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26th May 2025

Dear Lucy and the CMA Vets MI Team,

Response to CMA May 2025 Working Papers on Potential Remedies

XLVet UK Ltd (XLV) is a company owned by 67 independent veterinary practices based throughout the UK. Each veterinary practice is an autonomous and separate legal entity owned by veterinary professionals working in that practice, and each practice provides services to their local communities. XLV provides support to these practices and the people working within them.

We thank the CMA team for their working paper and the opportunity to respond.

In our response to the Working Papers published by the CMA in February 2025, we noted that our emergent view was of concerns regarding asymmetry. With the publication of this Working Paper on Remedies, it is now our provisional conclusion that the Market Investigation is **flawed by asymmetry**:

- Firstly by the apparent **lack of input** to the process (including a function of the relative amount of 'airtime' and 'response-time') provided to various parties and
- Secondly by way in which it is evident that there is **inequitable impact** of the proposed remedies falling upon independent veterinary practices. (Appendix 2)

Whilst we support the positive intent of many of the Remedies and Recommendations, it is clear that the total economic cost will fall **disproportionately** and with **inequality** upon independently owned veterinary practices. Furthermore, there are a large number of **unconsidered consequences** which will affect the ability of these locally owned veterinary practices to continue to serve the communities in which they live and work. Our initial calculations are that a large number of remedies will **lead to increased consultation times and consultation** costs to animal owners. As such, we would assert that many of the Remedies will have the opposite effect from that intended; rather than improving market function, it will cause **market degradation** and a **reduction in the affordability and availability of veterinary care** to the communities served by our members. (Appendix 1)

The XLVets community:

- **supports transparency**, clarity of information and **choice for clients**, full **professional accountability**, and **fair redress**,
- **endorses the regulation of veterinary business**, promotion of **VCMS,** legal protection of the title '**vet nurse'** and the consideration of that role for the future
- but **strongly opposes forced decoupling** of prescribing and dispensing of medicines,
- and is **deeply concerned** about policies that actively **pushes medicine dispensing online** and impose **disproportionate administrative burdens upon independent practices**.
- As a community that includes veterinary businesses providing services to **farm and equine clients** we are disturbed to see no apparent consideration for the impact of the Remedies on the delivery of these products and services. Whilst the delivery of these are **out-with the scope of the Market Investigation,** many remedies will **impact the whole veterinary profession** and the impact upon those businesses providing **services to a mixed client base** may affect their **overall functioning and viability**.

We would be pleased to meet with the CMA MI Team to explain any of the concerns that we have raised and to provide further evidence and expand upon any of the points made in our full response below. We ask that the CMA exercises its powers with care and leaves the provision of veterinary care improved and not degraded.

Thank you for giving this matter careful consideration.

Yours sincerely

[redacted]

Andrew Curwen
XLVet UK Ltd
On Behalf of the XLVets Community

Our responses to each of the potential remedies and questions follow on the following pages

Question 1

Q: We welcome comments regarding our current thinking on the routes to implementing the potential remedies set out in this working paper.

A: We support the CMA's consideration of implementation routes but urge caution in applying a one-size-fits-all model. The current proposals disproportionately burden smaller independent practices lacking the corporate infrastructure of large groups. We call for graduated **compliance based on business size,** and oppose any implementation mechanism that assumes scale or digital integration capacity equivalence between different businesses. Remedies must be framed to maintain and enhance diversity of provision, not entrench or create monopolies.

Question 2

Q: Should information remedies be trialled before full implementation? If so, which ones and how should trials be assessed?

A: Yes. Trials are appropriate for information remedies, especially all of those with unclear consumer response or high implementation costs (e.g. standardised pricing, comparison tools, web portals). Trials should focus on **actual behavioural change** in pet owner choices, not just compliance outputs. The trial design must include meaningful participation from small, independent practices to ensure feasibility and fairness. Outcomes must also **measure unintended market concentration effects**.

Remedy 1: Require FOPs and referral providers to publish information for pet owners

We appreciate the CMA's efforts to increase transparency in the veterinary market, and we fully support the intention behind Remedy 1: empowering pet owners through clearer access to information about prices, ownership, services, and complaint mechanisms. As a community of independent veterinary practices, we believe in and practice:

- Transparency and clarity of information to enable informed decision-making,
- Full professional accountability,
- Trust-based, continuity-oriented relationships with clients,
- And a robust, fair redress framework, such as through the VCMS.

We also endorse regulation at the business level, the promotion of the VCMS, and the legal recognition and empowerment of veterinary nurses.

However, Remedy 1 must be **implemented proportionately and sensitively** if it is to succeed in enhancing market functioning without undermining trust, access, or diversity of provision. The CMA's remedy, as currently articulated, risks introducing unintended consequences that could harm smaller, community-based practices and the very market dynamics it seeks to improve.

The CMA appears to view trust as a distortion of market efficiency. We strongly disagree. Trust is not a drag on the market - it is the foundation of it. Clients do not act upon veterinary advice unless they trust the vet giving it. Prescriptions are not filled, follow-ups are missed, and welfare suffers without trust. Trust reduces the need for second opinions and switching, lowers treatment delays, and underpins cost-effective, preventative care.

We urge the CMA to recognise trust not as an inefficiency, but as a functional necessity in any market that delivers credence goods like veterinary care. **To erode this trust through standardisation without nuance would be counterproductive.**

Recommendation: Design Remedy 1 to enhance confidence and transparency, not to push price-driven switching or commoditisation.

We support mandatory disclosure of ownership structures. Clients are often unaware they are attending a FOP that is owned by a corporate group, and clear disclosure supports informed choice. In independent practices, accountability has historically been community-rooted - owners live and work among the people they serve. Remedy 1 should help reinforce that local accountability, not erase it through standardised formats that reduce all providers to identical listings.

Remedy 1's intention to enable comparison through standardised information is noble - but comparability without context leads to confusion. Veterinary services are complex. A consultation cost may reflect follow-up care, species range, or additional services. Oversimplified data comparisons risk misleading clients and undervaluing higher-quality or more comprehensive service models.

This is compounded if comparison tools (e.g. future websites) focus on price above all else, eroding the value of continuity, preventative care, and locally adapted models.

Recommendation: Allow narrative context in listings and enable clients to understand why prices differ - not just how much they differ. Perhaps an easier, more appropriate option would be to roll out an extended version of the CMA's own web page "Choosing a vet practice and treatments for your pet". Every practice could signpost clients to this before they join the practice. Suggested information for clients could include,

1. Average local costs for treatments

2. Breed problems and costs

3. Finding a vet,

4. Asking for options during a consultation,

5. Access to prescriptions,

6. Information on sensitive topics such as cremations

7. How to complain.

This could be incorporated with the RCVS Find A Vet website

Large corporate groups have legal, communications, and IT departments to standardise and update information across hundreds of sites. Independent practices do not. For smaller practices, compiling, formatting, and maintaining structured data is a material operational burden.

This creates an unintended asymmetry in compliance feasibility, **which could accelerate consolidation by default** - not through improved service, but through regulatory scale advantages.

Recommendation: Offer phased implementation, RCVS-backed templates, and exemption thresholds for smaller businesses.

If Remedy 1 fuels an eventual price-focused comparison platform, the veterinary market may begin to resemble a utility market - where price is the primary driver, and continuity, context, and care quality are undervalued. This is inappropriate for healthcare provision. It will encourage:

- Fragmentation of care,
- Unnecessary switching,
- Loss of personalised service,
- And potential treatment delays.

We support greater consumer education on treatment options and pricing without mandating disruptive market dynamics that erode trust. This must be the acid test.

Remedy 1 must not be viewed in isolation. It interacts with other remedies (e.g. comparison websites, prescription mandates) that together risk re-engineering the veterinary market in a way that:

- Favors price above trust,
- Incentivises volume over care continuity,
- And potentially privileges online channels over physical, holistic service providers.

The veterinary market is not 'broken' because information is hidden. It is under pressure because the market dynamics have shifted toward third party investor return (with interest repayment of PE debt) through leveraging "gold standard care", not because smaller, trust-based providers have failed to explain themselves. Remedy 1 should support transparency that enhances trust and professional accountability, not drive artificial parity that suppresses individuality and community care.

We welcome the CMA's efforts to make the veterinary market more transparent and consumer-aware. But we urge a Remedy 1 that:

- Strengthens trust, not just switching,
- Enables clarity, not confusion,
- And supports all types of practices - not just those with the capacity to absorb regulatory load.

A well-functioning veterinary marketplace depends not on identical listings, but on fair access, informed confidence, and proportionate transparency. Remedy 1 can support that vision - but only if implemented with care, fairness, and insight into the diversity of veterinary care delivery.

Question 3

Q: Does the standardised price list cover the main services a pet owner is likely to need? Should anything else be included?

A: Whilst the list is broadly sensible, the principle of it is fundamentally flawed and at the very least we caution against expanding it excessively or allowing it to be gamified. Over-detailed pricing may confuse rather than clarify, and does not reflect the clinical discretion required in many cases. The pricing of treatment and care is inherently as complex as the care itself. It is important that the CMA recognises that pricing cannot always be fixed in advance due to case variability. Adding too many services risks turning practices into price-advertisers rather than clinicians. This would reduce trust in the critical vet-client relationship which would be to the detriment of effective animal health and welfare. **The key metric that should be published is total cost per dog or cat at the practice per year and a list of all procedures and services offered by the practice. That is the way to show meaningful comparison.**

Question 4

Q: Is the proposed information feasible for practices to provide? Is anything missing?

A: Much of the proposed information is technically feasible, but resource-intensive. Moreover the **cost-benefit of this information needs to be reconsidered**. For smaller practices, the burden of maintaining accuracy and comparability may lead to **cost-passing to clients or service reduction**. We recommend that information fields be streamlined, with strong RCVS guidance, and that practices have the option to explain variations in cost (e.g. for complex cases) rather than adhere to strict templates.

Question 5

Q: Do you agree with the proposed factors (animal size, age, etc.) by which to separate prices? Which are most useful for comparability?

A: We accept that some price segmentation by animal size or type may help comparability, but caution that this adds complexity without guaranteeing better outcomes. Practices should retain discretion to structure pricing logically for their service model. Comparability should not come at the cost of flexibility or fairness in patient care. There is also risk of consumer misinterpretation or "shopping by spreadsheet."

Question 6

Q: How should price ranges or 'starting from' prices be calculated to balance transparency with realism?

A: 'Starting from' pricing must be coupled with clear disclaimers about variability due to clinical judgment. Calculating price ranges could be based on historical average case costs, but this requires data analytics infrastructure that many independents lack. A realistic solution would be to publish a 'typical case' cost, supplemented with narrative context, rather than attempt to engineer false precision.

Question 7

Q: Would the standardised price list be valuable to pet owners?

A: It could be valuable if implemented proportionately and explained clearly. However, without context, such lists risk over-simplifying nuanced clinical choices, leading clients to make decisions based on cost rather than care and potentially giving clients a

false sense of transparency which may be more harmful than the current perceived lack of transparency. We support price transparency, but not in isolation from professional judgment. There is also a real risk of commoditising care, which could erode trust in the vet-client relationship.

Question 8

Q: Do you think that it is proportionate for FOPs and referral providers to provide prices for each service in the standardised price list?

A: Yes, but the prices must be accompanied by further information as to the nature of the treatment that is being provided and therefore, because comparing a price necessitates comparing explanations of the price and how it might vary, it makes it unsuitable for a simple price-comparison / comparison site.

Question 9

Q: Could the standardised price list have any detrimental consequences for pet owners and if so, what are they?

A: Yes, the standardised price list could have several unintended detrimental consequences for pet owners, especially if implemented without sufficient flexibility or context, and price comparison sites are notoriously poor at providing context.

From the perspective of independent veterinary practices that support transparency and informed choice, the core concern is that over-simplified pricing tables may mislead rather than inform. Clients may:

- Misinterpret standard prices as fixed quotes, leading to confusion or frustration when individualised care (based on animal condition, urgency, or complexity) results in variation.
- Prioritise cost over care, potentially deferring treatment or selecting providers on price alone, rather than continuity, clinical quality, or trust.
- Assume comparability where none exists, believing that all “vaccinations” or “consultations” are identical across practices, despite differences in time spent, follow-up care, or support services.

For pet owners, this could result in weaker relationships with their vet, fragmented care, or even welfare compromises if decision-making becomes overly cost-driven.

We therefore urge the CMA to ensure the price list is accompanied by explanatory context, and framed as a guide, not a guarantee, preserving the importance of tailored,

trust-based veterinary care. And we note that to do this is not straightforward, nor is it without significant administrative and financial cost to the business.

Question 10

Q: Could the standardised price list have any detrimental consequences for FOPs and referral providers?

A: Yes, the standardised price list could have **detrimental consequences for First Opinion Practices (FOPs)** - particularly **independent and smaller practices** - if not implemented with proportionality and flexibility.

It represents a disproportionate compliance burden for smaller FOPs that often lack dedicated admin, legal, or marketing teams. Producing, maintaining, and updating a standardised price list - especially in a format suitable for digital publication - imposes a **non-trivial administrative load**, taking time away from clinical care.

While many FOPs now have websites, a meaningful minority **do not** - and among those that do, capabilities vary significantly. A uniform requirement risks excluding or penalising practices that serve lower-income or digitally marginalised communities.

Without room to contextualise prices (e.g. explaining why a consultation may cost more due to follow-up care or specialist species expertise), the list may:

- Undervalue higher-quality or more comprehensive service models,
- Lead to price-driven competition, with independent providers **forced to undercut to compete**, threatening sustainability.

Referral centres deal with highly variable, case-specific procedures. Standardising prices in this context may:

- Reduce clarity by over-simplifying complex, bespoke interventions,
- Discourage clients from seeking specialist input due to perceived high cost or confusion about value.

The impact of a standardised price list will vary significantly by practice size, business model, and client base. **Larger corporates** with centralised functions will find compliance relatively easy. **Independent and community-based practices** will bear a **greater relative burden**, potentially widening competitive disparities in the sector.

Question 11

Q: What quality measures could be published in order to support pet owners to make choices?

A: We support the publication of quality measures **only where they genuinely help clients understand the nature and standard of care provided**, without encouraging superficial or misleading comparisons.

We believe quality measures should be:

- **Meaningful** (reflecting standards of clinical care or client experience),
- **Understandable** to the general public,
- **Proportionate** to the size and capacity of the practice,
- And **resistant to gaming** or misrepresentation.

Recommended Quality Measures might include

- RCVS Practice Standards Scheme (PSS) accreditation status
- Continuity of care indicators – e.g. whether a practice offers 24/7 care directly or through a named provider.
- Post-operative complication rates (aggregated and anonymised) – if available through central reporting frameworks. (However, we should caution that practices may be selective about cases they treat and how they treat them to avoid skewing their data. This has been seen in human healthcare scenarios)
- Staff qualifications and CPD commitment
- Participation in the VCMS and a brief summary of complaints-handling procedures.

Remedy 2: Create a comparison website supporting pet owners to compare the offerings of different FOPs and referral providers

We understand and respect the CMA's intention in proposing a comparison website to allow pet owners to make more informed choices about veterinary services. We agree that clarity, accountability, and better understanding of service offerings are important goals, and we support efforts to enhance consumer confidence and access to high-quality care.

However, as independent veterinary practices, we hold serious reservations about the design, implications, costs and underlying assumptions of Remedy 2. If implemented without caution and nuance, a comparison website could unintentionally commoditise

care, penalise practices that prioritise trust and continuity, and reinforce the market dominance of large corporate and online-first operators.

The analogy that vets are utility providers is false.

The idea of a comparison website draws heavily from retail and utility models, where services are standardised, and price is a logical differentiator. But veterinary care is a complex, trust-based healthcare service, not a commodity.

Clinical outcomes vary depending on:

- Individual patient needs and histories,
- Species and breed,
- Client–practitioner relationships,
- Geographic and socioeconomic context.

A comparison site built on price, basic service descriptions, and ratings will inevitably steer consumers toward simplified judgments that undervalue trust, continuity, and clinical nuance.

Furthermore it could easily reinforce **Digital Channel Asymmetry.** Many independent practices have limited digital marketing capabilities. By contrast, large groups can afford SEO optimisation, digital design, and data manipulation to enhance visibility. A comparison site - especially if achieved through scraping process, commercialised or algorithm-driven - risks becoming a corporate-biased visibility funnel, where the best-resourced players dominate.

As highlighted in our previous submission to the CMA, a true remedy should be channel-neutral. Yet this proposal moves the system toward online-first behaviours, favouring internet pharmacies and volume-led providers.

If pursued, the site must be hosted by a neutral authority (such as the RCVS) with equal visibility rules, no advertising, and a careful guard against algorithmic favouritism.

There should be clarity about what should (and what shouldn't) be compared

We support a site that helps pet owners:

- Understand types of services offered (e.g. out-of-hours availability, accreditation),
- View clearly disclosed ownership structures,
- And locate appropriate referral or emergency services.

But we oppose ranking or comparison of:

- Treatment prices without clinical context,
- Pet care plans without standardisation safeguards,

- Review scores without verification or consistency.

Such metrics can be easily gamed, and disproportionately impact small providers who are less likely to solicit or manage client reviews at scale.

Recommendation: Focus the comparison site on informational parity, not competitive rankings.

There could be unintended impacts on practice behaviour

- A comparison website risks distorting professional behaviour. Practices may:
- Shift pricing strategies to appeal to consumers rather than align with best practice;
- Reduce investment in less profitable but high-welfare services;
- Or push services online or toward standardised offerings to remain "comparable."

This could diminish diversity in the profession and erode innovation tailored to local community needs.

A price-focused comparison platform may push practices to adopt low-cost, low-engagement models - eroding welfare, trust, and continuity.

A much better alternative is "Client Empowerment, Not Comparison"

Rather than creating a website that fosters competitive switching, we recommend a site that;

- Educates clients on what to expect from veterinary care,
- Describes professional standards and complaint routes,
- Offers a directory, not a ranking,
- And helps clients ask informed questions.

This would preserve client agency without commoditising care.

If it is taken forward, the platform must

- Be technically accessible to all practice sizes and models,
- Include an appeal or correction process for inaccurate listings,
- Avoid mandatory real-time updates that disproportionately burden small providers,
- And ensure data standardisation support is provided centrally.

A comparison website could be informative, but must not become a distorting market force. Remedy 2 must avoid the fate of other well-intentioned digital tools that, once

commercialised, favoured scale, suppressed diversity, and shifted trust from professionals to algorithms.

As independent practices, we stand for care, continuity, and client-centred trust. Remedy 2, if it is to support a well-functioning market, must not corrode those values. We encourage the CMA to **reframe this remedy as a directory and client education portal, rather than a price-focused ranking engine**.

Question 12

Q: What information should be displayed on a price comparison site and how?

A: The site should focus on core, relatively comparable services (e.g. consultation fees, routine vaccinations, neutering), presented with clear caveats that prices may vary by case. Medicine prices should only be shown if based on accurate, real-time data, which is not feasible for many FOPs. Composite price measures should be avoided, as they misrepresent the clinical variability inherent in veterinary care.

Question 13

Q: How could a comparison website be designed and publicised to maximise usefulness?

A: It should function as an informational directory, not a ranking tool. Prioritise clarity over competition. Include:

- Practice opening hours,
- Species treated,
- Accreditation (e.g. PSS),
- Complaints handling info (e.g. VCMS).

Avoid gamified or review-driven formats that distort professional services into retail metrics.

And be mindful that AI driven Large language models will probably replace price comparison websites in the near future

Question 14

Q: Which model is more effective?

A: Option (a) - a single, professionally governed site (e.g. via RCVS) - is preferred. It ensures neutrality, accuracy, and accountability. Open data models risk exploitation by

commercial aggregators that privilege large providers through advertising or algorithmic prominence, undermining fairness and trust.

Question 15

Q: What are the main administrative and technical challenges?

For smaller practices:

- Regularly updating accurate pricing is time-consuming and distracts from clinical work.
- Many FOPs lack digital teams or CRM infrastructure.
- Mislabelled services (e.g. “consultation”) may lead to client misunderstanding.

Resolution: provide template input tools, allow annual data submission, and exclude very small practices or offer compliance support.

Question 16

Q: Feasibility of pricing for different animal characteristics?

A: Highly impractical for most FOPs. Pricing is influenced by a wide range of variables. Attempting to pre-price by age, species, and weight would result in confusing over-disclosure and misleading precision. Prices should reflect base ranges with disclaimers that a quote will be confirmed after clinical assessment.

Question 17

Q: Where and how to present variable pricing (e.g. bundling or complexity)?

A: Use price ranges (e.g. “from £x”) with optional narrative explanation: *“Price may vary depending on condition, size, and service combination.”* Avoid fixed “basket” prices without context. Veterinary care is not modular or uniform - bundling should not imply interchangeability across providers.

Question 18

Q: Best means of funding the comparison website?

We should be absolutely clear that in the end it will be the pet owner who will end up paying for this one way or the other. As such, this question is begging another: *“Who will*

place tangible value upon this site and why?" Funding should come from sector-wide contributions, scaled by practice size and turnover. RCVS could administer it with public subsidy, ensuring it serves public interest, not corporate marketing. Independent practices must not be disproportionately charged for a platform that risks steering clients to high-volume, low-price operators.

Remedy 3: Require FOPs to publish information about pet care plans and minimise friction to cancel or switch

We recognise the CMA's intent in Remedy 3 - to improve transparency and comparability of pet care plans (PCPs) and make it easier for consumers to understand what they are purchasing and how to switch or cancel if they choose.

We support the underlying goals of clarity, fairness, and informed consent. However, we urge the CMA to carefully distinguish between enhancing transparency and introducing mechanisms that commoditise clinical relationships and increase administrative load for providers without evidence of material consumer harm.

Pet Care Plans are relationship tools, not consumer subscriptions. They are not generic financial products. They are:

- Practice-specific tools to foster continuity of care,
- A way to promote preventative health,
- And mechanisms for improving client engagement and affordability of core services.

Standardising their presentation risks misrepresenting their purpose, especially if plans are compared like mobile phone packages or gym memberships.

Recommendation: Focus on improving clarity and communication - not uniformity of structure or feature list.

We support the requirement to:

- Clearly list services included and excluded,
- Present cancellation terms in plain language,
- Provide illustrative examples of how the plan helps typical pet owners.

Many independent practices already do this as a matter of ethical and commercial good practice.

However, mandatory digital publication, templated formatting, or worked examples defined by the CMA (e.g. “standard adult cat”) risk flattening clinical and community-specific differences.

Recommendation: Allow flexibility in how practices present their plans, but include a checklist of essential disclosures (e.g. pricing frequency, eligibility, benefits covered).

While we accept that switching should be straightforward and not obstructed, we caution against framing PCPs primarily as products to be compared and switched.

Encouraging clients to switch plans frequently risks:

- Interrupting preventative care schedules,
- Disincentivising investment in long-term client relationships,
- Undermining trust in professional continuity.

Remedies that encourage transactional, price-first decision-making can undermine the value of trust, which is critical in delivering welfare-centred care.

Recommendation: Reinforce that PCPs are tools for continuity - not interchangeable consumer bundles.

For independent practices, ensuring compliance with new rules on PCP publication and cancellation requires:

- Reviewing plan structures,
- Updating promotional materials,
- Training admin teams,
- And potentially renegotiating third-party provider contracts (e.g. direct debit services).

These costs are manageable only if guidance is clear, support is available, the standardisation is not excessive and adequate time is allowed to put new guidance into action, perhaps also allowing the use of existing marketing materials for a given period to avoid unnecessary waste.

Recommendation: Provide templated language for cancellation and switching terms, and a best-practice guide to plan transparency, especially for smaller practices without marketing or legal departments.

There is significant risk that Remedy 3, when combined with Remedies 1 and 2, contributes to a market ecosystem where client loyalty is devalued, and service offerings become hyper-comparable at the expense of clinical nuance.

If PCPs are listed on a comparison website without contextual explanation, the result will be a ‘*race to the bottom*’ on headline pricing, and a false equivalence between plans that are not clinically or structurally similar.

Recommendation: Prohibit the inclusion of pet care plans on commercial comparison platforms unless they meet consistent definitional standards and include explanatory footnotes about clinical scope and intent.

We support greater clarity and fairness in pet care plans. Remedy 3, if carefully implemented, could improve client understanding and trust. However, it must:

- Avoid commoditisation,
- Respect clinical and community differences,
- And avoid creating unnecessary compliance burdens for smaller practices.

The CMA must view PCPs not as interchangeable consumer products but as part of a long-term professional care relationship. Remedy 3 should support that goal - not undermine it in the pursuit of misplaced comparability.

Question 19

A: What would be the impact on vet businesses of this remedy option? Would the impact change across different types or sizes of business?

For independent and smaller practices, this remedy could create a disproportionate administrative and compliance burden, especially if the requirement for publishing, updating, and standardising pet plan content is overly prescriptive. Pet care plans are often bespoke tools for client engagement and preventative health - not mass consumer products.

Larger corporates with standardised offerings and centralised marketing teams would find compliance easier. Uniform requirements may unintentionally favour corporatised models, reducing flexibility for smaller practices to design plans suited to their community.

Question 20

Q: How could this remedy affect the coverage of a typical pet plan?

A: If the remedy prioritises comparability over customisation, some practices may simplify or reduce the scope of pet care plans to avoid complexity in publication and switching. This risks a narrowing of preventative care options, reduced client choice and undermining innovation or tailored benefits that reflect client or regional needs.

To maintain the diversity and usefulness of plans, practices must retain the ability to design coverage that reflects their clinical ethos, client demographics, and species mix - not just what is easiest to publish and compare.

Question 21

Q: What are the main administrative and technical challenges on FOPs and referral providers with these remedy options? How could they be resolved or reduced?

A: Challenges include:

- Mapping plan benefits into standardised formats,
- Managing real-time updates across digital channels,
- Integrating cancellation/switch processes into existing admin systems.

For small practices, especially those using third-party pet plan providers or lacking in-house IT support, this is labour-intensive and distracting from clinical priorities.

Solutions include:

- Provide RCVS-backed templates and clear guidance,
- Allow phased or threshold-based compliance (e.g. exempting micro-practices),
- Encourage voluntary compliance first, before any mandated implementation.

Remedy 4: Provide FOP vets with information relating to referral providers

We recognise that access to clear, relevant information about referral providers is important to empower pet owners, support informed decision-making, and foster a more transparent system of clinical referrals. We support the principle of greater visibility in referral pathways and choice. However, we caution that this remedy must be implemented with nuance and a deep understanding of clinical realities and referral ecosystems.

"Referrals are clinical decisions, not just consumer preferences"

The CMA's framing of referrals as a consumer choice risks misrepresenting the core nature of referral practice. Referrals are not mere vendor selections; they are clinically governed handovers of complex cases, where specialist expertise, prior knowledge, and trust in diagnostic protocols are paramount.

Unlike in other healthcare or service markets, clients are not always equipped to assess referral competence, availability, or appropriateness.

Recommendation: Ensure any remedy supports vet-led shared decision-making, not consumer self-navigation of referral networks.

We support the CMA's proposal that first opinion practices (FOPs) should:

- Be aware of a reasonable range of referral options,
- Disclose financial or corporate links (if any) to referral centres,
- And share clinically appropriate alternatives when relevant.

We also support clients being offered:

- Clear information about specialist accreditation,
- Geographical considerations,
- And practical information such as wait times and service scope.

Important: This information must not be reduced to a list of providers based on commercial ranking or distance alone - it must be anchored in clinical relevance.

If Remedy 4 incentivises a blanket disclosure of multiple referral options regardless of clinical relevance or patient condition, it may:

- Confuse pet owners,
- Undermine trust in the referring clinician,
- Delay urgent referrals,
- And weaken continuity between practice and specialist.

This risks turning veterinary referrals into client-led shopping rather than coordinated, outcome-focused care.

Recommendation: Require practices to offer alternative options only where clinically appropriate, and allow them to explain preferred referral relationships based on past outcomes, communication quality, or continuity of care.

Independent and rural practices often rely on trusted, regional referral networks built over time. These are:

- Geographically appropriate,
- Based on established communication protocols,
- And critical to continuity of care.

Requiring disclosure of distant or generic alternatives simply to meet a disclosure quota is both impractical and potentially detrimental to patient outcomes.

Recommendation: Allow contextual discretion in referral disclosure - e.g., *"These are our primary referral partners due to established relationships and consistent outcomes. Other options may be available on request."*

Some large veterinary corporates own both FOPs and referral centres, creating in-house pipelines. While transparency in such arrangements is essential, a poorly designed Remedy 4 could paradoxically strengthen these models by:

- Normalising referrals within corporate ecosystems,
- Undermining smaller, independent referral centres that cannot afford mass visibility,
- And incentivising scale-driven self-referral pathways over merit- or outcome-based referrals.

Regulation must not entrench vertical dominance or structural opacity under the guise of transparency.

Remedy 4 is valuable in its intent, but its design must reflect clinical realities and safeguard continuity of care. The solution is not to expand consumer referral options indiscriminately, but to equip clients with confidence and context when their trusted vet recommends a referral.

We support:

- Disclosure of referral relationships,
- Transparency in ownership and scope,
- And client rights to second opinions or alternatives.

But we oppose formulaic, list-based mandates that risk replacing clinical judgement with arbitrary consumerism in the referral process.

The CMA must be careful to enhance referral transparency without undermining the professional relationships and patient-centred care models that define good veterinary practice

Question 22

Q: Feasibility and value of supporting FOP vets to offer referral choices

A: Supporting FOP vets to give meaningful referral options is feasible and clinically appropriate when based on relevance, proximity, and existing relationships. The value lies in increasing transparency, but it must not be confused with commercial neutrality - referrals are clinical, not consumer, decisions.

Question 23

Q: Potential detrimental consequences

A: If poorly designed, this remedy could:

- Overwhelm clients with irrelevant options,
- Undermine trust in the primary vet's judgment, and

- Delay urgent care due to administrative over-disclosure.
  It may also benefit corporately integrated referral networks by default if prominence is driven by brand recognition or digital reach.

Question 24

Q: Administrative and technical challenges on referral providers

Referral providers may face:

- Pressure to standardise complex, case-by-case pricing,
- Increased admin in responding to data requests or updating portals,
- Uneven burden depending on size and digital maturity.

Smaller or specialist referral centres may struggle to comply without support. Challenges could be reduced by using templated profiles maintained centrally by a neutral body such as the RCVS.

Question 25

Q: Independent practice perspective

As independent FOPs, our referral decisions are:

- Based on clinical fit, past outcomes, and communication quality,
- Tailored to each case - not just price or distance
- Influenced by relationships with, and prior knowledge of, the professional and their team to whom the referral is being made

Any remedy must protect our ability to recommend what is clinically best, not simply offer a list.

Question 26

Q: Useful information for clients on referral options

A: We support sharing:

- Accreditation status (e.g. RCVS Recognised Specialist),
- Specialist areas and species treated,
- Location and estimated wait times,
- And whether the referral provider is independent or part of a corporate group.

This ensures clients are informed without undermining clinical oversight or overloading them with irrelevant comparisons.

Remedy 5: Provision of clear and accurate information about different treatments, services and referral options in advance and in writing

We agree in principle with the CMA that clients benefit from clear, accessible information about treatment options and associated costs. Remedy 5 proposes that veterinary practices be required to provide written, pre-treatment explanations of the available clinical options and their respective prices, in order to support informed decision-making.

We endorse the underlying purpose of this remedy: ensuring that pet owners understand their choices and can make decisions that reflect both clinical appropriateness and their own preferences or financial means.

However, we are deeply concerned that the practical design of this remedy, if implemented without flexibility, could:

- Undermine clinical workflows,
- Disrupt urgent or sensitive care interactions,
- And introduce significant administrative burden, particularly for smaller, non-corporate practices.

"Clinical consultation is a conversation, not a consent form". The veterinary consultation is a dynamic process of dialogue, investigation, reassurance, and shared decision-making. Turning this into a formalised, written process for every decision - even routine or low-risk ones - risks bureaucratising care, and reducing the richness of communication to a legalistic transaction.

Recommendation: Written summaries should be required only:

- For high-cost or multi-pathway treatments,
- When clinically appropriate,
- Or where clients explicitly request written options.

This balances the desire for transparency with the need for professional agility.

Independent practices typically have:

- Smaller teams,
- Less administrative support,
- And limited digital infrastructure.

Remedy 5 would add documentation time, communication workload, and storage responsibility, with no clear evidence that it would meaningfully improve care outcomes in the majority of cases.

In contrast, larger corporate practices with templated workflows and digital compliance teams can absorb and automate this burden more easily - creating an unintended structural bias.

Recommendation: Apply proportionality in scope. For example, set a threshold (e.g. £750+) or a list of categories (e.g. surgery, chemotherapy) where written treatment summaries are expected.

If clinicians are required to generate written summaries for all treatment discussions, there is a risk that:

- Urgent care could be delayed,
- Clients might defer care due to perceived complexity,
- Or consultations could become overly formal, reducing comfort and openness.

In particular, situations involving emergency, distress, or vulnerable clients (e.g. elderly pet owners or grieving families) are ill-suited to a paperwork-first approach.

Recommendation: Include clear exemptions for urgent cases and allow clinical discretion for real-time documentation.

"Encouraging transparency, not Tick-Box compliance". We support efforts to standardise high-quality communication. But requiring written documentation for every case may foster defensive practice - where vets record every possible option not to educate, but to protect against complaint or regulatory scrutiny. This is counterproductive, and could even erode trust if clients feel overwhelmed or perceive the vet is distancing themselves from responsibility.

Instead, empower practices to use:

- Illustrated leaflets,
- Verbal summaries followed by optional written notes,
- Or structured follow-up emails post-consultation.

We support the VCMS and efforts to improve complaints handling. Remedy 5 should be seen as one part of a wider quality and transparency strategy - not a silver bullet. Over-reliance on written options may create false security and distract from the core goal of improving client understanding.

Recommendation: Encourage best practice in treatment explanation through CPD, templates, and RCVS guidance - not rigid regulation.

Remedy 5 must be implemented with proportionality, flexibility, and trust in clinical professionalism.

A "one-size-fits-all" written requirement would:

- Create administrative drag on smaller practices,
- Risk commoditising the consultation process,
- And undermine trust by replacing conversation with documentation.

We urge the CMA to design this remedy to support - not replace - professional communication. A well-informed client is a cornerstone of effective veterinary care, but the route to that outcome must be practical, humane, and proportionate.

Question 27

Q: Should there be a minimum treatment cost threshold before mandatory written information requirements apply (e.g. £250/£500/£1,000)?

A: Yes, thresholds are essential to avoid administrative overload. Written treatment summaries for all procedures - even minor ones - would swamp clinical time. A threshold of **£750** would strike a fair balance between cost transparency and practicality. However we also note that there will be significant geographical variation as to what an appropriate figure would be.

Question 28

Q: Should there be a mandatory 'thinking time' before certain treatments, and if so, how long and under what conditions?

A: We strongly caution against mandatory delays. Many treatments involve time-sensitive care. Vets already offer space for decision-making where appropriate. A blanket rule risks undermining clinical autonomy and could delay necessary interventions, negatively impacting welfare.

Question 29

Q: Should exemptions apply for urgent treatment where delays could compromise animal welfare?

A: Absolutely. Clinical discretion must always override process mandates where

welfare is at stake. Any regulatory model must clearly empower vets to bypass written procedures in emergency or time-sensitive cases.

Question 30

Q: What is the scale of the burden of requiring vets to keep records of all treatment options presented to pet owners?

A: Significant. For independents without bespoke software, logging all options per case will add manual time and increase risk of documentation error. A more proportionate approach would be to require records of significant decisions or consent points only - such as surgery or multi-step diagnostics. AI automation will support the administration, but practice management systems (PMS) are highly variable, with a poor track record of integration with new technology. Once again, large corporates with scale can easily gain competitive advantage in the face of increased administrative costs.

Question 31

Q: What are the advantages and disadvantages of using treatment consent forms to obtain the pet owner's acknowledgement that they have been provided with a range of suitable treatment options or an explanation why only one option is feasible or appropriate? Could there be any unintended consequences?

A: While consent forms are essential for all prospective procedures, requiring formal acknowledgment for every treatment decision risks bureaucratising care. For routine cases, this would interrupt clinical flow and could be interpreted as defensive practice rather than partnership. Overuse may lead to client fatigue or false perceptions of liability.

Question 32

Q: What would be the impact on vet businesses of this remedy option? Would any impacts vary across different types or sizes of business? What are the options for mitigating against negative impacts to deliver an effective but proportionate remedy?

A: The impact would be significantly heavier on small practices. While corporates may automate such documentation within their PMS, independents may rely on manual

records. Mitigation should include clear thresholds for applicability (e.g. by treatment value) and allow for narrative note-taking in lieu of client-signed forms in low-risk cases.

Question 33

Q: Are there any barriers to, or challenges around, the provision of written information including prices in advance which have not been outlined above? Please explain your views.

A: Yes - many treatments evolve following diagnostic assessments, making advance written estimates highly speculative. Moreover, differences in local supplier costs and case complexity mean standardised pre-treatment pricing is rarely reflective of final costs. Vets must retain flexibility to update clients as treatment plans develop.

Question 34

Q: How would training on any specific topics help to address our concerns? If so, what topics should be covered and in what form to be as impactful as possible?

A: Training should focus on effective client communication, ethical pricing, and shared decision-making. Online CPD modules accredited by RCVS or BVA would be accessible for all practices. However, training per se is not a substitute for respecting professional autonomy and clinical context.

Question 35

Q: What criteria should be used to determine the number of different treatment, service or referral options which should be given to pet owners in advance and in writing?

A: The number of options should be guided by clinical relevance and patient welfare, not by arbitrary quotas. Vets should offer a range only where safe, evidence-based alternatives exist. A “minimum of one clinically appropriate alternative” may be a fair baseline as there is always another option.

Remedy 6: Prohibition of business practices which limit or constrain the choices offered to pet owners

We strongly support the intent of Remedy 6: to uphold veterinary clinical independence and to ensure that clients are presented with treatment options that reflect the unique needs of their animal and personal circumstances. This is a core tenet of veterinary ethics.

We welcome any move that strengthens the ability of veterinary surgeons to exercise their professional judgment free from non-clinical commercial interference. However, we believe the risks posed by this remedy lie not in overreach, but in under-specification and uneven enforcement, particularly between different ownership and business models.

Independent veterinary practices are typically owned and managed by veterinary professionals who are directly accountable for their decisions. Clinical freedom and continuity of care are foundational values, not just regulatory requirements. In our model:

- Treatment is tailored to individual clients and animals,
- Decisions are not filtered through corporate KPIs or sales targets,
- And the clinician's primary obligation is always to the animal's welfare.

We therefore support this remedy as a tool to protect the integrity of the profession, particularly in the face of commercial pressures that appear to have emerged in corporatised business models.

This Remedy must not be toothless. The CMA identifies that:

- Some Practice Management Systems (PMS) bundle treatments,
- Financial incentives may prioritise certain product categories,
- Vets may be administratively discouraged or contractually constrained from offering cheaper or clinically preferable alternatives.

These practices can:

- Reduce client trust,
- Erode clinical autonomy,
- And result in pets receiving suboptimal or more expensive care.

We urge the CMA to define these practices clearly, and to ensure that enforcement is meaningful - not reliant on weak attestations or theoretical commitments.

The risk of Remedy 6 backfiring lies in applying its obligations equally to providers who are not equally contributing to the problem. If the CMA applies the same monitoring or auditing obligations uniformly across the sector, independent practices will bear an

unnecessary compliance burden, while the largest groups - those with the greatest potential to distort clinical choice - can absorb and deflect scrutiny with in-house compliance teams.

Recommendation: Target implementation and monitoring toward larger, multi-site, corporately owned providers, where economic incentives are more likely to be separated from clinical leadership.

We welcome the idea of evolving this remedy from a prohibition-based model into a principle-based obligation to promote and protect access to appropriate, tailored veterinary care. However, to do this effectively:

- The RCVS must be meaningfully resourced and empowered to participate in guidance and enforcement,
- There must be clear case studies and examples provided of what constitutes a breach (e.g. prescribing restrictions, sales targets, referral funnels),
- And there must be reporting pathways for veterinary professionals to raise concerns where their clinical independence is being compromised.

We believe that attestation alone is insufficient. The proposal for a single annual attestation by First Opinion Practices (FOPs) is unlikely to deter those whose business model is built on maximising commercial gain. We caution against a "tick-box culture" and recommend:

- Spot checks or audits (scaled by business size),
- Integration with RCVS inspection regimes (e.g. Practice Standards Scheme),
- And public accountability where patterns of 'gold plating' are observed

Remedy 6 is one of the most important and potentially transformative proposals in the CMA's package. If properly specified and enforced, it will:

- Safeguard clinical autonomy,
- Reinforce public trust in veterinary professionals,
- And curb commercial distortions that are increasingly creeping into treatment and referral behaviour.

We urge the CMA to implement this remedy with clear definition, focused enforcement, and close partnership with the RCVS. Above all, the remedy must differentiate between business models - so that those who are causing the problem are held accountable, and those already upholding professional integrity are not burdened with unnecessary compliance.

Question 36

Q: Are there any specific business activities which should be prohibited which would not be covered by a prohibition of business practices which limit or constrain choice?

A: We strongly support a prohibition on **coercive business incentives** that restrict clinical autonomy. Such pressures are more common in corporate models and distort the clinician-client relationship. However, care must be taken not to inhibit group purchasing or stock standardisation practices that benefit both clients and practices.

Prohibited: Sales targets for treatments and procedures, and exclusive referral arrangements.

Allowed: Internal efficiency policies, responsible formulary standardisation, or non-binding treatment protocols that preserve clinical discretion.

Q: If so, should a body, such as the RCVS, be given a greater role in identifying business practices which are prohibited and updating them over time?

A: Yes

Question 37

Q: How should compliance be monitored and enforced?

A: Self-certification alone is insufficient, particularly for corporates with complex incentives. We recommend:

- Independent audits for large veterinary groups (LVGs),
- Integration of this requirement into RCVS Practice Standards Scheme reviews, and
- Spot checks or anonymous reporting routes for staff to raise concerns.

The RCVS, if adequately resourced, is the appropriate body to lead on monitoring due to its professional oversight remit.

Question 38

Q: Should LVGs receive greater compliance scrutiny?

A: Yes. LVGs often implement top-down business models with practices replicated across many sites. These models:

- Have greater potential to constrain clinical choice at scale,
- Are more likely to include centrally designed performance incentives, and
- Serve a larger proportion of the public, amplifying potential harm.

Enhanced monitoring of LVGs is justified, fair, and necessary to maintain a level playing field for all FOPs.

Question 39

Q: Should "business practices" include informal guidance and internal culture?

A: Yes. Business practices must be broadly defined to include:

- Internal "guidance" or cultural norms that implicitly discourage certain options,
- Informal KPIs, league tables, or "required procedure" messaging,
- And unwritten expectations that shape how vets communicate with clients.

This ensures regulation captures actual clinical influence, not just formal systems. The focus must remain on upholding clinical independence and client choice, regardless of how influence is exerted.

Remedy 7: Changes to how consumers are informed about and offered prescriptions

We understand the rationale for Remedy 7: to improve client choice and facilitate access to veterinary medicines via alternative suppliers, including pharmacies outside the prescribing practice. Independent veterinary practices are committed to professional integrity, and we support transparency around the availability of medicines.

However, the mandatory provision of written prescriptions - without appropriate context, exemptions, or safeguards - risks misunderstanding the nature of clinical prescribing, while introducing practical, financial, and safety concerns that would disproportionately affect smaller, independent practices and potentially reduce the quality and immediacy of care for clients.

Written prescriptions are already available and offered. Under current RCVS guidance, vets must already issue a prescription upon request, unless doing so would compromise animal welfare. In independent practices, this is routinely upheld and embedded in a professional culture that values client openness and informed decision-making.

There is no credible evidence that independent vets withhold prescriptions inappropriately or act in bad faith to constrain client choice.

A mandatory model implies otherwise and introduces a blanket requirement that may be excessive and unnecessary, particularly for straightforward or urgent cases.

Mandating a written prescription for every POM-V medicine issued would:

- Increase consultation time and follow-up administration,
- Require staff training and record-keeping systems for script management,
- And create inefficiencies in fast-paced or emergency settings, especially in sole-charge or out-of-hours practices.

Unlike large corporate groups with centralised support functions, independent practices cannot absorb this administrative burden without cost or clinical trade-off.

Recommendation: Continue to allow prescription issuance on request, rather than by default. Alternatively, limit the mandatory requirement to certain thresholds (e.g. for repeat medication or long-term conditions) where clients are more likely to compare options.

Prescribing is not a commercial act - it is a clinical responsibility. It involves:

- Patient history,
- Dosage calculations,
- Palatability and administration considerations,
- And compliance planning with the client.

Automatically generating a prescription for each POM-V issued could:

- Encourage clients to seek cheaper but suboptimal alternatives,
- Increase the risk of misuse or inappropriate substitution, particularly for sensitive medicines (e.g. antibiotics, controlled drugs),
- And dilute the importance of continuity in medicine supply, especially where patients need tailored titration or follow-up.

We note that the stated theme from the CMA includes the words “and measures to increase online purchases of medicines”. We would contend that the CMA should be “channel-agnostic”. The design of Remedy 7 appears to facilitate increased online pharmacy usage by default - whether or not that is in the best interest of the animal or the clinician-client relationship.

We are concerned that:

- Clients may feel nudged away from in-practice dispensing,
- Online providers may dominate the supply chain via economies of scale, potentially undermining service quality,

- And physical practices will be left as uncompensated prescribers, bearing all clinical risk but none of the revenue needed to support safe supply.

We support clients having access to written prescriptions, but a mandatory issue model is a blunt tool for a complex problem. Instead, we propose:

- Mandatory signage and verbal disclosure that prescriptions are available on request,
- Template prescription formats issued by the RCVS or VMD,
- And periodic audit sampling rather than universal documentation.

This would balance client empowerment with clinical flexibility, without overburdening independent practices or fragmenting patient care.

Remedy 7, as currently conceived, risks transforming the act of prescribing from a clinical safeguard into a consumer transaction, with consequences for patient safety, practice sustainability, and the trust that underpins high-quality care.

We urge the CMA to:

- Retain the current "prescription on request" model as the standard,
- Avoid defaulting toward an online supply preference,
- And recognise the administrative and clinical asymmetry this remedy would create between corporate and independent providers.

Transparency should be about enabling informed dialogue, not mandating documentation that may compromise the agility, affordability, and safety of veterinary care.

Please note: the size of the gap created between the point of prescription and the point of dispensing opens the space for error to occur. Notwithstanding that the example 'ticket' provided on page 111 of the Working Paper does not contain the appropriate wording required by the Veterinary Medicines Regulations (VMR) for a legal prescription, it also contains a fundamental element of doubt that can lead to inappropriate dispensing. Is it for meloxicam oral 32 ml (licensed for dogs), or is it for meloxicam oral 30 ml (which is licensed for cats)?

We note that the VMD, in its response to the February paper, confirmed that:

" the CMA should be aware of the potential (and documented) abuse of written prescriptions by owners."

Question 40

Q: Should medicines administered by the vet be excluded from mandatory prescriptions?

A: Yes. Medicines administered directly by the vet - such as injections during a consultation or surgical recovery - should be explicitly excluded from any mandatory prescription requirement.

These are:

- Clinically necessary and immediate,
- Integral to the consultation or procedure,
- Not suitable for remote or third-party dispensing.

Recommendation for signage: *"Medicines administered by a veterinary surgeon at the time of consultation or procedure, as part of immediate care, are exempt from prescription issuance requirements. Please speak with your veterinary surgeon to discuss this further"*

Question 41

Q: Do the written prescription remedies present further challenges?

A: Yes. We'd wish to highlight:

- Risk of treatment delay, particularly for time-sensitive conditions.
- Client confusion over the difference between prescription availability and medical appropriateness.
- Professional vulnerability, where vets may feel pressured to prescribe inappropriately to maintain client satisfaction.
- Digital exclusion risks, especially in older demographics**.**

These can be addressed by:

- Preserving discretionary prescribing, not automatic issuance,
- Reinforcing clinical justification as central, and
- Offering clear, RCVS-approved explanatory scripts for clients.

Question 42

Q: How can the prescription process be secure, low cost, and fast?

Keep the process:

- Paper- or email-based, allowing handwritten or digitally generated forms from within standard PMS.
- Ensure simple templates, not over-engineered portals.
- Protect against fraud with vet ID numbers, practice stamps, or e-signatures.
- Require all pharmacies to receive the prescription directly from the prescribing veterinary practitioner

Do not require real-time online validation or integration with third-party platforms, which would exclude smaller practices and escalate IT and training costs.

Question 43

Q: What transitional period is needed?

At least 12–18 months, with:

- Phased implementation by practice size,
- Voluntary pilots in year one,
- And co-development of templates and client comms materials by RCVS, SPVS, and independent practice groups.

This allows time for:

- Staff training,
- PMS adaptation,
- And client education - without disrupting care.

Remedy 8: Transparency of medicine prices so pet owners can compare between FOPs and other suppliers

Most practices already offer clear price information, advise clients on their options, and do so with integrity.

However, Remedy 8, as currently framed, risks moving from transparency toward price-led behavioural steering, which may result in:

- Erosion of clinical responsibility,
- Fragmentation of care,
- Errors at the point of dispensing and
- A competitive disadvantage for smaller, physical practices unable to match the infrastructure or pricing of online-only retailers.

The loss of marginal income to many businesses could be very significant. This could lead to:

- Increased prices for other services provided
- The removal of other services that have a low or negative marginal impact on the business (such as the provision of Out of Hours Care)
- The threat of impact upon other aspects of work undertaken by businesses providing services to farm and equine (e.g. cross over with pharmacy staff) with consequent impact upon the ability of these practices to deliver services to farm and equine clients.
- A readiness and ability to invest in the FOPs facilities and services.

Printing a single benchmark price next to a prescribed medicine risks positioning the FOP as overpriced, even when differences are due to:

- Storage and cold chain management,
- Immediate dispensing during emergency care,
- Client convenience and welfare considerations (e.g. need for same-day start),
- Or support and follow-up services associated with the act of dispensing.

Integrating real-time pricing into prescription systems, formatting the data correctly, and keeping it current would require:

- Software integration costs,
- PMS upgrades and maintenance,
- Staff training and change management.

All of which LVGs may be able to absorb and dilute with internal IT teams; and which independent practices cannot.

Option C is the most technologically ambitious, it also presents the highest risk of distorting market dynamics. It would:

- Shift the dispensing choice to an online platform,
- Encourage clients to compare based on price alone, regardless of service quality,
- Channel business to low-margin, high-volume online operators,
- And reduce the viability of in-practice dispensing, which often funds practice overheads and allows same-day care.

This model strongly resembles retail price aggregator platforms like those used in insurance or consumer electronics, but veterinary medicine is not a fungible product. It involves:

- Clinical responsibility,

- Continuity of care,
- And patient-specific communication, especially for long-term treatments.

We would strongly recommend that the CMA does not proceed with Option C unless it includes safeguards that protect in-practice dispensing, ensures full clinical context, and provides choice without coercion.

All three options share one concern: they assume that veterinary medicines can and should be evaluated like consumer goods.

In fact, the medicine is just one part of a wider package that includes:

- Clinical diagnosis and judgment,
- Communication and counselling,
- Handling, safety checking, and dosing support.

Reducing medicine supply to a price comparison exercise risks commoditising healthcare, and encourages behaviour (e.g. delayed treatment, inappropriate substitution) that could compromise welfare.

The real remedy is supported, contextualised price transparency - not automated comparisons devoid of explanation.

We support

- A low-cost, scalable way to improve client awareness,
- A general education tool that encourages clients to ask about price
- Transparency to clients with statements such as *"Prices vary by source and may reflect differences in service, availability, or urgency. Ask your vet if you would like to discuss options."*

We propose the CMA consider a multi-tiered transparency model:

1. Tier 1 (Mandatory): Practices must display medicine prices in a clear, accessible way for common products and offer prescriptions on request.
2. Tier 2 (Voluntary): Practices may choose to include QR codes or pricing references on prescriptions, with appropriate context.
3. Tier 3 (Monitored): Independent review of market pricing practices across channels to prevent misleading price practices or over-promotional discounting online.

This model supports transparency without enforcing digital dependency, penalising physical practices, or reducing clinical prescribing to a lowest-cost race.

We are reminded of the potential for parallels with the price promotion restrictions regarding infant formula *"To ensure that decisions around infant feeding are **health-led, not commercially driven**."*

Remedy 8, in its current framing, leans too far toward a price-led view of veterinary medicines. While price awareness is important, the real value of veterinary dispensing lies in timely, safe, professional care, not simply the product delivered.

We urge the CMA to:

- Protect the clinical, welfare-focused nature of veterinary practice,
- Avoid reforms that drive structural advantage for large, online actors at the expense of community providers,
- Avoid costly and untrialled digital solutions,
- And promote transparency in a way that respects context, supports informed dialogue, and preserves the integrity of veterinary care.

Question 44

Q: What price information should be communicated on a prescription form?

A: Listing exact price comparisons would be misleading and difficult to maintain. Veterinary surgeons are required to be honest in all of their transactions and there is no credible way that they can be held to account for the provision of this information. Instead, include a **disclaimer noting that medicine prices vary** across providers, and **refer clients to external price comparison resources** rather than requiring vets to provide pricing intelligence.

Question 45

Q: What should be included in what the vet tells the customer when giving them a prescription form?

A: The vet should explain that the client may present the prescription to any legally authorised pharmacy and provide safety advice. However, the CMA must ensure vets are not coerced into *promoting online channels* over physical ones - true neutrality must include **no pressure to direct clients to specific fulfilment modes**.

Question 46

Q: Do you have views on the feasibility and implementation cost of each of the three options?

A: Any system requiring real-time price updating or e-verification between practices and pharmacies is untested, will be costly to set up and runs a risk of being gamed by a third party to be "last supplier left standing". There is likely to be a highly disproportionate burden upon independent FOPs. Option 1 (manual paper-based with guidance) is the most feasible and could remain a compliant route permanently, not just as a transitional step.

Remedy 9: Requirement for generic prescribing (with limited exceptions) to increase inter brand competition for medicine sales

We understand the CMA's interest in exploring generic prescribing as a mechanism to promote competition in the veterinary medicines market. The proposal is motivated by the aim of reducing medicine costs for consumers and reducing the influence of brand-led prescribing that may limit client choice.

From the perspective of independent veterinary practices, we strongly agree that medicines must be prescribed in the best interests of the animal, with cost considered alongside efficacy, safety, formulation, and client compliance.

However, we have serious concerns that mandating generic prescribing in veterinary medicine - where differences in formulation, palatability, bioavailability, packaging and administration can materially affect treatment outcomes - risks compromising clinical care and reducing the effectiveness of the prescribing process itself.

Prescribing is a clinical act - not a commodity selection

Prescribing veterinary medicines is not simply about identifying an active ingredient. It involves:

- Judging the specific condition and species,
- Understanding patient history and response to prior medication,
- Selecting a product with the correct administration format, palatability, and dosing schedule,
- And considering compliance likelihood with the owner.

Unlike human generics - where formulation and delivery can often be standardised - veterinary medicines vary significantly in form (tablet, paste, injectable), dosing frequency, and animal acceptance.

Recommendation: Retain the vet's discretion to prescribe by brand where clinically justified, and avoid mandates that reduce prescribing to the level of main active ingredient equivalence.

Clinical equivalence does not guarantee therapeutic equivalence

Two 'generic' products may contain the same active ingredient but differ in:

- Absorption rate (particularly in species with variable gastrointestinal processing),
- Taste and palatability (critical for compliance in cats, dogs, horses),
- Excipient ingredients (some of which can affect sensitive animals),
- And delivery method (e.g. chewable vs tablet).

These differences can lead to:

- Treatment failure,
- Reduced compliance,
- And client frustration, ultimately undermining trust in both the medicine and the prescribing vet.

Generic prescribing may appear to reduce cost, but could increase repeat consultations, delayed recoveries, or even worsening of conditions, creating hidden costs and welfare risks.

Clients may receive a prescription listing a generic name (e.g. "meloxicam") but be dispensed an unfamiliar or visually different product. This introduces:

- Confusion about dosage or administration,
- Loss of trust in prior successful treatments,
- And the potential for accidental misuse.

Consistency in medicine type and appearance matters - especially for elderly clients, multiple-pet households, or those managing chronic conditions.

We are very concerned about the disproportionate impact on independent FOPs who often work with a limited, trusted formulary of products that they stock, understand, and administer effectively. Mandated generic prescribing would:

- Complicate stock control,
- Increase costs through unplanned substitution and inventory duplication,
- And undermine group purchasing arrangements that help independents access competitive pricing through responsible volume alignment with preferred brands.

Larger corporates may absorb this disruption through central buying teams and automated PMS tools, including, through their internet pharmacies, the ability to obtain competitive prices on a range of generic medicines. Independent practices cannot.

Recommendation: If generic prescribing is pursued, allow branded prescriptions where clinical reasons, stock realities, or welfare considerations apply. Do not impose penalties or restrictions on brand prescribing.

Veterinary surgeons are regulated professionals, trusted to balance cost, efficacy, and welfare. Forcing generics by policy undermines that professional trust and risks creating perverse incentives where vets feel they must justify good clinical decisions against cost-driven assumptions.

The better path is to provide guidance, not mandates. Educate clients about generics, support vets in comparative decision-making, but do not override clinical discretion.

We support the CMA's efforts to ensure fair access to veterinary medicines and to address any unwarranted pricing discrepancies. However, generic prescribing cannot be treated as a simple efficiency mechanism. Veterinary medicines are not interchangeable commodities, and the prescribing process is not reducible to active ingredient selection.

Remedy 9, as currently framed, risks:

- Undermining welfare,
- Increasing treatment risk,
- Placing disproportionate operational burdens upon independent practices that already work responsibly and transparently.
- Reducing the functioning of the market by delivering through inappropriate legislation competitive advantage to LVGs.

At the very least, we urge the CMA to pursue this remedy only as a clinical option - not a regulatory obligation - and to centre its policy on supporting professional judgment, educating clients, and preserving continuity and safety in veterinary care.

Finally, we wish to be absolutely clear that we are not alone in our thinking about this matter. We note that the VMD response to the February Working Papers stated:

"The VMD is particularly concerned about veterinary prescriptions detailing only the active substance(s), rather than a specific product. It is considered likely that this would lead to medicines being selected and dispensed by those other than the prescribing veterinary surgeon, thereby failing to appropriately consider their clinical suitability for a given patient. This is considered ***incongruent with a veterinary surgeon taking full responsibility for any prescribing decision they make****, and the fact that such decisions must be clinically justified. It stands to reason that even with the best*

*intention, when given a choice between two seemingly identical products, owners may select the cheaper option to be dispensed, unaware that there **may be significant additional safety and efficacy considerations** for the product they have ultimately selected."*

We completely agree with the VMD on this matter.

Question 47

Q: How could generic prescribing be delivered and what information would be needed on a prescription?

A: Generic prescribing should remain a **clinician's choice**, based on therapeutic equivalence. Prescriptions could note either the generic or the branded form **at the vet's discretion**, especially where patient response or formulation differences exist.

Question 48

Q: Can the remedies proposed be achieved under the VMD prescription options currently available to vets or would changes to prescribing rules be required?

A: Some remedies - especially generic-only mandates - may require amending current VMD guidelines. We caution against any change that undermines the vet's right to choose the product they believe is safest or most effective. The prescribing cascade must remain in place and be clinically led.

Question 49

Q: Are there any potential unintended consequences which we should consider?

A: Yes - forced generic substitution may lead to poorer patient outcomes in cases where **bioavailability or administration form** varies. It also undermines confidence if a product known to work for a specific animal is replaced with a version the client sees as different, even if technically equivalent. Additionally, practices relying on preferred brand stock for affordability via GPOs may see prices rise if they lose critical volume discounts.

There is **considerable concern** from veterinary surgeons engaged in the delivery of **farm services** that this remedy does not get extended to limit their ability to be in

control of **withdrawal times** and the **maintenance of public health and trust** in our food.

We note that the VMD, in its response to the February paper, confirmed that:

" the CMA should be aware of the potential (and documented) abuse of written prescriptions by owners."

Question 50

Q: Are there specific veterinary medicine types or categories which could particularly benefit from generic prescribing (for example, where there is a high degree of clinical equivalence between existing medicines)?

A: No. Whilst there is variability between medicine groups this remedy is fundamentally flawed.

Question 51

Q: Would any exemptions be needed to mandatory generic prescribing?

A: Yes, exemptions must be allowed where specific formulations (e.g. palatability, release mechanism, dosing accuracy) materially affect treatment efficacy or compliance. Vets should retain full discretion to specify brands where medically justified. Mandated generics would risk undermining clinical outcomes and trust in practitioner recommendations.

Question 52

Q: Would any changes to medicine certification or approval processes be required?

A: Possibly. If generic prescribing becomes mandatory, regulatory authorities (VMD) must strengthen assurance that generics are fully equivalent in all aspects, not just pharmacokinetics and pharmacodynamics but flavours, coating, packaging etc. Guidance should also clarify substitution limits between medicines. Without this, the risk of misalignment between prescribing rules and safety standards rises.

Question 53

Q: How should medicine manufacturers be required to make information available to easily identify functionally equivalent substitutes?

A: A central, open-access database - perhaps hosted by the VMD - should list equivalent substitutes alongside licensing and formulation information. It should be searchable by molecule and formulation type. This must not be delegated to commercial platforms with potential conflicts of interest. However, we would repeat, this is adding cost – that will ultimately be borne by the animal owner.

Question 54

Q: How could any e-prescription solution best facilitate either (i) generic prescribing or (ii) the referencing of multiple branded/named medicines?

A: The tool should allow dropdown selection of active ingredient, then display equivalent branded options. Vets should be able to override the generic by stating a clinical justification. For smaller practices, the system must integrate with current PMS systems without extra licensing costs or staff training burdens.

Remedy 10: Prescription price controls

We recognise that the CMA is considering prescription price controls as a potential remedy to address concerns about the affordability and accessibility of veterinary medicines. However, we believe this approach fundamentally misunderstands the nature of prescribing, and risks introducing economic distortions and unintended consequences that would undermine both animal welfare and access to care, particularly in community-based, independent veterinary practices.

Prescribing Is a clinical act. It is not a transactional formality

The act of prescribing is not simply writing on a form. It is a complex, skilled clinical judgment, which involves:

- Careful assessment of the patient's condition, history, species, and temperament,
- Determination of the most appropriate medicine, dose, and route of administration,
- Consideration of contraindications, interactions, and client compliance,
- And a clear discussion of expected outcomes, risks, and necessary follow-up.

To frame prescribing as a consumer "right" that can be separated and commoditised through a capped price ignores the reality that it is one of the most risk-laden and professionally accountable decisions a veterinary surgeon makes.

Prescription writing is the tip of a clinical iceberg; not an administrative task.

If the CMA imposes controls that cap or artificially limit the price of issuing a prescription, practices will be forced to recoup this cost elsewhere. The likely outcomes are:

- Higher consultation fees, even for clients who do not request prescriptions,
- Increased pricing for complex surgeries or diagnostic procedures,
- And ultimately, a cost burden shift away from the specific user (the client requesting the prescription) and onto all clients, including those on lower incomes.

This undermines fairness, and paradoxically risks making access to care more difficult for the very groups the CMA seeks to protect.

Blanket price controls on all practices would punish responsible providers, and enable larger players to:

- Cross-subsidise low prescription pricing with higher service charges,
- Or leverage scale to dominate online dispensing, driving further consolidation.

This remedy, as framed, risks deepening the very market asymmetries the CMA aims to address.

A better alternative is transparency and not price fixing

We support clients being clearly informed of:

- Their right to request a prescription,
- What a prescription entails,
- And how it relates to the wider clinical consultation.

We also support practices being encouraged to display their prescription fees and, where possible, explain the basis of the charge. But we oppose fixed or capped pricing, which:

- Devalues the professional act of prescribing,
- Encourages transactional, price-first behaviour,
- And will drive unintended cost increases elsewhere in the care pathway.

Remedy 10, if implemented as a form of prescription price control, would represent a regressive, blunt intervention that:

- Ignores the complexity and clinical responsibility inherent in prescribing,

- Shifts costs in a way that harms lower-income clients,
- And further tilts the market in favour of scale-driven, corporatised operators.

Veterinary prescribing must remain a welfare-centred act, not a line item on a comparison website.

Question 55

Q: Do you agree that a prescription price control would be required to help ensure that customers are not discouraged from acquiring their medicines from alternative providers?

A: No. A blanket cap risks underfunding the real cost of prescribing. It may lead to increased charges elsewhere or discourage time-intensive prescribing. Practices must retain the right to charge a fair, cost-reflective fee.

Question 56

Q: Are there any unintended consequences which we should take into consideration?

A: Yes. Price caps could push small practices into unsustainable cost structures. They also signal that prescriptions are administrative rather than clinical tasks, which risks eroding respect for professional judgment and care continuity. Over time, this could disincentivise comprehensive prescribing consultations.

Question 57

Q: What approach to setting a prescription fee price cap would be least burdensome while being effective in achieving its aim of facilitating competition in the provision of medicines?

A: A cap only on repeat prescriptions or standardised requests, but allow flexible charging for new or complex prescriptions. A flat cap risks unfairly penalising those practices that provide high levels of individualised care.

Question 58

Q: What are the costs of writing a prescription, once the vet has decided on the appropriate medicine?

A: This question demonstrates the lack of understanding. The act of prescribing includes the act of deciding upon the appropriate medicine. The cost of preparing a written prescription includes clinician time, record updates, and administration. Where no digital tool exists, manual transcription takes longer. The CMA must factor in real-world labour inputs, especially where a full client discussion is required.

Question 59

Q: What are the costs of dispensing a medicine in FOP, once the medicine has been selected by the vet (i.e., after they have made their prescribing decision)?

A: The cost to dispense includes storage, stock control, labelling, handling, and pharmacist or trained nurse time, training costs and wastage. Higher costs apply for controlled drugs or cold-chain items. If dispensing becomes uneconomical due to margin compression, clients may lose access to immediate treatment.

Remedy 11: Interim medicines price controls

We acknowledge the CMA's concern around variation in the price of veterinary medicines and the motivation to act in the interim before structural changes are implemented.

However, price control on medicines (even temporarily) poses significant risks to clinical standards, practice sustainability, and market diversity. It represents an overly simplistic solution to a complex market dynamic and would likely result in unintended consequences, particularly for independent practices that provide personal, localised, and continuity-based care.

In-practice dispensing is not just a revenue stream. It is:

- Integral to continuity of care,
- Essential for emergency and time-sensitive treatments,
- And part of the safety net for clients who need help understanding or administering medicines.

Capping prices would likely:

- Force independents to consider withdrawing from medicine supply,
- Destabilise cash flow, particularly in smaller, rural or mixed practices,
- And lead to more prescriptions being fulfilled online, often without clinical oversight or counselling.

This would fragment care, increase errors, and weaken the vet–client–animal bond.

Price is only one component of value. Veterinary medicine prices reflect:

- Handling and storage (especially for cold-chain drugs),
- Clinical oversight and professional indemnity,
- Individualised advice and compliance checking,
- And in many cases, immediate access, which is often critical for animal welfare.

Comparing this to online fulfilment or retail-style markups ignores the service ecosystem that surrounds the dispensing of medicines.

Controlling the price without recognising the service devalues the act, undermines professional care, and reduces the resilience of local provision.

Price controls on medicines will likely lead to:

- Higher consultation fees or procedure costs,
- The withdrawal of poor margin services (historically covered by medicine margin) including out of hour (OOH) provision.
- And a two-tier market where large providers cross-subsidise medicine losses with other services, while smaller practices struggle to remain viable.

This could reduce access to care for lower-income clients contradicting the CMA's goal of affordability.

If intervention is needed in the short term, it should be:

- Accompanied by transparency measures, such as display of medicine pricing ranges,
- And implemented with monitoring, not blunt controls, to assess actual harm.

Interim remedies must avoid creating permanent damage to smaller, fair-value providers or eroding trust and flexibility in veterinary medicine supply altogether.

Remedy 11, though well-intentioned, would deliver:

- No overall gains in affordability,
- While creating major risks to continuity, care quality, and local practice viability.

If implemented at all, interim price controls should be highly targeted, short-term, and designed with active input from the veterinary profession.

Question 60

Q: What is the most appropriate price control option for limiting further price increases and how long should any restrictions apply for?

A: If necessary, apply **temporary caps** on a small subset of widely used medications, reviewed annually. Controls should not be permanent or universal. Medicines subject to price regulation must be carefully selected to avoid penalising practices that specialise in complex or niche therapies.

Question 61

Q: If we aim to use a price control to reduce overall medicine prices, what would be an appropriate percentage price reduction?

A: It is not appropriate to impose a flat reduction target without differentiating between high-margin products and those already sold close to cost. A blunt reduction of any percentage may severely erode the viability of in-practice dispensing for independents. A better approach is targeted oversight of outlier pricing rather than broad price cutting.

Question 62

Q: What should be the scope of any price control? Is it appropriate to limit the price control to the top 100 prescription medicines?

A: Limiting controls to a defined list is preferable to a sector-wide policy. However, even a top-100 list must consider volume-weighted impact, and formulation complexity. The scope should explicitly exclude cold-chain products where cost structures are distinct.

Question 63

Q: How should any price control be monitored and enforced in an effective and proportionate manner?

A: Self-reporting combined with light-touch audits would be most proportionate. Enforcement via public shaming or heavy penalties would chill clinical flexibility and could push independents to withdraw from medicine dispensing, which harms continuity of care and reduces competition in the market. Enforcement must be scaled with business size.

Consultation questions**: Implementation of remedies 7 – 11**

Question 64

Q: We welcome any views on our preferred system design, or details of an alternative that might effectively meet our objectives.

A: These seem to be untried, untested and expensive solutions. It would be a huge undertaking for an organisation to take on, and runs the risk of being undertaken by a third party with long term data mining objectives.

Question 65

Q: What do you consider to be the best means of funding the design, creation and ongoing maintenance of an e-prescription portal and price comparison tool?

A: We don't. There is no evidence that this will improve the availability of cost effective veterinary provision that supports animal health and welfare

Remedy 12: Restrictions on certain clauses in contracts with third-party out of hours care providers

We wholeheartedly support the elimination of excessive exit clauses that limit the ability of FOPs to move to alternative providers. We urge the CMA to obtain deep insight into the fragility of the provision of OOH care as a number of remedies that seek to decrease marginal income of medicines in FOPs that currently provide OOH care to their clients (and often other FOPs as well) could result in the withdrawal of these services, increasing the fragility of OOH availability.

Question 66

Q: What would be an appropriate restriction on notice periods for the termination of an out of hours contract by a FOP to help address barriers to FOPs switching out of hours providers?

A: 6 months

Question 67

Q: What would be an appropriate limit on any early termination fee (including basis of calculation) in circumstances where a FOP seeks to terminate a contract with an out of hours provider?

A: The average revenue of 3 months of work

Remedy 13: Transparency on the differences between fees for communal and individual cremations

Question 68

Q: Do you agree that the additional transparency on the difference in fees between fees for communal and individual cremations could helpfully be supplemented with revisions to the RCVS Code and its associated guidance?

A: Yes

Remedy 14: A price control on retail fees for cremations

As independent practices living and working within the communities we serve, we do not recognise the need for price control for cremations, other than for the prices we hear quoted from FOPs owned by LVGs. As such we wonder what evidence the CMA has for a blanket approach to this matter?

Question 69

Q: If a price control on cremations is required, should this apply to all FOPs or only a subset? What factors should inform which FOPs any such price control should apply to?

A: A universal rule is too blunt. Controls should apply only where there is direct evidence of excessive markups or exclusivity clauses. Many independents act as pass-through agents for third-party crematoria. Controls should focus on vertical integration cases or bundled plans with poor clarity.

Question 70

Q: What is the optimal form, level and scope of any price control to address the concerns we have identified?

A: A disclosure-based remedy is preferable *e.g.* requiring practices to state the underlying third-party cremation cost alongside any service fee. This approach preserves choice and transparency without setting arbitrary limits. Price control should be a last resort and must avoid penalising empathetic support at a time of client grief.

Question 71

Q: For how long should a price control on cremations be in place?

A: If deemed necessary, any price control should be strictly **time-limited** (e.g. 3 years), with mandatory review clauses. Permanent controls risk stifling service quality innovation or responsiveness during emotionally sensitive client interactions. A sunset clause ensures controls are genuinely corrective, not structural distortions.

Question 72

Q: If a longer-term price control is deemed necessary, which regulatory body would be best placed to review and revise such a control?

A: The RCVS, if appropriately resourced and with expert advisory support, would be best positioned due to its sector-specific insight. However, collaboration between the RCVS and consumer stakeholders would be essential for legitimacy, with safeguards against conflict of interest.

Remedy 15: Regulatory requirements on vet businesses

We strongly support the CMA's direction in Remedy 10 to introduce formal regulation of veterinary businesses, not just individual professionals. This is a long-overdue and necessary step to address the structural imbalance created by the emergence of large corporate providers whose scale and integration allow them to shape market behaviour beyond the scope of current regulation.

Current regulatory frameworks place professional accountability entirely on individual veterinary surgeons, yet many decisions affecting:

- Treatment pathways,
- Referral patterns,
- Prescribing restrictions,
- Pricing,
- And complaints handling

are made at the business or corporate level.

Without business-level accountability, non-clinical incentives and structures may go unchecked, creating pressure on clinicians and eroding trust in the profession. Introducing business regulation allows for:

- Transparent governance standards,
- Better enforcement of ethical business practices,
- And a clearer interface with consumer protections.

However, regulation must be proportionate and scalable

While the principle of business regulation is sound, the implementation must be tiered and risk-based, ensuring that:

- Smaller, independent practices are not overwhelmed by disproportionate reporting or compliance costs,
- Regulation is focused on governance, transparency, and accountability,
- And support is provided to help businesses, especially small and rural providers, understand and meet new standards.

A one-size-fits-all regulatory burden would risk accelerating consolidation and reducing diversity in the sector; precisely the outcome the CMA aims to prevent.

We support the RCVS as the appropriate regulatory body to take on this role, provided it is:

- Adequately resourced,
- Transparent in its governance,

- And equipped to regulate non-vet owners or boards.

It should focus on:

- Ethical business conduct,
- Integration with clinical standards (via the Practice Standards Scheme),
- And ensuring complaints handling (e.g. via the VCMS) is supported and signposted at the business level.

Business-level regulation should aim to:

- Support public confidence,
- Improve corporate transparency, especially regarding ownership and complaint resolution,
- And help preserve clinical independence by recognising and regulating the influence of commercial structures on care delivery.

Remedy 10 is essential to a fair, accountable, and well-functioning veterinary market. However, its success depends on:

- Targeted implementation,
- Proportional requirements for different practice sizes,
- And genuine engagement with independent providers.

We urge the CMA and RCVS to proceed with this remedy with stakeholder co-design and in a way that strengthens accountability without stifling clinical practice or burdening those already operating with integrity.

Question 73

Q: Would regulating vet businesses as we have described, and for the reasons we have outlined, be an effective and proportionate way to address our emerging concerns?

A: We accept that clearer accountability structures in business regulation could support transparency. However, the proposal must avoid dual-regulation burdens (RCVS current + CMA new) for smaller practices. A unified, coordinated framework - with a single primary regulator would be more proportionate and efficient.

Remedy 16: Developing new quality measures

We support the CMA's recognition that price alone cannot define value in veterinary care. Clients deserve meaningful, accessible information to guide decisions, and not just cost comparisons. Developing new quality measures, if done carefully, could help

reinforce trust and highlight the distinctiveness of high-integrity, relationship-based practices.

However, quality in veterinary care is not easily reducible to numerical scores or standardised KPIs. Done badly, this remedy could:

- Distort public understanding,
- Encourage tick-box compliance,
- And incentivise superficial over substantive improvements.

Quality measures must reflect the nature of veterinary practice, and quality cannot be defined solely by:

- Outcomes (which are often case- and owner-dependent),
- Online reviews (which reflect emotion more than clinical standards),
- Or standardised throughput metrics (which may reward volume over thoroughness).

Recommendation: Quality measures should focus on inputs and processes, not just outputs and offer insight into commitment to care quality; without reducing veterinary practice to a retail model.

We strongly caution against blunt tools that bring bias:

- Star ratings or league tables, which misrepresent nuanced services,
- Unverified online reviews, which skew toward extremes and may disadvantage rural or referral-heavy practices,
- Or standardised outcome metrics (e.g. complication rates), without accounting for case mix, client compliance, or referral complexity.

Smaller practices, which deliver personalised care and have loyal clients, could be punished by scale-based metrics that favour corporates with digital marketing resources.

If this remedy proceeds, the CMA should:

- Co-develop quality frameworks with RCVS, BVA, SPVS, and independent practice groups,
- Avoid compulsory publishing of misleading or unaudited data,
- Focus on educational tools for clients, not just comparative dashboards,
- And ensure quality indicators are designed to support improvement, not penalise diversity of practice models.

Remedy 16 offers a valuable opportunity—if approached as a means of public education and professional recognition, not competitive ranking. Clients want confidence, not complexity. The focus should be on:

- What practices invest in (training, systems, people),
- How they ensure continuity and ethical care, and
- Whether they foster trust.

We support meaningful, fair, and carefully developed quality measures. However, we oppose any attempt to reduce veterinary care to simplistic, scalable scores that misrepresent the profession's complexity and compassion.

Question 74

Q: Are there any opportunities or challenges relating to defining and measuring quality which we have not identified?

A: Yes. A key challenge is that clinical outcomes are often shaped by client compliance, animal factors, and case complexity, which cannot be standardised or fairly compared. An opportunity lies in developing some process-based indicators that reflect quality of input.

Question 75

Q: Would an enhanced PSS or similar scheme support consumer decision-making and competition on quality?

A: Yes. It has the potential to do so. An enhanced RCVS Practice Standards Scheme (PSS) could provide trusted, profession-led quality signals for clients. It should focus on voluntary tiered recognition, accreditation by species or service area, and transparent standards. This would support client confidence without defaulting to price-based competition.

Question 76

Q: How could enhancements be designed to reflect the quality of different vet business types and avoid discrimination?

Enhancements must be scalable and flexible, recognising that:

- Smaller or rural practices may offer fewer services but still provide high-quality care,
- Species-specific practices (e.g. equine, exotics) require different benchmarks,
- Practices should not be penalised for size, IT infrastructure, or online presence.

Allowing customised quality pathways and supporting non-corporate practices to engage with accreditation is essential to avoid structural bias.

Question 77

Q: Are there any other options we should consider?

A: Yes. The CMA could also consider:

- Encouraging RCVS-led client education campaigns on what defines veterinary quality,
- Promoting quality storytelling (e.g. case examples, staff training highlights) over metrics alone.

These options focus on trust and transparency, rather than gamified scoring systems.

Remedy 17: A consumer and competition duty

Question 78

Q: Should any recommendations we make to government include that a reformed statutory regulatory framework include a consumer and competition duty on the regulator?

A: Yes. For the reasons set out in the Working Paper

Question 79

Q: If so, how should that duty be framed?

A: In a manner that supports ongoing public confidence in the veterinary profession and those businesses providing veterinary products and services.

Remedy 18: Effective and proportionate compliance monitoring

We agree that remedies are only meaningful if compliance is monitored and enforced. However, compliance mechanisms must be designed with proportionality, ensuring that:

- Monitoring focuses on areas of greatest systemic risk (e.g. vertically integrated corporate groups),
- Requirements are scalable by practice size and complexity, and

- Administrative burden does not fall unfairly on independent practices, which already operate with high trust and professional accountability.

Without this, compliance risks becoming a compliance burden, inadvertently driving consolidation and penalising ethical providers.

Question 80

Q: Would the monitoring mechanisms described help protect consumers and promote competition?

A: Yes, if targeted appropriately. Effective monitoring could:

- Promote transparency and positive outcomes,
- Deter anti-competitive practices
- And raise public trust.

But overly broad or indiscriminate monitoring could reduce diversity in the market by pressuring smaller providers through disproportionate oversight.

Question 81

Q: How should monitoring mechanisms be designed to be proportionate?

They should be:

- Risk-based: focused on business models with higher structural influence or historical concerns,
- Tiered by size and complexity: with lighter-touch self-certification for smaller practices, and fuller audits for large or multi-site operators,
- Integrated into existing frameworks (e.g. RCVS Practice Standards Scheme) to avoid duplication.

Question 82:

Q: What are the likely benefits, costs, and burdens of these monitoring mechanisms?

A: Benefits: Improved market oversight, client confidence, and clarity of standards.

Costs/Burdens:

- For independent practices: administrative workload, training time, software adjustments, scheme fees and documentation requirements.
- For regulators: development of tools, audit systems, and enforcement teams.

Without proportionality, independents may bear an outsized burden, undermining market plurality.

Question 83:

Q: How could costs and burdens be mitigated and who should bear them?

- Costs should be scaled to business size and turnover, not applied uniformly.
- Support should be provided to smaller practices — such as templates, CPD-aligned training, or phased implementation timelines.
- Funding should come from a mix of regulatory levies on larger groups and sector-wide contributions, especially where remedies address market-wide structural issues.

Remedy 19: Effective and proportionate enforcement

Question 84

Q: Should the regulator have powers to issue warning and improvement notices to individuals and firms, and to impose fines on them, and to impose conditions on, or suspend or remove, firms' rights to operate (as well as individuals' rights to practise)?

A: Yes. Proportionate escalation powers are necessary but must include clear appeal routes, due process, and thresholds of harm or repeat breaches. There should be **different levels of sanction** for business versus professional failings, and guidance on proportional response tailored to practice size.

Question 85

Q: Are there any benefits or challenges, or unintended consequences, that we have not identified if the regulator was given these powers?

A: Risk of 'defensive regulation' where practices focus on compliance optics over clinical care. There is also a chilling effect: smaller practices may exit the market due to fear of heavy sanctions. Ensure sanctions reflect intent and impact, not minor admin lapses. The biggest risk is the increase in level of anxiety expressed by a younger generation of veterinary surgeons who appear to live in fear of "being struck off". It will be absolutely critical to put clear measures in place to mitigate their concerns.

Remedy 20: Requirements on vet businesses for effective in-house complaints handling

Question 86

Q: Should we impose a mandatory process for in-house complaints handling? Please explain your views.

A: Yes, if implemented with flexibility. Most independents already handle complaints professionally. Standardising core expectations (e.g. timelines, documentation) could improve consistency, but there must be room to accommodate varying scale and systems. The PSS is a good implementation vehicle.

Question 87

Q: If so, what form should it take?

A: A three-step model would be workable:

1. Acknowledgment and informal resolution,
2. Internal review with clinician oversight,
3. Escalation pathway (e.g., VCMS).

It should come with guidance templates and CPD support. Avoid mandatory use of external tools or systems that are costly for smaller practices.

Remedy 21: Requirement for vet businesses to participate in the VCMS

Question 88

Q: Would it be appropriate to mandate vet businesses to participate in mediation (which could be the VCMS)?

A: Yes, with safeguards. A mandatory baseline could encourage resolution and improve public confidence. However, the scheme must remain proportionate and mediation must not be used for or abused by vexatious or abusive complaints.

Question 89

Q: How might mandatory participation in the VCMS operate in practice and are there any adverse or undesirable consequences to which such a requirement could lead?

A: Participation could be triggered after exhaustion of in-house routes. The main risks are resource strain on smaller clinics and perception of lost autonomy. Consequences can include emotional burden on clinicians and distraction from clinical duties during complex or prolonged disputes, although a defined process of mediation can mitigate this. One clear concern is the scalability of the service offered by VCMS; is sufficient provision and resource available if this is now to become a mandatory process? Practice experiences with VCMS to date have been variable. It would be good to see a consistently high net promoter score being tracked for this service by both clients and veterinary practices alike.

Question 90

Q: How might any adverse or undesirable consequences be mitigated?

A: Mitigations could include:

- Caps on case time or cost per practice per year;
- Clear guidance on frivolous complaints;
- Dedicated VCMS liaisons for small practices
- Tracking of Net Promoter Score

Support must be proportional and guided by case volume and business size.

Remedy 22: Requirement for vet businesses to raise awareness of the VCMS

Question 91

Q: What form should any requirements to publicise and promote the VCMS (or a scheme of mediation) take?

A: Practices should be required to display VCMS information clearly at reception and on their websites. Standardised template text and printed materials should be provided by the scheme administrator. This avoids creating variable burdens across practices and ensures consistent messaging to the public.

Remedy 23: Use of complaints insights and data to improve standards

Question 92

Q: How should the regulatory framework be reformed so that appropriate use is made of complaints data to improve the quality of services provided?

A: The RCVS should publish anonymised trend reports on complaints, identify system-wide learning points, and integrate insights into CPD guidance. Individual complaints should not be used punitively without due process. The goal must be service improvement, not fear-based compliance.

Remedy 24: Supplementing mediation with a form of binding adjudication

Question 93

Q: What are the potential benefits and challenges of introducing a form of adjudication into the sector?

A: Benefits include resolution certainty for unresolved cases and reduced court pressure. However, risks include adversarial dynamics, increased legal costs, and discouragement of early resolution. Adjudication must be voluntary, proportionate, and limited to disputes with clear clinical or contractual parameters.

Question 94

Q: How could such a scheme be designed? How might it build upon the existing VCMS?

A: Build adjudication into a tiered model: informal resolution → VCMS mediation → binding adjudication as a final step. The VCMS would need new powers, and a panel including both vets and legal experts to ensure balanced decisions. Costs could be means-tested to avoid deterring access.

Question 95

Q: Could it work on a voluntary basis or would it need to be statutory?

A: It could start on a voluntary basis but would need statutory underpinning to provide

legal authority for outcomes. Without enforceability, the scheme risks being ineffective. However, participation criteria and scope must be carefully defined to protect clinical discretion.

Remedy 25: Establishment of a veterinary ombudsman

Question 96

Q: What are the potential benefits and challenges of establishing a veterinary ombudsman?

A: Benefits: credibility, consistent rulings, and sector oversight. Challenges: high cost, risk of bureaucratic expansion, and separation from clinical realities. Any ombudsman must work in partnership with the RCVS and avoid undermining clinical autonomy or becoming a consumer complaints clearinghouse disconnected from practice realities.

Question 97

Q: How could a veterinary ombudsman scheme be designed?

A: It should:

- Sit independently but work in collaboration with the RCVS;
- Involve veterinary professionals in its panels;
- Have clear, limited jurisdiction (e.g., billing disputes, communication complaints);
- Be funded by a mix of public and professional contributions, with per-case cost caps for small businesses.

Question 98

Q: Could such a scheme work on a voluntary basis or would it need to be statutory?

A: Voluntary participation could be patchy and favour larger players. A statutory basis would ensure consistency and enforceability. However, if implemented, it should exempt or offer an alternative route for very small practices or sole traders to avoid disproportionate compliance costs.

Remedy 26: Protection of the vet nurses title

Remedy 27: Clarification of the existing framework

Remedy 28: Reform to expand the vet nurse role

Question 99

Q: What could be done now, under existing legislation, by the RCVS or others, to clarify the scope of Schedule 3 to the VSA?

A: The RCVS could issue more detailed guidance, publish role-mapped examples, and update the PSS to incentivise structured delegation. A Schedule 3 training framework with recognised levels of nurse capability would help practices deploy RVNs more effectively and confidently within current legal limits.

Question 100

Q: What benefits could arise from more effective utilisation of vet nurses under Schedule 3 to the VSA, in particular for the veterinary profession, vet businesses, pet owners, and animal welfare? Might this result in any unintended consequences?

A: Benefits include increased efficiency, job satisfaction, access to care, and reduced pressure on vet teams. Risks include delegation beyond competence and dilution of clinical oversight, and reduced access to training opportunities for newly qualified veterinary surgeons. Strong protocols and supervision structures are essential. The CMA must avoid assuming that nurse-led care automatically substitutes for vet-led care.

Question 101

Q: What benefits could arise from expansion of the vet nurse's role under reformed legislation, in particular for the veterinary profession, vet businesses, pet owners, and animal welfare? Might this result in any unintended consequences?

A: Expansion could bring several benefits: it would ease vet workloads, reduce wait times for clients, improve job satisfaction for nurses, and create new service delivery models. However, without clear training standards and regulatory safeguards, it may lead to fragmented accountability or unsafe delegation. Reform should emphasise

complementarity, not substitution, of the veterinary nurse's role. Lessons must be learned from the challenges seen in human healthcare regarding Physician and Anaesthetist Associates.

Proportionality

We welcome the CMA's recognition that an enhanced system of regulation must be proportionate: not only in principle, but in its design, delivery, and funding. However, we believe the proportionality arguments currently presented underestimate the risk of regulatory and cost burdens falling unevenly on smaller, independent practices, and overestimate the competitive benefits of certain reforms if not properly calibrated.

Regulatory reform must leave consumers better off, and this must not rely on a redistribution of cost from large, multi-site corporates onto smaller providers who already operate with high standards and local accountability.

We strongly support the idea that:

- Registration, monitoring, and PSS fees should be scaled by size and revenue,
- High-complaint practices bear a greater share of ADR costs,
- And the regulator should focus more intensively on practices that carry greater systemic risk, such as vertically integrated or highly standardised business models.

But this must not become a 'light-touch for all, equally' system, which risks undermining its core intent by treating unequal contributors equally.

While we welcome proposals for online or automated self-certification tools, these:

- Still require training, oversight, and data input time which is especially burdensome for smaller practices with no dedicated compliance staff,
- Risk becoming tick-box exercises if not backed by contextual understanding from regulators and clients,
- And may inadvertently reward those with better digital infrastructure, rather than better clinical care.

The system must include support for implementation, not just scaled fees. For example:

- Free templates,
- Training modules tied to CPD,
- Phased timelines for smaller practices,
- And consultation channels for feedback and adjustment.

Accreditation and Quality Awards must not become 'pay-to-compete'

Encouraging businesses to distinguish themselves through accreditation is reasonable. But if such awards become the only way to stand out in a comparator-driven marketplace, they risk creating a two-tier system:

- Well-resourced corporate groups will chase recognition as a marketing tool,
- Smaller practices may be priced out, even if offering higher-touch, higher-trust services.

Voluntary accreditation must remain meaningful but accessible, and not a gateway to visibility or legitimacy in comparison tools or portals.

Complaints and redress funding must reward resolution, not reputation management.

We support a fee-based model where unresolved complaints that reach a third-party scheme incur a cost, provided the VCMS or any successor body remains neutral, proportionate, and professionally informed.

However, we caution that:

- Disproportionate exposure to reputational damage may drive defensive practice,
- And the financial model must not discourage good-faith engagement with complaints due to fear of automatic penalty.

We support the direction of reform and the CMA's intention to deliver a fairer, better-regulated veterinary market. But proportionality must be operationalised, not just promised. That means:

- Scaled fees and risk-based monitoring,
- Targeted interventions where market distortion is most evident,
- Support for implementation by smaller practices,
- And a shared commitment to ensure that regulation protects market diversity, not just market performance.

If well designed, this could enhance trust, improve outcomes, and protect the best of independent veterinary practice. If poorly calibrated, it risks increasing costs, reducing access, and accelerating the consolidation the CMA rightly seeks to address.

Question 102

Q: Do you agree with our outline assessment of the costs and benefits of a reformed system of regulation? Please explain your views.

A: Broadly yes, but the CMA's cost assumptions likely underestimate the **relative**

burden on smaller practices. Compliance time, staff training, software adaptation, and policy development represent a much larger proportion of operational capacity for independents than for corporates. A reformed framework must include **scale-sensitive mechanisms**.

Question 103

Q: How should we develop or amend that assessment?

A: Incorporate case studies from a **range of practice sizes**, particularly smaller and rural clinics. Include cost modelling with **tiered thresholds**, identify time investments for compliance activities, and consult across regions to capture diverse economic conditions and staffing availability. Assess not just financial but **opportunity costs**.

Question 104

Q: How could we assess the costs and benefits of alternative reforms to the regulatory framework?

A: Use pilot schemes, simulations, and structured feedback from a representative practice sample. Embed a **regulatory impact assessment** (RIA) within any reform proposal. Collaborate with professional bodies like SPVS or VMG for operational data. Emphasise the **lived experience** of applying compliance rules in real practice.

Question 105

Q: How should any reformed system of regulation be funded (and should there be separate forms of funding for, for example, different matters such as general regulatory functions, the PSS (or an enhanced scheme), and complaints-handling)?

A: Funding should be modular and transparent. Regulatory functions (e.g., standards and CPD), inspection (e.g., PSS), and complaints should be separately costed and billed. Consider using practice size-based fees or progressive levies, with discounts for small (or sole practitioner) models. Public interest elements, such as complaints-handling, should consider carefully who is paying and why.

A final thought upon Proportionality: *Politics, Economics and Philosophy*

While we welcome the CMA's investigation into the veterinary sector and recognise the need for markets to function fairly and transparently, we are concerned that the current framing of the issues appears to focus narrowly on price signals, consumer choice, and competition metrics. Veterinary care, like other forms of professional medical service, occupies a specific role in society: it is not a purely transactional market but a vocation grounded in ethical responsibility, trust, and the welfare of sentient beings. The veterinary profession is increasingly strained by corporatisation and commercial pressures, with growing evidence of burnout, moral injury, and as a function of corporatisation and a lack of "contextualised care" / or the delivery of "gold standard care", diminished trust in professional motives. The CMA must ensure that any market interventions do not inadvertently worsen this position. In fact, the CMA has the opportunity to support a positive redefining of the social contract between animals owners and the professionals and businesses that deliver service to them.

In line with the spirit of the PPE tradition - which places Philosophy before Politics and Economics - we urge the CMA to consider the broader societal function of the veterinary profession, especially in the support of a One Health agenda, and to develop regulatory approaches that support both ethical practice and public interest. Regulation must do more than correct price failures; it must also consider the moral fabric and public value of the professions it governs and seek to support a better world for all.

Forty years ago, my father taught me a lesson. The aged car that I had acquired needed two new tyres. My Dad kindly accompanied me to a small backstreet garage where we encountered a mechanic. This was a businessman who had clearly not been having a good day. He was surly, dismissive and made it very clear that he was far from certain that he was going to be able to resolve the issue with the tyres.

But my father did not take this initial interaction to be fully representative of everything that made this man who he was. Instead with a few, simple, open questions, he engaged him in conversation, and they rapidly established that for a short time they had both worked in a Pirelli factory. There was now a human connection. The surliness evaporated, the willingness to serve appeared, and very quickly I was the proud owner of two new tyres complete with complementary free wheel balancing and inspection on all the other wheels.

The CMA Market Investigation and its potential Remedies poses challenging questions for both society and the veterinary profession.

- What does society want from those who provide veterinary services?
- How do they provide it?

Veterinary Services are indeed a credence market, places where the customer can not be sure of the need for, or quality of, the purchased product or service. So I found the report from the BBC [redacted]

[redacted]

The CMA's Remedies working paper, while aiming to improve competition and information flows, contains many proposals (especially those that assume arm's-length consumer behaviour) that have the potential for the **degradation of that human connection between veterinary professionals and their clients**. And if that connection degrades, there will be a degradation of the ability of veterinary professionals to support animal health and welfare and play their full role in one health.

We urge the CMA to play its part in bringing a balance of economics, politics and philosophy to this matter, to allow all parties to be really clear about what is valued and how we might nurture and strengthen our human and animal connections for a better world.

Appendix One: A survey of XLVet Members ***"To What Extent Will This Remedy Contribute To A Better Functioning Veterinary Services Market"***

Likert scale from "*Strongly Improves market function*" (+5) to "*Strongly Undermines market function*" (-5)

Remedy	Type	Mean Score
Remedy 6: Prohibiting Restrictive Business Practices	Functioning of Market	**3.41**
Remedy 26: Protection of Vet Nurse Title	Functioning of Market	2.70
Remedy 4: Referral Options	Functioning of Market	2.64
Remedy 20: Internal Complaints Handling	Functioning of Market	2.00
Remedy 1: Publication of Standardised Information	Functioning of Market	1.81
Remedy 27: Clarify Vet Nurse Scope	Functioning of Market	1.74
Remedy 28: Expand Nurse Role	Functioning of Market	1.67
Remedy 23: Learning from Complaints	Functioning of Market	1.54
Remedy 3: Pet Care Plans	Functioning of Market	1.52
Remedy 19: Proportionate Enforcement Power	Functioning of Market	1.36
Remedy 5: Written Explanation of Treatment Options	Functioning of Market	1.30
Remedy 13: Cremation Price Transparency	Functioning of Market	1.23
Remedy 21: Participation in Mediation Services	Functioning of Market	1.10
Remedy 16: Quality Metrics	Functioning of Market	0.81
Remedy 18: Compliance Monitoring	Functioning of Market	0.78
Remedy 12: Out of Hours Contracts	Functioning of Market	0.73
Remedy 22: Promote VCMS Awareness	Functioning of Market	0.48
Remedy 25: Veterinary Ombudsman	Functioning of Market	0.04
Remedy 15: Veterinary Business Regulation	Functioning of Market	0.04
Remedy 17: Consumer Protection and Competition Duty	Functioning of Market	-0.19
Remedy 14: Cremation Price Controls	Functioning of Market	-0.44
Remedy 24: Binding Adjudication Option	Functioning of Market	-1.36
Remedy 2: Comparison Website	Functioning of Market	-2.29
Remedy 8: Medicine Price Transparency	Functioning of Market	-2.83
Remedy 10: Prescription Fee Regulation	Functioning of Market	-2.93
Remedy 7: Mandatory Prescriptions	Functioning of Market	-2.96
Remedy 11: Interim Price Controls	Functioning of Market	-3.14
Remedy 9: Non-Branded Prescription Only	Functioning of Market	**-3.69**

Appendix Two: A survey of XLVet Members *"To What Extent Do You Think This Remedy Would Affect Smaller Veterinary Businesses Differently From Larger Ones?"*

Likert scale from "***Strongly favours smaller*** *businesses*" (+5) to "***Strongly favours large*** *businesses*" (-5)

Remedy	Type	Mean Score
Remedy 6: Prohibiting Restrictive Business Practices	Impact Favours Smaller	**2.56**
Remedy 4: Referral Options	Impact Favours Smaller	0.48
Remedy 12: Out of Hours Contracts	Impact Favours Smaller	0.35
Remedy 13: Cremation Price Transparency	Impact Favours Smaller	0.04
Remedy 27: Clarify Vet Nurse Scope	Impact Favours Larger	-0.23
Remedy 17: Consumer Protection and Competition Duty	Impact Favours Larger	-0.43
Remedy 19: Proportionate Enforcement Power	Impact Favours Larger	-0.45
Remedy 21: Participation in Mediation Services	Impact Favours Larger	-0.59
Remedy 14: Cremation Price Controls	Impact Favours Larger	-0.69
Remedy 26: Protection of Vet Nurse Title	Impact Favours Larger	-0.77
Remedy 22: Promote VCMS Awareness	Impact Favours Larger	-0.83
Remedy 3: Pet Care Plans	Impact Favours Larger	-1.07
Remedy 28: Expand Nurse Role	Impact Favours Larger	-1.08
Remedy 18: Compliance Monitoring	Impact Favours Larger	-1.26
Remedy 25: Veterinary Ombudsman	Impact Favours Larger	-1.26
Remedy 20: Internal Complaints Handling	Impact Favours Larger	-1.27
Remedy 1: Publication of Standardised Information	Impact Favours Larger	-1.37
Remedy 5: Written Explanation of Treatment Options	Impact Favours Larger	-1.44
Remedy 23: Learning from Complaints	Impact Favours Larger	-1.46
Remedy 24: Binding Adjudication Option	Impact Favours Larger	-1.50
Remedy 15: Veterinary Business Regulation	Impact Favours Larger	-1.64
Remedy 16: Quality Metrics	Impact Favours Larger	-1.72
Remedy 10: Prescription Fee Regulation	Impact Favours Larger	-2.45
Remedy 2: Comparison Website	Impact Favours Larger	-3.21
Remedy 11: Interim Price Controls	Impact Favours Larger	-3.25
Remedy 9: Non-Branded Prescription Only	Impact Favours Larger	-3.28
Remedy 7: Mandatory Prescriptions	Impact Favours Larger	-3.29
Remedy 8: Medicine Price Transparency	Impact Favours Larger	**-4.24**