Question 3 *Does the standardised price list cover the main services that a pet owner is likely to need? Are there other routine or referral services or treatments which should be covered on the list? Please explain your views.*

A standardised price list may capture common procedures (e.g. vaccinations, neutering), but it cannot adequately represent complex or chronic conditions such as diabetes mellitus. Treatment approaches and costs vary significantly depending on the species, breed, comorbidities, and response to therapy. Attempting to standardise such services may lead to oversimplification and mislead pet owners about actual costs. There are too many variables to simplify this question. I am in agreement that clients need to have a cost estimate before agreeing to investigation and /or treatment of their pet, however I do not agree to having a centralised price comparison website for complicated conditions.

Question 4: *Do you think that the 'information to be provided' for each service set out in Appendix A is feasible to provide? Are there other types of information that would be helpful to include?*

It may be feasible for standardised services, but for variable treatments, particularly chronic or referral-level cases, this is much more difficult. For example, diabetic treatment plans depend on factors like weight, insulin sensitivity, concurrent diseases, and owner compliance. Any "standard" price would either omit necessary detail or require a wide range, which may not be meaningful to pet owners.

Question 5: *Do you agree with the factors by which we propose FOPs and referral providers should be required to publish separate prices for? Which categories of animal characteristics would be most appropriate?*

Animal characteristics certainly affect costs, but the granularity required to make price comparisons truly meaningful would be extensive (species, breed, age, condition severity, pre-existing conditions). Publishing separate prices for each of these variables would not be feasible and may overwhelm or confuse pet owners rather than inform them.

Question 6: *How should price ranges or 'starting from' prices be calculated to balance covering the full range of prices that could be charged with what many or most pet owners might reasonably pay?*

"Starting from" prices risk creating unrealistic expectations. Wide ranges may better reflect true variability, but are unlikely to be helpful without explanation. Ideally, pricing should be discussed after clinical assessment, which allows the veterinary surgeon to provide a more tailored and realistic estimate.

Question 7: *Do you think that the standardised price list described in Appendix A would be valuable to pet owners?*

Basically NO. It may be helpful for routine services, but could be misleading or of limited use for more complex or referral treatments. For conditions like diabetes mellitus or oncology referrals, no two cases are alike, and prices vary accordingly.

Question 8 : *Do you think that it is proportionate for FOPs and referral providers to provide prices for each service in the standardised price list?*

No, not for all services. Expecting practices to provide exact prices for all services — especially where variation is significant — is not proportionate. It may divert resources from patient care to administrative compliance and may not add practical value to the pet owner.

Question 9 *Could the standardised price list have any detrimental consequences for pet owners?*

Yes. Oversimplified or generic pricing could mislead pet owners into selecting services based on perceived cost alone, rather than clinical need, quality, or suitability. It could also create unrealistic expectations, leading to dissatisfaction or mistrust when actual costs differ. A more nuanced approach that promotes communication and trust between vets and owners would be more appropriate.

Question 10 *Could the standardised price list have any detrimental consequences for FOPs and referral providers?*

Yes. It places an administrative burden on practices, especially small or independent ones, which may not have the resources to continually update price information or maintain a comprehensive website. It may also shift focus from quality of care to cost-driven decisions, potentially compromising patient outcomes.

Question 11 *What quality measures could be published in order to support pet owners to make choices?*

Instead of extensive price lists, quality indicators such as clinical outcomes, accreditation status (e.g. RCVS Practice Standards), staff qualifications, client feedback, and emergency availability would be more meaningful and help owners make informed choices beyond just price.

Question 12: *What information should be displayed on a price comparison site and how?*

If implemented, only basic information for routine procedures (e.g., vaccinations, neutering) should be displayed, with clear caveats. For complex or chronic conditions, composite price measures are misleading due to the vast variability in treatment paths and outcomes. Medicine prices are similarly dependent on dosage, availability, and ongoing monitoring — publishing them without context would not serve the public effectively and could create false expectations. The list of suggested conditions to be included for referral centres was strange – for example PDA (patent ductus arteriosus) occlusion – a condition with such a low prevalence in dogs and cats, how often is this going to be needed? If I did have a patient with a PDA, I would contact my local referral centres to inquire about the pricing at the time, and then present the options to the client. I would also have some preferences for where I would recommend referral, based on knowledge of referral centre suitability based on their facilities, staffing (experience of specialists, nursing care etc), all of which I would explain to my client. One referral centre may have an experienced specialist able to do a PDA occlusion today, but then if that person moves/retires etc, it may be that a different referral centre is better suited for the procedure next month. Price is relevant, but only when comparing apples to apples.

Question 13: *How could a price comparison website be designed and publicised to maximise use and usefulness to pet owners?*

I believe this question overlooks the fundamental issue: a price comparison tool will not add clarity for complex veterinary care. Pet owners are often unfamiliar with the nuances of diagnosis and treatment — adding layers of pricing without context may overwhelm rather than empower them. Personalised, in-practice communication is far more effective for supporting informed choices.

Question 14: *What do you think would be more effective - (a) a single site operated by the RCVS/third party or (b) an open data solution?*

Neither option is appropriate in this context. A centralised system would require constant updates and oversight, which could consume significant resources.

Question 15: *What are the main administrative and technical challenges on FOPs and referral providers?*

Maintaining accurate, meaningful, and frequently updated pricing information would be a significant burden, particularly for smaller or independent practices. Most veterinary practices operate with lean administrative teams, and redirecting these resources could detract from patient care. Every added cost (time, personnel, infrastructure) is eventually passed to the client, meaning pet owners would bear the financial burden of such a system.

Question 16: *Feasibility of providing price info based on animal characteristics?*

This is not feasible. Prices vary based on not just species, age, and weight, but also breed-specific conditions, owner compliance, concurrent conditions, and diagnostic findings. These cannot be meaningfully quantified into a list format without sacrificing accuracy or utility.

Question 17: *Where price varies (e.g. bundling/complexity), how should info be presented?*

In these cases, case-specific pricing discussions are far more effective than broad estimates. Complex care (e.g. cancer, endocrinology, orthopaedics) involves numerous stages of diagnostics, treatment adjustments, and follow-ups. A website cannot capture this variability, and attempting to do so would risk misinforming the public.

Question 18: *Best means of funding such a website?*

Regardless of funding source, the ongoing maintenance and compliance costs would ultimately be absorbed by practices and passed on to pet owners.

Question 19: *What would be the impact on vet business of this remedy option? Would the impact change across different types or sizes of business?*

The impact on independent practices such as ours would be significant, especially when compared to larger corporate providers with centralised systems. Our practice health plan data is not fully integrated within our practice management software (PMS). For many plan members, parasiticides, are supplied via home delivery services, and are therefore not recorded in the patient's invoicing history on the PMS.

Producing detailed annual statements showing full benefit usage would require manual checks across multiple platforms and systems. We estimate that compiling an accurate record takes approximately 20–30 minutes per pet, which becomes unmanageable across 1,400+ plans without significant staffing and cost implications.

Question 20: *How could this remedy affect the coverage of a typical pet plan?*

If enforced in its current form, this remedy could result in narrowing the scope of pet health plans. Practices may be forced to simplify or reduce benefits to ensure they can track and report them accurately.

This could lead to fewer included services or medications, removal of third-party involvement (e.g. home delivery), and less flexibility and personalisation in plans. The end result is that pet owners may receive less value and fewer preventive care options — directly opposing the intended goal of improving transparency and affordability.

We offer our health care plan specifically to try to encourage clients to maintain preventative treatment for lungworm in dogs (Angiostrongylus vasorum) because we have firsthand experience in this disease killing young dogs and the resulting heart ache for families. Our health care plan includes unlimited consultations, to encourage owners to bring their pets in for us to assess – rather than spend time deliberating if they need veterinary input or not. Administration of our plan currently requires approximately 10 hours per week. If we were to add in the reporting layers suggested in the remedies paper, the cost to client would need to increase to cover the added administrative burden (which would be estimated to double, at a minimum).

Question 21: *What are the main administrative and technical challenges on FOPs and referral providers with these remedy options? How could they be resolved or reduced?*

The main challenges for FOPs include:

- Fragmented data: Benefits are not centralised in one record or software system (e.g., in-practice care vs. home-delivered medication).
- Manual tracking: Current systems do not support automatic benefit tracking; each plan requires time-consuming manual cross-referencing.
- Lack of standardisation: Health plans vary widely across practices and cannot easily be summarised or compared using standard formats. They evolve over time, the health care plan we offer our clients now is different than 5 years ago, and systems evolve as well.
- Staffing costs: Processing 1,400+ yearly statements manually would require dedicated staff time, increasing overheads.

Potential resolutions could include:

- Allowing practices to continue issuing benefit summaries on request, as we currently do — this supports informed decisions without overburdening staff.
- Recognising that automated benefit tracking may not be technically feasible in many practices, and offering guidance rather than mandates.
- Focusing on transparency about general plan structure, pricing, and cancellation terms, rather than requiring full itemised statements for every member annually.

I also note that referral providers typically do not offer pet health plans, so these proposals may be irrelevant or inapplicable to that sector.

Question 22: *What is the feasibility and value of remedies that would support FOP vets to give pet owners a meaningful choice of referral provider?*

From our perspective, this remedy is not necessary. We already offer meaningful choice based on clinical appropriateness of the referral, our knowledge of the expertise available locally, accessibility, location, and client preference

As FOP vets, we maintain strong working relationships with multiple referral centres in our area. We know their clinical capabilities and subspecialties.

Question 23: *Are there any consequences which may be detrimental and if so, what are they?*

Undermining the clinical judgment and relationships FOP vets have developed with referral centre, time-sensitive referrals could be delayed if clients are expected to make decisions based on generic or broad data rather than guided, case-specific advice, unnecessary administrative burden for both FOPs and referral providers will lead to increased client costs and detract from patient care. There is also a risk of over-simplifying complex referral decisions, which must factor in more than just price (e.g. case complexity, specialist availability, owner compliance, and location)

Question 24: *What do you consider are likely to be the main administrative, technical, and operational challenges on referral providers in this remedy? Would it apply equally to different practices?*

Referral providers would face challenges including keeping referral pricing up-to-date for a wide range of complex service, communicating nuanced differences in service quality, facilities, or case selection criteria in a way that is understandable to the public and being expected to standardise inherently variable cases, which may not reflect the personalised, case-by-case nature of referral veterinary medicine

Question 25: *If you are replying as a FOP owner or referral provider, it would be helpful to have responses specific to your business as well as any general replies you would like to make.*

As an independent FOP owner we refer routinely and selectively, based on clinical need, client circumstances, and established professional judgment. We contact referral centres directly when needed for pricing or logistical queries. We do not believe that additional data tools or platforms would improve our ability to guide owners when choosing a referral centre.

Question 26: *What information on referral providers that is directly provided to pet owners would effectively support their choice of referral options?*

In our experience, the most helpful support for owners comes through guided discussion with their FOP vet — not standalone data or comparison tools. Pet owners often rely on their vet's judgment and the reassurance that we are recommending a centre with the right expertise.

If any information is to be made public, it should be limited to general service categories and contact details (e.g. orthopaedics, internal medicine, imaging). Anything beyond that risks causing confusion, especially without clinical context.

Question 27: *Should there be a minimum threshold (e.g., £250, £500, £1,000) for written provision of treatment options?*

For most diagnostic or treatment pathways, costs accrue in stages — often not known at the outset. For example, diagnosing a complex internal medicine case may involve testing and diagnostic exclusion, with no finalised “path” known until weeks into the process.

Attempting to document a “range of options” prematurely would be speculative, potentially misleading, and of limited value to the pet owner.

Question 28: *Should a 'thinking time' requirement be introduced, and how should it be structured?*

A blanket requirement for thinking time is impractical and could lead to treatment delays.

Where costs are significant and decisions are elective, owners have time to consider options and practices facilitate this. We always provide clients with written estimates, which have an expiry date, and they are welcome to have those price estimates updated if they consider the treatment beyond the expiry date.

Question 29: *Should this remedy not apply in some circumstances (e.g., emergency treatment)?*

Absolutely. This remedy should not apply in any emergency, urgent, or time-sensitive medical situation. Delays caused by preparing written documentation would be contrary to the animal's welfare and could have ethical and legal implications for the veterinary surgeon.

Question 30: *What is the scale of the burden of keeping a record of treatment options offered?*

Clinical options are often discussed verbally and notes made during consultations, and outcomes evolve over days or weeks. Recording "all possible options" in writing would require significant extra time from veterinary surgeons, reduce clinical appointment capacity, certainly increase costs for pet owners due to additional admin resource and be redundant, as clinical notes already record the decision-making process.

Question 31: *Advantages and disadvantages of using treatment consent forms to record that options were provided?*

While a consent form with tick boxes may seem like a solution, it may encourage default simplification of choices to reduce admin burden, thereby reducing true informed choice. Also it may lead to box-ticking over proper dialogue and increase paperwork while reducing consultation time for actual discussion.

Question 32: *Impact of this remedy on vet businesses, and how impacts may vary?*

Small and independent practices will be disproportionately impacted due to fewer admin staff to support documentation and limited tech solutions (e.g., integration between practice software and forms).

Question 33: *Are there additional barriers to providing written information including prices in advance?*

Yes- the main reason is that treatment pathways are rarely linear: they evolve based on findings from diagnostics and patient response. Many conditions have multiple stages with unknown costs until earlier steps are completed. Price estimates for advanced diagnostics or referral care are often outside the FOP's control and may require direct liaison with other providers.

Question 34: *How could training help address concerns, and on what topics?*

If any changes are introduced, training should focus on communication skills and shared decision-making, not just documentation. Topics might include managing client expectations, explaining uncertainty and staged treatment, ethical and legal implications of written consents and avoiding information overload while ensuring informed consent. This training should be embedded included in the veterinary school curriculum.

Training should also include guidance for dealing with complex or chronic cases, where multiple evolving decisions must be made over time.

The RCVS does have a bank of training material within their Academy and Knowledge departments which veterinary surgeons and registered veterinary nurses can access.

Question 35: *What criteria should determine how many treatment options are provided in writing?*

A rigid numerical requirement (e.g. 3 options per case) would be unrealistic. Instead, guidance should support reasonable and proportionate communication, tailored to the case and client.

Question 36: *Are there specific business activities that should be prohibited? Should a body such as the RCVS identify and update prohibited practices?*

As the owner of an independent first opinion practice, I fully support ethical, transparent, and patient-centred veterinary care. We do not implement financial incentives or internal targets that would influence clinical decision-making. In my experience, veterinary surgeons are highly motivated by animal welfare and would strongly resist any attempt to undermine their clinical integrity with financially driven incentives.

We agree that any business practices that limit client choice or compromise clinical independence should be prohibited.

The RCVS is the appropriate body to identify, define, and update prohibited business behaviours, as it already regulates professional conduct and understands the nuances of clinical veterinary care. Their oversight would provide consistency and legitimacy, rather than adding another regulatory body.

Question 37:
How should compliance be monitored and enforced? Would self-certification suffice, or should external audits be used?

For independent practices, self-certification with the option for spot checks or complaint-based reviews by the RCVS would be sufficient and proportionate. Most small practices operate transparently, with minimal layers of corporate oversight, and the burden of formal third-party audits would be disproportionate.

However, larger veterinary groups (LVGs) with standardised business models and central management structures may require greater external oversight, especially where corporate policies could influence clinician behaviour across multiple sites.

Question 38: *Should LVGs be subject to greater monitoring due to the impact of centralised policies?*

Yes. LVGs have the capacity to implement top-down business models that may affect clinical recommendations across dozens or hundreds of sites. These standardised systems — such as incentive schemes, supplier contracts, or internal referral guidelines — have the potential to limit both pet owner choice and clinician autonomy.

Question 39: *Should "business practices" be defined broadly to include informal internal guidance, even if not formalised?*

This is hard to answer. As a practice, we use certain brands for familiarity so that we can assist our clients using the medications on their pets. So although I think that broad definitions of business practices are appropriate, I do not think the practical solution of not stocking every single possible version of meloxicam in the practice is causing staff to behave in a way that is anti-competitive for meloxicam manufacturers.

Question 40: *Should medicines administered by the vet be excluded from mandatory prescriptions?*

Yes, medicines administered directly by the veterinary surgeon during consultation or treatment should be excluded. These are often necessary for immediate care, and requiring a written prescription in these situations would delay treatment, increase administrative burden and add confusion and potentially undermine patient care.

This exemption should apply clearly to any medicines given in-practice at the time of diagnosis or during a surgical or medical intervention.

NOTE: I am strongly opposed to mandatory prescriptions in all circumstances

Question 41: *Are there any challenges with written prescription remedies not yet considered?*

Yes. The root cause of concern around medicine pricing is not that clients are unaware of options — it is that independent FOPs cannot purchase medicines at the same price as large veterinary groups (LVGs) or online pharmacies. These entities benefit from bulk-buying power, exclusive wholesale deals and vertically integrated supply chains.

Question 42: *How can the prescription process be improved (secure, low cost, fast)?*

Prescriptions should be digital where possible (integrated into PMS systems), simple and standardised in format and low-cost to issue, ideally via software automation for routine repeat scripts.

However, any solution must not increase the administrative burden on veterinary surgeons. Practices should retain the ability to charge a reasonable fee for issuing prescriptions, reflecting the clinical responsibility and time required.

Question 43: *What transitional period would be needed to implement the prescription remedies?*

A minimum of 24-36 months would be required, especially for small practices to update systems, train staff and to communicate changes to clients.

Phased implementation would be advisable, starting with repeat prescriptions for non-urgent medications, and only expanding where clinically appropriate and administratively feasible.

Practices would also have to gradually increase their service fees to compensate for the loss of income from medication sales.

Question 44: *What price information should be communicated on a prescription form?*

None. Including external pricing would create false expectations and potential disputes.

Question 45: *What should the vet tell the customer when giving them a prescription?*

We spend so much time speaking to a client to obtain a clinical history, then examine the animal, then use our problem solving brains to make a diagnostic and therapeutic plan – whey do we need to spend time doing price comparisons or speaking to them about the costs of medication from different sources. Why can't we just prescribe what the pet needs, and provide it for the clients at a reasonable price?

Mandating a prescriptive verbal script for every case would be overly rigid and potentially confuse owners — especially when the medicine is part of a complex or ongoing treatment plan.

Question 46: *Views on feasibility and cost of implementing transparency options?*

The options suggested for price transparency carry significant administrative costs and, again, risk further undermining smaller practices:

For true transparency and fairness, the CMA should investigate wholesale pricing disparities, supply chain control by LVGs and online retailers and market share consolidation among major players.

Without addressing these, increased client access to prescriptions may simply shift sales to large-scale suppliers, eroding independent practice viability and reducing client choice in the long term.

A fairer market requires equal access to medicines at comparable prices, not further privileging volume buyers.

Independent practices provide essential personalised care — including face-to-face prescription management, clinical follow-up, and continuity. The current remedies risk diminishing this without correcting the true source of price inequality.

Ultimately the loss of income generated from medicine sales will need to be recouped by higher service fees

Our job depends on client trust, we should not be forced to use a statement that generates mistrust such as "medicines may be cheaper" online. There is no other industry where this is required

Question 47: How could generic prescribing be delivered and what information would be needed on a prescription?

Currently, it is not feasible to deliver generic prescribing reliably. To prescribe generically, a veterinary surgeon would need access to a central, up-to-date database listing all licensed generic equivalents, with formulation, dosage, packaging, and licensing details ,clear and consistent product naming standards across NOAH, VMD, wholesalers, and online pharmacies, PMS (Practice Management Software) that supports selection and accurate printing of generic medicine names.

Without this, a generic prescription could not accurately reflect dosage or quantity, ensure product equivalence in palatability or delivery method, or importantly protect the pet owner from confusion or the pet from misadministration.

If you type "meloxicam" as active ingredient into NOAH Compendium (which most vets use on a daily basis) you uncover 5 different brand names. On the VMD SPC website that list includes at least 10 more brands, where they can be bought I do not know. The packaging is different, so they come in different volume sizes, and there will be differences in other components of the medication e.g. excipients. Vets cannot be expected to be familiar with every single iteration of a medication. The SAFEST thing for their patient if for them to prescribe a medication that they are familiar with.

Question 48: Can the remedies proposed be achieved under the VMD prescription options currently available to vets?

No, not without changes to the current prescribing rules, tools, and regulatory infrastructure. Vets are responsible for ensuring the appropriateness of prescribed medication, and under the existing system different products have different SPCs, licensed uses, and species indications. Writing a generic prescription places that responsibility on the vet without any control over which brand the pet owner receives creates unacceptable legal, clinical, and ethical risks under current VMD frameworks.

Question 49: Are there any unintended consequences that should be considered?

Yes. Potential unintended consequences include: client confusion if the dispensed product differs from the one recommended (e.g. taste, form, dosing), increased errors in medicine administration due to packaging/dosing differences, vets avoiding prescribing where risks are unclear, reducing treatment options, increased workload as vets field calls from owners confused about their dispensed products, erosion of client trust in veterinary recommendations.

Furthermore, vets may be forced to spend additional unpaid time checking online suppliers or navigating databases — a cost that will eventually be passed to the pet owner.

Question 50: Are there specific medicine types where generic prescribing could work better?

Generic prescribing may be more feasible where there is strong clinical equivalence, palatability, concentration, and delivery are identical and licensing and withdrawal periods are consistent across brands.

Examples might include certain routine NSAIDs (e.g. meloxicam) or wormers, but only if brands are functionally and practically interchangeable. Even within categories like meloxicam, however, there are significant formulation and palatability differences that may impact compliance and efficacy.

Question 51: Would any exemptions be needed?

Yes, exemptions would be essential for species-specific formulations (e.g. cat-only oral liquids), products with distinct administration devices, medications for complex or chronic conditions where stability, taste, or specific formulation matters or any case where substitution would present clinical risk.

There should also be clear provisions allowing the vet to prescribe by brand when they judge it clinically necessary.

Question 52: Would changes to medicine certification or approval processes be required?

Yes. For generic prescribing to function medicines would need harmonised packaging sizes, formulations, and indications, the VMD approval process would need to include assessment of functional equivalence and SPCs should reflect interchangeability standards, including palatability and compliance data. Without this, generics cannot be assumed to be clinically identical.

Question 53: How should medicine manufacturers make information about equivalent substitutes available?

There must be a mandatory, centralised database listing licensed generics by active ingredient, species, form, dose, and pack size, integration with practice software (PMS), public access for both professionals and pet owners and standardisation of product descriptions and naming.

The VMD is best placed to oversee this, in partnership with NOAH and wholesalers.

Question 54: How could an e-prescription system facilitate generic prescribing or referencing of multiple brands?

An e-prescription platform should allow the vet to list either a generic active ingredient or select from multiple equivalent branded options, include drop-down menus that reflect current availability, licensing, and formulation, automatically validate dosage and licensing appropriateness and allow vets to restrict substitution where clinically appropriate (similar to “do not substitute” in human medicine).

Crucially, this platform should integrate with existing PMS systems, be secure, and reduce — not increase — administrative burden.

Question 55: Do you agree that a prescription price control is required to avoid discouraging clients from seeking medicine elsewhere?

No, I do not agree.

The suggestion that prescription fees are a barrier to consumer choice overlooks the core issue: veterinary prescriptions are not a commodity, they are a regulated clinical act involving risk, professional judgment, and legal accountability.

Prescription fees compensate for the time and clinical responsibility involved, reflect the fact that vets remain responsible for any adverse effects or dosing errors, even if the client sources the product from a third party, and are already modest in most practices and not routinely challenged by pet owners.

Question 56: Are there unintended consequences that should be considered?

Yes. Several serious unintended consequences include:

1. Increased liability for vets
   If a client uses a cheaper generic product from an online pharmacy and an adverse effect occurs (e.g. phenobarbitone brand switch affecting seizure control), the prescribing vet may be held accountable, despite no control over the dispensed brand, packaging, or advice given by the third-party provider.

2. Reduced quality of care
   Vets may avoid issuing prescriptions for medications where switching brands could pose clinical risks. This could reduce treatment options, especially for long-term conditions.

3. Reduced availability of prescription services
   If capped below cost, issuing written prescriptions becomes a loss-making activity, particularly in small practices. This could result in fewer practices offering the service, or longer waits.

4. Increased demand on vet time
   As more clients seek prescriptions to source medicines elsewhere, practices face a significant administrative burden without appropriate compensation.

Question 57: What approach to setting a prescription fee cap would be least burdensome?

If a cap were to be considered (which I do not support), it must be based on actual time and overhead costs, allow regional flexibility based on cost of living and staffing and include provisions for complex cases or medications requiring multiple checks, formulation discussions, or follow-up advice.

A “one size fits all” cap would be unworkable and unfair, particularly for small or rural practices where staffing costs are proportionally higher.

Question 58: What are the costs of writing a prescription (after clinical decision)?

Even after the clinical decision is made, issuing a prescription typically takes 10-15 minutes of a vet’s time, including reviewing records, ensuring correct product, dosage, and withdrawal period, generating the prescription, discussing usage with the client

Support staff time for documentation, printing and filing.

Professional responsibility, which continues after the prescription is issued if a client contacts the practice about availability, side effects, changes in medication source or brand etc.

This is equivalent to £15–£30 in direct costs, depending on practice overheads and regional staffing costs.

Question 60: What is the most appropriate price control option for limiting further price increases and how long should restrictions apply?

None of the proposed price control options are appropriate at the practice level. A more proportionate and impactful remedy would involve regulating the wholesale pricing structure, ensuring fairer access to medicines for all suppliers, including independent practices.

Small practices pay significantly more to purchase the same medicines than large vet groups or online pharmacies. If the CMA wishes to protect consumer interests and ensure competition, it should focus on the upstream pricing model, not restrict what independent providers can fairly charge based on their higher procurement and overhead costs.

Question 61: If a price control were used to reduce overall medicine prices, what would be an appropriate percentage reduction?

No fixed percentage reduction is appropriate unless procurement costs are equalised across the sector.

Applying arbitrary reductions would force small practices to sell below cost, creating unsustainable losses and also lead to withdrawal of medicine dispensing services from small providers. Client access to in-person medication advice and follow-up would be reduced. Ultimately a price control would encourage consolidation, pushing more owners toward LVGs and online pharmacies — ultimately reducing market competition.

Question 62: What should be the scope of any price control? Should it be limited to the top 100 prescription medicines?

Restricting controls to the “top 100” medicines is still problematic unless tied to regulated acquisition pricing. Many commonly prescribed medicines (e.g. NSAIDs, long-term epilepsy medication) vary widely in cost depending on supplier size.

Limiting dispensing prices without controlling purchase prices is not workable. For small practices, it would create increased losses, further reliance on charging for services, which increases overall client costs and reduced willingness to stock key medicines.

Question 63: How should any price control be monitored and enforced?

Price controls, if implemented, would require real-time monitoring of procurement prices to avoid penalising small practices, clear documentation and exemptions where costs exceed capped prices and a reporting mechanism for practices to flag when they are unable to meet the capped price due to supplier costs.

However, the administrative burden and cost of enforcing such a system across thousands of small practices would be significant — and likely disproportionate to the benefits.

Question 64: Views on system design or alternatives to meet CMA's objectives

I do not support the CMA's current preferred design, which proposes an e-prescription portal and comparison tool as a core solution. The proposal overestimates the readiness of practices and regulatory frameworks, and underestimates the clinical, legal, and administrative complexity of prescribing and dispensing veterinary medicines. Furthermore the proposal risks burdening small practices with disproportionate compliance demands that may reduce service availability, increase appointment fees and impact animal welfare due to delays or care limitations.

Including average or lowest online prices on prescriptions will directly divert revenue from small practices to corporate-owned online pharmacies.

As a regulated professional, I should not be expected to promote external retailers at the point of clinical decision-making — especially when I carry the liability for treatment outcomes.

Question 65: Best means of funding the design, creation, and ongoing maintenance of an e-prescription portal and price comparison tool

This initiative, if pursued, should not be funded by FOPs or passed on to pet owners.

A fair and sustainable funding model could include Government funding through the CMA or DEFRA, reflecting its public-interest nature or a regulatory levy shared proportionally across all market participants, including Large Veterinary Groups (LVGs), Pharmaceutical wholesalers, and Online pharmacies.

This model reflects the principle that those who benefit most from a centralised price comparison or prescription system (such as LVGs and online retailers) should also contribute most to its funding.

Question 66: 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?

As an independent small animal practice owner, I believe that a maximum notice period of six months would be appropriate. This timeframe strikes a reasonable balance between allowing the out of hours (OOH) provider time to adjust their staffing and services, while also enabling First Opinion Practices (FOPs) the flexibility to switch providers if service levels, cost, or other important factors necessitate a change.

Question 67: 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?

Early termination fees should be proportionate and justifiable, rather than punitive. I would suggest that any early termination fee should be capped at no more than the equivalent of one month's average service charges (based on the past 12 months of usage) or the remaining term of the contract, whichever is lower.

The fee should be clearly outlined in the contract with transparent calculation methods, and should only be applied to recover legitimate costs incurred by the OOH provider due to early termination.

Question 68: 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? Please explain your views.

As a small independent small animal practice owner, I agree that greater transparency on the differences in fees between communal and individual cremations would be beneficial, and that this could be helpfully supported by revisions to the RCVS Code and its associated guidance.

We have chosen a pet crematorium that we have personally visited, and witnessed how they handle the pets. This way we can reassure our clients that we use this particular pet crematorium because of our trust we have in their services. There is a cost that comes with individual cremation and it varies due to the return vessel choice that the client makes for the cremains. We have to explain that distinction to clients frequently. When they look at the pet crematorium website, they often miss the fact that the price of the return vessel does not include the service of individual cremation.

Clearer communication and guidance would ensure that veterinary professionals consistently provide full and honest explanations, helping clients make informed choices at a very sensitive time. This is especially important for maintaining trust between practices and pet owners.

Question 69: 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?

If a price control on cremations is deemed necessary, it should apply consistently to all practices, including FOP and referral, to ensure fairness and transparency across the sector. Applying controls only to a subset of practices (e.g., only independents or only corporate groups) could distort competition and create an uneven playing field.