# VETERINARY SERVICES FOR HOUSEHOLD PETS MARKET INVESTIGATION

# Summary of hearing with Pets at Home held on 5 December 2025

***Introductions and introductory remarks***

1. Pets at Home (PAH) emphasised the importance of the investigation to its veterinary business and its overall business.

2. PAH told the CMA it broadly supported many of the CMA's proposed remedies (including information on prices and pet care plans), supported others subject to moderation or refinement and opposed a smaller set it considered inappropriate. PAH highlighted three fundamental points before turning to detailed discussion of remedies:

    - the characterisation of the econometrics analysis;
    - the requirement that it should promote its LVG competitors' online pharmacies business and
    - PAH's pro-competitive business model.

## Fundamental issues

***Econometrics analysis***

3. PAH disagreed with how its pricing was characterised in the PDR. It explained that, in the CMA's econometric analysis of insurance data, each of c.380 treatments were given equal weight, whereas in practice spending was concentrated in a small number of treatments. PAH submitted that when prices were weighted using an alternative approach, as taken elsewhere in the CMA's work, the pricing outcomes were different. PAH asked that the final report reflect this distinction.

*Pricing analysis presentation*

4. PAH presented high-level points on the PDR's pricing and profitability findings. On pricing, it reiterated that customer-expenditure weighting

materially changed the relative position of PAH versus independents. On profits, PAH agreed that economic profit could be used as an indicator of detriment but said superior efficiency and business-model innovation could legitimately earn and produce a surplus. PAH argued that parts of the bottom-up analysis (for example, start-up losses) understated investment costs, and said reliance on a small number of high-performing PAH practices skewed results. PAH said that adjusting these inputs would lower the industry-wide profitability figure and therefore the implied detriment.

*PAH and industry profits are overstated*

5. PAH said the mechanical attribution of all economic profits above the cost of capital to detriment risked misrepresenting efficient players. It suggested that recognising start-up losses across a wider set of FOPs would reduce the average return on capital employed.

***Promotion of LVG competitors online pharmacies business***

6. PAH stated that requiring FOPs to proactively promote online pharmacies risked being anti-competitive. It stated that directing clients to competitors' online pharmacies - particularly those owned by vertically integrated LVGs - could advantage those groups (for example through access to customer data and opportunities for self-preferencing). PAH said it did not object to informing clients of the option to buy online but opposed obligations that would link or steer clients to specific sites or lists.

7. PAH reiterated its concern that obligations requiring proactive encouragement to purchase medicines at online pharmacies could tilt the market towards vertically integrated LVGs with owned online pharmacies. It said the remedy could create data-sharing advantages and risk post-investigation inflation across online pricing. PAH supported informing clients that they had the option to request a prescription and then buy it online but had some concerns about how this might be mandated and the adverse impact this might have on its business.

***PAH's pro-competitive business model Operational independence***

8. PAH explained that each JV practice was a separate company. It said JV practices set local pricing, employ their own teams, and make operational and clinical decisions, while PAH provided branding and back-office support

(including practice management systems (PMS)). PAH stated that support took the form of guidance and templates rather than prescriptive rules and that JV practices controlled their own financial plans, subject to safeguards where significant investment was proposed.

*Benefits of joint venture ownership model*

9. PAH supported the CMA's proposed legal test for identifying the entity operating a first opinion practice (FOP). PAH asked for clarity to ensure that LVG-specific remedies did not blur the lines of its differentiated business model.

10. PAH said that its JV model enabled organic entry and growth, with favourable bank funding supported by group relationships, and with practice owners retaining 100% of profits and equity value. It said that its current model created incentives for individual vets to own their own businesses and to compete on that basis. It said national branding helped attract customers, while central services allowed practice owners to focus on clinical care.

*Joint venture practice*

11. PAH confirmed it would support practices with guidance and PMS templates and noted that JV agreements included protections to ensure legal and governance requirements were met.

*PAH is not like other LVGs*

12. PAH contrasted its model with other LVGs, stating it had not grown through acquisition and was not vertically integrated. PAH reiterated that remedies aimed at LVG control should not apply to PAH's JV practices.

***PAH position on the features of the market***

13. PAH acknowledged that some sector-wide features - such as limited price transparency - could affect pet owners' ability to assess costs. It claimed its JV practices already published prices online, competed locally, and encouraged transparency at practice level. PAH noted that technology and search tools were changing how customers accessed information and said it expected the CMA's remedies to support those trends.

## Remedies discussion

### *Levy proposal*

14. PAH accepted the need for a proportionate Royal College of Veterinary Surgeons (RCVS) levy to resource remedies but said apportioning the levy only to small-animal FOPs was disproportionate. It argued that all business revenues, including vertically integrated business (such as referral centres or crematoria) should count towards the levy base.

### *Ownership information*

15. PAH supported clearer, prominent group-ownership disclosures and said that recent rebranding by another group illustrated a useful approach. PAH favoured a mandate covering practices, hospitals and associated businesses so pet owners could readily identify group ownership across the estate.

### *Standard price list*

16. PAH supported price transparency but said that any price list should focus on commonly offered, standardisable services. It said that including complex surgeries (eg specialist procedures) risked misleading customers due to variability. PAH asked that lists exclude variable elements (such as post-operative analgesia) to avoid giving false precision. PAH opposed inserting price lists into all digital communications, saying practice emails and texts were targeted to clinical reminders; it supported website publication and availability on request.

### *Preferred parasiticides price publication*

17. PAH raised concerns that publishing prices of prescription-only parasiticides could contravene Veterinary Medicines Regulations and noted the Veterinary Medicines Directorate (VMD) requirements for equal prominence across all products in a category. PAH said preferred products varied by practice due to clinical judgement and local factors, making a single published list impractical and potentially misleading. PAH explained it used in-practice calculators to show clients the annual value of pet care plans versus pay-as-you-go, tailored to the animal and the practice's prescribing choices.

### *RCVS enhanced Find a Vet platform*

18. PAH considered an enhanced national platform unnecessary and duplicative if practices already published standardised information on their own websites. It said local competition and modern search (including AI tools) already aggregated publicly available data. PAH described the existing Find a Vet platform as out of date.

### *Bi-Annual Group-Level Survey*

19. PAH questioned the usefulness of a national survey and preferred local, practice-level measures of service quality. It proposed at least annual cadence and noted that many practices already send post-consultation surveys (eg Net Promoter Score-style questions), while cautioning that low per-practice response volumes could limit reliability.

### *Written Estimate for Treatments*

20. PAH agreed that pet owners should have clear cost information, particularly for significant treatments (except where urgent care was required). It recommended providing estimates as ranges and maintaining flexibility for evolving clinical situations. PAH said requiring estimates for external referrals was unworkable for non-integrated practices that did not control third-party pricing. PAH opposed allowing clients to decline estimates, saying this could erode transparency and later lead to complaints; it preferred that estimates be issued as a matter of course.

### *Repeat prescriptions*

21. PAH supported reducing barriers to written prescriptions but highlighted operational realities. It said immediate production by the vet could disrupt clinical workflows where registered veterinary nurses typically dispense medicines already prescribed. PAH favoured an outcome-based requirement that avoided clients having to return to the practice, with flexibility when digital prescriptions were used. PAH raised prescription-fraud risks (for example, duplicate use of emailed prescriptions) and described mitigations such as embossing paper prescriptions and sending prescriptions directly to pharmacies where feasible. PAH noted that most online pharmacies did not offer integrated portals, which increased administrative burdens for non-integrated practices.

### *Prescription price cap*

22. PAH said a £16 national cap (set at the lower quartile) was disproportionate and proposed a cap closer to the median of £20. It argued that a single fee per consultation should allow incremental charges for multiple prescription medicines, recommending an additional £8 per medicine to reflect added clinical review and compliance checks. PAH noted that costs varied regionally and reiterated typical prescription-duration policies (for example, 6-12 months for stable conditions, shorter durations for unstable cases and controlled drugs), aligned between dispensing and written prescriptions.

## Closing remarks

23. PAH thanked the CMA for the opportunity to present its case and said it supported many of the proposed transparency measures, subject to targeted refinements to ensure proportionality, clinical appropriateness and fair competition.