RESPONSE TO CMA CONSULTATION

The Veterinary Services Market Investigation Order 2026 (draft Substantive Order)

Submitted by: [redacted]

3 August 2026 | Consultation closes 20 August 2026

Introduction

This response answers the CMA's invitation, in its consultation on the draft Substantive Order, to comment on whether the drafting is consistent with the Final Report of 24 March 2026 and whether it achieves the aims of the remedies package set out in it.

I focus on four areas. First, a gap in how the Order delivers transparency of ownership as between first opinion practices (FOPs) and online pharmacies. Second, prescription-related messaging that I believe functions as compelled advertising for a single supply channel and risks undermining, rather than protecting, competition in medicine supply. Third, several remedies which I believe risk being counterproductive, because complying with them as drafted will generate costs that are inevitably passed back to the client – working against the aims the remedies are meant to serve. Fourth, a structural gap between the Order's assumption of a fixed consulting premises and the reality of ambulatory veterinary businesses – those delivering primary care at a client's home, yard or other location rather than from a static practice building – whose clients risk receiving systematically less of the intended consumer protection for reasons unconnected to the underlying aims. I give specific examples throughout.

Part 1: The Order does not deliver transparency of pharmacy ownership at the point it matters

The Final Report's remedies package identifies "transparency of the ownership of Veterinary Businesses" (aim (a)(i)) and "increased awareness of the ability to purchase medicines online and potential savings" (aim (a)(iv)) as distinct but related aims. Read together, they are meant to let a pet owner make an informed choice about where to buy medicine, including an informed view of who actually owns the business making the recommendation and the business receiving the resulting sale.

Article 5 (Ownership Information) is the mechanism intended to deliver aim (a)(i). It defines 'the supply of medicine products online' as an 'Other Relevant Service' (Article 5(1)(b)(iii)), and requires that wherever a Main Entity has Ownership, Control or Influence over both an FOP and an online pharmacy as part of a Group or Network, that Main Entity's name must appear Clear and Prominent on the pharmacy's website – on the homepage, in metadata, and in search results (Article 5(2)-(4)) – at equal prominence to the pharmacy's own trading name.

In principle this addresses the exact problem the Final Report identified: online pharmacies that appear independent but share ownership with large FOP groups. In practice, I believe the mechanism fails to deliver the aim for three specific reasons.

First, Article 5 only applies once a Main Entity with Ownership, Control or Influence can be established under the Order's own definitions (Article 2(1), 'Ownership and Control Factors' and 'Influence Factors'). A shareholding structured just below the thresholds in those definitions – for example, a minority stake accompanied by supply, branding or financing arrangements that fall short of the specific factors listed – would place a commonly-linked pharmacy outside the disclosure duty altogether, even though the underlying competitive relationship is the same one the remedy is meant to address.

Second, and more importantly, the consumer-facing mechanism that is actually meant to operationalise this aim – the Standard Written Prescription Notice (Schedule 2) and the Standard Flyer for Ongoing Medication (Schedule 3), both required under Article 14 and Article 16 – contains no ownership disclosure at all. Both documents direct the pet owner to "compare prices online" and link generically to the VMD Register of Online Retailers and the RCVS help page. Neither requires the FOP to disclose whether the online retailers a pet owner is being pointed toward share ownership with the FOP itself, or with the Group or Network the FOP belongs to. This means the aim (a)(i) disclosure that Article 5 does create sits on a webpage the pet owner has no particular reason to visit, while the actual point of referral – the poster in the waiting room and the flyer handed over with a repeat prescription – carries none of it.

Third, the VMD Register of Online Retailers is, on the face of this Order, not required to display ownership or parent-company information for any listed retailer. This is the specific resource both Schedule 2 and Schedule 3 signpost pet owners to (via a QR code and a direct weblink) as the trusted source for verifying an 'Authorised Online Pharmacy'. A pet owner acting exactly as the Order intends – checking the Register before buying – still cannot see common ownership there.

The practical effect, in my view, is that the aim is delivered on paper – Article 5 exists – but not in substance at the moment a purchasing decision is actually made.

I would also note that this gap places an asymmetric burden on FOPs specifically, which is directly relevant to later parts of this response: the FOP bears the full cost of prominent, itemised, repeatedly-refreshed disclosure obligations under Articles 5, 7, 14 and 16, while actively directing the client toward a supplier that, in a meaningful proportion of cases, bears none of the equivalent disclosure cost and may be under the same ultimate ownership. The FOP absorbs the compliance cost of transparency; the online pharmacy that may benefit competitively from any resulting sale does not.

Part 2: The prescription-related messaging functions as compelled advertising for one supply channel, and risks undermining rather than protecting competitive medicine supply

Aim (a)(iv) is to increase pet owners' awareness of their ability to purchase medicines online and of potential savings. I support that aim. My concern is with how Article 14 operationalises it, in particular through the Invoice and Receipt Notification.

Article 14(12)-(14) requires every invoice or receipt on which a medication is sold to carry the statement: 'Written prescriptions are available upon request. At this practice, the cost of a written prescription for the first medicine prescribed within a consultation is £[prescription fee price]. You may be able to buy medicines significantly cheaper online. Compare prices online and at third-party retailers to see the savings you might make.' This must appear 'in the same font and no smaller than the main text used for the invoice or receipt'

(Article 14(14)) – it is not a footnote, but a required, full-prominence statement repeated on every single transaction in which a business sells medicine.

There is a difference between informing a pet owner of a right and requiring a business to advertise, at full prominence and on every sale, that a competitor's product is likely to be cheaper than its own. The drafting does the latter. It also embeds, as a blanket statement applied identically to every FOP regardless of its own pricing, an assumption that FOPs cannot or do not price medicines competitively against online retailers. That is not true in every case: a number of businesses price medicines competitively as a matter of policy, and a mandatory statement telling their clients otherwise, on every receipt, is not accurate information – it is compelled promotion of an alternative supplier, regardless of whether that alternative is actually cheaper for the specific product in question.

This matters for the competition aim itself, not only for individual businesses. A remedies package that requires every FOP, on every transaction, to actively promote an unspecified 'online' alternative risks steering medicine supply toward that channel structurally, independent of whether it is actually the more competitive option in a given case. Combined with the ownership-transparency gap described in Part 1 – under which a pet owner directed 'online' has no way of knowing whether the retailer they land on shares ownership with a large FOP group – the practical effect may be to concentrate medicine supply further in the hands of the largest, often vertically-integrated operators, which is the opposite of the outcome the Final Report's competition aims are meant to protect.

The businesses least able to absorb this are smaller and independent FOPs, which typically rely on medicine supply margin to a greater extent than large groups with multiple revenue lines, and which are simultaneously carrying the compliance costs described in Part 3 of this response. A business required to actively discourage its own clients from buying medicine from it, while also absorbing rising compliance costs elsewhere, has a limited number of ways to remain viable, and the most likely response is to recover the shortfall through fees that are not subject to the same price-transparency and fee-cap requirements, such as consultation fees. That outcome is less transparent to the client than the position today, not more, and it is the smaller, independent end of the market – rather than the large, often vertically-integrated groups the Final Report's remedies were principally concerned with – that is pushed hardest toward it.

I recommend more moderate, neutral language: a statement of the pet owner's right to request a written prescription and to purchase medication from a supplier of their choice, without a mandatory comparative price claim repeated at full prominence on every transaction. This would preserve the informational aim in (a)(iv) without functioning as compelled advertising for a single channel, and without assuming, incorrectly in some cases, that the FOP itself cannot compete on price.

Part 3: Several remedies risk being counterproductive because their compliance cost is passed back to the client

The Final Report's remedies are framed around empowering pet owners and removing barriers to competition. Several of the mechanisms chosen to deliver those aims, as currently drafted, impose a compliance cost that a business – particularly a small or newly-established one without existing administrative infrastructure – has no way to absorb except by building it into the price the client pays. Where that happens, the remedy works against its own stated aim rather than for it. I give four specific examples.

Example 1: Written estimates for higher-cost treatments (Article 11) risk producing worse information, not better – aim (a)(iii)

Article 11 requires a Written Estimate wherever a Treatment Pathway is reasonably likely to meet or exceed the Monetary Threshold (£500 inc. VAT initially) and more than 20% of that cost relates to future or uncertain spend. The estimate must be "as accurate and specific as reasonably possible" (Article 11(4)) and must, in any case, be provided no later than the end of the Working Day following the day it was recommended (Article 11(7)(b)).

These two requirements pull against each other in practice. Where a Treatment Pathway involves Referral Services, Article 11(6) requires the FOP to estimate the referral cost while only being able to advise the pet owner to confirm the actual price with the referral provider – because the FOP does not set that price, and referral centres are not always quick to quote. A business facing the choice between missing the statutory deadline and sending a fast, deliberately padded 'worst case' figure to stay compliant will rationally choose the latter. That is less accurate pricing information reaching the client, not more – the opposite of aim (a)(iii). Avoiding this outcome requires the FOP to build dedicated administrative capacity – staff time, or a costed-pathway system integrated with billing – purely to meet the clock; for a business without an existing back office, that capacity is a direct new cost, recovered only through the price of treatment.

Example 2: Prescription fee caps (Article 18) risk a hidden cross-subsidy that undermines aim (b)(ii)

The Initial Primary Prescription Fee Cap is set at a placeholder £21 inclusive of VAT, and the Initial Additional Prescription Fee Cap at £12.50 inclusive of VAT (Article 2(1), 'Initial Primary/Additional Prescription Fee Cap', both subject to inflation adjustment before the Order is made). Article 18(1) prohibits charging more than this for a compliant Written Prescription.

If the real cost of issuing a compliant prescription – professional time to prepare it, the administrative process of producing a paper or digital copy within the turnaround times set by Article 15, and associated record-keeping – exceeds the capped fee, a business has two options: absorb the shortfall as a loss on every prescription issued, or recover it by raising fees elsewhere across its client base, including clients who never request a prescription at all. Either outcome is a cost pass-through; the second is a cross-subsidy that is considerably less transparent to the client than the fee it replaces. A cap that sits below the real cost of compliant delivery does not make a written prescription "easier to get and use" (aim (b)(ii)) – it simply moves the cost of providing one somewhere less visible.

Example 3: Ongoing price-list synchronisation duties (Articles 7 and 8) create a recurring compliance cost with no compensating revenue

Article 7(5) requires a business to update its published Price List before any revised price is charged to a client; Article 8(2)(b) imposes the same duty for the Parasiticide Price List specifically. In practice, a wholesale price increase on a common medicine or consumable requires the business to update its published, itemised online price list – potentially across every affected FOP or webpage it operates – before the new price can be charged at the till, on pain of non-compliance. For a business without a system that links supplier pricing directly to the published price list, this either requires manual double-checking on every supplier price change (a recurring staff-time cost) or a subscription to software that can do so automatically (a recurring software cost). Neither is compensated for elsewhere in the Order; both are, again, ultimately recovered through client-facing pricing.

Example 4: Mandated physical-format disclosure (Schedules 2 and 3) imposes a recurring printing cost, and is inconsistent with the Order's own approach elsewhere

Article 14(6)-(9) requires the Standard Written Prescription Notice to be displayed as a physical A2 poster and A3 notices, replaced within one Month of any update the CMA or RCVS issues 'from time to time'. Article 16(1)-(2) requires the Standard Flyer for Ongoing Medication to be given 'along with the medication, in the form of a physical A5 flyer' as the primary method, with email available only 'if the Pet Owner requests' it.

This is a recurring cost with no stated end point: every future revision to either template requires every affected business to reprint and redistribute physical materials, at its own expense, indefinitely, rather than a sustainable digital-first alternative. It also sits oddly against the approach the Order takes elsewhere. Article 4(8) establishes a sensible, lower-cost default for other Part 2 disclosures: digital provision is acceptable so long as a physical copy is made available on request. Articles 14 and 16 reverse that default for prescription-related disclosure specifically, requiring physical distribution as the primary method and treating digital as the exception a pet owner must actively request. I do not see a reason, connected to the aims in the Final Report, for prescription-related disclosure to be treated differently from every other disclosure duty in the Order.

I recommend Articles 14 and 16 be brought into line with Article 4(8)'s approach: digital as the default method, with a physical copy provided promptly on request.

Part 4: The drafting does not provide a workable equivalent for ambulatory veterinary businesses

A significant part of the sector operates without a fixed consulting premises: home-visit and mobile veterinary businesses that deliver primary care at a client's home, yard or other location rather than from a static practice building. The Order's own definition of 'First Opinion Practice' at Article 2(1) recognises this directly. Where a FOP does not operate 'from a site or physical premises', the definition instead treats it as 'the set of mobile facilities and equipment a Veterinary Business uses', and its parenthetical provides that 'any requirements in this Order which refer to actions being taken upon a physical premises do not apply to that FOP'.

The difficulty is that this is a disapplication, not a substitute. Where a requirement's only delivery mechanism is physical – a poster in a waiting room, signage in a reception, a notice fixed to a consulting-room wall – the Order simply switches the obligation off for ambulatory businesses rather than replacing it with an equivalent. The practical effect is that clients of ambulatory FOPs receive systematically less of the consumer protection the remedies package is meant to deliver than clients of fixed-premises FOPs, for reasons unconnected to the underlying aim. I give four examples.

Article 14(6)-(7): the Standard Written Prescription Notice must be displayed as an A2 poster in 'the waiting room area(s) or, where a FOP has no waiting area, the reception area(s)', and as an A3 notice in 'each consulting room'. An ambulatory FOP has none of these three spaces. The Order's own fallback only accounts for the absence of one of them – no waiting area, use the reception – and does not contemplate the absence of any fixed location at all. An ambulatory business is left with nothing to display, and, per Article 2(1), is simply excused from the obligation altogether. Its clients are the one group of pet owners who receive no equivalent of the single most visible disclosure in the entire prescription-awareness remedy.

Article 5(6): Ownership Information must be displayed ‘at the premises of each FOP… including… storefront signage’. An ambulatory FOP has no storefront and no fixed premises to affix signage to, so this limb of the ownership-transparency remedy described in Part 1 above simply does not reach its clients at all.

Article 21(3)(c) and (i): the in-house complaints process and the Decision Tree must each be displayed as ‘signage in the FOP’s… reception’. An ambulatory FOP has no reception in which to place it.

Articles 7(3)(b), 8(1)(b) and 9(1)(b): the Price List, the Parasiticide Price List and the Pet Care Plan Standard Information must each be made available ‘at the premises of each FOP’. An ambulatory FOP has no premises at which to do so.

Article 4(4) does list posters, leaflets, noticeboards and digital screens as acceptable media, and Article 4(8) requires a paper copy on request where information is provided digitally – useful flexibility, but neither addresses the specific size and location instructions (A2/A3, waiting room, consulting room, reception, storefront) that recur through the substantive Articles, nor gives an ambulatory business anything to substitute for them. Being told a requirement ‘does not apply’ is not the same as the underlying aim being met by some other means; in these cases, it simply is not met.

Taken together

Each part of this response describes a related failure mode. Part 2 shows a specific disclosure mechanism operating as compelled promotion of a competing channel rather than neutral information, in a way that may concentrate rather than diversify medicine supply over time. Part 3 shows remedies whose compliance cost, once incurred, has nowhere to go but the client's bill. Part 4 shows requirements that, for a defined and significant part of the sector, cannot be complied with in their current physical form at all, and are simply disapplied rather than replaced – leaving that part of the sector's clients with less protection, not equivalent protection delivered differently. Combined with the ownership-transparency gap described in Part 1, the net effect risks being that fixed-premises FOPs carry an increasing, itemised compliance burden that shows up in their prices while being required to actively steer clients toward a channel that may be commonly owned with their larger competitors, and that a comparable population of ambulatory FOPs and their clients receive little of the intended benefit at all. None of these outcomes matches the aims set out in the Final Report, and the businesses least able to absorb the resulting pressure are the smaller and independent ones the wider remedies package is, in significant part, meant to protect.

Recommendations

1. Require the VMD Register of Online Retailers to display ultimate/Main Entity ownership for every listed retailer, and require online pharmacies to self-certify ownership on application and renewal.

2. Add a standard disclosure line to Schedule 2, Schedule 3 and the RCVS Written Prescription Literature, noting that some online pharmacies share ownership with veterinary practice groups.

3. Replace the mandatory comparative price claim in the Invoice and Receipt Notification with more moderate, neutral language stating the pet owner's right to request a written prescription and purchase medication from a supplier of their choice, rather than a claim that online supply is likely to be cheaper, applied identically regardless of an individual business's own pricing.

4. Adjust Article 11’s estimate deadline to accommodate cases genuinely dependent on a third-party referral centre quote, so that businesses are not forced to choose between missing the deadline and reducing the accuracy of the estimate provided.

5. Review the Initial Primary and Additional Prescription Fee Caps against the real cost of compliant delivery – professional time, record-keeping, turnaround requirements – before the Order is made, to avoid an unintended cross-subsidy.

6. Consider a transitional or de minimis allowance for the price-list synchronisation duties in Articles 7 and 8 for businesses below a specified size, reflecting the disproportionate cost of real-time compliance for those without existing back-office systems.

7. Bring Articles 14 and 16 into line with Article 4(8)'s approach elsewhere in the Order: digital as the default method for prescription-related disclosure, with a physical copy provided promptly on request, to avoid an open-ended printing cost with no sustainability rationale.

8. Build a specific ambulatory-equivalent delivery mechanism into the Order itself for every requirement currently delivered only via fixed signage – for example, a mandatory verbal disclosure at first consultation, inclusion of the full notice text in booking confirmations and invoices, and a recognised durable digital equivalent – so that Article 2(1)'s disapplication does not, in practice, leave ambulatory clients with no equivalent protection at all.

9. Clarify that the disapplication in Article 2(1) is intended as a placeholder pending a substitute obligation, not a permanent exemption, and consult specifically on what that substitute should be for each affected Article (5, 7, 8, 9, 14 and 21).