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Competition and Markets Authority investigation into veterinary services for household pets: joint response to the working papers setting out the current assessment of the evidence gathered and emerging views

1. The British Veterinary Association (BVA) is the national representative body for the veterinary profession in the United Kingdom. With almost 20,000 members, our mission is to represent, support and champion the whole UK veterinary profession. We are a professional body, and our members are individual veterinary surgeons. We take a keen interest in all issues affecting the profession, including animal health and welfare, public health, regulatory issues, and employment matters.

2. We welcome the opportunity to respond to the CMA's working papers which set out the current assessment of the evidence gathered to date and the CMA's emerging views. Our submission has been compiled jointly with four of our specialist divisions and affiliate organisations, for which the investigation has the most relevance:

   - The British Small Animal Veterinary Association (BSAVA) which has a membership of 11,000 individuals mainly comprised of veterinary surgeons working in small animal practices treating household pets but also includes registered veterinary nurses (RVNs) and student veterinary surgeons and nurses. Its mission is to enable the community of small animal veterinary professionals to develop their knowledge and skills through leading-edge education, scientific research, and collaboration. It works closely with BVA to represent and support the profession in specific areas of relevance to small animal practitioners.

   - The Society of Practising Veterinary Surgeons (SPVS) whose mission is to provide a supportive membership community offering representation and industry-leading guidance for leaders in veterinary practice.

   - The Veterinary Management Group (VMG), who are the UK's leading representative body for veterinary professionals working in leadership and management roles.

   - The British Veterinary Nursing Association (BVNA) is the independent membership organisation providing services to and representing the veterinary nursing community with 6,500 members. We have a strategic alliance, and their mission is to empower veterinary nurses to develop as individuals and increase their impact on the profession and animal welfare.

3. We have greatly appreciated the many opportunities to engage with the CMA as the investigation has progressed. We consider that the emerging thinking set out in the working papers clearly shows that the inquiry group has been listening to the concerns raised and is working hard to understand the complexities of both the veterinary landscape and how clinical services are delivered. We are particularly pleased to see the hard work and dedication of vet teams acknowledged and welcome the assurances that nothing in the investigation should be taken to cast doubt on the professionalism, clinical skills or ethics of the vast majority of individual veterinary practitioners.

4. We support the CMA's view that in order for animals to be protected and well cared for, we need a thriving veterinary industry, staffed by dedicated and capable vet professionals. We also agree that it is important that the provision of veterinary services works well for consumers. We have been clear that we fully support healthy competition, consumer choice and diversity of business models as this

enables clients to select from a wide range of veterinary service providers – whether vet practices are small independents or part of a large chain - choosing the best option for their needs and for the health and welfare of their animals.

5. We have previously highlighted that the veterinary profession is operating in a very challenging landscape, and we welcome the CMA's acknowledgement of the significant changes the sector has undergone over the last 10 to 15 years.

6. We particularly welcome the CMA's recognition that Veterinary Surgeons Act 1966 is outdated and has not kept up with changes in the industry. As we have explained, alongside the RCVS, BVA and BVNA are lobbying for legislative reform, supporting a raft of RCVS recommendations under the headings of embracing the vet-led team, enhancing the role of RVNs including protection of the veterinary nurse title, fitness to practise, and mandatory practice regulation.[1] More recently, we have begun work with Defra on a series of policy proposals for public consultation, ahead of developing a draft Bill which will ultimately lead to veterinary legislative reform.

7. Although veterinary legislative reform is essential for the future of the veterinary professions and will address many of the challenges highlighted during the course of the investigation, we recognise that it represents a longer-term solution and that there are some consumer-facing solutions which could be implemented in the short to medium term. Although the household pet veterinary sector is robust and adaptable, veterinary professionals are already working under tremendous pressure. For that reason, we would ask that any proposed remedies, including those relating to medicines, are carefully considered and introduced in a way that allows businesses to adapt, as well as avoiding any unintended consequences. We do however recognise the need for change, and we are keen to play our part in supporting a well-functioning market.

Summary of responses to the working papers

8. We are responding in full to of each of the CMA's working papers. However, given the level of detail in each paper and the considerable overlap in content, we have summarised our key points under the headline concerns in the CMA's overview paper as follows:

CMA concern: Consumers face difficulties in making informed choices about the services they buy. There appears to be limited information available to pet owners about price, options available, quality of services and (in some cases) ownership of vet businesses.

- We agree that there is a lack of available and comparable information available to pet owners on price, quality or business ownership.

- Transparency around costs and the true value of veterinary care is key to giving clients choice. Practices should be able to tailor price lists to display those services which are most relevant to their client base.

- We do not support a 'one-size-fits-all' approach in the shape of an online comparison tool for pricing as this risks diminishing the value of veterinary care and fails to take into account the critical importance of contextualised care.

- We do not support mandatory standardised metrics for quality outcomes. Although quality measures for surgical outcomes are available and increasingly used, for most clinical cases the variability in case complexity, treatment protocols, and patients, could lead to misleading comparisons and potentially misinform consumers rather than aiding them in making informed decisions.

[1] https://www.bva.co.uk/take-action/our-policies/legislative-reform/

- Information about the ownership of vet businesses should be provided to clients in the terms of business, readily available on the practice website, and at the practice premises.

CMA concern: Consumers appear to place relatively little weight on price when choosing a veterinary practice or when making decisions about treatment.

- We recognise that many owners may not consider multiple options when choosing a vet practice. When they do, and as we have previously stated, the factors they take into consideration will vary depending on individual circumstances, with proximity and accessibility likely to be key.

- Decisions about non-routine treatments and diagnostics are likely to be more urgent and involve greater information asymmetry between pet owners and vets. This is when an established Vet-Client-Patient-Relationship (VCPR) built up over time becomes all the more important, facilitating the delivery of contextualised care even in emergency situations.

CMA concern: Pet owners often do not shop around or switch providers even when they might get lower prices, or a service better suited to their circumstances, elsewhere.

- The way in which veterinary care is delivered and valued is far removed from the way consumers behave when shopping around for more 'transactional' services such as insurance or utilities. Clients who frequently switch practices risk fragmented care for their pet, potentially leading to suboptimal treatment and communication, and additional cost.

CMA concern: There has been a long period of sustained price rises for the delivery of vet services, higher than the level of inflation, and increases in vet salaries.

- Increasing technological advances mean that vets now have the ability to detect and treat more complicated medical and surgical cases. Along with advances come rising veterinary costs.

- Client expectations have also changed significantly, often reflected in a greater desire to spend more on their pet's health. This has also seen average consultation times increasing in the last decade from 6-10 minutes in length to closer to 15-20-minutes in order to deliver the service now expected by clients

CMA concern: Vet businesses have high retail prices for veterinary medicines, which have increased significantly in recent years.

- To facilitate choice with regard to medicines there should be a consistent approach with practices proactively offering a prescription where clinically appropriate and providing clients with dispensing options, alongside clear communication regarding the cost of the prescription.

- Prominently displaying the fees most commonly associated with administering and dispensing medicines should be relatively simple to implement now and could also be introduced as a reasonable requirement of mandatory practice regulation in the future.

- We do not support imposing a maximum charge for issuing a written prescription as this would result in prescription fees becoming standardised, with most clients likely paying the maximum. Instead, practices should clearly display their prescription fee to help clients make an informed decision.

- Vets should have the clinical freedom to prescribe a licensed veterinary medicine by generic name and/or a specific trade name depending on the context and what is best for the animal and owner's circumstances.

- We welcome the CMA's emerging view that prescription length is not a barrier to using third-party retailers and strongly support vets being able to retain their professional autonomy in matters of responsible prescribing and dispensing.

- We would support further investigation as to the reasons why some FOPs and third-party retailers do not or cannot join buying groups with Preferred Products or, in some cases, decide not to join a buying group at all.

- Dismantling the Cascade and allowing human generic drugs to be prescribed to animals brings risks to both animal welfare and antimicrobial resistance (AMR). There is a role for RCVS and VMD in providing improved clarity around the application of the Cascade to support vets in decision-making.

CMA concern: Initial analysis suggests that around 6% of local areas are served by only one or two FOPs.

- We welcome the CMA's finding that the supply of FOPs is not generally concentrated, with 85% of FOPs competing with at least three local rivals. In fact, there are only 49 FOP sites identified by the CMA which may not face competition from any other local providers, accounting for only 1% of total sites. Those sites with no competition probably exist in areas where there is insufficient caseload for multiple veterinary businesses to exist.

CMA concern: There may be limited consumer choice of services such as referral centres for more advanced diagnostics and treatment, especially for highly specialised services.

- Referrals involve considering the animal's health needs alongside accessibility and convenience for the client and will be also based on close professional relationships between referring and referral clinicians. Explanatory resources for clients, including greater clarity around the qualifications of the referral vet, should be developed.

- The CMA's stated intention to potentially carry out further analysis of concentration of referrals at a specialism level is unlikely to provide meaningful data. The presence of a specialist is informed by the availability of sufficient caseload.

- Self-preferencing for cremation and other services has the potential to bring efficiencies which financially benefit the client. Where the cremation service is associated with the practice and owned by the same company, this should be clearly communicated to clients.

CMA concern: Many local vet practices have little choice of supplier when they outsource their obligations to provide out of hours (OOH) services.

- We would strongly advise against any remedies which shift the requirement to deliver OOH back to individual vet practices. For many, this would be commercially unviable to deliver due to insufficient demand set against the challenge of modern working practices and recruiting to cover an OOH rota in addition to the normal daytime provision.

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

- There is scope for further debate and guidance for veterinary professionals, including undergraduates, on how to deliver contextualised care.

- There should be a shift towards new models of pet healthcare plans which focus on tailored check-ups rather than relying on the sale of products.

CMA concern: The regulatory framework does not help drive competitive processes and good consumer outcomes in the way that would be expected in a well-functioning market.

- We consider that more could be done to promote the RCVS Code, including changes and additions to it, and to ensure that all registrants are up to date and compliant. RCVS would need access to a much wider range of sanctions to support this.

- We support the development of a modern ‘fitness-to-practise’ regime, in line with the principle of right-touch regulation, to focus on remedial action in relation to the individual and the wider context within which they work.

- We strongly support the CMA’s emerging view that Registered Veterinary Nurses (RVNs) could be more fully and effectively utilised within the framework of existing legislation and that greater clarity with respect to interpretation of the existing regulatory framework could help enable this.

- Extending the range of tasks that RVNs are permitted to undertake, with appropriate additional training and supervision, could offer positive benefits for veterinary professionals, animal owners, and animal welfare.

- The protection of the veterinary nurse title is long overdue and would enhance transparency and consumer confidence, improve consumers’ ability to compare offerings between firms and therefore help stimulate competition between rivals.

- Mandatory practice regulation should be introduced as part of veterinary legislative reform.

- A formal, agreed and consistent complaints process for the veterinary sector, that is both pragmatic and proportionate, should be introduced as part of Supporting Guidance to the RCVS Code and then made part of the requirements of mandatory practice regulation.

- There is scope for better promotion of the Vet-Client Mediation Service (VCMS) both within the professions and to clients. Any development of the current framework should be careful to avoid the unintended consequences of the loss of person-centred complaints resolution at a local level.

Competition and Markets Authority working paper on how people purchase veterinary services

1. We welcome the CMA's recognition that pet owners display high levels of trust in veterinary experts and their advice, with 87% of respondents to the CMA's pet owners survey agreeing that their vet focuses on the highest standard of care for their pet's health. We agree that pet owners usually have a strong emotional attachment to their pet and often need to rely on veterinary experts both to recommend the services or treatments their pet might need, and to give access to some of these services or treatments. However, we do not accept the CMA's assertion that this dynamic creates a potential conflict of interest in relation to the clinical recommendations veterinary professionals may make, as being influenced by financial incentives would be entirely contrary to the declaration every vet and Registered Veterinary Nurse (RVN) makes on admission to the profession:

   " I PROMISE AND SOLEMNLY DECLARE that I will pursue the work of my profession with integrity and accept my responsibilities to the public, my clients, the profession and the Royal College of Veterinary Surgeons, and that, ABOVE ALL, my constant endeavour will be to ensure the health and welfare of animals committed to my care."[1]

   This declaration and the professional responsibilities which vets and RVNs adhere to, as set out in the RCVS Code and Supporting Guidance, serve to protect clients and pets from all other factors, including the influence of financial gain.

2. Notwithstanding this, we do recognise that there is a potential for conflict caused by the absence of practice regulation and where practice protocols put in place by non-vet owners may seek to influence clinical recommendations for the financial gain of the business entity. We welcome the CMA's clear recognition of the challenges caused by the absence of veterinary practice/business regulation in the working paper '**Regulatory framework for veterinary professionals and veterinary services**'. As we have previously stated, with no statutory regulation that is specific to veterinary practices, there is no means of recourse when there are failings in the system that do not sit with the individuals regulated by RCVS. We consider, along with RCVS, that it is reasonable for the public to expect that all veterinary practices are assessed to ensure that they meet at least the basic minimum requirements including appropriately addressing consumer concerns.

Choice of First Opinion Practice

3. We recognise that many owners may not consider multiple options when choosing a First Opinion Practice (FOP). When they do, and as we have previously stated, the factors they take into consideration will vary depending on individual circumstances, with proximity and accessibility likely to be key.[2] We agree that some pet owners may not consider multiple options because they mistakenly believe that all FOPs provide similar services at similar prices, and that there is a lack of available and comparable information available to pet owners on price, quality or practice ownership.

4. BVA's guidance on transparency and client choice (2024) is clear that transparency around costs and the true value of veterinary care is key to giving clients choice and facilitating informed consent.[3] We encourage veterinary professionals to think about the way in which the value of the veterinary care is communicated, tailoring it to the needs of clients, their animals, and the veterinary practice. Practices may choose to display case studies in the waiting area, testimonials from clients, or profiles of the

[1] https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/
[2] https://www.bva.co.uk/media/5766/bva-transparency-and-client-choice-guidance.pdf
[3] https://www.bva.co.uk/media/5766/bva-transparency-and-client-choice-guidance.pdf

veterinary team alongside their qualifications and particular areas of interest. This is particularly important for showcasing the key role played by RVNs, and their invaluable contribution towards successful medical and surgical outcomes for animals. We are clear that inviting and encouraging open and honest conversations about fees at an early stage and educating and empowering the veterinary team to champion the value of the veterinary care being offered, is key to the best possible outcomes for animal health and welfare, increased client trust, loyalty, and thriving veterinary businesses.[4] We are also keen to educate and help clients understand how fees support and contribute to the running of a veterinary practice and all it entails.[5]

Pricing information

5. We note that the evidence received by the CMA to date indicates there is a wide range in the amount of pricing information made available to pet owners, and that this is generally limited to some standard services rather than more complex treatments.

6. As we have stated in our response to the CMA's working paper '**Competition in the supply of veterinary medicines**', we know that many practices already display price lists, in the practice and/or on their websites, for their most frequently offered services. Although we consider that practices should be able to tailor price lists to display those services which are most relevant to the client base, examples of the standard services which most practices should be able to display as either a fixed price or as a range include:

    - a standard consultation with a vet
    - a vaccination or course of vaccinations
    - neutering services for cats and dogs
    - prescription fees
    - insurance administration fees
    - microchipping
    - out-of-hours consultation charges

7. BVA's guidance on transparency and client choice (2024) suggests that when developing a price list for frequently offered services:

    - It should be clear whether the price displayed is for a one-off service, such as a consultation, and whether there are any limitations associated with that service (e.g. duration or time of day/night).
    - It should be clear whether the price displayed is an aggregate price for a package of services (such as a vaccination course), what is included and what isn't.
    - It should be clear whether there are any factors unique to the animal which might influence the price, such as size/weight or age.
    - It should be clear whether there is any follow-up care associated with the service, and whether this is included in the price or will result in an additional charge.
    - It should be easy to understand and should facilitate client choice.

8. To maximise the benefits associated with transparency of fees, we consider that clients should be invited and encouraged to discuss costs as early as possible. This normally means in advance of treatment taking place, however, veterinary practices should also tailor their approach such that cost is discussed by the appropriate member of the veterinary team at the appropriate time. For example, where life-saving emergency care is required, it may be necessary for one team member to start delivering first aid, whilst another member of the team is responsible for obtaining consent and providing estimates.

[4] https://www.bva.co.uk/media/5766/bva-transparency-and-client-choice-guidance.pdf
[5] https://www.bsava.com/wp-content/uploads/2023/09/bsava-explainer-of-veterinary-costs.pdf

Price comparison tools

9. The working paper notes that there are no tools available to help pet owners make price comparisons across the extensive range of medicines and services offered by FOPs. In our response to the CMA's Issues Statement we were clear that a 'one-size-fits-all' approach in the shape of an online comparison tool for pricing - and indeed quality information - risks diminishing the value of veterinary care and fails to take into account the critical importance of contextualised care, including animal factors and human factors, all of which must be balanced with the skills and equipment that are available within a practice. We continue to hold this view and would be concerned that practices viewed as 'desirable' by prospective clients, based on a comparison website output, may not always be able to accept additional clients, leading to potential client dissatisfaction when registering with their second or third choice practice. This could present unnecessary challenges for building a rapport with the client, with the potential for avoidable negative impacts on animal welfare and consumer satisfaction.

10. Price comparison tools may also lead to the potential creation of loss-leaders as practices in the area compete for business, resulting in further complexity and cross subsidisation of fee structures. Comparison tools may also inadvertently dissuade clients and potential clients from approaching the practice to discuss alternatives, with the opportunity to discuss the particular circumstances of individual clients potentially lost.

Service range and quality

11. We note the CMA's assessment that FOPs typically provide a range of information regarding the services they offer and where quality information is communicated these qualitative features lack any form of standardised metrics. We welcome the acknowledgement in the CMA's working paper of our previous assertion that quality and outcome related measures are rarely available from clinical practice, and that variability in case complexity, treatment protocols and patients makes it challenging to standardise such measures. We note that Which? also submitted that it would be challenging to make objective assessments on the quality of veterinary care.[6]

12. Information about facilities, species seen, Practice Standards Scheme (PSS) accreditation and awards, training and staff including advanced qualifications, are all available on the RCVS Find-a-vet website. This would form a good basis for some client comparisons of practices in their areas and has the potential to be expanded. Use of the site is however not currently compulsory.

13. We agree with the RCVS Knowledge submission that while measuring quality in veterinary care is not impossible – indeed many practices carry out measurements of patient outcomes internally - without data sharing the large-scale population studies that allow clinical outcomes in human medicine to be evaluated are extremely rare in veterinary medicine. Although quality measures for surgical outcomes are available and increasingly used[7], for most clinical cases the variability in case complexity, treatment protocols, and patients, makes it challenging to standardise such measures across different practices. This variability could lead to misleading comparisons and potentially misinform consumers rather than aiding them in making informed decisions. It is crucial to consider these limitations and the potential unintended consequences of mandating the provision of these data.

14. We are strong supporters of evidence-based veterinary medicine but while available data remains scant, any move towards mandating practices to provide information to consumers about quality/outcome related measures could undermine vets and jeopardise contextualised care. We have previously explained that clinical decision-making as part of the crucial Vet-Client-Patient-Relationship (VCPR) is far more complex than the provision of quality related data and we continue to hold significant concerns that the CMA may be considering a remedy which mandates standardised metrics. We do not consider that such a move would meaningfully support informed consumer choice

[6] https://assets.publishing.service.gov.uk/media/66bf5c34885e2bf285cc3886/Which.pdf
[7] https://knowledge.rcvs.org.uk/quality-improvement/canine-cruciate-registry/

but would instead risk animal welfare by diminishing the provision of veterinary care to equivalence to an annual service on a vehicle where a client might shop around for the best value locally available.

15. Instead, we strongly advocate for any move to utilise outcome-based measures in clinical practice to come from the profession with animal health and welfare at its heart, rather than being mandated by the CMA. We consider that there is an opportunity to encourage local audit at a practice level, sharing that information with clients as a key first step in facilitating client understanding by allowing practices flexibility to tailor their communication, and to take into account regional variations in pet populations and ensure client confidentiality. In the longer term, a move towards standardised data collection at a national level, appropriately funded and perhaps building on systems such as the Small Animal Veterinary Surveillance Network (SAVSNET)[8] established by BSAVA, subsequently funded by the Biotechnology and Biological Sciences Research Council (BBSRC) and now solely funded by University of Liverpool, would support vets to build conversations about expected outcomes into consultations with clients such that animal welfare is optimised, and client choice is better informed.

Practice ownership

16. We note the CMA's evidence that indicates that pet owners are poorly-informed about practice ownership for four of the six large corporate groups and the emerging thinking that this lack of awareness could give customers the illusion of choice and competition when comparing services.

17. Transparency of ownership, whether a vet practice operates independently or is part of a large group, plays an important role in helping pet owners to make an informed choice aligned with their preferences, circumstances and values. That does not mean that the individual identity of a practice cannot be expressed. We consider that information about the ownership of a veterinary practice should be provided to clients in the terms of business, readily available on the practice website, and at the practice premises, through clear signage, as an information leaflet for clients and on any branded materials. Clients should not have to search for such information. Where there are third-party services recommended by the practice and owned by the same company, this should be clearly communicated to clients both in the terms of business and on the practice website and should also be verbally communicated when presenting referral options. These may include laboratories, pharmacies, cremation or burial services, and referral practices and hospitals.

18. We do not consider that uniform branding of veterinary practices within the same group necessarily simplifies consumer decisions, as this overlooks the diverse array of services, expertise, and pricing structures that may be offered by practices under the same brand, potentially misleading clients and impacting their decision-making process.

Switching First Opinion Practice

19. Although we agree that where there are variations in the offerings of different FOPs, including on price, quality and range of services, some consumers may benefit from switching, we are also of the view that establishing and maintaining a strong VCPR is essential for ensuring continuous, high-quality veterinary care. A strong VCPR builds trust and effective communication, allowing vets to thoroughly understand an animal's medical history and their and their owners' unique needs and circumstances. It is a key foundation in providing clients with the information needed to make informed decisions about treatment options and their animals' health and welfare. Conversely, clients who frequently switch practices risk fragmented care for their pet and fail to build a strong relationship with a practice they trust, potentially leading to suboptimal treatment and communication, and additional cost associated with the professional time needed to assess the new patient and establish a new VCPR. We welcome the CMA's acknowledgement that pet owners highly value the trust and relationship that comes from remaining with a particular FOP practice, or with a particular veterinary professional.

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[8] https://www.liverpool.ac.uk/savsnet/

20. Evidence from the CMA's pet owners survey indicates that switching rates are relatively low at 3%, with the CMA's emerging view that switching rates may be lower than might otherwise be expected in a well-functioning market. We understand that the CMA has considered how the rate of switching FOPs compares to potential benchmarks and welcome the recognition that different circumstances in other sectors may lead to different consumer switching rates. We strongly agree that customers of commodity services such as insurance, energy and mobile are unlikely to receive the benefits that pet owners might receive by remaining loyal and improving their relationship and trust with their existing FOP. We note the CMA's work relating to retail banking where switching rates by customers were also comparatively low - this may serve to emphasise the desire for stability and consistency by consumers across different sectors who avail of key services they consider important.

21. As we set out in our response to the CMA's Issues Statement, the way in which veterinary care is delivered and valued is far removed from the way consumers behave when 'shopping around' for more transactional services such as insurance or utilities. The VCPR is key to achieving long-term good animal welfare outcomes, through reliance on a consistent and thorough understanding of the patient's medical history, behaviours, and needs alongside an understanding of the client's circumstances and how these relate to the provision of care. Veterinary practices have longstanding relationships with clients that often exist over several generations of pets, and it is these relationships that aid the sort of good client communication aspired to both by the profession and the CMA.

Choice of pet care plan

22. We note the emerging view of the CMA that while pet healthcare plans can reduce annual spend for many pet owners, they may not offer value for money for some pet owners who would otherwise not use many of the routine services included in plans. Pet healthcare plans can be made up of a variety of services and products but typically include vaccinations, flea and worm control.

23. We consider that a 'one-size-fits-all' approach to pet healthcare plans is no longer appropriate, particularly given the growing imperative to reduce the prophylactic use of parasiticides due to environmental harms and risk of resistance. The vast majority of the UK's dogs and cats receive regular worm and flea treatment[9] and although the actual frequency of use is unknown, routine prophylactic parasite treatment is widely recommended by product manufacturers and some vets, with many animals receiving year-round treatment as part of their healthcare plans. Like all medicines, parasiticides should be used responsibly, and a risk-based approach to treatment should be taken. When deciding what parasiticides to use to treat an animal, vets should consider the risks, to both pets and owners, from all parasites and come up with a treatment plan tailored to that individual.[10] [11]

24. To shift away from routine parasiticide use, a change in mindset of both veterinary professionals, veterinary business owners and animal owners is needed. Veterinary professionals wanting to use parasiticides more responsibly may be presented with challenges within their working environment, such as practice protocols, the prescribing behaviours of team members and neighbouring practices, retaining client trust if there is a shift from vets historically promoting blanket or prophylactic parasiticide use to now advising otherwise, and a lack of client understanding. As new evidence develops, the small animal sector as a whole, which includes pharmaceutical companies and Government agencies, needs to acknowledge the challenges and work together to consider what constitutes responsible use of parasiticides.

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[9] pdsa_paw-report-2024.pdf

[10] Responsible use of parasiticides for cats and dogs | British Veterinary Association

[11] BSAVA Scientific Position Statement (SPS)
https://www.bsava.com/position-statement/parasite-control/
BSAVA Formulary: https://www.bsavalibrary.com/content/formulary/backmatter/canine-and-felineguidelinesforresponsibleparasiticideuse

25. In the interim, we are of the view that pet healthcare plans which include the routine use of POM-Vs such as flea treatments and wormers, should only be sold to clients where the vet has carried out a clinical assessment and is prescribing responsibly, as would be the expectation in all other prescribing scenarios. It should not be acceptable for lay members of the veterinary team to promote or sell pet healthcare plans which include POM-Vs. We would also like to see a shift towards new models of pet healthcare plans which focus on tailored check-ups rather than relying on the sale of products.

Choice of non-routine treatments and diagnostics

26. We agree with the CMA's assessment that, compared to other choices, decisions about non-routine treatments and diagnostics are likely to be more urgent, give rise to higher financial costs, have greater potential animal welfare implications and involve greater information asymmetry between pet owners and vets. These contextual factors may mean that pet owners need to place even more trust in their vet's clinical judgement and recommendations. This is when an established VCPR and the relationship of trust built up over time becomes all the more important, facilitating the delivery of contextualised care even in emergency situations, optimising animal welfare outcomes and consumer satisfaction. We also recognise the time constraints of a consultation and that owners may need to take in significant amounts of new information about a treatment, which can be unrealistic in the moment. BSAVA has developed a library of resources to support transparency and help owners understand procedures which might be recommended by their vet.

27. For non-routine treatments, estimates are commonplace given the potential for variability. We recognise that orally communicated information does not allow consumers to refer to the quoted price in future and relies on memory of the conversation, which may be less reliable in complex treatment scenarios. However, whilst a written estimate is of course preferable, in some situations the speed of decision-making needed is a key consideration. As mentioned above, where life-saving emergency care is required, it may be necessary for one team member to start delivering first aid, whilst another member of the team is responsible for obtaining consent and providing estimates, with immediate animal welfare taking precedence over the provision of itemised written estimates for the care being delivered (including first-aid). In these emergency situations cost can be low down in client priorities and once again a good VCPR is essential in providing appropriate contextualised care.

28. We welcome the CMA's findings that there appears to be widespread appreciation across the veterinary profession of the value of delivering contextualised care. Although 20% of pet owners in the CMA's survey did not agree that their vet takes their personal circumstances into consideration (25% visiting for non-routine treatment, compared to 16% visiting for routine treatment), we agree that this may often be because the owner is not aware of the considerations vets are taking into account. We welcome the CMA's recognition that there is a risk that owners may find it difficult to understand the health outcomes of different options. As set out in our response to the CMA's Issues Statement, we would not wish to see a shift from contextualised care to an approach where all clients are offered choices irrespective of their circumstances and without due consideration for individual animal welfare. Offering unaffordable options as superior choices can cause emotional distress to clients and undermine their trust in vets, particularly if they feel burdened with making critical medical decisions they feel ill equipped to handle. Greater choice does not necessarily always lead to better animal welfare outcomes or improved client satisfaction, and can result delayed decision making and the erosion of the VCPR.

29. Although we do not disagree with the CMA's observation that the cost of consultation fees and diagnostic testing as part of obtaining a second opinion on alternative treatment options may also be a barrier to shopping around, we do not consider that it would be fair or reasonable to expect a veterinary professional providing a second opinion to provide their professional services free of charge or even at a reduced rate. Often second opinion consultations are more detailed and involved with significant amounts of pre-existing complex case history and clinical detail that needs to be carefully explained to clients.

Choice of referral provider

30. We note the CMA's assessment that pet owners may not be receiving or engaging with sufficient information to inform their choice of referral provider, and that while FOP vets generally provide sufficient information regarding referral treatment risks, outcomes and practicalities, the provision of pricing information for pet owners is delivered inconsistently.

31. As we have previously stated a referral is not merely a transactional arrangement between service providers. Referrals involve considering the animal's health needs alongside accessibility and convenience for the client and will be also based on close professional relationships between referring and referral clinicians. Over time, these relationships build a deep understanding of skills (for example post graduate RCVS recognised training compared to on-the-job experience), expertise, possible costs, waiting times, type/level of follow up/after care and availability of CPD and telephone support, which in turn builds confidence for the referring vet that they can be confident in their referral. This also means they are better placed to advise clients on what to expect.

32. The evidence from the CMA's pet owners survey indicates that a pet owners' trust in their vet is a key driver of referral centre choice, and that most pet owners do not shop around when recommended a referral by their FOP vet. Although we accept that this may mean there is weak competitive pressure on those making and offering referrals, we have also explained that the presence of a specialist is informed by the availability of sufficient caseload. There are some specialisms where there will be competition in many localities but there will also be numerous situations where it is necessary to phone around for even one option for less common presentations. Where the volume of work is low it simply is not reasonable to expect that there will be more than one referral option in a locality, and in some cases none at all.

33. We agree with the emerging view that pet owners to do not always understand the different types of referrals (eg Specialist vets, as defined by the RCVS, who will have at least a postgraduate diploma level qualification, RCVS Advanced Practitioners, certificate holders, or simply colleagues within the same practice or externally to another practice who have a particular interest in a particular area of work) and consider that greater clarity around qualifications is needed for consumers to fully understand this element of referrals. RCVS could be encouraged to develop explanatory resources for owners, including greater clarity around the qualifications of the referral vet.

34. We agree that limitations on the price information pet owners have when choosing a referral may lessen their ability to make comparisons between options. However, it must be recognised that it cannot be the responsibility of the FOP vet to provide detailed price information when referring to another professional or veterinary business and where the diagnosis, treatment, or prognosis is unknown. It may be possible to provide estimates where the referral is for particular surgical procedures such as cruciate ligament surgery or fracture repair. Estimates for complex medical conditions are however much more difficult to determine until the referred patient is seen by the referral vet.

Choices regarding medicines

35. We note the CMA's emerging view that many pet owners are still not aware they can acquire veterinary medicines from third parties rather than their FOP, and that some FOPs may not inform pet owners in an effective manner that they can buy medicines from elsewhere. While some pet owners may prefer to buy medicines from their FOP for a variety of reasons, the way in which information may be given could result in consumers not shopping around, leading to weak price competition between retail suppliers of veterinary medicines.

36. As we have explained in our response to the CMA's working paper 'Competition in the supply of veterinary medicines' prominently displaying the fees most commonly associated with administering and dispensing medicines should be relatively simple for most FOPs to implement now and could also be introduced as a reasonable requirement of mandatory practice regulation in the future.

37. We have also stated that we recognise that a substantial proportion of pet owners are not aware they can purchase veterinary medicines from third-party retailers with a prescription and that lack of effective promotion may be one of the many factors that explain this. In BVA's guidance on transparency and client choice we are clear that there should be a consistent approach which includes:

   - proactively offering a prescription where clinically appropriate and providing clients with dispensing options.
   - clear communication regarding the cost of a written prescription, the reasons for the time period of the prescription, and any further charges for repeat prescriptions and associated further examinations.
   - a quote for the cost of purchasing the prescribed product directly from the prescribing practice.
   - signposting to the Veterinary Medicines Directorate (VMD) Accredited Retailer Scheme where appropriate.

Choice of Out of Hours provider and services

38. We note the CMA's emerging view that evidence indicates that pet owners needing to choose an Out of Hours (OOH) provider typically do not shop around and that there may not be a sufficiently strong customer response for effective competition in OOH services.

39. As set out in our response to the CMA's working paper 'Analysis of local competition', OOH veterinary services need a critical mass of work to be commercially viable for the provider of the service. In areas of high human population density, there will be correspondingly more pets, but in many other areas, especially rural or remote areas, there is not enough work to support multiple OOH providers. For owners in geographically remote areas of the UK, access to a choice of OOH providers is simply not feasible. For smaller practices, with limited close neighbouring practices with whom OOH cover can be shared, outsourcing OOH to one practice as an OOH provider may be the only way that local FOPs practices can meet the obligation to provide 24/7 emergency first aid and pain relief, retain staff, and remain viable as businesses.

Choice of cremation provider and services

40. We note the CMA's emerging view that while there are some positive benefits to consumers purchasing cremations services from the provider with which their FOP has a contract, evidence indicates that pet owners are often not made aware by their FOP that they have alternative options.

41. In our response to the CMA's Issues Statement we observed that the CMA commissioned market research found that pet owners felt relieved that their veterinary practice had taken the lead in dealing with cremation arrangements, and they were happy to leave the choice about which cremation provider to use to their vet. In many cases the provider recommended by the vet will be one where the relationship has been built over time and where the vet can feel confident that the service provided will be compassionate and in the best interests of the owner at a distressing time.

42. We do, of course, agree that where the cremation service is associated with the practice and owned by the same company, this should be clearly communicated to clients both in the terms of business and on the practice website and should also be verbally communicated when presenting the referral. Such self-preferencing for cremation services however has the potential to bring efficiencies which financially benefit the client.

43. To further support transparency and consumer choice we consider that practices should always be clear that owners can carry out their own research on alternative cremation options. To support this, practices should, where space allows, offer to store the cadaver for a defined period of time, to give owners the emotional space to make the decision which is right for them.

March 2025

Competition and Markets Authority working paper on business models, provision of veterinary advice, and consumer choice

1. In order to meet the needs of pet-owners and the welfare of their animals, veterinary practices must function as financially sustainable, viable businesses. This means they need to charge appropriately for their services, to cover a range of costs including salaries, equipment, medicines, premises, and other overheads, as well as make a reasonable return on investment and an appropriate level of profit such that they are incentivised to improve quality, innovate, and expand. We have always been clear that we fully support healthy competition and diversity of business models so that clients can select from a wide range of veterinary service providers, whether practices are small independents or part of a large chain, choosing the best option for their needs and for the health and welfare of their animal.

2. As outlined in the working paper '**Regulatory framework for veterinary professionals and veterinary services**' the Veterinary Surgeons Act 1966 does not reflect the way the sector currently operates; in particular, it contains no provision to regulate vet businesses. We agree with the CMA's observation that the changes in ownership and management structures mean there is a range of actors – corporate bodies and individuals – not subject to direct regulation, who are taking or influencing business decisions without regulatory constraint. We welcome the CMA's clarification that, when considering business models, statements about veterinary professionals relate to the pressures they may be under as employees in, or owners of, vet businesses and should not be taken to be an adverse reflection on the professional conduct or integrity of individual vets and vet nurses. We strongly agree with the CMA's view that the vast majority of veterinary professionals show high levels of dedication to the animals under their care and the animals' owners.

Competition on price

3. We note the CMA's assessment that there is likely to be a weak consumer response to price increases as movement of consumers between First Opinion Practices (FOPs) is low. BVA's guidance on transparency and client choice (2024)[1] is clear that transparency around costs and the true value of veterinary care is key to giving clients choice and facilitating informed consent. As set out in our response to the working paper '**How people purchase veterinary services**', we recognise that many owners may not consider multiple options when choosing an FOP. When they do, the factors they take into consideration will vary depending on individual circumstances, with proximity and accessibility likely to be key, although we also recognise that price will be a factor for many.

4. In our response to the CMA's Issues Statement we were clear that a 'one-size-fits-all' approach in the shape of a comparison tool for pricing - and indeed quality information - risks diminishing the value of veterinary care and fails to take into account the critical importance of contextualised care, including animal and human factors, all of which must be balanced with the skills and equipment that are available within a practice. We were also clear that the way in which veterinary care is delivered and valued is far removed from the way consumers behave when 'shopping around' for services such as insurance or utilities. We consider that the value placed on the Vet-Client-Patient-Relationship (VCPR), which is key to achieving long-term good animal welfare outcomes, will be a key factor for many consumers, over and above making choices about veterinary care based primarily on price.

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[1] https://www.bva.co.uk/resources-support/practice-management/transparency-and-client-choice-guidance/

Treatment intensity

5. We agree that any increases in treatment intensity could largely reflect a greater desire by pet owners to spend more on their pets' health in response to the increased availability of complex or more advanced treatments, which would not be a competition concern.

6. As we explained in our submission to the CMA's call for information in autumn 2023, increasing technological advances mean that vets now have the ability to detect and treat more complicated medical and surgical cases. Client expectations have changed significantly, which has seen the average consultation times increasing in the last decade from 6-10 minutes in length to closer to 15-20-minutes in order to deliver the service now expected by clients. Given the complex contextual factors which inform treatment intensity, we agree with the CMA's observation that it is difficult measure and therefore assess whether it has increased.

KPIs and targets

7. We welcome the CMA's recognition that vets are conscientious professionals who have taken an oath to do the best for the animals under their care. We note that many of the CMA's conversations with vets over the course of the investigation have shown veterinary professionals' strong motivation to do the best for the animals they treat.

8. We recognise that vets not only work as individuals in a regulated context, but also in the context of a practice selling commercial services to consumers. We also recognise that veterinary businesses are commercial operations which must make sufficient returns for there to be an adequate supply of veterinary care available to support animal welfare and meet the needs of pets and their owners. Veterinary teams work hard and should expect to be appropriately paid for their work. However, as explained in our response to the working paper 'How people purchase veterinary services' being inappropriately influenced by financial incentives, such that they impact clinical decisions, would be entirely contrary to the declaration every vet and Registered Veterinary Nurse (RVN) makes on admission to their profession.

9. As the CMA has recognised, different KPIs work towards different aims, including attempts to consider public health concerns, improve business efficiency or improve customer service. The use of financially driven KPIs is the norm in many professions, and application of such an approach in a veterinary setting in our view simply represents standard management practice. However, we would be concerned if the setting and monitoring of certain KPIs might put undue pressure on vets to change how they recommend treatments to pet owners in a way which did not lead to the best possible animal welfare outcomes. Similarly, we would have concerns if unnecessary checks or procedures on pets were being carried out which were of no tangible benefit to the pet and indeed, in some cases might compromise their welfare. In this context we would support expansion of RCVS's powers to monitor outcomes for consumers and sanction breaches of the Code, as well as regulate veterinary practices.

Contextualised care

10. We note the CMA's assessment that there appear to be differences within the profession as to whether contextualised care means a vet should evaluate what might be best to recommend in the circumstances and present a single personalised option to the pet owner, whether a full range of options should be presented to allow the pet owner to choose the best option, or whether the outcome should be arrived at through an open discussion between vet and pet owner.

11. We are clear that contextualised care must take into account both the owner and the animal, considering their relationship and understanding the context in which the animal lives, the owner's finances, lifestyle, preferences, and their ability to provide suitable care. This approach acknowledges that the owner's attitudes, resources, and commitment to the animal's wellbeing significantly influence the treatment's success and the overall health of the patient. Additionally, contextualised care involves consideration of an animal's living conditions, quality of life, pain management, and overall welfare during clinical decision-making.

12. Contextualised care has very much become the preferred term within the veterinary profession and although already a well-established principle, with existing resources available to support the profession[2], it is a concept we are keen to develop further. We consider that there is scope for further debate on this important concept and further guidance for veterinary professionals, including undergraduates, on how to deliver contextualised care.

Vertical integration

13. We note the CMA's assessment that consumers may not be given sufficient information about their referral options at all types of FOP, irrespective of their degree of vertical integration with referral services. Limitations on the price information pet owners have when choosing a referral may lessen their ability to make comparisons between options. However, it must be recognised that it cannot be the responsibility of the FOP vet to provide detailed price information when referring to another professional or veterinary business and where the prognosis is unknown. The evidence from the CMA's pet owners survey indicates that a pet owner's trust in their vet is a key driver of referral centre choice, and that most pet owners do not shop around when recommended a referral by their FOP vet. Notwithstanding this, accessible price lists for the services offered most frequently by referral practices would be welcomed and should be encouraged.

14. As we have previously stated a referral is not merely a transactional arrangement between service providers. Referrals involve considering the animal's health needs alongside accessibility and convenience for the client and will be also based on close professional relationships between referring and referral clinicians. Over time, these relationships build a deep understanding of skills (for example post graduate RCVS recognised training compared to on-the-job experience), possible costs, waiting times, type/level of follow up/after care and availability of CPD and telephone support, which in turn builds confidence for the referring vet in their referral. This also means they are better placed to advise clients on what to expect.

15. We do, of course, agree that where vertically integrated groups engage in self-preferencing this should be clearly communicated to clients both in the terms of business and on the practice website and should also be verbally communicated when presenting the referral. Such self-preferencing does have the potential to bring efficiencies which financially benefit the client but should never hinder professional judgement, restrict the recommendations veterinary professionals are able to make, or put animal welfare at risk.

March 2025

[2] https://www.bsava.com/wp-content/uploads/2024/02/bsava-veterinary-medicine-on-a-budget-2.pdf

Competition and Markets Authority working paper on competition in the supply of veterinary medicines

1. We understand that the CMA has chosen to focus on veterinary medicines because it is concerned that competition may not be working well for pet owners. In particular, the CMA consider that the increase in average unit price for medicines at a retail level and the mark-ups set by First Opinion Practices (FOPs) suggest that there may be weak competition in relation to veterinary medicines.

2. Whilst we acknowledge the CMA's concerns regarding a potential lack of competition for supply of veterinary medicines to pet owners, and the need to support improved choice for consumers in this area, we are also concerned about the unforeseen consequences that reducing direct sales of veterinary medicines may have upon veterinary FOP businesses and their clients. These include:

   - Veterinary fees for consultations, diagnostic tests and/or surgery will undoubtedly have to increase to ensure that FOPs remain profitable. Whilst no longer having medicine sales compensating for undercharging on fees may be 'fairer' for some pet owners, for example those with pets on long-term medication, for others the overall cost of veterinary services will increase. This is unlikely to be an outcome consumers will be expecting from the CMA investigation and could impact negatively on animal welfare.
   - The impact of any changes on medication prescribing and supply are likely to be felt to a greater extent in small businesses and rural practices, where the scope for diversification of fee structures is more limited.
   - Consumers unable to access the full range of choices in supply of medicines, for example those in remote areas or with poor access to the internet, may be hit harder by any changes.
   - It is unclear if potential remedies such as mandatory maximum prescribing fees or decoupling of prescribing and dispensing would extend beyond medicines for household pets. To limit given methods of prescribing to certain species would be difficult and open to abuse, but to do otherwise would impact negatively upon other sectors, such as equine and livestock veterinary medicine. This requires careful consideration by the CMA and is of course outside the stated remit of the investigation.

Accessing and comparing prices for veterinary medicines and associated services

3. We recognise that the information made available to clients with regard to veterinary medicines varies significantly from practice to practice. FOPs may provide information, in the practice or on a website, on the most commonly prescribed veterinary medicines and may also provide information on associated fees such as vaccinations or prescriptions, but this information is not standardised, and we agree that this may make it challenging for pet owners to effectively compare prices or respond to the competitive offerings of alternative FOPs. We recognise that this means that FOPs may be able to set prices with little regard to competition, and this could result in pet owners paying more for veterinary medicines and associated fees.

4. BVA's guidance on transparency and client choice (2024) is clear that transparency around costs and the true value of veterinary care is key to giving clients choice and facilitating informed consent.[1] Additionally, transparency in relation to fees helps support the wider veterinary practice team, making it easier to discuss costs with clients. We know that many practices already display price lists, in the practice and/or on their websites, for their most frequently offered services. Although we consider that practices should be able to tailor price lists to display those services which are most relevant to

[1] https://www.bva.co.uk/media/5766/bva-transparency-and-client-choice-guidance.pdf

the client base, a vaccination or course of vaccinations is an example of a typical service where an FOP could reasonably make price information readily available to clients. We consider that such information should be available in a variety of formats to ensure the information is accessible to all clients, and should be displayed:

- Prominently in the reception area – both as a poster and as a leaflet for clients to take away.
- In the window or in such a way that anyone passing by the practice can readily access the information.
- Prominently on the practice website

5. Prominently displaying the fees most commonly associated with administering and dispensing medicines should be relatively simple for most FOPs to implement now and could also be introduced as a reasonable requirement of mandatory practice regulation in the future. It should always be made clear what these fees include, for example if a prescription fee is for one product only or several on the same script, and what is included in the dispensing fee such as label/bottle/syringes/physical dispensing. There should be no ambiguity that leads to further consumer confusion.

6. However, we would not wish to see a return to the requirement for practices to display a list of 'Top 10 medicines', one of the measures introduced following the Competition Commission investigation into veterinary medicine sales in 2005. The requirement was subsequently dropped in 2013 by the Office of Fair Trading in response to concerns regarding the variability in the way 'most commonly prescribed' was calculated (eg by price, volume, number of prescriptions) alongside the confusion which could be caused by different formulations, brands or pack sizes of the same active ingredient. Not only was this potentially misleading for consumers but was also time consuming for practices with no discernible benefits.

Awareness of options and barriers to using third-party retailers

Awareness

7. We recognise that a substantial proportion of pet owners are not aware they can purchase veterinary medicines from third-party retailers with a prescription, despite the CMA's acknowledgement that all the practices visited do display waiting room signage, and that lack of effective promotion may be one of the many factors that explain this. We note that the CMA's qualitative research indicates that individual vets do not always proactively offer prescriptions and are less likely to offer prescriptions for one-off medications than for on-going medications. In BVA's guidance on transparency and client choice we are clear that there should be a consistent approach which includes:

    - proactively offering a prescription where clinically appropriate and providing clients with dispensing options.
    - clear communication regarding the cost of a written prescription, the reasons for the time period of the prescription, and any further charges for repeat prescriptions and associated further examinations.
    - a quote for the cost of purchasing the prescribed product directly from the prescribing practice.
    - signposting to the Veterinary Medicines Directorate (VMD) Accredited Retailer Scheme where appropriate.

8. We have previously suggested that a concerted communications campaign to ensure that all veterinary practices are aware of and acting on the related RCVS Code of Conduct guidance is needed[2]. Whilst in some instances it may not be in the best interests of the animal to delay dispensing by going to an online retailer, greater awareness of the option to do so could provide

[2] https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/fair-trading-requirements/

significant benefits to clients with pets suffering from chronic conditions which require long-term medication, as online pharmacies can often supply these medicines more cheaply due to lower overheads and the benefits of economies of scale.

9. We would however caution against any move towards complete decoupling of prescribing and dispensing, which could reduce prompt availability of veterinary medicines, as FOPs would stop stocking anything other than a few commonly used products. This would potentially compromise animal welfare, as well as making it difficult for some members of the public to access medications for their pets. Such a move could also lead to a greater consolidation of the market, including where large corporate groups acquire pharmacies, ultimately resulting in fewer choices for consumers and potential price increases over time due to reduced competition. The loss of medicine sales would additionally lead to FOPs increasing consultation and other fees, so any perceived benefit to clients would likely be lost and some clients would overall be affected negatively.

Fees for written prescriptions

10. We note the CMA's suggestion that the current levels of prescription fees may act as a barrier to pet owners purchasing veterinary medicines through third-party retailers. The RCVS Code is clear that vets may make a reasonable charge for written prescriptions, and we have previously provided evidence from the SPVS fees survey which found the average prescription fee to be around £18 in 2023.

11. As we have previously explained, when a client requests a prescription, the vet is required to take the time to check the animal is under their care, review the clinical notes, assess the clinical need for ongoing medication, check the dose, and only then if the vet is satisfied that medication is required can they issue the prescription. All of this takes time, and vets need to charge appropriately for their professional time and skill. The RCVS consider veterinary certification, of which a prescription is a form, to be one of the highest levels of professional responsibility[3] and should not be taken lightly or undervalued. Prior to the 2001 Competition Commission review of dispensing, the professional time devoted to the process of prescribing was not given a clear value. The partial decoupling of the right to prescribe and the right to dispense has meant that veterinary practices, rightly and understandably, are now much more likely to charge properly for professional services (although many still do not), including the provision of a written prescription.

12. We do not support imposing a maximum charge for issuing a written prescription as this is likely to result in prescription fees becoming standardised, with most clients likely paying the maximum. This fails to take into account regional differences, and different business models, which could ultimately have a detrimental impact on those clients who are less able to afford veterinary care. If veterinary businesses feel the fee for a prescription does not cover the time and resources required to issue it, they will simply make up the deficit in other charges, such as increasing the basic consultation fee. Practices should clearly display their prescription fee such that it helps to inform decision-making for clients.

Own brand products

13. We note the CMA's suggestion that corporate 'Own Brand' versions of veterinary medicines may represent a barrier to pet owners purchasing medication from third-party retailers. Although Own Brand products may often be the appropriate product for the particular circumstances, we recognise that consumers may not realise they could obtain a product with the same active ingredient elsewhere. We consider that improved transparency about active ingredients, along with caveats associated with opting for alternative products, may support consumer choice.

14. Vets should always be free to exercise their professional clinical judgement, regardless of the type

[3] https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/certification/

of practice in which they work. When issuing a written prescription, vets can and should prescribe a licensed veterinary medicine by generic name and/or a specific trade name depending on the context and what is best for the animal and owner's circumstances. We would not wish to see prescribing flexibility removed as it would restrict professional clinical judgement and vets' freedom to cater to the preferences of their clients.

Repeatability

15. In our response to the CMA's Issues Statement, we raised significant concerns about the suggestion of requiring vets to provide prescriptions for extended time periods. We were clear that vets typically select the time period for a prescription based on several factors, including the specific medical needs and condition of the animal, the nature of the illness or injury, stability of the condition, and anticipated response to treatment, as well as taking into consideration the availability and shelf-life of the medicine being prescribed. Mandating longer prescription periods without allowing vets to exercise their clinical judgement and allowing for regular clinical evaluations could pose a serious threat to animal welfare. We were also clear that there is a real danger that prescribed medication could be continued inappropriately without timely clinical check-ups, leading to potential issues such as the development of resistance to medications, unmonitored side effects, or the progression of health conditions. Furthermore, animal owners frequently misunderstand the need for repeat examinations and may be focused disproportionately on cost, which can result in them prioritising savings over necessary ongoing veterinary care. Additionally for some drugs, such as controlled drugs, there are controls in place to limit the amount prescribed at one time for reasons of human safety.

16. Although we accept that the length of a prescription could be a contributing factor to the barriers faced by pet owners when choosing to purchase medication from third-party retailers, we welcome the CMA's assessment that the evidence is inconsistent that the length of treatment in written prescriptions has been reduced to increase the need to purchase prescriptions. We welcome the CMA's emerging view that prescription length is not a barrier to using third-party retailers and strongly support vets being able to retain their professional autonomy in matters of responsible prescribing and dispensing.

Injectables

17. We note the CMA's intention to further investigate the suggestion that prescribing injectables could represent a means of disincentivising purchase from a third-party retailer.

18. Vets are required by the RCVS Code to prescribe responsibly and with due regard to the health and welfare of the animal. The CMA's qualitative research found that vets consider different formats of medications when prescribing, discussing their respective prices and benefits or drawbacks with pet owners, and make recommendations based on circumstances of the pet owner or pet. This is contextualised care. Many owners find it difficult to administer oral medications to their animals. Where suitable injectable medications exist owners often chose to take up this treatment option for the reassurance that their pet is receiving appropriate ongoing treatment. This is how contextualised care works; the vet gives the owner a range of treatment options and the owner makes a choice that suits their needs and context. In some cases, clients with pets on long-term treatment may become accustomed and more proficient in technique by using injectables frequently, although safety aspects must also be considered (eg where a product may be toxic to humans in the event of accidental needlestick).

19. Although we accept that veterinary businesses as commercial entities may have a commercial incentive to prescribe medications that pet owners cannot, or would prefer not to, administer to their pets themselves such as injectables, the RCVS Code prohibits individual vets, from making decisions based on commercial incentives. The introduction of mandatory practice regulation could help address this tension, where it exists.

Negotiating power

20. We note the assertion in the working paper that the ability of some FOPs and some third-party retailers to negotiate lower purchase costs than others, where these lower purchase costs reflect efficiencies of certain business models (such as a greater volume of sales or a wider scope of their activities), is not in itself a feature of the market that would adversely impact competition. We also note the emerging view that there are no significant barriers to smaller vet businesses increasing their negotiating strength with wholesalers and manufacturers, on the basis that buying groups appear to be a relatively effective way to achieve a negotiating strength broadly similar to large corporate groups. A fixed fee or percentage fee may have to be paid to achieve the negotiating position.

21. Although veterinary wholesalers are required to supply vets and pharmacies on the same terms for the same volumes, we have previously heard concerns that some online pharmacies sell medicines at prices lower than the prices available to independent practices via the wholesale channel. Despite the assertions of the CMA that independent FOPs are not unreasonably disadvantaged, this is not the viewpoint of some of our members. We would support further investigation as to the reasons why some FOPs and third-party retailers do not or cannot join buying groups with Preferred Products or, in some cases, decide not to join a buying group at all.

March 2025

BVA British Veterinary Association | BSAVA British Small Animal Veterinary Association | spvs | vmg Veterinary Management Group learn share grow | BVNA British Veterinary Nursing Association

Competition and Markets Authority working paper on the regulatory framework for veterinary professionals and veterinary services

1. We welcome the CMA's clear acknowledgment in the working paper of the changes that the industry has undergone in the past 60 years, particularly so in the past 10-15 years, and the challenges caused by the absence of practice regulation, alongside a lack of a modern regulatory framework for regulation of individual professionals. We broadly support the emerging view of the CMA that the current regulatory framework does not contain the right combination of substantive requirements, monitoring, enforcement, or redress mechanisms.

2. We strongly agree that a well-functioning market for veterinary services for household pets should protect animal welfare and public health, alongside the rights of consumers, and that an effective system of regulation, set at the right level, is needed to support such a market.

Forms of regulation

Self-regulation

3. We note the CMA's observation that the regulatory framework for veterinary services is based on the self-regulation model, and that the suitability of that model in modern professional markets has been called into question. Self-regulation is a process where a profession oversees its own standards, conduct, and disciplinary measures to ensure accountability and maintain public trust. It does not necessarily require that its council members be registrants of the profession, nor does it require that they are democratically elected. Instead, Councils generally include appointed members with relevant expertise, focusing on upholding professional integrity and adapting regulatory practices to meet evolving needs and expectations. In our BVA policy position on RCVS Governance we suggest better clarity between RCVS regulator and governance functions is required and suggest options for a modernised structure for an RCVS with both regulatory and college functions.

4. The question of external scrutiny has been considered at length by our working group tasked with developing a BVA policy position on RCVS Governance. The working group recognised that while the Veterinary Surgeons Act (VSA) gives the Privy Council a role in some regulatory matters including appeal of disciplinary cases, in practical terms this does not represent external or independent oversight or audit. By way of comparison, in the human healthcare sector, The Professional Standards Authority for Health and Social Care (PSA), which is an independent organisation accountable to the UK Parliament, exists to oversee and audit the ten statutory bodies that regulate health professionals in the United Kingdom and social care in England. The PSA's remit is to protect the public by overseeing the regulation and registration of healthcare professionals. They do this by:

   - Reviewing the work of the regulators of health and care professionals.
   - Accrediting organisations that register practitioners in unregulated occupations.
   - Giving policy advice to Ministers and others and encouraging research to improve regulation.

5. The working group also considered that, with calls for reform of the VSA it is likely that attention will be drawn to the current absence of independent oversight of the veterinary professions. The trend away from autonomous self-regulation towards independent oversight should not be ignored, with the public perception being that self-regulation is insufficiently robust. However, we are also clear

that any proposed changes must be based around the principles of right-touch regulation, such that the level of regulation is proportionate to the level of risk.

6. BVA's policy position on RCVS Governance recommends that RCVS should commit to external scrutiny against similar standards to the PSA and publish the outcomes of that assessment in full.[1] In July 2023 BVA responded to the RCVS consultation 'Ensuring good governance'[2] and, following the decisions at the RCVS Council meeting in November 2024 we welcomed the proposed changes including RCVS's commitment to consider in more depth external scrutiny against similar standards to the PSA.[3]

7. We note the CMA's assertion that other professional services in the UK are regulated in ways that seek to balance public interest concerns, quality assurance, consumer protection and competition considerations, and the intention to consider whether there are lessons that may be learned from regulation in other sectors. Whilst appreciating that the veterinary sector can learn from others, the primary function of veterinary professionals, embedded in law, is to ensure the health and welfare of animals under their care. We would urge the CMA to give due consideration to the RCVS's aim of modernising its governance structure, as part of calls for reform of the VSA, to enhance transparency, lay representation, and effectiveness in regulating the veterinary professions and allied professionals, and its recommendations for a package of measures that will enhance transparency and accountability, ensuring RCVS remains a trusted and effective regulator.

Regulation of vets

Entry requirements to register as a vet

8. We support the CMA's recognition that the entry requirements to register as a vet pursue important public policy objectives - protecting animal welfare and public health by helping to ensure that those who provide veterinary care are competent to do so. We understand that the CMA has seen some evidence that the entry requirements, especially for foreign-qualified vets, may be set inappropriately, contributing to a shortage of vets in the UK.

9. The number of EU vets registering in the UK remains lower than pre-Brexit levels and there is still an urgent need for overseas vets while UK training capacity is being expanded. We warned the then Defra Secretary of State in March 2024 that the implementation of the £48,100 salary threshold will make it almost impossible to recruit veterinary surgeons from overseas unless they are either very experienced and warrant such a salary or under 26 years of age and can be paid the lower age threshold, and reiterated those concerns in our submission to the National Audit Office (NAO) study on Skilled Worker visas.[4] The change is likely to have far-reaching implications across the UK veterinary profession, particularly impacting areas such as public health, veterinary education, and remote and rural livestock practice.[5] As such we have called on the Home Office to reset the salary threshold for vets to the standard rate of £38,700 and would welcome any recommendation by the CMA that the Government should review this.

10. Veterinary professionals from veterinary schools that are not European Association of Establishments for Veterinary Education (EAEVE) or RCVS accredited enter the RCVS register by one of two means, direct entry via RCVS recognised qualifications or via the RCVS Statutory Membership Exam. It is unclear from the working paper whether the CMA also considers that educational standards of entry onto the register should be reviewed, with the aim of facilitating entry to vets who have qualified overseas, or if the admission process and costs associated should be re-

[1] https://www.bva.co.uk/media/6250/bva-position-on-rcvs-governance-final-july-2024-002.pdf

[2] https://www.bva.co.uk/media/6006/response-to-rcvs-consultation-ensuring-good-governance.pdf NOTE also BVNA response: https://bvna.org.uk/blog/bvna-publishes-response-to-rcvs-good-governance-consultation/

[3] https://www.bva.co.uk/news-and-blog/news-article/bva-responds-to-rcvs-governance-reform/

[4] https://www.bva.co.uk/media/6018/bva-response-to-nao-skilled-worker-visa-final.pdf

[5] https://committees.parliament.uk/work/8164/vet-shortages

considered. We would strongly oppose moves towards a two-tier system whereby vets who qualified overseas were permitted to join the register with veterinary qualifications which fell below the standard delivered by the UK veterinary undergraduate programme, or other accredited schools, as this would risk animal welfare and public health, could damage consumer confidence, and could disincentivise prospective home-sourced veterinary students. We consider that RCVS should retain the power to determine the veterinary qualifications and language competency requirements for overseas vets. We welcome the recent efforts of RCVS to arrive at a set of practical and deliverable changes to the RCVS Statutory Membership Exam that alleviate some of the stress involved around timescales, opportunity and finance.

11. It worth noting that RCVS workforce modelling has suggested that within clinical practice, the number of small animal vets is projected to increase by 62%, to 27,920 by 2035.[6] The number of full-time equivalent (FTE) vets is projected to increase by 42% between 2023 and 2035 (compared with the growth in headcount numbers of 52%), with the average FTE falling from 0.85 in 2023 to 0.79 in 2035.

RCVS Code and consumer interests

12. Vets are required by the RCVS Code to make animal health and welfare their first consideration. We note the recent updates to the Supporting Guidance relating to informed consent and the publication of an additional chapter which consolidates RCVS advice on the ‘consumer-facing’ aspects of regulation. We also note the CMA’s suggestion that, despite the updates, the RCVS Code still does not give sufficient weight to those provisions which seek to protect consumers and does not reference the role that competitive markets play in advancing animal welfare.

13. We consider that more could be done to promote the RCVS Code, including changes and additions to it, and to ensure that all registrants are up to date and compliant. We would reiterate, however, that whilst consumer protection and animal welfare are closely linked, in the current legislation vets primary concern is safeguarding animal health and welfare. Consumer protection is delivered by the Vet-Client-Patient-Relationship (VCPR) in that clients trust veterinary professionals to help and guide them through choices that enable the best welfare outcome for the pets involved. Contextualised care and the VCPR are at the heart of this, and care needs to be taken not to damage this and in doing so compromise animal welfare.

Monitoring and enforcement of compliance with veterinary regulation

14. We note the CMA’s assertion that there are insufficient and inappropriate mechanisms for the monitoring and enforcement of vets’ compliance with the RCVS Code, and that this assertion could also reasonably apply to veterinary nurses. We recognise that enforcement is currently reactive and complaints-driven and consider that the current disciplinary process is cumbersome and backward looking, with the focus being on whether or not a vet should be punished for a mistake which happened in the past - possibly several years previously. The current system does not take into account whether a vet is currently impaired, whether they have taken remedial action since the event, nor does it address systemic issues in the workplace which may have contributed to behaviours. We support the principle of modernising the system, in line with the principle of right-touch regulation, to focus on remedial action in relation to the individual and the wider context within which they work.

15. We also agree that RCVS has access to a limited range of sanctions, in particular where conduct falls below the threshold of serious professional misconduct. In our response to the RCVS Legislation Working Party recommendations, we supported the proposal that the Disciplinary Committee should be given the power to impose conditions of practice as a less onerous sanction

[6] https://www.rcvs.org.uk/news-and-views/news/new-rcvs-workforce-model-highlights-need-for-more-vets-working/

in suitable cases, whilst still adequately protecting animals and the public.[7] We consider that RCVS would need access to a much wider range of sanctions if monitoring and enforcement of the RCVS Code was to be enhanced. There would also need to be careful consideration of the additional costs associated with enhanced monitoring and enforcement.

16. We support the CMA's observation that a disciplinary system based on proving and sanctioning serious professional misconduct differs significantly from that employed by some other regulators, where 'fitness to practise' frameworks are seen as the more modern and effective way to protect patients and maintain public confidence. We are currently engaging with Defra, RCVS, BVNA and other key stakeholders to develop the proposals for a modern and forward-looking fitness to practise regime as part of the wider package of measures which are intended to form the basis of new primary legislation.

Regulation of veterinary nurses

Interpretation of current legislation

17. We recognise the CMA's observation that uncertainty around what is permitted under current legislation may be leading to Registered Veterinary Nurses (RVNs) being under-utilised across the sector. There is a need for greater clarity around what can be delegated under Schedule 3 of the VSA, how this should be done, and who is responsible when inappropriate delegation occurs. This lack of clarity is having an impact on the confidence of both vets and RVNs to increase the use of Schedule 3, despite some initiatives from the RCVS[8] and BVNA[9]. Although we consider that attempts to produce a definitive list of tasks appropriate for delegation to RVNs would not be future-proof, additional guidance relating to specific tasks which are mistakenly believed to be inappropriate for RVNs, and additional case studies to enhance existing RCVS guidance on Schedule 3 would be welcomed by the professions.

18. We strongly support the CMA's emerging view that RVNs could be more fully and effectively utilised within the framework of existing legislation and that greater clarity with respect to interpretation of the existing regulatory framework could help enable this.

Extending the range of tasks

19. We welcome the CMA's recognition that extending the range of tasks that RVNs are permitted to undertake, with appropriate additional training and supervision, could offer positive benefits for veterinary professionals, animal owners, and animal welfare. We have previously expressed broad support for increasing the role of RVNs in the induction and maintenance of anaesthesia and consider that there are opportunities to develop the role for RVNs in a range of other disciplines including, but not limited to: ultrasonography, nutrition, and rehabilitation/mobility. Crucially, post-registration pathways must be open to all RVNs, regardless of their route to initial qualification. Although it is beyond the remit of the CMA to mandate expansion of the RVN role, we welcome the discussion in the working paper and the recognition being given to the key role RVNs play in the veterinary team.

Protection of the veterinary nurse title

20. We support the CMA's emerging view that protecting the veterinary nurse title might enhance transparency and consumer confidence, improve consumers' ability to compare offerings between firms and therefore help stimulate competition between rivals.

21. We have long argued that the title 'veterinary nurse' should be protected to prevent its use by unqualified, unregulated individuals. The lack of protection for the title 'veterinary nurse' remains an

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[7] https://www.bva.co.uk/media/4038/response-to-rcvs-legislative-reform-consultation-final-11-march-2021.pdf
[8] https://www.rcvs.org.uk/document-library/superb-poster-a4-pdf/
[9] http://bvna.org.uk/wp-content/uploads/2024/12/For-veterinary-professionals-Maximising-RVN-role-11.12.24.pdf

issue, with some lay people in veterinary practice still describing themselves as nurses. A recent BVNA survey (2024) found that 52% of respondents knew an individual using the 'veterinary nurse' title inappropriately.[10] There is a lack of understanding amongst animal owners that only veterinary nurses registered with the RCVS can call themselves Registered Veterinary Nurses, although most assume that an individual who is referred to as a 'veterinary nurse' would be properly qualified and regulated.[11] As such, alongside BVNA, we maintain that protection of the title 'veterinary nurse' is long overdue and welcome the CMA's recognition of the benefits which this protection could bring.

Regulation of veterinary practices

22. We welcome the CMA's clear recognition of the challenges caused by the absence of veterinary practice/business regulation. As we have previously stated, with no statutory regulation that is specific to veterinary practices, there is no means of recourse when there are failings in the system that do not sit with the individuals regulated by RCVS. We consider, along with RCVS, that it is reasonable for the public to expect that all veterinary practices are assessed to ensure that they meet at least the basic minimum requirements including appropriately addressing consumer concerns.

23. We agree that attempts to fill the regulatory gap through the RCVS Practice Standards Scheme (PSS) have not been as effective as they need to be. The PSS has done much to raise standards, and changes have been made in recent years to develop the scheme and make it more accessible for a wider range of practices, with assessments now a much more collaborative and positive process. The introduction of mandatory practice regulation should be phased in as an evolutionary process from the current PSS 'Core' standard in order to increase the achievability for all practices. It is essential that standards are equally achievable for small independent practices as well as those supported by large corporate groups, and there must be appropriate and accessible guidance available to practices to support compliance.

24. Practice regulation must not be a tick box exercise, costing money without supporting and improving animal health and welfare, public health, and the well-being of the veterinary team. There are parallels with Ofsted where a collaborative focus has shifted over time and a culture of fear has bedded in. It is essential this is not replicated for the veterinary sector and that the creation of poorly considered KPIs and the pursuit of targets relating to practice standards does not inadvertently detract from quality of care.

25. As mandatory practice regulation will of course require legislative change, and therefore does not represent an immediate solution to the multiple challenges identified, we do consider that some of the consumer issues identified in the working paper can be address through improved provision of adequate and timely information on issues such as pricing, services (including referral services), ownership of practices, where to purchase medicines and range of treatment options available.

Consumer redress and complaints

In-house complaints processes

26. We agree that if a consumer's complaint can be effectively addressed by their veterinary practice, this is likely to be the best outcome, both for clients and for the veterinary practice concerned if improvements are implemented in response to the substance of a complaint. However, we recognise that complaints handling processes are not standardised at the practice level, and in some practices may be inadequate or even absent entirely.

27. A formal, agreed and consistent complaints process for the veterinary sector, that is both pragmatic and proportionate, should be introduced as part of Supporting Guidance to the RCVS Code and then

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[10] https://bvna.org.uk/blog/bvna-releases-preliminary-results-from-its-inaugural-survey-of-the-vn-profession/

[11] https://bvna.org.uk/wp-content/uploads/2023/05/PTT-Report-Final-19.05.23.pdf

made part of requirements of mandatory practice regulation, ensuring that all practices operate complaints procedures of a certain standard. We recognise that other regulated professions have similar requirements, and we can see the benefits to clients, veterinary professionals and businesses. We would welcome an opportunity contribute to the development of advice and guidance on a proportionate approach to complaints handling where a 'no blame' culture is embedded, accompanied by signposting to parallel support for veterinary teams.

Third-party redress schemes

28. We have previously suggested that the Veterinary Client Mediation Service (VCMS) has an important part to play in redress as a voluntary, independent, and free mediation service. We have also cautioned against the creation of another process for consumers to obtain redress on the basis that an additional layer would have little benefit and lead to increased costs of regulation, which may ultimately be passed on to consumers. We support the VCMS view that wherever possible local and first-tier complaint resolution is optimal for clients and veterinary practices. Any development of the current framework should be careful to avoid the unintended consequences of the loss of person-centred complaints resolution. We agree that the VCMS has played a significant role in reducing the consumer complaint burden on the RCVS, and consider that there is scope for better promotion of VCMS both within the professions and to clients. This promotion could also be linked with pet bereavement services, given the proportion of complaints which are grief-driven.

29. We are concerned that the CMA working paper does not acknowledge the role the Veterinary Defence Society (VDS) plays in supporting practices to achieve resolution of client complaints whilst preserving relationships between veterinary professionals and their clients. This includes providing advice prior to escalation to complaint level and settling claims promptly in the event of a client incurring a financial loss as a result of professional negligence.

30. There are a number of providers offering a variety of courses and workshops aimed at training veterinary professionals in a range of areas including improving their communication skills with their clients to foster better relationships, and how to deal with complaints in an equitable manner. Of these VDS is particularly prominent and also shares data about the causes of complaints and claims with members in order to encourage and support continuous improvement. The VDS has also developed VetSafe, a comprehensive online tool which is available to the majority of the practising profession and is designed to drive proactive continuous improvement and clinical risk management through the collection, interpretation and sharing of data insights, which the entire veterinary team can learn from. Other mechanisms for adverse event reporting are widely adopted including via the Veterinary Medicines Directorate (VMD), and through various in-practice systems.

Regulation of the supply of veterinary medicines

The Cascade

31. We note that the CMA's qualitative research reported a number of vets who identified the Cascade restriction as problematic, in particular the inability to use cheaper human generic medicines where the cost difference might be significant. We recognise that there may be cost benefits to consumers in allowing the use of human generic alternatives, and that in some cases animals might currently go untreated due to the high cost of authorised products. However, we also consider that each situation must be dealt with on a case-by-case basis, and that this is allowed for within the existing Cascade – essentially a risk-based decision tree which vets use as a framework taking into account the individual circumstances of each patient. Dismantling the Cascade and allowing human generic drugs to be prescribed to animals brings risks to both animal welfare and antimicrobial resistance (AMR). There is a role for RCVS and VMD in providing improved clarity around the application of the Cascade to support vets in decision-making.

32. As we have previously outlined, veterinary medicines sometimes cost considerably more than chemically identical human equivalents because they are subject to a separate licensing procedure

specific to animals only. Human equivalents are not necessarily chemically identical to veterinary medicines, and in some cases, a different formulation may be needed due to different bioavailability. There can be considerable difficulties and risks in comparing absorption, distribution, metabolism and excretion (ADME) of veterinary licensed and generic medicines, and the requirement to abide by the Cascade and use veterinary licensed products where they exist, is in no small part because the ADME particulars have been tested fully. As the VMD has pointed out, potential risks to the target species increase with each step down the Cascade, and this is why affordability alone cannot and should not be a justification for moving down the steps of the Cascade.

33. We welcome the recognition in the working paper that the CMA may not be best placed to draw conclusions on the most effective weighting of competition (including consumer cost and choice) factors against the wider public policy issues involved, including animal welfare. We agree that the VMD, with other stakeholders, should take the lead on any review of the Cascade. At present, pharmaceutical companies are only required to prove the efficacy of their product in one species for one clinical condition for it to fall under the Cascade, and there is no requirement to compare the efficacy against a pre-existing generic product. The VMD could consider changing the marketing authorisation process to require an impact assessment including both cost and animal health and welfare implications. Perhaps more importantly, the R&D process should also have ethical considerations built in (ie the impact on pet owners of a generic being replaced by a POM-V) as it is arguably too late at the point of applying for a marketing authorisation.

34. Although the challenges associated with the regulatory framework for veterinary medicines cannot be resolved at a practice level, we do recognise the difficulties faced by consumers who, understandably, lack awareness as to why licensed veterinary products may be more expensive than human products with the same active ingredient. Within the setting of contextualised care vets will already be discussing a range of treatments, including their likely effectiveness and cost, and we consider that VMD and RCVS, with the support of the veterinary associations, have a role to play in supporting veterinary professionals to communicate this information to their clients. The development of simple explanatory material for waiting rooms and practice websites could represent a more immediate solution to address the information asymmetry on this particular issue.

‘Under care’ requirement for prescribing parasiticides

35. We recognise the concerns caused by the changes to RCVS ‘under care’ guidance that require vets to physically re-examine pets when prescribing parasiticides. Whilst we consider that responsible use of parasiticides is essential for reducing the growing risk of AMR caused by misuse and overuse, and for protecting against environmental contamination, we also understand that the introduction of a requirement for a repeat examination when prescribing parasiticides has had some negative impacts on vets and owners as the new prescribing systems bed in.

36. Veterinary professionals should always take a risk-based approach to prescribing medicines, including parasiticides. They should avoid blanket treatment, and instead risk assess use of parasiticides for individual animals, taking into account animal, human and environmental health risks, in addition to lifestyle factors. Although the requirement for a repeat examination has stimulated some discussion around responsible use - which can only be a positive outcome – the potential for inconvenience and possible additional cost to clients may have outweighed the benefits and created an additional burden in practice.[12] We would support a review of the requirement, led by RCVS.

Provision of veterinary care

Telemedicine and remote prescribing

37. We agree that telemedicine (or rather, remote provision of veterinary services) provides an additional avenue for consumers to access veterinary services and may therefore widen access to professional

[12] https://www.bva.co.uk/media/5533/bva-under-care-rules-leaflet-for-clients.pdf

care and broaden choices available to pet owners. We also agree that there is scope for the benefits of telemedicine to be further realised to help improve consumer choice, reduce the resource burden on vets and promote animal welfare in a greater number of settings.

38. The remote provision of veterinary services can be a valuable adjunct to the existing models of veterinary practice. Under an established VCPR, remotely provided services can add value to the client/patient care package, supporting animal health and welfare, public health, and good biosecurity. Where remote provision is done well and forms a credible part of a veterinary business, it may also ensure more effective and efficient use of veterinary time, benefitting both vets and their clients.[13]

39. In the absence of a VCPR, the animal, its clinical history and the animal owner are unknown. There is no access to previous clinical notes and levels of trust have not been established. The lack of previous 'hands on' clinical examination of patients that cannot speak up for themselves and owners who are not always fully aware of the pet's clinical condition can make remote prescribing without a VCPR both difficult and potentially dangerous for animal welfare. After remote prescribing through necessity during the Covid-19 pandemic, it is now clear that both vets and clients generally prefer face-to-face consultations, as is illustrated in the CMAs own qualitative research. Remote veterinary service provision, whether by a stand-alone dedicated provider or as part of an existing veterinary practice's services, should be limited to offering generic information and advice only and making an onward referral to physical veterinary services.

40. Responsible prescribing of all veterinary medicines must always be ensured, including when clinical assessment is by remote means. Responsible prescribing is necessary for both animal health and welfare and human health. An established VCPR supports responsible prescribing and represents the only appropriate opportunity for remote prescribing of POM-Vs and POM-VPSs. Remote prescribing should only be available when a VCPR has been established and, in the professional judgement of the vet, the trust levels are sufficient that remote prescribing represents an enhanced service, which is necessary for animal health and welfare and promotes responsible prescribing and use of medicines.

41. We strongly welcome the suggestion in the CMA working paper that RCVS, as part of their review of the implementation of the Under Care guidance, could consider defining the concept of the VCPR in a way that might provide a clearer framework for developing telemedicine.

Limited Service Providers and 24/7

42. We note the suggestion in the working paper that, in respect of Limited Service Providers (LSPs) the current regulatory framework could be seen as over-protective of traditional business models at the expense of market opening measures which could foster new entry and innovation. Although the 24/7 requirement on LSPs was recently relaxed such that they are only required to provide coverage within the context of the service(s) rendered we note the emerging view of the CMA that there could be benefit in RCVS reviewing the requirement, potentially with a view with removing it for some LSPs.

43. We have long supported the RCVS requirement and guidance on emergency first aid and pain relief, which is clear, appropriate, and reflects the ethical responsibility of individual vets, and consider the willingness of vets to provide 24/7 emergency care as one of the main reasons that the public places such trust in the professions.

44. We consider that LSPs, who offer specific healthcare services, however limited, have a duty of care to the client and patient, effectively entering a VCPR within the context of the specific provision. There is a professional responsibility, and a reasonable expectation from clients, that in the context

[13] https://www.bva.co.uk/media/3966/bva-policy-position-on-under-care-and-the-remote-provision-of-veterinary-services-january-2021.pdf

of an established VCPR there will be some degree of veterinary care available overnight and on other out-of-hours occasions. Limited-service providers, and those offering peripatetic veterinary services, should not be considered exempt from this responsibility, which would place additional burden on neighbouring practices, risk animal welfare and damage client trust. As with other veterinary businesses, there is no obligation to provide that care themselves, and the provision can reasonably be outsourced.

March 2025

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Competition and Markets Authority working paper on analysis of local competition

1. We understand that the CMA has chosen to analyse local competition as a result of the acceleration in acquisitions and consolidation through the 2010s, with large corporate groups now owning around 60% of First Opinion Practices (FOPs) in the UK. The assertion is that this change in market structure has led to an increase in the degree of local concentration in the UK, with concerns raised by some parties during the CMA's consultation on a market investigation reference that there is now an insufficient number of competitors in some areas.

2. We have previously stated that the factors which animal owners take into consideration when choosing a vet surgery for their pet will vary depending on individual circumstances, with proximity and accessibility likely to be key.[1] We therefore fully recognise the CMA's assessment that a customer's choice of veterinary practice will usually be limited to those located within the geographic area where the customer is willing and able to travel.

3. We welcome the CMA's analysis which has found that the supply of FOPs is not generally concentrated, with 85% of FOPs competing with at least three local rivals. In fact, there are only 49 FOP sites identified by the CMA which may not face competition from any other local providers, accounting for only 1% of total sites. Those sites with no competition probably exist in areas where there is insufficient caseload for multiple businesses to exist.

Further analysis of FOP concentration

4. We note that the strength of competitive constraint imposed on each focal area has been calculated using metrics relating to the services provided and capacity of each site, including: opening hours, the number of consulting rooms, operating theatres, number of Full Time Equivalent (FTE) vets, veterinary services provided at the site, and type of in-clinic diagnostic equipment.

5. We also note the intention to consider further assessment of competition in some areas using metrics such as share of FTE vets or share of consultation rooms. As part of any further analysis, it may be helpful to consider additional metrics such as:

    - Whether the practice offers small animal services only or whether facilities are shared with farm or equine work. This will impact the amount of FTE vet time spent on small animal.
    - Number of FTE RVNs who will also provide client services and use consultation rooms
    - Number of branches, and whether those feed into a central facility.
    - Provision of referral services (including peripatetic visiting vets), or Out of Hours (OOH) provision for other practices in the area, both of which will use FOP space and resources.

Out of Hours providers

6. We note the CMA's view that its analysis suggests that the provision of outsourced OOH care is more concentrated than the supply of FOPs, possibly because there is less demand and fewer suppliers which may be because OOH care is typically only accessed in emergencies. The analysis identified 356 providers of outsourced OOH services and, of these, 69 (19%) face no local

[1] https://www.bva.co.uk/media/5766/bva-transparency-and-client-choice-guidance.pdf

competitors and a further 88 (25%) face only one local competitor. In total this represents 44% of OOH sites.

7. As we have previously explained that historically veterinary practices have provided their own OOH cover with all vets employed by the practice on an on-call rota, supported by a locum if needed. In many cases this service was not charged for commercially. Many practices saw it as their duty to provide this service for their clients, as well as an RCVS requirement, and it was delivered at a loss, cross-subsidised from other areas of practice income.

8. OOH veterinary services need a critical mass of work to be commercially viable for the provider of the service. In areas of high human population density, there will be correspondingly more pets, but in many other areas, especially rural or remote areas, there is not enough work to support multiple OOH providers. In recent years there has been a significant shift in the companion animal sector to outsourcing OOH care to providers with a more commercially viable structure that specialise in delivering OOH care, with professional staff specifically employed to work nights and weekends[2] This has gone a long way to supporting a diversity of veterinary practice business models offering daytime care, including smaller independently owned practices. It also supports a better work/life balance for veterinary teams, which ensures that practices can recruit and retain experienced staff, and enables the delivery of good quality veterinary care both day and night.

9. For owners in geographically remote areas of the UK, access to a choice of OOH providers is simply not feasible. For smaller practices, with limited close neighbouring practices with whom OOH cover can be shared, outsourcing OOH to one practice as an OOH provider may be the only way that local FOPs practices can meet the obligation to provide 24/7 emergency first aid and pain relief for all animals, retain staff, and remain viable as businesses. Outsourcing OOH work to dedicated providers also supports the sustainability of the workforce by allowing those vets who cannot or chose not to work on an OOH rota to stay in practice.

10. We therefore support the CMA's assessment that the nature of outsourced OOH means that its provision is likely to be more highly concentrated than for FOPs due to less demand, and that OOH care is also more expensive to provide as it depends on staff working unsocial hours. We agree that it may be the case that concentration is high in a number of local areas, with no likely scope to increase the number of competitors.

11. We would strongly advise against any remedies which shift the requirement to deliver OOH back to individual practices. For many, this would be commercially unviable to deliver due to insufficient demand set against the challenge of modern working practices and recruiting to cover an OOH rota in addition to the normal daytime provision. Any such shift could have serious consequences, in particular for more remote and rural areas of the UK, leading to inability to recruit staff, closures and therefore reduced consumer choice and animal welfare harms.

Referral centres

12. We note the CMA's view that its analysis suggests that the vast majority (79%) of referral sites may compete with at least five other local suppliers. However, the analysis to date has considered all referral centres as competitors, irrespective of the specific services they offer. As acknowledged, whilst competition within referral practice for some disciplines such as orthopaedic surgery might be good, for other less common specialisms such as ophthalmology, there is unlikely to be much local competition. This is a simply a reflection of veterinary specialism and case load.

13. As we have previously explained, few vets and veterinary practices, if any, can do everything, and ensuring appropriate care for animals often requires referral to specialists. This involves considering

[2] https://www.rcvs.org.uk/news-and-views/publications/the-2019-survey-of-the-veterinary-profession/ (Section 7.6)

the animal's health needs alongside accessibility and convenience for the client. Referrals are also based on close professional relationships between referring and referral clinicians. Over time, these relationships build a deep understanding of skills (for example post graduate RCVS recognised training compared to on-the-job experience), expertise, possible costs, waiting times, type/level of follow up/after care and availability of CPD and telephone support, which in turn builds confidence for the referring vet that they can be confident in their referral. This also means they are better placed to advise clients on what to expect. A referral is not merely a transactional arrangement between service providers.

14. The working paper appears to focus on referrals to Specialist vets, as defined by the RCVS, who will have at least a postgraduate diploma level qualification. This view of referrals is far too narrow and fails to recognise that referrals may also be to RCVS Advanced Practitioners, certificate holders, or simply to colleagues within the same practice or externally to another practice who have a particular interest in a particular area of work. We recognise that greater clarity around these qualifications is needed for consumers to fully understand this element of referrals.

15. The working paper rightly recognises that since a referral centre that specialises solely in oncology is unlikely to be a substitute for one that specialises solely in orthopaedics, the analysis could differ if each specialism was considered individually. However, we do not consider that the stated intention to potentially carry out further analysis at a specialism level will provide meaningful data. The presence of a specialist is informed by the availability of sufficient caseload. There are some specialisms where there will be competition in many localities – in particular surgical disciplines such as cruciate ligament surgery, fracture repair, and non-urgent cases such as CT imaging – but there will also be numerous situations where it is necessary to phone around for even one option for less common presentations. Where the volume of work is low it simply is not reasonable to expect that there will be more than one referral option in a locality, and in some cases none at all.

March 2025