43] However, including the PAH data does not materially change the CMA's OOH findings. PAH's economic advisors, NERA, replicated the CMA's calculations of the average catchment area using ArcGIS geocoding and found the average drivetimes remained largely unchanged.[44] Further, PAH's data adds only 12 'new' OOH providers into the analysis, so does not materially change the CMA's OOH local concentration findings.

3.19 The CMA uses the FOP postcodes to calculate OOH catchment area drivetimes rather than using the postcodes of actual OOH customers,[45] noting that a FOP is likely to be a good proxy for the average customer of an OOH site as customers are likely to be fairly evenly distributed around a FOP.[46] The CMA also notes that OOH services are often accessed in an emergency.[47] In such emergency situations, customers will travel directly to the OOH site from their homes, and not travel to the FOP. Consequently, the distance from the customer's residence to the nearest OOH site appears to be a relevant factor. PAH therefore suggests using actual OOH customer postcodes to calculate OOH catchment area drivetimes, rather than FOP postcodes.

E PAH's response to the information requested at the CMA Hearing

3.20 In this section, PAH responds to the information requested by the Inquiry Group in relation to OOH services at the CMA hearing held on 5 March 2025. In particular, PAH provides information on:

(a) the number of local practices supported by the [REDACTED] PAH FOPs that offer OOH services, the prices and the notice periods offered by these [REDACTED] PAH FOPs and how these compare to the prices set by [REDACTED] in the area;

(b) why outsourcing OOH provision leads to higher quality care compared to

42 Local Competition WP, paras 3.22-3.24 and Table 3.5.
43 In Annex 003 to this Response, PAH has re-submitted its response to Questions 11 and 11a from RFI4, which now includes the postcode of the OOH provider (column H) for each PAH FOP that outsources OOH provision to another OOH provider. As per the CMA's request, PAH has also included the name of the dedicated OOH provider where applicable (column R). Furthermore, PAH has provided the drive time in minutes from each PAH FOP to its corresponding OOH provider (column S), along with the current notice period length for [REDACTED] sites associated with PAH FOPs (column T).
44 Local Competition WP, para 3.15.
45 Local Competition WP, para 3.15.
46 Local Competition WP, para 3.18.
47 Local Competition WP, para 3.18.

providing these services in-house;

(c) the costs and investment involved in the provision of OOH services; and

(d) the correlation between OOH local market concentration and notice period length in the [REDACTED] contracts with PAH FOPs.

Prices and notice periods offered by the PAH FOPs

3.21 PAH has only [REDACTED] FOPs that operate an OOH service and these [REDACTED] FOPs provide OOH cover to just over [REDACTED] of the FOPs in the PAH Vet Group (and in some cases other local FOPs outside of the Vet Group).

3.22 As the practice owners maintain clinical freedom and autonomy to manage their FOPs, the contracts for OOH provision are all local arrangements, and the prices and notice periods are set at the discretion of the practice owners. The OOH consultation prices offered by the [REDACTED] PAH FOPs do not vary between PAH and non-PAH FOP customers.

3.23 In Table 4 below, PAH provides the number of PAH and non-PAH FOPs that contract-out their OOH cover to each of these [REDACTED] PAH FOPs, the prices and notice periods offered by the [REDACTED] PAH FOPs, and the prices offered by a [REDACTED] site in the area.

Table 4: [REDACTED]

Outsourcing OOH provision leads to higher quality care compared to providing these services in-house

3.24 As explained above in Section A above, PAH considers that dedicated, contracted-out OOH provision has resulted in better care from both the FOP (through better staff retention, mental health and wellbeing in FOP) and the OOH provider (via more emergency and critical care (**ECC**) services specialisation and better facilities at the OOH site). In particular:

(a) Having a dedicated team of night vets and nurses ensures that the staff is well prepared and develops skills to handle emergency cases.

(b) OOH providers use additional equipment and medicines over and above what a standard FOP would have onsite. OOH providers often operate from 'host practices' that are already well-equipped with more advanced equipment and also have better access (parking, security, lighting, etc) that matters to OOH customers at night.

Costs and investments involved in the provision of OOH services

3.25 As explained previously in PAH's response to Question 10 of RFI 7, there is significant additional cost to providing OOH services. The main driver of higher cost is the higher salary costs.

3.26 To be specific, the [REDACTED] FOPs within the Vet Group that offer some OOH care [REDACTED]. This wage premium is necessary to compensate these vets for working outside of normal working hours. OOH Nurses also earn much higher salaries compared to non-OOH Nurses.

3.27 Another cost factor is that OOH Vets are typically less utilised on average. By its nature, OOH work is based on emergencies and so is less predictable. The [REDACTED] FOPs within the Vet Group that offer some OOH care need to be prepared for surges and therefore there can be periods of lower demand and 'capacity' (staff and equipment) standing idle. The implication is that OOH Vets have less throughput, which means the 'effective' salary cost to the Vet Group is higher.

3.28 PAH has also previously submitted internal documents[48] to the CMA that illustrate the higher OOH costs. For example, **DOC-00001424** and **DOC-00001434** discuss the challenges of OOH cover. These documents explain that:

(a) It is more challenging to make an overnight service profitable compared to a daytime FOP as there are large overheads with an unpredictable income.

(b) Practices must also be mature, large and profitable before considering providing OOH services as the high additional costs of OOH cover make it difficult for younger practices to remain viable.

(c) A minimum level of marketing should be a compulsory part of approving any request to move to providing 24/7 cover as a practice would need at least 8 or 9 feeder practices to be viable (with 15 quoted as ideal).

Correlation between OOH market concentration and notice period length

3.29 As requested at the CMA Hearing, NERA has run an analysis for [REDACTED] measuring the correlation between OOH local market concentration and notice period length in the [REDACTED] contracts.[49]

3.30 This analysis does not find a statistically significant relationship between OOH local market concentration (measured as the number of competing OOH fascia within each catchment area) and notice period length.

3.31 Therefore, the empirical evidence does not suggest that [REDACTED] is imposing, or that FOPs are accepting, longer notice periods in areas where there are fewer other

[48] See PAH response to Question 43(a) of Section 3 of RFI3.
[49] PAH was able to collect notice period information [REDACTED].

OOH choices.

4 CREMATIONS

4.1 In this section, PAH makes the following key points:

(a) The cremation market is one that PAH's vets rely on for the safe running of their FOPs. Cremations are an essential and integrated part of PAH's range of client offerings, like medicines, and similarly they require direct and indirect skills and costs to provide the service that customers choose and value.

(b) PAH FOPs incur significant integrated costs to deliver cremation services, and PAH FOPs price fairly to reflect these costs, as well as competitively to reflect the local market conditions.

(c) PAH does not have concerns about the functioning upstream cremation market at this stage. [REDACTED].

A PAH's vets are excellent at guiding customers through the full range of end-of-life choices for their pet, despite difficult circumstances

4.2 The death of a pet is a difficult and emotional time for customers and a delicate balancing act for vets. It takes time, experience, and sensitivity to support distressed, grieving owners through this time (from discussing the options available to the owner to gathering memories and pawprints). Processes must also be discreetly followed in handling the deceased pet in the correct way, filling out paperwork, and organising collection. PAH's staff are highly skilled at managing this, whilst guiding pet owners to make best choices for their pet's memory at a difficult time.

4.3 As humanisation continues, more owners tend to choose individual cremation options – and even within individual cremations there are a wide range of choices for the customer on the types of mementos they choose.

4.4 But lower cost options such as taking the pet home for burial and communal cremations still account for almost [REDACTED]% of PAH customer choice. Pet owners are not forced into more expensive options.

4.5 Figure 8 below presents the breakdown of PAH's end-of-life customer choices in FY24: [REDACTED]% of PAH pet owners who had a pet pass away in practice chose to take the pet home and make their own arrangements; [REDACTED]% chose a communal cremation with PAH taking responsibility for the pet; and [REDACTED]% chose an individual cremation with PAH taking responsibility for the pet. Customers are exercising choice, including choosing lower cost options.

Figure 8: [REDACTED]

Source: PAH

Notes: Based on PAH data collected from April 2023 to July 2024, approximately [REDACTED]% of pet owners who had a pet pass away in practice chose to take the pet home and make their own arrangements (see PAH Issues Statement response, para 15). The remaining [REDACTED]% of pet owners who had a pet pass away in practice chose to have their pet cremated. PAH's cremation volumes data for FY24 indicate that [REDACTED]% of PAH's cremations were individual cremations, and [REDACTED]% were communal cremations. This split is applied to the [REDACTED]% to calculate the [REDACTED]% and [REDACTED]% estimates shown in the figure.

B PAH FOPs price fairly and competitively to reflect significant integrated costs of offering cremations

4.6 PAH FOPs incur significant costs on a range of additional services and activities in providing cremation services to customers, on top of the cremation fee paid by PAH FOPs to cremation providers, including the following significant staff time incurred at all stages of the cremation process and other costs (described in detail in PAH's consolidated response to Q9 of RFI7):[50]

(a) Time and space investment for end-of-life customer support (even if not resulting in cremation) often well beyond the initial decision; and

(b) Safely handling, labelling and storing the remains (space and freezers), arranging and supervising collection, and sensitively managing customer retrieval of ashes.

4.7 In particular, PAH incurs additional costs for individual cremations, on top of the costs incurred for communal cremations (e.g. more time with customer choosing caskets, urns, keepsakes etc; arranging, supervising and managing customer retrieval of ashes).

4.8 PAH FOPs' contracts with cremation providers are important partnerships:

(a) Cremation providers are a critical trading partner that often also cover specialist clinical waste disposal requirements.

(b) Administration costs and risk of errors rise when working with multiple cremation suppliers.

(c) There is often limited local choice of cremation supplier due to the need for scale and restricted location options.

4.9 PAH FOPs price fairly to reflect the true cost of providing cremation services and competitively to reflect local market conditions. Cremation services are only a small part of PAH's overall veterinary business, accounting for less than [REDACTED]% of PAH's veterinary services revenue in FY24 (c.£[REDACTED] million out of £[REDACTED] million, or only c.£[REDACTED] per PAH FOP). While PAH does not in the ordinary course of business consider the profitability of cremation services in

[50] PAH consolidated response to RFI7, paras 9.3-9.6.

isolation, PAH's gross margin (expressed as a percentage of revenues) for cremation services on an accounting basis was c.[REDACTED]% in FY24, but PAH's true margin accounting for the significant indirect costs described above would be much lower. PAH recommends that its FOPs charge customers in line with the 'walk-in' prices at their local crematoria (even though the customer then undertakes some of the storage, transport and collection duties themselves that the FOP would otherwise incur).

4.10 Appendix B of the CMA's Demand WP presents a "cremations mark-ups analysis". In Table 9.1 and Table 9.2 of its Demand WP, the CMA shows the percentage difference between the prices charged by and to PAH FOPs for an individual cremation ([REDACTED]%) and a communal cremation ([REDACTED]%) of a medium-sized dog, expressing the difference retained by PAH as a percentage of the price paid to the crematoria.

4.11 If the CMA instead expressed the difference retained by PAH as a percentage of the price paid to PAH FOPs by customers (which is how gross margins are normally calculated and expressed as a percentage of revenues), then the percentage difference between the prices charged by and to PAH FOPs would be [REDACTED]% for an individual cremation and [REDACTED]% for a communal cremation of a medium-sized dog.

4.12 As the CMA recognises in its Demand WP, the CMA's "simple calculation" does not take into account that the LVGs incur other costs in organising a cremation on behalf of their clients,[51] and overstates the 'bottom line' margins earned when providing these services.[52] As noted above, PAH FOPs incur significant integrated costs throughout the cremation process, and any measure of the profitability of cremation services should take these costs into account.

4.13 The CMA's analysis only shows the percentage difference for a medium-sized dog and not for any other size of dog or type of pet, although PAH notes the CMA's plan to carry out similar analysis for other types of cremation services (for example cats or other sizes of dogs).[53]

C The market for cremation services currently functions well to provide customer choice and fair prices

4.14 PAH's vets are excellent at guiding pet owners through the full range of end-of-life choices for their pet, despite difficult circumstances, and customers are able to choose the service that is right for them and their pet.

4.15 PAH FOPs incur significant integrated costs to deliver cremation services and price

[51] Demand WP, para 9.8.
[52] Demand WP, para 9.11.
[53] Demand WP, para 9.13(b).

fairly to reflect these costs as well as competitively to reflect the local market conditions.

4.16 For FOPs, there are usually relatively few choices upstream in the cremations market. PAH is concerned that the CMA's Demand WP provides no data, description, or analysis of the upstream markets for the provision of cremation services, including the identity and number of pet cremation providers in the UK (not just those crematoria vertically integrated with LVG5s but also independent crematoria), shares of the upstream cremation market at the national level, evidence of entry and exit, the degree of concentration in the provision of cremation at the local level, or the profitability of these cremation providers etc. This information would assist in considering the dynamics of cremation provision and whether any AEC is present.

4.17 This said, PAH is currently able to contract for cremation and waste disposal services effectively across the UK. Some cremation suppliers seek exclusivity requirements. PAH does not have concerns about the functioning upstream cremation market at this stage. [REDACTED].

4.18 PAH supports remedies that ensure customers of all FOPs are given an appropriate range of choices at the end of the life of their pets. However, PAH does not support remedies that ignore the integrated cost and support provided by FOPs, as they would result in an inappropriate financial burden, particularly on independent FOPs.

5 PET CARE PLANS

5.1 The CMA's Demand WP seems to suggest that pet care plans may have negative effects, such as causing overtreatment.[54] PAH strongly challenges this suggestion.

5.2 Pet care plans are good for customers and pets and highly valued by many pet owners.

5.3 As the CMA's own Pet Owners Survey shows, pet owners listed a range of reasons for taking up pet plans, and amongst the most important were to keep up with preventative care for their pet (53%), value for money (50%), the feeling of reassurance it could provide (46%), and help with financial planning (43%).[55] This shows that many pet owners value pet care plans not only for their clinical and financial benefits, but also for the reassurance, predictability and peace of mind they provide.

5.4 PAH has provided the CMA with evidence on the significant savings that customers can enjoy when using a PAH pet care plan.[56] These savings are shown transparently to the customer via a bespoke calculator tailored to their pet.

5.5 In this section, PAH makes the following key points:

(a) PAH's pet care plans are a great example of how PAH transparently delivers significant value for customers. Pet care plans allow PAH to offer greater convenience, choice, and flexibility to its customers and provide significant cost savings on necessary preventative care for their pets.

(b) PAH's pet care plans are designed to focus on preventative care. This can save the customer further money in avoiding more expensive curative care. There is no evidence provided by the CMA that PAH's pet care plans cause any overtreatment. Indeed, the CMA must please be cautious in making such a statement without empirical evidence and without testing for causation. There is a real risk here of confusing 'causation' and 'correlation' where those people who choose pet care plans may be more engaged with the health of their pets and so more likely to seek treatments – it is not the plan 'causing' more treatments.

(c) Given the benefits customers derive from pet care plans, PAH would not support any remedies that damage or restrict the provision of pet care plans. PAH would welcome remedies that improve the comparability of plans between providers, as this would enhance competition, and allow PAH to further demonstrate the value of its plans to customers.

5.6 PAH's pet care plans deliver significant value to its customers. Pet care plans allow

[54] Demand WP, paras 5.108-5.114.
[55] Demand WP, para 5.79.
[56] PAH response to RFI1, Question 23, Annex 12.

PAH to offer greater convenience, choice, and flexibility to its customers. PAH's pet care plans allow customers to make significant savings of over £300 on preventative care compared to the total cost of buying the treatments individually. PAH provides customers with a bespoke (to the specific pet) 'savings illustration' before they subscribe with colleagues using a detailed calculator tool. Pet care plans also help customers budget and spread the cost of preventative care.

5.7 Pet care plans also create greater engagement between the customer and the FOP, and for PAH creates a subscription revenue model. Increased customer spend (from the whole preventative spend of the customer from being on the care plan) and retention is an important part of PAH's strategic rationale for pet care plans, but the preventative care and welfare of pets is at the front of PAH's mind when designing pet care plans. In 2023, PAH worked with its vets to redesign its pet care plans to focus on preventative care, separate from curative care.

5.8 For Complete Care, the current benefits included in the plan were selected through consultation with Practice Owners and the Joint Venture Council (**JVC**), consumer research activity and also regular analysis of the utilisation of care plan benefits by existing plan holders.[57] Over the last five years, there has been only one change made to the benefits included in June 2023[58] [REDACTED].[59]

5.9 PAH's pet care plans include: highly effective veterinary strength parasiticide treatments for flea, tick and worm; boosters, vaccinations and annual health check; two veterinary consultations and three RVN consultations; unlimited access to PAH's 24/7 Vet Careline for advice and RVN support; annual urine screen; and discounts on microchipping, blood screens, dental care and neutering.

5.10 PAH's pet care plans ensure that pets receive vaccinations sufficiently frequently to keep their immunity topped up and protected against a number of diseases. They are not more frequent than necessary. Leaving aside pet care plans, all of PAH's FOPs recommend an annual health check for cats, dogs and rabbits during which the clinician would assess any vaccinations needed to maintain a pet's immunity to preventable diseases (or similar).

5.11 Given the benefits customers derive from pet care plans, PAH would not support any remedies that damage or restrict the provision of pet care plans. PAH would welcome remedies that improve the comparability of plans between providers, as this would enhance competition, and allow PAH to further demonstrate the value of its plans to customers.

[57] PAH response to RFI2, para 9.1.
[58] PAH response to RFI2, para 10.1.
[59] PAH response to RFI2, para 11.1.

6 FUTURE REGULATION

A Introduction

6.1 As set out in its response to the CMA's Issues Statement (**IS Response**)[60], PAH views the CMA market investigation as an important opportunity to evaluate the veterinary sector regulatory framework and address areas of needed reform.

6.2 The Regulatory Framework WP sets out the CMA's current assessment of the evidence it has gathered and its emerging views on: "*whether the current regulatory framework contains the right combination of substantive requirements and monitoring, enforcement and redress mechanisms to support the competitive process and outcomes we would expect in a well-functioning market.*"[61]

6.3 PAH is a leading advocate of sensible regulatory reform in the veterinary sector to update the current outdated regulatory framework to the benefit of all stakeholders in the sector.[62] For instance, in November 2024, as part of PAH's VSA reform campaign, PAH convened a 'round table' in Parliament, which was hosted by Lord Trees, to discuss VSA reform. The session was attended by key policy and industry colleagues, bringing together the BVA, RCVS, BVNA, DEFRA and EFRA to discuss reform with policymakers.

6.4 PAH believes that the right regulatory reform needs to deliver a balanced outcome that is positive for customers, pets and veterinary businesses and professionals, in particular by:

(a) **continuing to prioritise animal welfare**: the protection of animal welfare and, to that end, the maintenance of high clinical and professional standards, is a central and important feature of the current regulatory framework that must be preserved;

(b) **supporting the competitive process**: by

(i) **supporting the consumer interest**: in particular by ensuring veterinary professionals and veterinary businesses provide sufficient information, at the right time, to pet owners to enable them to make informed decisions as to the purchase of veterinary and related services and products; and

(ii) **supporting a market that is attractive for investment, growth,**

60 IS Response para 12(d)(i).
61 Regulatory Framework WP, para 3.
62 See the PAH's reform suggestions in PAH's response to the CMA's MIR consultation (**MIR Consultation Response**) (paragraph 23) and in the IS Response (paragraphs 12(d) and 70). However, PAH's support for sensible regulatory reform has not been confined to its involvement in the CMA's market investigation and market review.

> **innovation and employment**: by avoiding the imposition of unnecessary or disproportionate regulatory restrictions, burdens or costs on veterinary professionals and businesses, particularly on the independent FOP-only half of the market (which includes the Vet Group).

PAH believes that these are all important features of a well-functioning market (**WFM**).

6.5 In PAH's view, any regulatory reform proposals should, where possible, build on the current regulatory framework, which FOP businesses (including PAH) and other stakeholders are familiar with and which has evolved over time in consultation with stakeholders (notwithstanding that there are certainly areas which can be improved). Such an approach will likely minimise unnecessary disruption and uncertainty in a market which (including due to the ongoing CMA market investigation) has already been considerably impacted by high levels of uncertainty.

6.6 For this reason, in PAH's view, it would be preferable to maintain the RCVS as the market regulator, even if with strengthened powers and an expanded role, rather than replace it with a new regulatory body. Similarly, as regards any changes to substantive regulatory consumer interest requirements, PAH favours building on the current RCVS Code and Supporting Guidance requirements, rather than replacing them with an entirely new body of rules.

B Entry requirements for the veterinary profession

6.7 PAH supports [63] measures to help address the acute shortage of veterinary professionals.

6.8 PAH welcomes the CMA's consideration of the entry qualification requirements for veterinary surgeons and its recognition that at the moment entry requirements, especially for foreign qualified veterinary surgeons, may be set inappropriately, contributing to a shortage of vets in the UK.[64] In its MIR Consultation Response, PAH suggested that one way to help address this would be to amend the minimum salary requirements for Skilled Worker visas to make it easier for overseas veterinary surgeons and veterinary nurses to work in the UK.[65]

6.9 PAH agrees with the CMA's suggestion that, in view of their potential to affect competition, it may be appropriate for the RCVS and government to assess whether those requirements appropriately take into account a balance of animal welfare, public

[63] Paragraph 12(d)(i) IS Response.
[64] Regulatory Framework WP, paras 2.22 and 2.24.
[65] Paragraph 23(a)(i) MIR Consultation Response; see also paragraph 12(d)(i)(C) IS Response.

health and consumer and competition interests.[66]

C Substantive regulatory requirements addressing the consumer interest

6.10 The Regulatory Framework WP accepts that *"On the face of it, therefore, the RCVS Code and Supporting Guidance contain provisions that seek to protect consumers, or should have the effect of doing so, and which might help to promote competition for veterinary services".*[67] This is because the RCVS Code and Supporting Guidance (including the recently added Chapter 10) does contain a wide range of substantive provisions addressing the consumer interest, including requirements to:

(a) communicate effectively with clients appropriate information about the vet practice, including the costs of services and medications and to obtain informed consent before treatments/procedures are carried out, including explaining to clients a range of reasonable treatment options, including as to cost, taking into account the needs and circumstances of the consumer[68];

(b) provide independent and impartial advice and to inform clients of any conflict of interest[69]; and

(c) refer cases responsibly and in the best interests of the animal, to a competent colleague/organisation/institution and considering all relevant factors (ability and experience, location, urgency, owner's circumstances and financial situation) and making the consumer aware of the expertise and status of the referral vet(s)[70].

6.11 However, the Regulatory Framework WP states "*We remain concerned…that the regulatory framework may not give enough weight to these matters*"[71] and advances three main reasons for such concerns:

(a) such consumer interests are outside of *"the fundamental purpose of regulation by the RCVS, reflected in the VSA…to regulate entry into the profession and oversee vets' conduct as professionals"*[72];

(b) *"there may be inadequate monitoring and enforcement of compliance"*[73]; and

(c) notwithstanding these requirements, the CMA has observed evidence that

66 Regulatory Framework WP, para 2.25.
67 Regulatory Framework WP, para 2.40.
68 Regulatory Framework WP, paras 2.32 – 2.33 and 2.37.
69 Regulatory Framework WP, para 2.34.
70 Regulatory Framework WP, paras 2.35(a)-(e).
71 Regulatory Framework WP, para 2.40.
72 Regulatory Framework WP, para 2.41.
73 Regulatory Framework WP, para 2.42.

> *"there is limited price information available for many services, that information on clinical options is not always communicated effectively and that pet owners tend not to shop around…"*[74]

6.12 PAH's view is that the RCVS Code and Supporting Guidance contains an existing body of consumer interest requirements going to the concerns identified by the CMA, which FOPs and veterinary surgeons are familiar with and which has evolved through consultation with many stakeholders. As such, the focus of any reform of the RCVS Code and Supporting Guidance consumer interest substantive requirements should be on supplementing and strengthening them in a proportionate and measured way, rather than replacing them with an entirely new framework, which would be much more disruptive for the sector.

6.13 For instance, one area in which the current RCVS Code and Supporting Guidance could be strengthened is as regards price transparency for the most frequently provided services. PAH's Practices have recently started rolling out the prominent provision on PAH's Practice's website of the prices for the most frequently provided services[75] and PAH would support this being made a requirement of the RCVS Code and Supporting Guidance. As regards whether this should be extended to requiring the provision of online pricing of the most commonly used medicines, in PAH's view it is not clear that this would be useful for customers given the significant variations across different veterinary practices as regard what medicines are stocked based on clinical preferences, regional diseases, areas of specialty and other factors.

6.14 Likewise, and as indicated at paragraph 5.11 above, PAH would welcome remedies that improve the comparability of plans between providers, as this would enhance competition, and allow PAH to further demonstrate the value of its plans to customers. Detailed information on its pet care plans is already available online on all PAH's Practices websites.

6.15 However, in PAH's view it would not be practicable or useful to require FOPs to provide price lists (offline or online) for complex treatments or procedures, given the variables involved in pricing these for individual pets. For complex treatments and procedures, PAH believes that customers' interests are best served by maintaining (and clarifying if necessary) the requirement to provide a written bespoke fee estimate in advance of treatment, in line with existing requirements under the RCVS Code and Supporting Guidance[76].

6.16 PAH also does not support any remedy that would mandate the creation of regulated platforms for market price comparison. In PAH's view, if FOPs do publish online the

[74] Regulatory Framework WP, para 2.43.
[75] See, by way of example, the main page on the Altrincham Vets for Pets website. As at 26 February 2025, 291 Practices make available on their websites the prices for the most frequently provided services in this way.
[76] RCVS Code para 2.4 and Supporting Guidance Chapter 10 and Chapter 11.

prices of their most frequently provided services (as per paragraph 6.13 above), pet owners will be well able to use the internet to shop around if they wish to, and imposing a mandatory price comparison platform will not materially enhance their position in that regard but rather would carry very significant risks of being overly complex, burdensome, expensive for FOPs and ineffective.

6.17 Finally, and as set out below, in PAH's view a revised mandatory Core Standards accreditation, reflecting the minimum legal requirements of a FOP business, could further support consistent interactions between FOPs and clients to promote customer transparency and the provision of sufficient information to enable customers to make informed choices.

D Regulation of veterinary practices and their owners

6.18 PAH supports extending the RCVS' statutory remit from individual practitioners to FOP businesses and their owners[77].

6.19 As regards the Practice Standards Scheme (**PSS**)[78], although the CMA's emerging view is that *"the PSS is unlikely effectively to regulate veterinary practices for reasons that relate to: its status; its objectives and scope; its monitoring and enforcement and its lack of visibility to consumers"*[79], the CMA acknowledges that, in seeking to raise the standards of veterinary care provided by practices, the PSS has the potential to improve quality and that this would benefit consumers.[80]

6.20 Across the Practices within the Vet Group, there is a high level of engagement with the PSS with [REDACTED]% of Practices being accredited and a number achieving higher tiers of accreditation. This reflects that most Practice owners recognise the value to their business of participating in the PSS as it helps to demonstrate to customers and potential customers that the Practice meets high standards of quality care and service, helps develop and maintain structured protocols and best practice and ensures compliance with the latest regulations.

6.21 PAH believes that the PSS offers FOPs a framework of good practice standards which does have an important role in any reformed regulatory framework and PAH would support the PSS Core Standards accreditation, strengthened in certain respects, being made a mandatory requirement for all FOPs in the UK.

6.22 PAH believes that the 'Client Experience' module as part of the Core Standards, General Practice and Veterinary Hospital accreditations provides for practice standards which protect consumer interests but agrees with the CMA's view that both

77 Regulatory Framework WP, paras 4.39 – 4.40.
78 Regulatory Framework WP, paras 4.10 – 4.40.
79 Regulatory Framework WP, para 4.25.
80 Regulatory Framework WP, para 4.27.

the design and implementation of the PSS could be supplemented to better improve interactions between veterinary practices and consumers. Accreditation could be improved to support consistent interactions between veterinary practices and clients to promote customer transparency and the provision of sufficient information to enable them to make choices that protect their interests and the welfare of their pets.

6.23 As regards consumer awareness, PAH believes that strengthening the Core Standards accreditation and making it mandatory for all veterinary practices in the UK would ensure that customers receive a consistent and minimum standard of veterinary care and information. The PSS should continue to offer higher levels of accreditation and PAH believes that many FOPs would have competitive incentives to obtain such higher accreditations and to promote that they have them, including by displaying their higher levels of accreditation online and in practice.

E Monitoring and enforcement of regulatory compliance, complaints and consumer redress

Monitoring and enforcement

6.24 The Regulatory Framework WP identifies a concern that *"the mechanisms for monitoring vets' compliance with the requirements of the framework, and taking enforcement action and imposing sanctions for non-compliance may be too limited"*[81].

6.25 In principle, PAH is open to remedies which bolster the RCVS' ability to proactively monitor FOP's compliance with regulatory requirements (including as regards consumer interest requirements) and to impose sanctions in cases of clear and material proven infringements.

6.26 However, in PAH's view, it is important that any strengthening of the RCVS' role and powers in this way should ensure that any monitoring or enforcement action must be transparent, accountable, proportionate, consistent, targeted only at cases in which action is needed and not impose an undue compliance cost on FOPs. There should be a presumption in favour of constructive engagement with FOPs, with intrusive enforcement action (e.g. unannounced visits and covert surveillance) reserved for the most serious cases and where there is a genuine concern that constructive engagement will not be productive.

6.27 In a similar vein, PAH has a concern that the range of additional sanctions which the CMA is considering[82] has the potential to significantly add to the costs of running a FOP business, which would likely deter new entry, particularly by independent FOPs

[81] Regulatory Framework WP, para 2.74(b).

[82] Regulatory Framework WP, para 2.67 notes that the RCVS does not have the power to order vets to "*carry out additional treatments; apologise to consumers; refund or cancel fees; give clinical advice about treatments; pay compensation; or resolve issues relating solely to negligence*".

and so could actually entrench the position of LVGs. As such, it is important that any remedy (including recommendations to Government on recommended regulatory reforms) to give the RCVS *"a full regulatory toolkit"*[83] contain safeguards to ensure that, in the interests of promoting growth and investment, there is a bias in favour of light touch regulation wherever possible.

6.28 PAH reads paragraph 2.72 of the Regulatory Framework WP[84] as providing at least some recognition for the importance of this but we are concerned that the current emphasis of the Regulatory Framework WP on this point is towards over-regulation, which in our view has the potential to undermine investment and growth incentives (particularly for independent FOPs).

6.29 In particular, PAH would be very concerned by any proposal that the RCVS should have a role in determining whether or not a given fee is *"excessive"*[85] where the fee was in line with the fee estimate provided to the customer in advance of treatment.

6.30 PAH recognises that an enhanced RCVS with an expanded role will need an appropriate budget and resources. That said, it will be important that the budgetary implications for the RCVS and industry stakeholders (including FOP businesses and businesses in related markets) are fully thought-through and consulted on.

Complaints and consumer redress

6.31 PAH believes that it has an effective complaints procedure[86] whose stated aim is to resolve customer complaints "*promptly and thoroughly*". This is a key aspect of the Vet Group's client service and competitive offering.

6.32 As such, PAH would support a requirement (for instance, as part of a mandatory PSS Core Accreditation) that FOPs have an effective in-house complaints handling process.

6.33 Currently, the PSS requires only that veterinary practices have a scheme in place for considering complaints and does not set out elements that such a scheme must

[83] Regulatory Framework WP, para 2.52.

[84] "*We might expect an effective regulatory framework to contain a mixture of 'softer' approaches (for example, guidance, education, codes and warning notices) and 'harder' actions such as fines, prosecutions and striking off the Register, that can be targeted in a proportionate way for the benefit of both vets and consumers*".

[85] Regulatory Framework WP, paras 2.60 – 2.61.

[86] The Vet Group, Complaints Statement and Procedure (available here). Customer complaints for veterinary services are typically dealt with at Practice level, in the first instance, by Practice colleagues / owners. Certain complaints may be shared with the Client Services team at support office should the client feel they do not wish to contact the Practice or as an escalation route. Complaints may also be escalated to the Business Development Partner (**BDP**) for the Practice or to independent bodies, including the Citizens Advice Bureau or the Veterinary Client Mediation Service (**VCMS**). If a complaint raises a concern of a clinical nature, the Vet Group's Clinical Services Team may also work with the Practice on the matter and support the BDP with the reply if a complaint is escalated. At a group level for complaints presented by customers, or those escalated by Practices directly to the Clinical Resolutions Team and Client Services Team, complaints are systematically recorded. Thematic analysis of complaint type is conducted and used by the Quality Improvement Team to guide client experience improvements across the Vet Group.

include[87]. Similarly, the RCVS Code prescribes that "*veterinary surgeons must respond promptly, fully and courteously to clients' complaints and criticism*" with no specifics for setting up the complaints procedure.[88] The PSS Core Standards accreditation could be strengthened by clearly stipulating the elements that in-house complaints schemes must include.

6.34 If an improved Core Standards accreditation was made mandatory for all veterinary practices in the UK, this could be used to ensure that a formal, agreed and consistent complaints process which sets out the expectations on veterinary businesses (for example, on outcomes and timescales) is in place, and ensure that all veterinary businesses operate complaints procedures to that standard.

6.35 PAH considers that the veterinary sector's third-party redress system, the VCMS, is an effective third-party redress scheme that offers consumers a means to pursue complaints they are unable to resolve with their veterinary practice. As acknowledged by the CMA, the fact that almost all complaints to the scheme in 2022 to 2023 reached a conclusion suggests that, often, the VCMS offers consumers the possibility of practical resolution of their complaints.[89]

6.36 Therefore, if an effective inhouse complaints procedure were to become a regulatory requirement, in PAH's view the VCMS in its current form can be maintained, without the need to institute a mandatory independent or third-party redress scheme, thereby avoiding an additional layer of cost and complexity to the reformed regulatory framework.

F Regulation of veterinary nurses

6.37 PAH agrees with the CMA's emerging view that *"[…] reducing the list of activities restricted to vets and extending the range of tasks that RVNs are permitted to undertake, with appropriate additional training and supervision, could offer positive impacts for veterinary professionals and pet owners and their pets"*.[90]

6.38 In its IS Response, PAH proposed that the delegation procedures in Schedule 3 VSA be extended to enable registered veterinary nurses or student veterinary nurses (with appropriate supervision) to carry out more clinical duties, which should help in increasing retention levels within the profession of both veterinary nurses (as this will likely increase veterinary nurse job satisfaction and career progression) and veterinary surgeons (as this will lessen the burden on veterinary surgeons).[91] PAH would support the RCVS Council's recommendation to increase the role of veterinary nurses in the induction and maintenance of anaesthesia via reform of Schedule 3 of the VSA, on

87 Regulatory Framework WP, para 5.12.
88 RCVS Code para 2.7.
89 Regulatory Framework WP, paras 5.27 and 5.30; VCMS Insight Report 2022-23 (available here), page 19.
90 Regulatory Framework WP, para 3.3.
91 IS Response, pages 6-7.

condition that such veterinary nurses are required to undertake additional training in anaesthesia.[92] PAH believes that such reform would expand the application of advanced specialisms for veterinary nurses, which are currently available but limited in application due to Schedule 3 restrictions. PAH is also in favour of nurse practitioner roles working in a similar way as those existing in human nursing (one possible example being 'nurse prescribers', working in a similar way to supplementary or independent nurse prescribers in the NHS).[93]

6.39 PAH agrees with the CMA's finding that the *"[p]rotection of the veterinary nurse title is of high importance to the RVN profession and to the veterinary sector more widely" and is supportive of the CMA's emerging view that "protecting the veterinary nurses' title might enhance transparency and consumer confidence, improve consumers' ability to compare offerings between firms and therefore help stimulate competition between rivals"*.[94] PAH believes that protecting the veterinary nurse title combined with extending the delegation procedures in Schedule 3 would increase job satisfaction, career progression and earning potential for RVNs (potentially improving staff retention). Finally, knowing that their pets are being cared for by registered veterinary nurses would increase consumer confidence in the veterinary profession.

6.40 PAH agrees with the CMA's emerging view that "*vet nurses could be more fully and effectively utilised within the requirements of existing regulation and that greater clarity with respect to interpretation of the existing framework could help enable this*".[95] In particular, PAH believes that Schedule 3 of the VSA should be clarified in respect of areas reserved for veterinary surgeons. For instance, veterinary nurses cannot perform surgery entering into *"a body cavity*";[96] however, the definition of "*a body cavity"* is left to interpretation which leads to concern from practitioners. PAH believes that the framework should be expanded with more areas of prescriptive advice to clearly guide practitioners.

6.41 PAH believes that it has an effective system in place for the development and progression of veterinary nurses. PAH currently provides access to structured development for its veterinary nurses and practice support for full utilisation so veterinary nurses can appropriately and safely: (i) lead on preventative care; (ii) provide advanced clinical care; (iii) undertake client education; and (iv) take on leadership and mentoring roles within RCVS guidelines. As such, PAH would support a more detailed framework for structured development of veterinary nurses, which would give vets confidence in delegating specified tasks. PAH would also support displaying clear signposting to relevant certificates for veterinary nurses, reinforcing

92 Regulatory Framework WP, para 3.30(a).
93 Regulatory Framework WP, para 3.30(b).
94 Regulatory Framework WP, paras 3.16 and 3.17.
95 Regulatory Framework WP, para 3.25.
96 VSA, Schedule 3, para. 1.

and giving greater profile to the broader RVN role.

G Regulation of the supply of veterinary medicines and other restrictions on the provision of veterinary care

The Cascade Restriction

6.42 PAH agrees with the CMA's emerging view that, in certain instances, 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.[97] PAH supports the recommended changes to the Cascade put forward by the Competition Commission following its investigation of the supply of prescription-only veterinary medicines in 2003, to allow recourse to the cascade in the case of non-food-producing animals where, notwithstanding the existence of an authorised medicine for the species and condition in question, the veterinary surgeon having the animal under his care considers this justified on grounds of animal welfare including cases where the cost of treatment would otherwise cause the animal to go untreated.[98]

6.43 PAH believes that the CMA should recommend that the public bodies responsible for regulating the prescribing of medicines (Defra, VMD, RCVS) should consider whether animal welfare, public health and environmental protection are appropriately weighted against the need to ensure veterinary services in the UK can deliver competitive prices, innovation and growth. PAH agrees with the CMA's view that this could include measures to introduce more flexibility in the Cascade for specific circumstances, or requiring products that are displacing a widely-used Cascade alternative to demonstrate value-for-money.[99]

H Telemedicine and remote prescribing

6.44 PAH acquired The Vet Connection (**TVC**), the UK's largest independent veterinary telehealth provider, in 2020. TVC provides on-demand telehealth advice, as well as triage and ancillary services, to pet owners through white-labelled veterinary/telehealth services (e.g. Vetfone) as well as to veterinary practices.

6.45 PAH believes that telemedicine provides an additional avenue for consumers to access veterinary services and therefore widens access to professional care and broadens choices available to pet owners. Like the CMA[100], PAH considers that there is scope for the benefits of telemedicine to be further realised within the context of veterinary services to help improve consumer choice, reduce the resource burden on

97 Regulatory Framework WP, para 6.38.
98 2003 CC Report (available here), Appendix 1.3, paragraph 40 – recommendation 19.
99 Regulatory Framework WP, para 6.46.
100 Regulatory Framework WP, para 6.81.

vets and promote animal welfare.

6.46 Regarding restrictions to the provision of telemedicine, PAH supports the continued need for a physical examination to protect the accuracy of diagnosis. However, PAH believes that it should be made easier for vets, once the pet is 'under their care', to continue to prescribe through telemedicine routes without unnecessary physical re-checks. As such, PAH agrees with the CMA's suggestion that the RCVS should reconsider the approach to the definitions of 'under care' and 'clinical assessment' as they relate to the prescription of POM-Vs.[101] PAH is open to remedies which remove requirements for repeat physical examination for the prescription of antibiotics, antifungals, antiparasitics or antivirals POM-Vs[102], in cases where the initial physical examination has already taken place and the pet is 'under care' of the specific veterinary surgeon. PAH believes that such relaxation of the requirement for a physical examination would allow greater flexibility for telemedicine services in the context of the ongoing vet-patient relationship. PAH would however be concerned by any proposal to fully remove the (at least initial) physical examination requirement for the prescribing of antibiotics, antifungals, antiparasitics, antivirals or controlled drugs where examination is currently mandatory (except in exceptional circumstances),[103] due to concerns that this lack of 'hands on the animal' control may negatively impact the accuracy of diagnosing the pet and appropriate prescribing.

[101] Regulatory Framework WP, para 6.99.
[102] All other POM-Vs (excluding controlled drugs) do not require a repeat physical examination and can be re-prescribed based on clinical assessment.
[103] Regulatory Framework WP, paras 6.54-6.56.

7 PAH COMMENTS ON OTHER EMERGING ISSUES

7.1 In this Section, PAH makes comments on other emerging views and analyses set out by the CMA in its WPs that are not already addressed above. The comments in this Section are organised by WP.

A Demand WP

CMA Evidence on Switching

7.2 In its Demand WP, the CMA estimates a 3% 'proactive' switching rate between FOPs in the past 12 months from its Pet Owners Survey.[104] This estimate is calculated by dividing the number of 'proactive' switchers in the last year with the survey sample size of 2,344. The number of 'proactive' switchers in the last year is determined by the following three cumulative criteria:

(a) Include respondents who have been with their current FOP for less than one year;[105]

(b) Include respondents who switched to their current FOP from another FOP;[106] and

(c) Exclude respondents who switched FOPs due to their previous FOP closing or because they moved home.[107]

7.3 By counting only those respondents who meet all three criteria, the CMA calculates what it terms a 'proactive' switching rate of 3% in the last year. PAH notes that the CMA also calculates a 'proactive' switching rate of 6% in the past two years, rising to 13% in the past five years.[108]

7.4 The CMA is concerned that the relatively low annual FOP switching rate of 3%, among other factors highlighted in its Demand WP, may imply weak competitive forces in the FOP market.[109]

The CMA's switching rate does not accurately reflect the true level of market competitiveness

7.5 PAH does not agree with the CMA's concerns that the FOP market is facing weak

[104] Demand WP, paras 6(b) and 5.58.
[105] Respondents who answered "Less than 1 year" to the pet owners survey Q11 (H*ow long have you been at your vet practice?*); Demand WP, footnote 198.
[106] Respondents who answered "Yes" to the pet owners survey Q12A (*Did you move to your current practice from another vet practice?*); Demand WP, footnote 197.
[107] Respondents who did not answer "I moved home" or "Previous vet practice closed down" to the pet owners survey Q33 (You said earlier that you had moved to your current practice from another practice. Why did you decide to leave your previous vet practice?); Demand WP, para 5.58 and footnote 197.
[108] Demand WP, para 5.58.
[109] Demand WP, paras 6(b) and 7.

competitive forces. FOPs must continually remain relevant and competitive in their local markets due to significant client churn over time, driven by several factors, including:

(a) Pet owners moving in and out of the area;

(b) The natural cycle of pets passing away and owners acquiring new pets; and,

(c) Competitive pressure from other local FOPs, prompting customers to switch FOPs.

7.6 PAH's own experience is that FOPs face churn in their client base. [REDACTED].[110] [REDACTED].[111] [REDACTED][112] [REDACTED]. Faced with the risk of churn, FOPs have to continually strive to attract new customers, indicating substantial competitive pressure. This dynamic contrasts with the CMA's 'proactive' switching rate of 3%, which underestimates market competitiveness by deliberately not accounting for pet owners who must choose a vet when acquiring a new pet or moving to a new area.

Insurer data suggests a higher switching rate

7.7 In considering the switching rate between FOPs, it is important to explore alternative data sources that may provide a more comprehensive understanding of consumer behaviour. While survey data, such as the CMA's pet owners survey, offers insights, it may also present limitations. For example, survey respondents may have imprecise recollections on what they did.

7.8 To address these limitations, NERA examined the insurer datasets used in the CMA's Econometrics WP, which offer an alternative perspective on switching rates based on actual customer behaviour and a much larger sample size of observations than the Pet Owner Survey. Confidential Annex 001 sets out NERA's analysis of the insurer datasets, which suggests a higher FOP switching rate is visible in the insurer data than the CMA's smaller survey suggests.

The CMA's switching rate overlooks critical moments of reassessment of veterinary options

7.9 It is also important to consider the broader context in which pet owners make decisions about their veterinary care providers. The CMA's exclusion of respondents who switched due to moving home or at the point of choosing a FOP for a new pet overlooks critical moments when consumers must reassess their purchase decisions.

7.10 For example, data from the CMA's Pet Owners Survey reveals that many respondents

[110] PAH response to RFI13, Annex 004, slide 16.
[111] PAH response to RFI13, Annex 004, slide 20.
[112] [REDACTED]

who switched vets due to moving home or vet closure *also* cited additional reasons for switching. These reasons include dissatisfaction with the quality of care at their previous veterinary practice, as well as a desire for more competitive pricing.

7.11 By excluding these respondents, the CMA survey *underestimates* the true level of competitive constraints in the market. Including these instances in the switching rate calculation would acknowledge the natural points at which consumers reassess their options, thereby exerting competitive pressure on veterinary service providers. When these respondents are included, the annual switching rate rises from 3% to 5%, the two-year switching rate from 6% to 11%, and the five-year switching rate from 13% to 22%.

A low switching rate does not necessarily imply competitive concerns or poor outcomes for customers

7.12 There are several pro-competitive reasons why the switching rate in a market may be low, such as there being benefits to the customer and to the wellbeing of the pet for staying with a trusted vet, as well as high satisfaction with the service they receive and the price they pay. A relevant metric of market competitiveness is the customer's ability to switch. The CMA's Pet Owners Survey indicates that 85% of respondents feel they could switch vets if they wished, and 64% believe that doing so would be fairly or very easy. These findings suggest that barriers to switching are not significant factors in the FOP market.

There are benefits to FOP loyalty, unique to the veterinary market

7.13 The CMA acknowledges that there are benefits to consumers in remaining loyal and improving their relationship and trust with their existing provider, which might contribute to the lower switching rates between FOPs than benchmarks in other household services.[113] As such, it is not unexpected to observe a relatively low switching rate in this market, as pet owners prioritize stable, consistent care for their pets over frequent changes in providers.

7.14 For example, an examination of switching rates across different pet age groups reveals a trend of declining switching rate as pets mature. Using the CMA's approach to calculating the switching rate, which excludes those who switch due to moving home or vet practice closures, the 'proactive' switching rate is 4% for owners of young or very young pets, 3% for owners of adult pets, and 2% for owners of old or elderly pets. This pattern suggests that once a pet owner finds a veterinarian they trust, they tend to remain loyal, recognizing the benefits of continuity in care as their pets age.

[113] Demand WP, para 5.68.

Highly satisfied customers are less likely to switch vets

7.15 The CMA's Pet Owners Survey provides valuable insights into customer satisfaction with their FOPs. Notably, the survey results indicate a high satisfaction rate over 80% in several key areas: the care provided to pets; the quality of service received; the outcomes of veterinary visits; and the information or advice given by veterinarians. Moreover, the survey reveals that a majority (56%) of respondents expressed satisfaction with the cost of the service. Such high levels of satisfaction suggest that pet owners generally have positive experiences with their current FOPs.

7.16 Given these high satisfaction rates, it is reasonable to expect a relatively low switching rate among pet owners. When consumers are largely satisfied with the quality and cost of services, there is less incentive to change providers.

B National WP

Risk of Overtreatment

7.17 The CMA sets out concerns that: (i) vets may not consistently give sufficient information and suitable recommendations to pet owners; (ii) vets may focus on offering higher quality and higher cost treatments, potentially at the expense of lower cost clinically justified alternatives, when there is a range of appropriate treatments for the animal in their care; and (iii) as a result, this could be leading to increases in treatment intensity that do not properly reflect pet owners' preferences (that is, increases in treatment intensity may not reflect the diagnostics and treatment options pet owners would have chosen if they had been given more information and more suitable recommendations).[114]

7.18 In line with the RCVS Supporting Guidance and the PSS Toolkit, PAH's Vet Group provides guidance to its FOPs which stipulates that clients should always *"have the opportunity to consider a range of reasonable treatment options, with associated fee estimates and have had the significance and main risks explained to them before they sign the consent form"*.[115]

7.19 PAH undertakes customer surveys to understand whether customers are satisfied with the information and range of options provided by their vets.[116] PAH analyses the survey results to identify and recommend improvements across its FOPs.

7.20 [REDACTED].

7.21 Operational independence and clinical freedom are at the heart of PAH's JV model. PAH does not reward its vets financially for performing more treatments. Practice

[114] National WP, para 2.164.
[115] PAH response to RFI1, Annex 008 RFI1 ("Example SOP informed consent-estimates"), page 1.
[116] See, for example, PAH response to RFI3, Annex 606, Annex 608, Annex 609.

Owners decide how to reward themselves (e.g. setting the level of their salary, deciding whether to take a dividend or reinvest profit into the FOP).

Information about Referral Options

7.22 The CMA states there is some evidence that might suggest a broader potential concern that all types of FOP (whether vertically integrated or not) do not give enough pet owners sufficient information about a range of referral options, which could result in weaker competition in the supply of referral services than it might expect if the market was working well.[117]

7.23 In line with the RCVS Supporting Guidance and the PSS Toolkit, PAH's Vet Group provides guidance to its FOPs which stipulates that clients should always *"have the opportunity to consider a range of reasonable treatment options, with associated fee estimates and have had the significance and main risks explained to them before they sign the consent form"*.[118]

7.24 Within the PAH JV model, JV POs have an incentive to move, through training and experience, into more specialized vet work over time. This enhances the ability of vets to treat new and more complex conditions in-house within the FOP, and can help save the customer money in the long-term (by doing the more complex vet work in-house within a FOP, rather than referring the pet on to another corporate group often at a materially higher price) and reduce stress for the animals.[119]

[117] National WP, para 8(b).
[118] PAH response to RFI1, Annex 008 RFI1 ("Example SOP informed consent-estimates"), page 1.
[119] PAH response to RFI7, page 2 and para 1.69. PAH response to Profitability WP, para 3.23.