MEDIVET GROUP LIMITED'S RESPONSE TO THE CMA'S PROVISIONAL DECISION REPORT DATED 15 OCTOBER 2025

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A. INTRODUCTION AND EXECUTIVE SUMMARY

(1) Medivet welcomes the opportunity to respond to the CMA's Provisional Decision Report dated 15 October 2025 (the ***PDR***) in connection with its market investigation into the provision of Veterinary Services[1] to household pets in the UK (the ***Investigation***). Medivet's response is structured as follows:

(a) **Section B** sets out Medivet's views on the PDR's provisional finding of an adverse effect on competition (***AEC***) – also summarised at paragraph (3) below; and

(b) **Section C** sets out Medivet's overarching views on the package of provisional remedies proposed by the PDR and certain specific concerns relating to a sub-set of six remedies in relation to which Medivet has the greatest concerns – also summarised at paragraphs (4) and (5) below.

(2) At the outset, Medivet wishes to highlight that the PDR's description of Medivet as a 'Large Veterinary Group' (***LVG***)[2] is overly simplistic and therefore. There are a number of unique aspects of Medivet and its business model which distinguish it from the other LVGs and which the conclusions in the PDR do not fully recognise. Medivet stresses the importance of these unique aspects and urges the CMA to give them due recognition in its final report:

(a) **The PDR does not recognise Medivet's unique partnership business model**. Medivet operates a branch partnership model through which individual independent vets are co-owners in their clinic alongside Medivet. This is a fundamental and central element of Medivet's business strategy. Through this model, branch partners not only provide an excellent service to clients and their pets, but also influence various clinical and operational matters for their clinic. This model has been rolled out to approximately [redacted]% of the Medivet's First Option Practice (***FOP***)[3] estate (which in 2024 accounted for c. [redacted]% of Medivet clinic revenue). The number of FOPs with branch partners has increased by 8% since April 2024, with plans to expand the model to 100% of Medivet's full FOP estate by 2027. Given that this model already covers a large – and growing – proportion of Medivet's FOP estate, the PDR's simplistic characterisation of Medivet as an LVG is factually incorrect and misleading.

(b) **Medivet leads the market in already achieving high levels of transparency**. Medivet's business model and transparency practices are a blueprint for the PDR's remedy proposals:

(i) Medivet is fully transparent regarding its ownership of FOPs. Medivet operates all its brick-and-mortar services, communications and

[1] Defined in the PDR as services listed in the Terms of Reference for this Investigation.

[2] According to the PDR, LVG means any of the six largest veterinary groups in the UK: CVS Group plc, Independent Vetcare Limited, Linnaeus Veterinary Limited, Medivet, Pets at Home Group Plc, and VetPartners Limited.

[3] FOP means a general veterinary practice that provide primary care for pets. It is the first point of contact for pet owners and may refer more complex cases to an advanced practitioner, a specialist or referral centres when advanced care is needed.

digital presence under the single 'Medivet' brand (and has internal policies and guidelines to guarantee and maintain this approach);[4]

(ii) Medivet has pricing transparency, providing price information for common services. Medivet publishes: (i) practice level price lists for the most common products and services for dogs and cats (closely aligned with the PDR findings regarding the most common veterinary spend items); and (ii) out-of-hours services (***OOH***)[5] consultation fees at its 24-hour practices; and

(iii) Medivet has policies to ensure pet owners receive information to make informed decisions. Medivet operates an 'informed consent' policy, requiring its vets to: (i) provide pet owners with upfront estimates for treatment work following a consultation, and to seek re-approval if treatment price exceeds the written estimate; and (ii) provide a range of reasonable options, where relevant, in advance of proceeding with treatments, surgeries and diagnostics.

I. Medivet fundamentally disagrees with the PDR's AEC finding in relation to the retail supply of Veterinary Services by FOPs and considers that the PDR fails to make the case for an AEC

(3) In relation to the PDR's provisional conclusion of an AEC, Medivet makes the following points:

(a) **The PDR has found that high local concentration is not widespread enough to be a driver of price increases.** Accordingly, the PDR does not conclude that the presence of LVGs in local markets is driving weaker competition and rising prices.[6]

(b) **Furthermore, the PDR has not identified any evidence of market-wide supernormal profits; and its comparison of LVG vs. Independent prices is undermined by failing to compare like with like.**

(i) The PDR's provisional finding is that "*four of the six LVGs were making profits materially above their cost of capital*" which make up [redacted]% of overall market revenue.[7] As regards Independent Practices[8] (which make up 40% of the market),[9] the PDR notes that they achieved a wide range of earnings margins with no overall conclusion

[4] 76% of Medivet's clients could name Medivet when asked about their practice's ownership, which stands in stark contrast to the 9% to 26% awareness levels for clients of other major LVGs (Pet Owners Survey, Figure 35).

[5] According to the PDR, OOH means Veterinary Services provided at times when the Veterinary Practice (a business providing Veterinary Services) where the animal has been receiving treatment is closed.

[6] See PDR Part A, paragraph 6.9, which states that "*89% of FOPs are in local areas where there are at least four competitors, and for most areas (81%) there are five or more competitors*".

[7] See PDR Appendix C, paragraph 4.51.

[8] Defined in the PDR as a veterinary practice with one or more FOPs which is not part of a Large Veterinary Group.

[9] See PDR Part A, paragraph 16.43.

on profit levels. Even assuming that the PDR's provisional findings in this regard are accurate, the profit levels of four providers, whose FOPs represent less than half of those in the market[10] cannot be a solid evidential basis for a market-wide AEC finding.

(ii) One of the PDR's headline findings is that on average there is a 16.6% price difference between LVGs and Independents.[11] As Medivet has consistently raised to the CMA, this finding is entirely unreliable. It is undermined by the PDR's flawed economic analysis that fails adequately to control for fundamental differences in the services offered. Due to size, scale and investment, LVGs are capable of offering a much greater range of complex treatments and care, which Independents typically cannot. The PDR's economic analysis does not control for these differences, and therefore the PDR's price comparison between LVGs and Independents does not compare like with like and should be disregarded.

(c) **Instead, the PDR claims that prices have increased above general services inflation as the basis for finding an AEC. However, the PDR fails to justify why it has benchmarked prices against general services, rather than a more appropriate comparator, such as the UK healthcare sector**. When the PDR's claimed veterinary price rises are benchmarked against UK healthcare expenditure, the claimed prices are in fact comparable.

(d) **Furthermore, the PDR does not reflect the reality of how the market functions – it has not taken account of positive market developments in the past 18 months; and has instead based its AEC finding on a static and historic assessment of market conditions that no longer exist**. This is despite the CMA's own recent market research confirming a significant increase in price transparency that is inconsistent with a finding of an AEC. Moreover, in Medivet's case, even prior to the Investigation, Medivet has operated its estate under a single brand and has been consistently transparent about corporate links across all its services, and publicises price lists for core treatments on clinic websites.

(e) **The PDR's conclusions of an AEC also rely on the findings of the Pet Owners Survey,[12] which suffers from methodological and design limitations that significantly undermine its credibility and in any case is now outdated**. The PDR's provisional conclusions based on findings from the Pet Owners Survey are unreliable, and the PDR's selective use of datapoints risks being misleading. The PDR builds its case by mistaking subjective customer satisfaction for objective quality, while ignoring evidence showing that customers actively choose LVGs on the basis

[10] As per PDR Part A, Table 2.1.

[11] See PDR Part A, paragraph 7.4.

[12] The Pet Owners Survey in this response refers to the Vet Users Survey Final Report (and its annexes) commissioned by the CMA and produced by Accent, dated January 2025, available at: https://assets.publishing.service.gov.uk/media/67a3aae008d82b458c553ce8/Quant_Market_Research_Report__Accent.pdf.

of tangible benefits. In any case, given it was conducted in 2024, the Pet Owners Survey is now outdated and cannot be used to justify any finding of an AEC in 2026.

(f) **While the PDR acknowledges that Veterinary Services are inherently complex and the outcomes uncertain, it does not recognise the reality that these features also make pricing unpredictable and quality comparisons challenging.** Upfront pricing certainty is particularly difficult for inherently complex treatments and procedures but even impacts more straightforward treatments when unexpected complications arise. Quality comparisons are inherently challenging, particularly since the factors that each customer may use to assess quality – and the relative weight they place on each – vary considerably.

II. Medivet contends that implementing market-wide transparency of ownership is the key to addressing the CMA's purported concerns, but the PDR's proposed ownership transparency remedy (PDR R1) will fail to deliver real change due to the vague standard it imposes

(4) Medivet welcomes that the CMA has taken onboard stakeholder feedback and that the PDR's provisional remedy package no longer includes some of the more interventionist remedies, including in respect of medicine pricing and caps on medicine and cremation prices. In line with its consistent position throughout the Investigation, Medivet considers that transparency of ownership is key to addressing the CMA's purported concerns, but the proposed remedy falls materially short of what is necessary to be fully effective.

(5) **In particular, the proposed ownership transparency remedy (PDR R1) is inappropriately narrow, lacks sufficient prescriptive action and is at risk of easy circumvention.** For example, it needs to mandate clear and consistent co-branding across all client-facing assets in a manner that is objective and to a measurable standard. Medivet's proposed changes would help address its serious concerns that the provisional remedy risks easy circumvention and ineffective compliance monitoring due to the vague standard it imposes.

(6) If the ownership transparency requirements were more precise and subject to clearer implementation measures, **Medivet's firmly held view is that the remainder of the extensive remedy package would be largely redundant and the CMA could resolve the Investigation with fewer, less interventionist and burdensome market-wide remedies**. Nevertheless, should the CMA decide that some or even all of the other remedies set out in the PDR are necessary, Medivet makes the following points relating to a sub-set of remedies in relation to which Medivet has the greatest concerns:

(a) **PDR R2b: The proposed price lists remedy would not aid comparability of FOPs or treatments because, for most of the treatments, pricing relies on contextualised information that reflects pet-specific and case-specific circumstances. The remedy would in fact risk false comparisons between dissimilar services and would also be operationally unworkable**. To address Medivet's serious concerns that a price list would confuse or mislead pet owners, whilst also

risking a reduction in vets prioritising quality, any price list should (i) be reduced to a limited core set of treatments and services that are most commonly offered by FOPs market-wide and able to be provided on a standardised basis where price is less prone to pet-specific and case-specific circumstances; and (ii) in each case mandate a clear definition of what is included for such core set of treatments and services listed.[13]

(b) **PDR R3: The proposed enhancements to the *"Find a Vet"* platform represent a step towards an inappropriate commoditisation of veterinary care and suffer from the same concerns as expressed in paragraph (a) above.** Medivet has serious concerns that in addition to presenting potentially misleading, 'de-contextualised' data, this remedy would impose significant administrative burdens with far too short an implementation period. A better and more proportionate solution would be for the Royal College of Veterinary Surgeons (***RCVS***)[14] to update its platform in line with Medivet's proposals as outlined in paragraphs (69) to (71) below and Medivet's Response to the Remedies Working Paper.[15]

(c) **PDR R4: The proposed biennial vet survey would be unreliable and reflect an outdated snapshot in time with significant limitations for pet owners.** The proposed survey would be unreliable and likely incur disproportionate expense and resources. Displaying survey results at a nationwide LVG group-level and comparing these against a single generic 'Independents' group would not provide usable conclusions to inform a pet owner's choice of FOP at a local level.

(d) **PDR R7: The proposed oral reminder remedy for prescriptions will not be capable of being monitored, risks being detrimental to animal welfare and is unnecessary.** The PDR's objective is better achieved through the standardised signage or written material elements already proposed by Remedy 7, which Medivet fully endorses. These would address Medivet's serious concerns that an oral reminder in-consultation (and with every consultation) would create unmitigable risk of non-compliance and complaints for veterinary professionals because it is incapable of being policed and impossible to defend evidentially. Additionally, the proposed remedy will disrupt medical consultations by diverting focus from animal welfare and eroding the essential trust between a vet and their client.

(e) **PDR R10: The proposed default repeat prescriptions remedy is impractical and would be rendered unnecessary by standardised literature.** As proposed, the provisional remedy misunderstands the nature of how repeat prescriptions are issued and creates unnecessary

[13] As Medivet already proposed to the CMA in its Response to the Remedies Working Paper, Part B, Table 2, row 13 and its Response to the February Working Papers, page 63, paragraph 6.75 and footnote 135.

[14] RCVS means is the regulator for veterinary practitioners. It is also the accrediting body for veterinary education.

[15] Medivet's Response to Remedies Working Paper, paragraph 2.5(a).

administrative burden: the aim the remedy seeks to achieve would already be achieved by the written communications[16] remedy alone.

(7) Medivet is also concerned that, despite any package of remedies being targeted at LVGs and Independent Practices, **the ongoing day-to-day burden of implementing and complying with any remedies, and risks associated with failures to comply, will in fact be borne by individual vets** whose professional behaviour is already subject to regulatory obligations and professional duties focussed on animal welfare and fostering a relationship of trust with pet owners. It is imperative that in the CMA's final decision takes this into consideration when concluding on the scope of any remedy package.

(8) Finally, Medivet looks forward to continuing its positive engagement with the CMA throughout the remainder of its Investigation to assist it in concluding the Investigation with the right outcome, so that the sector can return to growth and investment whilst continuing to prioritise pet owners, pets and animal welfare.

[16] PDR Part B, Remedy 7.

B. THE CMA'S PROVISIONAL FINDINGS OF AN ADVERSE EFFECT ON COMPETITION

I. AEC in the market for the retail supply of Veterinary Services by FOPs

(9) Medivet fundamentally disagrees with the PDR's AEC finding in relation to the retail supply of Veterinary Services by FOPs and does not consider that the case for an AEC has been made. In particular, the PDR's findings suffer from the following critical shortcomings:

(a) **The PDR's finding of an AEC is not sufficiently substantiated by the evidence put forward** (see paragraphs (10) to (13) below). Notably, the PDR does not identify local concentration driving supernormal profits or otherwise identify market-wide evidence of supernormal profits.

(b) **The PDR's findings and supporting evidence do not contextualise claimed price increases and fail to take into account material market developments** that have taken place across the past 18 months that would already address, at least in part, any purported AEC (see paragraphs (14) to (24) below).

(c) **The PDR's use of certain datapoints as evidence for an AEC is, at times, misleading**. When interpreted plainly, these datapoints offer far less compelling support for any finding of an AEC or otherwise are indicative of conclusions that are contrary to those drawn in the PDR (see paragraph (25) below).

(d) **The PDR has not adequately considered the complexity and unpredictability of pricing and not made adequate allowance for the challenges in quantifying quality comparisons**, which are inherent features of providing Veterinary Services (see paragraphs (26) to (29) below).

The PDR's finding of an AEC is not sufficiently substantiated by the evidence put forward

The PDR does not identify local concentration driving supernormal profits or otherwise identify widespread evidence of supernormal profits and relies on problematic and flawed econometric analyses

(10) Medivet has previously noted a number of limitations with the local concentration, profitability and econometric analysis, which are not repeated here.[17] The implications of these limitations are that the analysis presented in the PDR is flawed, at times contradictory and incomplete. The evidence cannot support an AEC finding.

(11) Even when taken at face value, the PDR has clearly not identified consistent evidence of an AEC for the provision of FOPs.

[17] See, for example, Medivet's response to the CMA's *The impact of corporate acquisitions on treatment costs* paper (September 2025) and to the CMA's working paper on *Financial and Profitability Analysis* (May 2025).

(a) As the PDR concedes, there is little or no evidence of local concentration driving sustained supernormal profits in any market. The analysis in the PDR has identified that 89% of FOPs are in local areas where there are at least four competitors, and for most areas (81%) there are five or more competitors. There is therefore ample choice for consumers in the vast majority of local areas. The PDR itself notes that, as concentration is not widespread, it is not a driver of price increases.[18]

(b) The information presented in the PDR correctly identifies that there is a wide range of profitability outcomes across the sector, and that therefore there is no widespread evidence of supernormal profits in the market. There is no consistent evidence of sustained supernormal profits across LVGs, with two out of six LVGs identified as not achieving supernormal profits.[19] [redacted][20] For Independent Practices, the PDR has identified a wide range of EBIT margins, ranging from 9% to 34%, with a weighted average EBIT margin of 11%. This compares to a weighted average EBIT margin for LVGs of 14%, only slightly higher.[21] Taking these findings together, the PDR has only been able to identify supernormal profits for providers accounting for [redacted]% of the market. It is then clear that these profitability outcomes do not provide evidential basis for a market-wide AEC.

(c) It should be clear that referring to the profit levels for a handful of more profitable providers – whose clinics represent less than half of the FOPs in the market – cannot be a solid basis to conclude that there is a detriment for the market overall. Doing so (as the PDR does) casts significant doubts on the PDR's related claim that LVGs have earnt economic profits of £1 billion over the last five years – which Medivet fundamentally disagrees with. Moreover, the figure is clearly imprecise and sensitive to the assumptions made. The sensitivity analysis presented in Annex C of the PDR shows that the figure is highly sensitive to alternative assumptions and does not consider the cumulative impact of applying all sensitivities together. It may well be that the correct measure of aggregate profits is much lower. This uncertainty needs to be considered in the proportionality assessment of the remedy package, as noted in Section C below.

(d) As noted above, Medivet has previously raised that the econometric analysis is flawed and its evidence is not conclusive. The analysis of price differentials between LVGs and independents through cross-sectional regressions is evidently weak and should be disregarded entirely. The claim of an average price difference of 16.6% estimated between LVGs and independents is not meaningful or reliable, as it cannot control for differences in quality and treatment complexity across providers. The fact that the PDR's analysis does not adequately control for these substantive

[18] PDR Part A, paragraph 6.9 and 6.10.

[19] PDR Part A, Table 7.1.

[20] PDR Part A, paragraphs 7.56 to 7.57.

[21] PDR Part A, paragraph 7.62.

differences means that it does not compare like with like. As a result, the PDR's claim of price differences is undermined and should be disregarded.

(e) Even the PDR's more sophisticated difference-in-difference analysis is far from conclusive. It yields no robust econometric evidence of the impact of corporate acquisition on the cost paid by consumers for treatment, either for Medivet or the market as a whole. The evidence has not been assessed and presented holistically or consistently. Indeed, findings relating to first-year treatment costs, arguably the most relevant pricing variable, do not identify any such causal effect in relation to Medivet.

(f) Compared to interim versions of the analysis in CMA working papers, the PDR no longer argues that LVGs earn higher margins on veterinary medicines relative to Independent Practices, or that an increase in medicine prices beyond services price inflation indicates an AEC. While its provisional view remains that competition between FOPs and online retailers is restricted, the PDR acknowledges that this could nevertheless be consistent with outcomes expected in a well-functioning market (***WFM***), particularly given that its survey results show many pet owners view purchasing medicines directly from their vet as the most convenient and preferred option.

(g) Finally, the PDR's evidence on the margins associated with cremations is imprecise and is based on very high-level approximations of the costs that LVGs incur as part of supporting owners through cremations.

(12) The PDR seeks to dismiss the importance of LVG investment as a relevant driver of prices by noting that it was unclear *"the exact mechanism by which LVG investments in quality would lead to price rises,"* and that no LVG provided evidence that *"clearly linked price setting decisions to investments in quality"*. However, this suffers from a number of shortcomings.

(a) Documentary evidence is not needed to support a statement that quality investments could lead to price increases. In the case of Medivet, Medivet adjusts its prices at a local level to account for local demand and supply conditions.[22] Costs will vary materially across locations for various reasons even for comparable levels of quality (e.g., rental, labour, business rates). Investments to improve quality will be taken into consideration when Medivet sets prices, however, prices will not always respond immediately or proportionately to quality investment at all locations. If this were the case, i.e., if Medivet were simply able to increase local prices at-will to recoup a local investment expenditure, this would suggest a level of unilateral price-setting power not consistent with a competitive market. Moreover, investment in quality / capability may also be reflected in higher volumes which are attracted by additional offering, and not simply price increases.

(b) Contrary to the PDR's findings, there is indeed evidence of accrued differences in quality across sites resulting in price differentials. For example, [redacted]

[22] Medivet's response to RFI 1, Questions 8 and 10.

[redacted][23]

(13) In addition, the PDR suggests that, because of limited pricing pressure from customers and insurers, LVGs are able to charge prices materially above costs (and beyond what could be justified by quality-related investments). This reasoning, however, cannot be applied to Medivet, [redacted].[24] There is therefore no evidence that Medivet's price increases are inconsistent with its investment in quality; or with what would be expected in a WFM.

The PDR's findings and supporting evidence do not contextualise claimed price increases and fail to take into account material market developments

The PDR's claimed price increases in fact appear to be in line with other comparable sectors

(14) The PDR's reference to general service inflation as a price benchmark for veterinary pricing is not appropriate, and the PDR still has not explained why veterinary prices should change in line with inflation.[25] Medivet submits that any purported price rises in the veterinary sector are in line with the broader healthcare industry in the UK. An analysis of the Office for National Statistics' data shows that total UK healthcare expenditure rose by 55% between 2016[26] and 2023,[27] with this trajectory projected to surpass a 65% increase in 2024.[28] Increased costs likely explain a significant portion of this increase. The PDR's finding that prices in the veterinary sector rose by 63% is therefore not an anomaly driven by a lack of competition, but could in fact be reflective of similar levels of cost pressures inherent to comparable healthcare industries. Further, the PDR uses a broad 'general services' benchmark which encompasses a wide and diverse range of sectors, many of which will have exhibited very different changes in cost and demand drivers over the past decade; the PDR does not explain why the Consumer Price Index measure of inflation is the most appropriate benchmark to adopt when seeking to support its AEC finding, rather than a more comparable sector such as

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23 [redacted]

24 PDR Part A, paragraph 7.8.

25 As Medivet already submitted in Medivet's Response to February Working Papers, paragraph 6.49.

26 In 2016, UK healthcare expenditure was officially reported to be £191.7bn (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/ukhealthaccounts/2016).

27 In 2023, UK healthcare expenditure was officially reported to be £298bn (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/ukhealthaccounts/2023and2024).

28 Provisional estimates indicate that nominal UK healthcare expenditure was approximately £317 billion in 2024 (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/ukhealthaccounts/2023and2024). The official ONS data for total UK healthcare expenditure for 2024 has not been published yet.

healthcare, whose similar price rises would support a more accurate finding that input cost pressures have contributed to any increasing consumer prices.

(15) Any industry-wide price increases have, per the PDR profitability assessment, not translated into consistent, market-wide supernormal profits. As noted above, the PDR profitability assessment did not identify any supernormal profitability for veterinary businesses representing over half of FOPs in the veterinary sector.[29] This shows that rising prices cannot simply be assumed to be caused by a non-competitive market delivering supernormal profits. This does not preclude that prices are in fact a function of the sector's high operational costs and investment needs.

The provisional conclusions in the PDR do not reflect the reality of how the Veterinary Services market functions

The PDR does not account for differences between LVGs or market developments.

(16) As Medivet highlights at paragraph (2) above, the PDR does not acknowledge the material differences that exist between LVG business models and how these differences impact the relevance of any AEC to a particular LVG. In Medivet's case, even prior to the Investigation, Medivet has operated its estate under a single brand and has been consistently transparent about corporate links across all its services. Medivet has also included transparent price lists for core treatments on clinic websites. The PDR's finding of an AEC based on a lack of ownership and/or price transparency are therefore not relevant to Medivet's business model or practices.

(17) Medivet also observes that the CMA's refreshed website review in May and June 2025 clearly indicates a significant positive shift in pricing transparency elsewhere in the market that is inconsistent with a finding of an AEC. The PDR notes a "*significant increase in the provision of prices on FOP websites,*" with 60% (i.e., the majority) of FOPs in May and June 2025 displaying pricing information online, up from 14% in February and March 2024.[30] Amongst the LVGs, the change has been even greater, increasing from 13% in February and March 2024 to 68% in May and June 2025.[31] It is therefore imperative that the final report's assessment of the market, and the presence of any purported AEC and remedies proposed as a result of it, reflects the differences between LVGs and the conditions of the market as it functions today.

The PDR relies on the Pet Owners Survey to support its finding of an AEC, which suffers from severe methodological limitations

(18) The methodology applied in commissioning the Pet Owners Survey results in a significant risk of selection sample bias. This is for two primary reasons:

(a) **The Pet Owners Survey uses internet-only sampling to source respondents, which introduces selection bias**. Online respondents are likely to be more interested in the survey's topic and have higher internet

[29] Based on market shares in PDR Part A, Table 2.1, [redacted].

[30] PDR Part A, paragraph 8.24 and Table 8.2.

[31] PDR Part A, Table 8.2.

literacy, making them overrepresented. This method underrepresents, for example, both pet owners who lack internet access or comfort, including vulnerable consumers, and those indifferent to Veterinary Services.

(b) **The Pet Owners Survey offered a financial incentive for pet owners to complete it**. Such financial inducements (such as the £10 voucher offered to respondents of the Pet Owners Survey) introduce selection bias that risks undermining the representative value of the sample. Respondents were therefore incentivised to complete the Pet Owners Survey to receive the financial incentive, even if they had not visited a vet.

(19) Taken together, it is not at all clear that respondents would be representative of approximately 30 million UK pet owners as a whole, and the methodology undermines both the results of the Pet Owners Survey and any conclusions that may be drawn from it.

The Pet Owners Survey is poorly designed, limiting any conclusions which can be drawn from it

(20) The design of the Pet Owners Survey further undermines the reliability of any conclusions which can be drawn from it:

(a) **Respondents' perceptions had already been influenced by the CMA by the time the survey was launched**. The Pet Owners Survey took place in November and December 2024, several months after the CMA's sector review and initial concerns were publicised.[32] [33] This likely affected consumer views of LVG clinics – especially those openly LVG-owned, like Medivet – and possibly also those where ownership status was unclear.

(b) **The completion rate was very low**. Even among the respondents potentially interested in completing the survey, (i) 794 only clicked the link; (ii) 316 dropped out over the course of the survey; and (iii) 777 had to be excluded as ineligible.[34] Therefore, of the 4,263 individuals who were interested in responding,[35] almost 50% of interested respondents did not proceed – only the most motivated completed the survey, further compounding the selection bias issues outlined at paragraph (18) above.

(c) **Self-reported 'awareness' is not reliable**. The Pet Owner Survey and PDR separate customers by their *'awareness'* of LVG ownership, but this measure is self-reported and often inaccurate. Respondents may guess or

[32] The CMA launched its review with a call for information, published on 7 September 2023 (https://www.gov.uk/government/news/cma-launches-review-of-vet-sector). The CMA referred the supply of Veterinary Services for household pets in the United Kingdom for a market investigation on 23 May 2024 (https://www.gov.uk/government/news/cma-presses-ahead-with-full-investigation-into-vets-market).

[33] See, for example, the Board Advisory Steer dated 23 May 2024 (https://assets.publishing.service.gov.uk/media/664df56fae748c43d3794062/Board_Advisory_Steer.pdf), the CMA Issues Statement dated 9 July 2024 (https://assets.publishing.service.gov.uk/media/668cc8b84a94d44125d9cece/Issues_Statement.pdf) and the *"Vets Market Investigation frequently asked questions"* video published on 9 July 2024 (https://www.youtube.com/watch?v=aloKktQO4z0&embeds_referring_euri=https%3A%2F%2Fwww.gov.uk%2F&embeds_referring_origin=https%3A%2F%2Fwww.gov.uk).

[34] Pet Owners Survey, page 9.

[35] The 3,469 individuals who entered the survey and the 794 who clicked the link.

misclassify ownership. The reliability of any Pet Owner Survey findings should be caveated accordingly.

(d) **Confounding factors introduce further unreliability**. Further to the 'awareness' limitations outlined above, there may also be underlying differences between customers of LVGs who are unaware vs. those who are aware that they are attending an LVG. These underlying factors could confound with differences in factors such as client demographics or frequency of vet visits. The PDR cannot draw firm conclusions unless it can be shown that these factors have been controlled for and that awareness of LVG ownership is the only difference between the groups being compared.

(e) **The Pet Owners Survey is now in any event outdated**. Given its methodological issues and the fact that it was conducted in late 2024, it should not be used to support an AEC finding in 2026. The PDR's provisional conclusions rely heavily on this survey, which fails to consider market changes already acknowledged by the CMA Chair in March 2025[36] – such as increased online pricing by vet businesses, new transparency guidelines from the BVA, and RCVS initiatives. If the PDR had used an updated survey that addressed these flaws, the findings would likely differ and offer even less evidence of any AEC.

The provisional conclusion of an AEC is overstated, given its reliance on Pet Owners Survey results that the PDR concedes are not statistically significant

(21) **The Pet Owners Survey produced results which the PDR itself concedes were not statistically significant but which, despite this, are treated as fact by the PDR**. For example, the PDR is quite firm in its conclusion that clients at Independent Practices are more satisfied across all four attributes of quality[37] compared to clients who are unaware that they attend an LVG.[38] This provisional conclusion is, however, predicated on results where each attribute of quality failed to reach statistical significance on an individual basis. Far from being a firm conclusion, it suggests that any differences are likely to be small and inconsistent; the evidence of any systematic difference in perceived quality therefore appears, at best, weak and uncertain.

(22) **Even if the Pet Owners Survey results were reliable (*quod non*), the PDR does not accurately apply the results in supporting its provisional conclusions**. The PDR's assertion that lower satisfaction at LVGs proves that their price levels do not reflect higher quality[39] is unsubstantiated for two reasons:

(a) First, the PDR concedes that, when quality metrics are examined individually, the differences in satisfaction are not statistically significant.[40] In any event, the Pet Owners Survey included only 158 respondents who

[36] https://www.gov.uk/government/speeches/vets-market-investigation-an-update-from-the-inquiry-chair.

[37] The attributes being: quality of information and advice; the quality of service; the outcome of their visit; and the cost of service. See PDR Part A, paragraph 7.73.

[38] See PDR Part A, paragraph 7.73.

[39] See PDR Part A, paragraph 7.70 and Pet Owners Survey, Question 55b.

[40] PDR Part A, footnote 281.

were customers of Medivet clinics. This sample size is very limited and indicates that Medivet has been systematically under-represented.

(b) Second, the PDR seeks to reach market-wide conclusions based on the CMA's interpretations of the results of the pet owners survey – which sampled feedback from only 2,376 respondents representing less than 0.02% of UK pet-owning households.[41] A sample of this size cannot support market-wide AEC findings due to its minimal scale and potential selection bias, as noted in paragraph (18) above. Additionally, for the reasons at paragraph (18) above, any finding of an AEC that relies on the Pet Owners Survey results are statistically unfounded insofar as it relates to Medivet's FOP clinics.

(23) **Beyond its minimal sample size, the PDR conflates customer satisfaction with clinical quality**. The PDR uses subjective pet owner ratings like "*quality of services*" and "*outcome of visit*",[42] rather than objective measures of quality and care. As these impressions do not reliably reflect clinical standards or expertise, the PDR relies on non-expert opinions to draw conclusions on a subject it concedes cannot be properly measured without professional expertise.[43]

(24) **This flawed analysis is compounded by the PDR's decision to ignore what its own survey shows: that pet owners actively choose LVGs for a range of tangible benefits**, including easier access to appointment (55%) and a wider range of services (42%).[44] These are two critical elements of the customer experience that the PDR disregards. First, it confirms the value of an operational scale that reduces wait times and provides more timely care for a sick pet. Second, it validates the direct benefit of investment in advanced diagnostics and in-house specialisms. The PDR is therefore measuring perceived dissatisfaction on certain narrow metrics (which, as noted above, it fails to show to any statistically significant extent on any single datapoint) while ignoring other drivers of choice and satisfaction that the Pet Owner Survey confirms are valued by customers.

The PDR's use of certain datapoints as evidence for an AEC is, at times, misleading

The provisional conclusions in the PDR rely on only selective Pet Owners Survey findings which, when read plainly, would not in fact support such conclusions

(25) Medivet maintains that the Pet Owners Survey is poorly designed and unreliable. Even if accurate, the survey data does not support an AEC finding under the CMA's criteria. Some datapoints cited in the PDR, based on the CMA analysis, are misleading and suggest conclusions that are contrary to those drawn in the PDR. Key examples of survey statistics contradicting the PDR findings include:

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41 Pet Owners Survey.

42 PDR Part A, Table 7.3.

43 See PDR Part A, paragraph 8.54 which states: *"[…] even in a well-functioning market, it is likely to be inherently difficult for pet owners to assess aspects of quality of clinical care, even in retrospect"*.

44 See https://assets.publishing.service.gov.uk/media/67a3aae008d82b458c553ce8/Quant_Market_Research_Report___Accent.pdf, Question 23.

(a) **Price is not the dominant driver of demand**. For FOP services, only 25% of respondents, compared to 68% for convenience / location and 44% for trust / recommendation.[45] For veterinary medicines, only 3% cited price as the primary reason for purchasing medicines from a vet instead of third-party retailer; most prioritise convenience (50%) and trust in care and medication reliability (36%).[46]

(b) **Most pet owners are aware that they can purchase medications elsewhere**. 57% of pet owners know this, with over a third being informed by their vet.[47] 26% already purchase repeat medication online.[48]

(c) **LVGs already provide pricing information**. 82% of pricing information available to consumers was sourced through the vet practice, with LVGs doing so significantly more than independents (81% vs 69%).[49]

(d) **Most pet owners agree that their vets clearly communicate treatment options**. 82% agreed that their vet took time to explain various treatments, and 83% confirm that they understand the options presented to them and can make informed decisions.[50]

(e) **Pet owners reported they felt free to switch**. The vast majority of pet owners (85%) already feel empowered to change practices if they wish.[51]

(f) **No clear conclusions on drivers of pet owner choices relating to pet cremations**. While 88% of pet owners did not compare cremation providers, the CMA's own data on cremation choices is inconclusive by design. It combines those who opted not to compare with those lacking the opportunity into a single 38% figure. Therefore, it is impossible to determine whether this behaviour reflects any market failure or simply the consumer preference.[52]

(g) **Client satisfaction with LVGs is overwhelmingly positive for core Veterinary Services**. 86% for pet care, 83% for service quality, and 81% for visit outcomes.[53]

The PDR has not adequately considered the complexity and unpredictability of pricing and not made adequate allowance for the challenges in quantifying quality comparisons

(26) The PDR itself recognises that there are certain inherent features of the market that impact supply of Veterinary Services to household pets by FOPs, including *"the*

45 Pet Owners Survey, Figure 21.

46 Pet Owners Survey, Table 15.

47 Pet Owners Survey, Figures 89 and 90.

48 Pet Owners Survey, Figure 93.

49 Pet Owners Survey, Table 8 and Figure 23.

50 Pet Owners Survey, Figure 36.

51 Pet Owners Survey, Figure 29.

52 Pet Owners Survey, Figure 100.

53 Pet Owners Survey, Page 48.

complexity of many Veterinary Services", the *"uncertainty in vet care"* both about what treatments are needed and their outcomes, the *"expertise and advice"* needed for diagnoses, treatments, referrals and prescriptions, and the *"highly sophisticated"* nature of treatments now available.[54]

(27) Based on these inherent market features, contrary to the PDR's assertion, challenges with pricing accurately in advance are to a large extent also an inherent market feature. Those same features are also inherent in other retail services (such as private dental or medical services) that pet owners are familiar with, and similarly for which prices are not typically set up front.

(a) **Price uncertainty is largely inherent in complex, unpredictable Veterinary Services**: Where Veterinary Services are complex and unpredictable, it is also inherently the case that pricing will reflect this, and it will be inherently challenging to consistently provide predictable pricing upfront.[55] Such information is only feasible for a subset of the simpler treatments offered by veterinarians. It is not feasible for the wide spectrum of Veterinary Services that are highly complex and sophisticated, involve a high degree of uncertainty, and require ongoing expertise and advice – also often requiring reactive and adaptive approaches to the developing health condition of an individual pet over time.

(b) **Price uncertainty is similarly inherent in comparable retail services**: Pet owners are likely also customers of other retail services that share the same inherent features, and it is no surprise that these are services for which upfront price lists are not a prevalent market practice. For example, private dental or medical services where, other than for core services, prices are typically not provided upfront – rather, prices are estimated and only after treatments are concluded, taking account of the actual combination of services provided in a particular case, can prices be confirmed.[56]

(28) In respect of comparing quality, in line with Medivet's Response to February Working Papers, Medivet submits that there is an inherent challenge in quantifying and comparing levels of quality. This challenge is due to the features the PDR recognises as inherent – i.e., complexity, uncertainty and expertise. This challenge is also due to the fact that the factors that customers use to assess quality – and the relative weight they place on each – vary considerably between customers.

(29) While there is scope for market-wide price and quality transparency improvements, given the inherent nature of these complexities, any CMA transparency remedies can only go so far. The PDR itself notes that certain inherent features can be expected even in a WFM[57] – and Medivet would submit that notwithstanding these inherent features, competition (in price or quality) does work well. In Medivet's experience, customers do perceive quality and value for money of the services they

[54] PDR Part A, paragraph 16.14(a).

[55] PDR Part A, paragraph 16.14(b)(ii).

[56] The same features are inherent in e.g., auto repairs and home renovations – where work is typically agreed and commenced based on an estimate, rather than a fixed upfront price (which, even then, remain subject to updates depending on unforeseen complications / additional labour).

[57] PDR Part A, footnote 1614.

receive, and the effect of this accrues over time in brand value / word of mouth. This is essential to success in this market.

II. AEC in the market for outsourced OOH provisions to FOPs

(30) Given that Medivet does not use long-term contracts to provide OOH services to FOPs, Medivet has no material views on the PDR's findings of an AEC, save to note that, as a customer of OOH services, Medivet has experiences of OOH service providers using long notice periods and high termination fees as a method of imposing long-term contracts for the provision of OOH services, which the PDR highlights.[58] Medivet notes that such practices can inhibit switching and thereby create barriers to entry and expansion for alternative OOH providers which ultimately limits OOH service provider choices for FOPs across the market.

(31) Accordingly, in its capacity as a customer of OOH services, Medivet endorses the PDR's proposed Remedy 12 to create a more competitive and dynamic market for OOH services.

[58] PDR Part A, paragraph 12.56.

C. PROVISIONAL REMEDY PACKAGE

I. Medivet's overarching comments on the remedy package

(32) Medivet welcomes the upcoming conclusion of the Investigation next year and is keen to re-focus management and veterinary attention on best serving clients and their pets after nearly two years of CMA engagement.

(33) Medivet does, however, note that, prior to the CMA launching its Investigation, the LVGs collectively reached out proactively to the CMA in February 2024 with an offer of a range of remedy proposals to which the LVGs were willing to commit, to avoid a market-wide investigation. The proposals the LVGs offered to the CMA at that time included commitments relating to (among others):

(a) increased transparency of ownership for those LVGs (unlike Medivet) not already single-branded;

(b) increased pricing transparency;

(c) increased awareness of purchasing medicines online; and

(d) improved presentation of treatment options with price estimates.

(34) Medivet notes that the CMA chose not to take up the offer and instead launched a lengthy and intensive market-wide investigation, which has had an extremely negative impact on veterinary surgeon and staff morale and public sentiment towards the sector. This is a particular disappointment as many of the provisional remedies outlined in the PDR are effectively iterations on the commitments offered by the LVGs. Had the CMA opted to engage with the LVGs on those commitments in February 2024, Medivet considers that any remedy discussions and implementation could have been materially accelerated and the need for a market investigation and the associated negative impact could even have been avoided.

(35) Nevertheless, Medivet reiterates its readiness to assist the CMA to ensure that any remedies strike the right balance of effectively addressing the CMA's concerns while being proportionate and capable of implementation swiftly, simply and unambiguously so that the sector can return to focusing on patient care, investment and growth.

(36) Medivet also welcomes that the CMA has taken onboard stakeholder feedback on some of the more interventionist and practically challenging remedies that were contemplated in the CMA's Remedies Working Paper, for example in respect of medicines pricing. Nevertheless, while the package of provisional remedies set out in the PDR is overall narrower than that in the Remedies Working Paper, Medivet remains concerned that the remedy package goes too far and that several remedies are unnecessary, disproportionate, or otherwise risk failing to be effective.

(37) Medivet provides the following overarching comments on the package of remedies set out in the PDR:

(a) **Transparency of ownership**. As already set out in Medivet's Response to the Remedies Working Paper, Medivet is of the view that **the most important remedy which would resolve the root cause of the CMA's**

purported concerns is to increase transparency of ownership. That being so, Medivet is concerned that **the PDR's proposed version of this remedy falls materially short of what is necessary to be fully effective**. Medivet provides more detail on its view, and its suggestions of how to enhance the remedy proposal, at paragraphs (44) to (49) below.

(b) **Other provisional remedies**. Conversely Medivet has concerns that the other provisional remedies in the PDR are:

(i) not proportionate to the purported AEC, not least given the market shifts Medivet has already witnessed and the PDR itself has acknowledged since the beginning of the Investigation (as already mentioned above at paragraph (9));

(ii) unlikely to be effective in practice in achieving the stated aim; and

(iii) not capable of implementation in the manner or timeframe the CMA has proposed.

(38) **As a result, if the transparency of ownership remedy is made more effective, Medivet considers that the remainder of the extensive remedy package would be largely redundant.** Nevertheless, should the CMA decide that some of them are appropriate, Medivet sets out below its views and proposals for the enhancement of certain of these remedies:

(a) **The 48-item price list**: paragraphs (50) to (61) below;

(b) **The enhanced "*Find a Vet*" platform**: paragraphs (62) to (72) below;

(c) **The biennial vet survey**: paragraphs (73) to (81) below;

(d) **The oral reminder of written prescription rights**: paragraphs (82) to (87) below; and

(e) **Repeat prescriptions**: paragraphs (88) to (93) below.

(39) **Taken as a whole, the provisional remedy package proposed by the PDR is unjustified and overly burdensome**. Medivet remains concerned that requiring implementation of a full package of 16 multi-part remedies is disproportionate, more so given that the evidence does not support the PDR's conclusion of an AEC. The overall package of proposed remedies, when considered together, amounts to a very significant set of changes which would impose a huge burden and cost on all Veterinary Practices across the sector.

(40) Moreover, Medivet is concerned that the PDR has not properly considered the significant pressure that its provisional implementation timelines would impose on veterinary businesses, and individual vets in particular, when many of the remedies would need to be implemented along concurrent timeframes (in most cases, three months for LVGs / six months for independents). The need to implement the full package of proposed remedies concurrently within a three-month period would involve a significant transformation project, requiring veterinary businesses sector-wide to divert their organisational resources, which will likely already have been allocated to other important projects. In Medivet's case, there is already a pipeline

of [redacted]
Moreover, Medivet's experience is that, in reality, [redacted]

(41) Medivet is also concerned that the PDR's estimates of the costs of implementing the remedies are a material underestimate. As a package, implementation would require the allocation of significant resources and increased workload on vets, given (among other things):

(a) the reality that the concurrent implementation of all proposed remedies would necessitate a major IT systems overhaul, requiring a minimum six-month cycle for design, testing, and safe implementation across the entire estate. This process cannot be rushed – any changes to Medivet's proprietary Freedom PMS must be coordinated with other existing business-critical projects, and meticulously planned and tested to avoid any risk to patient care;

(b) the need to carefully design, rollout and test compliance measures to a large number of sites;[59] and

(c) the need to update policies and employee training materials, including guides, videos, and live sessions delivered to 3,200 partners and staff across hundreds of clinics.[60] Medivet's response to RFI 13 confirms that [redacted]. Any new, mandatory administrative training program would therefore represent a material and unbudgeted financial burden, diverting significant resources directly from patient care and other clinical investments.

(42) As noted at paragraph (7) above, even though any package of remedies imposed by the CMA would be targeted at LVGs and Independent Practices, in reality the ongoing day-to-day burden of implementing and complying with many of the remedies on an ongoing basis will in fact be borne by individual vets and Medivet's branch partners. These vets are regulated professionals who are already subject to robust and stringent regulatory obligations and professional duties. Medivet is therefore very concerned that the burden of a CMA remedy package may risk overwhelming existing vets, and disincentivising entry into the profession by adding burdensome 'red tape'. It is also the case that individual vets would become

[59] Medivet's response to RFI 4, Column A shows 374 sites.

[60] Medivet's response to RFI 13, Question 15 confirms that Medivet has trained 5,805 clinic colleagues between FY22 and November 2024.

subject to the additional risk associated with failures to comply with those remedies that require actions to be taken by individual vets.

(43) Medivet therefore urges the CMA in its final decision to take into consideration the long-lasting day-to-day impact of any remedy package on individual vets.

II. Specific remedies

R1: Ownership transparency – the PDR's proposal lacks sufficient prescriptive action, whereas if the remedy were properly implemented market-wide, it would be the solution to the PDR's purported concerns and avoid the need for an extensive package of remedies

Substantive concern

(44) Transparency of ownership of service providers is the core of a well-functioning retail market. Medivet's concerns with the PDR's ownership transparency remedy are that: (i) it does not go far enough to achieve the CMA's objectives; and (ii) without more precise ownership transparency requirements, many of the remedies in the PDR's proposed package (regardless of how laudable their aims may be) would fail to be effective. In particular, without transparent business ownership, the PDR's provisional remedies designed to encourage and facilitate customer switching (including, e.g., remedies 2a to 4, 7 and 13) would not result in actual switching taking place between distinct suppliers if, unbeknown to the consumer, the switching only occurs internally between different branches or services operated by the same LVG.

(45) By contrast, Medivet submits that if the ownership transparency requirements imposed by the CMA were more precise, the extensive package of remedies would largely be redundant and the CMA could accordingly resolve the Investigation with fewer, less interventionist and burdensome remedies. This is because, once ownership is transparent:

(a) **Choice of FOP**. Clients would become aware of their FOP's corporate ownership and make FOP choices accordingly. Medivet is aware that (unlike Medivet's single-branded approach) some LVGs' strategies involve retaining the independent branding of a FOP clinic after having acquired it, rather than rolling out the LVG's corporate branding, which is a strategy that risks misleading the FOP's customers as to its true corporate ownership.

(b) **Choice of referral / specialist / OOH provider**. Pet owners would be aware when a vet's recommendation for e.g., a referral, a specialist treatment, or an OOH provider is in fact to a service provider within the same corporate group, and accordingly would recognise such a recommendation may be influenced by commercial incentive. As the CMA would itself recognise, pet owners would then have the option to check for alternatives outside the LVG in question, if they so wished.

(c) **Choice of medicines**. The same is true for vet recommendations of own brand medicines or recommendations to purchase medicines from an online pharmacy operated by the same LVG. Again, as the CMA would itself recognise, clients would become aware of the potential conflict of interest

in such recommendations and would have the option to check externally for genuine alternatives.

Concern with the CMA's proposed implementation

(46) The PDR provisional remedy mandates veterinary businesses to *"clearly"* and *"prominently"* disclose common ownership or control.[61] However, in Medivet's view, this proposal is ineffective because:

(a) **Vague standard and insufficient clarity**. *"Prominently"* is a subjective and vague standard and is insufficiently clear or prescriptive to ensure ownership transparency or measure compliance against.

(b) **At risk of easy circumvention**. It would allow LVGs to be in technical compliance with the remedy with only minimal efforts and not truly in the spirit of the requirement (e.g., implementing a pictorial logo, without wording, embedded in a website header may arguably meet the requisite remedy standard). This creates a box-ticking exercise where LVGs can effectively continue operating behind the veil of local clinic names.

(c) **Risk of ineffective compliance monitoring**. The remedy only appears to require attestations and spot checks to monitor compliance, which are insufficient to ensure comprehensive uptake and compliance.

(47) This lack of clear prescriptive direction sits in contrast to other PDR transparency-related provisional remedies where the CMA has provided significantly more direction on what compliance should look like: (i) easily accessible website placements for price lists *"a maximum of one click from the homepage"* / *"without scrolling"* / *"using* 'price*', '*pricing*' or '*fees*' in page navigation and page metadata"*;[62] (ii) waiting room signage featuring *"a clear, bold heading highlighting the potential savings from going online"* and *"succinct text explaining the process and how quickly a prescription will be issued"*;[63] and (iii) prescription reminders in font *"no smaller than 12pt."* on invoices / receipts *"stating that written prescriptions are available on request and the cost of getting such a prescription"*.[64]

Medivet's suggestion

(48) In order to properly implement ownership transparency market-wide, Medivet would urge the CMA to mandate clear and consistent co-branding across all client-facing assets in a manner that is objective and to a measurable standard.

(a) **Consistent naming protocol**. As proposed in Medivet's Response to the Remedies Working Paper, Medivet suggests strengthening the remedy to require LVG FOPs and all associated businesses to state the name of the veterinary group in the name of the practice, *"practice [X]: part of the [Y] group"* or as a subtitle to the name of practice, in a format such as *"practice [X]: a [Y] practice".* The PDR recognises this requirement as an *example* of

[61] PDR Part B, paragraph 3.9.

[62] PDR Part B, paragraph 3.65(a).

[63] PDR Part B, paragraph 5.26.

[64] PDR Part B, paragraph 5.32.

how to achieve ownership transparency, but should be prescriptive in mandating such transparent naming protocols.[65]

(b) **Comprehensive usage**. This naming format should (i) extend across all services (including OOH providers, referral centres, crematoria, online pharmacies and other associated businesses); and (ii) be displayed on all media and marketing materials, client communications (including invoices, estimates and leaflets), client digital experience and brick-and-mortar sites (including signage both inside and outside brick-and-mortar practices and on staff uniforms).

(c) **Minimum visibility**. The CMA should prescribe certain minimum font size requirements and locations for each media format, e.g., for signage, written materials etc.

(d) **Evidenced compliance**. The CMA should require express confirmation of compliance, with accompanying evidence, that demonstrates how branding is compliant with the prescribed requirements across all materials, online / in-clinic / literature – with such confirmations due at the end of the specified implementation period and ongoing spot checks thereafter.

(49) As stated above, if the ownership transparency requirements imposed by the CMA were more precise, the extensive package of remedies would largely be redundant. Nevertheless, should the CMA decide that some or even all of the other remedies set out in the PDR are appropriate, Medivet sets out the following feedback on specific remedy proposals that pose the greatest concern.

R2b: Standardised price list – would not aid comparability of FOPs or treatments; would risk false comparisons; and would be operationally unworkable

(50) Medivet restates its position that, whilst supportive of price transparency in principle, a 48-item price list would be operationally unworkable and risk unintended adverse consequences.[66]

Substantive concern

(51) For the reasons already provided at paragraph (27) above in relation to inherent features of complexity and uncertainty, veterinary treatments and/or procedures cannot be regarded as discrete commodities capable of pricing accurately in advance in the form of a published price list.

(52) **Too many uncontrolled variables**. The PDR's remedy ignores critical variables that could impact the cost of even relatively simple treatments. The PDR concedes that separate price lists are needed for different animal categories (*"cat, small dog (0-20kg), medium dog (20-40kg) and large dog (>40kg)"*) and that additional charges may need to be *"listed separately or highlighted in free text"*.[67] However, there are other determining factors which impact prices in reality, such as breed and age of the pet; even leaving aside quality differentials driven by the level of

[65] PDR Part B, paragraphs 3.25 to 3.26.

[66] Medivet's Response to Remedies Working Paper, row 3, page 43.

[67] PDR Part B, paragraphs 3.58 and 3.60.

service, clinician expertise and available facilities (e.g., GP vs CertAVP).[68] For example, there is no 'standard' price for anaesthesia because there is no standard patient – each protocol is dictated by clinical necessity and patient's specific breed, condition, and risk profile, making a single price entirely inappropriate. Similarly, a fixed price for an 'ultrasound' (full abdominal and echocardiogram) is misleading as it fails to account for the 40% of cases requiring sedation to achieve satisfactory imageries. Moreover, it would be clinically impossible to predict in advance which additional treatments would be required for the case of each individual pet, making a separately listed price list for 'add-ons' administratively unworkable.

(53) **Misleading expectation of price certainty.** A standardised price list which does not account for these determinative variables would both mislead consumers by offering an illusion of fixed prices, and discourage pet owners from considering alternative (and perhaps more suitable) clinical options not included on the price list.[69] For example, only during a surgery for a fracture, the veterinary surgeon may find that the condition is more complicated than initially anticipated. If the animal has an undiagnosed clotting disorder, a transfusion could become necessary during the procedure, or if the animal experiences a sudden decline, emergency support may be required. Medivet notes that independent providers have raised similar clinical concerns.[70]

(54) **Over-prioritising price**. The PDR – which claimed that a *"race to the bottom"* was not a *"significant risk"*[71] – presents an unrealistic vision of clinical outcomes and commercial behaviour, ignoring how price lists would impact *consumer* behaviour and decision-making – to the detriment of competition based on quality and risking animal welfare, for several reasons:

(a) Even if vets explained *"clinical and other non-price aspects"* when *"recommending a course of action"*: (i) pet owners would likely be lured to the lowest list price, or view the price list as a proxy for *"best practice treatments"*, unaware that lower prices might represent a lower standard of care;[72] and (ii) the PDR does not explain how exactly such veterinary explanations or recommendations would take place, i.e., if a pet owner were to visit multiple FOP websites (i.e., independently and online) to compare price lists prior to making a decision on which FOP to choose, how are they then supposed to obtain such accompanying explanations or recommendations from each FOP being compared (i.e., requiring a conversation, presumably in person or via telephone call).

(b) Even if a cheaper treatment option is clinically-sound, over-emphasis on price could undermine other quality or convenience considerations, such as by encouraging pet owners to select a *prima facie* cheaper FOP located further away – increasing inconvenience and emergency response times.

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68 Medivet's Response to Remedies Working Paper, row 3, Table 2, page 43.

69 Medivet's Response to Remedies Working Paper, paragraph 1.4(d)(i), page 5.

70 See, for example, Anonymous respondent (29)'s submission to the Remedies Working Paper, link: https://assets.publishing.service.gov.uk/media/68ee07e02adc28a81b4ad019/Respondent_29.pdf.

71 PDR Part B, paragraph 11.82.

72 Medivet's Response to Remedies Working Paper, row 9, Table 2, page 46.

(c) The PDR's argument that regulatory safeguards sufficiently prevent a *"race to the bottom"*[73] is unfounded (or, at the least, unevidenced). Vets may simply be incentivised (or forced through an over-prioritisation of price) to lower quality standards to the minimum regulatory level, rather than seeking to compete on quality of their services. Played out over time, this could ultimately have a negative effect on animal welfare.

(55) **Pricing structures**. Not all FOPs price the same items in the same way – there are a significant number of factors which feed into a business's decision of what price it will charge. This raises two concerns in relation to the PDR's proposed remedy:

(a) **Like-for-like comparisons will be extremely challenging (if not impossible) to achieve and all pricing will need to be heavily caveated to avoid misleading consumers as to the scope of the treatment / services included by any given FOP**. For example, a listed price for a 'cytology test' is inherently misleading because it creates a false equivalence between a basic in-house review and a comprehensive external lab analysis – a service that some practices, lacking the necessary equipment, cannot even offer, rendering any price comparison meaningless. And those caveats will be so numerous that they will likely lead to more confusion. For example, a FOP could produce a price list that technically complies with the prescribed price list but which would in reality, through the use of heavy caveats and free text explanations (as would be permitted by the remedy proposal), fail to reflect the actual pricing options which the FOP would offer in any particular pet owner's case. The proposed remedy would therefore exacerbate pricing uncertainty and risk damaging the relationship of trust between pet owners and vets;[74] and

(b) **Vet businesses may be incentivised to structure pricing with *"loss leader"* items on the list, and increased prices for off-list items**. While the PDR seeks to pre-empt this concern by stating that the price list includes *"less variable non-routine treatments"*,[75] such treatments would necessarily require additional commentary in the price list (see paragraphs (51) and (52) above: 'less variable' does not mean 'not variable'). Given also that the price list necessarily remains non-comprehensive, it remains the case that certain treatments will stay off the price list and therefore at risk of such pricing practices.

(56) These pricing tactics, made more likely by the PDR's proposed remedy, would (i) by comparison result in higher-quality providers simply appearing more expensive; and (ii) reduce any actual transparency of pricing for consumers and could even undermine vets' clinical judgement by narrowing down treatment options.

(57) **Changes to prices due to complications over the course of a treatment**. As soon as complications arise during treatment, the price list would no longer be an

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73 PDR Part B, paragraph 11.82.

74 Medivet's Response to Remedies Working Paper, row 5, Table 2, page 44.

75 PDR Part B, paragraph 3.193(c).

effective indicator of actual treatment price, particularly if a treatment involves a referral to a different clinic.

Concern with the CMA's proposed implementation

(58) **Disconnecting quality**. As Medivet already noted above, there are inherent challenges and complexities with comparing quality – much more so than a *prima facie* ability to compare quantitative data such as price. The PDR's attempt to facilitate comparisons on both price and quality through: (i) published price lists; and (ii) a biennial client survey, fails as a result of implementation problems. The survey and price list have different implementation timeframes and, importantly, since the quality survey is not per-clinic, there will be no ability to make side-by-side comparisons of both quality and price at a clinic level.

(59) **Caveats**. As noted at paragraph (55)(a) above, FOPs will need to heavily caveat the price list to ensure adequate detail is communicated to pet owners. The PDR concedes that a price list without caveats could be incomplete, noting that *"free text"* could be *"presented alongside each price"* to detail what is included in each service.[76] However, if such *"free text"* is adopted, price lists would no longer serve as a like-for-like comparison of providers, defeating their original purpose.

Medivet's suggestion

(60) As already submitted to the CMA in Medivet's Response to the Remedies Working Paper[77] and Medivet's Response to the February Working Papers,[78] and for the reasons reiterated above, Medivet considers publishing uniform price lists for the e.g., top-10 most common services would be far more effective in increasing actionable transparency compared with a 48-item list that would add confusion and be unworkable in practice.

(61) Accordingly, Medivet urges the CMA to:

(a) **Reduce the list to a more limited core set of services that are more standardised in nature and therefore more easily comparable**. Any mandated price list must be strictly limited to the handful of treatments and services – such as vaccinations and routine consultations – that are most commonly offered by FOPs market-wide and which are able to be provided on a standardised basis where price is less prone to pet-specific and case-specific circumstances. These are services that the CMA's own survey identifies as being the primary focus of consumer price comparison.[79] This more confined and predictable price list would enable consumers to engage on price comparison for a core set of products when evaluating alternative FOPs without having to engage with heavily caveated price lists of complex treatments that pet owners will generally already be unfamiliar with; and

[76] PDR Part B, paragraph 3.63.

[77] Medivet's Response to the Remedies Working Paper, Part B, Table 2, row 13.

[78] Medivet's Response to the February Working Papers, page 63, paragraph 6.75 and footnote 135.

[79] The top services consumers searched for by price are vaccination (72%), routine consultation (63%), flea and/or worming medicines (49%), neutering (38%), emergency consultation (21%), and prescription (21%). See Pet Owners Survey, Table 9.

(b) **Mandate a clear definition is provided, outlining exactly what is included within each such listed service / price**.

R3: Enhanced *"Find a Vet"* platform – a step towards an inappropriate commoditisation of veterinary care

(62) Medivet has, throughout the Investigation, supported calls for enhanced transparency in relation to quality standards to empower consumers to make more informed choices based on competitive drivers such as quality, which Medivet is aware are consistently more highly valued than e.g., price (as also borne out by the results of the Pet Owners Survey).[80]

Substantive concern

(63) While Medivet continues to support in principle enhancements to the RCVS Find a Vet platform,[81] the PDR's proposals are unlikely effectively to facilitate pet owners' decision making to *"compare the services of FOPs and referral centres".*[82]

(64) **De-contextualised comparisons of a multitude of datapoints would not enhance transparency or effectively support pet owner decision making**. An 'enhanced' RCVS Find a Vet platform (or a price comparison website, which it would facilitate) in the form envisaged by the PDR,[83] risks overwhelming consumers with decontextualised data causing confusion, over burdening consumers and achieving precisely the opposite of the PDR's stated goal of providing clarity and avoiding information overload.[84] For example, as mentioned in paragraph (55)(a) above, comparing 'cytology tests' on the platform would risk being inherently misleading as it would facilitate comparisons that do not distinguish basic in-house review from comprehensive external lab analysis. Absent clinical advice on what level of cytology test is required, it is also not clear how a pet owner can be expected, to understand whether a basic in-house or laboratory test is recommended in a particular circumstance. Presenting fundamentally different services such as these under the same item line without the context of a clinical conversation would invite pet owners to make solely price-based decisions that would not best reflect their decision-making priorities or ultimately protect animal welfare.

(65) The PDR recognises that *"providing too much detail may make it harder for pet owners to interpret and act on information"*.[85] While the PDR implies that *"standardisation and centralisation (e.g., on Find a Vet)"* could address this issue, simply putting a significant amount of data and information in one place (i.e., on Find a Vet) creates a real risk of information overload and unrealistically expects

[80] Medivet's Response to February Working Papers, paragraph 1.12.

[81] Medivet's Response to Remedies Working Paper, paragraph 2(b)(iii).

[82] PDR Part B, paragraph 3.111.

[83] Including a large number of additional datapoints / information relating to prices for a standard set of defined services (Remedy 2b), prices for preferred pesticides (Remedy 2c), and pet health care plan data (Remedy 2d).

[84] PDR Part B, paragraph 3.132.

[85] PDR Part B, paragraph 3.251(c).

consumers to synthesise large amounts of detailed information to make informed choices.

(66) **Veterinary Services are not a price-driven market**. The Veterinary Services market is not primarily driven by price, the CMA's own survey data demonstrates.[86]

(a) **Given the large number of non-price factors which drive pet owner decision making, the PDR does not address how the proposed 'enhanced' RCVS Find a Vet platform, nor any price comparison website Remedy 3 facilitates, would guard against de-contextualised comparisons that fail to capture important non-price factors**. Facilitating a price comparison tool through the sharing of information provided by PDR Remedy 2b and 2c,[87] would be damaging to the industry and animal welfare.

(b) **The PDR fails to explain how price comparison tools operated by unregulated commercial third parties would guard against the risk of animal welfare being negatively impacted**. Unregulated, commercial price comparison tools, facilitated through the PDR's proposal to allow approved operators access to practices' business and service information,[88] opens the possibility of commercial influence (and the associated risks of it) on how care is offered (by providers) and chosen (by pet owners) outside the purview of the RCVS's regulatory checks and balances that help protect animal welfare. This is particular a concern given the proposed remedy provides no certainty over how a price comparison tool could function or what safeguards would exist to protect against such influence.

(67) The proposed 'Pet Care Plan Value Calculator' is a clear example of the PDR's flawed, de-contextualised approach particularly in its treatment of parasiticides.[89] It creates a false equivalence by comparing the all-inclusive cost of a pet care plan against only the standalone online drug price, failing to capture the additional mandatory consultation and prescription fees that would be required to access that online price. Such a comparison could encourage pet owners away from a pet care plan on the false premise that the only cost they would need to compare is the cost of the medicine. Without including other essential costs, the calculator would not provide a like-for-like comparison and would be misleading.

(68) For these reasons a price comparison website for a complex Veterinary Services market, which is not primarily driven by price, and which necessarily reflects individual cases and circumstances, cannot possibly be comprehensive and risks misinterpretation. Equally, as outlined in paragraphs (50) to (57) above, a price comparison website spanning 48 services risks over-prioritising competition on price for a wide range of treatments for which variances in the quality of the service offered by different providers will be material. As proposed in paragraph (61)(a)

[86] PDR Part B, paragraph 3.50(b) says that word-of-mouth recommendations is "*one of the most important factors in pet owners' choice of FOP*"; see paragraph B.I(25)(a).

[87] PDR Part B, paragraph 3.108.

[88] PDR Part B, paragraph 3.110(c) and paragraphs 3.136 *et seq.*

[89] PDR Part B, paragraph 3.134(c).

above, this should instead be limited to only core treatments commonly offered across the market, for which quality differences are less stark and therefore less important in consumer decision-making.

Concern with the CMA's proposed implementation

(69) Medivet remains supportive of enhancements to Find a Vet.[90] New functionalities and information must, however, be proportionate and effective. Given the concerns identified above, the PDR's proposed remedy will not achieve an effective solution.

(70) By contrast, and putting aside any substantive concerns relating to information overload, Medivet's proposals for an enhanced Find a Vet platform did not involve the material additional burdens to which the PDR's proposals give rise.[91] While Medivet supports the addition of certain information (e.g., relating to ownership transparency), the burden associated with providing and maintaining *"as soon as reasonably possible following a change"*[92] the scope of information proposed by the PDR would be significant.

(71) Medivet has the following comments on the PDR's proposed remedy implementation:

(a) **The format for submission of data to the RCVS will be more administratively burdensome than the PDR envisages**. While the RCVS might already be expanding its *"web form to capture a range of other information from vet practices"* such that more data fields are *"feasible"*,[93] the CMA will itself know from data collection throughout its Investigation that practice management systems (***PMS***) of different FOPs across the sector are not homogenous and there will therefore be limitations on the comparability of data submitted, absent significant sector-wide investment in rolling out homogenised systems.

(i) Capex requirements. Medivet has not been able in the short time available to submit its response to the PDR (nor in the absence of the RCVS having finalised its data collection processes) to confirm [redacted]. Furthermore, Medivet's experience suggests that, in reality, any preliminary estimate can be inherently unreliable, as even simple system changes can carry unforeseen cost escalations. For example, [redacted]

[90] See, for example, Medivet's Response to February Working Papers, paragraph 1.12, and Medivet's Response to Remedies Working Paper, paragraph 2(b)(iii).

[91] Medivet suggested that the Find a Vet coverage be expanded to encompass all FOPs and include datapoints able to be drawn from existing information on PSS (Practice Standards Scheme) rating, a top 10 price list, trading hours, NPSs (Net Promoter Scores) and qualifications. See, for example Medivet's Response to Remedies Working Paper, Part B, Table 2, row 13.

[92] PDR Part B, paragraph 3.153.

[93] PDR Part B, paragraph 3.144(a).

[redacted] a complex, front-facing data interface with the RVCS's Find a Vet platform will undoubtedly require significant capital expenditure, the full extent of which cannot be accurately known until more concrete technical specifications are finalised. The PDR's assertion that providing data to the RCVS would be a "*relatively straightforward*" process is premature and unsubstantiated. The administrative burden will likely be a result of the technical integration required to submit the data to the RCVS's as-yet-undefined system, not from the data itself. Until the RCVS provides technical specifications and a testing environment, any claim about this task being straightforward is purely speculative.

(ii) Switching PMS providers is not a straightforward process, as implied by the PDR. The PDR suggests that if "*technical challenges*" cannot be addressed,[94] businesses may choose to outsource processes to a third-party PMS provider and there may be a need for "*businesses operating FOPs and referral centres to choose a PMS which includes this process"*.[95] Migration of PMS is not a straightforward process, it is operationally costly and time consuming to ensure there is no impact on business operations. The CMA has not sought to quantify the proportion of the market which may need to consider such a systems migration, and accordingly the PDR's estimates of cost of this remedy are not adequately scoped.

(A) Medivet uses its proprietary Freedom PMS: the vast majority of its clinics have been migrated to Freedom, and when it acquires a new practice, Medivet seeks to migrate their PMS to Freedom, a process that can be very time-consuming, depending on the legacy system being migrated from.

(B) It has not been possible in the short time available for Medivet to submit its response to the PDR (nor in the absence of the RCVS having finalised its data collection processes) to confirm [redacted].

(iii) Manual data output, review, and input (if required) would impose a very significant administrative burden. The PDR recognises that its proposed remedy "*would take some additional administrative time per practice"* (emphasis added).[96] This requirement *may* in the absence of automated / technical solutions, recur each year. Medivet has a network of over 350 practices and 27 24-hour practices.[97] While Medivet [redacted] there is a real concern that having to manually obtain, check, verify, review, and upload to a separate

94 PDR Part B, paragraph 3.149.

95 PDR Part B, paragraph 3.150.

96 PDR Part B, paragraph 3.151.

97 See www.medivetgroup.com.

online form all of the information proposed by the PDR would be an extensive and burdensome administrative task that would risk diverting resources away from other important business functions. In labour costs alone, costs incurred would be extensive. It is, therefore, simply not the case that, as the PDR purports, the administrative impact and costs of the remedy (whether they be related to system upgrades, migrations, or manual fallback processes) are insignificant.

(b) **The three month implementation period is not sufficient**.[98] Given the considerations outlined above, veterinary businesses will not be able to 'frontload' work required, and will need to wait until the RCVS has finalised the information it requires and the format in which it should be provided.[99] Only once confirmed could veterinary businesses prepare internal structures to ensure effective interface with the RCVS' system design, and as explained in paragraphs (40) and (41) above, a period of at least six months will be required to implement the proposed remedies.

(i) Medivet also notes that, while the PDR notes that businesses *"may choose to outsource these processes"*[100] it is not the outsourced providers of such services who would be required to comply with any CMA Order. While arrangements with third party providers might be subject to contractual controls, Medivet cannot delegate its regulatory responsibility. Should the outsource provider fail to deliver within any CMA Order's implementation period, Medivet alone would face the direct financial penalties and reputational damage for compliance failure it did not cause and could not control.

(ii) For all the reasons above, Medivet reserves its rights with respect to the timeline for implementation of the Find a Vet remedial solution.

(c) **The PDR does not offer solutions to avoid the information overload risk that is has identified and significantly over-simplifies reasonably foreseeable limitations**. While the PDR cites measures such as *"presenting commonly used services more prominently than those less commonly used; and allowing users to click hyperlinks or dropdown menus to find further information about specific services",*[101] those alone would not effectively address the risk of information overload given the large number of datapoints proposed for inclusion. Any design solutions must ensure there is a balance between information that is effective digestible and simplified but which acknowledges important nuances around data

98 PDR Part B, paragraph 3.158.

99 Medivet recognises that the RCVS will be required to *"provide FOPs and referral centres with a data input template, related guidance and support in advance of the requirement coming into force such that FOPs and referral centres can adequately prepare"*. PDR Part B, paragraph 152.

100 PDR Part B, paragraph 3.150.

101 PDR Part B, paragraph 3.132.

limitations and appropriate caveats.[102] To achieve this, Find a Vet would require a significantly more sophisticated design.[103]

Medivet's suggestion

(72) **Find a Vet platform**. To address the unintended consequences of the PDR's provisional remedy that Medivet has identified, third parties should not be able to access data provided by veterinary businesses to the RCVS to facilitate enhancement of the platform. An effective and proportionate solution is for the RCVS to update its platform in line with the proposals that Medivet already made in its response to the Remedies Working Paper[104], or at the very least to address the concerns raised at paragraphs (71)(a), (b) and (c) above.

R4: Biennial Vet Survey – an outdated snapshot in time with significant limitations and from which no usable conclusions can be drawn to inform consumer choice

(73) Medivet welcomes the PDR's conclusion that the scope of the earlier proposed survey would be *"very large and expensive… [with a] high burden".*[105] The PDR's amended survey proposal nonetheless remains flawed and suffers from the same significant administrative burdens.

Substantive concerns

(74) Medivet has explained above why the Pet Owner Survey conducted by the CMA provided unreliable, biased and unscientific results. Future surveys following the same or a similar format would suffer from the same issues.

(75) Medivet remains of the view that a standalone survey is entirely unnecessary: there are numerous other 'review' and 'feedback' mechanisms already available to consumers (e.g., Trustpilot, Google Reviews etc.). These tools already provide continuously available and up to date measures of customer satisfaction – all of which is publicly available, significantly more intuitively accessible through internet searches and Google Maps, and specific to a particular clinic that a pet owner will be comparing.

(76) Medivet also has concerns relating to the very significant limitations of such a survey (and the explanations that would be necessary when interpreting its findings). A group-level, national survey is unnecessary and will not ultimately facilitate meaningful consumer choice or decision making:

(a) **The survey would not capture elements of quality less observable to pet owners**. The survey would most likely capture observable elements of

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[102] See, for example, paragraphs (64), (65) and (70).

[103] While the PDR recognises that *"[a]dditional comparison functionalities could take longer to design and implement"*, Medivet notes that the examples provided focus on enhanced functionalities to facilitate comparisons and are not focused on enabling consumers to understand individual practice information clearly and concisely. Introduction of comparison functionality in the absence of ensuring individual practice information is easily understandable risks adding only a further layer of complexity. See PDR Part B, paragraph 3.133.

[104] Medivet's Response to Remedies Working Paper, paragraph 2.5(a).

[105] PDR Part B, paragraph 3.174.

quality available to the majority of consumers (e.g., the state of the veterinary practice). The survey would not likely capture evidence from customers on more nuanced outcomes that a non-expert pet owner cannot be expected to judge or only rarely observe (e.g., the speed of recovery / treatment outcome), and lesser so still the recovery given the specific circumstances of their pet (e.g., given complications). It is, ultimately, these less observable elements of quality which are some of the most important indicators of quality and on which weight *should* be placed.

(b) **The survey risks misinterpretation by consumers, being 'gamed' by providers, or necessarily being so highly caveated that it does not offer any valuable insight.**

(i) FOP markets are local[106] – and so survey data grouped on a national and group basis is not informative. When choosing between veterinary practices, a pet owner will only be interested in those local to them within a given area. For those practices, consumers want to understand *inter alia* the quality of the local facilities, the staff working at their local practice, and the services and treatments offered. The survey would not offer any new information to that already available.

(ii) Comparing 'averages' is equally uninformative. As above, FOP markets are local where Medivet typically competes against a range of other LVG and independent providers. Comparing an average score for Medivet against the average of either (i) another named provider;[107] or (ii) a homogenised group of independents (which are all unconnected companies, and which will necessarily not be homogenous) is not insightful. The survey results would not therefore account for or reflect either the local practices *actually* being considered by the consumer, let alone the range of quality offered by any one individual practice nor the experience of that practice's clients.

In the case of each (i) and (ii) above, a survey would be no more informative than word of mouth or online reviews of the specific local practice of interest to the consumer. In fact, a survey in the form proposed by the PDR is likely to confuse consumers by providing them with irrelevant information, lacking any form of specificity, or requiring such significant health warnings that it would be unclear what conclusions can be drawn from it at all.

(iii) Further and in any event, the survey would be unable to account for the mix of services (and quality) provided by different groups or across the pool of Independent Practices. Notwithstanding the overarching concern with accurately reflecting quality (see (a) above), a veterinary business could score highly on certain metrics (e.g., by focussing on less complex, routine procedures). Veterinary business could equally shift their business model to ensure such

[106] PDR Part A, paragraphs 4.33 *et seq.*

[107] Veterinary groups may be added from time to time; see comments in paragraph (80).

outcome. Irrespective, the survey introduces a real risk that consumers mistakenly mis-interpret quality across a provider's full portfolio of services and treatments.

(c) **The survey's results will be outdated for the majority of time consumers seek to rely on them**. As also applies to the Pet Owner Survey,[108] the biennial cadence of the proposed survey means that its results will have limited probative value and will be out of date no sooner than they are published.

Concern with the CMA's proposed implementation

(77) Given the concerns identified above, Medivet is concerned that the PDR's proposed remedy will not achieve an effective solution, all while imposing further costs on the named providers[109] required to fund it.

(78) **The proposed biennial survey would likely add significant cost on LVGs without providing any commensurate benefit for consumers**.

(a) The PDR is likely to have underestimated the costs expected in delivering the survey. It has neither provided evidence to support its £400,000 estimate for the survey cost in the first year, nor specified any *"lower"* cost estimate for the following iterations.[110] By contrast, Medivet has direct, real-world experience in projects of this nature and the much more significant costs that they involve. [redacted][111] Even this figure is likely to be a conservative baseline, as the PDR's proposed survey – requiring a statistically representative national sample – is a more complex undertaking [redacted]. This demonstrates that the resources required for a credible national survey are an order of magnitude higher than the PDR's figure.

(b) Even if these costs were to be incurred *"at the group level",*[112] similarly to cost recovery needed in relation to the PDR's provisional Remedy 3, costs of this nature tend to lead to fee increases.

(79) In any event, given the PDR proposal for the survey to be funded by LVGs (with no contribution from independents), the RCVS should be required to consult with LVGs before commissioning a market research agency / awarding it a contract, given: (i) the RCVS would have no direct incentive to minimise costs; and (ii) LVGs will have little control over or insight into the RCVS' process in awarding any survey contract for which they will bear the cost.

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108 See paragraph (20)(e).

109 The LVGs, for at least the first iteration.

110 PDR Part B, paragraph 3.183.

111 Medivet's response to RFI 13, Question 2(a)

112 PDR Part B, paragraph 3.185.

(80) **The PDR does not future proof the survey or indicate at what point a non-LVG veterinary business would be required to contribute**. The PDR does not indicate at what point a veterinary business would be deemed to be *"sufficiently large"* such that it would be included in the survey and be required to contribute to the cost of administering the survey.[113]

Medivet's suggestion

(81) **The biennial survey is neither required nor expected to be effective**. As outlined at paragraph (73) above, the biennial survey is not likely to deliver to consumers useful information on their local veterinary practices in a meaningful or timely way to facilitate their decision making or stimulate local level competition. The CMA should instead focus attention on the enhanced Find a Vet platform in the form Medivet has outlined in paragraph (72) above.

R7: Oral reminder – an unenforceable and unnecessary remedy

Substantive concern

(82) As set out in Medivet's Response to the Remedies Working Paper, Medivet has supported the core objective of Remedy 7 through proportionate transparency measures that empower pet owners. Specifically, Medivet has consistently advocated for increased transparency and therefore supports the PDR's proposal for clear, standardised signage and written materials to ensure pet owners are aware of their ability to request a written prescription.[114]

(83) However, Medivet's sole, substantive objection with Remedy 7 is the newly proposed requirement for a mandatory oral reminder during every consultation where medicine is prescribed.[115]

(84) This additional requirement is flawed on two grounds. *First*, it is inherently unenforceable, creating unmitigable risk for professionals if accused of failing to provide the reminder, without any viable mechanism for oversight. *Second*, by focusing on a formalistic and potentially time-consuming process, it takes the focus away from animal welfare and, negatively impacts the relationship between a veterinarian and client.

(85) While providing an oral reminder about sourcing medicines more cheaply online may on its own not take much time to recite in a consultation, it will inevitably trigger some degree of follow-up questions from pet owners on topics such as pricing, online medicine platforms, delivery, and drug equivalency that is likely to turn a brief script recital into a longer diversion during time-limited consultations. Time spent explaining online medicine purchasing options as a result of follow-up questions detracts from valuable clinical time a vet could spend focusing on examining and treating a pet. Built up over time, this oral reminder requirement and the follow-up questions it would likely invite would tangibly reduce the amount

[113] PDR Part B, paragraph 3.184.

[114] Medivet's Response to Remedies Working Paper, paragraph 2.2(a)(iii) and 2.2(c)(iv).

[115] PDR Part B, paragraph 5.10(b).

of clinical time spent focusing on treating animals and discussing clinical issues and therefore risks deprioritising pet welfare.

Concern with the CMA's proposed implementation

(86) Medivet submits that a requirement to provide an oral reminder in-consultation is unnecessary in order to achieve the CMA's objectives, and incapable of effective policing and monitoring, on two key grounds.

(a) The PDR's objective is achieved as (if not more) effectively, and without the downsides set out above, through clearer, less intrusive means. Medivet has consistently argued that transparency is best served by providing information on standardised and prominent written materials.[116] This includes effective in-clinic and online signage, methods which are persistent, auditable, and inform clients without impeding the integrity of the medical dialogue.

(b) A remedy that occurs solely in a confidential oral medical discussion is by its very nature incapable of being policed. There is no viable mechanism for the CMA, or the veterinary business themselves, to monitor compliance. The PDR's suggested self-attestation system can be easily circumvented and offers no meaningful assurance of compliance. In practice, it risks creating a regulation with no consequences for non-compliance, effectively penalising compliant practices with administrative burdens while leaving their non-compliant counterparts with no credible risk of being held accountable. Similarly, it is likely to create an immediate and unresolvable 'he said, she said' conflict in the event a pet owner claims that an oral reminder was not provided or considers that an oral reminder was not effectively communicated, exposing every veterinarian to the perpetual risk of complaints that are impossible to defend evidentially.

Medivet's suggestion

(87) Medivet urges the CMA not to mandate the unenforceable oral reminder. The superior – and only practicably enforceable – remedy is to require clear, standardised written information on materials provided to clients before and after consultation, as the PDR is already proposing under Remedy 7. Should the CMA insist on retaining this flawed requirement, it must, at a minimum, be limited to the client's first consultation only.

R10: Annual choice of default for repeat prescriptions – an unnecessary proposal, given the standardised literature remedy, that would be unworkable and overly burdensome

Substantive concern

(88) The PDR's proposed 'choice of default' approach for repeat prescriptions is impractical since it does not reflect how repeat prescriptions are effected in practice. Contrary to the PDR's characterisation of repeat prescriptions as ongoing issuances of medication without client and vet contact over the span of several

[116] Medivet's Response to Remedies Working Paper, paragraph 2.2(b)(viii).

years, repeat prescriptions are, at least as regards Medivet, accompanied by refreshed clinical assessments to ensure the medication remains appropriate – a mandatory step rooted in patient safety that this remedy does not take into account. For example, a pet's health status can change – kidney function can decline, weight can fluctuate – making a previously safe medication inappropriate or even dangerous.

(89) The proposed remedy therefore incorrectly treats a medical service like an annual renewal service or subscription (for, e.g., insurance or a gym membership). To the contrary, in reality repeat medication is not and should not be passively renewed – rather, pet owners actively request a repeat medication based on their pets' current medical needs which then requires an updated professional judgement. Medivet is therefore concerned that an annual confirmation and associated administrative record keeping, as proposed by the remedy, would introduce a layer of unnecessary bureaucracy that fails to address real-world consumer behaviour and fails to reflect best practice as regards animal welfare. Allocating 5-10 minutes to each prescription may significantly reduce the time available for pet care at the end of the day and place a disproportionate burden on teams that are already constrained.

Concern with the CMA's proposed implementation

(90) The PDR's proposed implementation would be complex and introduces a default setting that is rendered meaningless by the fact that the issuance of repeat prescriptions requires a clinical review to ensure the medication remains appropriate. Additionally, it risks creating confusion with the false expectation of an automated process, only to undermine it with a necessary clinical check. Medivet's position is that the PDR proposals in Remedy 7[117] for signage and literature that reminds pet owners of their ability to request written prescriptions would also cover repeat prescriptions and be sufficient to address any purported concerns relating to repeat prescriptions.

(91) Medivet is also concerned about the significant administrative and unfunded burden of the proposed remedy. Specifically, the proposed requirement expects that every practice tracks and updates individual client preferences, overhauls IT systems to reflect them, and generates compliance reports for the RCVS.[118] This is likely to require a material expansion of Medivet's central administrative team and a new layer of bureaucracy.[119] This is a burdensome, sector-wide systems change with no clinical benefit, that diverts critical resources away from patient care. As explained in Medivet's RFI 12 response, [redacted].[120] As a result, [redacted]. It imposes

[117] i.e., the proposal to require transparent written notices of the availability of written prescriptions in FOP materials and literature.

[118] PDR Part B, paragraph 5.102.

[119] Medivet's Response to RFI 7, Question 9.

[120] Medivet's Response to RFI 12, Question 8(b).

a material cost burden on a sector already facing intense operational pressures, a concern that Medivet has already raised.[121]

Medivet's suggestion

(92) Medivet contends that the goal of empowering pet owners is already achieved more effectively and safely through the written communications mandated elsewhere in the PDR.[122] The point of client decision is not an abstract annual default; it is the moment a client actively requests medicine. Reinforcing messaging on signage and invoices delivers the necessary information at the appropriate moment (unlike an annual confirmation divorced from any actual request for medication).

(93) Accordingly, the written communications mandated in Remedy 7 already provide the correct and sufficient solution for all prescriptions, including repeats. Medivet submits that the default mechanism of Remedy 10 is therefore largely redundant and should be set aside.

[121] Medivet's Response to Remedies Working Paper, paragraph 1.10(e).

[122] PDR Part B, paragraph 5.10.