IVC EVIDENSIA RESPONSE TO CMA PROVISIONAL DECISION REPORT DATED 15 OCTOBER 2025

CMA MARKET INVESTIGATION INTO UK VETERINARY SERVICES FOR HOUSEHOLD PETS

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CJ/AMZL/FXJ/LPP/BXXB

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1. Executive summary

Introduction

1.1 As throughout this regulatory process, **IVC is committed to engaging collaboratively with the CMA to find effective, meaningful, and workable solutions to industry-wide challenges**, that are consistent with the '4Ps' set out in the CMA's Annual Plan[1] and applicable CMA Guidance,[2] and do not generate significant unintended consequences or disproportionate administrative, technical, or financial burdens on the sector.

1.2 In that spirit, IVC welcomes the opportunity to comment on the CMA's Provisional Decision Report (the "**PDR**") in its market investigation into veterinary services for household pets and to continue engaging collaboratively with the CMA to identify a package of remedies that are effective and fit-for-purpose in light of the specific characteristics of, and challenges faced by, the sector. We summarise IVC's primary observations on Parts A and B of the PDR in turn below.

Part A of the PDR

Vet sector challenges are industry-wide – not a consequence of large veterinary group ("**LVG**") entry

1.3 IVC **has noted on several occasions throughout this regulatory process that there are significant industry-wide challenges in the vet sector**, which all market participants should do more to overcome, to make the industry work better for all stakeholders. These challenges include:

(i) A deficit in pet owner and broader stakeholder understanding of how vet businesses operate commercially;

(ii) Entrenched drivers of cost and price inflation, e.g. labour shortages, coupled with global pressures on supply chains, has resulted in ongoing rises in costs for critical inputs including equipment, medicine prices, and rent (as well as overheads such as maintenance, energy, and water and waste costs); and

(iii) An outdated and ineffective regulatory and legislative framework, which offers insufficient protection for pets, pet owners, and veterinary professionals.

1.4 However, IVC does not agree with several aspects of the PDR's analysis of adverse effects on competition ("**AEC**") in the retail supply of veterinary services by first-opinion practices ("**FOPs**"), and the market for outsourced out-of-hours ("**OOH**") provision to

[1] The '4Ps' set out in the CMA's Annual Plan (i.e. pace, predictability, proportionality, and process) are designed to drive growth by promoting competition, protecting consumers, and enhancing business and investor confidence. See CMA's Annual Plan to drive growth by promoting competition, protecting consumers and enhancing business and investor confidence - GOV.UK.

[2] CMA guidance on markets remedies (the "**Guidance**") indicates that remedies should be proportionate, and not more costly or onerous for market participants than is needed to be effective. See https://assets.publishing.service.gov.uk/media/6728f949fbd69e1861921b06/__Draft_markets_remedies_guidance___.pdf, paragraph 3.5.

FOPs. In particular, **IVC is concerned that the PDR inaccurately presents LVGs as delivering inferior market and consumer outcomes** (for example in relation to pricing, profitability, and customer experience) in comparison to independent businesses. In fact:

(i) **LVGs and independents are not homogenous groups** and a rigid bifurcation between them is not supported by the available evidence, including in the PDR. Indeed, a deeper analysis of pricing, profitability, and pet owner survey data referenced in the PDR shows that there is a wide and overlapping range (or dispersion) of outcomes for both LVGs and independents. For example: (a) the PDR's pricing analysis found that the highest prescription fees in the market were charged by an independent practice;[3] (b) the PDR's profitability analysis found that the most profitable independents earned a higher profit margin than all of the LVGs;[4] and (c) the CMA's consumer survey did not find a statistically significant difference in net satisfaction scores between IVC (or several other LVGs) and independents in terms of quality of service, care given to their pet, and overall outcome of the visit.[5]

(ii) **Dampening potential competition between FOPs**. Exacerbating a 'LVG vs independent' narrative risks oversimplifying the competitive landscape. It could lead pet owners to view their choice as a binary question - "*should I use an LVG or an independent?*" - rather than assessing differences between individual practices. In reality, competition *between* LVGs and *between* independents is an important source of competitive rivalry in the FOP market. If the remedies proposed in the PDR are intended to promote more informed pet owner choice and stronger competition between FOPs, framing the market too narrowly around ownership type could inadvertently weaken those very objectives.

(iii) **The six LVGs have also brought significant benefits to the vet sector** in the last decade, including hundreds of millions of pounds of investment in robust evidence-based care standards, training, equipment and technology as part of an enduring commitment to high quality contextualised care, vet professionals' pay and benefits, research and public health initiatives, welfare initiatives, and charitable and sustainability initiatives.

1.5 An unfounded focus on LVGs as a significant source of consumer and market detriment risks:

(i) **Exacerbating pre-existing pressures on LVG vets' morale**, contributing to higher attrition rates, which in turn increase labour shortages and cost pressures, entrenching industry challenges.

(ii) **Encouraging distortions in remedy design**. Any remedies that only apply to some (or do not apply consistently and proportionately to all) market participants are not justified by the AEC analysis and would generate significant harmful

[3] PDR, Part B, Table 6.1.

[4] PDR, Appendix C, Financial and Profitability Analysis; based on EBIT margins.

[5] PDR, Part A, Table 7.3.

distortions in competition and market outcomes – see further paragraphs 1.8 and 1.9 and **Section A** below.

Part B of the PDR

IVC welcomes many of the remedy proposals in the PDR

1.6 In light of the industry-wide challenges mentioned above, **IVC welcomes many of the remedy proposals in Part B of the PDR**. In particular, IVC supports the PDR's focus on:

(i) **A package of transparency remedies** - designed to enhance pet owners' ability to make informed decisions; and

(ii) **Reform of the legislative and regulatory framework** - to make it fit-for-purpose for the modern day and deliver robust protections for veterinary professionals, pet owners, and pets, including by enhancing the pre-existing protections over clinical autonomy and the trust-based vet-client relationship.

1.7 As a result, IVC considers that the **PDR remedies package is a significant step forward** in identifying an effective, workable, proportionate resolution to the regulatory process. IVC's views on the remedies it supports are briefly summarised in **Section E.**

Industry-wide challenges require industry-wide, objective, consistent solutions

1.8 That said, and given the industry-wide nature of the vet sector's challenges and a lack of evidence of LVG-specific harm (as discussed above), IVC urges the CMA to ensure that **remedies are always applied on an industry-wide, consistent, objective basis – without being affected by 'LVGs vs independents' sentiment (including in the broader stakeholder environment).** Remedies that only apply to some (or do not apply consistently and proportionately to all) market participants are not justified by the PDR's AEC analysis, and would generate significant harmful distortions in competition and market outcomes (for example, uneven or inconsistent transparency requirements creating 'blind spots' for consumers on particular service providers or service standards) - to the detriment of pet owners, pets, and wider industry stakeholders.

1.9 Of **particular concern in this respect is the PDR's proposal (in Remedy 4) for an RCVS pet owner survey** that assesses LVGs separately (at group level), but independents as a single homogenous body, with no differentiation between individual clinics or businesses. This is clearly misleading and not helpful for pet owners. If survey results are to be meaningful for pet owners in their decision-making, pet owners should be able to see up-to-date survey results for the service options available *to them* (i.e. at a clinic level for options in their particular local area). This is particularly important as the CMA defined the market for FOP as *local* in nature, and the CMA's customer research found location is an important driver of clinic choice. Nationwide biennial survey results are essentially meaningless in this context and – worse still – risk rewarding underperforming clinics and harming those who go above and beyond in their commitment to high quality service delivery to pet owners. Please see further in **Section A.**

Some remedy proposals in the PDR remain incompatible with the '4Ps' and CMA Guidance

1.10 IVC is also concerned that **not all PDR remedies** (even if consistently applied to all market participants) are **fully aligned with the '4Ps' and CMA Guidance**, or adapted to the specific characteristics and challenges of the veterinary services sector. Therefore, IVC has focused this response (in **Sections B – D**, and summarised in **Table 1.1** below) on setting out its suggestions on how the PDR remedies package could be further developed and refined to enhance its effectiveness and proportionality, and to avoid unintended and harmful consequences.

1.11 As emphasised in IVC's response to the Remedies Working Paper dated 31 May 2025, fully aligning the remedies package with the '4Ps' and CMA Guidance is crucial to promote the interests of pet owners, patients, veterinary professionals, and the industry; to reinvigorate investment into UK veterinary services (which has significantly diminished since the start of this CMA regulatory process); and to send a clear message to the wider economy that the UK regulatory environment prioritises "*action to drive growth and investment whilst fulfilling its core purpose to promote competition and protect consumers*."[6]

IVC's proposed amendments to the remedy package

1.12 Key priority elements of IVC's proposed refinements to the PDR remedy package are summarised in **Table 1.1** below.

Table 1.1
Key elements of IVC's proposed refinements to the PDR remedy package

Theme	PDR remedy	IVC amendments and refinements
(1) Enhancing the effectiveness of remedies **See Section B**	**Remedy 4 –** RCVS pet owner survey	**(a) RCVS pet owner survey proposal is ineffective and unworkable**: i. **Assesses independents as a single homogenous group** rather than differentiating between separate independent vet businesses/clinics (and assesses LVGs at the group level, not at clinic level) - so will not support clinic choice, will confuse and mislead pet owners, and hinder quality-led competition. ii. **Biennial data collection** by the RCVS will generate poor reliability and accuracy, whilst incentivising "survey time" driven performance over everyday delivery. **Instead: subjective pet owner surveys** on the customer experience to be: i. **Carried out at the clinic (not group) level,** differentiating between individual clinics (both independent and LVG) – to be meaningful to pet owners, and incentivise quality-based competition and avoid free-rider problems.

[6] See https://www.gov.uk/government/publications/cma-annual-plan-2025-to-2026#:~:text=The%20Competition%20and%20Markets%20Authority,promote%20competition%20and%20protect%20consumers.

Theme	PDR remedy	IVC amendments and refinements
		ii. **Issued immediately post-visit by individual vet businesses** (rather than biennially by the RCVS) – to improve survey coverage and accuracy. iii. **Made up of a limited number of standardised questions** – for simplicity and comparability across the sector. **(b) Subjective pet owner surveys to be supplemented by publishing data on objective clinical care standards:** i. **Based on the RCVS Practice Standards Scheme ("PSS"),** with any changes developed through an industry-driven process – to minimise the time and cost burden of implementation, and to allow for meaningful competitive differentiation between vet businesses on objective clinical standards. ii. Participation by clinics can be **voluntary.** iii. **Publication** of assessment outcomes **in practice literature** (in-clinic and online) and of participation and outcomes on **RCVS Find A Vet**.
	Remedy 3 – Enhanced RCVS Find A Vet platform and 'open data' remedy for third-party comparison websites	**(a) Comparison websites required to prominently display accessible and meaningful quality information (see IVC proposals (a) and (b) on Remedy 4 above)** – to ensure pet owners can assess value for money. **(b) No pet care plan ("PCP") value calculator** – as this is likely to: i. **Mislead pet owners** (not all benefits likely to be quantified; difficult for pet owners to predict uptake of some services); and ii. **Stifle innovation** – 'race-to-the-bottom' on PCP value propositions; and reductive from a client proposition perspective. **(c) Commercial incentives of third-party operators should not distort impartiality, accuracy, and reliability** of information presented – commercialised functionalities such as paid on-site appointment booking and e-commerce systems to be prohibited alongside paid rankings.
	Remedies 2b – d – Standardised price list for a defined selection of services and preferred parasiticides; and information about PCPs	**Limited refinements to price lists** – to ensure these are as understandable and user-friendly as possible for pet owners.
(2) Enhancing the <u>proportionality</u> of remedies – to avoid a disproportionate time and process burden on vets and clinics **See Section C**	**Remedy 7** – Information measures to increase written prescription awareness	**No oral disclosure requirements** – to avoid disproportionate time burden in consultations and interference with the clinical process. **Instead (per PDR proposal): standardised literature containing relevant disclosures** – published in-clinic and on the website, and shared with pet owners at registration and at regular intervals (for example, annually).
	Remedy 10 – Choice of (written) default for repeat prescriptions	**(a) Streamlined process for recording default preferences**, only at the time of new client registration, and for pre-existing clients proactively asking for a default (with information on the option to request a default published in standardised in-clinic

Theme	PDR remedy	IVC amendments and refinements
		and online literature - see above) - to avoid duplicated disclosure requirements. **(b) Simplified reporting to the RCVS**, removing the requirement to report the proportion of repeat medicines where the FOP recommended purchasing in-clinic (including the reasons why) – for a less onerous reporting burden. **(c) Margin of appreciation for vets' clinical judgment** to dispense in-clinic where appropriate for animal welfare.
	Remedy 13 – 'Cooling-off' period for pet owner choice of cremation services	**No 'cooling-off' period (for pet owners who have made a firm decision on their choice of cremation service)** – to avoid a transactional approach; ambiguities in the status of cadavers creating significant logistical challenges and additional storage expenses; and the health and safety risks of longer cadaver storage times and the increased manual handling burden. **Instead (per PDR proposal)**: i. **Enhanced transparency on cremation services,** including on (i) option for pet owners to get cremation services from a third party; and (ii) fee estimates for each of communal vs individual cremations - to ensure informed decision-making by pet owners. ii. **Two working-day pet owner decision-making window –** does not generate the same ambiguities and difficulties as the post-decision 'cooling-off' period; will ensure sufficient space and time for pet owners to make the right decision, recognising the emotionally charged context.
	Remedy 17 – Recommendation for a binding independent adjudication mechanism (VCMS+ or ombudsman)	**No binding independent adjudication mechanism or ombudsman** – significant administrative burden; increased risk of frivolous claims; complaints dealt with in a top-down manner with negative implications for the vet-client relationship. **Instead (per PDR proposal): (i) mandatory minimum standards for in-house redress; and (ii) enhanced voluntary (VCMS+) mediation** – ensures that pet owners experience a consistent and fair process across the sector; builds on existing frameworks to minimise implementation timeframe and resource burden; maintains scope for complaints to be dealt with in an open and collaborative manner; consistent with standards in other trust-based professions.
(3) Avoiding significant unintended consequences – of unnecessary and distortive prescription fee price controls **See Section D**	**Remedy 11** – Prescription fees capped at £16	**(a)(i) No prescription fee cap –** highly interventionist remedy unsupported by sufficient evidence to the required legal standard of an AEC; and likely to create market distortions across multiple veterinary services (e.g. higher treatment prices). **(a)(ii) At the very least, prescription fee cap to be subject to guardrails,** including being 'sunset' after a defined period. **(b) In any case, prescription fees to be subject to transparency requirements (per PDR proposal)** – i.e. published in price lists (per Remedy 2).

1.13 As before, IVC stands ready to work constructively with the CMA, alongside specialist governmental and industry bodies and in consultation with the sector, to further develop and finalise the PDR remedy package.

The structure of this paper

1.14 As previewed above, this response contains the following sections:

2. Section A – Industry-wide challenges require consistent, industry-wide solutions

Summary of IVC's views

2.1 Before discussing the PDR remedies package in detail, IVC would like to address a consistent theme in the PDR AEC analysis (which has also featured in subsequent public discourse): the bifurcation of LVGs and independents into separate, homogenous groups, with LVGs positioned as delivering inferior consumer and market outcomes, relative to independents.

2.2 This framing:

(i) Is an inaccurate characterisation of the veterinary services sector in the UK, as confirmed by the evidence (even if not all the commentary) in the PDR;

(ii) Does not recognise LVGs' significant contributions to major new developments and benefits (for vets, pets, and pet owners) in the sector, and creates unnecessary divisions in the veterinary profession, with a detrimental impact on LVG vets' morale and the trust-based vet-client relationship;

(iii) May dampen potential competition between FOPs, by oversimplifying the competitive landscape and risk leading pet owners to view their choice as a binary question - "*should I use an LVG or an independent?*"; and

(iv) Creates certain distortions in the PDR remedy package which risk undermining their effectiveness.

2.3 **As the veterinary sector's challenges are industry-wide, the solutions to address the challenges must also be industry-wide.** IVC urges the CMA to ensure that a specific and mistaken focus on LVGs as a purported source of consumer harm (in the PDR or in subsequent discourse in pockets of the stakeholder environment) is not reflected in its Final Report or in its remedy design – such that remedies are designed to be actionable and implemented consistently and objectively across all market participants, to prevent harmful distortions in consumer and market outcomes.

The evidence on market outcomes does not support a rigid bifurcation between LVGs and independents

2.4 LVGs and independents are **not two homogenous groups**.

(i) There are approximately 2,000 **independent veterinary clinics** across the UK, comprising a diverse set of businesses with different business models and competitive positioning. An "average" price or "average" measure of customer satisfaction across these diverse veterinary clinics is not informative of the varied experiences pet owners can expect across the range of these businesses. Indeed, the PDR acknowledges that: "*it is important to recognise that as distinct*

groups independent veterinary firms appear to be even more heterogeneous than LVGs."[7]

(ii) The **six LVGs** are similarly each distinct businesses, with different models, commercial focus, and competitive strategies. The PDR also recognises this: *"there are important differences between [LVGs]"* [8] and the "*LVGs are not homogeneous in structure."*[9]

2.5 Indeed, a rigid bifurcation between LVGs and independent veterinary practices (for the purposes of the AEC analysis or remedy design) **is not supported by the evidence in the PDR on market outcomes**:

(i) The PDR **pricing analysis** concludes that: *"large groups charge higher prices on average than independent vets."*[10] However, this masks significant variations in pricing strategies and competitive positioning by LVGs. The PDR analysis shows that LVG price differences versus the average independent clinic range between [5%] and [25%].[11] IVC notes in this respect that the PDR does not contain a price dispersion analysis across independent practices, where it is likely that there are also material pricing variations (and that prices in some independent clinics are likely to be materially higher than prices in some LVG clinics).

(ii) The PDR's **prescription fee market analysis** found that the highest fees in the market were charged by an independent.[12]

(iii) The PDR also finds no evidence of **increases in average prices** at two of the five LVGs (i.e. 40% of LVGs) post-acquisition of FOPs since 2015, and one of the LVGs has not followed an acquisition strategy.[13] This means that three of the six LVGs (i.e. 50%) did not – even on the CMA's flawed analysis[14] - display post-FOP acquisition increases in average prices since 2015.

(iv) In relation to pet owner **satisfaction**, the PDR notes that *"our pet owners survey indicated that LVG customers are less satisfied on measures of service compared to customers of independent vets",* and that *"the average satisfaction score on quality of service was 83% for independents and 76% for LVGs."*[15] Yet, as with pricing, there is considerable variation across LVGs behind these aggregate figures, with average satisfaction by LVG ranging from 67% to 79%. Importantly, the PDR analysis shows the difference relative to independents is statistically

[7] PDR, Part A, paragraph 7.63.

[8] PDR Summary, paragraph 23.

[9] PDR, Part A, paragraph 2.36.

[10] PDR Summary, paragraph 1.

[11] PDR, Part A, paragraph 7.25.

[12] PDR, Part B, Table 6.1.

[13] The PDR Summary, paragraph 26, states that *"for at least three of the five LVGs that acquired FOPs since 2015, our analysis indicates that acquisitions led to an increase in average prices of 9% four years later".*

[14] See further Annex 2, paragraphs 1.6 - 1.8 below.

[15] PDR Summary, paragraph 27.

significant for only two of the six LVGs.[16] Equally, it would also be expected that there would be significant variation in pet owner satisfaction across independent veterinary practices (although the PDR notably does not explore this, which unhelpfully contributes to the inaccurate and misleading conclusion that LVGs offer lower quality service to pet owners).

(v) Notwithstanding the substantial flaws in the PDR's **profitability analysis**, this has provisionally found that *"four of the six LVGs were making profits materially above their cost of capital"*[17] – but two of the six LVGs (i.e. 33%) were not. For independents, the PDR found a wide range of EBIT margins from -9% to 34%[18], with all LVGs sitting within this range. Indeed, the PDR concluded that *"some independent firms are making profits that we would not expect in a well-functioning market."*[19] Specifically, the PDR's profitability analysis shows that the most profitable independents earned a higher profit margin than all of the LVGs. A fuller response to the PDR profitability analysis is provided in **Annex 2** to this paper.

2.6 Ultimately, there are no clear and rigid distinctions between LVGs and independents – vet businesses display a range of characteristics, business models, and market outcomes, irrespective of ownership or size. It is not surprising that the evidence in the PDR does not support such a distinction either.

LVGs have contributed significant benefits to the veterinary sector

2.7 The suggestion in the PDR that LVGs have delivered inferior market outcomes for consumers (in comparison to independents) also fundamentally ignores **the significant contributions the six LVGs have made to the veterinary sector in the last decade**, including major new benefits for veterinary professionals, pet owners, and pets. These include substantial investments in:

(i) **The latest animal care techniques, technology and equipment** – e.g. IVC has invested more than £[REDACTED] over the past three years into modernising, improving and extending practices across the UK, to improve the options available to pet owners as part of a commitment to contextualised care.

(ii) **Research and data-sharing,** to drive new and better treatments and quality of care – e.g. IVC has funded over 100 research projects with the IVC Evidensia Research Fund (through which it makes up to £[REDACTED] available each year), with results shared widely within the profession, including with VetCompass – benefiting the whole industry.

[16] PDR, Part A, Table 7.3.

[17] PDR, Part A, paragraph 7.53.

[18] PDR, Part A, paragraph 7.62.

[19] PDR, Part A, paragraph 7.63.

(iii) **Public health objectives** – e.g. IVC has prioritised the fight against antimicrobial resistance, reducing antibiotic use from 10.8% in 2022 to 7.7% in 2024[20], and targeting the further reduction in antibiotic use to 5% of total outpatient consultations by 2030.

(iv) **Vet professionals' pay and benefits** (including in relation to maternity and paternity leave, and mental health support) to combat attrition, increase welfare, and improve standards – e.g. IVC has increased annual spend by £50 million since July 2022, including substantial (often above inflation) increases in pay. IVC also supports over 200 graduates a year through its Graduate Programme and invests approximately £12 million per annum in training and continuous development.

(v) **Charitable and sustainability initiatives** – e.g. the IVC Care Fund has contributed more than £4.1m since 2021 to support over 4,500 families with the cost of vet treatments.[21] Further, IVC aims to reduce Group emissions to net zero by 2050 and releases data on its performance towards this (and other sustainability goals) each year.[22]

(vi) **Welfare initiatives** – e.g. IVC's Non-Accidental Injury helpline, which is available free of charge 24/7 to the whole of the profession, as well as dedicated welfare specialists to support vets, pet owners, external stakeholders and the business.

2.8 By contrast, an unbalanced and inaccurate 'LVGs vs independents' narrative risks exacerbating already significant pressures on LVG vets' morale (alongside the day-to-day challenges of a high-stakes, high-pressure environment) – with a corresponding detrimental impact on attrition rates, the vet-client trust-based relationship, and ultimately pet owner interests and animal welfare.

<u>The vet sector's challenges are industry-wide</u>

2.9 Ultimately, as the PDR also provisionally concludes, **industry challenges are sector-wide** and not specific to any particular business model or ownership structure:

(i) *"It is important to note that the problems we have found in the veterinary industry are not confined to the LVGs."*[23]

(ii) *"The competition concerns we have provisionally identified derive from some features that are inherent to the market and from some, such as the lack of information available to pet owners, that apply across the market."*[24]

[20] IVC Positive Pawprint Report 2024, page 42.

[21] See further, IVC's response to the CMA's Issues Statement, paragraphs 5.1 and 5.2.

[22] IVC Positive Pawprint Report 2024, page 46.

[23] PDR Summary, paragraph 103.

[24] PDR, Part B, paragraph 2.65.

2.10 These **challenges** include:

(i) **Significant cost pressures** prompted by a systemic national shortage of vets and veterinary nurses, a general high inflation economic environment, and rapid technological and scientific developments;[25]

(ii) **Increasing pet owner expectations** on care standards, and significant expansion in demand for pets since the COVID-19 pandemic, but **without a corresponding degree of understanding of associated costs** and veterinary services business models;[26] and

(iii) An **outdated and ineffective legislative and regulatory framework** that needs reform to ensure robust protection of pets and pet owners, and to create a better platform to unlock the talents and productivity of veterinary professionals.[27]

Remedy design must adopt an industry-wide and consistent approach

2.11 It is therefore critical that the **PDR remedy package adopts an industry-wide and consistent approach across all market participants**, to ensure that it effectively addresses sector-wide challenges.

2.12 IVC welcomes the recognition in the PDR **that remedies should apply to all veterinary businesses** (with the exception of Remedy 1 on ownership transparency) given that industry-wide challenges "*point to a need for market-wide remedies*."[28] IVC encourages the CMA to ensure that this holds in both the Final Report and the CMA Order - and not to allow any 'LVGs vs independents' sentiment in (pockets of) the broader stakeholder environment to affect this principled position on remedy design and implementation.

2.13 IVC notes that applying **(transparency) remedies inconsistently to different market participants also risks harmful distortions in competition**, e.g. due to uneven or inconsistent information being made available to pet owners on different service providers or services. This concern is particularly pertinent with respect to the PDR's proposals for **Remedy 4** (RCVS-commissioned pet owner survey), which envisages providing pet owners with only group-level customer experience scores for independents (treated as a homogenous cohort) and each LVG (on an individual group basis); and requiring only LVGs to publish these group-level comparisons in FOP clinics and on their websites.

2.14 This risks **dampening potential competition between FOPs**. Exacerbating a 'LVG vs independent' narrative risks oversimplifying the competitive landscape. It could lead pet owners to view their choice as a binary question - "*should I use an LVG or an independent?*" - rather than assessing differences between individual practices. In reality, competition *between* LVGs and *between* independents is an important source of competitive rivalry in the FOP market. As proposed, **Remedy 4** will not be effective in

[25] IVC's response to the Remedies Working Paper, paragraph 1.5; IVC's response to CMA's Issues Statement dated 30 July 2024, paragraph 8.1; IVC's response to Question 1, RFI1 dated 13 September 2023.

[26] IVC's "teach-in" presentation to the CMA dated 1 July 2024, pages 9 and 10.

[27] IVC's response to the Remedies Working Paper, Section E.

[28] PDR, Part B, paragraph 2.65.

helping to better inform pet owners' choice of clinic, and could dampen the potential for stronger competition between FOPs.

2.15 IVC sets out its detailed proposals for how to refine and develop the remedy package in **Sections B – D** below.

3. Section B – Enhancing the effectiveness of transparency remedies

Summary of IVC's views

3.1 **IVC supports the PDR's view that the veterinary sector should do more on transparency of prices (including of treatments, medicines, and cremation options), clinic ownership, and quality standards**. IVC therefore welcomes the PDR's focus on designing a transparency remedy package that will give pet owners the breadth and depth of meaningful information needed to make informed decisions between veterinary service providers and the services they offer; and thereby enhance broader stakeholder understanding of how vet businesses operate commercially.

3.2 However, IVC is concerned that not all of the PDR's proposals are adapted to the specific characteristics and challenges of the sector, and **would not be fully effective in achieving these remedial objectives**. IVC is therefore proposing refinements to some PDR remedies to address these concerns:

(i) First, **Remedies 2b – 2d** represent a broadly proportionate and workable approach to achieving **enhanced pricing transparency** for treatments, veterinary medicines, and PCPs. In particular, IVC is encouraged by the PDR's focus on a core set of routine and high-volume treatments and parasiticides, which together account for a significant share of practice revenue. However, IVC has identified a (limited) set of further refinements, to ensure that **price lists are as understandable and user-friendly as possible for pet owners.** IVC's suggestions also aim to **avoid other unintended consequences** of the PDR price transparency remedies, e.g. the mandatory disclosure of commercially sensitive procurement information belonging to vet businesses; potential inconsistencies with applicable veterinary medicines regulations prohibiting the advertising of POM-V products; or potential incentives for PCP suppliers to reduce the scope of their service offering.

(ii) Second, increased transparency on price should be accompanied by a **meaningful, accessible, workable quality transparency framework**, to incentivise quality-based competition across the sector and avoid a race to the bottom purely on price. Assessing **customer experience (via pet owner surveys) could be a useful element of this framework**, but the RCVS survey proposal in **Remedy 4** would very clearly not be effective or workable, as these surveys would: (a) not be conducted at clinic level, which is essential to support the pet owner's clinic choice; (b) assess independents as a single homogenous group rather than differentiating between separate independent vet businesses (and also group together different practices within each LVG), so this (highly aggregated) information would not be meaningful to, and indeed would mislead, pet owners, and risks distorting individual FOPs' ability and incentive to compete on quality; and (c) biennial data collections by the RCVS would generate only a limited number of pet owner responses and poor reliability and reference value. Instead, pet owner surveys should be: (a) conducted at the individual practice level (for LVGs and independents) to support pet owner clinic choice and avoid distorting quality-based competition, (e.g. through free-rider problems); (b) made up of a limited number of simple, standardised questions to allow for effective comparisons between different types of vet businesses and services; and (c)

ideally issued at the point of service by vet businesses directly,[29] to promote better pet owner engagement and reliability of responses. Additionally, **to supplement these (subjective) surveys, the quality transparency remedy should also include, in a proportionate way, an element of (objective) clinical care standards**, based on the pre-existing PSS for quicker, cheaper, and more effective implementation. Participation would be voluntary (in line with the current position under PSS), but practices would be required to publish the results of their participation on their websites, in premises, and on Find A Vet (or other comparison tools using the same data) – where an absence of participation by a practice would otherwise be recorded – to support informed pet owner choice. Greater transparency on quality standards incentivising higher quality veterinary care across the industry ultimately leads to healthier pets, applying downward pressure on the longer-term costs of pet ownership, and improving not just veterinary but also consumer outcomes.

(iii) Third, any **sector-wide comparison websites** such as (an enhanced version of) the RCVS Find A Vet website under **Remedy 3** should ensure that the **user interface and experience is as simple and intuitive as possible, and limited to key information, to improve pet owner engagement** (and reduce the implementation burden both on the RCVS and the wider sector). For example, the Find A Vet site should avoid a complex front-end incorporating the full, extensive price list that vet businesses will be required to publish on their own websites and in-clinic under Remedy 2b, (and instead use URL links to clinic websites to refer pet owners to those full price lists). Similarly, the proposed 'PCP value calculator' would be complex to design and deliver effectively, very difficult for pet owners to understand and use, and would risk misleading them on PCP value (as well as disincentivising innovation and quality improvements by PCP providers) – so should not form part of the Remedy 3 requirements. Comparison websites should also be required to **display meaningful and accessible information on quality** at least as prominently as other practice-related information, to ensure that pet owners are able to effectively assess value for money. Further, open data access to RCVS-collated industry data for third-party comparison tool operators must be subject to clear conditions **prohibiting** not just paid rankings, but also other **commercialised functionalities** such as paid on-site appointment-booking or e-commerce systems – to ensure information is presented to pet owners in a fair and impartial manner, without any distortions due to the commercial incentives of private comparison website operators.

[29] CMA guidance on customer surveys emphasises that survey response quality will deteriorate if surveys are excessively detailed or time consuming, and that the timing of last purchase is also important to avoid respondent recall problems. Please see CMA, Guidance on Good Practice in the Design and Presentation of Customer Survey Evidence in Merger Cases, paragraphs 3.6 and 3.23.

Remedy 2b – Standardised price list for a defined selection of services

IVC supports increased transparency through standardised treatment price lists

3.3 In line with its response to the Remedies Working Paper,[30] IVC broadly supports Remedy 2b – i.e. the requirement for FOPs, referral centres and crematoria to publish standard price lists for a defined set of veterinary services. Subject to the CMA considering a number of important design and implementation details (see below), the proposed measure represents a proportionate and workable approach to improving price transparency.

IVC encourages the CMA to consider refinements to the PDR price list

3.4 IVC welcomes the strong degree of consistency between the PDR's price list – as outlined in the list of defined services[31] – and the refined price list presented in IVC's response to the Remedies Working Paper.[32] In particular, IVC is encouraged by the focus on a core set of routine and high-volume treatments that account for a significant share of practice revenue. The effectiveness of this proposal will however depend on the detail of its implementation. IVC summarises below specific areas where IVC urges the CMA to **consider additional clarification for more effective transparency, or reconsider its proposals on the basis of limited consumer relevance.** In particular:

(i) IVC broadly supports including the reduced list of higher-complexity treatments in the price list in Section 6 – titled "Specialist treatments and procedures" in the PDR. However, IVC suggests renaming this category to "Advanced treatments", given that these can often be performed by professionals who are not RCVS Specialists, e.g. Advanced Practitioners, and the current terminology may therefore confuse pet owners.

(ii) The PDR's reference to "Ultrasound (Echocardiogram and ECG)" should be corrected, as an echocardiogram and an ECG are distinct diagnostic procedures. An echocardiogram is an ultrasound-based examination assessing the heart's structure and function, whereas an ECG records its electrical activity. IVC considers that only the echocardiogram should therefore be included in the proposed price list, as it is the relevant imaging-based service.

(iii) "Ultrasound (POCUS)" is typically used as an emergency diagnostic procedure and is not relevant to pet owners when seeking to compare practices. IVC suggests that it is likely to have very limited benefit to consumers, and instead would lengthen the price list (and make it more complicated and less user-friendly), beyond what is necessary to achieve transparency objectives.

(iv) IVC encourages the CMA to reconsider the inclusion of "Lateral Condylar Fracture surgery". Unlike the remainder of Section 6 of the PDR list, the total cost

[30] IVC's response to the Remedies Working Paper, paragraph 2.10.

[31] PDR, Part B, Table 3.1.

[32] IVC's response to the Remedies Working Paper, Annex A.

of this surgery depends heavily on factors such as the complexity of the fracture, the cause, and breed. Including this item in the list with a single indicative price, even with the use of the detailed notes column, creates a risk of misleading pet owners. Moreover, this procedure stands out as less useful to pet owners relative to the other items on the list, as it is less common[33] and is therefore unlikely to add material value to the standardised price comparison. For these reasons, IVC would encourage the removal of this procedure from the price list. However, if the CMA considers that it is necessary, IVC would strongly encourage the price to be listed as "starting from", to avoid the risk of misleading pet owners.

(v) In relation to 'Cremation: each discretionary add-on', IVC considers that the current proposal would make the list unhelpful and unnecessarily long. By way of example, there are more than 80 options for add-ons (including caskets, urns and memory items), making like-for-like comparison across providers difficult. This level of detail is not expected to be useful or proportionate, and will make the price list lengthier and more difficult to understand. IVC suggests limiting the price list to a set of illustrative add-on options, with full details on pricing options for add-ons provided as part of literature on cremation options (covered under Remedy 13).[34] IVC believes this is a proportionate solution that other veterinary businesses could also follow if their discretionary add-on list was similarly lengthy.

3.5 Finally, IVC would like to highlight that some prices in the PDR list will not be directly comparable across FOPs. This is particularly relevant for services such as 'pre-surgical blood tests' and 'routine blood profiles', where legitimate differences in the scope of services provided (e.g. included tests, processing methods, and reporting) can lead to material price variations. IVC will seek to include the appropriate level of detail in the explanatory notes to the price list to aid customers in making comparisons. IVC encourages the CMA to provide specific guidance on the approach to these explanatory notes, to ensure that the information provided by veterinary businesses is clear to customers.

3.6 Subject to the points above, IVC considers that the PDR's proposals can be implemented effectively and deliver meaningful transparency benefits for pet owners in the time period available for implementation (three months). A proportionate and flexible approach – focused on the services most important to pet owners and supported by clear definitions – will ensure that the standardised price list remains practical for providers and genuinely useful to consumers.

Remedy 2c – Price list for all "preferred" parasiticides

IVC supports enhanced medicines price transparency – subject to refinements

[33] For example, in the last 12 months only [REDACTED] lateral condylar fracture surgeries were conducted across IVC's FOP and one dedicated referral centre, in contrast to over [REDACTED] TPLOs (an advanced treatment also included in the proposed price list).

[34] For example, for IVC this could comprise each of its four discretionary supplementary charges, priced depending on size and material of the receptacle, alongside a representative example of what is included in each supplement (as opposed to every single option). For example, "Supplement A - £43 – e.g. Mahogany Casket".

3.7 IVC generally supports proportionate measures to improve medicines price transparency and broadly welcomes Remedy 2c. However, IVC encourages the CMA to re-consider and clarify the details of the proposed requirement on FOPs to publish prices for "preferred" flea, tick, and worming products. This remedy is expected to require the publication of a lengthy list of prices that may reveal vet businesses' procurement strategy, and may also be inconsistent with existing Veterinary Medicines Directorate ("**VMD**") guidance placing restrictions on the advertising of POM-V veterinary medicines.

Parasiticide price lists would be disproportionately lengthy, and may expose commercially sensitive information

3.8 Remedy 2c would require each FOP to publish, for all "preferred" parasiticide products, separate prices for different formulations and pack sizes, and in the case of FOPs owned by LVGs, all those designated under "preferred" product procurement schemes.[35]

3.9 IVC stocks over [REDACTED] parasiticide SKUs that are classified as "preferred" products. This list is deliberately expansive, to support clinical autonomy and also to cover a wide range of clinical needs (e.g. pet species, breed, age etc.). Listing a price for each SKU would create an extensive list that pet owners may find difficult to interpret or compare.

3.10 Additionally, Remedy 2c would indirectly disclose elements of the structure of veterinary businesses' commercial procurement arrangements, by revealing which products are "preferred". Such information is commercially sensitive, not ordinarily made public, and not relevant to pet owners' purchasing decisions – so requiring its disclosure would be disproportionate and generate harmful unintended consequences for vet businesses.

3.11 Alternatively, IVC recommends that the CMA consider a consistent approach for independent and LVG-owned FOPs – i.e. requiring the publication of the price of the top parasiticide most frequently prescribed and dispensed at the individual FOP-level, for each of the animal profiles set out in Remedy 2b.[36] This should require a clear disclaimer that the example parasiticides may not be suitable for all animals. The appropriate parasiticide for a pet is based on a clinical risk-based assessment carried out by the prescribing vet after a physical examination.

Consistency with veterinary medicines regulations

3.12 The proposed publication of a subset of POM-V prices under Remedy 2c may also contravene the VMD's guidance on the advertising of veterinary medicines, referenced in Appendix J to the PDR.[37]

3.13 Under the VMD's guidance, price lists are exempt from advertising restrictions only where all products in a category are listed with equal prominence and presented neutrally. Publishing prices for a defined subset of "preferred" products gives prominence to

[35] PDR, Part B, paragraphs 3.83 and 3.84.

[36] PDR, Part B, paragraph 3.83.

[37] PDR, Appendix J, paragraph 3.29.

selected prescription medicines and therefore may fall within the scope of the advertising restrictions applying to POM-V products.

3.14 As such, IVC requests that the CMA clarify in the Final Report that the VMD has confirmed that Remedy 2c is fully consistent with applicable veterinary medicines regulations, or whether a change to the VMD guidance will be necessary to ensure practices can remain compliant when implementing Remedy 2c.

Remedy 2d – Pet care plans

IVC supports enhanced transparency for customers of PCPs

3.15 IVC generally supports the proposed Remedy 2d but would like to raise one key concern regarding the statements PCP providers can make of potential savings for pet owners using their plans.

3.16 Remedy 2d indicates that "*where services are offered on an 'unlimited' basis (e.g., consultations), [a PCP provider has to] calculate savings using a reasonable declared estimate of the mean usage of those services in the past 12 months. For consultations, this should be no more than two per year of the specified consultation."*[38]

3.17 IVC agrees that savings should be calculated on a reasonable basis, including an estimate of actual typical (or mean) pet owner usage. However, IVC is concerned by the PDR's suggestion that consultations would be limited to just two per year. This is an arbitrary limit, with no basis to support it. In particular, IVC's Pet Health Club Plus offers unlimited consultations, with the average pet owner receiving [REDACTED] consultations a year under this plan. Pet owners that value this part of the offering have deliberately chosen this plan (e.g. risk averse owners, or those with elderly unwell pets).

3.18 By limiting a business' ability to advertise its savings based on a reasonable usage level for a service (such as consultations), the PDR is incentivising a reduction in service offering. Businesses would not be incentivised to offer unlimited services if they were only able to advertise the benefits on the basis of a limited service offering, below the average uptake. A more proportionate alternative, as the PDR suggests for other 'unlimited' benefits, would be to calculate savings based on mean usage.

Remedy 4 – RCVS-commissioned pet owner survey

The fundamental importance of quality transparency in driving competition

3.19 **Quality is a critically important outcome** in a healthcare market such as veterinary care, and price trends and other market outcomes cannot be properly understood without reference to quality. A key trend in the sector, which corporatisation has facilitated, is an increase in clinical standards, and the provision of higher quality pet care.[39] IVC supports the PDR's finding that "[t]*he quality of services businesses offer can be a key differentiator*

[38] PDR, Part B, paragraph 3.99(d).

[39] See further IVC's response to the CMA's Issues Statement dated 30 July 2024, paragraph 9.14; IVC's response to Question 29, RFI 9 dated 7 October 2024; IVC's response to Question 11, RFI 11 dated 13 November 2024.

between them and one of the bases on which they compete with one another"[40] and that an effective regulatory framework should provide a system for meaningful quality differentiation between practices, to support informed choice.[41] This framework should be comprised of **quality metrics that measure <u>both</u> (subjective) customer experience <u>and</u> (objective) clinical care standards**, the latter underpinned by the pre-existing PSS. Indeed, the RCVS specifically cautioned against an incomplete framework (that contains only a subjective element) in its response to the Remedies Working Paper: "*Quality measures that [only] reflect the relationship and treatment of customers and business practices would necessarily be limited […] as they would not provide any measure of animal welfare or clinical outcomes*".[42]

<u>IVC has fundamental concerns with the design of the RCVS pet owner survey</u>

3.20 Remedy 4 appears to be aimed at enhancing transparency on quality in the veterinary sector by requiring the RCVS to commission and publish the results of a group-level pet owner survey, with a combined rating for each LVG and for all independents as one group. Whilst IVC welcomes a greater recognition of the need for quality assessments to sit side-by-side with price, to ensure pet owners are better able to compare and contrast their available options, **IVC is concerned that Remedy 4 is fundamentally flawed**.

3.21 A survey based on national group-level scores, including combining all independents into one homogenous group, will:

(i) **Be ineffective in supporting pet owner FOP choice based on quality, and would instead mislead pet owners**. By aggregating results at the group-level, pet owners will not be able to compare customer-reported quality measures for the limited number of local FOPs they are considering. Indeed, the PDR has provisionally concluded that competition in the retail supply of FOP services is local (not national), and that location is an important determinant of pet owner choice of FOPs.[43] Presenting group-level results (rather than at the FOP-level) would mislead pet owners, by giving an inaccurate view of the quality of the specific FOP they are considering. For example, a pet owner may mistakenly believe that a FOP they are choosing has much higher customer-reported quality than in reality, or vice versa.

(ii) **Distort FOPs' ability and incentive to compete on quality.** The PDR's proposal risks undermining competition on quality between FOPs by aggregating results at the group-level. For independent FOPs, a single collective score would obscure differences in performance, removing opportunities for higher-quality operators to signal their superior offering, and reducing incentives for lower-quality FOPs to improve. This dynamic allows weaker performers to "free ride" on the reputational benefits created by stronger ones. Similarly, within LVGs, group-level publication masks variation in quality across individual FOPs. Lower-quality

[40] PDR, Part B, paragraph 10.31.

[41] PDR, Part B, paragraph 10.32.

[42] RCVS' response to the Remedies Working Paper, page 37.

[43] See, for example, PDR, Part B, paragraph 3.168.

FOPs gain from association with higher-performing peers, while stronger FOPs see their efforts diluted within an average result. The result is a weakening of competitive pressure to improve quality across the board.

3.22 Additionally, Remedy 4 envisages that the **costs of the survey would be covered by a levy exclusively on LVGs** (estimated by the PDR at ~£400,000 in aggregate for the first year and less in subsequent years),[44] which is (as discussed in Section A above) disproportionate and unjustified by the AEC analysis. Instead, IVC suggests that the necessary RCVS funding be sourced from (an increase in) annual membership fees and charges paid by all veterinary businesses on an industry-wide but *pro rata* basis - which will still ensure that the largest financial burden (to pay for the survey) will fall on LVGs.

Significant variations in customer-reported metrics across FOPs within the same group

3.23 The PDR's proposed group-level approach would **aggregate FOPs with very different customer-reported quality**. This is clearly shown by the empirical evidence.

3.24 **First, IVC's pet owner satisfaction survey data**[45] shows wide variation even within IVC FOP performance:[46]

(i) On Net Promoter Score ("**NPS**"), the median across IVC's FOPs is [REDACTED], with a minimum of [REDACTED] (scored by [REDACTED] IVC FOP) and maximum of [REDACTED] (scored by [REDACTED]IVC FOPs).

(ii) On 'the clinician listened to your concerns' metric, the minimum score achieved by an IVC FOP was [REDACTED] and the maximum was [REDACTED].

(iii) On 'the warmth of welcome' metric, the minimum score achieved by an IVC FOP was [REDACTED] and the maximum was [REDACTED].

3.25 This variation in scores across IVC's practices shows that there can be material variation in quality across FOPs within the same group, despite common ownership and group-level levers to drive improvements in quality. Indeed, IVC tracks customer satisfaction at the practice level in the ordinary course of business (and this forms part of an IVC practice's balanced scorecard), as understanding clinic-level performance is key to identifying how to make improvements.

3.26 **Second,** the PDR notes "*more variation*" between independents based on their ownership[47] compared to LVGs, on the basis of the underlying **net satisfaction score** ("**NSS**") in the **CMA's pet owners survey.** Although the publicly available survey data

[44] PDR, Part B, paragraph 3.183.

[45] As the CMA is aware, IVC collects data assessing pet owner satisfaction with its internal pet owner satisfaction survey sent to clients after consultations. This survey measures pet owner satisfaction of an IVC FOP through questions asking pet owners to rate different aspects of service quality on a scale of 1 (very poor) to 5 (excellent), alongside the calculation of each practice's Net Promoter Score (NPS).

[46] [REDACTED].

[47] PDR, Part B, paragraph 3.179.

does not include FOP-level identifiers, each respondent is tagged by region.[48] **Figure B.1** below replicates the national NSS for independent practices[49] and shows the significant underlying regional variation that underpins the national score referenced by the PDR in its comparisons with LVGs.[50]

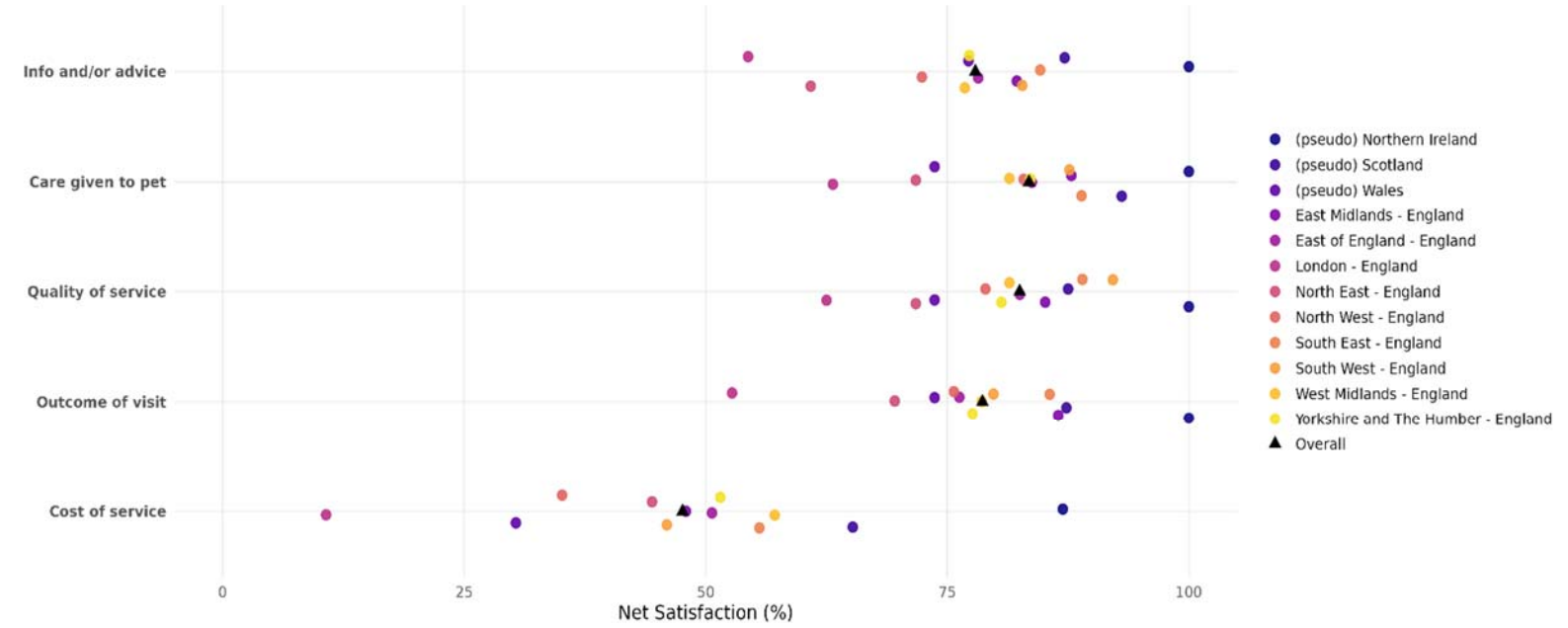
3.27 Across all five of the satisfaction metrics shown in **Figure B.1**, there is substantial variation between the minimum and maximum NSS, rendering the national average of extremely limited practical value. For example:

(i) In relation to the metric showing the widest range – 'cost of service' – the average NSS for pet owners in independent FOPs in London is 11%, compared to 87% in Northern Ireland. A publicised single national average of 47% for this measure would therefore be uninformative for pet owners seeking to compare FOPs in the same local market, and furthermore risk misleading them about relative pet owner satisfaction and value.

(ii) Even in relation to the metric showing the narrowest range – 'care given to pet' – where NSS varies between 62% and 100%, the persistence of regional-level differences limits the usefulness of a single national figure.

Figure B.1

Net Satisfaction Score by region (independent FOPs)



[48] Accent vet user research dataset, accessed 29 October 2025. Net Satisfaction Score calculated as satisfied minus unsatisfied responses, divided by the total number of valid (excluding 'don't know' and 'invalid') responses on a regional basis.

[49] PDR, Part A, Table 7.3.

[50] PDR, Part A, paragraphs 7.72 and 7.73.

Source: Frontier Economics Analysis, Accent pet owners survey (Q55b).

3.28 While **Figure B.1** shows the variation at the regional level, it is reasonable to expect that the variation would be even greater at the FOP level, and demonstrates how misleading grouping all independents (and all clinics operating under the same LVG banner) together would be to a pet owner.

3.29 The PDR's proposed approach to address this variation is to mandate that the independent average score be shown alongside a clear explanation of the methodology. IVC strongly disagrees that this will be sufficient to ensure that pet owners understand what the independent score represents, given that pet owners are unlikely to be familiar with, or pay close attention to, survey methodologies.

FOP-level alternatives to the PDR's proposed group-level survey

3.30 In IVC's view, there is **value in a measure of customer-reported quality**. But any measure must be at the FOP-level if it is to support pet owners' FOP choice based on quality.

3.31 The PDR recognises that a survey at FOP-level would be the "*most comprehensive indicator of price and quality that informs pet owner choice and drives competition*"[51] but believes this is not "*practicable or proportionate*" given it would be a "*very large and expensive survey*" with a "*high burden*" on businesses.[52]

3.32 IVC disagrees that a FOP-level approach is not practical, and submits that this can be done in a way that places a proportionate burden on FOPs.[53] In relation to **Remedy 4,** IVC recommends that the CMA consider a revised approach under which:

(i) The RCVS would:

(a) Limit the survey to a short set of questions focused on customer-reported quality metrics. IVC is aware of numerous precedents of similar surveys being used in this (and similar) industries, so the RCVS could develop the list of questions quickly and easily with industry assistance.

(b) Provide FOPs with a standardised cover text and survey questions to ensure consistency across providers.

(c) Upon receipt of the data at regular intervals from each FOP, analyse and verify the results for each FOP, and publish the scores on the Find A Vet webpage (see further the discussion of Remedy 3 below).

(ii) FOPs would:

[51] PDR, Part B, paragraph 3.173.

[52] PDR, Part B, paragraph 3.174.

[53] In putting forward this alternative proposal, IVC has drawn on established survey design best practice and precedent from other regulated sectors where similar transparency measures have been implemented successfully.

(a) Send the survey invitation to every pet owner following a visit to the FOP[54] using the standardised cover text provided by the RCVS.[55]

(b) Collect the survey response data and submit it to the RCVS at pre-determined regular intervals.

(c) FOPs, if they wished, could analyse the data themselves to generate insights on how they could improve quality.

(d) Once their score is verified by the RCVS, survey results could then be presented on each FOP's[56]: (1) RCVS Find A Vet profile page; (2) website; and (3) in-clinic.

3.33 IVC considers that this would be effective and not disproportionately burdensome for FOPs. However, a pragmatic alternative (that requires even less involvement by FOPs) could instead involve:

(i) The RCVS would share a survey link and standardised cover text with FOPs.

(ii) FOPs would send out survey invitations to all of their registered clients at set intervals (for example, twice per year).

(iii) The survey results would be collected and analysed directly by the RCVS, with results shared back with the FOPs by the RCVS.

(iv) As before, survey results could then be presented on each FOP's[57]: (1) RCVS Find A Vet profile page; (2) website; and (3) in-clinic.

3.34 This alternative would provide less accurate and reliable results versus a post-visit survey. However, it would involve less direct input from, and a lesser administrative burden on, FOPs.

3.35 Most importantly, both variations would be considerable improvements on the PDR's current proposal. These alternatives both involve a FOP-level measure of customer-reported quality, that would provide information that will be effective in supporting pet owners' FOP choice based on quality, and more generally help strengthen FOP competition based on quality.

3.36 Please see **Annex 1** for further design considerations that address the PDR's concerns with a FOP-level approach.

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[54] With suitable exceptions, for example ensuring pet owners are not surveyed immediately after a euthanasia appointment.

[55] This is in line with the standard approach to satisfaction surveys, that many FOP's – including IVC – already take, and ensures that recall of customers is strong and therefore insights are as accurate as possible.

[56] This should apply to both LVG and independent FOPs.

[57] This should apply to both LVG and independent FOPs.

Remedy 17 – Enhanced quality measures

Objective clinical care standards are a fundamental element of the (quality) transparency framework

3.37 A robust, meaningful, and effective quality framework requires that subjective surveys measuring customer experience should be supplemented with an objective, standardised quality assessment framework for **clinical care**, to enable meaningful quality-driven competition between clinics. These complementary measures of quality will provide a **rounded view of both clinical quality (PSS) and broad customer experience (survey)** and equip pet owners with relevant and digestible information to support informed choice.

3.38 While Remedy 17 envisages that veterinary businesses will inform pet owners of the current PSS accreditations and awards they hold, alongside details of qualifications held by practice staff (as set out in Remedy 2a) for enhanced transparency on clinical standards, IVC agrees that these are "*short-term*" measures only.[58] A more robust quality transparency framework (as described in paragraphs 3.40 – 3.44 below) should be a central element of the PDR's overall remedy package.

3.39 IVC also fundamentally supports the PDR's view that an optimal framework would have both: (i) an indication of the **baseline level of quality** that is expected to be met by all veterinary practices; and (ii) further transparency on the **relative levels of quality** between practices above this baseline, via a voluntary accreditation scheme.[59] However, IVC considers that an **entirely voluntary scheme** (i.e. without a mandatory baseline), that allows vet businesses to opt in or out of PSS assessments, would give smaller clinics with fewer resources further time and space to consider the benefits (e.g. competitive differentiation) and (investment) costs of the (enhanced) system, based on practical real-world experience, before committing to participate. However, to support the CMA's remedial objectives and to facilitate informed decision-making by pet owners, IVC suggests that pet owners be made aware (via Find A Vet or other comparison tools using the same data) of whether a practice has chosen to participate in the scheme.

Clinical care standards should be based on PSS, which already exists and is well-understood by the industry

3.40 IVC proposes using **PSS as the starting point for this framework**, **because PSS already exists (i.e. to 'avoid reinventing the wheel').** Developing a quality transparency framework which leans on the quality measures already captured by the PSS is **practical and proportionate** on the basis that the timescales, administrative burden, and costs (for the RCVS and industry) of effective implementation will be significantly less than creating an entirely new quality framework, and as the scheme is already well-known among vet professionals (based on the PDR's estimates, around 69% of eligible practices are already members).[60] Basing an enhanced quality framework on PSS has also received

[58] PDR, Part B, paragraph 10.34.

[59] PDR, Part B, paragraph 10.29.

[60] PDR, Part B, paragraph 10.36.

support from the RCVS in its response to the Remedies Working Paper: "*RCVS accreditation levels and awards as part of the Practice Standards Scheme would be the most comprehensive indicator that a practice had submitted to quality assurance*."[61]

PSS could be developed further through an industry-driven process to make it more effective and accessible for pet owners[62]

3.41 IVC considers that the key elements of an effective quality scheme[63] proposed in the PDR could be applied to the current PSS framework (to the extent not already present) with relatively limited time and resource investment, to improve PSS's effectiveness and accessibility, through an industry-driven process. In particular, the PDR proposes:

(i) **"*A clear structure and communication of the scheme*"[64] to improve pet owner awareness.** In its current form, IVC agrees that the PSS has limited pet owner engagement, which is its main shortcoming. This is echoed by the BVA's concern that the PSS "*is poorly promoted and poorly understood (by clients and also by some in the profession)*."[65] However, IVC considers that this could be addressed through **limited changes to branding and improved advertising**, e.g.: (1) PSS (and certain accreditations and awards) could be renamed or rebranded, to improve pet owner understanding of what is being assessed; (2) clearer signposting of PSS (as a measure of quality) online and in-clinic; and (3) other forms of advertisement of the framework, such as via the comparison tool Remedy 3 (see e.g. **Figure B.2** below) and channels of communication with pet owners as part of the survey Remedy 4.

(ii) **"*A range of accreditations*" including "*some specifically targeting consumer matters*" and incorporating clinical elements "*in the longer term*"[66], in consultation with industry.** PSS already incorporates effective measures of both clinical and service quality.[67] Further, IVC considers that **clarifications to the current structure to more clearly delineate between accreditations and awards should enable pet owners to meaningfully differentiate between the quality offering of practices**. In particular, it should be made clear to pet owners and practices that: (1) 'Core Standards' operate as the lowest, basic level of accreditation; (2) 'General Practice' and 'Veterinary Hospital' offer an enhanced tier in quality standards; and (3) awards are separate and incremental to accreditations, as a mark of excellence in discrete assessment

[61] RCVS' response to the Remedies Working Paper, page 9.

[62] Alongside the RCVS' ongoing five-yearly review of the PSS.

[63] PDR, Part B, paragraph 10.37.

[64] PDR, Part B, paragraph 10.37.

[65] BVA's response to the Remedies Working Paper, page 38.

[66] PDR, Part B, Paragraph 10.37.

[67] In relation to service quality, module 3 of the PSS already contain numerous requirements pertaining to the client experience (including in relation to matters such as complaints and client communication) – see also PSS award 2. In relation to the quality of clinical care a practice can deliver, this is covered (at least in part) by many of the existing PSS modules, such as module 1 (anaesthesia), module 2 (clinical governance), module 5 (diagnostic imaging), module 7 (infection control and biosecurity) and module 8 (in-patients).

categories. New awards targeting consumer matters could be developed in an industry-driven process, with a limited time and resource burden, using the current awards system as the procedural model, and the CMA's Final Report for the substantive tests.

(iii) **"*Accessibility*" to practices of all sizes and business models, and "*a proportionate approach which encourages participation in the scheme, particularly amongst smaller independents*."**[68] IVC agrees that a quality framework must not impose a disproportionate compliance burden, and must be designed to enable all practices to participate to support informed pet owner choice. For these reasons, IVC considers that the **PSS assessment process would be: (a) entirely voluntary** (as explained above); **and (b) simplified into one single assessment event (with a single fee payable)**[69] instead of having an assessment for each level of accreditation with an additional assessment for any awards (with separate fees for each), to reduce the burden and cost on practices and create a more efficient process. Additional clarity (including via the changes proposed above) on the PSS modules and awards that are most relevant and accessible to individual practices will also help them navigate and apply the system much more efficiently.[70]

(iv) **"*Effective monitoring*"**[71] **to build pet owners' and vet professionals' trust that the scheme effectively measures and signals quality**. IVC supports the PDR's broader proposals for enhanced monitoring powers for a competent sectoral regulator[72], and considers that these powers should extend to oversight of the enhanced PSS framework. To help manage the uptick in assessments and the need to expand the pool of PSS-approved assessors, industry should provide the necessary resource and funding on a *pro rata* basis (such that LVGs would bear most of the funding burden).

<u>The clinical care assessment framework should be implemented as soon as possible</u>

3.42 IVC recognises that the (further) development of this framework will require the involvement of a range of industry stakeholders, including industry bodies, market participants, and pet owners[73] – but considers that using PSS as the basis will significantly reduce the time and resource burden of implementation.

3.43 IVC strongly encourages the CMA to ensure that the **implementation timeline for this remedy follows the same (broad) timeline as for the survey remedy (in Remedy 4)**.

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[69] For the avoidance of doubt, a practice would need to satisfy the requirements of the mandatory 'Core Standards' in order to obtain an award.

[70] By way of example, IVC's internal policy is to [REDACTED]. Additionally, IVC signposts and explains the awards that are relevant to its referral practices e.g. Impatient Service, Team and Professional Responsibility, Client Service, Diagnostic Service, Emergency and Critical Care Service, and Environmental Sustainability.

[71] PDR, Part B, paragraph 10.37.

[72] PDR, Part B, paragraphs 10.49 to 10.70.

[73] PDR, Part B, paragraph 10.38.

Without this alignment, pet owners will be unable to effectively compare between practices across a comprehensive range of quality metrics encompassing both pet owner experience and clinical quality.

3.44 Therefore, IVC urges the CMA to ensure that provisions for objective clinical care standards as part of an effective and comprehensive quality transparency framework are incorporated into the CMA Order – rather than form part of recommendations to Government.

Remedy 3 – Enhanced RCVS Find A Vet platform and 'open data' remedy

IVC supports the creation of industry-backed comparison tools – but these will only be effective if they successfully promote consumer engagement

3.45 As explained in its response to the Remedies Working Paper, IVC is open to the PDR's proposal to provide pet owners with the ability to access in one place the types of information set out in Remedies 1 and 2 (including quality) for different service providers, to enable pet owners to easily compare the offerings available across the market. In particular, IVC supports the implementation of an enhanced version of the RCVS Find A Vet website, developed with the support (operational and financial) of the industry. IVC still retains concerns that sharing practice information and data collected by the RCVS for the purposes of the Find A Vet platform with third parties (to enable them to create their own comparison tools) may lead to unreliable, incorrect, or commercially distorted information being presented to consumers – but, if these third-party platforms are subject to safeguards (proposed below), they could have the benefit of creating wider consumer choice and a competitive 'backstop' or alternative to Find A Vet.

3.46 However, IVC believes that a comparison tool (whether operated by the RCVS or a third party) will only be effective if it successfully promotes consumer engagement, by observing the following principles:

(i) Information provided must be **meaningful** (including on price and quality) and presented in an accessible way.

(ii) The website operator should be familiar with the specific characteristics of the veterinary services sector, and should **not be commercially incentivised to present distorted or biased information** at the expense of pet owners and the veterinary profession.

(iii) Information provision requirements for vet businesses should not be disproportionately **time and resource-intensive**, to ensure consistent coverage and effective comparability across the industry.

Industry comparison tools must be subject to guardrails

3.47 IVC therefore encourages the CMA to consider the following guardrails when developing this remedy proposal further.

3.48 **First, simplicity and accessibility are key**: the format and level of granularity of the information provided to pet owners should be specific and comparable, in line with the

principles underpinning the CMA's ambition for consumer protection, in particular that UK consumers "*feel confident that they have clear, accurate information so they can shop confidently and find the best deal for them*",[74] and the associated provisions set out in the Digital Markets, Competition and Consumers Act 2024.[75] In particular:

(i) The publication of a **full price list** on comparison websites mirroring the price transparency requirements in Remedy 2b/c is unlikely to be helpful or accessible to pet owners because of the price list's depth, which does not lend itself to quick and easy comparisons across multiple service providers 'at a glance' (which is the basic premise of comparison tools). In the case of Find A Vet, it would also be highly resource- and time-consuming for the RCVS to implement the more sophisticated filtering, searching, and comparison front-end functionalities needed to accommodate a lengthy on-site price list. Therefore, IVC suggests that Find A Vet should carry URL links to individual clinic websites, where the full price lists (mirroring Remedy 2b/c) would be available for pet owners to review, if they wish. This would also reduce the burden on the RCVS which, pending the organisational and funding reforms contemplated by the PDR's legislative reform proposals, is likely to find it challenging to meet the logistical, technological, and financial requirements of designing, implementing, and operating a 'gold-plated' industry comparison website.

(ii) The PDR has provisionally decided that it would require RCVS Find A Vet to display information on PCPs as part of a '**pet care plan value calculator'**, with the aim of helping pet owners compare providers and determine the best value plan for them. Pet owners would input their expected usage of services over a 12-month period and the calculator would generate a personalised estimate of the total cost had the pet owner paid for the services individually, allowing pet owners to see their potential savings – and presumably compare potential savings across different pet care plans. However, **a PCP value calculator will not be effective and would likely lead to worse outcomes for pet owners**, for the following reasons:

(a) A PCP value calculator would be **highly complex for pet owners to use (and for the RCVS and vet businesses to deliver)**. It would need to have sufficient flexibility to account for a wide range of: (1) pet specifications (e.g. species, weight, age); and (2) different PCP plans across the market, each with different sets of benefits. While most plans include a common set of benefits (e.g. vaccinations, flea and worming), there are many distinct elements on offer in different PCPs,[76] as PCP

[74] Paragraph 1.7, *The CMA's approach to consumer protection*, April 2025. See also the CMA's blog post "*Why clear and accurate pricing matters – and how businesses can get it right*".

[75] In particular, sections 226 and 227, Digital Markets, Competition and Consumers Act 2024.

[76] For example, IVC's PHC Plus plan includes unlimited consultations and 20% off selected medicines – which can generate significant savings for the target group of pet owners who need to take their pet to the vet more regularly. Similarly, Medivet's Extra plan offers 10% off all vet bills (including professional fees and medicines) which can generate material savings especially with unexpected vet bills. It also includes a free annual blood test and analysis, which can be helpful for spotting issues earlier especially for older pets, where their health is beginning to deteriorate.

providers innovate to meet client needs.[77] Further, the PCP value calculator would need to be regularly updated to reflect innovations to PCPs across the market, which would lead to frequent and significant changes in the user interface, plus back-end functionality.[78] Reflecting these variations and updates would require highly complex functionality which would make the user experience cumbersome, time-consuming, and inconsistent across PCP providers (and would require significant technological sophistication and compliance costs to implement, which would likely be beyond the resources of the RCVS and many vet businesses).

(b) **A 'minimum viable' PCP calculator would mislead pet owners on value and could stifle innovation and quality**. Given the complexities of delivering an effective PCP value calculator, a 'minimum viable' version which seeks to quantify only a subset of common benefits (e.g. vaccinations, flea and worming), may seem attractive from a remedy design perspective. However, PCPs are priced to reflect expected uptake across the full range of benefits. If a PCP value calculator only focuses on a set of basic and common benefits, PCPs with more extensive benefits would misleadingly appear worse value for money – either in absolute terms or relative to other PCPs. This would also: (1) create an incentive for PCP providers to pare down their offerings to a bare minimum of benefits; and (2) reduce incentives for PCP providers to innovate – leading to a 'race-to-the-bottom' on PCP value propositions via orienting the market toward 'bare minimum' cover plans at low prices that may not represent best value for money for pet owners nor meet the needs of their pet depending on life stage and health.

(c) **The PCP value calculator is likely to understate pet owner benefits**. It can be difficult for pet owners to accurately predict their usage of different services over a 12-month period, and this is likely to vary year-on-year depending on the health of a pet. For example, IVC's analysis of pet owner savings based on their actual usage of benefits shows that an important element of savings is from discounts on medicines – many of which a pet owner could not anticipate given this can depend on their pet getting sick.[79] Likewise, other PCPs across the market can offer

[77] Therefore, to enable meaningful plan comparisons, a PCP value calculator would need to account for the range of benefits and innovations on offer in each PCP, reflecting pet owners' varying degrees of expected usage. For example, if the PCP value calculator only considered a common set of benefits (e.g. vaccinations, flea and worming), PHC Plus would artificially look much worse value compared to PHC Essentials, given the higher monthly subscription fee and because only the value of the same set of benefits would be quantified.

[78] For example, more pet owners can be expected to purchase flea and worming medications from online retailers as the PDR's proposed medicines-related remedies take effect. This could challenge the current economics and value proposition of PCPs, and providers will need to adapt and innovate to evolve their PCP offerings.

[79] The PCP value calculator would also give pet owners the option to calculate their savings versus a situation where they purchase flea and worming medicine online rather than from their FOP. For instance, [REDACTED]% of pet owners on IVC's Pet Health Club are up to date with flea and worming vs just [REDACTED]% for non-subscribers. Indeed, one of the things pet owners value about their PCP is that it helps them be confident they are doing the right thing by their pet in keeping up with preventative healthcare. The PDR acknowledges that preventative healthcare measures improve

discounts on all veterinary fees – so pet owners get extra value when their pet is unwell. While most plans include flea and worming, the exact medication prescribed to pets is based on a clinical assessment by the vet after a physical examination. This means some pet owners (i.e. new pet owners, or those that have lapsed with flea/worming treatments) would not be able to judge the appropriate product they need – and therefore any supposedly individual-specific savings estimate is likely to be inaccurate. Additionally, the value of the plan is not limited to monetary savings, but also the peace of mind they provide (especially for the benefits that cover more unpredictable needs) and the ability to spread the cost, for example in the case of unlimited consultations - which would not be captured in the proposed calculator. It will also not be able to account for the fact that subscribing to a PCP is a big driver of whether a pet owner keeps up with preventive healthcare for their pet. In this instance, a pet owner's optimism bias means they may overstate the likelihood of taking up preventative medicines if they were not subscribed to a PCP.

(d) For these reasons, the proposed PCP value calculator would not be effective in helping pet owners make more informed choices between PCPs, and **should not be included in Remedy 3**. This is also **reinforced by the PDR AEC analysis**, which finds that the CMA has not seen evidence of insufficient information on PCPs, and the CMA's pet owner research recognises that PCPs are not a driver of FOP choice.[80] Instead, the PDR expresses "*some concerns from a consumer protection perspective*"[81] – but these are addressed by the enhanced transparency required under Remedy 2d (discussed above), which aims to make it "*easier for pet owners to assess value for money of pet care plans and compare pet care plan offerings across different FOPs, [as a result of which] pet owners would be better equipped to choose a pet care plan that best suits their needs*."[82]

3.49 **Second**, for the reasons set out in paragraphs 3.19 – 3.39 above, a comparison tool **should be required to include a measure of quality** to contextualise price differentials, and to avoid a 'race-to-the-bottom' on price. In paragraph 6.14 of its response to the Remedies Working Paper, IVC presented an illustrative example of a 'quality badge' that captures measures of pet owner experience (using a survey approach) and clinical care (relying on the PSS accreditations and awards framework), and which could be displayed in-clinic and online (on clinic and comparison websites). IVC suggests that a comparable

animal welfare and subscribing to a PCP means uptake of these services is higher. PCP services can decrease the likelihood and severity of preventable health conditions, which would require significant care, saving pet owners in the long run and providing better pet health outcomes. This is acknowledged in the PDR: *'We note that pet care plans offer benefits to many pet owners such as spreading costs and encouraging preventative care by reducing the marginal cost of taking up additional preventative treatments, which may also lead to future savings" (*PDR, Part A, paragraph 139).

[80] PDR, Part A, paragraphs 9.14, 9.15 and 9.33.

[81] PDR, Part A, paragraph 9.15.

[82] PDR, Part B, paragraph 63.

simple and accessible format, adapted to the design of the final form quality framework, would provide effective and meaningful transparency for pet owners on relative quality standards 'at a glance', including on a comparison website. If a pet owner wishes to see further information, the comparison website could provide hyperlinks to RCVS survey scores, external customer review aggregator websites, and PSS assessment summaries.

Figure B.2
Illustrative example of a quality badge

3.50 **Third**, IVC emphasised in its response to the Remedies Working Paper that the market for household pet care is complex, heterogeneous and characterised by the trust-based relationship between vet and pet owner. Due care and attention must be afforded to the way in which information, including pricing and measures of quality, is collated, aggregated, and presented to pet owners via a comparison website. The RCVS would of course be well-placed to do this for Find A Vet. However, **third-party operators of comparison tools** making use of the 'open data' remedy to offer meaningful alternatives to Find A Vet should be required to:

(i) Have **sector-specific knowledge** to ensure that information being provided by clinics is well-understood and appropriately processed and implemented.

(ii) **Not be incentivised to subordinate the accuracy and reliability of the information presented to pet owners to their own commercial interests**, which would generate harmful distortions to competition, to the detriment of pet owners by fundamentally undermining the purpose of the comparison tool to "*improve pet owners' ability to distinguish and choose between providers and stimulate competition on price and quality*"[83]. Therefore:

(a) IVC supports the view expressed in the PDR that third-party commercial entities making use of the proposed 'open data' remedy should <u>not operate a sponsored ranking structure</u>, whereby vet practices pay a fee to appear at a higher position in search results (i.e. first in the search results or on page one). This would otherwise undermine the neutrality of the comparison tool, since rankings would be influenced by payments made by (greater resourced) vet practices rather than by objective

[83] PDR, Part B, paragraph 3.111.

criteria, and risks information being presented to pet owners in an unclear or misleading way.

(b) In addition, third-party operators should be prohibited from implementing other commercialised functionalities which could have similar distortive effects on website (search and filtering results) presentation, e.g. selling direct on-site appointment booking systems or e-commerce functionality to select suppliers (as opposed to pet owners clicking through a URL link to a vet business' own website to make bookings or online purchases). Any such paid functionality would discriminate between different service providers on the basis of the website operator's commercial interests, rather than the characteristics of their service propositions, and disproportionately impact smaller businesses which lack spare funds to pay for such features – both of which could have a distortive impact on (what should be objective and impartial) rankings. This diminishes the core purpose of a comparison tool – to equip pet owners with clear, accessible and objective information on vet practices, to support them in making informed decisions.

(c) Website operators could still however sell display advertising (e.g. on the margins of the user interface), including to vet services providers, to provide the necessary commercial revenue streams, so long as these do not (as above) interfere with the presentation of reliable and impartial search and filtering results.

3.51 **Fourth**, IVC stated in its response to the Remedies Working Paper that a remedy mandating an industry comparison tool should seek to **minimise the operational and logistical challenges** associated with initial implementation and ongoing maintenance. If disproportionately high, these challenges would risk undermining the consistency of or delaying industry-wide roll-out and, given their inflationary impact on vet businesses' cost base, likely feed through into significant price rises for pet owners.

(i) For Remedy 3, the PDR envisages a period of nine months from the date of a CMA Order (or an RCVS Undertaking) for the RCVS to create the design, specifications, and requirements of the Find A Vet platform.[84] FOPs and referral centres in larger groups would then have a further three months to comply with these data requirements (and would need to update their information as soon as reasonably possible following changes, and provide an attestation of the accuracy of the information provided to RCVS Find A Vet every 12 months).[85]

(ii) IVC is concerned that **the envisaged industry implementation period of three months is disproportionately short to establish automated integrations with RCVS systems**. Without these automations (to facilitate timely and efficient data transfers), vets and clinics would have to carry out manual data collections and transfers, which would be significantly less reliable and consistent (with high

[84] PDR, Part B, paragraph 3.157 - more complicated front-end functionalities and data sharing processes could follow, if necessary.

[85] PDR, Part B, paragraph 3.244.

risk of manual errors and delays), and impose a disproportionate process and cost burden on vets and clinics (and ultimately, pet owners).[86]

(iii) Therefore, instead of breaking the implementation period into two discrete blocks of time (one for the RCVS; another for industry), **IVC suggests that the RCVS work directly and collaboratively with industry over a total period of 12 months to design, implement, and roll out the new Find A Vet platform**. This would allow vet businesses to have earlier notice of, and input into, the RCVS data specifications as they develop, and avoid a 'standing start' to comply at the end of (an exclusively RCVS-driven) nine-month design and implementation period. A collaborative approach would also make it much more likely that the end result is practical, workable, and meaningful for pet owners, and that industry compliance is effective and timely.

(iv) Without visibility of the RCVS's design process (as proposed in (iii) above), data integration with RCVS systems and **automated compliance with information requirements from a 'standing start' would take much longer** for industry to implement than the three months envisaged by the PDR - possibly as much as 9-12 months, but the exact time required is difficult to predict with certainty until the RCVS technical specifications are known.

3.52 **IVC is committed to working with the CMA and broader industry stakeholders to develop this proposal further**, with a view to: (i) implementing a robust and workable RCVS comparison tool which will enhance transparency across the market and improve pet owner choice; as well as (ii) facilitating third-party alternatives through the 'open data' remedy, for wider consumer choice and a competitive constraint on RCVS Find A Vet, but subject to guardrails to ensure that the commercial incentives of private operators do not distort the information presented to pet owners in a way that would undermine the PDR's remedial objectives.

[86] As explained in IVC's response to the Remedies Working Paper, IVC prefers that practices directly share the necessary information with the RCVS (and any other operator of a comparison website), e.g. via an API or web portal, rather than information being obtained via web scraping, to both ensure the accuracy of the information and to encourage practices to engage with the comparison site. IVC also echoed the Remedies Working Paper's concern that web scraping could pose certain technical challenges, including the requirement to have technical expertise to maintain a scraping system that works across a variety of different practice websites, and also to maintain a comprehensive up-to-date list of webpages for all providers that is continually updated in real time to link to practices' own webpages.

4. Section C – Enhancing the proportionality of the remedies package

Summary of IVC's views

4.1 IVC also encourages the CMA to ensure that remedies **are always proportionate to the competition issues** – otherwise they risk **undermining the PDR's remedial aims**. Therefore, IVC is concerned that some elements of the PDR remedies package (in isolation or in aggregate) are excessively resource- or time-intensive for vets and clinics, with the following consequences: (i) inflating the time and compliance process burden on consultations, generating higher costs for vet businesses and pet owners; (ii) placing an artificial regulatory process straitjacket on the trust-based relationship between vet and pet owner, with detrimental effects on clinical autonomy and animal welfare; and/or (iii) imposing an unmanageable compliance burden on smaller businesses and potential new entrants.

4.2 In IVC's view, (all of) the **following refinements to the PDR package** are required to fully address these **proportionality concerns**:

(i) First, IVC supports increased transparency on prescriptions and medicines purchasing channels under **Remedy 7**, but opposes a **blanket oral disclosure requirement on vets in every consultation**, which is likely to distract from clinical work in an already compressed consultation window. These transparency measures should instead be focused on written literature in-clinic and online, which could also be shared with clients upon registration and at regular (e.g. annual) subsequent intervals.

(ii) Second, complex requirements in **Remedy 10** for soliciting, recording, and reporting on **pet owner default preferences for written prescriptions** will impose a very significant resource, process, and time burden on vets and vet businesses, given the need (in practice) for repeated verifications of pet owner choices in consultations; and significant investments in practice management systems ("**PMS**") and customer relationship management ("**CRM**") tools. Instead, IVC suggests: (a) applying these requirements only to new client registrations (for a gradual and more proportionate 'phasing-in' effect) and/or clients proactively asking for a prescription default (on the basis of information published in information packs they are provided, and in standard written materials widely made available in-clinic and online); (b) streamlining RCVS reporting requirements; and (c) ensuring that clear exemptions to prescription defaults are available for vets' clinical judgement (with a wide margin of appreciation).

(iii) Third, the **one working-day "cooling off" period** under **Remedy 13**, to allow pet owners to change their minds once they have made a decision on **cremation options**, will introduce: (a) high operational complexity; (b) significant infrastructure (e.g. storage and tracking system) costs; (c) increased health and safety risks; (d) physical and emotional strain on clinical and cremation staff; and (e) increased risk of human error (which in the context of a cremation can have devastating emotional consequences for pet owners and staff). IVC has also not seen (and the PDR does not present) any material evidence that pet owners want or need a "cooling off" period – IVC data shows that pet owners rarely change their minds and (in IVC's experience) prioritise a swift and efficient end-of-life

process for greater emotional comfort. The transparency measures and the two working day decision-making window proposed in Remedy 13 are effective and sufficient to resolve any consumer protection concerns in cremation services, and avoids the need for interfering with the process of handling deceased pets, with the unintended consequences that creates.

(iv) Fourth, **binding third-party adjudication or a veterinary ombudsman** proposed under **Remedy 17** would create another layer of administrative responsibilities and time burden for vets, increase pet owner incentives to pursue frivolous claims, and damage vet-client relationships by imposing top-down, inquisitorial mechanisms in a trust-based sector.

Remedy 7 – Information measures to increase awareness of online medicines channels

IVC supports increased transparency on prescriptions and medicines purchasing

4.3 The PDR envisages wide-ranging transparency measures to increase pet owners' awareness of their ability to: (i) request a written prescription; and (ii) buy medicines online to save money. Vets and vet businesses would be required to inform pet owners at various points before, after, and during consultations via multiple channels including digital, printed, and oral communication.

4.4 IVC supports the principle of increased transparency by the vet sector on pet owners' options for requesting prescriptions and purchasing veterinary medicines, but is concerned that the requirement on vets to make mandated oral disclosures during consultations creates a disproportionate additional regulatory compliance burden for veterinary professionals in an already stressful and challenging working environment, artificially interferes with the consultation process; and ultimately risks damaging the trust-based vet-client relationship, to the detriment of animal welfare.

IVC's concerns with Remedy 7

(i) **Burden on vet time**: The PDR alleges that an oral disclosure would take only "*seconds or perhaps a minute*".[87] However, this does not take account of the significant time pressures vets face in a typical consultation. Within a 15-minute window (of which even one minute is a material percentage), a vet must complete a series of steps at speed.[88] An additional requirement to deliver a standardised oral statement each time would add an unnecessary and disproportionate time and process burden to consultations, including because it is likely to prompt surprise and follow-up questions from pet owners – who are not used to artificial disclosures or disclaimers in the consultation room – e.g. on process, timing,

[87] PDR, Part B, footnote 572.

[88] For example, greeting and connecting with the owner and pet; gathering information (e.g. past medical history, pet physical appearance, gauge the temperament of the pet and identify the reason for the visit); examining the pet physically; diagnosing the condition; explaining the diagnosis to the owner; explaining the treatment options to the pet owner and answering questions; consulting the pet owner and agreeing on the treatment option; administering the treatment (which may or may not include administering medicine); giving advice on follow-on care and issues to watch out for.

safety, and price. The consultation timeslot with a vet is not the best time or place to deal with these questions (which could, upon pet owner request, be addressed by clinic administrative staff in the waiting room or via email or telephone correspondence, for example), as it would disrupt the clinical focus of the consultation. The consultation should remain reserved for diagnosis and treatment.

(ii) **Compliance concerns**: The veterinary profession is often highly cautious in its approach to the regulatory requirements, with a view to avoid any notion of non-compliance. An additional requirement to orally communicate the availability of prescriptions will add to these compliance concerns. Exceptions based on clinical necessity and vets' professional judgement (e.g. "*where the medicine needs to be administered by the vet or started immediately*" [89]) are important and necessary, and should expressly be afforded a wide margin of appreciation by any final form remedy (if the oral element of this remedy is not ultimately set aside) – to avoid excessive risk aversion in clinical decision-making to the detriment of animal welfare. However, even with (wide) exemptions, some vets would nonetheless default to extensive record keeping or feel the need to explain in detail to pet owners why they consider a written prescription is not appropriate in that situation – further increasing the time burden on vets, and potentially delaying urgent medication.

(iii) **Interference with the clinical process:** A vet's primary focus during a consultation is the welfare of the animal and the wellbeing of its owner. Their professional skill lies in judging what information to share, and when, so as not to overwhelm the owner while ensuring they can make informed decisions about treatment and aftercare. Mandating that vets must always mention the option of buying medicines online would be incongruent with this clinical process. It is likely to feel uncomfortable for both vet and pet owner, and could undermine the quality and clarity of communication at a sensitive time. IVC therefore encourages the CMA to focus on the other elements of its remedy package that aim to raise pet owners' awareness of online options *outside* the consulting room, rather than interfering with the integrity of the clinical interaction itself.

(iv) **Undermining the trust-based vet-client relationship**: Vets having to read out a standardised oral statement in an artificial way also risks undermining the trust-based vet-client relationship, and introducing a more transactional relationship – akin to a mortgage advisor reading out a set of standard terms and conditions – to the detriment of animal welfare.

(v) **Increased costs for pet owners**: Any measures that increase the regulatory compliance burden on vets' time will lead to less time available for clinical work, and therefore more expensive consultations and treatments for pet owners.

[89] PDR, Part B, paragraph 5.29(a).

IVC's alternative proposals

4.5 Other (written) transparency measures envisaged under Remedy 7 would already generate an extensive disclosure effect – these include publication of relevant information in in-clinic literature, prominent in-clinic notices, clinic websites, appointment confirmations, and invoices, among others. Some of these materials could be provided to clients as part of a standard information pack at client registration and subsequently at regular, e.g. annual, intervals. These measures are more effective, proportionate, and sufficient in combination to achieve the PDR's remedial aims, whilst avoiding disproportionate and harmful burdens on the narrow consultation time slot.

4.6 Remedy 7 should therefore entirely set aside the requirement for any proactive oral communication at any stage of the pet owner journey, and instead focus on other (written) transparency measures under Remedy 7.

Remedy 10 - Choice of default for repeat prescriptions

IVC's concerns with Remedy 10

4.7 IVC has similar concerns in relation to Remedy 10, which requires that all pet owners are afforded the opportunity to choose whether their default for repeat prescriptions is a written prescription or medication dispensed in-clinic – and are defaulted to written prescriptions if they did not respond.[90] This remedy would also generate a **significant additional administrative burden** on vets and clinics, and additional costs for vet businesses (and ultimately pet owners), for the following reasons:

(i) **Need for vets to repeatedly verify pet owner default preferences.** Some pet owners may not have previously actively expressed a preferred choice between written prescriptions or in-clinic dispensing, so would be defaulted onto written prescriptions. Others that did previously express a preferred choice may not recall their response (e.g. due to time elapsed or understandable focus on clinical rather than procedural aspects of a clinic visit). In other cases, pet owner preferences may depart from chosen defaults depending on the disease, medicine, or administration type. In practice, these reasons mean that a vet would need to reconfirm the pet owner's 'default choice' preference in the consulting room each time a repeat prescription is discussed, to ensure informed consent and contextualised care – but this would place a further burden on vets' time in the consulting room.

(ii) **High burden of collating and recording pet owner preferences in the PMS.** Practices would have to reach out to all registered clients to record their default choices, and the PDR considers that the cost of implementation would be "*limited*".[91] IVC is concerned that the PDR has underestimated the time and effort required to collect and record pet owner default choices in the PMS, and

[90] FOPs must follow certain steps for contacting clients, recording their preferred choice, and reporting annually to the RCVS. IVC requests that the CMA clarify the definition of a 'registered' client (e.g., this could cover clients who had visited within the previous 12 or 18 months, and for whom a FOP has an email or mobile number on record).

[91] PDR, Part B, paragraph 5.125.

overestimated the average FOP's capacity to automate this task. By way of illustration, an IVC FOP has on average around [REDACTED] unique clients[92] and some clinics are likely to have to collect this data manually, especially in (common) cases where the PMS is not directly connected to CRM systems. Some practices may have to invest significantly to integrate their PMS and CRM systems for greater automation, with substantial upfront costs. Any requirement to contact clients via post (as well as or instead of text message or email) would involve even more burden and cost.

(iii) **Complex reporting requirements.** Each FOP would be required to report annually to the RCVS the following data points:[93] (a) the total number of written prescriptions issued; (b) the proportion of customers selecting defaults; and (c) the proportion of repeat medicines where the FOP recommended purchasing in-clinic, including the reasons why. IVC is concerned that (c) would be highly onerous for vets to record in the consulting room on a *per visit* basis; and for veterinary businesses to programme the necessary functionality on their PMS to record this information (also on a *per visit* basis – [REDACTED]) and to report on it.[94] IVC is generally concerned that the PDR has vastly overestimated the typical FOP's PMS capabilities, and capacity to extend or develop these to meet new remedy process requirements. It is also unclear what benefit all of this effort and cost (for practices and ultimately pet owners) provides. Firstly, the data is unlikely to provide meaningful insights. in practice, many of the exceptions are likely to be pet owners who did not respond, so were automatically defaulted onto written prescriptions, but whose real preference in the consultation room was for medicines to be dispensed in-clinic. This information is not informative in terms of effectiveness of the remedy. Additionally, it is also unclear what the RCVS will be able to do with this data, e.g. even if the data shows lots of pet owners are switching from their default option. Without any clear purpose for or value of this data, IVC would question the value of imposing such significant process changes and costs on vet clinics.

IVC's alternative proposals

4.8 Instead, IVC encourages the CMA to:

(i) **Streamline requirements for collating and recording default preferences**, e.g. apply these only to new client registrations (to make implementation more gradual and proportionate, through a 'phasing-in' process) and clients proactively asking for a default (for example on the basis of information they have seen on

[92] Calculated using the number of unique customers recorded in IVC's PMS (Merlin) for FOP-only sites, from June 2024 to June 2025.

[93] PDR, Part B, paragraph 5.99.

[94] In most practices, the PMS is controlled and developed by a third-party vendor, which limits a practice's ability to add structured, reportable fields quickly such that compliance is essentially reliant on these third parties. Even in IVC's case, which has a relatively sophisticated PMS, retrofitting this (e.g. for multiple choice recording in drop down boxes) would require substantial investment such as: (1) redesigning prescription templates; (2) custom software development executed by the PMS vendor, and (3) extensive staff training on correct filing of exemptions and running annual report.

the option to ask for default written prescriptions published in standard written materials disseminated in-clinic and online, per Remedy 7 above);

(ii) **Remove the requirement to report the proportion of repeat medicines where the FOP recommended purchasing in-clinic**, including the reasons why, to the RCVS; and

(iii) As for Remedy 7 above, ensure that **exemptions to 'default' written prescription choices based on clinical necessity and vets' professional judgement** are expressly afforded a wide margin of appreciation by any final form remedy. The importance of protecting clinical judgment in this respect is also emphasised by industry bodies – for example in the joint response to the CMA's spring working paper on the supply of veterinary medicines by the British Veterinary Association ("**BVA**"), the British Small Animal Veterinary Association ("**BSAVA**"), the Society of Practising Veterinary Surgeons ("**SPVS**"), the British Veterinary Nursing Association ("**BVNA**"), and the Veterinary Management Group ("**VMG**"): "*We would not wish to see prescribing flexibility removed as it would restrict professional clinical judgment and vets' freedom to cater to the preferences of their clients*."[95] The PDR also recognises that "*vets rightly pride themselves on their dedication to the care of animals and their professional skills. Everything we have seen demonstrates that the vast majority of individual vets behave entirely ethically with respect to the animals in their care."*[96]

Remedy 13 – Transparency on the options and fees for cremations

IVC supports increased transparency and a decision-making period for pet owners

4.9 IVC supports increased transparency on cremation options and associated fees. IVC also fully accepts that FOPs should offer pet owners a decision-making window to consider their pet's end-of-life options. In IVC's experience, most FOPs currently have a system to distinguish between cadavers where a pet owner: (i) is still deciding on the preferred end-of-life option; and (ii) has made that decision. For example, [REDACTED]. This system is relatively uncomplicated to manage, effective, and avoids uncertainty for both FOPs and cremation services providers.[97]

IVC's concerns with the "cooling off period" on cremation decisions

4.10 However, IVC has very significant concerns with the proposed mandatory **one working day "cooling off" period** to allow pet owners to change their minds *after* they have made a decision on the preferred cremation option for their pet. Remedy 13 would add an additional, time-dependent status for animals subject to this period, which would introduce **disproportionate operational and risk management complexity and time**

[95] See Microsoft Word - 4 Competition in the supply of veterinary medicines FINAL.docx.

[96] PDR Summary, paragraph 16.

[97] The PDR clarifies that veterinary businesses operating a FOP are in the scope of this remedy. IVC notes that OOH providers also offer end of life services, and there could be a risk of inconsistency between FOPs and OOH which may confuse pet owners. IVC would encourage the CMA to acknowledge this as part of its Final Report and provide clarity on how this should be approached.

and cost burden for vet practices and cremation service providers. In particular, it would generate:

(i) **A need for further layers of tracking and verification**: For example, this could involve the need for barcoding or digital logs to monitor each pet's status accurately, which would need significant investments in new systems.[98]

(ii) **Significant strain on already limited cold storage capacity**: FOPs could be expected to need new storage solutions, for example separate areas or refrigeration units to segregate 'post-client decision' cadavers which are ready for collection from those still subject to "cooling off" periods. The PDR acknowledges the logistical challenges, but the exemptions for constraints on cold storage capacity are limited to small practices,[99] when the impact would in practice be most acute for larger practices that manage higher caseloads. These challenges would be particularly acute for larger animals that cannot easily be stored in standard facilities. Many practices already operate with limited cold-storage capacity and, where possible, schedule euthanasia (particularly for larger animals) to enable same-day collection.[100] A mandatory "cooling off" period would exacerbate these challenges.

(iii) **Significant health and safety concerns**: Longer storage times and more frequent handling of remains would increase hygiene risks, including deterioration, leakage, and potential contamination.

(iv) **Significant strain on clinical and cremation services staff:** Increased cadaver manual handling by FOP and crematoria staff would also place greater physical and emotional strain on clinical staff already managing sensitive and distressing client interactions.

(v) **Increased risk of human error**: Increased manual handling and a more complex system of 'statuses' for cadavers creates increased risk of human error in triage and processing, potentially causing significant emotional distress for both staff and pet owners (e.g. if cadavers are misallocated). A pet's body is already handled by multiple people in moving from a FOP to a crematorium. By adding more complexity to the process there is an increased chance of mishandling across the custodial chain in the absence of separate storage or investment in e.g. an electronic tagging system.

(vi) **Significant additional business costs**: The PDR acknowledges labour and material costs,[101] but new tracking systems, storage units and areas, and an

[98] In IVC's practical experience, labels are not sufficient as they are prone to falling off in fridges which risks creating unidentified cadavers or mix-ups.

[99] PDR, Part B, paragraphs 8.20 to 8.26.

[100] For clarity, cold storage at FOPs are often standard domestic chest freezers in a small room. Accommodating this remedy (to avoid any mishandling) may require a second freezer for most sites, which may not be feasible or would require re-purposing existing space that is already used for clinical activity.

[101] PDR, Part B, paragraphs 8.20 to 8.26.

increased staff and storage time burden would require significant new investments and ongoing operational expenses, which is likely to be difficult for some businesses to provide for, and will ultimately need to be reflected in the prices paid by pet owners.

The "cooling off" period is anyway unnecessary

4.11 The PDR notes that decisions about end-of-life options are made by pet owners "*during highly emotional and distressing moments*".[102] FOPs do not rush these decisions, but IVC emphasises that (in its experience) the **primary concern for most pet owners following their pet's death is typically a timely cremation and return of ashes**. The introduction of an additional "cooling off" period risks creating delays in both processes, particularly in smaller practices that may not operate every weekday or where collections occur just once a week. Such delays would prolong the emotional distress experienced by bereaved pet owners, many of whom wish to finalise arrangements promptly as part of the grieving process.

4.12 Many pet owners will attend a scheduled euthanasia appointment having already considered the different burial or cremation options for their pet, or attend the appointment ready to discuss and agree these options with their veterinary professional. When a pet's death is unexpected or an owner has not had the opportunity to consider the options before the euthanasia takes place, IVC's clinical experience is that 2 working days is (in the majority of cases) generally sufficient time for a pet owner to decide on the option that is best for them. However, in instances where pet owners require a longer period of time due to personal reasons or where the owner is not immediately available (i.e. they are uncontactable or microchip details are out of date), IVC clinicians will do their best to accommodate such requests (to the extent practically possible).

4.13 Therefore, IVC feels strongly that the introduction of significant additional complexity and cost for cremation service providers (and pet owners) through the addition of a further mandatory "cooling off" period *after* the decision on cremation has already been taken would **not deliver better outcomes for pet owners** – and the PDR has not shown that there is a consumer or competition problem to solve with this (highly burdensome) remedy. Put another way, the PDR has not presented any evidence that pet owners are being pressured into making an immediate decision, nor that they subsequently regret their choices:

(i) Pet owners ask for – and are allowed to take – adequate time to reach a decision about their pet's end-of-life arrangements. In such cases, most FOPs already adopt a compassionate and flexible approach that allows clients to reflect and decide at their own pace. IVC clinics have established processes to accommodate undecided cases, [REDACTED].

(ii) Once pet owners have taken the time to decide on cremation options, in IVC's experience it is very rare for them to change their minds. This is supported by internal data from IVC's cremation service provider, CPC. Over the 12-month period ending September 2025, CPC received only [REDACTED]"seek and find"

[102] PDR, Part B, paragraph 8.4.

requests (i.e. where a cadaver had already been collected and where pet owners changed their minds about their preferred cremation option). This represents fewer than [REDACTED]% of all cremations carried out by CPC during this period (totalling [REDACTED] cremations). This demonstrates that the proportion of pet owners who would theoretically benefit from the "cooling off" period is extremely small.

IVC's alternative proposals

4.14 IVC submits that:

(i) The proposed mandatory post-cremation-decision "**cooling off period**" **is disproportionate and unworkable**, and is not supported by evidence of an AEC or consumer harm; and

(ii) The **transparency measures and the two working-day decision-making window** proposed in Remedy 13 are **effective and sufficient** to resolve any concerns with competition and consumer outcomes in cremation services. They also avoid the need to interfere further with the sensitive process of handling deceased pets.

Remedy 17 – Option for consumers to seek binding independent redress

IVC supports mandatory in-house standards for complaints and enhanced mediation

4.15 Consistent with Remedies 14 and 15,[103] IVC supports sector-wide mandatory standards for robust in-house complaints handling and enhanced third-party mediation options (based on an enhanced version of the extant VCMS scheme (VCMS+)) – in each case communicated clearly to clients both online and in-practice and enforced by a strong specialist regulator with a deep understanding of the vet sector.[104]

IVC's concerns with binding adjudication or an ombudsman

4.16 However, IVC **does not support binding third-party adjudication or a veterinary ombudsman** as part of Remedy 17.[105] These proposals would:

(i) Add another layer of **unnecessary and disproportionate administrative responsibilities on vets**, resulting in significant additional costs being imposed on the sector given the resource and process burden associated with such a

[103] The PDR (through Remedy 14) proposes "*a requirement for all veterinary businesses operating FOPs to have an in-house complaints process for each of its FOPs which meets specified minimum criteria*" (PDR, Part B, paragraph 9.9). Secondly, the PDR (through Remedy 15) proposes "*a requirement for all veterinary businesses operating FOPs to engage in mediation in good faith in cases where the pet owner's complaint is not resolved in-house and the pet owner wishes to engage in mediation*" (PDR, Part B, paragraph 9.43).

[104] IVC's response to the Remedies Working Paper dated 31 May 2025, paragraph 6.19.

[105] The PDR (as part of Remedy 17) proposes that "*pet owners should have the option to seek a determination from a binding independent redress scheme*", which could be through a "*new veterinary services ombudsman with the power to make determinations binding on veterinary businesses*" (CMA PDR, Part B, paras 10.73 and 10.97).

system - further eating into clinical time, promoting a risk averse 'compliance culture' in clinical work, and placing further pressures on veterinary professionals' welfare and increasing attrition rates, all of which would have a detrimental impact on animal welfare and quality of service.[106] Indeed, the PDR cites evidence that binding adjudication would be "*lengthy, stressful, time consuming and costly, particularly for small and independent veterinary businesses*".[107] While LVGs could, over time, employ compliance officers to take some of the new administrative burdens away from vets, vets in independent FOPs would likely be particularly diverted from clinical responsibilities.

(ii) Be **neither appropriate nor effective in a trust-based sector** that relies upon collaboration between pet owners and vets. As the PDR acknowledges, neither the dental nor optical sectors have binding independent redress schemes – and the PDR otherwise points to ombudsman schemes in professions that are less comparable to veterinarians than dentistry and opticians.[108] The CMA has previously accepted that ombudsman schemes are top-down, investigative, and inquisitorial in nature.[109] These dispute resolution processes would be wholly inappropriate in the veterinary sector, given the potential damage to the relationship between vets and pet owners, considering also increased pet owner incentives to pursue frivolous claims.

IVC's alternative proposals

4.17 IVC submits that the PDR remedy package should instead focus on **mandatory minimum standards for in-house redress** and a **strengthened third-party mediation process**, based on an enhanced VCMS ('VCMS+').

(i) This **echoes the approach of other regulated industries** such as the legal sector, to ensure that clients receive a **consistent and fair process** throughout the veterinary industry.[110]

(ii) Building on the existing VCMS scheme – which is already familiar to and trusted by both veterinary employees and pet owners, and is the only provider currently approved to offer a mediation service specifically for the vets sector – **would minimise the timeline and resources necessary for effective implementation** of an improved complaints mechanism. In particular, IVC considers that the following will enhance the effectiveness of the existing scheme, and should be folded into a sector-wide VCMS+:

[106] IVC's response to the Remedies Working Paper dated 31 May 2025, paragraph 6.18.

[107] PDR, Part B, paragraph 10.82.

[108] PDR, Part B, paragraphs 10.78 to 10.79.

[109] Remedies Working Paper, paragraph 6.107.

[110] IVC's response to the Remedies Working Paper dated 31 May 2025, paragraph 6.19.

(a) Registration with the VCMS scheme to be made **mandatory** for all vet practices,[111] and for vet practices to engage in good faith with mediation in appropriate cases where a client's complaint is not resolved under an in-house procedure and the client elects to use the scheme. IVC agrees with the PDR's view that this (alongside sector-wide mandatory standards for robust in-house complaints handling, in line with Remedy 14) would "*address the lack of appropriate, consistent and "joined up" complaint and redress mechanisms in the regulatory framework*"[112] by ensuring that pet owners have robust and clearly delineated avenues to resolve legitimate complaints without the need for litigation.

(b) **Greater transparency requirements** imposed on practices to raise awareness of VCMS to pet owners,[113] both as part of an internal complaints handling process and more generally via clear signage online and in-practice, also via the channels of communication with pet owners as part of the survey Remedy 4, so that pet owners are aware of VCMS sufficiently early in their engagement with the relevant FOP and understand how to access it.[114] The could be supplemented by advertising of the scheme by the VCMS through consumer-facing avenues such as the Citizens Advice and relevant charities.[115]

(c) The VCMS to communicate **best practice guidance** including clear criteria to establish when a complaint is suitable for mediation as well as information on timelines, and guidance on e.g. reasonable adjustments and support for vulnerable customers, as well as publish information on insights it has from complaints processes, which practices would then use alongside their own complaints data to improve standards, as well as encouraging the resolution of legitimate complains at the earliest possible stage, to the benefit of vets, pet owners and their pets.

(iii) Increased standards for redress and mediation, which do not require binding third-party adjudication or an ombudsman, would ensure that the complaints of pet owners would be dealt with in a **collaborative and open fashion** – consistent with other trust-based sectors.

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[111] As the PDR acknowledges, one of the key "deficiencies" of the current redress framework is that engagement in mediation is voluntary only – PDR, Part B, paragraph 9.48.

[112] PDR, Part B, paragraph 9.50.

[113] As the PDR notes, currently only 5% of participants in its pet owners survey were aware of the existence of the VCMS, and only 6% of those who made a complaint also complained to the VCMS – PDR, Part A, paragraph 14.184.

[114] Indeed, the VCMS itself noted in its response to the CMA's Spring Working Papers that "'*Analysis indicates where a practice refers to the VCMS in their complaint policy, engagement is higher*" – see page 14.

[115] Which the PDR notes that the VCMS is already beginning to do – PDR, Part A, paragraph 14.185(a).

5. Section D – Avoiding significant unintended consequences

Remedy 11 – Prescription fee cap

Summary of IVC's views

5.1 The prescription fee cap proposed in Remedy 11 is a highly interventionist remedy which:

(i) Is **unsupported by sufficiently robust evidence** to the required evidentiary standard that the level of prescription fees charged by FOPs causes an AEC.

(ii) Will have **significant unintended consequences** by creating distortions in market, consumer, and clinical outcomes, e.g. higher in-clinic treatment prices to compensate for vets' below-cost prescribing activities; and potential incentives for (some) vets to take shortcuts either on prescribing or other elements of consultations, with corresponding risks to animal welfare.

(iii) Should, if implemented, be **subject to safeguards to minimise these unintended consequences**, including: (a) a clear time limit (or sunset clause) of three years; (b) a higher initial price level (i.e. above the current £16 threshold), linked to the industry median level; and (c) an inflation-linked annual cap increase reflecting vet sector CPI (not general CPI).

The prescription fee cap is not supported by sufficient evidence of an AEC

5.2 The prescription fee cap proposed in the PDR is a highly interventionist remedy with significant unintended consequences for the vet sector. Before discussing these unintended consequences, IVC would like to emphasise that the PDR has **not presented sufficient evidence to the requisite legal standard of an AEC** caused by prescription fee levels currently charged by FOPs.

5.3 **First,** the PDR's **concerns on the effects of prescription fees on pet owner decision-making remain hypothetical**: *"The presence and magnitude of prescription fees **may** discourage some pet owners from requesting a written prescription"*[116] (emphasis added). The PDR states anecdotally that in "*some cases*" prescription fees offset cost savings from purchasing online. On this basis, the PDR provisionally (and mistakenly) concludes that vets have the ability and incentive to discourage the purchase of online medication by increasing prescription fees.[117] However, the PDR does **not** provide sufficient evidence to show that: (i) current levels of prescription fees do not reflect time investment by vets; or (ii) current levels of prescription fees actually discourage online buying. On the contrary, evidence in the PDR suggests that prescription fees do **not** play an important role in pet owners' decision to purchase veterinary medicines online: "*our survey shows that the current **level of prescription fees may not be an important factor** in the*

[116] PDR, Part A, paragraph 11.273.

[117] PDR, Part A, paragraph 11.275.

decision of pet owners to purchase veterinary medicines directly from their FOP"[118] (emphasis added).

5.4 **Second, the PDR misleadingly compares the prescription fee of some LVGs (in the range of £20-30) against a consultation fee of £40** (which is at the lower end of the market) and concludes that the price of a written prescription "*may appear large relative*"[119] to a consultation fee. In response, IVC notes:

(i) This is **misleading as it compares a prescription fee at the more expensive end of the market with a consultation fee at the cheaper end** of the market. IVC aims to set prescription fees at approximately [REDACTED]% of the price of a consultation, as it considers this price level is reflective of the amount of time, effort, risk, and cost involved.

(ii) In IVC's view, a **more appropriate reference point for the price of a prescription (when considering its effects on pet owner incentives to buy medicines online) is the savings pet owners can make when buying medicine online versus in-clinic**. In these terms, the CMA's own analysis shows that "*there are generally substantial savings available to pet owners"*, even taking into account the prescription fee – which further underlines that there is no reasonable justification for imposing a prescription fee cap. IVC notes in this respect that where pet owners are buying medicines in smaller quantities, and the savings of buying online are smaller (and therefore closer to prescription price levels), this will only be in a limited set of circumstances, e.g. where the medicine is required to be dispensed immediately or where it is purchased just for the next few days (rather than for repeat prescriptions). In these cases (and unlike for repeat prescriptions), the PDR acknowledges that buying online is a less viable option for pet owners – as this may not be appropriate from a clinical or animal welfare perspective.

The prescription fee cap will have unintended consequences, including harmful distortions in market, consumer, and clinical outcomes

5.5 Additionally, capping the price of written prescriptions will lead to **significant unintended consequences** for sector stakeholders, including distortions which will harm consumer outcomes and pet welfare.

5.6 As explained in IVC's previous submissions,[120] writing prescriptions requires a significant amount of vet time, and individual professional accountability as it involves a number of steps. This can significantly prolong the time needed for a consultation and indeed many written prescriptions are not associated with a consultation at all (i.e. following a pet owner request for further supply). IVC's prescription fees seek to reflect this additional time requirement. **A prescription fee cap preventing veterinary practices from covering the costs of this time would make prescribing a loss-making activity for vets** (with

[118] PDR, Part A, paragraph 11.274.

[119] PDR, Part A, paragraph 11.273.

[120] IVC's response to Question 2, RFI 17; IVC's response to the Remedies Working Paper, paragraph 3.41.

the effect compounded if the cap only rises in line with the general CPI, not vet sector CPI[121]). Indeed, IVC notes that the Competition Commission mandated in 2003 that prescription fees could not be charged for a period of three years.[122] The fact that the market has since then moved back to charging prescription fees as a common, customary practice is indicative of the costs incurred by vets when prescribing. It also shows that a significant restriction of the fees that can be charged for written prescriptions is not economically sustainable for veterinary practices.

5.7 Therefore, imposing a prescription fee cap would have the following significant unintended consequences:

(i) **Higher treatment prices elsewhere**, given the need for vet practices to recover the costs of prescriptions elsewhere, effectively leading to a further need for cross-subsidisation.[123]

(ii) **Risks to animal welfare** due to the risk of creating incentives for (some) vets to: (1) deviate from the high prescription standards in place today, if vets felt pressured to rush certain important elements; or (2) rush (other) elements of the consultation, e.g., diagnosis, treatment, client communication.

(iii) **Limit price competition on prescription fees in the future**. A prescription fee cap will inevitably become an anchor price point across the market, and the majority of FOPs would be expected to price to this level. This will dilute the potential pro-competition benefits of the PDR's other price transparency remedies, which include transparency on prescription fees.

Any prescription fee cap should be subject to safeguards to minimise unintended consequences

5.8 A prescription fee cap is therefore not justified by the available evidence and carries significant risks for vet sector stakeholders (and the PDR's remedial objectives). Nonetheless, if the CMA intends to impose a prescription fee cap, it should:

(i) Be time-limited, with a 'sunset' clause taking effect after a defined period of year, e.g. two or three years.

(ii) Be set at a higher level than the proposed £16 threshold, to ensure the starting point is more economically sustainable for vet businesses.

(iii) Increase each year in line with veterinary services CPI, rather than general CPI.

[121] See https://www.ons.gov.uk/economy/inflationandpriceindices/timeseries/l7hh/mm23, accessed 30 October 2025.

[122] See https://www.legislation.gov.uk/uksi/2005/2751/article/3/made.

[123] Indeed, given that the PDR's concerns with high in-clinic veterinary medicine prices are caused in large part by vets undercharging for their time via treatment prices (and therefore needing to make up the shortfall through in-clinic medicines sales), preventing vets from charging fully for their time to prepare a written prescription may hinder a rebalancing of the vet sector away from cross-subsidies.

Prescription fee cap should be 'sunset'

5.9 The PDR suggests, without evidence, that higher prescription rates will increase FOPs' incentives to raise prescription fees, so proposes that the prescription fee cap would stay in place indefinitely (with a possibility for the CMA to review at a later point in time).

5.10 In IVC's view, the positive market-opening impact of the PDR's proposed price transparency remedies are a good reason not to maintain price controls (at all, or at least not indefinitely) – a position the PDR recognises with respect to cremations.[124] A time-limited cap would provide an adjustment period while the PDR's wider transparency remedy package is implemented and takes full effect, such that pet owners' awareness grows of their ability to request a prescription and make savings by purchasing veterinary medicines online.

Prescription fee cap should be set higher than £16

5.11 First, IVC notes that the PDR does not indicate whether the £16 prescription fee limit is inclusive or exclusive of VAT. This will make a significant difference to the revenue impact on vet businesses (discussed above), given that VAT is charged at 20%. IVC encourages the CMA to clarify that the proposed threshold is exclusive of VAT – and, importantly, to ensure that it has treated VAT consistently throughout its market analysis and in its consideration of the appropriate prescription fee cap level.[125]

5.12 If the CMA considers that the proposed £16 fee cap is inclusive of VAT, this would not reflect common pricing practice across the market - and is based only on a small sample of clinics. The CMA presents evidence based on data submitted by LVGs and independents, suggesting prescription fees range between £0 and £60 (at an independent), with the median prescription fee in 2023 of £20.[126] Other evidence by the SPVS shows fees ranging between £12 and £36, with a median of £18 excluding VAT, which equates to £21.60 including VAT.[127] [128] This evidence shows that the median prescription fee in 2023 lies above the cap that the PDR is proposing to introduce.

5.13 This is because the PDR's proposed fee cap: (i) is informed by the lower quartile of clinics across the market, i.e. the 25% of clinics charging the lowest prescription fees; and (ii) is equivalent to the median prescription fee charged by the independents in this sample

[124] In PDR, Part B, paragraph 8.46(b), with respect to cremations the CMA rules out a cremation price control in part: "*Indeed, if combined with transparency measures, a price control would risk undermining the positive impact of those transparency measures*".

[125] In particular, IVC notes that the CMA has referenced other figures (e.g. SPVS) in its analysis that are exclusive of VAT but does not recognise this in the summary of its analysis.

[126] PDR, Part B, Table 6.1.

[127] PDR, Part A, paragraph 11.163.

[128] IVC understands that the SPVS fee survey results are all exclusive of VAT.

(£15), with an additional inflation adjustment of £1.[129] This approach is not appropriate because:

(i) The CMA's underlying data spans 2,187 LVG sites but only 151 independent sites.[130] Relying on the median fee among the independents in its sample places undue weight on just 151 data points – equivalent to only 6% of the sample. The small sample size used raises significant concerns about the completeness and reliability of the data, and therefore the PDR's proposed prescription fee cap.

(ii) The PDR's analysis assumes that the small sample of 151 independents is representative of all independents.[131] However, this assumption is directly contradicted by the CMA's own analysis in previous working papers which noted that these practices *"may not be fully representative of independent practices overall"*.[132] As such, the PDR's proposed prescription fee cap is based on an extrapolation from a dataset which is known to be unrepresentative.

(iii) The PDR states (without supporting evidence) that "*a lack of competitive pressure*" allows the majority of FOPs to charge higher prescription fees,[133] and therefore only looks at the cheapest clinics. In arriving at its proposed £16 prescription fee cap, the PDR has put undue weight on the pricing practices of a small group of clinics – who may themselves not be pricing in a sustainable way. The sector as a whole has made important steps forward to charge for the time of clinicians on a cost-reflective basis, but IVC is concerned that Remedy 11 would force the sector to take a step back in this respect.

5.14 Moreover, charging practices differ widely in the industry: some clinics may charge a prescription fee per prescribing event (i.e. covering more than one medicine), while others charge a prescription fee per medication. It is unclear if and to what extent the PDR has taken account of these diverging practices in their analysis. Should the PDR not have accounted for this, it is likely that the prescription fee cap is based on those clinics that charge on a per-medicine basis, rather than the lowest charging clinics overall.

5.15 If the CMA is minded to impose a prescription fee cap, then in IVC's view the industry median level (i.e. ~£21 including VAT or ~£18 excluding VAT) would be less arbitrary and distortive of market and consumer outcomes.

5.16 This value should also be adjusted for the veterinary services CPI at the time of remedy implementation, as suggested below.

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[129] PDR, Part B, paragraph 6.26.

[130] PDR, Part B, footnote 247.

[131] PDR, Part B, footnote 247.

[132] CMA working paper on "Business models, provision of veterinary advice and consumer choice", para 6.8 (page 117).

[133] PDR, Part B, paragraph 6.25.

Prescription fee cap should increase annually in line with veterinary services CPI

5.17 The PDR proposes to increase the prescription fee cap annually in line with CPI, which it considers to be a "*suitable proxy for the increases in costs across the market*".[134] In IVC's view, the CMA should apply the veterinary services CPI[135] rather than the overall CPI to index how the prescription fee cap evolves over time.

(i) The PDR recognises that veterinary services CPI has outstripped general CPI in recent years.[136] This has mainly been driven by increased operating costs across the sector.

(ii) If operating costs in the veterinary sector continue to grow ahead of the wider economy, and the prescription fee cap increases only in line with general inflation, prescription fees will fall further behind other professional fees in the sector. This will make prescription activities even more unsustainable, and increase the fee cap's distortive effects (as explained above).

(iii) There should be no cause for concern that veterinary services CPI will be distorted by any perceived weaknesses in price competition in the veterinary sector – the PDR's comprehensive package of price transparency measures will be effective in removing this risk.

5.18 IVC also notes that the £16 figure selected by the CMA is based on 2023 market values, with a £1 adjustment for inflation. Given the prescription fee cap would come into force at the earliest in autumn 2026, it is important the CMA revises the cap to reflect ongoing input cost inflation.

[134] PDR, Part B, paragraph 6.33.

[135] CPI Index 09.3.5.0 "*Veterinary and other services for pets*".

[136] PDR, Part A, paragraph 7.18.

6. Section E – IVC's position on other remedies

6.1 Subject to its comments and proposals in **Sections A – D** above, IVC endorses the remedies proposed in the PDR and welcomes the CMA's work to develop an appropriate remedy package to address its concerns, whilst being mindful of the challenges the veterinary sector faces. In particular, IVC supports and appreciates the PDR's focus on:

(i) Remedies designed to enhance transparency in the sector, for pet owners to make more informed decisions.

(ii) Recommending reforms to the legislative and regulatory framework, to unlock greater productivity and deliver enhanced protections and welfare for sector stakeholders, including pets, pet owners, and veterinary professionals.

6.2 IVC's views on the remedies not yet addressed in this paper are briefly summarised in **Table E.1** below.

6.3 IVC encourages the CMA to continue to engage with industry ahead of the Final Report and the CMA Order to ensure that the practical details of remedy design and implementation (including with respect to the remedies addressed in **Table E.1** below) are effective, proportionate, workable, and avoid unintended consequences for the veterinary sector.

Table E.1
IVC's position on other remedies

PDR remedy	IVC's views
Remedy 1 - Requirement to clearly display common ownership on signage, websites, and marketing materials, and when referring pet owners to commonly owned services.	IVC broadly supports the PDR's proposal to increase information transparency relating to vet businesses, including ownership and basic service information. It will be effective and proportionate in increasing awareness of ownership links.
Remedy 2a - Requirement to publish basic service information, including OOH provider contact and address details, staff qualifications and accreditations, and any PSS awards and accreditations.	
Remedy 5a - Requirement to provide an estimate of total cost of recommended treatment in advance and in writing where such treatment is expected to be £500 or more (including VAT) and updates provided where estimated costs increase by 20% or £500 (whichever is lower).	IVC broadly supports the PDR's proposal – it is already IVC group policy to provide and update written estimates to pet owners (including an up-front estimated range for all anticipated treatment costs, followed by daily updates on accrued costs and a more informed and accurate estimate for the next 24 hours), to enable informed pet owner decision-making. This also aligns with the RCVS Code of Professional Conduct.
Remedy 5b - Provision of itemised bills for treatments and services with sufficient detail to let consumers understand the cost of the bill's components.	IVC already offers itemised bills to pet owners and broadly supports making this an industry-wide standard.
Remedy 6 - Requirement for written policies and processes to ensure that vets can act in accordance with the RCVS Codes and Guidance (including the provision of	IVC broadly supports the prohibition of business practices which limit or constrain choices offered to pet owners. IVC protects and promotes its vets' clinical autonomy and professional expertise to provide appropriate treatment and referral options to pet owners, and to prioritise the best interests of

PDR remedy	IVC's views
independent and impartial advice and a range of treatment options where appropriate).	patients and pet owners. All of this is consistent with the pre-existing requirements of the RCVS Code of Professional Conduct, including the Principles of Practice and Professional Responsibilities[137] and the requirement that "*veterinary surgeons must provide independent and impartial advice and inform a client of any conflict of interest*".[138]
Remedy 8 - Written prescriptions must be provided in hard copy by the end of the consultation, or digitally by the end of the day of the consultation.	IVC broadly supports the requirement for FOPs to provide timely written prescriptions. IVC considers that the measures are feasible for FOPs without excessive administrative burden. Where timely provision of written prescriptions does not already happen, this measure would remove tangible friction from many pet owners' experience of the consultation process.
Remedy 9 - Labelling of own brand medication must state: (i) active ingredients and (ii) that branded equivalents are available. Name of branded equivalent to be provided alongside medication when dispensed and pet owners to be told that branded equivalents can be purchased from third parties.	IVC understands this remedy to require the active ingredient and a statement that branded equivalents are available to be included on the labelling, packaging and invoice, but for the name of the branded equivalent(s) to be included on the invoice only (rather than the label or packaging of the own brand medicine itself). IVC considers that there would be practical difficulties with including the name(s) of branded equivalents on labels or packaging given space constraints, and such information risks obscuring other critical information, such as instructions on how to administer the given medicine. On the basis of this interpretation, IVC broadly supports the additional labelling and information transparency on own brand medicines. IVC considers that the measures are a proportionate and effective way to increase awareness of alternative options to own brand medicines, in a way that complies with the specialist regulatory framework governing veterinary medicines, ensures the safety of pets, and avoids unnecessary professional risks for vets.
Remedy 12 - Restrictions on clauses in FOP contracts with third-party OOH care providers (both existing and new contracts): (i) notice periods capped at 12 months; and (ii) no termination fees where full notice period is served.	IVC broadly supports capping termination notice periods in OOH partner practice contracts at 12 months. Capping termination notice periods at any shorter duration would have an adverse impact on the economic viability of OOH clinics.
Remedy 14 - Requirement for FOPs to publish and provide pet owners with an in-house complaint process which meets specified minimum criteria and share a log of complaints (at the FOP level) with the RCVS when requested, to be reviewed periodically to facilitate learnings from individual cases and identify systematic issues.	IVC broadly supports sector-wide mandatory standards for robust in-house complaints handling and enhanced third-party mediation options, which ensure that pet owners experience a clear, consistent, and fair process regardless of the clinic they visit; build on existing frameworks to minimise the timeframe and resource burden for effective implementation; maintain scope for complaints to be

[137] See further Code of Professional Conduct for Veterinary Surgeons - Professionals.

[138] RCVS Code of Professional Conduct, paragraph 2.2. For completeness, see also section 2.4 of the Code and Supporting Guidance at section 11.2 - the RCVS Code explicitly sets out that vets must communicate effectively (which may be fulfilled orally) with clients and ensure that they obtain informed consent before treatments or procedures are carried out. The Supporting Guidance explains that this involves giving pet owners a range of reasonable treatment options to consider, with associated fee estimates, and having the significance and main risks explained to them.

PDR remedy	IVC's views
Remedy 15 - Requirement for FOPs to engage in good faith mediation (at pet owner's request) where complaint is not capable of being resolved in-house – with the aim of incentivising the resolution of legitimate complaints at the earliest stage.	dealt with in an open and collaborative manner, protecting the vet-client trust-based relationship; and align with standards in other trust-based professions.
Remedy 16a - RCVS to develop (potentially with support from e.g. the BVA and BSAVA) and publicise a decision tree to support pet owners in navigating the different routes to redress, which should be included in FOPs' complaint handling process (per Remedy 14).	
Remedy 16b - RCVS to collect, analyse and publish (on an annual basis) data and insights on complaints - to support continuous learning and improvements among vet businesses and professionals and inform broader regulation of the market.	
Remedy 17 - Recommendation to revise/replace the statutory regime (VSA) regulating veterinary services for household pets, to include: i. Regulating veterinary businesses and the practices they own in relation to competition and consumer matters. ii. Regulating the professional conduct of vets and vet nurses, including a lower threshold for regulatory action, enforceable requirements to promote competition and protect consumers, including an annual declaration of compliance. iii. Robust and effective monitoring and enforcement powers for the regulator, including a broader and more effective range of sanctions. iv. Statutory duties for the regulator to promote competition and further the interests of pet owners. v. An independent and effective veterinary regulator underpinned by key operational principles to ensure the effectiveness of new legislation and the regulatory regime that would sit under it.	IVC welcomes the PDR's recommendations for reform to the regulatory and legislative framework: i. Regulatory requirements on vet businesses (as well as vets) effectively plugs a gap in the regulatory regime as many decisions affecting pets, pet owners, and veterinary professionals are made by vet businesses (rather than at the individual vet level). ii. Reform and clarification of the regulatory framework governing the veterinary nurse role facilitates more efficient allocation of staffing resources within veterinary practices, including by freeing up vets to undertake vet-specific tasks; helps address attrition and increase morale across the profession; promotes career progression opportunities for veterinary nurses; alleviates labour-related cost pressures on the industry; and provides pet owners with greater accessibility, transparency and confidence in the professional qualifications of those who are treating their pet. iii. Robust monitoring and enforcement of the new regulatory regime by an empowered industry regulator (RCVS) effectively supports transparency remedies (including e.g. quality transparency) and regulatory reforms (e.g. new requirements on complaints handling / mediation); and offers more robust protection to pets, pet owners, and the profession. iv. An enhanced regulatory remit for the RCVS (e.g. ability to impose a wider range of sanctions), subject to governance reforms (including switching to appointed governance and new resourcing arrangements). IVC looks forward to continuing to work with competent governmental authorities on the details of legislative and regulatory reform for the veterinary sector.

6.4 IVC believes that the above package of remedies, alongside the measures discussed in Sections B to D above, would provide an effective and proportionate solution to enhance customer transparency and choice, and drive increased competition in vet services. These measures and recommendations (as amended by IVC) would also be consistent with the '4Ps' (and CMA Guidance), which is crucial to ensure that: (i) there is renewed incentive for investment in UK veterinary services (which has significantly diminished through the CMA regulatory process), to the benefit of pets, pet owners, veterinary professionals, and wider stakeholders; and (ii) the CMA sends a clear message to the wider UK economy that it is serious about driving growth and investment whilst fulfilling its mission of promoting competition and consumer welfare. IVC stands ready to work constructively with the CMA, alongside specialist governmental and industry bodies, in consultation with the sector and pet owners, to further develop these reforms.

Annex 1
Design considerations for a revised quality survey remedy

1.1 The PDR has argued that a FOP-level survey would impose an unreasonably high burden and cost on businesses given the sample would need to be sufficiently large.[139]

1.2 IVC's proposed survey design - the "**alternative survey design**" - addresses the PDR's concerns. Specifically:

(i) **On sample size:**

(a) Firstly, it is important to note that the aim of a customer-reported quality measure is not necessarily aiming for a 'statistically representative sample' of clients. The purpose of this remedy is to provide pet owners with transparent 'signals' of quality. From a remedy design perspective, IVC does not necessarily consider that a low response rate for some clinics to be a weakness, as long as the volume of responses is also published along the scores. Indeed, the volume of responses is also helpful to a pet owner in interpreting these 'quality signals' – in much the same way as a prospective patron of a restaurant would consider the number of Google reviews alongside the distribution of star ratings.

(b) Notwithstanding this, IVC considers both of its alternatives is likely to generate a sufficient number of responses for each clinic to be informative for pet owners.

(I) The CMA has drawn conclusions from c. 2,300 survey respondents to its pet owners survey – and in some cases, presented results for cohorts with just over 100 respondents.[140] A similar sample size would be achievable for each practice, particularly given sample sizes for other similar surveys focused on measuring customer satisfaction.[141]

(II) IVC FOPs each had an average of around [REDACTED] unique clients in the 12 months from June 2024 to June 2025.[142] Achieving a sample of 100 respondents would therefore only require an average [REDACTED]% response rate. Even for

[139] PDR, Part B, paragraph 3.174.

[140] For example, some of the LVG results presented in Table 7.3 (PDR, Part A) are based on NSS calculated with just over 100 respondents – see for example the underlying data for Linnaeus available in the Accent data tables.

[141] IVC notes that Money Saving Expert's banking poll, which the CMA references in para. 8.74 (CMA PDR, Part A), has a minimum threshold of 75 responses per bank (see How do you rate your bank account's service?, accessed 30 October 2025). On a similar note, the 2025 NHS GP Patient Survey, conducted by Ipsos, applies a minimum threshold "as far as possible" of 100 responses per practice (see NHS *Patient Survey, Technical Annex*, accessed 30 October 2025).

[142] Calculated using the number of unique customers recorded in IVC's PMS (Merlin) for FOP-only sites.

smaller FOPs and independents, reaching a 100-respondent threshold would be more than feasible.

(III) IVC's experience in collecting FOP level survey data (via its internal pet owner satisfaction survey) demonstrates that a FOP-level survey is practical and achievable, with the average IVC practice receiving over [REDACTED] responses over a year to the satisfaction-focused questions in this existing survey.[143]

(IV) Furthermore, the CMA's own survey guidance aims to achieve a minimum of 100 completed interviews for a pre-defined group of interest.[144]

(c) A survey conducted at the FOP level would therefore be consistent with the CMA's best practice, practical and proportionate from a sample size perspective, and provide more meaningful and locally-relevant insights even with a relatively low response rate needed per FOP.

(ii) **On business burden and cost:**

(a) The PDR's concern that a FOP-level survey would impose an excessive burden on providers is overstated. Many practices will already have CRM systems in place that allow them to send out surveys post-visit in a straightforward manner, and the upfront cost to adding a CRM system is limited for those without.

(b) Operationally, the alternative survey design is therefore not more burdensome than other remedies in the PDR remedy package – in particular Remedy 10[145], which requires all FOPs to contact clients annually to confirm their default option for repeat medications. This remedy will require a CRM system, which could also be used for the implementation of a FOP-level survey proposal.

(c) The alternative survey design would likely be delivered at lower cost compared to the PDR's proposed approach (estimated at £400,000 for the first year). In particular, IVC's proposal would eliminate the need for extensive fieldwork and the cost of participant incentives by a research company (commissioned by the RCVS). Existing IVC evidence shows that sending an email to a client is associated with a cost to the practice

[143] Based on IVC's internal pet owner satisfaction survey data for the 12-month period ending in October 2025 for about [REDACTED] practices. Each of the satisfaction-focused questions receive at least [REDACTED] responses on average in the 12-month period.

[144] See CMA, Guidance on Good Practice in the Design and Presentation of Customer Survey Evidence in Merger Cases, paragraph 2.31.

[145] Remedy 10 requires all FOPs – both independent practices and LVGs – to contact clients annually to confirm their default option for medication.

of just [REDACTED], and an SMS [REDACTED].[146] Costs for the RCVS would therefore be limited to survey analysis, reporting, and platform maintenance.

The alternative survey design follows best practice and precedent in other industries

1.3 The alternative survey design aligns with established principles of survey design – including the CMA's own guidance – in addition to precedent in other regulatory contexts. The alternative survey design is in line with the CMA's own guidance on sample size and sourcing, survey length and survey language (avoiding bias).[147] It is imperative that the CMA embeds these principles in its final decision such that the remedy provides information which is genuinely useful for pet owners, whilst avoiding unintended distortions to competition in the veterinary sector.

1.4 **More frequent data collection than the PDR's current suggested bi-annual collection would ensure results presented for practices are reflective of recent performance**.

1.5 Increasing the data collection intervals from the PDR's proposal of once every two years would ensure that results better capture the dynamics of customer satisfaction over time. Customer experience can change quickly as staff, management, or local pricing policies evolve at the practice level.

1.6 Increasing the frequency of data collection would minimise inaccuracy stemming from recall issues over long time periods.[148] As IVC has outlined to the CMA previously, customer recall accuracy drops sharply after an event, particularly for emotional or routine visits, and therefore survey responses collected a long time period after the event are unlikely to provide reliable evidence.[149]

1.7 As mentioned in paragraph 3.32(ii)(a), ideally survey data would be collected on an ongoing basis after every suitable consultation via email or text invitations (similar to how IVC collects its internal pet owner satisfaction survey data). This would be consistent with the CMA's preferred methods for sample sourcing for surveys in its guidance, given the option of "*intercepting customers at stores*" [150] is referenced by the CMA as a similar sample sourcing method to post-visit survey invitation, as per the alternative survey design. Many FOPs already have CRM systems set up to facilitate this sort of data collection.

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[146] Costs taken from IVCs existing internal pet owner satisfaction survey.

[147] See CMA, Guidance on Good Practice in the Design and Presentation of Customer Survey Evidence in Merger Cases. Paragraphs 2.1 (e), 2.6, 2.14, 2.24, 2.31, and 3.6.

[148] See CMA, Guidance on Good Practice in the Design and Presentation of Customer Survey Evidence in Merger Cases, paragraph 3.23.

[149] Frontier Economics (on behalf of IVC) comments on CMA draft customer survey, page 4-5.

[150] See CMA, Guidance on Good Practice in the Design and Presentation of Customer Survey Evidence in Merger Cases, paragraph 2.6.

1.8 The pragmatic alternative (as outlined in paragraph 3.33) – conducting the survey with RCVS collection at set intervals (for example, twice per year) – still has the benefit of increased frequency versus the PDR's proposal. In addition, using a FOP's own customer list to source the sample is consistent with the CMA's stated preferred methods[151] and ensures respondents are in fact customers of the FOP, and have had a confirmed interaction.

1.9 In contrast, sample sourcing via "free-finding" – as per the CMA's proposal – risks accuracy issues and as the CMA themselves state in their survey guidance should only be used *"where no customer or reputable external lists exist"*.[152]

1.10 Either variation of the alternative survey design would therefore better ensure results reflect the recent investments, staffing changes, or changes in ownership that may affect customer satisfaction versus the PDR's proposal, while at the same time striking a balance between the accuracy, quality of insight and burden of collection on practices.

1.11 An annual or more frequent survey would align with established practice in other sectors. For example:

(i) the Banking Service Quality Indicators survey is conducted twice a year[153]; and

(ii) the NHS Friends and Family Test reports monthly.[154]

1.12 Both examples, referenced by the CMA, demonstrate that more frequent and standardised publication is achievable and proportionate in a regulatory context.[155]

1.13 IVC believes, however, that beyond frequency of data collection the design of the *NHS Friends and Family Test* is more relevant to the veterinary services sector compared to the *Banking Service Quality Indicators* survey. The CMA has provisionally concluded the market for the retail supply of FOP services is local.[156] On this basis alone, the *NHS Friends and Family Test* – which captures continuous, practice-level feedback from patients – is a much more appropriate baseline for the design of any survey for the veterinary sector. In contrast, the CMA has previously defined the market for personal

[151] See CMA, Guidance on Good Practice in the Design and Presentation of Customer Survey Evidence in Merger Cases, paragraph 2.14.

[152] See CMA, Guidance on Good Practice in the Design and Presentation of Customer Survey Evidence in Merger Cases, paragraph 2.24.

[153] The Banking Service Quality Indicators survey is conducted nationally for the largest banking providers. See IPSOS – Personal banking service quality, accessed 28 October 2025.

[154] The NHS Friends and Family test captures continuous, practice-level feedback from patients. See Friends and Family Test (FFT) data collection - NHS England Digital accessed 28 October 2025.

[155] PDR, Part A, paragraphs 8.74 and 8.75.

[156] PDR, Part A, paragraphs 4.38.

banking to be *national*[157], rather than local. Therefore, while a national brand-level survey may have been a suitable survey design choice in the context of retail banking – it does not follow that it is a suitable design choice for the veterinary sector. Other reasons for seeing user experience measurements from the NHS as a closer proxy to veterinary care than retail banking are obvious.

1.14 **The scope of the survey design should remain concise and focused on customer-reported quality metrics,** such as client satisfaction, perceived quality of service and value for money perceptions. This is because:

(i) Respondents struggle to answer a large number of questions (i.e., survey fatigue)[158], whereas a short set of questions can generate higher response rates. IVC's own experience with its internal pet owner satisfaction survey sent to clients after consultations suggests that a short set of focused questions can generate hundreds of responses per practice.[159]

(ii) Pet owners will struggle to make comparisons across practices with too many dimensions in the survey results. For pet owners to make meaningful comparisons, the results presented will need to be limited in length and easy to understand, so as to support their use in informing their choice of FOP. The CMA should therefore limit the survey length – and consequently the results presented – with the ease of comparisons for pet owners in mind.[160]

1.15 A reasonable approach would be for the survey to adopt the same five sub-questions in Q55b of the CMA's pet owners survey, each measuring customer satisfaction on a five-point "very satisfied" to "very dissatisfied" scale.[161]

1.16 **The alternative survey design proposal should not allow practices to influence results.** Specifically, IVC considers that:

[157] See for example paragraphs. 4.38-4.48 in https://assets.publishing.service.gov.uk/media/57ac9667e5274a0f6c00007a/retail-banking-market-investigation-full-final-report.pdf.

[158] Frontier Economics (on behalf of IVC) comments on CMA draft customer survey, page 4-5.

[159] Based on IVC's internal pet owner satisfaction survey data for the 12-month period ending in October 2025 for about [REDACTED] practices. Each of the satisfaction-focused questions receive at least [REDACTED] responses on average in the 12-month period.

[160] See CMA, Guidance on Good Practice in the Design and Presentation of Customer Survey Evidence in Merger Cases, paragraph 3.6 to 3.9.

[161] These are (i) the information and/or advice provided, (ii) the care given to the pet, (iii) the overall quality of service, (iv) the outcome of the visit; and (v) the cost of service.

(i) Survey questions should avoid leading language (e.g. asking whether a vet provides the "highest standard of care"[162]) and instead use neutral satisfaction scales to ensure unbiased responses.[163]

(ii) Survey wording should avoid language that may trigger emotional bias, to ensure responses reflect genuine experience rather than emotional reactions.

(iii) To eliminate any possibility of practices influencing outcomes, the RCVS should retain full control over the survey content, wording, and distribution materials, including the invitation template. This centralised oversight would ensure a consistent, neutral tone and standardised presentation across all providers, safeguarding the integrity and comparability of results.

1.17 **The proposed survey design prioritises clarity and interpretability for pet owners.** IVC considers that the use of the NSS – used by the CMA in its pet owners survey – risks misleading consumers. NSS condenses multiple response categories into a single figure that masks the distribution of how strongly people feel about a particular service quality dimension. Two providers with very different satisfaction profiles can produce the same NSS, making it hard for consumers to interpret differences in experience.[164]

(i) Instead, the proposed alternative survey design should report an average satisfaction score[165], derived from the same five-point response scale used in the CMA's survey. This metric offers an additional, easily interpretable indicator that captures the intensity of customer sentiment, not just its direction. It is also a well-established approach in public reporting – for example, the ONS publishes mean well-being scores using a comparable 0-10 satisfaction scale.[166]

(ii) Alternatively, the CMA could adopt a simpler measure by reporting the percentage of satisfied customers[167], defined as the share of respondents selecting "very satisfied" or "fairly satisfied" on the five-point scale. This would be

[162] Example from Question Q36r1 of the CMA's pet owners survey.

[163] See CMA, Guidance on Good Practice in the Design and Presentation of Customer Survey Evidence in Merger Cases, paragraph 1.26 and 3.10 to 3.11.

[164] For example, excluding neutral views, FOP A might have 60% of customers "very satisfied" and 20% "fairly satisfied," while FOP B has 20% "very satisfied" and 60% "fairly satisfied." Both FOPs would yield an identical NSS, despite clear differences in the strength of satisfaction across their customers.

[165] In this case, the average score represents the mean satisfaction level across all respondents, calculated by assigning numerical values to each response category (e.g. 5 = "very satisfied" to 1 = "very unsatisfied") and taking the weighted average.

[166] See Life satisfaction - ONS, accessed 22 October 2025.

[167] Unlike the NSS, the percentage of satisfied customers retains the full distribution of views (excluding those who don't know), which includes those expressing a neutral view. This makes the measure more transparent and less prone to exaggerating small shifts in sentiment, providing a clearer reflection of overall customer experience.

in line with the Independent Service Quality Survey in the Retail Banking sector[168], or the NHS Family and Friends Test.[169]

(iii) IVC considers that the survey results should be presented in a simple, standardised format. Each FOP should display a standardised RCVS formatted infographic, showing the FOP's average satisfaction score for each dimension of customer satisfaction. If the CMA considers pet owners would benefit from a benchmark, the national average could be shown as a reference point. However, as IVC previously noted, competition in the veterinary services sector is local, and such comparisons are unlikely to offer meaningful insight for pet owners.

[168] See IPSOS, PCA_Detailed_Methodology_February 2025, accessed 22 October 2025. Scores are computed as the percentage of customers that they were "extremely likely" or "very likely" to recommend a provider, excluding those answering "don't know".

[169] NHS Friends and Family Test results are typically reported at the practice, trust, or Integrated Care Board level, showing the percentage of positive and percentage of negative responses separately and without netting off neutral responses.

Annex 2
IVC comments on the PDR profitability findings

1.1 The PDR provisionally concludes that "*four of the six LVGs were making materially above their cost of capital*"[170] and that across LVGs "*economic profits sum to around £1 billion over the period 2020 to 2024*".[171]

1.2 These findings are based on calculations that are assumption-heavy, weakly evidenced, entirely unrobust, and ultimately unreliable. IVC has consistently cautioned the CMA about these limitations and has provided recommendations for improving the CMA's methodology beyond the current 'proof of concept' stage. However, the methodology used in the PDR continues to suffer from the same material limitations.

(i) In the absence of more robust analysis, in IVC's view, in the CMA's Final Report the CMA must:

(a) Recognise the significant limitations of its analysis, and very clearly caveat its findings.

(b) Not place any weight on the findings of this flawed analysis, nor attempt to draw sweeping conclusions on the level of excess profitability.

<u>IVC has been consistent in its submissions that it would be extremely challenging to establish a robust economic profitability analysis for the vet sector</u>

1.3 IVC has been clear that an economic profitability analysis (using a ROCE methodology) in the veterinary sector will face significant data and methodological challenges.

1.4 Addressing these challenges requires the CMA to adopt a revised methodology – one that goes beyond adjustments to accounting data and effectively 'starts from scratch'. It also requires good quality data to inform the analysis.

1.5 IVC warned that if, despite best efforts, the CMA is unable to develop a robust analysis overcoming these fundamental challenges, then the CMA cannot reliably place any weight on this analysis in its assessment of the market.

<u>The CMA's profitability analysis is entirely unrobust, and subject to significant and fundamental flaws</u>

1.6 The CMA has not, in the time available, been able to develop a robust profitability analysis. It has not moved beyond a 'proof of concept' method, yet it has published customer detriment figures without caveats and without transparent recognition of the limits of its analysis.

[170] PDR, Part A, paragraph 7.53.

[171] PDR, Part A, paragraph 16.42.

1.7 In IVC's view, the PDR's findings are still subject to significant and fundamental issues which are highly problematic for drawing conclusions. In particular:

(i) The CMA has not been able to evolve its methodology beyond "proof of concept" approaches, in part, given data availability challenges. The PDR's approach does not comprise a robust, detailed methodology.

(ii) The PDR's analysis is heavily assumption-driven – and many of the assumptions have limited – and often no – evidential support.

(iii) The findings hinge on the experience and data of a handful of unrepresentative clinics (representing ~1% of clinics).

(iv) The findings are very sensitive to the choice of assumptions made – and there is a range of plausible results

1.8 As a result, the CMA should not place any weight on the profitability findings, nor draw conclusions on excess profitability from such a flawed analysis

Despite this, the CMA has failed to acknowledge the material limitations in its profitability analysis

1.9 IVC had previously cautioned[172] the CMA that it should recognise the significant limitations of its analysis, and very clearly caveat its findings. The CMA has not done so.

1.10 The PDR's findings on excess profitability are presented as "fact" with no recognition of the material limitations of its analysis.

1.11 Specifically, in the PDR:

(i) There is no recognition that sweeping, broad-brush assumptions have been used at every stage of the PDR's profitability analysis.

(ii) The CMA frames the ROCE exercise as if it simply requires two adjustments to LVG financial statements, namely to tangible and intangible assets.

(iii) It does not disclose that almost the entire capital base that underpins the £1 billion headline figure is constructed from high level numbers drawn from a handful of clinics,[173] about a quarter of which are sited within a retail location and not representative of the wider market.

1.12 Appendix C contains numerous examples of the PDR's heavy reliance on untested assumptions, with little to no evidence base (again presented without caveats about robustness):

[172] See IVC's Response to Financial and Profitability Analysis Working Paper dated 1 May 2025, paragraph 1.7.

[173] The CMA uses 8 clinics in its estimation of marketing costs incurred by greenfield sites for intangible assets, and data from 28 clinics for its estimation of fit-out costs for tangible assets.

(i) On tangible assets:

(a) Revaluations are estimated from fit-out costs at only 28 clinics, extrapolated out to c.2,700 sites, without any verification of asset coverage, comparability of cost data or representativeness.

(b) The PDR's asset life assumption rests on two data points (10 years and 20-25 years). Shifting within this range moves ROCE by 7ppt but the CMA provides no acknowledgement that its profitability conclusions are hypothesis-led.

(ii) On intangibles:

(a) The PDR concedes in Appendix C that "*there is limited evidence on which to base our assessment estimates*"[174] and "*in the absence of any suitable methodology we have made our own assumptions based on the evidence available to us*"[175] regarding vet and nurse time allocations, but does not reflect this uncertainty when it presents its headline profitability findings in the main body of the PDR.

(b) The CMA acknowledges of its preferred approach that a "*common criticism of a purely cost-based approach is that it carries a risk of understatement its preferred bottom-up*".[176]

(c) The CMA's alternative start-up losses method extrapolates from just six sites to c. 2,700 clinics with no acknowledgement of the lack of robustness or uncertainty.

<u>The CMA's own sensitivity analysis demonstrates the lack of confidence in its findings</u>

1.13 The CMA's sensitivity checks give some sense of the scale of the problem:

(i) The CMA's full set of ROCE estimates range from 15% to 28%, with a baseline estimate of 19%.

(ii) This ROCE range translates to between c.£630m to £1.30bn.

1.14 The enormous range in estimates shows the profound uncertainty in these results. A robust analysis would not produce swings of this magnitude.

1.15 This range also demonstrates the significant impact of individual inputs on the results. The CMA is plainly unsure whether asset lives are 12, 16 or 20 years. Changing this

[174] PDR, Appendix C, paragraph 3.183.

[175] PDR, Appendix C, paragraph 3.186.

[176] PDR, Appendix C, paragraph 3.139.

single input alone shifts the result by £335m. Again, a robust analysis would not be this sensitive to one variable.

1.16 However, even the CMA's sensitivity estimates are misleading:

(i) The CMA identifies five plausible alternatives but tests them only in isolation.

(ii) If the CMA were to: (a) increase valuations for fit-out costs by 25%; (b) shorten the expected useful life for fit-out costs; and (c) adopt an efficient start-up losses approach to valuation, this combined would move the PDR's lower end of the range for ROCE from 15% to 12% - within the margin of error of WACC.

(iii) Meanwhile, combining the high-end scenarios would move the upper end of the range from 28% to 30%.

(iv) Against a baseline ROCE estimate of 19%, an overall range of 18ppt (spanning 12% to 30%) demonstrates unequivocally that the PDR's analysis is entirely flawed. Put differently, this 18ppt range is equivalent to approximately £1.14bn in economic profit terms, which further illustrates the scale of the uncertainty that the CMA's estimates are subject to.

1.17 The provisional decision fails to acknowledge the uncertainty baked into the CMA's assumptions or the weight placed on a handful of data points. Presenting unqualified conclusions of this kind is highly misleading.

Conclusion

1.18 To conclude:

(i) IVC has been consistent in its submissions that it would be extremely challenging to establish a robust economic profitability analysis for the vet sector.

(ii) The PDR's profitability analysis is entirely unrobust, and subject to significant and fundamental flaws.

(iii) Despite this, the CMA has failed to acknowledge the material limitations in its profitability analysis.

(iv) The CMA's own sensitivity analysis demonstrates the lack of confidence in its findings.

(v) In IVC's view, in the CMA's Final Report:

(a) The CMA must recognise the significant limitations of its analysis, and very clearly caveat its findings.

(b) Not place any weight on the findings of this flawed analysis, nor attempt to draw sweeping conclusions on the level of excess profitability.