Competition and Markets Authority

Veterinary Services Market Investigation

Response to the Consultation on the Draft Order and Supporting Documents

Submitted by:

[redacted]

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Documents Addressed

This response provides comments on the following consultation documents:

- Draft substantive Order
- Draft Schedule 1 – Price List Schedule
- Draft Schedule 2 – Standard Written Prescription Notice
- Draft Schedule 3 – Standard Flyer for Ongoing Medication
- Draft Explanatory Note
- Draft Annex 1 – Indicative Price List
- RCVS Monitoring Proposal

Scope of this Response

This submission responds to the Competition and Markets Authority's consultation on the drafting and implementation of the proposed remedies following the Veterinary Services Market Investigation.

It addresses whether aspects of the draft Order and supporting documents:

- are consistent with the decisions set out in the Final Report;
- achieve the intended objectives of the remedies; and
- represent a proportionate and practical means of implementation within first opinion veterinary practice.

This response does **not** revisit the Competition and Markets Authority's findings of an adverse effect on competition or the decision to introduce remedies. Instead, it focuses on the practical implementation of those remedies, with particular consideration of proportionality, operational feasibility, digital infrastructure and the delivery of clinical care.

1. Executive Summary

This response relates to the implementation of the draft Veterinary Services Market Investigation Order. It does not challenge the Inquiry Group's findings or the objectives of the proposed remedies. Greater transparency, informed consumer choice and effective competition are legitimate aims that should benefit both consumers and the veterinary profession.

The concern is whether the draft Order, as currently implemented, represents a proportionate means of achieving those aims. Individually, many of the proposed requirements appear reasonable. Collectively, however, they introduce a level of administrative and operational burden that, in my view, has been underestimated.

The central concern underpinning this response is that the draft implementation underestimates the value of clinical time.

Veterinary consultations are a finite resource. Every additional mandatory discussion, explanation or administrative process competes with time available for clinical assessment, diagnosis, treatment planning and communication with clients. Where additional time cannot be created, practices must either absorb these requirements within existing appointments or recover the resulting costs elsewhere.

The practical consequences are likely to extend beyond medicines. Reduced consultation capacity, higher operating costs and increased administrative demands may ultimately affect consumer access to veterinary services, the cost of professional care and the quality of the clinical interaction. These effects are likely to be felt most acutely by smaller independent practices, where implementation responsibilities cannot easily be distributed across dedicated management or compliance teams.

The draft Order also assumes a level of digital capability and interoperability that is not yet consistently available across the profession. In several areas, responsibility for overcoming limitations in existing systems appears to fall upon individual veterinary practices despite those practices having little influence over the underlying infrastructure.

This response considers the draft Order from the perspective of its practical implementation within first opinion veterinary practice. It examines whether the proposed measures are likely to achieve the CMA's stated objectives once applied in day-to-day clinical settings and identifies areas where unintended consequences may arise. Where appropriate, practical amendments are suggested that would reduce those consequences whilst remaining consistent with the objectives of the market investigation.

2. About the Respondent

I am a practising veterinary surgeon with over 30 years' experience in first opinion small animal practice, having qualified from the Royal Veterinary College in 1996. Alongside clinical practice, I have held senior regulatory, governance and professional conduct roles within the veterinary profession, the NHS and the financial sector. My experience includes serving as an RCVS Case Examiner, sitting on professional conduct committees, chairing fitness to practise panels, acting as a member of the ICAEW Conduct Committee and holding non-executive director positions within the NHS. I have also worked within the pharmaceutical industry as a technical advisor and acted as an expert witness.

Collectively, these roles have provided experience of regulatory frameworks across several professions and regulated markets, including veterinary practice, healthcare and financial services. They have required me to consider not only whether regulation achieves its intended objectives, but whether it is proportionate, evidence-based and capable of practical implementation. That perspective has informed this response.

I own and operate Neighbourhood Vet, an independent first opinion small animal practice in Gosport, Hampshire. The practice provides approximately 1.8 full-time equivalent veterinary capacity. As both owner and practising clinician, I am responsible for delivering clinical care whilst also managing regulatory compliance, governance, finance, information technology, supplier relationships, human resources and implementation of regulatory change. Unlike practices operating within larger veterinary groups, these functions are undertaken within the practice rather than supported by centralised corporate teams.

The practice serves clients from communities spanning a broad socioeconomic spectrum, including neighbourhoods experiencing significant socioeconomic deprivation. Affordability and access to veterinary care are therefore practical considerations in day-to-day clinical and business decision-making, providing direct experience of balancing high clinical standards with financial sustainability and accessible pricing.

The observations contained within this response are informed by both professional experience and objective operational data extracted from the practice management system. Where operational evidence is presented, it is intended to illustrate how the proposed measures are likely to operate in everyday clinical practice rather than describe the circumstances of a single business in isolation.

My assessment is informed by three complementary perspectives:

- as a practising veterinary surgeon delivering front-line clinical care;
- as the owner of an independent veterinary practice responsible for implementing regulatory change; and
- through experience of professional regulation and governance across the veterinary, healthcare and financial sectors.

It is from those combined perspectives that I have assessed the draft Order.

3. The Market Investigation: Objectives and Intended Outcomes

The purpose of this response is not to revisit the findings of the Competition and Markets Authority's Market Investigation into veterinary services. The Inquiry Group concluded that features of the market give rise to an adverse effect on competition and that regulatory intervention is required. This consultation concerns how those remedies should be implemented through the draft Veterinary Services Market Investigation Order.

The question is therefore not whether the CMA's objectives are appropriate, but whether the draft Order represents the most proportionate means of achieving them.

The Market Investigation identified concerns relating to transparency, consumer information and competition. The proposed remedies are intended to:

- improve transparency of veterinary pricing and medicine costs;
- help pet owners make better informed decisions;
- make it easier for clients to obtain and use written prescriptions;
- increase awareness of alternative medicine suppliers;
- improve complaints handling and consumer redress; and
- strengthen competition where the Inquiry Group concluded it could be improved.

These are legitimate objectives. Better informed consumers, greater transparency and effective competition should improve the way the market operates if they can be achieved without creating unnecessary burdens elsewhere.

The Inquiry Group did not conclude that veterinary clinical care itself was failing. Its concerns related to how the market functions rather than the quality of clinical decision-making. That distinction is fundamental. The proposed remedies are intended to improve the operation of the market whilst maintaining the delivery of veterinary care. If the implementation of those remedies diverts clinical time, reduces consultation capacity or creates operational pressures that affect the delivery of care, then the implementation risks compromising an aspect of veterinary practice that the Inquiry Group did not identify as being deficient.

Nothing in this response should be taken as opposition to the objectives of the Market Investigation. The concern is that the draft implementation may create unintended consequences which, if left unaddressed, risk compromising the delivery of veterinary care whilst offering limited additional consumer benefit.

This consultation does not invite respondents to reopen the findings of the Market Investigation. Instead, it asks whether the draft Order gives proper effect to those findings and whether the proposed implementation is appropriate. That is the approach taken throughout this response.

Accordingly, this response considers whether the draft implementation is likely to achieve the CMA's objectives once applied in everyday veterinary practice. It examines not only the intended benefits for consumers, but also the foreseeable consequences for clinical delivery, practice operations and accessibility. Where unintended consequences are identified, practical alternatives or amendments are suggested that would better achieve the Inquiry Group's objectives whilst reducing unnecessary burden.

The next section considers the wider context in which the draft Order will operate. Consultations, prescribing, medicine supply, practice software, staffing and practice finances are closely linked. As demonstrated in the following analysis, changes to one part of this system have consequences for the others. The draft Order should therefore be assessed as a whole rather than as a series of individual measures considered in isolation.

4. The Veterinary Care Pathway: Clinical Time as a Finite Resource

4.1 The Consultation as a Finite Clinical Resource

The draft Order regulates the behaviour of individual veterinary practices. However, veterinary practices do not operate in isolation. They form part of a wider clinical, regulatory and commercial system in which changes to one component influence the others. It is therefore important to consider the practical environment within which the proposed remedies will operate.

Unlike many retail markets, veterinary medicine is fundamentally a professional healthcare service. The consultation is the central component of that service. It is during the consultation that the veterinary surgeon obtains the patient's history, performs a clinical examination, develops differential diagnoses, recommends further investigation where appropriate, discusses treatment options, obtains informed consent and, where necessary, prescribes medicines. Medicine supply is therefore only one element within a much broader episode of clinical care.

The draft Order regulates the way information is communicated during veterinary consultations. In doing so, it regulates not only the information itself, but also the clinical time required to communicate it. Clinical time is not an unlimited administrative resource. It is the same finite resource used to examine patients, explain diagnoses, obtain informed consent, discuss treatment options and answer owners' questions. Every additional regulatory requirement introduced into a consultation therefore competes for time that would otherwise be available for clinical care. As demonstrated in the following analysis, changes to one part of this system have consequences throughout the wider veterinary care pathway, affecting practice capacity, accessibility and the delivery of veterinary services.

My practice provides standard 15-minute consultations. This duration has been selected to balance clinical quality, appointment availability and affordability for the local population. It allows sufficient time for the majority of first opinion consultations whilst maintaining access to veterinary care in an area where financial constraints are a frequent consideration for clients.

That balance is necessarily delicate.

The duration of a consultation cannot simply be extended without consequence. Increasing the standard consultation from 15 to 20 minutes would reduce appointment capacity by approximately 25% unless additional veterinary resource were employed. Additional veterinary capacity increases the cost of delivering care and those costs must ultimately be recovered through professional fees. Alternatively, maintaining existing consultation lengths requires additional activity to be absorbed within the same fixed period, reducing the proportion of time available for direct clinical care. There is no third option.

The consultation is therefore the principal limiting resource within first opinion veterinary practice.

Throughout this response, the term **clinical opportunity cost** is used to describe the displacement of time, professional attention and clinical judgement away from direct patient

care as a consequence of regulatory requirements. This concept provides the analytical framework against which the practical impact of the draft Order is assessed.

The finite nature of consultation capacity is illustrated by objective operational data from my own practice. During a recent three-month period, I undertook 550 standard consultations scheduled within 15-minute appointment slots. The median consultation duration was 12.8 minutes. Overall, 56.2% of consultations were completed within the allocated consultation time, 71.9% within 20 minutes and 7.7% exceeded 30 minutes.

These findings should not be interpreted as a benchmark for clinical performance. Consultation duration is influenced by case complexity, client communication, clinical uncertainty and the individual needs of each patient. This variability is further illustrated by data from a second veterinary surgeon within the same practice. Over the same period, 438 standard consultations had a median duration of 22.6 minutes, with 20.3% completed within 15 minutes, 37.2% within 20 minutes and 19.5% exceeding 30 minutes. Both veterinary surgeons worked within the same practice, appointment structure and regulatory framework, yet consultation duration differed markedly.

The significance of these data is not that one consulting style is preferable to another. Rather, they demonstrate that consultation duration is inherently variable, reflecting differences in case mix, communication, consulting style and clinical judgement. Additional mandatory communications and administrative tasks are therefore not introduced into spare consultation capacity. They are introduced into a workflow in which time is already a constrained and highly variable clinical resource.

4.2 Capacity, Access and Opportunity Cost

Clinical time is not consumed in isolation. Every minute devoted to one consultation is unavailable to another patient. The practical effect of introducing additional mandatory activities into consultations therefore extends beyond the individual client receiving that information.

A veterinary practice has only a finite amount of clinical capacity available each day. If consultations become longer, fewer appointments can be offered unless additional veterinary resource is employed. Increasing clinical capacity increases the cost of providing the service. Maintaining existing capacity requires additional work to be absorbed within the same consultation. In practice, those are the available options.

This relationship is important because capacity, accessibility and affordability are closely connected. A reduction in appointment capacity is likely to result in longer waiting times, increased costs or reduced availability of appointments. The effects are therefore experienced not only by the client involved in a particular consultation, but across the wider client population.

Throughout this response, I use the term **clinical opportunity cost** to describe the displacement of clinical time, professional attention and judgement away from direct patient care. The relevant question is not simply whether a proposed requirement takes additional time, but what that time would otherwise have been used for and whether the resulting consumer benefit justifies its displacement.

The same principle applies beyond the consultation itself. The draft Order introduces obligations that require planning, implementation, staff training, monitoring and ongoing administration. Those activities are undertaken by the same people responsible for delivering veterinary care.

In larger organisations, elements of that work may be undertaken by dedicated teams responsible for information technology, compliance, communications or project management. Within my practice, those responsibilities rest with me. Time spent implementing regulatory change is therefore time unavailable for consulting, surgery, business management, staff development or other activities necessary to maintain the practice.

This is relevant not because independent practices should be exempt from regulation, but because proportionality cannot be assessed without considering the resources required to implement it. The practical impact of the same regulatory obligation will inevitably differ according to the structure and resources of the organisation expected to deliver it.

4.3 The Wider Veterinary Care Pathway

The Market Investigation considered competition across veterinary services as a whole. Medicine supply formed one element of that wider assessment alongside clinical care, pricing, transparency, referrals and consumer information. The draft Order, however, places a substantial proportion of its most prescriptive operational requirements on prescribing and medicine supply.

This distinction is important because medicines represent only one component of a typical episode of veterinary care. Many consultations do not result in a prescription at all. Others derive most of their value from clinical examination, diagnosis, interpretation of diagnostic tests, treatment planning, preventive healthcare, surgery, nursing care or ongoing case management. Even where medicines are prescribed, the prescribing decision is only one part of the wider professional service being provided.

The value delivered during a veterinary consultation therefore extends well beyond the supply of medicines. Clients attend because they require professional expertise to diagnose disease, assess risk, explain treatment options and support decision-making. Medicines are one possible outcome of that process, not its purpose.

This distinction is relevant when considering proportionality. A regulatory framework that places substantial operational emphasis on medicines inevitably consumes clinical time within consultations whose primary purpose is the delivery of healthcare. The cumulative effect should therefore be assessed in the context of the whole veterinary care pathway rather than medicine supply in isolation.

The veterinary care pathway should therefore be considered as an integrated whole. Clinical assessment, diagnosis, prescribing, client communication, treatment and follow-up are not independent activities but interconnected elements of a single episode of care. Changes affecting one part of that pathway inevitably influence the others. The practical implications of that relationship provide the context for assessing whether the measures proposed within the draft Order represent a proportionate means of achieving the CMA’s objectives.

5. Structural Asymmetry in the Veterinary Medicines Pathway

5.1 The Integrated Clinical Pathway

The remedies relating to written prescriptions and medicine supply are intended to strengthen competition by enabling consumers to obtain prescribed medicines from alternative suppliers where they choose to do so. Improving consumer choice and facilitating price comparison are legitimate policy objectives. The purpose of this section is not to argue against those objectives, but to consider whether the practical implementation of the proposed remedies appropriately reflects the structure of the veterinary medicines pathway and the consequences of separating activities that are currently delivered within an integrated clinical service.

Whilst the Market Investigation considered competition across the veterinary services market as a whole, the practical emphasis of the draft Order is upon facilitating competition in the downstream supply of prescribed medicines. Consumers are encouraged to compare medicines supplied by prescribing veterinary practices with those supplied by third-party dispensers. Although these markets are closely related, they comprise participants performing materially different legal, professional and commercial functions. Comparisons between them should therefore be interpreted with appropriate caution.

The veterinary medicines pathway is not a conventional retail market. It is an integrated healthcare process comprising clinical assessment, diagnosis, prescribing, medicine supply and ongoing clinical management. Although medicine supply may be undertaken by different organisations, responsibility for the clinical decision to prescribe remains with the veterinary surgeon.

This distinction is reflected in the regulatory framework. A veterinary surgeon may prescribe a POM-V medicine only where the animal is under their care following an appropriate clinical assessment. The prescribing veterinary surgeon remains professionally accountable for that prescribing decision irrespective of where the medicine is ultimately dispensed. Third-party dispensers, whether community pharmacies or internet retailers, lawfully supply medicines against that prescription but do not assume responsibility for the underlying clinical assessment, diagnosis or prescribing judgement.

The participants therefore perform complementary rather than equivalent functions within the veterinary medicines pathway.

This distinction has important commercial consequences.

5.2 Economics of integrated care

Veterinary practices incur the costs associated with providing integrated clinical care. These include consultation facilities, diagnostic equipment, surgical infrastructure, emergency medicines, inpatient care, professional staffing, clinical governance, continuing professional development, regulatory compliance and professional indemnity. These costs are incurred before any medicine is dispensed and remain substantially unchanged irrespective of whether medicines are supplied by the practice or by a third-party dispenser.

Revenue generated from medicine supply therefore contributes to the overall financial sustainability of delivering clinical services alongside consultation fees, diagnostic procedures and other professional services. Medicine supply forms one component of an integrated healthcare service rather than an isolated retail activity.

The procurement of veterinary medicines is similarly characterised by structural differences. Under the Veterinary Medicines Regulations, authorised retailers may obtain veterinary medicines from authorised manufacturers or holders of a Wholesale Dealer's Authorisation. The legislation does not prescribe a single procurement route.

In practice, however, procurement opportunities vary considerably according to the nature and scale of the organisation. Independent veterinary practices commonly purchase medicines through veterinary wholesalers, reflecting commercial realities including purchasing volumes, access to products from multiple manufacturers, stock availability, consolidated logistics and credit arrangements. Larger third-party dispensers may operate under procurement models that are not routinely available to smaller independent practices, including direct supply agreements with manufacturers, substantially greater purchasing volumes, centralised distribution and higher stock turnover. Other dispensers may continue to purchase through wholesalers or adopt mixed procurement models. The important point is not that one procurement model is preferable to another, but that medicines are not necessarily acquired under equivalent commercial conditions.

Differences in retail prices may therefore arise from legitimate differences in procurement arrangements, purchasing power, inventory management and economies of scale rather than from ineffective competition within the veterinary services market. Accordingly, comparing the retail price of an individual medicine supplied by a veterinary practice with that supplied by a third-party dispenser is not a comparison between directly comparable economic activities. One organisation is recovering the costs associated with delivering an integrated episode of healthcare; the other is primarily supplying medicines prescribed by another professional.

5.3 Organisational Interfaces and Transaction Costs

The separation of prescribing from dispensing also fundamentally changes the operational characteristics of the medicines pathway. Where medicines are dispensed by the prescribing practice, prescribing, dispensing, record keeping and clinical oversight are largely completed within a single organisation using a single clinical record. Where medicines are supplied elsewhere, activities that previously formed part of an internal clinical workflow become transactions between independent organisations operating under different systems, commercial priorities and regulatory responsibilities.

This structural change creates additional interfaces throughout the prescribing process. Prescriptions must be generated, transferred, verified and retained. However, in my experience, the process frequently continues after the prescription has left the practice. Clients may return because the chosen supplier is unable to source the prescribed medicine, stocks only an alternative product, requests clarification of the prescription or requires amendments before dispensing can proceed. Supply shortages, discontinued products, unavailable pack sizes and requests for clinically appropriate alternatives may similarly require further professional review before dispensing.

Practices also encounter situations in which third-party dispensers request amendments to prescriptions, seek additional information or ask that prescriptions be reissued in a format compatible with their own dispensing processes. Whether these requests arise from legal requirements, internal operating procedures or system limitations is largely immaterial from the perspective of implementation. They nevertheless require further professional and administrative input from the prescribing practice before medicines can be supplied.

These interactions consume professional and administrative resource despite no additional episode of clinical care taking place. The veterinary surgeon retains responsibility for the prescribing decision whilst the practice must continue supporting a dispensing process that now extends beyond its own systems and control. Much of the associated administrative burden falls upon the prescribing practice because it remains responsible for issuing, amending and clinically reviewing prescriptions whilst retaining professional accountability for the prescribing decision.

Importantly, these transaction costs should not be viewed as failures of implementation. Many arise despite both the veterinary practice and the third-party dispenser acting entirely appropriately. A pharmacy may legitimately be unable to source a particular product, identify an issue requiring clarification before dispensing or require discussion regarding an appropriate clinically equivalent alternative. Equally, a client may decide to change supplier after a prescription has been issued. These are foreseeable consequences of introducing additional organisational interfaces into the medicines pathway rather than exceptional events.

The draft Order therefore does not simply facilitate competition; it changes the organisational structure through which medicines are supplied. Activities that previously occurred within a single clinical organisation are redistributed across multiple independent organisations, each operating under different regulatory responsibilities, commercial incentives and information systems. The additional transaction costs arising from those interfaces are therefore an inherent consequence of the proposed model rather than a defect in its implementation.

Those costs may be justified by the consumer benefits arising from increased choice and price transparency. However, they should nevertheless form part of any assessment of proportionality. They also contribute directly to the clinical opportunity costs described in Section 4. Time spent resolving prescription queries, issuing amended prescriptions, responding to dispensing requests or supporting external suppliers is time unavailable for direct patient care.

5.4 Infrastructure and Proportionality

The effectiveness of the proposed remedies also depends upon the infrastructure supporting them. Unlike many areas of human healthcare, there is currently no widely adopted interoperable electronic prescribing infrastructure enabling secure transfer of veterinary prescriptions, automated validation, dispensing confirmation and seamless integration with veterinary practice management systems. Much of the current process therefore remains dependent upon paper documentation, PDF files, email and manual administration.

The absence of interoperable infrastructure does not prevent competition, but it increases the transaction costs associated with exercising consumer choice. Those costs fall disproportionately upon veterinary practices because they retain professional responsibility for

prescribing whilst also undertaking much of the administrative work generated when medicines are dispensed elsewhere.

The draft Order therefore has the potential to redistribute costs within the veterinary care pathway rather than eliminate them. Reduced expenditure on medicines may be accompanied by increased professional fees where practices recover the costs of additional prescribing activity, administration and regulatory compliance through consultation charges rather than medicine supply. Whether this ultimately improves consumer value depends not only upon reductions in medicine prices but upon the overall cost and quality of the episode of care.

This distinction is fundamental to the implementation challenges considered throughout the remainder of this response. The issue is not whether consumers should be free to obtain medicines from alternative suppliers; they should. Rather, the draft Order increasingly promotes competition within the medicines supply chain by comparing participants performing fundamentally different legal, professional and commercial functions. In doing so, it separates activities that are currently integrated within a single clinical pathway and necessarily creates additional administrative interfaces, transaction costs and clinical opportunity costs. Those consequences should be recognised alongside the intended consumer benefits when assessing whether the proposed implementation is proportionate.

6. Digital Infrastructure, Systems Integration and Implementation

6.1 Digital Infrastructure and Interoperability

The practical success of the proposed remedies depends not only upon the legal framework established by the draft Order but also upon the digital infrastructure required to support it. Effective competition depends upon information flowing accurately, efficiently and securely between participants. Where that infrastructure remains fragmented or underdeveloped, implementation costs increase and the intended consumer benefits may be diminished.

The veterinary sector currently lacks a widely adopted interoperable electronic prescribing infrastructure. There is no sector-wide mechanism for creating, transmitting, validating and reconciling electronic veterinary prescriptions across different practice management systems and third-party dispensers. As a consequence, much of the prescribing process continues to rely upon paper documentation, PDF files, email and manual administration.

This limitation extends beyond the prescription itself. The draft Order assumes that information can pass efficiently between veterinary practices, consumers and third-party dispensers. In reality, the process frequently depends upon multiple independent information systems developed for different purposes that do not routinely communicate with one another. Veterinary practice management systems, communications platforms, payment providers and third-party dispensers typically operate independently, requiring information to be transferred manually or re-entered at multiple stages.

The challenge is therefore not simply one of software development but of systems integration. The proposed remedies require multiple independent organisations, operating under different commercial incentives and using different digital platforms, to function as a coordinated prescribing pathway. Achieving that coordination extends beyond modifying individual software applications. It requires cooperation between organisations that neither share common technical standards nor operate under common governance.

This creates practical implementation challenges throughout the prescribing pathway. Prescriptions must be generated, transmitted securely, received, interpreted and verified. Clarifications, amendments and replacement prescriptions frequently require further communication between the dispensing organisation and the prescribing practice. Clinical records must also remain accurate regardless of where medicines are ultimately dispensed. Each additional interface introduces further administrative activity and increases reliance upon manual processes.

The absence of interoperability also limits opportunities for automation. Whilst individual software suppliers may develop functionality to support aspects of the draft Order, many implementation challenges arise at the interfaces between independent systems rather than within any single application. Consequently, changes made by one supplier alone are unlikely to eliminate the need for manual processes unless equivalent functionality exists across the wider prescribing pathway.

6.2 Practical Implementation Experience

My own experience illustrates these practical limitations. In addition to my veterinary qualifications, I am a professional certified software developer and have written middleware to integrate veterinary systems using published application programming interfaces (APIs). This work has involved creating software to automate workflows between independent commercial platforms within my own practice.

Despite having the technical knowledge to undertake this work directly, developing relatively modest workflow automation required substantial technical investigation, iterative development, extensive testing and repeated refinement. Whilst the APIs provided the technical building blocks for integration, they did not themselves provide interoperable workflows. Considerable development was required simply to bridge the gaps between independent systems.

This experience is relevant because it is not representative of the wider profession. Most veterinary surgeons and practice owners do not possess software development expertise and are therefore wholly dependent upon commercial software suppliers to interpret regulatory requirements, design technical solutions, prioritise development work and deploy compliant software. The ability of individual practices to develop local solutions or mitigate implementation burdens independently is therefore likely to be very limited.

The implementation challenges presented by the draft Order are also considerably more complex than those I have encountered. My work has involved integrating systems used within a single practice. The proposed remedies require reliable coordination between multiple independent organisations using different software platforms, operating procedures and commercial priorities. That level of interoperability cannot be achieved by an individual practice acting alone and depends upon coordinated development across multiple software vendors and service providers.

In practice, this means that the pace and effectiveness of implementation will be determined not only by the willingness of veterinary practices to comply, but by the development priorities, technical capabilities and delivery timescales of independent software suppliers. The regulated entity may therefore have only limited control over the speed or manner in which compliance can be achieved.

6.3 Implementation and Proportionality

This dependency has important regulatory implications. Compliance with many aspects of the draft Order will not be determined solely by the actions of veterinary practices. Instead, it will depend upon the development priorities, implementation timescales and technical capabilities of external software suppliers over whom practices exercise little or no control. Smaller independent practices are particularly exposed because they lack dedicated information technology teams and generally have limited influence over commercial product development.

The consultation accompanying the draft Order recognises direct implementation costs, including software development. However, implementation extends beyond software engineering. It includes requirements gathering, workflow redesign, testing, staff training, troubleshooting, supplier coordination and ongoing operational support. These activities

represent significant opportunity costs for practices and are likely to fall disproportionately upon owners and senior clinical staff within smaller organisations.

Implementation should therefore be assessed not only by whether compliance is technically achievable, but by whether the supporting digital infrastructure is sufficiently mature to deliver the intended consumer benefits efficiently and consistently across the sector. Where infrastructure remains fragmented, additional regulatory complexity is likely to increase coordination costs, reinforce the transaction costs described in Section 5 and contribute further to the clinical opportunity costs described in Section 4. These wider implementation costs should form part of any assessment of whether the proposed remedies remain proportionate to the consumer benefits they are intended to achieve.

7. Mandatory Consumer Information and Clinical Communication

Transparency is central to the objectives of the draft Order. Consumers should receive sufficient information to understand their options, make informed decisions and exercise choice where appropriate. These objectives are widely supported across the veterinary profession and have been publicly endorsed by the principal professional and representative bodies. This section considers not whether greater transparency should be achieved, but whether the mechanisms proposed by the draft Order represent the most effective and proportionate means of achieving those objectives.

7.1 Professional Communication within the Clinical Consultation

Veterinary consultations are dynamic clinical interactions. The information exchanged is determined by the patient's presentation, the owner's understanding, clinical findings, diagnostic uncertainty and treatment options. Veterinary surgeons continually adapt both the content and timing of communication according to the individual circumstances of each consultation. Effective communication therefore depends upon tailoring information to the needs of the individual client rather than delivering standardised information at predetermined points within the consultation.

7.2 Prescribing the Architecture of Communication

Rather than specifying only the information consumers should ultimately receive, the draft Order prescribes the architecture of that communication, including its timing, location, wording, prominence, repetition and presentation within the clinical pathway. These features are not merely matters of implementation. They influence how consumers perceive, interpret and respond to information and therefore form part of the substantive regulatory intervention itself. This distinction is important because communication during a veterinary consultation differs fundamentally from communication within a conventional retail transaction.

The draft Order introduces mandatory communications into that interaction. Whilst the information itself may be relatively brief, its practical effect extends beyond the prescribed wording. Information communicated by a trusted professional is naturally likely to prompt questions, discussion and requests for clarification. The time required to answer those questions cannot be standardised because it depends upon the individual client, the clinical circumstances and the complexity of the treatment being discussed.

The principal implementation burden therefore arises not from displaying notices or communicating prescribed wording, but from the additional conversations that those communications are intended to generate. Indeed, if the notices failed to stimulate discussion or improve consumer awareness, they would be unlikely to achieve the objectives of the draft Order. Their effectiveness therefore depends upon precisely the interaction that creates additional demands upon consultation time.

This presents an important issue of proportionality. Veterinary consultation time is a finite clinical resource shared across all patients attending the practice. Additional discussion with one client inevitably reduces the time available for subsequent consultations or requires

practices to extend appointment durations, reduce capacity or recover the associated costs through higher professional fees. The opportunity cost therefore extends beyond the individual consultation in which the discussion occurs.

7.3 Behavioural Design of the Proposed Communications

The proposed communications extend beyond the disclosure of factual information. Their purpose is to increase consumer awareness of alternative purchasing options and encourage consumers to consider exercising those choices. Whilst this is consistent with the objectives of the draft Order, the communication should remain balanced and proportionate. The role of the Order is to facilitate informed consumer choice rather than influence the manner in which that choice is exercised.

The behavioural effect of the proposed communications arises not solely from their wording but from the cumulative impact of several prescribed design features. Official UK Government branding, prescribed wording, prominent placement and repeated presentation throughout the client journey increase the salience and authority of the message. Repeated exposure is recognised to increase familiarity and the perceived importance of a message, whilst the credibility of the source influences how information is interpreted. These features should therefore be regarded as integral components of the regulatory intervention rather than neutral matters of presentation.

The proposed notices are mandatory statutory communications that practices must display prominently and reinforce during consultations. Prominently displayed UK Government-branded notices are commonly associated with matters of public protection, statutory compliance and other regulatory obligations. Whilst the consumer detriment identified by the CMA is of a different nature, the cumulative presentation of the proposed communications may nevertheless convey a level of regulatory concern that exceeds that reflected in the evidence underpinning the Market Investigation. Whether this communication model is proportionate to the detriment identified is therefore a legitimate consideration.

7.4 Presentation and Consumer Interpretation

The visual design of the notice reinforces this concern. Established principles of typography and information design recognise that colour, emphasis and visual hierarchy determine which elements of a message readers notice, remember and act upon. In the draft notice, the phrase **“significantly cheaper online”** is afforded clear visual prominence, whereas the qualifying word **“may”** receives comparatively little emphasis. The dominant message is therefore the prospect of significant financial savings, whilst the uncertainty inherent in that statement becomes visually subordinate.

This distinction is important because the qualification is central to the accuracy of the message. Not all medicines will be significantly cheaper from alternative suppliers and, as discussed in Section 5, a lower medicine price does not necessarily translate into a lower overall cost of veterinary care. By giving substantially greater visual prominence to the potential benefit than to the qualification that limits it, the notice risks creating stronger consumer expectations than are supported by the wider economic context.

Consumers are therefore prominently informed of the possibility of obtaining medicines more cheaply elsewhere without receiving equivalent context that the overall cost of veterinary care

may remain unchanged or, in some circumstances, increase as practices recover prescribing, administrative and regulatory costs through professional fees rather than medicine supply. Communications that repeatedly emphasise potential medicine savings whilst omitting this wider economic context may inadvertently reinforce the perception that medicines supplied by veterinary practices are routinely more expensive than necessary or represent poor value. That inference does not necessarily follow from the evidence considered during the Market Investigation and has the potential to cause reputational harm to practices whose pricing reflects the legitimate costs of delivering integrated clinical care.

7.5 Consequences for Clinical Communication

Trust is fundamental to effective veterinary care. Veterinary surgeons are entrusted to recommend investigations, prescribe medicines and advise on treatment in the best interests of their patients. Communications that inadvertently encourage clients to question the integrity of those recommendations, rather than simply understand the choices available, risk weakening the therapeutic relationship upon which effective clinical decision-making depends.

Several of the proposed communications also invite consumers to consider whether practices have complied with specific regulatory obligations during the consultation. Whilst improving accountability is a legitimate objective, this changes the character of the clinical interaction by introducing a regulatory dimension into discussions that would otherwise remain focused on clinical decision-making.

The draft Order also reduces the clinician's ability to determine how and when information is communicated. In many cases veterinary surgeons already discuss medicine prices, written prescriptions and alternative purchasing options where these are relevant to the patient's circumstances or where clients seek that information. The issue is therefore not whether these matters should be discussed, but whether the Order should prescribe the timing, format and sequencing of those discussions irrespective of clinical context. The most effective point at which information should be provided varies considerably between consultations and is often best determined through professional judgement.

There is also an important distinction between transparency and information overload. A consultation already encompasses history taking, clinical examination, diagnosis, discussion of treatment options, informed consent, costs, medicine instructions, follow-up arrangements and clinical record keeping. Adding further mandatory communications risks increasing the cognitive burden on clients at a point when they may already be processing complex or emotionally significant information. Simply increasing the quantity of information provided does not necessarily improve informed decision-making.

7.6 Summary

The objective should therefore be to ensure that consumers receive clear and accessible information without unnecessarily prescribing the architecture of professional communication. A more proportionate approach would specify the information consumers must receive whilst allowing practices discretion regarding how, when and through which communication channels that information is delivered, taking account of the clinical circumstances and existing practice workflows.

The issue is therefore not whether consumers should receive this information, but whether the current implementation achieves transparency in a balanced manner without unnecessarily influencing consumer perceptions, constraining effective clinical communication or causing avoidable reputational harm to practices that are complying fully with both their professional obligations and the requirements of the draft Order.

8. Assessing the Proportionality of the Proposed Remedies

8.1 The Focus of Regulatory Intervention

The principal concern arising from the draft Order is not its objectives. Greater transparency, informed consumer choice and effective competition are legitimate regulatory aims. The issue is whether the proposed implementation represents the most proportionate reasonably available means of achieving those objectives within the operational realities of first opinion veterinary practice.

Throughout this response, a consistent theme has emerged. Many of the proposed remedies operate not at the point where consumers choose between competing veterinary providers, but during the delivery of clinical care itself. This distinction is important because interventions introduced within an active consultation have fundamentally different operational, clinical and economic consequences from those delivered before or after the consultation.

Many of the transparency measures contained within the draft Order naturally support competition before a purchasing decision is made. Practice websites, published pricing, consumer information and pre-appointment disclosures enable prospective clients to compare providers before selecting a veterinary practice. These measures influence provider choice without materially altering the subsequent delivery of veterinary care.

The medicines provisions are materially different. They become relevant only after the client has selected a veterinary practice, attended a consultation, received a clinical examination and reached the point at which treatment recommendations are being made. At that stage, competition between providers of veterinary services has already taken place. The draft Order instead introduces measures intended to influence decisions relating to medicine supply whilst the veterinary service itself is actively being delivered.

The consultation documentation explains why greater transparency and consumer awareness are considered desirable. It provides comparatively less explanation, however, as to why the consultation itself has been selected as the principal point of regulatory intervention, or how alternative implementation approaches were evaluated before adopting the proposed consultation-based model. Given that the consultation is the principal capacity constraint within first opinion practice, this is an important consideration when assessing proportionality.

The remainder of this section therefore considers whether selecting the consultation as the principal focus of intervention represents the most proportionate regulatory implementation model.

8.2 The Regulatory Implementation Model

The draft Order adopts a highly prescriptive implementation model. Rather than specifying only the consumer outcomes to be achieved, it prescribes elements of professional communication, including the timing, content, presentation and repetition of information delivered during veterinary consultations.

This implementation model warrants further explanation. Veterinary surgeons already practise within an established statutory professional framework administered by the Royal College of Veterinary Surgeons (RCVS). The Code of Professional Conduct regulates communication, informed consent, honesty, transparency and the provision of information necessary for clients to make informed decisions. These are therefore not unregulated activities.

The consultation documentation also envisages that elements of the proposed reforms will be implemented through the existing professional regulatory framework, recognising the RCVS's role in setting and maintaining professional standards. Comparatively little explanation is provided, however, as to why the communication requirements contained within the draft Order have instead been implemented through a separate statutory regime prescribing aspects of professional communication.

The issue is not whether consumers should receive this information, nor whether professional standards should evolve in response to the Market Investigation. Rather, it is why this particular aspect of professional practice requires direct statutory prescription rather than implementation through the existing specialist regulatory framework. Where several regulatory approaches could potentially deliver comparable consumer outcomes, understanding how those alternatives were evaluated would assist consultees in assessing whether the proposed implementation represents the most proportionate approach.

8.3 Medicine Supply as the Primary Regulatory Focus

The Market Investigation considered competition across the veterinary services market as a whole. Medicines formed one element of that wider assessment alongside transparency, ownership, referrals, pricing and consumer information.

The draft Order, however, concentrates many of its most operationally prescriptive obligations on prescribing and medicine supply, despite medicines representing only one component of an integrated episode of veterinary care. Many consultations involve no prescribed medicines whatsoever, whilst others derive their principal value from diagnosis, preventive healthcare, surgery, monitoring or professional advice rather than pharmaceutical supply.

The medicines provisions nevertheless introduce mandatory consultation discussions, prescribed written communications, waiting room notices, invoice disclosures, website information and written prescription requirements. Collectively, these account for a substantial proportion of the implementation burden generated by the draft Order.

The proposed implementation applies these requirements universally across veterinary practice irrespective of consultation type, prescribing frequency or clinical context. This emphasis should therefore be considered within the wider veterinary care pathway, in which consumer value is created through the combined delivery of clinical examination, diagnosis, treatment planning, surgery, nursing care, monitoring, communication and ongoing case management rather than medicine supply in isolation.

8.4 Consequences for Clinical Delivery

Veterinary consultations are structured clinical encounters during which diagnoses are explained, prognoses discussed, treatment options considered and informed consent obtained. Prescribing decisions frequently occur immediately after clients have received

unexpected or emotionally significant information regarding their pet, at a point when their attention is naturally focused upon understanding the diagnosis, recommended treatment and immediate next steps.

The medicines provisions require additional prescribed consumer information and prescribing discussions to be introduced during precisely this stage of the consultation. Whilst these communications relate to commercial aspects of medicine supply, they occur within a clinical interaction whose primary purpose is diagnosis, treatment planning and informed consent.

Clients informed of their prescribing options may reasonably seek medicine prices, revised estimates excluding medicines, written prescriptions, comparative costs or clarification regarding treatment timing. These questions are entirely consistent with the objectives of improving consumer choice and should therefore be regarded as a foreseeable consequence of the proposed implementation rather than an unintended operational issue.

Published evidence suggests that consultation time within first opinion practice is already a constrained clinical resource. Robinson *et al.* observed that 48.4% of UK small animal consultations exceeded their allocated appointment duration and demonstrated that consultation length increased as the number of presenting problems increased.^3 Subsequent work identified increasing case complexity, communication demands and cost discussions as recognised contributors to consultation time pressure, whilst also noting growing professional support for longer consultation times.^4

These findings are consistent with routine operational efficiency monitoring undertaken within my own practice, where consultation duration is reviewed as part of normal performance management and service planning. As an experienced veterinary surgeon with almost thirty years' clinical experience, my consultations generally operate close to their allocated appointment length, leaving little spare capacity within routine scheduling. A second competent veterinary surgeon within the practice, with less clinical experience and for whom English is not their first language, consistently requires longer consultation times despite delivering appropriate clinical care. This is not presented as criticism of individual performance, but as an illustration of the normal variation in consultation efficiency that exists across the profession. Regulatory assumptions that additional mandatory communication can simply be accommodated within existing appointment times risk overlooking both this natural variation and the limited resilience already present within consultation scheduling.

Delivering these discussions efficiently depends upon practice management systems capable of generating revised estimates, producing written prescriptions, recording mandatory communications and integrating these processes into normal clinical workflows. As discussed in Section 6, the maturity of veterinary practice management systems currently varies considerably across the profession. Many systems were not designed around the workflows envisaged by the draft Order and cannot yet support them efficiently without multiple manual processes.

These technological limitations are likely to improve over time. They nevertheless remain relevant when assessing proportionality because the draft Order creates immediate operational obligations despite much of the supporting digital infrastructure not yet being sufficiently mature to implement them consistently or efficiently.

The effectiveness of consumer information also depends upon timing. Veterinary consultations frequently involve complex clinical discussions delivered when clients may already be

processing unexpected or distressing news. Healthcare communication research indicates that increasing cognitive load can reduce an individual's ability to understand and retain information.^2 Introducing additional mandatory commercial information during treatment discussions may therefore reduce, rather than enhance, the effectiveness of informed decision-making.

8.5 Economic and System-wide Consequences

The operational consequences described above translate directly into economic consequences.

Additional consultation time reduces the number of appointments that can be delivered within existing clinical capacity. Unlike variable medicine costs, however, consultation time is closely linked to the fixed costs of delivering veterinary care. Staffing, premises, equipment, regulatory compliance, professional indemnity, information technology and clinical infrastructure remain substantially unchanged regardless of whether a veterinary surgeon undertakes thirty consultations or twenty-seven consultations within a working day. Extending routine consultation length is therefore not economically neutral.

Published evidence demonstrates that many veterinary surgeons already regard existing consultation times as insufficient for increasingly complex consultations. Nevertheless, routine appointment lengths have remained relatively stable across much of the profession. This reflects an economic constraint rather than a clinical preference. Although longer consultations may improve communication, they reduce clinical throughput unless consultation fees increase sufficiently to offset the resulting loss of capacity. Many veterinary surgeons may therefore wish to spend longer with clients in order to improve clinical care whilst recognising that doing so is not financially sustainable within the commercial realities of first opinion practice.

Practices therefore have limited options for absorbing these additional costs. They may increase consultation fees, accept reduced clinical capacity and longer waiting times, reduce profitability, or reduce investment elsewhere within the practice. None of these outcomes is cost free. The draft Order therefore appears more likely to redistribute existing costs within the veterinary care pathway than eliminate them.

The proposed requirements also create additional governance obligations. Practices must not only undertake the prescribed communications but also be able to demonstrate compliance through appropriate documentation and clinical records. Where these processes are not embedded within structured digital workflows, compliance is likely to depend upon manual record keeping, duplicate data entry or free-text documentation, increasing administrative burden whilst reducing consistency and efficiency.

Revenue generated through medicine supply contributes towards meeting the fixed costs of maintaining veterinary facilities, equipment, staffing, regulatory compliance, professional development and clinical infrastructure. If regulatory intervention reduces that contribution whilst those underlying costs remain unchanged, those costs must necessarily be recovered elsewhere unless investment is reduced or practices become financially unsustainable.

The likely consequence is therefore not the elimination of costs but their redistribution across other elements of veterinary service provision, particularly professional fees. Consumers may

ultimately pay a greater proportion of the cost of veterinary care through consultation and procedural charges rather than medicine margins.

Viewed collectively, the draft Order largely treats prescribing and medicine supply as a discrete commercial transaction capable of being regulated independently from the wider delivery of veterinary care. In practice, consultation, diagnosis, prescribing, dispensing, treatment, monitoring and follow-up form an integrated clinical pathway. Intervention within one component of that pathway inevitably has consequences for the wider system, influencing consultation duration, communication, digital workflows, practice economics, investment decisions and ultimately the cost and delivery of veterinary care.

The consultation documents explain the intended consumer benefits arising from increased transparency and medicines competition. They provide comparatively less explanation, however, as to why this particular implementation model was preferred over alternative approaches that might have delivered similar consumer outcomes with fewer operational consequences. Further explanation of that assessment would assist consultees in evaluating the proportionality of the proposed remedies.

8.6 Consumer Value, Trust and Competition

Veterinary practices compete through considerably more than medicine price alone. Clinical expertise, continuity of care, communication, accessibility, convenience, immediate treatment availability, nursing support, follow-up and professional trust all contribute to the value proposition offered to clients.

The proposed communications place repeated emphasis upon one dimension of consumer value: the potential availability of medicines at lower prices from alternative suppliers. They do not provide equivalent recognition that medicine price represents only one element of the overall value delivered through integrated veterinary care. As discussed in Section 7, the prescribed communications may therefore influence consumers' perception of value by repeatedly highlighting one aspect of competition whilst providing comparatively little context regarding the broader factors upon which veterinary practices compete.

The economic consequences discussed in Section 8.5 are also relevant to consumer value. If medicine supply contributes less towards recovering the fixed costs of veterinary provision, whilst mandatory prescribing communications increase the time and administrative resource required to deliver each consultation, practices are likely to recover a greater proportion of those costs through professional fees or reduced clinical capacity. Consumers may therefore experience lower medicine prices alongside higher consultation or procedural charges. The relevant question is therefore not whether one component of care becomes less expensive in isolation, but whether the overall affordability, accessibility and quality of veterinary care improve.

The prescribed communications set out in the draft Order accurately explain that medicines may be available from alternative suppliers at different prices. However, they provide little context that medicine pricing forms part of an integrated economic model in which consultation fees, professional expertise, clinical infrastructure, staffing and medicine income together support the delivery of veterinary care. Consumers may therefore be encouraged to evaluate one component of cost in isolation without appreciating the relationship between medicine pricing and the overall cost of accessing veterinary services.

Consumer welfare depends upon more than competitive pricing. It depends upon consumers making informed choices based upon the full range of factors relevant to healthcare, including quality, accessibility, continuity, convenience, professional trust and clinical outcomes. Regulatory measures that disproportionately emphasise one dimension of value therefore risk narrowing, rather than enhancing, consumers' understanding of the choices available.

8.7 Principal Findings of the Proportionality Assessment

The preceding sections do not question the objectives of the draft Order. Greater transparency, informed consumer choice and effective competition are legitimate regulatory aims capable of delivering consumer benefit. Rather, they identify the medicines provisions as the principal source of proportionality concern. Whilst the Market Investigation examined competition across the veterinary services market as a whole, many of the most operationally prescriptive remedies are concentrated upon the comparatively narrow medicines supply pathway.

Unlike the wider transparency provisions, these measures operate within the clinical consultation itself, at the point where diagnosis, treatment planning and informed consent are taking place. They should therefore not be assessed in isolation. Collectively, they create cumulative administrative, clinical, technological and economic consequences that extend throughout the wider veterinary care pathway.

The following section therefore considers whether the objectives of the medicines provisions could be achieved through alternative implementation approaches that preserve the intended consumer benefits whilst reducing unnecessary operational burden.

References

1. Royal College of Veterinary Surgeons. *Code of Professional Conduct for Veterinary Surgeons*. Supporting Guidance: Communication and consent (Chapter 11) and Code sections 2.3 (cost information) and 2.4 (communication and informed consent). Available at: https://www.rcvs.org.uk/veterinary-professionals/conduct-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/
2. Kessels RPC. *Patients' Memory for Medical Information*. Journal of the Royal Society of Medicine. 2003;96(5):219-222.
3. Robinson NJ, Brennan ML, Cobb M, Dean RS. *Investigating preventive-medicine consultations in first-opinion small-animal practice in the United Kingdom using direct observation*. Veterinary Record. 2014;174:484.
4. Robinson NJ, Brennan ML, Cobb M, Dean RS. *Capturing the complexity of first opinion small animal consultations using direct observation*. Heliyon. 2019;5:e02953.

9. Recommendations for a More Proportionate Implementation

The objectives of improving transparency, promoting informed consumer choice and supporting effective competition are supported. However, the analysis presented in this response suggests that aspects of the draft Order could achieve these objectives through less intrusive and more proportionate mechanisms.

The recommendations that follow are guided by three overarching principles. First, the intended consumer outcomes should be preserved. Second, implementation should represent the least burdensome reasonably available means of achieving those outcomes. Third, existing professional regulation and professional judgement should continue to play a central role in determining how those outcomes are delivered within individual clinical consultations.

9.1 Reconsider the Regulatory Focus and Point of Intervention

The draft Order places considerable emphasis on communications relating to the medicines supply pathway during the clinical consultation. Whilst the consultation is an important point for obtaining informed consent, it is also where veterinary surgeons must diagnose disease, explain treatment options, discuss prognosis, address welfare considerations and answer client questions.

Standardised consumer information should, wherever reasonably practicable, be delivered before or after the consultation, reserving the consultation for discussions requiring professional judgement and matters specific to the individual patient.

Consideration should therefore be given to whether greater use could be made of pre-consultation and post-consultation communications to deliver standardised consumer information whilst preserving the consultation as the principal setting for clinical decision-making and informed consent.

9.2 Adopt an Outcomes-Based Rather Than Process-Based Approach

The draft Order prescribes, in considerable operational detail, how aspects of communication relating to the medicines supply pathway should occur.

Consideration should instead be given to specifying the consumer outcomes that should be achieved, whilst allowing veterinary professionals appropriate discretion regarding how and when those outcomes are delivered within the consultation pathway.

The proposed approach should continue to allow veterinary surgeons to exercise professional judgement regarding the sequencing and emphasis of information according to the clinical circumstances, recognising that the priorities of an emergency consultation, an acute illness and a routine repeat medication review differ materially.

Compliance need not depend upon prescribing every aspect of professional communication. Where the required consumer outcomes are clearly defined, assurance could instead be

supported through appropriate clinical records, proportionate audit and, as digital capability matures, greater use of standardised reporting. Similar approaches are already used by the CMA in monitoring compliance with behavioural remedies in other market investigations.

At present, the maturity and interoperability of veterinary practice management systems are unlikely to support fully standardised reporting across the profession. Any such approach would therefore need to evolve alongside improvements in digital infrastructure and common reporting standards. Consideration should also be given to whether the detailed design of assurance mechanisms is more appropriately developed within the existing professional and medicines regulatory frameworks administered by the RCVS and, where relevant, the VMD, consistent with the CMA's proposed role for the RCVS in supporting and monitoring compliance with the veterinary remedies.

Such an approach would be more adaptable to differing clinical circumstances, evolving communication technologies and future changes in veterinary practice.

9.3 Give Greater Weight to Existing Professional Regulation

Veterinary surgeons already practise within a comprehensive professional regulatory framework governed by the RCVS Code of Professional Conduct. Existing obligations include informed consent, discussion of treatment options, communication of estimated costs, prescribing responsibilities and professional accountability.

Where additional consumer information is considered necessary, consideration should be given to whether the desired outcomes could be supported through existing professional regulatory mechanisms rather than through detailed statutory prescription of consultation processes.

9.4 Consider Less Intrusive Means of Delivering Consumer Information

Many of the transparency objectives could potentially be achieved through communication channels already widely used within veterinary practice, including practice websites, appointment booking systems, confirmation emails, reminder messages, client portals, waiting room information and discharge documentation.

These approaches appear capable of achieving many of the intended transparency objectives by ensuring that clients receive relevant information before treatment decisions are made, whilst allowing veterinary professionals to reinforce and contextualise that information according to the clinical circumstances.

Compared with the implementation approach proposed in the draft Order, greater use of these mechanisms would be expected to:

- reduce administrative burden and implementation costs;
- reduce opportunity costs within consultations;
- preserve professional judgement regarding the timing and emphasis of communications relating to the medicines supply pathway;

- reduce unnecessary commercial emphasis during consultations, thereby reducing the potential for reputational harm;
- reduce upward pressure on consultation fees arising from compliance costs; and
- improve the value of consultations by allowing a greater proportion of paid clinical time to be devoted to diagnosis, explanation, treatment planning and patient care.

These examples are not intended to suggest that any individual mechanism would necessarily achieve the CMA's objectives to the same extent as the proposed implementation. Rather, they illustrate that a spectrum of potential implementation approaches exists. The consultation documentation would be strengthened by providing a fuller explanation of how these and other alternatives were evaluated before selecting the preferred implementation approach.

9.5 Better Reflect Clinical Context

The potential consumer benefits arising from medicines price competition are unlikely to be identical across all prescribing decisions or clinical circumstances.

For long-term repeat medication, consumers may reasonably wish to compare suppliers where cumulative savings over time may be significant. By contrast, where medicines are required immediately to treat an acute condition, consumers may legitimately place greater value upon immediate access to treatment, convenience and continuity of care than comparatively modest differences in medicine price.

Different clinical contexts may also influence the relative importance of communications relating to the medicines supply pathway. Emergency presentations, acute illness, routine preventive healthcare and long-term disease management each involve different clinical priorities, different opportunities for consumer consideration and different practical implications for medicine supply.

Where immediate treatment is clinically indicated, timely access to medicines may represent a greater consumer and welfare benefit than delaying treatment to explore alternative supply arrangements.

Consideration should therefore be given to whether communications relating to the medicines supply pathway should better reflect differing clinical contexts rather than applying a largely uniform approach across all prescribing decisions.

9.6 Assess Digital and Operational Readiness

Successful implementation depends not only upon regulatory requirements but also upon the capability of practice management systems and associated digital infrastructure.

As discussed in Section 6, variation currently exists in digital functionality across the sector. Implementation should therefore take account of operational readiness to minimise unnecessary administrative burden and avoid unintended impacts upon consultation workflow.

Consideration should also be given to phased implementation aligned to demonstrable digital readiness. Measures dependent upon mature practice management systems, interoperability or standardised reporting may require different implementation timescales from those capable of being delivered using existing infrastructure.

9.7 Pilot and Evaluate the Operational Impact

Given the operational complexity of the proposed remedies, consideration should be given to piloting implementation before wider introduction.

A pilot would allow evaluation of both operational feasibility and consumer outcomes before wider implementation, including assessment of:

- consultation duration;
- administrative workload;
- consumer understanding;
- prescribing behaviour;
- impacts upon consultation fees;
- operational feasibility; and
- any unintended consequences affecting clinical workflow or patient care.

This would provide a stronger evidence base for determining whether the proposed implementation represents the most proportionate means of achieving the intended consumer benefits.

9.8 Undertake a Post-Implementation Review

Should the remedies proceed substantially as drafted, a formal post-implementation review should be undertaken after an appropriate period.

The review should assess whether the anticipated consumer benefits have been realised, whether the operational assumptions underpinning the remedies have proved correct and whether any unintended consequences have emerged. Consideration should include:

- consumer understanding;
- effective competition in medicines;
- consumer outcomes;
- consultation costs;
- consultation duration;
- prescribing behaviour;
- compliance demonstrated through existing governance and assurance mechanisms; and
- operational or clinical consequences affecting the delivery of veterinary care.

Future amendments should be informed by empirical evidence rather than assumption.

9.9 Demonstrating Proportionality

Throughout this response, a recurring observation has been that the consultation documentation explains the objectives of the proposed remedies and the consumer benefits they are intended to deliver, but provides relatively little detail of how alternative implementation approaches were evaluated before selecting an implementation approach centred on the clinical consultation.

Good regulatory design requires not only that regulatory interventions are capable of achieving their intended objectives, but also that implementation is proportionate to the problem being addressed and that unnecessary operational burdens are avoided wherever reasonably possible.

Before finalising the Order, consideration should therefore be given to publishing a fuller assessment of alternative implementation approaches, including greater reliance upon existing professional regulation, digital communication before or after consultations, practice management systems, administrative processes, proportionate assurance mechanisms and outcomes-based requirements, together with the reasons these approaches were considered insufficient or less appropriate for achieving the CMA's intended consumer outcomes.

Such an assessment would assist consultees in understanding why the preferred implementation approach has been selected in preference to other plausible approaches and provide greater assurance that the final remedies represent the most proportionate reasonably available means of achieving the CMA's intended consumer outcomes.

10. Closing Remarks

This response supports the CMA's objectives of improving transparency, informed consumer choice and effective competition within the veterinary sector. The principal concerns raised relate not to those objectives, but to the proportionality of the proposed implementation.

Throughout this response, a consistent distinction has been drawn between the intended regulatory outcomes and the mechanisms proposed to achieve them. Many of the transparency measures appear capable of delivering consumer benefit with relatively limited operational impact. The principal proportionality concerns arise where highly prescriptive requirements are concentrated upon the medicines supply pathway and implemented during the delivery of clinical care itself.

The recommendations set out in Section 9 are intended to demonstrate that alternative implementation approaches may be capable of achieving the CMA's intended consumer outcomes whilst reducing unnecessary administrative, clinical, technological and economic burden. Greater reliance upon existing professional regulation, digital communication and outcomes-based implementation may better preserve both consumer choice and the effective delivery of veterinary care.

I hope these observations assist the CMA in developing a final Order that achieves its intended objectives whilst recognising the practical realities of first opinion veterinary practice.