[redacted]

Veterinary Services Market Investigation Team

Competition and Markets Authority

Dear Sir or Madam,

Please find enclosed my formal consultation response to the Competition and Markets Authority provisional remedies for the veterinary services market. This submission sets out, from the standpoint of an independent provider, the operational, financial and competitive consequences of the proposed measures. It explains why the evolving remedy package diverges from the CMA purpose, how it disadvantages small independent practices and how it will harm competition and consumer outcomes at both local and national scopes.

Yours faithfully,

[redacted]

[redacted]

Consultation Response: CMA Provisional Remedies - Veterinary Services Market Investigation

I welcome the CMA scrutiny of the veterinary sector. However, the progression of this investigation shows clear mission creep. What began as an inquiry into market concentration, local monopolies and vertical integration has shifted toward measures that impose administrative and financial burdens on small independent practices while leaving the structural causes of market power untouched.

[redacted] is [redacted] only independent practice. All other practices within ten miles belong to one of four corporate groups: CVS, IVC Evidensia, VetPartners and Vets4Pets. In this setting, the current remedy package would reduce the remaining independent option to non-viability and would leave [redacted] as a one hundred percent corporate market. That would remove consumer choice and weaken competition in direct conflict with the CMA purpose.

Remedy 1: Transparency and price publication

Original intent: help consumers make informed choices.
Current effect: misrepresents the drivers of price differentials and stigmatises independents.

The CMA has repeatedly asserted in public communications that medicines supplied by vets are twice as expensive as online. No dataset has been published to support this claim. There is no declared basket, SKU list, pack sizes, VAT treatment, date range or wholesale cost base. This comparison ignores the supply chain constraints that apply to independents. We must purchase through licensed veterinary wholesalers. Our net purchase price is often at or above the online retail price paid by consumers, which includes VAT.

Examples from our practice are typical of a wider pattern:
- Parasiticide spot-on for cats, three pack. Typical online retail price including VAT: £20 to £22. Our net purchase cost from a major licensed wholesaler: £21 to £24 plus carriage, VAT chargeable on top.
Result: online price is equal to or lower than our acquisition cost.
- Meloxicam oral suspension 100 ml. Typical online retail price including VAT: £14 to £16. Our net purchase cost: £15 to £17.
Result: online price is at or below our acquisition cost.

[redacted]

These differentials arise from supply chain discrepancies, corporate economies of scale and vertical integration, not from excessive mark-up by practices. Dispensing margins within an independent practice are typically 30 to 40 percent on cost and cover clinical time for prescribing, stock management, cold chain, wastage and expiry, indemnity and quality systems. Removing or constraining recovery of these costs does not reduce the total cost to consumers. It simply moves the cost into other fee lines.

The CMA has also amplified the phrase there is no NHS for pets. While literally true, using this as a headline in a live remedies process frames veterinary care as a discretionary retail service and implies that cost recovery by practices is optional. This has already produced confrontations in consulting rooms and online as highlighted by professional bodies. It discourages early presentation and damages trust. The communication approach looks like political messaging rather than objective assessment and is inconsistent with the CMA guiding principles of evidence, fairness and proportionality.

Remedy 2: Mandatory written prescriptions

Original intent: increase freedom of choice for consumers.
Current effect: imposes disproportionate administrative burden, reduces clinical capacity and diverts revenue to corporate owned online pharmacies.

Every external prescription requires a veterinary review of the record, dose confirmation and interaction checks, compliant documentation and secure record keeping. These are professional acts required by the Veterinary Medicines Regulations 2013 and cannot be delegated to clerical staff. In our 1.8 FTE practice, external prescriptions currently occupy four to six hours of vet time per week at an internal cost of roughly £[redacted] to £[redacted]. If chronic medications are routinely transferred to external supply, workload would rise to about ten hours per week. That is a six percent reduction in billable clinical capacity. On a turnover of £[redacted] per month the implied capacity loss equates to around £[redacted] per year before any change in dispensing income. The CMA has not modelled this displacement of clinical time. The real world effect is fewer appointments, longer waits and higher fees.

[redacted]

Remedy 3: Capping of prescription fees

Original intent: Protect consumers from excessive charges.
Current effect: Makes legal compliance uneconomic and shifts cost elsewhere in the practice.

The CMA now proposes a single cap of £16 per written prescription, irrespective of the number of items listed. At [redacted], the average fully loaded cost to produce a compliant prescription, including veterinary time, administrative support, stationery, software licensing, and regulatory audit, is £10–£12 per item before VAT. When several medicines are prescribed together, the true cost per prescription typically exceeds £20.

A £16 ceiling therefore ensures that every prescription is produced at a loss once VAT and payment-processing costs are included.

With roughly 1,000 external prescriptions issued each year, this represents a direct annual loss of £[redacted]–£[redacted], on top of the £[redacted] of lost clinical capacity identified under Remedy 2. The combined effect is a £[redacted] annual impact, around 8% of gross turnover. To remain viable, consultation or procedure fees would need to rise by approximately 10%, meaning owners who do not require chronic medication subsidise those who do.

The total cost to the public does not fall; it is simply redistributed, and access to timely care declines.

For context, the NHS prescription charge in England is £9.90 per item, heavily subsidised by public funds and not reflective of the true administrative cost. Private medical providers typically charge £25–£45 per prescription, with repeats often billed at £10–£20. Veterinary practices operate with no subsidy, no central procurement discounts, and full regulatory liability under the Veterinary Medicines Regulations 2013.

It is therefore legitimate to ask why the CMA believes that veterinary professional time should be valued below that of our human medical counterparts.

Veterinary surgeons are equivalently qualified clinicians, subject to statutory regulation, professional indemnity, and inspection, yet expected to deliver the same standard of prescribing governance without any of the financial support structures that exist within the NHS. A £16 cap ignores these realities, undermines parity of professional value, and fails any reasonable proportionality or fairness test. Rather than protecting consumers, it diminishes the sustainability of regulated clinical work and risks eroding welfare standards.

[redacted]

Remedy 4: Ownership transparency and vertical integration

Original intent: expose market concentration and vertical integration.
Current effect: structural concerns acknowledged but not remedied and revenue flows redirected to integrated corporate channels.

The CMA initially stated that some areas have limited or no meaningful choice due to corporate concentration. If that is correct, why are the relevant groups not required to divest to restore competition. Instead, modest disclosure has been paired with remedies that increase the volume of mandatory external prescriptions, which in turn feed corporate owned online pharmacies. The Authority has also failed to highlight that several online pharmacies are owned by or contractually linked to the same groups operating clinical practices. This is vertical integration in substance and effect. The current package legitimises this model and transfers value away from independents into these integrated supply chains.

Remedy 5: Consumer information and communications

Original intent: improve public understanding.
Current effect: prejudices the consultation environment and erodes confidence through simplified and selective framing.

Phrases such as "medicines from vets are twice as expensive as online" and "there is no NHS for pets" have become the public face of this investigation. These claims omit wholesale constraints, pack size and formulation differences, VAT treatment and the bundled clinical costs inherent in in-practice supply. They have already biased public perception and have prompted hostility toward practice teams. They discourage timely veterinary care.

Procedural fairness and equality of arms

Corporate groups were represented collectively within the confidentiality circle and supported by legal counsel. Independent practices were required to apply individually. For small operators without legal departments this is an unrealistic barrier. This approach conflicts with the principle set out in R v Secretary of State for the Home Department, ex parte Doody 1994 that affected parties must have a fair opportunity to understand and respond to evidence. It also conflicts with CMA guidance on proportionate stakeholder engagement. The effect is indirect discrimination by scale and a risk of regulatory capture.

[redacted]

Local market impact: [redacted]

[redacted] is the only independent practice [redacted]. Within ten miles the remaining practices belong to CVS, IVC Evidensia, VetPartners or Vets4Pets. These groups benefit from shared marketing budgets, central compliance and integrated online pharmacies. The current remedies would remove around £50,000 per year from our operating model and reduce clinical capacity. The likely outcome would be sale or closure within eighteen months, after which [redacted] would be a one hundred percent corporate market. That would eliminate consumer choice and permanently entrench the local monopoly conditions originally identified by the CMA.

Cumulative effect and mission creep

Stage one focused on corporate consolidation and local monopolies, with divestiture on the table. Stage two emphasised ownership disclosure. Stage three now imposes administrative and price controls on individual practices. At no point has the Authority explained why structural remedies were set aside in favour of burdens on the smallest market participants. The diagnosis was monopoly power. The proposed treatment is paperwork for independents. The result is consolidation by regulation.

Legal and economic assessment

Under the Enterprise and Regulatory Reform Act 2013 the CMA must promote competition for the benefit of consumers. Measures that reduce market plurality, disadvantage independents and reinforce integrated corporate structures are irrational within the Wednesbury meaning and perverse in effect. Economically, the package creates a feedback loop. Administrative cost rises and profitability falls in independents. Independents exit or sell. Corporates acquire client lists and expand share. Once plurality is lost, transparency will not restore competition.

Behaviour inconsistent with CMA guiding principles

Proportionality is lost when identical compliance is imposed on micro businesses and multi billion pound groups. Fairness is undermined when corporate participants enjoy collective legal representation while independents must apply alone. Evidence based policy is weakened when headline statistics are published without transparent methodology. Consumer welfare is harmed when access falls and total cost is shifted into clinical fees.

[redacted]

Outstanding questions to the Authority

1. If the CMA has found limited or no meaningful choice in some local markets, why are dominant groups not required to divest assets to restore competition?

2. Why has the CMA not highlighted or remedied vertical integration between corporate practices and online pharmacies, including transfer pricing and cross subsidy?

3. Why has the consultation relied on public claims such as medicines are twice as expensive without disclosing basket definitions, VAT treatment, dates and wholesale acquisition costs?

4. How will the Authority ensure equality of arms for independent practices in future procedural stages, including access to evidence on a collective basis?

Conclusion

The provisional remedies and communications invert the CMA purpose. They transfer value from independents to integrated corporate channels, reduce clinical capacity and weaken local access to care.

In [redacted] the predictable outcome is the removal of the only independent provider and the creation of a one hundred percent corporate market. That is not consumer protection; it is consolidation endorsed by regulation.

The Authority should realign the remedy package with its original findings by addressing vertical integration, requiring divestiture where monopoly exists and calibrating all obligations to business scale. Public messaging should be corrected to remove selective claims and to reflect supply chain realities. Only then will the process promote true competition for the benefit of consumers.