11 Views of veterinary surgeons and veterinary organizations

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Introduction

11.1. This chapter is divided into four sections. The first part summarizes evidence presented by veterinary organizations and some individual veterinary surgeons, mainly at hearings and mostly between January and April 2002, including at a public hearing on 26 April. The second part deals with responses to the statement of 16 April 2002 from individual veterinary surgeons and veterinary organizations. The third part deals with the responses of veterinary surgeons and veterinary organizations to the statement of 17 September 2002. The final part covers other submissions, including evidence from buying groups.

11.2. The individual veterinary surgeons who submitted written evidence, mostly in response to the statement of 16 April and the statement of 17 September, are listed in Appendix 11.1.

General evidence/submissions

Royal College of Veterinary Surgeons

11.3. The RCVS said that it had a statutory responsibility for supervising veterinary undergraduate education, maintaining the register of qualified veterinary surgeons and overseeing their conduct. Whilst it had no statutory role in issuing advice or laying down rules for the guidance of the profession, it had issued a Guide to Professional Conduct, covering issues such as relations with clients and responsibilities towards patients, the general public and under the law. The Guide also commented on legal issues surrounding the use of veterinary medicines, and gave advice on interpreting some aspects of the Medicines Act, in particular those relating to animals under veterinary care and choice of medicines to be used.

11.4. Only members of the RCVS could practise veterinary surgery in the UK. There were, currently, almost 20,000 veterinary surgeons on the RCVS register, with just over half of them in general practice.

11.5. The RCVS said that it gave specific guidance on dispensing veterinary POMs. It was now a formal provision of its Guide that members should make clients aware that veterinary medicines might be obtained on prescription from other suppliers, including pharmacies. It had emphasized to members that prescriptions should not unreasonably be refused to clients who requested them. However, prescriptions should be issued only for animals under that veterinary practice’s care, and a reasonable charge could be made on those occasions. The RCVS added that there were circumstances in which it would be reasonable to refuse to supply medicines to clients; it would also be reasonable on such occasions to refuse to provide prescriptions.

11.6. The RCVS explained that its monitoring process was complaints-based, but that it had received very few complaints regarding the issue of prescriptions or about charges for prescriptions. Its guidance to the profession suggested that fees for prescriptions, following a consultation, should be reasonable in the circumstances and should not be designed to deter a client from seeking dispensing elsewhere. The OFT had said that it would be outside the remit of the RCVS to provide specific advice on fees for writing prescriptions; it followed that, whilst individuals might have views on the subject, the RCVS did not. The RCVS therefore, despite the Government’s response to the Marsh report on this subject, had no plans, beyond its annual autumn review of the Guide, to add to its advice to members in this respect. It agreed, however, that the price of a prescription should reflect the actual administration cost, including an appropriate profit element. Whilst a physical examination, resulting in a consultation fee, for example with repeat prescriptions, did not take place on every occasion, there would always be an essential professional input at some point, and a sum, reflecting the degree of that input, should be added to the final bill.

11.7. Complaints about varying levels of veterinary charges had been received by the RCVS. Whilst it accepted that there were veterinary practices whose prices were, on occasion, considerably higher than others, it had found difficulty in determining what constituted excessive prices. It had found that the
evidence provided by pet insurance companies in respect of companion animals, acknowledging the concept of average prices for the application of average techniques, had been most helpful. However, it continued to be discouraged from making suggestions about actual charges, since such advice could be interpreted as contributing to a restrictive practice, and thus be anti-competitive. The RCVS did not feel competent to advise members on how to assess costs. Other organizations, such as the Veterinary Practice Management Association, the BVA and the SPVS, were more competent to do so.

11.8. The RCVS commented on the lack of formal training given to veterinary surgeons in veterinary practice management. The formal university syllabus extended over five years and did not leave much time for practice management or business training. The matter was under consideration, particularly following the recommendations of the Marsh inquiry. A working party was currently considering good veterinary practice, and the RCVS suspected that it might recommend the issue of a code of practice on veterinary practice management.

11.9. Over many years, the RCVS said, it had advised that veterinary surgeons should be remunerated primarily through realistic professional fees and not through the sale of drugs. It added that the current tendency to undercharge for professional time had its origins in previous government disease eradication schemes which had subsidized fees. As that work had declined, fees had not increased realistically, and there had been a greater dependence on margins on drugs. The Government undervalued the worth of veterinary surgeons through low financial rewards for employment at abattoirs, and local authorities also paid low fees to veterinary surgeons. The RCVS denied that there was insufficient transparency in charging, and showed the CC some extremely detailed examples of invoices.

11.10. The RCVS thought that the scope for displaying price lists of medicines in practices was limited. There were too many individual products, and too much detail would render lists incomprehensible. It agreed that manufacturers’ prices differed considerably throughout the EC and that prices in the UK were higher than elsewhere in Europe. Manufacturers charged locally what the market would bear and, given the considerable reduction in the numbers of manufacturers, there seemed little scope for concerted action by veterinary practices to counter this pricing policy. High prices in the UK had contributed to the practice of importing, frequently illegally, from other parts of Europe, and in particular from the Republic of Ireland, and the RCVS believed such illegal practice would stop only when prices reached a common level. It added that veterinary practices were further disadvantaged in having to charge VAT whilst pharmacies were not required to do so.

11.11. According to the RCVS, there was a competitive market among veterinary surgeons. It was especially evident through the facility that clients had to change practice and to have medical records transferred automatically to the new practice. The RCVS acknowledged that it was easier for owners of companion animals owners than farm-animal owners to change practices, for instance because of the role of the veterinary surgeon in farm assurance schemes.

11.12. The RCVS believed that price competition was not necessarily the leading factor determining a person’s choice of veterinary assistance; it was more likely that people considered the veterinary surgeon’s reputation and this, together with the care offered and the ensuing rapport and confidence, were the significant factors for most clients and probably constituted significant competitive factors among veterinary surgeons. Whilst some members of the public would seek the cheapest goods, the majority would choose quality, and be prepared to pay for it.

11.13. In the RCVS’s view, if members of the public were offered a prescription for dispensing elsewhere, they would be inclined to take it to a pharmacist and not to another veterinary practice. However, the RCVS questioned the capacity of many pharmacists to dispense veterinary medicines without having additional veterinary training, particularly because it was a requirement in veterinary medicine to dispense precisely the product prescribed without the latitude of using appropriate generics. The RCVS suggested that, whilst in some prominent veterinary pharmacies the skills of the pharmacist complemented those of the prescribing veterinary surgeon, pharmacists generally might not understand the cascade or the rules on residues in food-producing animals.

11.14. The RCVS said that it had been aware of allegations of over-treatment in some circumstances where pet insurance had been involved, and that the subject was under investigation. However, each
contract was between veterinary surgeon and client and, in the final analysis, it would be for the insurer, and not the RCVS, to conduct its own inquiries into any misconduct.

11.15. Noting the increase in the numbers and availability of veterinary surgeons in the UK, partly due to an increase in registrations of non-UK nationals, the RCVS thought that supply would exceed demand in about five years. There had been a decline in the demand for veterinary services for large animals; demand had levelled off in respect of small animals and equine veterinary services. The role of veterinary surgeons had been changing as the focus had shifted to crisis management and the adoption of disciplines such as food hygiene and animal welfare, all of which had become important for the maintenance of food production standards. The need for traditional veterinary surgeons had further diminished as farmers had adopted food assurance schemes and increasingly attention was directed away from emergency veterinary attention in favour of practices aimed at continuous improvement.

British Veterinary Association

11.16. The BVA explained that its responsibilities, unlike those of the RCVS, were not defined by statute. Membership was non-obligatory, whilst registration with the RCVS was a requirement for all practising veterinary surgeons. The BVA, with its direct membership of over 10,000, represented the political and working ambitions of the profession. It had no disciplinary or regulatory role. It was organized into 51 divisions, comprising 30 territorial divisions and 21 specialist animal groups.

Availability and costs of veterinary medicines

11.17. The BVA was concerned that rigidities in the regulatory regime were restricting the availability of veterinary medicines and preventing veterinary surgeons from discharging their obligations for the welfare of animals. This was, in the BVA’s view, linked to the need to adapt the UK Medicines Act 1968 to EC Directives in the field of veterinary medicine. The imposition of MRLs for any food-animal medicine for food animals had led to a number of formerly widely-used veterinary medicines disappearing from the market because the data package to meet the new EC legislation was not available. The availability of medicines for horses and other so-called ‘minor species’ was particularly restricted in the UK, where these species, unlike in other parts of Europe, were not regarded as food animals. The cascade had also raised a number of questions. Although the BVA’s suggestions for changes to the European regime had been accepted in some parts of the European legislative chain (for example, the European Parliament), the BVA was concerned that any definitive change would take many years to promulgate.

11.18. The BVA believed that the different classification systems for veterinary medicines in Europe had stimulated illegal importing of drugs into the UK, although the evidence was largely anecdotal. Many members had expressed growing concern on this issue. It was of particular concern in the farm-animal sector, reflecting the decline in profitability of farming. A major source for illegal imports, including of counterfeit products such as antibiotics, was Central Europe, particularly Poland, the Czech Republic and Bulgaria. The BVA was concerned that the policing of such illegal imports into the UK was lax.

11.19. Price was one factor behind illegal importing, the BVA said, but the issue of availability was also important at a time when information on medicine supply was increasingly accessible through the Internet. It was tempting for clients to self-diagnose problems and obtain drugs illegally, cutting out the veterinary surgeon. Illegal usage of POMs and over-usage of OTC PML products had led to a worldwide problem of resistance to wormers and antibiotics; the BVA emphasized that the problem had not been caused by over-prescription. The BVA commented that gross costs might have been lowered by such practices, but at the expense of general animal health and at a potentially greater risk to food safety, whilst proper usage would have led to lower net costs.

11.20. The BVA emphasized that it was necessary to understand the cumulative costs of the veterinary medicines chain. This included manufacturers’ R&D, regulation, distribution and dispensing; expenditure needed to be assessed on a cost plus basis. In the BVA’s view, the scope for increasing competition in the supply of veterinary medicines might require the dismantling of the current veterinary medicine chain, with price reductions being realized closer to the manufacturing source than to the point of sale to the client.
11.21. The BVA noted that the costs to a pharmaceutical company of registering a veterinary medicine in the UK were among the highest in Europe. While some EC countries had considered that their regulatory authorities should be state-financed, others, including the UK, had required such costs to be financed by industry. Manufacturers had been less inclined to conduct clinical trials in the UK because regulations were more onerous than in other countries.

Common EC approach

11.22. The BVA had argued for some time that the application of a common EC approach to veterinary drug regulatory issues would contribute to more uniform prices for veterinary medicines throughout Europe. It held to the proposition in a 1999 report of its Medicines Committee that the classification of medicines, in relation to what are the appropriate distribution routes, should be decided on a basis of criteria agreed at European level. The BVA was firmly committed to maintaining the three principles or pillars of safety, quality and efficacy, which were the international regulatory norm for the licensing of veterinary drugs and were fundamental to EC, Japanese and US legislation. Before the UK Medicines Act 1968, safety alone had been the essential principle of the voluntary veterinary products safety precautionary scheme but data from manufacturers on efficacy was now considered essential to protect the consumer from spurious or misleading information. The BVA said that it would oppose—on the grounds of consumer protection—any return to earlier standards. It believed that reclassification of POMs needed to be considered on a drug-by-drug basis. It now supported—on the ground of the need to enhance confidence in the food chain—the current EC proposal that all veterinary medicines for food animals be available only through veterinary prescription, which would contribute to increased traceability and enhance food safety. It noted that the principle had been supported, in effect, by the OIE (World Animal Health Organisation), which had called for member governments to ensure that all food-animal veterinary antibiotics were available only on veterinary prescription, and supplied only to animals under the care of the prescribing veterinary surgeon.

Practice costs and management

11.23. The BVA said that it would not be practical to apply a common system for measuring the overall costs for the treatment of animals. The ratio of the various components of business costs—labour, equipment, materials, overheads and profits—differed from one part of the country to another. In veterinary surgery, veterinary medicines, whether prescription-only or others, comprised a principal element of the materials required to conduct the business effectively. The nature of a practice would determine the volumes of materials or medicines it needed to purchase; and this, in turn, influenced unit costs. Companion-animal treatment, for example, did not demand the bulk purchase of drugs, but buying small volumes was proportionately more expensive than purchasing large quantities.

11.24. The BVA recognized that there were considerable variations in the prices veterinary surgeons paid for drugs. It pointed out that this resulted, in part, from the size of practices and individual or group purchasing power. In the BVA’s view, although some veterinary practices had set up buying groups so as to reduce the costs of purchasing medicines, discounts were not of paramount concern to veterinary surgeons; most considered factors such as educational and other services from the manufacturers to be equally important. The BVA nonetheless thought that, provided veterinary surgeons were satisfied about the quality, efficacy and safety qualities of medicines, they would in general buy them from the source offering the best financial deal. Moreover, the BVA considered that business awareness would grow within the profession and veterinary surgeons would in future bring greater pricing pressure to bear on manufacturers and suppliers.

11.25. The BVA had conducted inter-practice operational comparisons of profit and turnover of veterinary practices for some 14 years, involving about 1,200 different veterinary surgeons; these showed that income and net profit per partner, percentage return on investment and so forth had not grown over recent years. Furthermore, an independent analyst, commissioned by the BVA, had found no significant evidence of excess pricing in respect of a range of veterinary medicines.

11.26. Recognizing that veterinary surgeons were primarily trained to care for sick animals, the BVA said that considerations of business efficiency and cost were often secondary for them. Business
skills were not part of the regular university training veterinary surgeons received. Considerable differences in approaches to business costing had been highlighted by surveys of veterinary practices, including variations in the extent to which margins had been added to drugs, professional fees or both. The BVA said that it was important to establish exactly what a pharmacy cost a practice to run, and the BVA had started such an assessment by commissioning a pilot study.

11.27. The BVA believed that the profession was changing and, as new graduates came into the profession, with new lifestyles, outlooks and attitudes, it would evolve further. The focus of practice management for many veterinary surgeons had already moved from pharmacy charges to professional fees. More veterinary surgeons had determined to sell their time at an economic price. More practices were rationalizing their holdings of drugs and their use of consumables, for example for operations. They were now able to afford to maintain lower stock levels of drugs since suppliers could deliver on a daily basis. There was, in the BVA’s view, still scope in some practices to rationalize further the quantity and range of drugs stocked; levels of wastage remained high, as a result particularly (although not exclusively) of emergency situations demanding the use of small amounts of drugs; under current regulations, any unused balance of multi-dose vial drugs had to be disposed of after 28 days, but the BVA noted an impression that insufficient effort was taken in some cases, particularly in larger practices, to use up the balance of opened drug packages before opening new stock.

**Switching practices**

11.28. The BVA said that the movement of clients between veterinary practices was neither uncommon nor difficult. Reasons varied but the extent to which switching took place was probably influenced by geographic location and personal mobility. Veterinary specialization had also increased, and farmers could choose different veterinary practices and surgeons for different animals.

**Policy on prescriptions**

11.29. The BVA said that its policy in relation to prescribing and dispensing medicines focused on professional control. Whilst present distribution networks for veterinary medicines in the EC ranged from pharmacy-based centralized systems to exclusively prescription-based schemes, the BVA had for many years endorsed the UK mixed distribution system. It had encouraged members to provide prescriptions for dispensing elsewhere if requested to do so (however, the BVA argued that charging for prescriptions was a separate issue). The BVA recognized that a degree of competition in the supply of POMs, principally through price controls, would benefit customers; competition in the supply of POMs inevitably had to be between veterinary surgeons and pharmacists, although agricultural merchants had a role in supplying PML drugs. However, the BVA suggested that the one-stop shop offered by veterinary surgeons stimulated more direct competition between veterinary practices than between them and pharmacies.

**Conclusion**

11.30. In conclusion, the BVA said that the use of medicines should be viewed as part of the whole process of providing total animal care; the role and purpose of food-animal veterinary medicine legislation was the protection of animal health and welfare and of public health; and the veterinary profession was the guardian of animal welfare, promoter of animal health and the co-custodian, with the medical profession, of public health.

**British Small Animal Veterinary Association**

11.31. The BSAVA—a specialist division of the BVA—represented the interests of almost 6,000 members in about 1,000 companion-animal (or pet) veterinary practices in the UK. Membership comprised over half of all practising UK veterinary surgeons. It included practices in both urban and rural locations providing varying levels of services, including some cut-price vaccination clinics, neutering clinics, veterinary hospitals, referral-only practices, and night-time-only accident and emergency clinics.
11.32. The BSAVA described its primary objective as educational, but it was expected to respond also to organizations and individuals requesting information or guidance on matters relating to pet-animal practice. It also operated a voluntary practice standards scheme, which covered legislative issues, as well as levels and standards of service provided. The BSAVA acknowledged that, whilst most veterinary practices subscribed to its aspirations of high standards in the supply and provision of services, there was a minority that did not.

11.33. The BSAVA expressed surprise at the monopoly reference. In its response to the Marsh report, it had recognized those areas relating to prescribing and dispensing in small-animal practice that had been subject to criticism. Since the Marsh inquiry had been wide ranging, the BSAVA had thought that further investigation would follow only in circumstances where recommendations adopted by the Government were considered to be ineffective.

11.34. The BSAVA emphasized the education and training required for the profession, its vocational nature, the long hours of work and the need to provide a 24-hour service. It also stressed the contribution the profession made to the welfare and health of the nation—for example, in looking out for any incidence of animal-borne infectious diseases of danger to humans, particularly following the relaxation of quarantine rules. It underlined the importance of companion animals to humans in terms of reducing stress and providing comfort.

**Competition**

11.35. In the BSAVA’s view, competition not only existed within the veterinary profession, and between the profession and the wider marketplace, but had recently been increasing. As a result, individual incomes were remaining static. There were a number of reasons for the increased competition. The total pet population, particularly of dogs, had declined. Farm-animal practice had contracted due to changes in agriculture, and this had caused veterinary surgeons to look for alternative sources of income. Veterinary surgeons had recognized that clients were prepared to ‘mix and match’, and to seek cheap prices for routine services such as vaccination, parasite control, neutering and simple dental procedures. The number of graduates from European veterinary schools coming to the UK in search of greater job opportunities had increased. Within the companion-animal sector, there was increasing competition from new practices, corporate group practices, animal charities, and other practices and specialized clinics, including some providing sub-standard veterinary treatment. In the wider marketplace, supermarkets and pet superstores were increasingly offering flea control, worming products and pet insurance (and, whilst a veterinary practice was restricted to supplying only registered clients, pharmacists could supply GSL products to any member of the public.)

11.36. The BSAVA doubted that the corporate practices sector would grow significantly. The practices could reduce inefficiencies in the industry, but the distribution of profits to shareholders and owners could result in clients receiving less value for money. Vaccine clinics could have a greater impact on competition, since their initial overheads were lower and their focus more directed. The BSAVA suggested that veterinary practices were responding to the challenge by competing more effectively in this area; vaccine clinics, likewise, were responding by broadening the scope of services they offered.

**Fees**

11.37. The BSAVA explained that a number of elements contributed to a veterinary fee. These included consultation—normally a fixed time at an advertised price—and the subsequent procedure, which might include an anaesthetic fee, theatre time, radiography and a procedure fee. Procedure fees could include costs of items such as needles and syringes. Invoices, generally, detailed these. The BSAVA suggested that potential customers were aware of the differences and were prepared to shop around, especially for relatively straightforward unit packages such as puppy vaccination and bitch spaying.

11.38. There were no remuneration scales for veterinary practices and fees were based on services on offer, level of expertise available, and geographic location; the OFT had rejected as anti-competitive a recent request by a veterinary association that practices might subscribe to a band of acceptable fees for certain defined procedures.
11.39. Veterinary fees were determined by practice partners or, in the case of corporate bodies, by the employing organization; they varied from practice to practice but were frequently prominently displayed in waiting rooms, a custom encouraged by both the RCVS and the Veterinary Defence Society. Professional fees took account of professional time, the use of practice equipment or disposable items, and the purchase of pharmaceutical products. The increasing use of computerized records and invoicing had created a facility for fees to be broken down, but, since there was no uniform system in operation, the level of detail had varied between practices. Other developments, such as the software link with stock control, ensured that medicines were separately identified from professional time.

11.40. Although, in the final analysis, charges related to the need to provide sufficient margin to cover overheads and other less visible costs, the BSAVA said that the method of determining professional fees varied between each practice. An accountancy approach tended to encourage an assumption of profit for a year, and fees were calculated at a level necessary to cover overheads and margins, and to achieve that profit. Most practices would not determine fees in this way but on the basis of the extent of competition around them. Pet owners had become accustomed to finding out the cost of treatment and vaccination in advance of making decisions on which practice to use.

11.41. Whilst constraints on the advertising of veterinary services had been relaxed, the BSAVA said that few practices had taken up this opportunity; most veterinary surgeons recognized that clients would normally select veterinary practices on the basis of convenience, cost, services, reputation, familiarity and previous experience; however, they would shop around for more routine procedures, as the impact of low-cost vaccination clinics had shown.

**Management and regulation**

11.42. Turning to veterinary practices management and regulation, the BSAVA said that, whilst there might be growing interest in developing sound business management within the profession, veterinary surgeons were, first, clinicians; business acumen came with experience. Some practices had retained a traditional approach to business management, but economic realities were forcing most, particularly in the companion-animal sector, to move into a more competitive environment. Regulators for the profession included the RCVS, employment law, health and safety law, and local authority statutes; and the BSAVA itself provided information on acceptable minimum standards for premises, equipment, employment and training.

11.43. Veterinary practices played an important role in providing education and training for the profession, with students ‘seeing practice’ during vacation periods. Practical experience, which complemented college training, was provided without charge for veterinary nurses. But all continuing professional development had to be funded from within the individual practice.

**Prices of POMs**

11.44. The BSAVA believed that, in the relatively small market for veterinary medicines, encouraging the use of cheaper generic products would lead to a corresponding drop in the use of licensed veterinary medicines, and a consequential adverse effect on animal health. It said that any review of the classification of veterinary medicines or products should be undertaken on the same grounds of safety, quality and efficacy that the original classification had been based.

11.45. The BSAVA said it was not aware that UK prices were higher than in the rest of Europe (but it noted that licensing costs differed from one country to another, possibly contributing to national price variations). There was little transparency on prices and discounts obtained from wholesalers, and manufacturers relied on individual negotiations. It followed that costs to clients varied, and reflected the amount of discount obtained. The BSAVA agreed that its members would pay different prices for medicines, and that these would reflect not only the size of the practice and its turnover, but also the extent to which practices operated within buying groups. However, prescriptions were written on the basis of diagnosis and the perceived effectiveness of the particular medicine, and not on the basis of price.
Margins

11.46. The BSAVA said that large-animal practices were more successful than small-animal practices in obtaining higher wholesalers’ discounts, which were most beneficial to practices ordering large quantities of individual drugs. The BSAVA suggested that the value of the discount on the wholesale price of medicines for a busy small-animal practice was, typically, in the region of 35 per cent. The sale price of medicines was reached by setting a margin above the wholesale price. Margins were essential to accommodate hidden costs such as stocking, dispensing, and staffing. Whilst margins varied between practices, resulting in further variations in resale price, on average they represented about one-third of the cost price. A wide-ranging stock of medicines, to ensure appropriate prescription, was invariably held by veterinary practices, though some of these had low turnover. These products would not normally be commercially attractive, but had, nonetheless, to be retained.

11.47. In the BSAVA’s view, the criticism levelled at the profession for not passing on discounts to the customer reflected the complexity and frequent changes in discount structures; it reflected, also, a perception among veterinary surgeons that discounts were reasonable additions to overall practice gross margins, achieved through successful negotiations. In any event, because the value of margins reflected the size and extent of transactions, small-animal practices did not earn high discounts and were not therefore capable of passing them on.

Future competition

11.48. The BSAVA expressed concern at a possible growth in the number of non-practice pharmacies, because these were likely to ‘cherry-pick’ high-volume sales, whilst veterinary surgeons maintained supplies of all essential drugs, but with a relatively small turnover. This would result in higher costs to veterinary practices and clients. However, the BSAVA considered that competition from supermarkets was not important. But it annoyed veterinary surgeons that, whilst they were constrained by statute to prescribe and dispense only for animals under their care, and to provide medications that had been checked for safety, quality and efficacy, supermarkets were permitted to sell similarly packaged products that were ineffective.

British Equine Veterinary Association

11.49. The British Equine Veterinary Association (BEVA) said that the majority of its 2,000 members were in solely equine practice, or in practices with a significant proportion of equine work. Its submission was from a perspective of equine practitioners.

11.50. BEVA did not believe that its members were involved in a monopoly situation. There were no veterinary practices sufficiently conjoined to account for 25 per cent of the supply or acquisition of POMs; nor were there veterinary practices engaged in conduct that had, or was likely to have, the effect of restricting, distorting or preventing competition. BEVA said that its members acted in a transparent manner, with clients having a choice as to which veterinary practice to employ. There was healthy competition within the profession.

11.51. Whilst acknowledging that a monopoly situation probably did exist, under law, regarding the medical treatment of sick animals, BEVA argued that the law did not prevent a client requesting a prescription and having it processed by a pharmacist, rather than by the prescribing veterinary surgeon. It added that there were, currently, few pharmacists providing a veterinary service, presumably for commercial reasons. BEVA did not accept that an increased supply of POMs through pharmacies would lead to price competition among veterinary surgeons. A more likely outcome would be an increase in drug prices due to lower-volume orders and poorer discounts, an increased cost of veterinary prescriptions to clients, a rise in professional fees and poorer animal welfare.

11.52. BEVA said that the procedure for obtaining a product licence and MA for a veterinary POM was generally more expensive in the UK than elsewhere in Europe. As a result, the cost of drugs tended to increase at a faster rate than the RPI. Price differentials could not therefore be explained by reference to exchange rates alone.
11.53. BEVA acknowledged the existence of retrospective discounts from wholesalers to veterinary practices. These were dependent on turnover in the same way that most businesses operated with suppliers. Limits on volumes available to veterinary surgeons were constrained only by their ability to sell in large volumes. It pointed out that current legislation restricted BEVA members’ own ability to supply POMs and other veterinary medicines to animals under their care. However, there was no legal reason to prevent clients obtaining prescriptions for POMs from BEVA members, whilst having them dispensed by a qualified pharmacist.

11.54. BEVA suggested that it was not viable for manufacturers to supply veterinary pharmacies. The veterinary POM market was relatively small compared with its medical counterpart. The present arrangements offered some advantages: stock levels of POMs at equine practices, including the less-frequently-used medicines, were based on local knowledge and experience; stocking those infrequently used could lead to wastage, whilst failing to stock other drugs needed quickly could lead to delays in treatment and unnecessary suffering; the best advice on the use of POMs came from those who had prescribed them and who had, additionally, detailed knowledge of animals under their care; drugs were administered on a body-weight basis, and the veterinary surgeon could divide drug packages, if necessary, to administer appropriate treatment, with the client paying only for the proportion used and the veterinary surgeon retaining the balance for (it was hoped) future use.

11.55. Other advantages in retaining present arrangements, BEVA maintained, were the availability of veterinary surgeons to dispense medicines on a 24-hours-a-day, seven-days-a-week basis; this encouraged a prompt start to a course of treatment, and frequently led to early recovery. Advice on the use of POMs, whether at the surgery or on the farm, was generally given without charge, even if it did not follow a consultation and examination. Accurate medical records were assured when the source was constant. Finally, there was a guarantee that treatment would be maintained until full recovery had been achieved.

11.56. BEVA said that higher prices of POMs in the UK were due to factors in the supply chain outside the veterinary profession. The constraints imposed on the supply of drugs acted as sufficient deterrent to competitive abuse. Cheaper drugs did not always lead to better husbandry, but frequently to greater drug use that masked inferior husbandry.

11.57. In conclusion, BEVA said that the present system of dispensing POMs ensured that animals had the best possible care. Whilst it might acknowledge a lack of competition between veterinary surgeons and pharmacies, sufficient competition among veterinary practices themselves existed. This, in turn, operated in favour of the client.

Society of Practising Veterinary Surgeons

11.58. The SPVS said that it represented veterinary surgeons who were either partners or employed in veterinary practice. Member businesses ranged in size from single veterinary surgeon to multi-site practices, but the majority were small and privately owned.

11.59. The SPVS was surprised at the OFT’s suggestion of a lack of transparency in the pricing of medicines. Legislation, covering food-producing animal practice, required the recording of all medicines used in the treatment of animals, and the complete traceability of all medicines from the time of purchase by the practice to sale to the farmer. Farmers were aware of what medicines were sold, and could readily make price comparisons with those supplied by pharmacists and others. In the companion-animal sector, itemized invoicing was an increasingly common procedure.

11.60. The SPVS said that both the pricing of medicines sold by individual practices and the purchase price from pharmaceutical houses varied according to the size and buying power of the business.

11.61. It explained that individual practices were restricted to supplying medicines to their own clients and animals. The supply of medicines to clients from other practices was not allowed. Wider potential sales were, therefore, restricted. On the other hand, clients could request prescriptions for processing at a pharmacy. The SPVS acknowledged the necessity for monitoring sales of POMs, maintaining low cost levels, and ensuring ready availability, but it pointed to the nature of medicine and
the adverse effects that misuse or overuse might have on animal welfare and human health. It argued that cheap and readily available antibiotics should not be used to treat diseases in circumstances where improved animal husbandry methods would have prevented a disease situation arising in the first place.

11.62. There was concern within the SPVS that reduced profitability for the manufacturers from sales of some important medicines, combined with the cost of product licensing, had already led to the removal of these medicines from the market for farm-animal medicines. Money for R&D came from the income from medicine sales, and further constraints on margins made by the major pharmaceutical houses would be likely to result in further problems in this area and a possible decrease in the number of new medicines coming on to the market.

**Pig Veterinary Society**

11.63. The Pig Veterinary Society (PVS), a specialist division of the BVA, disputed the view that veterinary surgeons were anti-competitive in the provision of services to pig-farm clients. For the most part, the service was comprehensive and included farm advice, quality assurance and medicine supply. Some specialist practitioners acted as consultants to outside clients; in such circumstances medicine sales were not included. In general, specialists’ charges were considerably higher than fees to those clients receiving a complete package.

11.64. The PVS said that the total veterinary bill to a pig farm comprised fees, medicines supplied, and medicines prescribed. Medicines prescribed were usually restricted to in-feed medication by feed compounders on the instructions of an MFS prescription supplied by a veterinary surgeon in attendance. Prescriptions were charged individually at between £8 and £10 per issue, a cost not dissimilar to that likely to be incurred should the veterinary profession issue them.

11.65. The PVS said that veterinary costs had been affected by a number of factors in recent years. There had been a severe downturn in the pig sector and a dramatic reduction in client bases. Veterinary surgeons had become more competitive. Clients had, increasingly, changed practices to obtain better deals. Illegal imports had continued in an uncontrolled manner. Price lists had become available on the Internet; and there had been developments in corporate pig farming, including the employment of in-house veterinary surgeons. Free market competition had contributed to reducing margins. It added that medicine costs to veterinary practices, as a percentage of sales, had increased by 5 per cent in the past year. On the other hand, due to the dire economic state of the pig industry, increases in professional fees had been uncommon.

11.66. The PVS explained that farmers had been, historically, reluctant to pay for advice. This reluctance had increased as the value of livestock had reduced. So as to encourage on-farm involvement, veterinary surgeons had kept professional fees low, but had supplemented them by charging margins on medicines. Typically, some services—including telephone advice, research related to individual client problems, and interpretation and discussion of laboratory results—had been provided without charge. In addition, there were indirect costs, for which no charge had been made, including talks to farmers’ groups, and liaison with representative bodies such as the National Pig Association, Assured British Meats and the Meat and Livestock Commission. Further, during the recent outbreaks of classic swine fever and FMD, expert advice from PVS practitioner members had been required by the Government, but without payment for either time or travel expenses. Where private practitioners had been used to help control FMD, payment had been at a rate unsustainable without a secondary income.

11.67. Other factors had to be considered, the PVS said, in calculating professional costs. The hidden costs of CPD, including subscription and registration fees, and opportunity costs were high. Professional obligations included a 24-hour service; the limited amount of out-of-hours work did not compensate for the high costs of providing the service. In some areas, for reasons of bio-security, it had been essential to maintain higher levels of staff so as to accommodate freedom from pig contact requirements before entry to a farm. Moreover, higher levels of in-house training, as a consequence of inadequate provision at university level, had been essential.

11.68. The PVS said that private veterinary surgeons provided a package of services; these incurred costs, which comprised, mainly, fees and medicine sales. A reasonable margin on medicine charges was both justifiable and necessary. If the facility to dispense was removed, or if the ability to supplement fee income from medicine sales was undermined, the nature of the service provided would change
drastically. Fee rates and services, for which a charge was currently made, would increase; farmers, however, would continue to pay a margin for medicines no matter the source of supply. The PVS expressed concern that an increase in fees would further discourage farmers from seeking advice. There would be consequential effects on time spent on quality assurance visits and the ability of the industry to monitor and detect disease outbreaks, with serious implications for animal welfare and productivity. Pharmacists would be unlikely to have in place essential systems for tracing food-producing animals; nor might they be prepared to stock a full range of essential medical products, in particular where a need existed for sufficient stocks to be held to accommodate a 24-hour potential demand. Furthermore, there would be considerable need for pharmacists to be trained in population medicine and animal husbandry.

11.69. According to the PVS, existing competition levels among veterinary surgeons had influenced the price of medicines to farmers; competition between pharmacists, on the other hand, was unlikely.

11.70. Illustrating the costs to veterinary surgeons of carrying and dispensing medicines, the PVS explained that these varied depending on practice size and the extent of local competition. Typically, such costs represented some 60 per cent of sales. The margin made on medicines was, on average, 30 per cent over the cost of supply. Price transparency was not an issue; current policy had encouraged itemized statements of all charges.

11.71. The PVS argued against a suggestion that products should be recategorized from POM to PML. It provided anecdotal evidence to support its view that pharmaceutical merchants supplying PML medicines had ill served farmers and pig stocks. In the PVS’s view, the correct use of biologicals was an integral and vital component of a pig herd health programme; the UK should operate in line with the rest of Europe by maintaining veterinary supply and by bringing PML vaccines into the POM category.

Sheep Veterinary Society

11.72. A representative of the Sheep Veterinary Society said (at the public hearing) that there were about eight sheep vaccines currently available, three of which had been classified as prescription-only. In the Society’s view, since POMs were so classified because they were potentially dangerous to animals and humans, suggestions that they should be reclassified betrayed a lack of understanding.

Portland House Veterinary Group

11.73. PHVG said that it comprised a veterinary practice, a specialist poultry practice and a specialist veterinary pharmacy. Each operated as a separate business. The pharmacy had been set up following the announcement of the Marsh inquiry.

11.74. Each business operated differently. The mixed practice purchased supplies direct from wholesalers. The poultry practice, being a specialist business, bought direct from manufacturers. Whilst the pharmacy had experienced initial difficulties in securing supplies from wholesalers, these had been overcome.

11.75. For PHVG’s comments on its pharmacy practice, Veterinary Drugs to Go, see paragraphs 12.84 to 12.87.

11.76. Noting that, historically, veterinary fees had been fairly low and static (because at one time in effect subsidized by various government-sponsored disease eradication schemes), PHVG identified the following features of veterinary practice and the supply of POMs:

(a) So as to compensate for loss of income resulting from the decline in farm work, margins on POMs had increased; the growth of companion-animal practice and involvement in meat hygiene work had stimulated some partial commercial recovery. PHVG acknowledged that it did not make a significant profit from its services and skills, as distinct from the sale of drugs, and believed this was true of most practices. Dispensing fees, injection and consultation charges had always been built into overall charges on drugs and drug sales. Whilst this approach had to
change, most veterinary business operations had been unable, in PHVG’s opinion, to break down their services to such an extent.

(b) Whilst the purchase of drugs had been based on quality rather than price, PHVG had no definitive sense of the net price it had paid for individual drugs, and recognized that, in the event of increased competition for dispensing medicines, it would require greater awareness of realistic margins.

(c) There was a shortfall in the range of products available because, in PHVG’s view, the cost of obtaining authorizations for new drugs had inhibited manufacturers from introducing them. The outcome was that there were, for example, only two licensed antibiotics for turkeys and some useful and safe products had been withdrawn from production because the manufacturer could not justify the expense of seeking to relicense.

(d) The alleged increase in volumes of lower-cost illegal drugs entering the UK, in particular from the Republic of Ireland, was causing PHVG concern, particularly as a high proportion of these would be for use with food-producing animals. Three obvious adverse effects arose from these imports: there was no guarantee that the product was exactly the same as its UK counterpart; instructions for use were in the language of the country of origin, and were sometimes difficult to interpret precisely; and records of illegal imports were unlikely to be kept by the end-user, creating difficulties for an accurate audit trail if subsequent problems arose.

(e) The basis for competition in the market for veterinary drugs rested with the manufacturers; it amounted to competition between brands. In PHVG’s view, wholesalers represented no more than a delivery service for manufacturers. But wholesalers provided the hardware and software for computerized purchasing, creating an incentive for volume purchases, and dealing with a single wholesaler facilitated practice administration.

(f) Perceptions of animal care and costs were changing. Farmers were beginning to accept the value of professional charges and the benefits of cost and billing transparency. Pig farmers were, for example, increasingly turning to specialist consultants for advice and practical help, and involving the veterinary surgeon less constantly. PHVG expected that veterinary surgeons would make fewer visits to cattle and sheep farms but there would be more discussions on long-term animal care and drug usage, with repeat prescriptions being issued to cover the forthcoming six-month period.

(g) Competition did not exist in respect of large-animal practices; farmers rarely changed veterinary practices and only after a dispute had arisen. With small animals, competition related more to service than to price; most owners stayed with the veterinary practice nearest to where they lived.

Veterinary Practice Initiatives

11.77. Veterinary Practice Initiatives (VPI) said that it was a corporate small-animal practice, set up in 1998, following a change in stance by the RCVS on the ethical acceptability of corporately-owned practices. Capital had been invested by three major venture capitalists, other investors, and a small amount put in by the management. VPI operated from 29 practice units situated throughout the country, with a combined turnover of £7 million to £8 million. One of its founders, its Chief Veterinary Surgeon, Mr John Sheridan, explained that the principles behind corporate veterinary practice management had been developed in the USA, where the partnership ethic had not developed as it had in the UK and where management trends in the profession over recent years had been related to the development of pet superstores and considerable consolidation in the market. Mr Sheridan’s ideas on management had been formed following a short-lived effort to organize some practices on a franchise basis. The corporate approach responded to the need to build teams, with financial, marketing and other skills, as well as veterinary expertise, capable of running the large, high-turnover businesses many veterinary practices had become.

11.78. Mr Sheridan said that a number of other corporate practices had been set up in the UK, operating according to different business models. These included Goddard, Medivet, CVS, Companion Care and Vets4Pets. VPI’s business model was based on acquiring practices already within the marketplace. It looked for practices which were busy, profitable and with potential for growth. Participation in a
corporate practice suited an increasing number of veterinary surgeons who did not wish to buy into practices and were unconvinced of the benefits of partnerships in terms of the level of investment required and the returns on investment it brought.

11.79. VPi believed in ‘soft branding’, leaving the practices they acquired with their existing, strong local identities. Each member practice was set financial targets based on business plans developed for each practice in the VPi group. Purchases of veterinary pharmaceuticals, dressings and other requisites were made centrally. The group’s holdings of POMs had been rationalized, but the decisions about what products to buy had been scrupulously based on professional judgements on efficacy and safety; price was the last consideration; the rationalization of stocks followed a general agreement on the desired characteristics and the vaccines, antibiotics, parasiticides etc to be ordered.

11.80. VPi agreed that its size enabled it to drive advantageous deals with manufacturers of POMs. Most were supplied through NVS, with small volumes supplied through Centaur. It received the normal cash settlement discounts from the wholesalers, the level dependent to some extent on the size of its purchases. From some manufacturers, VPi received—partly retrospective—discounts of some 30 to 40 per cent on list prices. VPi believed its greater buying power and more professional management brought down by about 2 per cent the costs of medicines in practices it acquired.

11.81. VPi’s Chief Veterinary Officer did not believe that the veterinary profession overcharged for drugs so as to subsidize other sources of income. He accepted that veterinary surgeons did not charge enough for consultation fees, but that was a separate issue. He maintained that mark-ups on veterinary medicines were designed to generate a net margin, taking into account the overhead costs of providing a pharmacy within the practice, including the share of nursing time devoted to it, the floor space, utility costs and so forth. The net margin generated by the pharmacy was comparable, in percentage terms, to the net margin targeted from the sale of professional services. In VPi’s case, this was some 15 to 20 per cent in both cases; for the drugs and other supplies, the cost would be some 20 per cent of total expenditure and the revenues would be some 30 to 35 per cent, suggesting a gross margin of some 30 per cent, before subtracting overheads. Should it become clear that a margin target for drug sales was not going to be hit, the practice would have to negotiate larger rebates or increase its mark-ups on medicines. It would not be possible, in practical terms, to establish the real price, after rebates and discounts, that a practice was paying for each product and then apply a mark-up to that discounted price.

11.82. If there were any cross-subsidizing within veterinary practices, in VPi’s view it was the common undercharging for some ‘shoppable’ items such as neutering procedures and vaccinations. Clients tended to shop around for these services and veterinary surgeons were often prepared to offer uneconomic prices in these cases so as to bond clients to their practices.

11.83. Whilst accepting that there had been a drop in the availability of drugs within the marketplace, VPi believed that the range of products for a small-animal practice was adequate to provide a high standard of service and ensure that animals did not suffer.

11.84. VPi would nevertheless like to see some relaxation of the cascade in respect of companion animals. In 2001 the company had investigated the likely savings on costs which could accrue from the use of generic drugs. The savings identified were not as great as had been expected, but were still substantial—some 5 per cent of the company’s spending on drugs and medical supplies. Further savings were limited by factors such as the absence of licences to testify that the products would be effective, and—for antibiotics especially—the sizing of tablets or capsules which was unsuitable for dogs and cats. The company had also looked into sourcing veterinary medicines from the USA or from mainland Europe (particularly the Netherlands), but had run into insurmountable licensing hurdles.

11.85. VPi issued a comprehensive policy manual on a whole range of operating, ethical and clinical issues. It enjoined veterinary surgeons within the group to provide prescriptions to clients requesting them. In practice the number of prescriptions requested was relatively small. At present VPi made no charge for prescriptions, but if the demand increased, it would have to work out an appropriate level of charging; Mr Sheridan thought the level would be in the region of £7.50 to £10, comparable to charges levied by other professions. This would need to take into account the continuing need to provide an in-house pharmacy service, notably for surgery and in-patient treatment. It was suggested that issuing
prescriptions for animals on long-term treatment would be more time-consuming and costly than present arrangements, under which clients called on the practice receptionist/nurse to pick up further supplies of the drugs the veterinary surgeon had instructed to be dispensed to treat the animal.

11.86. In VPi’s view, while there was growing competition between veterinary surgeons, the biggest competition for their services came from the other demands on the disposable income of clients, for example from alternative spending on holidays and hobbies. But price was of less importance in a client’s choice of veterinary practice than were standards and service issues.

A veterinary practice

11.87. A group practice said that it comprised three rural practices in the eastern part of England, employing both full- and part-time staff at each centre, with further specialist professional support available on a consultancy basis. It managed its farm- and small-animal operations separately. It was the only practice in its county conducting large-scale farm-animal work. That work represented just under half of total turnover, but was more profitable than the small-animal practice because it required fewer staff.

11.88. In its opinion, veterinary practices generally found it difficult to recruit assistants of suitable calibre for farm work who were quick learners and able to establish early credibility with farmers and other owners of large animals. Potential assistants tended to be reluctant to join a small country practice unless assured of training in the treatment of large animals. Training to deal with large animals took considerably longer than training for small-animal work, adding significant costs for a practice on top of the £20,000 annual starting salary for assistant veterinary surgeons.

11.89. The practice purchased POMs from all manufacturers. Although farmers were attracted by brand names, the group’s policy was, always, to buy the most effective medicine, and one that was, in the circumstances, easiest to use, if not necessarily the cheapest. In its view, different manufacturers produced similar medicines with, usually, similar effects on animals. It was against discounts in principle, believing that discounts from both manufacturer and wholesaler tended to obfuscate the pricing system, but it acknowledged that buying in quantity could provide significant cost savings; most discounts were retrospective and therefore difficult to pass on to the consumer, but the costs of others, such as vaccines, were more easily determined. Generally, the practice passed on manufacturers’ rebates to the farmers, where possible, if they paid the bill for supplied medicines within 30 days, but it retained the wholesaler’s 11 per cent settlement discount.

11.90. According to the practice, price competition existed only among manufacturers, and wholesalers competed only in respect of quality and nature of service. Moreover, the competition among manufacturers in the UK was limited to the operation of a rebates system; in the practice’s view, UK manufacturers did overcharge in the provision of drugs. It added that certain drugs were available only through licensed import; gentamicin, for example, was manufactured by several drug companies, but was not available in the UK for small-animal intravenous treatment nor for horses, whilst supplies from Germany were not only designed for horses and could be used for small animals, but were also considerably less expensive. The practice also considered that, whilst one company might manufacture a particular drug, it was not uncommon for others to buy it and sell it under a different trade name.

11.91. Noting that all wholesalers stocked a similar range of drugs, the practice said that it nonetheless purchased most of its drug supplies from a single source, NVS, which delivered daily. For veterinary practices generally, the choice of principal wholesaler centred on a number of factors, including the level of discounts, but the main criterion for the practice was the secure range and availability of medicines. On occasion, when specialist or human drugs might be required, it would contact an appropriate wholesaler, and it was able to acquire some human drugs through an equine vet. It also sourced some generics directly from manufacturers.

11.92. The practice believed it had a role in encouraging farmers to meet and become more aware about drug use, disease identification, vaccinations, preventive medicines and good herd management. The meetings were usually sponsored, in effect, by drug companies, which took the opportunity to inform attendees about current drug availability and potential. The practice expressed concern that many drugs, nevertheless, did not perform to potential and veterinary surgeons had to know about these
limitations. Whilst it appreciated the need for manufacturers to find new uses for drugs, and to promote them accordingly, it believed manufacturers at times encouraged a greater use of drugs than was necessary; it was noticeable that, if manufacturers were trying to promote a vaccine, they would try to discourage drug use, and if they were pushing a new drug, they would always seek new uses for that drug.

11.93. In the view of the practice, the range and choice of POMs was not adequate; more drugs should be widely available and should be cheaper. The cascade system, which required the use of a drug already licensed in the UK, constrained a wider importation of appropriate drugs for specific purposes. If a drug was available in any form in the UK, it was difficult to avoid being required to use it. Importation of substitutes and others was possible, but only for specific animals, and for specific treatments. On those occasions when a drug was not available in the UK, a free market would be opened up for the veterinary surgeon who could obtain appropriate medicines at a reasonable price, and, in turn, reduce costs to the farmer. The practice believed that the licensing process was excessive rather than inadequate.

11.94. The practice said that the issue of realistic charges for professional fees was a sensitive one; clients, including farmers, perceived value only in actual drugs provided, or, put another way, in what they could see. It was not acceptable to clients to charge properly for time spent on consultations. In many respects, the relationship between veterinary surgeon and farmer was seen as one of medicine provider rather than of diagnostician. Traditionally, the client had been reluctant to pay for a formal diagnosis—often, in the case of farmers, being able to diagnose their animals’ sickness—but had always been willing to pay an acknowledged mark-up price for a cure. The practice’s customary margin for antibiotics was 50 per cent on the wholesaler’s list price, and 20 per cent, or sometimes lower, for vaccines. If the issuing of prescriptions became more generalized, the practice would be forced to charge higher consultation fees.

11.95. Acknowledging that failing to charge the economic rate for veterinary services was a rarity among professional services, the practice said that this was a cultural issue reflecting current customer preference. There would be advantages for the practice in a system in which prescriptions were issued, in terms of not having to obtain and store medical stocks and maintain essential audit trails. But it emphasized that clients wanted the present system of low consultation fees and marked-up prices for veterinary medicines.

11.96. At all the group’s surgeries, invoices detailed appropriate individual items such as travelling time, professional fee, and treatment together with information on drugs prescribed and administered. Few owners of companion animals ever requested detailed bills but, when they did, till receipts were issued. Insurance companies were always provided with a detailed breakdown of charges. Costs were determined by individual veterinary practices, and guidance was not issued from any central source; nor was there an RRP for drugs. The practice’s own latest annual profit on drugs amounted to 28 per cent. Current charges for prescriptions reflected guidance given in the course of the Marsh inquiry. It added that there was no local facility for other price comparisons.

11.97. The practice said that UK regulations in respect of drug use appeared to be stricter than elsewhere in Europe and that this could be a factor in the UK’s higher prices. Illegal drug use had fallen following the introduction of freedom food schemes during the BSE crisis, farmers being afraid of the consequences of failing to provide information essential for audit trails.

11.98. The practice concluded that advice provided by veterinary surgeons about usage would continue to be a critical element in the supply of medicines and that, if veterinary practices no longer dispensed drugs, this essential advice would be lacking. Veterinary surgeons needed to keep up their professional knowledge about the storage, use and science of drugs; the practice considered that there was a case for making compulsory the current voluntary arrangements for CPD.

Specialist veterinary practices

11.99. The CC took evidence from veterinary practices specializing in the treatment of cattle, pigs, poultry and fish.
Mr John Blackwell and Ms Ruth Vernon

11.100. John Blackwell is a partner in a six-person mixed practice in Shropshire. Ruth Vernon is a partner in a five-person mixed practice in Norfolk. As individual practitioners, Mr Blackwell is mainly involved in the treatment of cattle and Ms Vernon specializes in cattle and pig work. Both are executive members of the British Cattle Veterinary Association (BCVA) and Mr Blackwell chairs its medicines committee.

11.101. They said that they dispensed almost all the medicine they recommended for treatments, with the significant exception of in-feed medication for pigs, for which prescriptions were written for supplies to be incorporated at mills. Since these prescriptions involved a considerable amount of work, Ms Vernon’s practice charged £14.58 plus VAT for the initial prescription and £9.56 plus VAT for repeat prescriptions. (The differential in costs took account of the initial extra workload in generating and cross-checking the data for the first prescription.) Whilst both had discussed the wider provision of prescriptions with farmers, it had proved more fruitful to talk of general management issues with a view to reducing the overall medicine bill.

11.102. Mr Blackwell and Ms Vernon agreed that the range of veterinary medicines was diminishing. As product licences came up for review, some, even for long-standing products with a so-called ‘licence of right’, were frequently allowed to lapse for commercial reasons. There were consequently large gaps in the market (although there had been some innovative developments in the field of antimicrobials). The BCVA had, for example, had to lobby fiercely to persuade one manufacturer to relicense a bovine sedative, Xylazine. There was no licensed product for anaesthetising calves, and a lot of low-usage products had disappeared, for example an antihistamine for cattle and a systemic treatment for ringworm in cattle. Although the prescribing of unlicensed products for use in food-producing animals was not allowed under the prescribing cascade, both practitioners had needed on certain occasions to resort to the cascade in the interests of animal welfare, while observing the necessary species withdrawal times. Any further relaxation of the cascade was considered inimical to food safety, and this could have a detrimental impact on the UK’s meat trade in Europe. Both veterinary surgeons believed that the current regulatory system was the correct way to ensure that POMs were proved to be efficacious. In this area, the UK system was superior to that in the USA, giving veterinary surgeons here the confidence not only to sell medicines but also to advise on health planning; whilst there were only two vaccines in the UK for bovine viral diarrhoea, a cattle disease, there were hundreds in the USA but they did not form part of an overall control package and their overall success was consequently poor. They also thought that increased use of generic medicines would sound the death knell for much R&D work; both veterinary surgeons tended therefore to remain loyal to original brands, with tested efficacy and safety, even if slightly cheaper alternatives came on to the market.

11.103. Speaking also on behalf of the BCVA, Mr Blackwell and Ms Vernon said it was important that prescriptive control was kept on all antimicrobials, in line with the policy being developed by the European Commission. There was widespread evidence of overtreatment when PMLs, acquired from agricultural merchants, were used, for example PML wormers. Even with small animals, overtreatment could be dangerous, for example when using flea treatments.

11.104. Both practices marked up POMs’ prices by generally some 50 per cent on list price. Mark-ups were often lower for the most expensive products. Some medicines were marked up by lower percentages (25 to 30 per cent) so as to encourage use of preventive-type vaccines, rather than curative antimicrobials. The mark-ups on PMLs was lower (15 to 20 per cent) because their availability on the market was greater; merchants were not restricted to selling products only to genuine clients, as was the case for veterinary surgeons, and consequently their market penetration was much wider; PMLs were often oversold to a perceived need rather than an actual need; high-volume sales enabled merchants to obtain greater purchasing discounts and to sell PMLs at low prices. However, no analogy could be drawn with the market for POMs; these were under prescriptive control, and similar mark-ups on these as were applied to PMLs would entail reducing stockholdings, particularly of low-usage products (stocked for emergency situations but often expiring and having to be thrown out) and increasing hourly consultation rates.

11.105. The two practices had looked into marking up on the basis of net net prices rather than list prices. But net net prices were difficult to calculate and a more transparent system of rebates would be welcomed, in particular by removing the retrospective application of some manufacturers’ rebates. Retrospective rebates were not considered to be fundamental to the management or profitability of either
practice; margins were set for product sales and, if retrospective rebates came in, pricing policies were simply restructured at that time. Neither Mr Blackwell nor Ms Vernon was influenced by the level of rebates in choosing products, except in cases where two products were equally efficacious and safe.

11.106. Turning to veterinary charges generally, Mr Blackwell said that if charges were prohibitive, whether for medicines or services, there was a risk that veterinary surgeons would not get out to visit farms. This was against the welfare of animals and the economic interests of farmers. For example, if a realistic rate for a cow caesarian was charged, the operation would never be performed. Whilst historically an imbalance had developed between prices charged for medicines and the level of consultation fees, mainly because the profession was grossly under-valued, efforts were being made to redress the balance. However, client surveys and the veterinary surgeons’ perception of their role suggested that medicines were seen as part of an integrated package of services.

11.107. Both practices issued fully itemized bills, setting out service charges, medicine charges, dispensing charges and the costs of most consumables. By law, all products had to be logged in and out, requiring that every item dispensed from stock had to be individually itemized so that an audit trail could be followed.

11.108. Mr Blackwell and Ms Vernon saw problems with the proposition that members of the profession be allowed to dispense prescriptions written by other veterinary surgeons. It would be worrying to dispense medicines for animals about which the dispensing veterinary surgeon had no knowledge. Conflicts of interest could arise if the dispensing veterinary surgeon did not agree that the right treatment had been prescribed for an animal. Mr Blackwell worried about the retired veterinary surgeon stocking his garage with products and merely fulfilling the dispensing role without giving any advice. Both practitioners recognized that the right of a pharmacist to dispense to a written prescription generated by a veterinary surgeon for an animal under his/her care was laid down in the Medicines Act. However, they observed that this did not currently take place because the infrastructure for supply was not provided by the pharmacist. The client therefore had difficulty in finding a pharmacist able to fulfil a veterinary prescription.

11.109. Both Mr Blackwell and Ms Vernon said that their respective practices faced significant local competition. Level of service was in their view the key factor in attracting clientele rather than the prices practices charged for medicines, and neither had any idea of the fees or prices charged by their competitors. There was a national problem of finding veterinary surgeons wanting to undertake farm work, and as a result clients were registering from further afield as more neighbouring practices pulled back from farm work. For their part, farmers were tightening their belts and rationalizing their calls on the services and expertise of veterinary surgeons.

Mr Mark White

11.110. Mr Mark White, representing the pig medicine part of the veterinary profession, said that there were no specialist pig practices currently in the UK; from a private practice viewpoint, all pig veterinary work was run from mixed practices; he was a member of a ten-person practice based in and around Hull in Yorkshire. His was one of five or six practices in the North of England providing specialist pig veterinary services.

11.111. Mr White explained that over the last 20 years there had been a steady decrease in livestock in the area served by his practice. He reckoned that the pig practice had halved over this period. His clientele had fallen to some 80 from 100 to 150 some ten years ago. He had one large corporate client, who formerly took up roughly half his time but now, with pig farming declining, accounted for about a quarter of it. He numbered some other corporate group farms among his clientele, and also provided services to a range of other clients down to the small pig farmer.

11.112. The only prescriptions he wrote on a regular basis were for MFS (formerly known as veterinary medicines directives). He explained that feed for pig farms was either supplied from specified manufacturers or made by the farmer. In both cases prescriptions were required for the feed medication. Some 1,600 prescriptions were currently issued each year, at a current charge per prescription of £8.40 plus VAT: this fee was based on the time an MFS prescription took to prepare. Prescriptions for non-feed medicines were a rarity; farmers did not ask for them and there was no structure in place to supply the medicines.
11.113. Mr White described the range and structure of the medicines he prescribed and dispensed as: vaccines, accounting for about half of the medicines used by value, and made up of high-volume, competitively-priced vaccines for growing pigs and vaccines for sows, which were supplied in lower volumes and for which competition was less intense; high-volume antimicrobial products, often in soluble form for mass medication of large numbers of animals; and individual treatments, for example bottles of antibiotics.

11.114. He said that the availability of drugs for pigs had gone down over the past decade, as licensing requirements had squeezed out medicines, in particular low-usage products such as anaesthetics. He did not think there was a case to downgrade any POMs to PML, and in his view some products listed as PML should carry a POM classification.

11.115. Turning to the question of the balance between veterinary fees and the prices charged for POMs, Mr White argued that the business of a veterinary practice had different components, each of which had to earn a profit. Consultancy work and medicine sales each had to make profits. He recognized that there were constraints in setting professional fees because farmers, although more ready than in the past to pay for ‘something they cannot actually hold’, remained reluctant to pay the full costs of veterinary services beyond that directly for ‘on-farm time’. Typically, Mr White travelled extensive distances to visit clients, and pig farmers, being technically competent, seldom called on emergency veterinary assistance. In terms of Mr White’s turnover, professional fees represented some 30 per cent and medicines some 70 per cent; each contributed about a half of gross profits.

11.116. Mr White said that average mark-ups on POMs and PMLs were highly variable. For low-usage items, the mark-ups could be about 30 per cent on list price, and discounts on these drugs would be limited. For high-volume ‘commodity’ medicines, for which there would be tougher competition, the mark-up would be 20 to 25 per cent on net net prices (in cases where it was possible to calculate the net net price). In making purchasing decisions, the technical characteristics of a product, especially its efficacy and withdrawal times, outweighed considerations of price. Mr White said that his practice had in the past been a member of a buying group but had withdrawn because it dictated the products the practice could use, took an unacceptably high commission and was unable to secure better deals with manufacturers than those the practice could arrange on its own behalf.

11.117. Mr White saw no reason why veterinary surgeons should not be allowed to fulfil a prescription from another veterinary surgeon, so long as adequate controls were in place. The current prohibition on doing so prevented veterinary surgeons purchasing high volumes of drugs.

Mr Mike Alcorn, Mr Dan Pearson, Mr Howard Hellig and Mr Richard Turner

11.118. Four veterinary surgeons engaged in poultry practice: Mr Mike Alcorn is a director of a large integrated poultry company in Ireland (both north and south), Mr Dan Pearson works as a company veterinary surgeon for a large UK poultry enterprise, Mr Howard Hellig is in private veterinary practice and advises a number of poultry trade associations in the UK and EC, and Mr Richard Turner is a member of a large-animal practice in Devon.

11.119. They explained that there were broadly four segments in the poultry industry: the broiler industry, of which between 80 and 90 per cent was controlled by seven or eight companies; the turkey industry, about 90 per cent of which was controlled by two companies; the duck industry, dominated by one large and a few smaller companies; and the egg industry, which was more diverse but in which one company accounted for 10 per cent of production. The whole industry was in structural decline, despite a growing market, as a result of import penetration following changes in world trade rules. From full self-sufficiency some years ago, the industry was now only about 80 per cent self-sufficient and was on a downward trend. Moreover, the situation was even worse when the commodity components of the sector’s import and export trade were analysed; the UK was mainly importing breast-meat, but exporting poultry heads and feet. Domestic companies were in consequence buying major production units abroad.

11.120. Somewhat less than 50 per cent of the industry was looked after by company veterinary surgeons, and the rest by private practices, normally on a regular basis. Some 50 veterinary surgeons altogether provided some kind of veterinary service to the industry. Competition among poultry veterinary surgeons was partly affected by the companies’ ability to move to employing an in-house veterinary surgeon.
11.121. Poultry veterinary surgeons purchased drugs directly from manufacturers (except for a few exceptions among smaller practices which bought through wholesalers). Some companies—particularly, but not only, those with in-house veterinary surgeons—negotiated medicine prices directly with manufacturers. Vaccines had been making up an increasingly higher proportion of drug purchases in the poultry sector; poultry veterinary practice was almost entirely focused on disease prevention, since the industry depended on the predictability (mainly in relation to the weight of the birds produced) that disease prevention brought. Availability of vaccines had been expanding, whilst that of antibiotics had been declining (as had that of PML ‘growth promoters’, which had been subjected to considerable political pressure). The reduction in the number of antibiotics had resulted from the complexities and expense of the licensing system, making it particularly difficult to license products for a limited market or minority species (and most vaccines were species specific). This was leading to some serious gaps in therapeutic availability, for example for the treatment of blackheads in turkeys. The problem was being exacerbated as more birds were reared free range, rather than on concrete. The use of drugs off-licence was extremely limited in the case of poultry.

11.122. The poultry veterinary surgeons said that they would benefit from being able to make use of vaccines licensed in other member states. The poultry industry competed at the European level, and even wider, and it would be helpful to enjoy equal access to pharmaceuticals throughout the zone of competition. At present, for example, it was illegal to export progeny from a flock not vaccinated with a UK licensed vaccine. There were particularly acute problems relating to certain inactivated vaccines licensed in other parts of the EC but not in the UK. Central European licensing had been largely unproductive as far as poultry medicines were concerned. The situation had helped stimulate significant levels of illegal imports. As far as costs were concerned, parallel imports of cheaper, identical medicines from elsewhere in the EC would greatly help the industry.

11.123. The two veterinary surgeons in private practice estimated that they wrote prescriptions for between 20 and 25 per cent of the medicines they supplied. These were for POMs that went into feed. The prescription fees were in the region of £10 to £15. Clients taking prescriptions would expect to buy direct from the manufacturer, rather than from a pharmacist or wholesaler.

11.124. On the question of professional fees, the two private practitioners said that they charged at reasonable levels, but fees would have to be raised if they made no profits from sales of medicines and vaccines. They were trying to educate clients to recognize that they could have cheaper drugs but at the expense of higher professional fees, including for some services, such as telephone advice, for which charges had not been levied in the past.

Mr Peter Southgate

11.125. Mr Peter Southgate is a partner in the only dedicated fish veterinary practice in the UK, situated at Inverness and Dumfries in Scotland but working throughout the UK and overseas. He explained that the bulk of its work was with fish farms (for salmon, trout, cod and halibut and other species); these were owned mainly in the UK by eight large companies, some of which also maintained in-house veterinary surgeons. The practice also worked with public aquariums and other fish-owning clients. Because its work was specialized, encompassing pathology, diagnosis and other laboratory work, it maintained extensive in-house facilities. The practice also undertook environmental impact studies to monitor the effect of fish farms on the environment. There were four partners in the practice (one of whom was a pathologist) and 11 employees.

11.126. Mr Southgate said that only three manufacturers produced fish medicines: Alpharma, Schering-Plough and Novartis. He dispensed almost all the medicines he prescribed. These were almost all therapeutics. But the number of licensed fish medicines was small: four antibiotics, three parasiticides and a new anti-fungal preparation. Fish medicines faced dual regulatory obstacles, not only having to satisfy safety, quality and efficacy criteria, but also having to meet environmental standards; the environmental agencies granted what was called a discharge consent for agricultural products, as well as registering and licensing the product. However, there were some efficacious fish vaccines and fish veterinary surgeons relied heavily on these, since they succeeded in preventing the bacterial diseases against which the antibiotics would otherwise have had to be used.

11.127. Mr Southgate said that the new anti-fungal agent (Pyceze) filled a significant gap in the market, replacing malachite green, about which there had long been concern with regard to environmental safety and residue issues.
11.128. There was little opportunity for clients to source fish medicines from elsewhere, Mr Southgate said. Veterinary surgeons bought and held consignment stocks direct from the manufacturers. They did not deal with wholesalers; earlier attempts at working with them had proved unsatisfactory because wholesalers had not been prepared to stock fish-medicine compounds, which generally had a short shelf-life, and delivery times had consequently been protracted. Consignment stocks were frequently required in large quantities, for example to treat a million salmon in the pens, and the farms were often located in remote areas; it made sense for these stocks to be available to go out to a farm immediately when needed.

11.129. However, Mr Southgate and his colleagues did not carry or sell stocks of vaccines. They wrote prescriptions for these under arrangements with the vaccine manufacturers, which supplied direct to the fish farms to be administered by teams on the farms.

11.130. Most medicines with which Mr Southgate dealt were classified POMs and he considered that it would be dangerous, from both welfare and environmental viewpoints, for that classification to be changed. Dosing had to be extremely carefully controlled to ensure efficacy and accepted discharge levels. There were few medicines fish veterinary surgeons could use under the ‘cascade’ because the number of licensed compounds was extremely restricted (although there was one wormer for pigs which could be used).

11.131. Turning to issues of competition, Mr Southgate said that the main challenge came from non-veterinary surgeons without experience of the fish business. He said that the companies were highly price-sensitive and he feared that if he raised his fees significantly (currently his hourly rate was £75), the fish-farming companies might turn to these non-veterinary surgeons for diagnosis and use his services mainly to supply medicines. In those circumstances, he would not visit the fish farms and this would be to the detriment of proper clinical control of fish health and welfare. If a choice had to be made between not being able to get out to the farms, because his fees were judged to be high, or increasing margins on the drugs, he would prefer the latter. In his business, margins on drugs were relatively low—mainly in the region of 20 per cent—but product volumes were high. Drug prices were marked up on the basis of their cost to the practice; but the practice received no rebates from the manufacturers. There was little competition between the manufacturers since they did not produce many directly competing products.

Other general submissions

11.132. Some individual veterinary surgeons sent in general submissions in advance of the consultation phase of the inquiry. Their names are included in the list of contributing veterinary surgeons at Appendix 11.1. One, for example, who had represented the independent veterinary surgeons at the Marsh inquiry workshops, noted that the Marsh inquiry had agreed that veterinary surgeons in the UK paid more for their pharmaceuticals that did veterinary surgeons abroad and that means should be found to reduce input costs. He also argued that the margins veterinary surgeons imposed on medicine sales, normally 33 per cent, were similar to the return pharmacists received for dispensing under National Health Service (NHS) arrangements; pharmacists also dispensed private prescriptions at a mark-up of 50 per cent plus VAT, and pharmacists could be paid more when opening for emergencies and on other occasions. Other points emphasized by veterinary surgeons at this stage of the inquiry included: the contribution of regulation to the relatively high prices of veterinary medicines in the UK; the convenience of one-stop-shop veterinary practices and the benefits and immediate drug availability as well as on the spot advice on administration and usage; the potential disadvantages of reliance on pharmacists for drug dispensing, such as their lack of veterinary knowledge and experience; the risk that consultation fees would have to be raised if income from medicines sales was constrained, and that the introduction of a further tier of ‘middlemen’ would increase costs for farmers and be detrimental to animal welfare. One correspondent questioned that pharmacists would in practice be prepared to devote valuable shelf space to animal medicines, some of which were bulky. Noting that R&D costs for animal medicines were extremely high and the overall market extremely low, he observed that the spin-offs from human medical research of value to veterinary medicine were fewer than in the past because human research today was focused mainly on the diseases of middle and old age.
Responses to statement of 16 April 2002

Individual veterinary surgeons

11.133. The statement was circulated to the 13,040 veterinary surgeons then registered with the RCVS as working in the UK. An abbreviated statement, and online form, were also posted on the CC website. Each veterinary surgeon was invited to comment: 205 did so but the level of participation by veterinary surgeons at this stage was considerably higher since some respondents had written on behalf of (unspecified) colleagues within their practices, and others who had not written had engaged in consultation processes within representative veterinary organizations and had endorsed the responses submitted by those organizations.

11.134. A summary of the responses to each of the 14 issues relating to veterinary surgeons is set out below. Where applicable, the responses have been presented in tabular form. However, the scope for a statistical analysis of the responses is limited: many dealt with only some of the issues, leading to the high proportions of ‘did not comment’ responses; the respondents would be expected naturally, with only a few exceptions, to challenge the premise of some of the issues; and responses were sometimes phrased hypothetically and occasionally ambiguously.

11.135. Many respondents also commented on issues relating to the regulatory system, the manufacturers and the wholesalers. These views are included, as appropriate, in the analysis below of the 14 issues relating to veterinary surgeons.

**Issue 4(i): Whether veterinary surgeons fail to inform animal owners of the option to have written prescriptions for veterinary medicines dispensed by a pharmacist**

**Issue 4(iii): Whether veterinary surgeons charge unreasonable sums for writing a prescription to be dispensed by a pharmacist**

**Issue 4(iv): Whether veterinary surgeons refuse to write prescriptions, or by some action or omission, discourage requests from animal owners for prescriptions**

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<td>Issue 4(i) (%)</td>
<td>70.3</td>
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11.136. The responses suggested that it was not uncommon for veterinary surgeons to fail to inform clients of their rights to request prescriptions for dispensing elsewhere. A few maintained that it was sensible commercial practice to withhold information on alternative sources of veterinary medicines. Over a quarter said that the decision was at least partly pragmatic: it would be pointless to inform clients of the right to prescriptions so long as pharmacies carried few stocks of veterinary medicines; and many clients, in these veterinary surgeons’ view, preferred the convenience of the ‘one-stop solution’ and 24-hour service provided by a veterinary practice, and had little confidence in the pharmacist’s likely knowledge of administering a drug or of its possible side effects.

11.137. However, many veterinary surgeons were in addition concerned about issues of principle. They believed strongly that their knowledge of the client, animal and local situation was essential in the administration, often by injection, of the correct drug (the issue of withholding time being especially important in dispensing for farm animals). One veterinary surgeon wrote: ‘the purchase of POM medicines (eg a parasiticide) cannot be separated from advice on its use … using the medicine (in whatever way) is part of veterinary science and service, and can no more be divorced from the whole than using a diagnostic procedure’. Another described drugs as the veterinary surgeon’s ‘therapeutic tools’.

11.138. Some veterinary surgeons were concerned that a separation of prescription-writing from dispensing would confuse the chain of responsibility in the treatment of animals and raise issues of veterinary surgeons’ liability for any errors made at the dispensing point.

11.139. Sixty-seven respondents (33 per cent)—the remainder mainly not commenting—argued that writing prescriptions involved more than time; the veterinary surgeon had to deploy expert knowledge...
and experience both in relation to the characteristics and dosages of drugs and to the animal under treatment (whose weight and condition influenced the choice of drugs). Consultations were therefore generally unavoidable before prescribing a drug, although about half the veterinary surgeons addressing this issue either did without consultations or charged reduced fees in certain circumstances, for example in dispensing flea and worm treatments or repeat prescriptions within a specified period (typically, six months).

11.140. Writing time nonetheless included the duplication of parts of the clinical record entries; many practices did not possess software to print prescriptions. A few claimed that other expenses, such as liability issues and the veterinary surgeons’ commitment to a 24-hour service, should be reflected in prescription charges. Almost all the veterinary surgeons who commented thought the cost of writing prescriptions would have to rise if the dispensing system was changed, either as a specific cost or as a charge for additional consultation time. Some commented that the likely overall costs of veterinary medicines might rise if the veterinary surgeons’ prescription charges were added to the pharmacists’ dispensing charges.

11.141. Most (but not all) respondents said that they currently charged for prescriptions, including repeat prescriptions. Fourteen revealed their current prescription charges, ranging from £1.79 plus VAT to £16.70, with the average around £5.40. Some veterinary surgeons suggested that doctors’ prescription charges (said to be between £8 and £10) might provide an acceptable model for veterinary charges if the dispensing system was changed, although others thought a higher charge would justifiably reflect the additional consultation time that would be necessary.

11.142. Sixty-two respondents (30 per cent) said that they would never refuse to write a prescription if requested. Some commented that requests were rare. Of the five veterinary surgeons (2.4 per cent) expressing doubts about the readiness to write prescriptions, three objected to doing so for pragmatic reasons or on grounds of principle (ie in the interests of the animal); the other two regretted that some professional colleagues might take measures, such as unreasonably high prescription charges or requests for additional examinations, to discourage clients from requesting prescriptions. The remaining 74.6 per cent of respondents offered no comment on Issue 4(iv).

**Issue 4(ii): Whether veterinary surgeons fail to provide itemised invoices showing a breakdown between the cost of professional fees and the cost of medicines dispensed**

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<td>69.3</td>
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11.143. The responses indicated that separate itemization on bills was common, and had been supplied for many years in some practices. However, a few of the 60 respondents, of the 63 answering this question, issued itemized bills only on request. On the other hand, some respondents claimed that clients frequently declined offers of itemized bills. In elaboration of this issue, some respondents wrote that they regularly informed clients in advance of costs or estimated costs for surgical and investigative work.

**Issue 4(v): Whether veterinary surgeons by some action or omission may have indicated to veterinary manufacturers and/or veterinary wholesalers that they should refuse to supply pharmacists, or supply them on less-favourable terms**

11.144. With one (implied) exception, all respondents to Issue 4(v)—representing 24.4 per cent of replies overall—did not believe that veterinary surgeons had influenced manufacturers or wholesalers over supplies to pharmacists.

11.145. A similar number—again with only one (by implication) dissenting voice—thought it was unrealistic to suggest that veterinary surgeons could exert influence on manufacturers not to reclassify POMs to a lower classification. Twenty-five respondents (12 per cent) believed the reverse to be the case and that manufacturers continued to reclassify POMs where possible to a lower classification so as to
increase market penetration after the medicines had been initially promoted by veterinary surgeons (and thus, as members of one group practice put it, given the medicines a ‘professional quality image’).

Issue 4(vii): Whether the regulatory regime causes veterinary surgeons not to dispense prescriptions written in other veterinary practices, thereby restricting competition between veterinary surgeons

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<td>Issue 4(vii) (%)</td>
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11.146. A significant majority of respondents addressing this issue would like to see a change in the provision (under the Medicines Act 1968) that veterinary surgeons can dispense prescriptions only for animals under their care. One veterinary surgeon described this restriction as ‘the biggest barrier to fair competition between vets, pharmacists and SQPs’. However, opponents argued that any change would increase practice costs by requiring more staff to deal with telephone enquiries and to staff the dispensaries, would be of most benefit to large practices, and would raise liability issues.

11.147. Some respondents pointed out that in practice veterinary surgeons would sometimes dispense prescriptions written by other veterinary surgeons when pet owners were away from home—in which case it would be normal practice to check with the owners’ veterinary surgeons on dosage. Others drew attention to the ‘anomaly’ that, whilst veterinary surgeons could not supply PML medicines for animals not under their care, pharmacists could do so. One respondent commented that in effect this rule obliged veterinary surgeons to treat as ‘POMs’ all medicines they supplied to the public.

Issue 4(viii): Whether, due to the regulatory regime, veterinary surgeons choose treatments for companion animals in an unnecessarily restrictive way, leading to higher costs for pet owners or a reduction in animal welfare

11.148. A total of 89 veterinary surgeons (43 per cent of respondents) commented on this issue. They divided roughly equally between those broadly supporting and those contesting the proposition. But a significant number recognized that the issue was finely balanced. They took the view that while the cascade contributed greatly to the high cost of veterinary medicines, it enhanced safety and helped manufacturers, operating in an extremely small market, to fund research and develop new drugs.

11.149. At least 15 respondents (7.3 per cent) advocated the relaxation of the cascade or even its removal for non-food animals, so as to enable low-cost drugs for human use to be prescribed for animals, as appropriate. In this connection, some would like to see rabbits and horses removed from the category of ‘food-producing animal’, which means that certain medicines cannot be prescribed for them. (However, two other respondents alleged that manufacturers’ prices for human generics tended to rise if they became in demand for veterinary treatment.)

11.150. Three respondents said that they used their discretion in interpreting the cascade.

11.151. Four veterinary surgeons challenged the argument that the cascade helped R&D into new drugs. They claimed that most manufacturers spent little on R&D, and were charging high prices for long-established drugs in a protected market. Another argued that the case that the cascade existed for the safety of animals was undermined by the ‘exemption’ from the scheme of some charities, which were allowed to treat large numbers of patients with generic drugs.

11.152. Commenting on other regulatory issues, at least 10 per cent of respondents said that efficacy testing of drugs remained vital, notwithstanding a widespread perception that the therapeutic range of drugs was diminishing. About 4 per cent commented on the possibility of allowing more outlets for PML drugs, for example pet shops. Some considered this feasible, provided staff received proper training, but more stressed the dangers for animal welfare of greater access to PMLs (for example, in heightening risks of anthelmintic resistance), as well as the commercial risks that new outlets might tend to stock only high-turnover drugs.
**Issue 4(ix): Whether veterinary surgeons take steps that make it difficult for animal owners to switch from one veterinary surgery to another**

11.153. Ninety-five respondents (46.3 per cent) addressed this issue. All said that clients wishing to switch from one surgery to another faced no barriers whatsoever. They noted that RCVS rules, as well as the interests of animal welfare, obliged veterinary surgeons to hand on patients’ records to their successors. One veterinary surgeon offered a ‘guessimate’ that 15 per cent of companion-animal owners switched practices every year. Members of another practice took issue with the RCVS’s ethical restrictions on advertising.

**Issue 4(x): Whether veterinary surgeons set their charges for dispensing medicines in such a way that they subsidise their consulting fees**

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<td>22</td>
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11.154. The responses revealed a wide range of positions on this issue, including among those broadly agreeing with the proposition:

(a) Some respondents recognized that cross-subsidization was ‘endemic’. Many recognized that the practice of cross-subsidization had grown up for historical reasons. They nonetheless considered it fully justified by the profession’s low levels for fees, particularly taking into account the 24-hour, on-call commitment, the free or reduced-cost services veterinary surgeons provided (for example, for wildlife and charities) and the requirement to treat all animals regardless of the owners’ ability to pay. Some echoed one respondent’s comment that: ‘Our clients fully appreciate that our retail margin subsidises their service and in general seem to prefer it that way’. One veterinary surgeon cited a survey of customers supporting the present balance between fees structure and the prices of medicines.

(b) At least 50 respondents (25 per cent) argued that professional fees would have to be raised if veterinary surgeons’ income from drugs fell. Estimates given of the necessary increases ranged from 15 to 250 per cent (the latter for farm animals). One respondent claimed: ‘the true cost of care … would be prohibitive for vast numbers of clients’, and, as the experience of some veterinary surgeons had already shown, the effect was likely to impact disproportionately on the poorer members of the community and on ‘low-value’ livestock. This would lead to fewer companion and farm animals overall being seen by veterinary surgeons. Further knock-on effects might be that fees from a reduced client base would have to rise even further and some small clinics might have to close or merge with larger practices.

(c) Many veterinary surgeons said that it would nonetheless be difficult to persuade clients of the case for higher fees; there was a widespread failure to value, and therefore be prepared to pay for, professional time; according to seven respondents, some clients even felt they had received poor service if they were not supplied with some form of medication. Some attributed this attitude to the existence of the free provision of healthcare under the NHS.

(d) Contesting the proposition that income from medicines subsidized veterinary fees, some veterinary surgeons argued that they set fees to cover consultation and surgery costs. A number within this group strongly believed that veterinary surgeons should make their livings from their expertise, and some were prepared to see drugs and vaccines, apart from a small stock of injectable medicines for emergencies, provided through normal pharmaceutical channels. One wrote that:

> Veterinary medicine [should] be paid for the unique specialist knowledge of medicine it brings to disease control and treatment of domesticated and in some cases wild animals. Therefore it is entirely inappropriate that it should obtain part of its revenue from drugs and vaccines … A prescription, as used by our medical colleagues, would be much more appropriate … vets should make a living through their knowledge, not through peddling drugs.

(e) A group of about ten respondents (5 per cent) argued that it would be misguided to focus on fees and medicine costs as separable items (one maintained that it was ‘nonsense to split [vet services
and goods] into component parts and demand that everyone be allowed to compete for each item, but not for the whole’). They argued that clients registered for a ‘health-care package’. Some elements of the package could never be wholly self-financing—for example, the on-call work (a 24-hour, year-round service), CPD, and some local initiatives such as an A&E helpline one practice runs, and the kidney dialysis machine another practice has installed. As one respondent wrote: ‘Vet practice has to support numerous activities that in reality do not have sufficient a critical mass to exist as an entity on their own. There is under these conditions going to be a degree of cross-subsidization between these activities’; however, the margin on medicines is only one of a number of activities (including some surgical procedures, laboratory work and sales of pet food) supporting overheads. Another wrote: ‘Veterinary surgeons charge a mark-up on drugs and supplies at a level designed to achieve a realistic net margin after the specific labour and overhead costs of maintaining the veterinary pharmacy, including in-house professional advice, CPD and a 24-hour service.’

(f) Some respondents, with similar views to those above, argued that the practice pharmacy could be regarded as a ‘cost centre’. One veterinary surgeon among this group thought that his drug costs roughly equalled his income from drugs, setting receipts from POMs against expenditure on non-consumables, such as anaesthetics, suture materials and dressings (and, according to another’s evidence, most POMs’ usage was ‘in-house’).

**Issue 4(xi): Whether veterinary surgeons charge higher than necessary prices on prescription only medicines**

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<td>Issue 4(xi) (%)</td>
<td>59</td>
<td>40</td>
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11.155. Almost all the respondents commenting on this issue contended that mark-ups on POMs were justified by the costs associated with running a well-stocked dispensary, such as staff (for labelling, recording and ensuring batch traceability and giving advice on administration, as well as dispensing medicines), floor space, stockholding, disposal and wastage. They maintained that mark-ups were not excessively high, compared with similar-sized businesses.

11.156. About 7 per cent of respondents provided details of the mark-ups they put on POMs. Their profit margins were extremely variable, with lower margins often applied to the more expensive drugs.

11.157. Some illustrative examples were:

— 35 to 58 per cent (all other items by 10 to 58 per cent);
— 50 per cent, plus £1.50 dispensing fee;
— 33 per cent with no dispensing charge, but 25 per cent for more expensive drugs;
— 8 to 10 per cent on net cost, rising to 52 per cent on list price, with higher margins for a few products stocked for emergencies but infrequently used and subject to high wastage; 18 to 31 per cent on many vaccines;
— 0 to 100 per cent ‘depending on our perceptions of how price sensitive these medicines are’; another wrote that ‘modern flea treatments are so expensive that many vets are nervous about making a large mark-up’;
— 50 to 60 per cent on POMs; 40 to 50 per cent on PMLs and GSLs;
— four veterinary surgeons marking up, respectively by 75 per cent, 100 per cent on wholesaler’s price before discount, 60 to 70 per cent, and 20 to 200 per cent; and
— various mark-ups between 0 and 70 per cent on manufacturers’ list prices, equivalent to a 50 per cent average on net net prices, or 22 to 25 per cent allowing for pharmacy costs.
11.158. A number of respondents argued that it was reasonable that veterinary surgeons should mark up POMs at higher margins than PMLs and GSLs because they had to employ their training, skills and experience in prescribing them. A few also commented that they were unable to compete with agricultural merchants on sales for PMLs because the merchants’ retail prices were lower than the net net prices available to veterinary surgeons.

11.159. One multi-surgery practice, with different pricing policies for each surgery, found that reducing POMs prices at some surgeries (to a 50 per cent mark-up with no prescription fee) drew in more customers. Whilst unable for economic reasons to apply this policy throughout the business, the practice maintained that the experience showed there was no monopoly and that ‘competition dictates the price that we can achieve for medicine sales’.

11.160. A few respondents argued that in terms of comparative living costs, or of purchasing power parities, UK veterinary prices were not significantly higher than in the rest of Europe. However, some 7 per cent of respondents commented on the nominally lower wholesale prices elsewhere in Europe, variously attributing the differences to manufacturers’ or wholesalers’ behaviour, import protection or the licensing system.

11.161. Only two veterinary surgeons agreed with the proposition; one believed that in some cases financial inefficiency led some colleagues to charge higher prices for PMLs and GSLs (and, by presumption, POMs) than did alternative suppliers; the other argued that drug prices had to be inflated to cover low consultation fees.

**Issue 4(xii): Whether veterinary surgeons allow their purchasing and dispensing decisions to be influenced by rebates or discounts from veterinary manufacturers, in such a way as to restrict consumer choice or to increase prices to animal owners**

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11.162. Almost all the veterinary surgeons who commented on this issue maintained that they prescribed what was clinically required for the animal, taking into account what the owner could afford. Considerations of the quality, safety and efficacy of a drug took priority over cost factors, although the latter became important where there were two identical products by different manufacturers, for example for small-animal vaccines. Some acknowledged that discounts acted as a strong incentive in stocking dispensaries, but other factors were more significant, such as pack size, presentation and ease of use.

11.163. Some veterinary assistants commented that in many practices they would be unaware of the terms under which drugs had been purchased, knowledge of which would be restricted to principals and partners, and could not therefore be influenced by rebate and discount levels.

11.164. The responses revealed a wide range of views about rebates and discounts. Whilst some regarded these as a perfectly legitimate part of a veterinary surgeon’s income, others considered them anti-competitive, and favoured a more transparent pricing structure from manufacturers and wholesalers, with clients gaining maximum benefits from the systems. Five veterinary surgeons expressed concern that manufacturers ‘bundled’ products for discount purposes. A few commented that small practices did not benefit significantly from rebates and discounts.

11.165. Non-price benefits from manufacturers, particularly their contribution to CPD, were considered by 14 respondents (19 per cent of those commenting on the issue and 7 per cent of the overall total of respondents) to be beneficial to both veterinary surgeons and clients.

11.166. One retired veterinary surgeon, working for an animal rescue charity, complained that wholesalers would only directly supply veterinary medicines (including non-POMs) to registered animal charities with a veterinary surgeon’s authority. Where there was no veterinary surgeon willing to provide voluntary help, the charity had to pay normal retail prices for supplies from a veterinary practice.
**Issue 4(xiii): Whether veterinary surgeons discriminate on prices charged to different animal owners (for example, depending on whether the client has a pet insurance policy)**

11.167. Of the 82 veterinary surgeons responding on this issue (40 per cent), none said that they charged differentiated prices to owners of insured animals, but some recognized that an insurance policy sometimes offered a wider range of choice in treating an animal than might otherwise be possible. However, a couple of respondents suggested that a small minority of practices might be inflating insurance claims (although this would be fraudulent).

11.168. Some respondents said that they discounted fees for certain categories of clients, sometimes on compassionate grounds—for example, for pensioners, the indigent, charities, small children—and on other occasions, for business reasons—for example, under contractual arrangements or for large purchases, such as large-scale vaccinations. One respondent observed that in a mixed practice, different conditions in the separate clinics, such as medicine storage or staffing costs, could lead to different prices being charged within the practice for comparable goods and services.

**Issue 4(xiv): Whether veterinary surgeons charge relatively higher prices in areas where there is less competition from other similar practices**

11.169. 30 per cent of respondents (62 veterinary surgeons) addressed this issue. Over half focused on the farm sector, arguing that the reduction in the number of large-animal clinics had resulted from changes in the structure of agriculture and not from any conscious aim to restrict competition; this trend seemed to be continuing, and a number of respondents commented on the declining appeal of farm work. In contrast, many respondents maintained that there were no serious competition issues among companion-animal veterinary surgeons.

**Veterinary organizations**

11.170. Four veterinary organizations responded to the statement of 16 April: the RCVS, the SPVS, the BSAVA and BEVA. Their responses are summarized below under the headings employed in the Statement of Issues Relating to Veterinary Surgeons.

**Written prescriptions; prescriptions costs; itemized billing**

**RCVS**

11.171. The RCVS guidance to veterinary surgeons stated that a reasonable charge may be made for writing a prescription. The RCVS would look seriously at any practice procedures which seemed designed to deter clients from obtaining prescriptions. However, as far as extra consultations for repeat courses of medicines were concerned, the RCVS said that it was normal good practice to see the patient at regular intervals so as to ensure that the treatment was still appropriate, regardless of whether the veterinary surgeon dispensed the medicines or issued prescriptions.

11.172. The RCVS *Guide to Professional Conduct* advised that fully itemized invoices must be provided if requested.

**SPVS**

11.173. The SPVS said that clients were being increasingly made aware, for example through magazines for animal owners, that prescriptions were available; however, clients would be confused if veterinary surgeons wrote prescriptions automatically because many pharmacies would be unable to fulfill prescriptions: prescriptions were therefore normally provided only when the owner knew that there was an accessible supply of the prescribed POM; clients tended to value the convenience of the ‘one-stop shop’ and all-hours service provided by the veterinary surgeon.

11.174. The SPVS said that pricing structure in a veterinary practice, including for prescription charges, was a decision of the practice owners; there was no recommended fee structure in the veterinary profession, but clients were free to shop around. (The SPVS said that it had been deterred by the OFT
from setting up a benchmarking fee structure—possibly including prescription charges—based on repeated surveys of pricing comparisons.)

11.175. Emphasizing that failure by a veterinary surgeon to issue a prescription on request was considered to be disgraceful professional conduct, the SPVS advocated that all members gave prescriptions under the same ruling as covered dispensing; however, this would entail consultations on a regular basis to establish that the animal was genuinely under the practice’s care.

11.176. According to a recent SPVS survey, the majority of practices provide itemized billing. The SPVS added that the ability to do so was increasing with the wider use of computers in practice. However, it noted that, while farmers needed itemized bills for VAT returns and management records, many small-animal clients did not wish to take them.

BSAVA

11.177. The BSAVA agreed with the recommendation in the RCVS Guide to Professional Conduct that veterinary surgeons should offer prescriptions, and must do so if requested. The BSAVA foresaw, following the Marsh report and the CC inquiry, an ‘inevitable increase in prescription writing’ and growing adaptation by both veterinary surgeons and pharmacists to wider dispensing of POMs, but change would be gradual (for example, pharmacists would have to get used to charging VAT on veterinary medicines, while it was not levied on sales of human medicines, and to applying the cascade). The BSAVA also agreed with a government view that prescription charges should be set in the same way as other veterinary charges; every veterinary practice would have to make an assessment of the cost of prescribing and set an appropriate professional fee; a prescription was a legal document requiring consideration of the health status of the individual animal and involving either a time-consuming manual system or a costly IT program to prepare.

11.178. According to the BSAVA, only a small minority of companion-animal practices failed to provide an itemized invoice.

BEVA

11.179. BEVA commented that the government response to the Marsh report accepted that the fee charged for a prescription was a matter for the individual veterinary surgeon; the RCVS could hold a veterinary surgeon accountable for a prescription; comparisons with fees charged by other professionals for comparable letters or certificates would suggest that most veterinary prescription fees were low; and if advice on the administration of a medication should properly come from a veterinary surgeon, it would be logical for the charge for that advice to be incorporated in the prescription fee.

11.180. On the issue of consultations for repeat prescriptions, BEVA underlined that veterinary surgeons might only prescribe medicines for animals under their care and said that re-examination intervals should be determined by the nature of the case and the medicines prescribed and not by whether or not the medicines were to be dispensed.

11.181. BEVA supported the issuing of detailed itemized invoices for services and medicines, and noted that most veterinary practices now did issue them.

Influence on manufacturers and wholesalers

SPVS

11.182. The SPVS considered that individual veterinary practices were in no position to influence pharmaceutical companies, most of which were multinational corporations, either in relation to supplies to pharmacies or the classification of medicines. The SPVS was aware of some unhappiness expressed by a small number of individual veterinary surgeons that veterinary wholesalers were supplying pharmacists, but the profession did not support such behaviour.
BSAVA, BEVA

11.183. The BSAVA and BEVA had no evidence that veterinary surgeons exerted any influence over manufacturers and wholesalers.

*Regulatory issues*

**RCVS**

11.184. The RCVS had welcomed the European Commission’s proposals for greater flexibility on MRL requirements; although it was clearly necessary to ensure that harmful residues did not persist in food, the MRL requirements had tended to reduce the availability of medicines for the minor food-producing species.

11.185. The RCVS considered that any suggestion that veterinary surgeons could safely prescribe some medicines for animals under their care without prior clinical examination needed to be approached with caution.

11.186. Whilst the RCVS had some sympathy for proposals to relax the cascade, it shared the concern of the BSAVA that the wider use of human generic medicines could have harmful effects in the long term by making it uneconomic for pharmaceutical companies to market veterinary products and carry out clinical trials on the target species. Nonetheless, the RCVS saw scope for improving the guidelines in AMELIA 8 to give prescribing veterinary surgeons wider discretion to prescribe generics for cost reasons in appropriate cases.

**SPVS**

11.187. The SPVS argued that any change in the law forbidding veterinary surgeons to dispense prescriptions written in other veterinary practices would need to establish whether the duty of care lay with the prescriber or the dispenser; and any relaxation of the cascade, whilst it might be helpful in the short term, needed to take account of the sources for future income streams to fund R&D.

11.188. Turning to other regulatory issues, the SPVS emphasized:

(a) the importance of MRLs in assuring food safety;

(b) the need to retain efficacy testing in the MA process, in the interests of animal welfare and safety, as well as in the public interest (‘the greatest expense to the client is when the drug used is the one that does not work even though its initial cost was the cheapest’);

(c) the extreme care needed in reclassifying POMs; full batch traceability and tracking of veterinary medical products from manufacturer to animal (currently required for food-producing animals and under consideration within the EC for companion animals also) was an issue in this context;

(d) possible extension of selling rights for PMLs to pet shops, supermarkets and other retail outlets raised concerns about the potential for incorrect use if sold without detailed and informed advice on usage; the SPVS was also concerned about possible resistance issues; and

(e) the frequent incidence of oversupply of veterinary medicines, particularly antibiotics, when pack-splitting had not been possible, raising fears of misuse or the diversion of medicines to the black market.

**BSAVA**

11.189. The BSAVA challenged the concept of prescribing drugs on the basis of another veterinary surgeon’s diagnosis. It believed that it would seriously confuse the chain of responsibility for a sick animal if one veterinary surgeon dispensed medicines prescribed by another. The BSAVA emphasized
that responsibility for the treatment and progress of a case rested with the examining veterinary surgeon, who was expected by the RCVS to act ethically and responsibly and had professional indemnity provided by one of several companies; this responsibility could not be shared between veterinary surgeons, one of whom had not examined the animal.

11.190. The BSAVA thought that in some cases the cascade had had the effect of forcing up prices. It also suspected that niche markets had been discovered for medicines to treat diseases hitherto treated with drugs only available from the human healthcare industry; this might have given rise to excessive charging. However, the general use of human medicines was only acceptable when they had been fully tested on the target species because efficacy and safety could be markedly different in each species.

11.191. On broader regulatory issues, the BSAVA:

(a) regarded MRL tests as vital in food-producing species;

(b) considered that efficacy tests were an essential part of the regulatory process and protected against animals being used as guinea pigs for a newly-marketed medicine. However, the BSAVA believed it was worth investigating why the licensing process in the UK appeared slower than in other European countries;

(c) did not support the concept of any POM being available unless the animal was under the care of a veterinary surgeon (possible reclassification of some medicines was a separate issue); the level of training and knowledge found in a veterinary practice made it the best environment for the proper control of even anti-parasitic preparations; and

(d) believed that, if there were to be any relaxation of current regulation of sales of PML drugs, it should bring in pharmacies but not pet shops or supermarkets.

BEVA

11.192. BEVA believed that the rule should be maintained that veterinary surgeons may only prescribe medicines for animals under their care; involvement of a chain of veterinary practices in the care of an animal was a recipe for disaster, making it difficult to establish clear case responsibility should anything go wrong.

11.193. In BEVA’s view, relaxation of the cascade might offer short-term attractions but was likely in the medium to long term to restrict further the development, and choice, of animal medicines.

11.194. Turning to broader regulatory issues, BEVA drew the CC’s attention to how changing legislation on dispensing of antibiotics and paraciticides would sit uncomfortably with the Government’s UK antimicrobial resistance strategy and action plan published in July 2000. BEVA strongly supported efficacy testing for new drugs, maintaining that both the public and veterinary surgeons had a clear interest in animal medicines being shown to be efficacious before sale and in that requirement being maintained in law. BEVA was particularly concerned that efficacy needed not only to be present at registration but also needed to be maintained. There was a clear need to guard against the development of resistance to drugs, for example by preventing inappropriate use of antibiotics and paraciticides; the most expensive drug that could be purchased was the one that no longer worked.

11.195. Classification of horses under EC law as a food-producing species, limiting the availability of veterinary medicines for them, had been the major medicines issue for BEVA for the past five years. BEVA argued that, in regulating the availability of medicines for horses, there was a clear need to distinguish between the small minority of horses slaughtered for food products and the vast majority that did not end up in this way.

Switching practices

RCVS

11.196. The RCVS said that clients were free to change practices. Its Guide to Professional Conduct advised, for the benefit of the patient, that the new veterinary surgeon should inform the original practice
and obtain a full clinical and treatment history; the consent of the original practice was not required, and it had to cooperate in making the history available.

SPVS

11.197. The SPVS maintained that practices benefited from competition for clients, not only gaining financially from a client moving to the practice but deriving some professional pride in taking a client from a neighbouring practice; it was normal in such cases to contact clients’ previous practices to obtain veterinary histories so as to avoid repetition of diagnoses and treatments; and the RCVS viewed any attempt by a veterinary surgeon to exert pressure on a departing client as unacceptable behaviour.

11.198. Surveys cited by the SPVS suggested that, in the majority of cases, clients switched practices because they were dissatisfied with service or because they were moving home; prices were less frequently mentioned.

BSAVA

11.199. The BSAVA reiterated the guidance from the RCVS (above). It added that, in addition to deferring to superseding veterinary surgeons at the request of the animal owner, veterinary surgeons often referred cases to other more specialized veterinary surgeons.

BEVA

11.200. BEVA emphasized that owners were free to change between veterinary surgeons; the practice of passing on medical histories to the new veterinary surgeon was for the benefit of the animal and owner. There was genuine competition between veterinary practices; price was only one factor in the owner’s decision to select a practice, and others, such as expertise, facilities, services, location and individual preference, could be equally important. Nonetheless, BEVA believed that client, animal and veterinary surgeon were in the long term usually best served by a stable relationship based on mutual trust and respect.

Cross-subsidization between consultation fees and medicine charges

SPVS

11.201. The SPVS maintained that apportioning pharmacy overheads for the dispensing of POMs was difficult. Some estimates have suggested that a mark-up on veterinary medicines of about 20 per cent was required to cover the cost of a pharmacy alone, substantially reducing any notional profit. On the other hand, in a competitive marketplace a veterinary surgeon often had to keep down consultation fees to levels the market could bear. Commenting that cross-subsidization occurred in other service industries, the SPVS argued that clients could shop around between practices and could pick a practice where fees were low and medicine costs high and could then request prescriptions for medicines.

BSAVA

11.202. The BSAVA did not accept that ‘we are cross-subsidising or overcharging for our pharmacy practice’. It argued that, in companion-animal medicine, the margin charged on medicines was a direct result of the costs associated with pharmacy practice. It conceded that historically it might have been true that the margin was arbitrarily calculated and might have been sufficient to subsidize other services within the practice; but with the significant rise in recent times of the costs of running a pharmacy, the true costs were now reflected in the margin ('the figure referred to as a margin is actually a fee charged to cover the cost of pharmacy practice'); the added value of the veterinary pharmacy was education, experience, CPD, clear and unambiguous advice, a 24-hour service, as well as specific knowledge of the species and individual animal undergoing treatment. (In contrast, the BSAVA argued, the NHS prescription effectively hid the true costs of medicines.)
11.203. As regards repeat prescriptions, the BSAVA said that the treatment of medical conditions with ongoing therapy required careful monitoring. It was considered good clinical practice for an animal under the care of a veterinary surgeon to be checked every three months when on prescription-only medication.

BEVA

11.204. BEVA argued that, while it was unlikely that in any business a sale or service rendered generated exactly the same percentage margin as any other, calculations of the cost of running a pharmacy in a veterinary practice suggested that current levels of medicine charges were probably only just covering the true overhead costs of maintaining that service.

POM prices

SPVS

11.205. The SPVS took issue with the suggestion that veterinary surgeons might have placed the highest mark-ups, based on list prices, to medicines attracting the largest discounts and/or rebates. It pointed to pricing surveys by the BVA, which showed a wide spread of prices for POMs and indicated that mark-ups were wide ranging. In response to the proposition that high mark-ups on POMs had allowed veterinary surgeons to price their non-prescription medicines competitively, the SPVS said that the majority of medicines supplied by a veterinary practice were POMs; veterinary surgeons could not compete with many animal-health suppliers on PML medicines, partly because they were limited to supplying to animals under their care and partly because of the economies of scale the other suppliers could apply (some PML products were sold to farmers by animal-health suppliers at lower prices than the veterinary surgeons could obtain from a wholesaler).

11.206. The SPVS considered that most veterinary practices in the UK had successfully managed to balance the needs for profitability and demands of animal welfare. The annual SPVS/BVA/Anval survey showed that neither returns on investment nor profitability for a cross-section of UK veterinary surgeons were excessive when compared with general levels of income for professional people.

BSAVA

11.207. The BSAVA’s views on margins are recorded above (see paragraph 11.201). Research conducted by the BSAVA had suggested that prices charged for POMs by veterinary surgeons were similar to those charged by online pharmacies. The BSAVA also commented that the relatively lower margins applied by veterinary surgeons to the more expensive medicines reflected the profession’s realization that overheads should be evenly distributed. It also pointed out that the discount given by wholesalers for prompt payment represented an opportunity cost for the veterinary surgeon, and there seemed no reason why that benefit should be passed on to the client. Generally, the BSAVA did not believe that rebates and discounts had any effect on the decision of a veterinary surgeon to prescribe or dispense a particular pharmaceutical preparation.

BEVA

11.208. As in dealing with the question of cross-subsidization (see paragraph 11.204), BEVA argued that, even allowing that completely even distribution of overheads was unlikely to occur in any business, medicine charges normally made by veterinary practices seemed barely to cover the costs of running a veterinary pharmacy. BEVA particularly refuted any suggestion that inefficient veterinary practices would be likely to have highly efficient pharmacies to keep them financially afloat. It said that there was little evidence of excessive returns to owners or employees of veterinary practices.

11.209. On the issue of the impact of rebates and discounts on purchasing decisions, BEVA said that veterinary surgeons chose to buy the most efficacious drug, because they would otherwise get dis-satisfied clients. It also acknowledged that, in cases where two identical drugs were priced differently, the veterinary surgeon obviously chose the cheaper one, and this also benefited the client.
**Discriminatory charging**

**SPVS**

11.210. The SPVS’s policy on pet insurance claims was clear: any veterinary surgeon charging more than the practice’s normal prices when dealing with a pet covered by insurance was acting in a fraudulent manner, and any evidence for such behaviour should be reported to the RCVS and the insurance company. The SPVS pointed out that a large amount of charity work was done within private practice, often at reduced cost, and all wildlife cases were normally treated free of charge. The SPVS questioned whether or not the CC’s inquiry deemed this to qualify as discriminatory charging.

**BEVA**

11.211. BEVA (and, it said, the insurance companies) would regard discriminatory charging for insured animals as fraud.

**Areas of low competition**

**SPVS**

11.212. The SPVS maintained that practices could not be forced to provide a service if it was uneconomic to do so, as had become the situation in large parts of the farming community. According to the SPVS, there were currently only eight farm-animal practices in Sussex, and there might soon be no farm-animal practices within the area circled by the M25. The SPVS recognized that opportunities for farmers to shop around for veterinary services were extremely limited in a situation where there were few practices serving huge areas of farmland, although they could obtain prescriptions so as to gain some freedom of choice in buying POMs.

**BSAVA**

11.213. The BSAVA said it was not aware that veterinary or medicine costs in the companion-animal sector were greater in less-populated areas and suspected the reverse to be the case.

**BEVA**

11.214. BEVA commented that a geographical monopoly would be rare in equine practice, and that, in the veterinary field as a whole, mergers and the emergence of corporate practices probably reflected general lack of profitability, including in medicine sales.

**Demand-side issues**

**SPVS**

11.215. The statement of 16 April suggested that, if there were enhanced competition between veterinary surgeons, companion-animal owners would be able to make choices based on price as well as quality, whereas there might be a tendency at present for veterinary surgeons always to dispense the most effective product, regardless of its cost. The SPVS said that clients were informed of the cost of treatment and treatment options were often discussed. However, a veterinary surgeon would be unlikely to advise the use of a medication with poor efficacy, at a cost to the owner but with little chance of success. In farm-animal practices, particularly, farmers and veterinary surgeons worked together closely to find the most economic option, recognizing that decisions on treating farm animals were extremely price-sensitive, and that there were situations where the successful treatment of an animal was not economic.
11.216. The BSAVA too believed that the cost of treatment and alternatives were discussed with the client, who expected advice and guidance, and that all professional decisions, including the choice of an appropriate treatment for a medical condition, were the result of an educated opinion. The BSAVA also emphasized that the non-treatment of an animal on cost grounds was not an option; veterinary surgeons had a moral and ethical duty to ensure that, regardless of circumstances, the welfare of the animal was the foremost priority.

Responses to statement of 17 September 2002

Veterinary surgeons

11.217. The statement of 17 September 2002 was circulated to the 13,600 veterinarian surgeons then registered with the RCVS as working in the UK (the registration list had grown since the distribution of the statement of 16 April 2002—see paragraph 11.133). Some 430 submitted substantive responses; 45 also attended joint hearings with the CC in three locations throughout the UK in mid-October. (Appendix 11.1 lists all the individual veterinary surgeons who submitted written evidence to the inquiry.) The overall participation by veterinary surgeons at this stage was considerably higher than the numbers given above since some of those sending submissions or attending hearings had done so also on behalf of colleagues in their practices; moreover many other veterinary surgeons had participated in consultation processes within representative veterinary organizations and had endorsed the responses submitted by those organizations.

11.218. The following paragraphs summarize the views of the individual veterinary surgeons expressed in written submissions or at the three joint hearings.

General comments

11.219. Most respondents argued that the inquiry’s terms of reference, in limiting its remit to the supply of POMs, had resulted in a distorted view of veterinary practice. A typical comment was: ‘The supply of POMs has been viewed completely independently of the supply and provision of the veterinary professional services. We feel it would be more realistic to look at the two together, as components of the whole veterinary service.’ According to this view, the supply of medicines could not be viewed in isolation from the wider context because the bundling of services helped advance animal welfare—the commitment to which had originally driven veterinary surgeons into the profession. Many therefore noted critically the absence of any public interest findings in the statement, as acknowledged in paragraph 11 of the statement, and argued that the question of the wider advantage to the public of bundled services was ‘key’ and should be ‘the cornerstone’ of the inquiry. One veterinary surgeon wrote: ‘To not take arguments about the benefits of the overall package into account is unfair and unjust and probably infringes human rights.’

11.220. Even veterinary surgeons who recognized that we were constrained by our terms of reference argued that it was unavoidable that we should address wider issues: for example, one wrote that, although the overall veterinary package might be beyond the CC’s remit, attempting to apply proposed remedies came up against the need to consider the overall package when looking at the practical consequences.

11.221. A few veterinary surgeons positively welcomed the possibility of changes in the market for POMs, on the grounds that, in their view, some colleagues overcharged for drugs and the profession as a whole needed to adapt to modern commercial practice. But most respondents considered that the current system worked well and there was no need to try to change it. Some said that the profession should not be looked on as homogeneous but rather as a collection of disparate individuals and practices, many serving different types of clients in different types of settings. Many veterinary surgeons observed that some clients and others tended to compare the provision of veterinary care with human healthcare delivered by the NHS, and this distorted their perceptions of the realistic costs of caring for animals.
11.222. There were also some comments on our collection of data, the methodology of the telephone survey in particular attracting some criticism. One respondent commented that the survey sample, covering allegedly only 4.6 per cent of veterinary surgeons, was too small. Another criticized the way the telephone survey had collected and analysed data (apparently in relation to cross-subsidization). Others protested that no questions had been asked about the capital invested in practices, in contrast to SPVS/BVA surveys; one veterinary surgeon said that these indicated that when partners paid salaries and charged a reasonable return on capital, most practices ran at a loss; another reported that in his practice the capital involved was £350,000 per partner. Some veterinary surgeons regretted that there were no questions in the survey about the number of hours worked, and others thought it should have included questions about the prices charged for management drugs (particularly large-animal vaccines) as well as the prices of curative antibiotics, since this distinction was important in the context of drug control (see paragraph 11.229).

11.223. One veterinary surgeon protested about the potential—but in the CC’s judgement non-influential—conflict of interest relating to the pet-owner survey, to which we had drawn the attention of every practising veterinary surgeon by letter and through the CC’s web site. But many veterinary surgeons questioned that the evidence of pet-owner dissatisfaction with the profession’s pricing of POMs was soundly based; they argued that the number was small in relation to the total of pet owners and it appeared that a large proportion of complainants were owners of chronically sick animals, who would have been particularly hard hit by the operation of the cascade.

‘Abnormal’ features of the market

11.224. Many respondents argued that the provision of veterinary medicines and services should not be treated as a normal economic market. The profession’s ethical commitments imposed under its system of self-regulation made it necessary for practices to pay for uneconomic work with income earned from other activities. Prominent among these commitments were the provision of a year-round, 24-hour service, treatment of any sick or injured animal regardless of its owner’s ability to pay, and the necessity to carry whatever animals under their care may need, including medicines needed infrequently but urgently.

11.225. Some veterinary surgeons maintained that the cross-subsidization of activities was the only way in which the 24-hour service could be financed without putting up fees to unacceptable levels. One veterinary surgeon said that ‘the out-of-hours accident and emergency service that we run costs 7 per cent of the turnover of our business, and it is not only POMs that we use to subsidise that service. We use a whole bundle of services to subsidise our out-of-hours service and other welfare matters’. One member of a four-veterinary-surgeon practice, with an annual turnover of around £650,000, estimated that the provision of 24-hour cover cost the practice between £30,000 and £50,000 a year. Another argued that there could be no way forward towards a fully competitive market for POMs without ‘deregulation’, in particular removal of the 24-hour obligation. Other respondents laid greater stress on the need for income from some activities to meet the capital costs of surgical and diagnostic equipment, buildings and clinics, and to pay for indemnity insurance, holidays and paid CPD of staff.

11.226. Veterinary surgeons in large-animal and mixed practices said that the market for veterinary medicines and services for the farming sector was particularly fragile. The ratio of drug sales to fees was higher in treating large animals than in dealing with companion animals. One mixed-animal practice reckoned that the ratio was 1.4:1 for small animals, as against 2.3:1 for large animals. Many respondents pointed to the steady decline in the number of large-animal practices. They maintained that the higher professional fees which would have to be charged by veterinary surgeons to compensate for any loss in income from POM sales would be beyond the means of the farming community; as one veterinary surgeon put it, there was no scope to increase fees for professional services to farming livestock and the status quo worked strongly in the public interest. According to the scenario they foresaw, higher veterinary fees would lead to farmers seeking veterinary help less frequently, particularly for animals of low economic value. Many farmers would seek alternative types of medicines, particularly PMLs, or alternative sources of POMs (in some cases from the black market or with counterfeit prescriptions), and would administer these medicines themselves; inexpert administration of drugs would harm animals and lead to higher antibiotic resistance, as had already occurred with PML anthelmintics (one veterinary surgeon commented: ‘it would be sad if the next food scare was due to antibiotic residues in meat’); more farm veterinary practices would go out of business, compounding the problem of reducing veterinary services on farms; and fewer veterinary surgeons on farms would lead to reduced surveillance
of disease, with potentially catastrophic impact on human health (the FMD outbreak in the UK in 2001 was held up as a cautionary case).

11.227. One veterinary practice, the only farm-animal practice in north-west Norfolk, illustrated the threat:

If we, as a practice, were to lose the profit made from drug sales the cost of attending a calving in this practice would rise to between £200 and £250, a bovarian caesarian would cost £500–£600 and a visit to see a lame cow would cost £150–£200. Clearly, because of the value of farm animals these prices would be unsustainable. Animals would have to go untreated resulting in welfare issues and it would not be viable for us to continue in farm practice … If we were to stop the farm side of our practice farmers would have to stop livestock farming in this area.

They argued that cross-subsidization was inevitable in farm practice, and this suited farmers, who were ready to pay higher prices for medicines than they might be charged elsewhere in return for a reasonable call-out fee and a 24-hour service.

11.228. As some veterinary surgeons emphasized, the problems of the farming community were particularly acute in marginal agricultural areas, such as the Highlands and Islands of Scotland. Here fees were constrained, not only by the economics of crofting in the region, but also by the terms of the Highlands and Islands Veterinary Service Scheme (HIVSS)—a support mechanism scheme set up in 1915 to ensure the availability of an adequate veterinary service at reasonable costs to crofters and others in similar economic circumstances.

11.229. Many veterinary surgeons also argued that the market for POMs was abnormal because their role was in practice often to control the use of medicines, rather than to maximize sales. In farming areas particularly, veterinary surgeons frequently tried to dissuade farmers from using POMs and generally tried to drive down the use of antibiotics in favour of wider use of vaccines. A veterinary surgeon from Scotland expanded on this theme:

Our practice, in common with many other mixed and large animal practices, uses differential mark-ups on antibiotics and what we call management drugs (mainly vaccines) … This method of pricing has worked in our area to the benefit of all. The farmer gets better production, the animal better welfare and the vet greater job satisfaction. It has also cut down our usage of antibiotics, which has to be in the public interest.

11.230. A common theme in the responses was that veterinary medicines could not be treated as ordinary consumer products, and that to do so entailed serious risks to animal and human health and welfare. One practice expressed this common sentiment as follows: the issues of ethical, health and welfare implications of the supply of veterinary medicines:

are central to the protection of human and animal health, viz MRSA (Methicillin-Resistant Staphylococcus Aureus), emerging diseases, exotic diseases and zoonoses. If the Commission fail to take these issues into account we feel that they will not only have failed to serve the pet owners and farmers of this country but also to have instigated severe potential hazard to public health and safety.

Conducts

11.231. The main focus of discussion regarding our provisional conclusions on veterinary surgeons’ conducts was the issue of the bundling of services and the prices of medicines. Although a few respondents thought it right that ‘veterinary surgeons should make their living through professional knowledge and skills’, most took strong issue with the statement (paragraph 10) that ‘prescribing of medicines, dispensing of those medicines and their administration are activities that are in many instances capable of separation’. They vigorously defended the ‘one-stop shop’ concept, in which different activities collectively financed the whole package of services and outputs (ie ‘cross-subsidization’). They gave the following grounds for this view:
The cost of running a practice pharmacy had to be borne by the selling price of POMs. One respondent summarized this argument as: ‘The cost of medication also includes the costs of drug storage (which may not be required and so go out of date and thrown away), staff time in dispensing smaller amounts of the drug from larger containers, cost of disposables (for example, pill bottles) and label printing.’ Some added that there was already an element of cross-subsidization in veterinary pharmacy prices to finance the costs of emergency drugs, which were seldom used and often went out of date.

The 24-hour service and other ‘unique’ ethical and professional commitments had to be paid for (see paragraph 11.224).

Other respondents laid greater stress on the need for income from non-core activities to meet the capital costs of surgical and diagnostic equipment, buildings and clinics, and to pay for indemnity insurance, holidays and paid CPD of staff (see paragraph 11.225).

The one-stop shop was needed because veterinary surgeons had a central role in administering drugs; many veterinary surgeons argued that neither clients nor pharmacists would have the skills to administer certain drugs to animals; only a veterinary surgeon could do so. Some gave the example of vaccines: these could not simply be dispensed; the animal had first to be examined to ensure that it was fit enough to take vaccines (or boosters); and unless the veterinary surgeon had performed the vaccination, he could not certify that the animal had been vaccinated. One poultry veterinary surgeon, arguing that his views applied to other specialist food-animal veterinary surgeons, said that the one-stop-shop approach was essential in this sector: prompt diagnosis and medication were necessary for bird welfare and optimal production; and it was vital that veterinary products for food animals were used within the terms of the product licence and that withdrawal times were met.

Many respondents said it was likely that some clients would not collect prescribed veterinary drugs from a pharmacy, as is frequently reported to occur in the NHS. One-stop shops ensured compliance.

Nonetheless, many respondents believed that competition remained intense within the regime of cross-subsidization. A typical argument was that veterinary surgeons had over many years manipulated fee structures to sell a package of animal health and welfare; the right balance of fees and sales had to be struck or veterinary surgeons would lose out to competing practices. In contrast, a few veterinary surgeons saw a case for national fee guidelines, as in Canada.

On the issue of the other specific conducts identified in the statement, few respondents acknowledged that they failed to inform animal owners of their rights to request prescriptions, otherwise discouraged owners from doing so, or failed to inform clients of the price of POMs. On the contrary, some said that they made strenuous efforts to inform clients of POM prices prior to dispensing. Many asked what the CC considered to be an ‘excessive’ prescription charge.

Many veterinary surgeons said that they regularly provided itemized bills, as was borne out by the recent survey, Quo vadis? 2002, which indicated that 75 per cent of veterinary surgeons did so. Some commented that, since clients often did not take them and piles of waste paper consequently built up, they had adopted a policy of only offering, but not automatically providing, itemized bills.

Most respondents did not accept that mark-ups were ‘excessive’; many argued that margins on POMs were not large, suggesting that this was the reason that some veterinary pharmacies had failed. One respondent said that if veterinary surgeons followed the practices of supermarkets, mark-ups would be some 400 per cent, and that in that sense it could be argued that professional fees were subsidizing the price of POMs.

Respondents in general said that their paramount considerations when buying veterinary medicines were safety, quality and efficacy, and cost was a secondary concern. One assistant veterinary surgeon testified: ‘I have worked for a variety of practices during my career and the only practice I have been in where we had a restricted drugs list, and we were told to prescribe only from this list, employed a large number of very unhappy veterinary surgeons who did not stay within that practice for very long because they regarded their right to prescribe as they saw fit very highly.’ Nonetheless, the question of manufacturers’ rebates provoked widely differing responses. Some veterinary surgeons said that they
would welcome an end to all discount and rebate schemes (although pointing out that wholesalers’
rebates were mainly rewards for prompt payment). Others thought discounts/rebates were vital for
business success, at least one maintaining that many practices could not survive without them. Some
thought the effects of discounts were neutral, and that if discounts were abolished it would be reasonable
to add on higher mark-ups to compensate. As one veterinary surgeon put it: ‘if we went to all the extra
trouble of trying to work out the net net price we would put a larger margin on that so that it did not
reduce our profits’.

11.237. Almost all responding veterinary surgeons laid emphasis on the likely alternatives to the
present conducts. They argued that if income from POMs was reduced, the prices for veterinary
consultations would have to be raised to ensure the business viability of the practice. Even some services
currently given freely, such as advice over the telephone, would have to be charged for. A typical
comment was: ‘By forcing clients to pay more for their fees and less for their medicines there will be
little net benefit.’ Some argued that securing POMs through a pharmacy would increase costs through a
combination of the veterinary surgeon’s prescription charges, the pharmacist’s dispensing charges and
higher veterinary fees to compensate from lower income from POM sales.

11.238. Higher fees were widely considered likely to choke off demand, many veterinary surgeons
arguing that people seldom ‘knowingly pay’ for advice. The effect was expected to be particularly, but
not exclusively, felt in the farming sector. Commenting on the likely public (in this case farmers’) likely
resistance to higher fees, one veterinary surgeon wrote: ‘Clients who only use a lawyer or accountant
occasionally expect a big bill but because we see them regularly they expect it to be reasonable.’ Some
veterinary surgeons feared that higher fees might mean that ‘going to the vet’ would become the preserve
of the wealthy or the very poor.

Remedies

11.239. Whilst many veterinary surgeons welcomed the general objective of making the pricing of
POMs more transparent, the vast majority strongly challenged many of the hypothetical remedies,
considering them either excessive or unnecessary. Some respondents pointed to some duplications and
contradictions among the hypothetical remedies, on the mistaken assumption that we were proposing that
these might be implemented as a package, rather than being an all-inclusive list of alternative remedies.
Many veterinary surgeons were concerned about the possible legal consequences of separating
prescription and dispensing should errors arise or side effects occur when pharmacists dispensed against
veterinary surgeons’ prescriptions. Some respondents offered alternative remedies. One suggestion was
that a formal letter of engagement between the veterinary surgeon and the client might be devised,
containing information on the practice’s policies in the areas of conduct identified in the statement. The
client’s signature would testify that he/she fully understood its contents. Another veterinary surgeon
argued that we ‘should treat small animal and large animal separately since they are completely different
and human health is involved (in large animal work)’. A couple of veterinary surgeons suggested that the
cost of medicines might be administratively controlled at the point of access to the public. One suggested
that mark-ups might be standardized at 50 per cent on cost price, giving a return of 33 per cent; this
regulation should be backed up by lower prices from the manufacturers, calculated on a standardized
basis and without any rebate systems.

Reducing barriers to obtaining prescriptions

(i) Requirement to display signs in veterinary surgeries advising clients of the availability of
prescriptions to enable them to obtain POMs from pharmacies if they wish.

(ii) A requirement to include on the signs envisaged under (i) above any price charged for issuing
prescriptions additional to the normal consultation fee.

11.240. Respondents were generally relaxed about signs in waiting rooms advising clients of their
rights to prescriptions and the costs. Some already displayed such signs, including costs of prescriptions.
Some suggested that the format, size and wording of such a sign should be approved and regulated by the
RCVS. Others suggested that a sliding scale for prescription charges might be more practical than a
single, set charge, particularly for large-animal practices. Some practices, such as equine veterinary
surgeons, that spent all their time visiting clients pointed out their difficulties in complying with this hypothetical remedy.

(iii) A requirement for veterinary surgeons to advise clients, immediately prior to any dispensing of POMs, other than POMs that need to be used immediately, of the availability of prescriptions to enable them to obtain POMs from pharmacies.

11.241. There was widespread opposition to this hypothetical remedy. It was seen as putting veterinary surgeons in a unique and exposed position: if this requirement were written into the RCVS guidelines, veterinary surgeons would need written confirmation that the advice had been given, to protect themselves against censure later; this would involve time and therefore cost; but they could easily fail to remember the obligation, putting them in professional jeopardy; however, it was hard to see how the remedy could be policed.

(iv) A requirement for veterinary surgeons to provide on request prescriptions for POMs whose use they have recommended.

11.242. There was no dissent to this hypothetical remedy.

(v) A requirement for veterinary surgeons recommending the use of POMs to provide prescriptions in every case other than for POMs used in emergency treatment, for treatments during surgical procedures or for the use of anaesthetics.

(vi) A requirement for veterinary surgeons to provide prescriptions in every case other than for POMs that need to be used immediately at the time of consultation.

11.243. No respondent considered these to be acceptable remedies, although the grounds for opposing them varied. Some interpreted the proposals to imply a loss of the veterinary surgeons’ ‘privilege’ of dispensing, i.e. as one respondent wrote, ‘to supply a prescription in every case for the client to take away to be filled elsewhere’; another asked, ‘How would it serve competition to insist that vets cannot supply medicines but pharmacists can?’ The particular problem that this would create, were it to be the case, for the care of military working animals was described by the Army Veterinary and Remount Services (see paragraph 11.272). Those not interpreting these hypothetical remedies in this way nonetheless considered them inefficient and unnecessary, and since they would add time to the consultations, would result either in additional costs or reduced levels of animal care. Some suggested that these remedies might require large investments in computerized systems and would certainly increase running costs and hence fees. One veterinary surgeon explained:

In our clinic we schedule ten minutes for each client consultation. A fair estimate of the time taken to explain and provide a prescription for each client would be 2 minutes, raising the time taken for each consultation to twelve minutes. Immediately the vet can only see five clients per hour where previously he or she would have seen six. To provide an equal hourly return to maintain coverage of current overheads, etc. the consultation fee must be raised by 20% by the simple requirement to provide and explain a prescription … Overheads rise further in order to satisfy the number of clients who wish to attend the practice (because seeing the same number of clients per day—30 in this case—takes an additional hour). Other estimates of the time taken to write a prescription for every item were higher, for example 30 to 40 per cent of the time currently spent on each patient. ‘A further increase in consultation fees is necessitated.’ Another veterinary surgeon queried whether prescriptions would have to be written for a single, identified animal, or whether it would be acceptable, in the case of farm animals, to write prescriptions for the herd.

11.244. One veterinary surgeon suggested that a remedy stipulating a ‘requirement to offer’ prescriptions in the circumstances described in remedies (v) and (vi) would be more practical than the proposed formula of being ‘required to provide’. Others suggested that the term ‘emergency treatment’ was vague and open to different interpretations by different veterinary surgeons; this carried animal welfare implications.
11.245. One respondent (a veterinary management consultant) presented the following alternative remedy for the circumstances in which prescriptions should be written: ‘The only real solution is that a written prescription should be written for all POMs which are to be dispensed for administration by the animal owner/keeper. If issued on a visit, or at the time of consultation, this should be at no additional charge.’

11.246. A few veterinary surgeons said that they would be seriously concerned about the auditing and monitoring of the large numbers of prescriptions that would be generated by these, and some other, remedies. They foresaw a likely increase in counterfeit prescriptions, analogous to the increase in the human medicine field, to serve the illicit narcotics market.

(vii) A requirement for veterinary surgeons to state on all prescriptions issued for POMs that the prescribed items may be dispensed by pharmacies.

11.247. This hypothetical remedy caused respondents little difficulty, but some commented that the application of remedies (i) and (ii) would render it superfluous.

(viii) A requirement for veterinary surgeons providing prescriptions to charge no more for issuing prescriptions than properly reflects the incremental cost to themselves in preparing these.

(ix) A requirement for veterinary surgeons to do so at no additional cost to the client beyond that of the consultation.

11.248. Most respondents raised objections to basing charging for prescriptions on the ‘incremental’ cost of preparing them. They said that incremental costs would vary between surgeries and it would need to be made clear what costs would be expected to be covered. (One veterinary surgeon claimed that prescription pads alone cost £1 per prescription.) Four members of one practice wrote that:

The present term ‘incremental cost’ stands out as imprecise in an otherwise precise document and it is essential that the cost of providing prescriptions … be analysed on the basis of a proper business plan for each practice. In addition to the professional time required physically to ‘write’ a prescription, the prescription charge would require to incorporate amounts sufficient to recover the appropriate proportion of the practice’s fixed and variable costs incurred by that activity. As practices have different salary, fixed and variable costs then the charge for issuing prescriptions we anticipate would vary accordingly.

This was put another way by one respondent, who said that establishing the ‘incremental’ cost for each practice would require separate time and motion studies. Other respondents pointed out that in large-animal work there was an obligation to provide traceability and prescriptions were accordingly wordy, having to include batch numbers, expiry dates and other details. Many veterinary surgeons emphasized that the cost for prescriptions, which were legal documents, should reflect the legal responsibility that veterinary surgeons took on when writing them. One veterinary surgeon said that the determination of incremental costs might have to take into account the costs that our remedies might introduce, for example enhanced audit trails.

11.249. There were also many objections to including the costs of writing prescriptions in consultation fees. Some veterinary surgeons pointed out that this would be unfair to clients not needing prescriptions. Others said that it would surely constitute cross-subsidization. In the general discussion of fee levels these remedies prompted, some veterinary surgeons said that fees for prescriptions should be based on a formula, not a set fee, whereas others, in contrast, wanted a standard national prescription charge. But most believed prescription charges should be unregulated, just as those in private medicine were. Some maintained that any charges levied for prescription writing should be based on those charged by medical doctors practising privately, since the medical profession was the most analogous to the veterinary profession, with respect to prescription writing and training.
(x) A requirement for veterinary surgeons to display signs stating their policies on frequency of examination of animals requiring repeat prescriptions and on the fees charged for such prescriptions.

(xi) A requirement for veterinary surgeons recommending the use of POMs to state when the animal will need further examination and, where the animal requires repeat prescriptions prior to that date, to charge no more for issuing such prescriptions than properly reflects the incremental cost to themselves of preparing these.

(xii) A requirement for veterinary surgeons recommending the use of POMs to state when the animal will need further examination and, where the animal requires repeat prescriptions prior to that date, to provide these at no further cost to the client on request.

11.250. Many respondents believed there were serious objections to posting signs in surgeries to state practice policies on frequency of re-examination for repeat prescriptions. They gave the following reasons: re-examination times depended on clinical conditions and any policy statements would have to be so vague as to be ‘meaningless’; different veterinary surgeons within a single practice often followed divergent policies in this area; while guidelines might be tenable, there would be no real benefit in trying to lay down definite re-examination times because an animal’s condition could change rapidly; the VMD’s rules on giving out one month’s supply of tablets at a time and checking animals on long-term medication seemed to many veterinary surgeons to be reasonable guidelines, but flexibility was necessary in implementing them; as one respondent expressed it, stating when an animal starting a treatment needed further examination ‘pre-supposes perfect predictive powers’. One veterinary surgeon said that advice on re-examination times needed also to take account of non-animal factors, such as owner intelligence for example, to ensure that verbal guidance was being implemented.

Improving price transparency and the ability of animal owners to understand and compare prices

(i) A requirement for veterinary surgeons to inform clients, on request, of the price of any POM they propose to dispense.

11.251. There were no serious objections to this hypothetical remedy. Some veterinary surgeons claimed already to discuss prices in advance with clients.

(ii) A requirement for veterinary surgeons to quote the price of any POM they sell to any person who asks.

(iii) A requirement for veterinary surgeons to display in the veterinary surgery the price of the most commonly dispensed POMs.

11.252. Some respondents saw little difficulty in implementing remedy (ii) but others believed it would contravene RCVS guidance, and that quoting POM prices to anyone who asked, other than a client, contravened the Medicines Act. Many argued that, if price displays were introduced, pharmacies and merchants should be required to do the same, since proper comparison with pharmacy costs would otherwise not be possible. Many veterinary surgeons pointed out that displaying prices would not be practical because prices changed frequently and it was open to question whether ‘most commonly dispensed’ drugs should be determined by volume or value; moreover, the most commonly dispensed POMs varied between practices and from week to week, making comparisons between practices problematic. However, the severest critics of these remedies maintained that they would ‘cause confusion and ill-feeling’, since the list could not reasonably be regarded as a ‘menu’, and clients could not be expected to be able to judge the appropriateness of the medications listed, nor the dosage that would be required, for their animals.
(iv) A requirement for veterinary surgeons when quoting the price at which they will dispense any POM also to state the cost of the POM to themselves.

(v) A requirement for manufacturers of POMs giving rebates to veterinary surgeons to provide sufficient information, either directly or through wholesalers, so as to enable the veterinary surgeon to ascertain with certainty the cost net of rebates of POMs supplied to them.

(vi) A requirement for veterinary surgeons to provide itemised bills distinguishing the cost of services from the cost of POMs.

11.253. No respondents supported (iv), which they argued would place veterinary surgeons in a unique position among businessmen and professionals. Whilst veterinary surgeons expressed widely differing views on the way rebates operated, many would like to see a more transparent system. Some sprung to manufacturers’ defence, on the grounds that rebates kept unit costs down and that manufacturers also contributed economically in other ways, for example by providing CPD. On the other hand, a large number of veterinary surgeons maintained that manufacturers’ rebates made transparent pricing impossible; some, particularly veterinary surgeons in small practices, would like to see them abolished. Typical among this group was a suggestion that a solution would be to stop all discounting under all circumstances; it was argued that this would level the playing field between large and small practices and between veterinary surgeons and pharmacists.

11.254. Itemized billing was already common. One veterinary surgeon pointed out a possible logistical problem in implementing remedy (vi) because computer programs do not distinguish between different classifications of drugs (for example, between POMs and PMLs).

11.255. Putting forward an alternative remedy, one veterinary surgeon asked: ‘Would it be too simplistic an idea for the Government to set a selling price for POMs by the wholesaler and a selling price by the vet to cover our costs of running a pharmacy and the capital tied up and remove competition from the equation?’

Reducing barriers to competition from pharmacies

11.256. Many respondents challenged the principle of giving pharmacies a greater role in the dispensing of POMs. Some said that assurances would be needed that pharmacies were capable of providing veterinary POMs before any changes were made in prescribing arrangements. Many argued that pharmacists were not trained in veterinary pharmacology (part of a veterinary surgeon’s five-year training programme) to dispense veterinary medicines. In particular, some veterinary surgeons said that pharmacists lacked knowledge of comparative pharmacology (covering, for example, side effects of veterinary drugs, adverse reactions and drug interactions). Neither were pharmacists trained to give advice on the administration of drugs; this was of concern to many veterinary surgeons and some added that they already often gave prescriptions to skilled animal handlers, such as breeders, in the confidence that they would be able to administer the prescribed medicines properly. Respondents raised questions about the provision and funding of appropriate training, and the application of the cascade. Another area of complaint was that pharmacies would provide unfair competition, because the veterinary profession was small, because the NHS underpinned pharmacies, and because restrictions on registering pharmacy premises protected them from competition from other pharmacies. Large chemist chains had enormous buying power, with which veterinary surgeons could not compete; as one expressed it, ‘they [the large pharmacy chains] will cherry-pick POMs to stock those with high turnovers, undercut us and vary their mark-ups on other less popular drugs’. Some veterinary surgeons speculated on the possibility that pharmaceutical companies might offer pharmacies rebates for combined human/veterinary medicine supplies. Many veterinary surgeons commented on the difficulties they encountered in trying to source human medicines at a reasonable cost for veterinary treatments (for example, chemotherapy drugs), and a few suggested that veterinary surgeons should be granted dispensing rights for human medicine, so that competition would take place on a level playing field.

11.257. Respondents emphasized the convenience of the one-stop shop offered by veterinary practices, often outlining an alternative scenario when clients took prescriptions to pharmacies; ‘they are going to have to face the prospect that after waiting in the vet’s waiting room to be seen, they are then going to have (usually) to drive to town, find somewhere to park, pay for it, queue up in the pharmacy … wait for the prescription to be processed, then pay for it’.

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11.258. Some veterinary surgeons questioned that pharmacy-sourced medicines would be less expensive than those dispensed by veterinary surgeons; one said that his ‘experience of pharmacies is that they charge exactly the same as we do. They have the same margins and the same discount scales from their wholesalers as we do’. Many veterinary surgeons argued that pharmacists would be tempted to stock only the fastest-selling POMs (‘cherry-picking’), while veterinary practices would either have to continue to stock the full range of drugs or operate with a reduced range of veterinary products. According to one veterinary surgeon, the NVS wholesaler had over 12,000 lines on its shelves, whereas a wholesaler of human pharmacy drugs stocked some 4,000. One typical comment was that from a commercial viewpoint it was ‘naive to think there will be widespread interest from pharmacies in supplying farmers with vaccines or medication because this is low margin, high-risk business’. Many respondents feared that dispensing through a pharmacy was likely to lead to higher incidence of non-compliance in administering prescribed medicines (ie clients would be less likely to fulfil prescriptions), and this could lead to increased resistance problems. Another potential difficulty identified by some veterinary surgeons was that pharmacists might be reluctant, or professionally unable, to split packages. A few veterinary surgeons suggested that another difficulty might be presented if animals were not allowed into pharmacies (particularly pharmacies within supermarkets) for reasons of hygiene.

(i) A requirement for manufacturers and wholesalers that supply POMs in the UK to supply pharmacies.

(ii) A requirement for manufacturers and wholesalers that supply POMs in the UK to supply pharmacies on terms that enable them to compete with veterinary surgeons.

11.259. There was little objection to these remedies, apart from some scepticism about wholesalers’ readiness to take on the extra costs of supplying pharmacists and about manufacturers’ readiness to supply product support.

(iii) A requirement for veterinary surgeons to display the name, postal address, telephone number and website address of any pharmacy supplying veterinary medicines that so requests.

11.260. Few respondents approved of this remedy, although one or two were prepared to accept that displaying the name of the nearest pharmacy dispensing POMs would be an acceptable and sufficient measure. However, the majority of respondents considered it unreasonable to expect one business to advertise a competitor’s services. Some—in some cases citing the RCVS Guide to Professional Conduct—argued that it would be professionally unethical to advertise another business on practice premises unless the practice had full confidence in the other business, since issues of liability for that business’s conduct could arise. As currently drafted, the hypothetical remedy was unspecific about whether or not Internet pharmacies should be advertised.

(iv) A requirement for veterinary surgeons when they write prescriptions for POMs to do so on an ‘or equivalent’ basis to enable those dispensing such prescriptions to supply alternative authorised veterinary medicines to the brand specified.

11.261. This hypothetical remedy elicited a wide range of responses, reflecting different interpretations of its meaning. On the assumption that the pharmacist was to be given the right to determine an ‘equivalent’ drug, most respondents strongly opposed the proposal. Some worried about the legal liability for substitutions, and said that the pharmacist would not have sufficient expertise on a species or particular animal to be able to determine an equivalent drug. Some suggested that the remedy would contravene cascade rules, whilst others welcomed it as offering a way around the cascade requirements. A widespread concern in relation to this remedy centred on the question of where responsibility lay between the prescriber and the dispenser.

11.262. Some veterinary surgeons maintained that the active ingredients in a drug were not the sole factors in a decision to prescribe it; there were other important considerations such as palatability and, for farm animals, withdrawal periods, and these would not necessarily be met by a clinically ‘equivalent’ medicine.

11.263. One veterinary surgeon, in charge of a large buying group, commented that at least some manufacturers did not accept comparing their trademarks, or any other descriptions that could be linked to their trademark, with any other product. He questioned whether or not a person dispensing a prescription written on an ‘equivalent’ basis risked breaching trademark law.
11.264. A retired veterinary surgeon, with extensive experience also in the pharmaceutical industry, maintained that even the substitution by an approved veterinary generic could lead to problems. He said that although generic medicines were cheaper than branded products no longer protected by patent, many experts considered that they were not necessarily as efficacious. He also said that whilst pharmacists were allowed to dispense generics for the treatment of humans when presented with an NHS prescription, as a result of changes introduced some time ago, they did not have this latitude with private prescriptions (including veterinary prescriptions) and had to dispense whatever medicine was prescribed.

Rebate schemes for cat and dog vaccines

11.265. Most veterinary surgeons thought that this provisionally identified complex monopoly was not, in itself, a serious issue, although some veterinary surgeons were opposed to rebate schemes as a whole (see paragraph 11.253). A number commented that the financial value of the total spend was what counted for rebates, whilst vaccines were the most competitive part of the market. In any case, many respondents agreed with the argument put by one veterinary surgeon that most cat and dog vaccines were ‘identical in terms of efficacy’, so that ‘price and after-sales support are the only two deciding factors’; there were other advantages in buying the same make of vaccines in terms of ‘compatibility of vaccine record cards, batch numbers, colour coding and labelling’. Another argued that cheaper prices led to more vaccines and promoted animal welfare. Many respondents emphasized that they chose vaccines purely on the basis of efficacy and safety.

Possible regulatory changes

11.266. There was little support among veterinary surgeons for the reclassification of some POMs as PMLs. Many believed this could lead to misuse of drugs, leading to resistance to their active ingredients, as they claimed had already occurred with PML anthelmintics. Many took issue with the statement that ‘the owner or keeper can be presumed to have a corresponding degree of expertise’, regarding it as fallacious and illogical. One veterinary surgeon reported that over one week recently he had seen two serious cases of poisoning in cats from products purchased in supermarkets for flea treatment but used incorrectly. A few respondents drew attention to the continuing ‘anomaly’ that, whilst merchants could sell PMLs to all customers, veterinary surgeons could only sell them to owners of animals under their care, making it difficult for veterinary surgeons to compete on price in PML sales. Many veterinary surgeons also thought considerable care needed to be exercised in extending the activities of SQPs.

11.267. There were wide ranges of responses to the statement’s suggestions on changes to the cascade. Some regretted that a number of far cheaper human generics could no longer be used as a result of the operation of the cascade, to the detriment, some claimed, of animal welfare (for example, lysodren for dogs with Cushing’s disease, and phenobarbitone for the treatment of arthritis). Others considered the cascade to be essential as a means of funding R&D in the veterinary pharmaceuticals industry.

11.268. There were similarly wide opinions about removing the prohibition on dispensing prescriptions from other veterinary surgeons, with a roughly 50:50 split on the issue. One objection was that this might encourage some practices to develop specialist drug supply services at the expense of their animal care services; another was that it would weaken the strong bond between client and practice, create confusion on the part of the client and run the risk of leading to inappropriate use of medicines. Another opponent, expressing ‘very grave reservations’, argued that if the change were introduced, practices should engage SQPs to undertake dispensing and be subjected to regular independent inspection. Other veterinary surgeons welcomed the prospect of this change, particularly in view of the reduction in large-animal practice.

11.269. Despite strong minority support for the idea, most respondents opposed advertising POMs. Vetcel, a buying group for over 60 practices, maintained that drugs should be used only selectively for specific conditions identified by a qualified veterinary surgeon; treating POMs as commodities entailed risks for animal and human health. One academic veterinary surgeon noted that advertising of human POMs in the USA had led to higher medical bills, with only the pharmaceutical companies benefiting.

11.270. Some respondents thought that the proposals for tougher RCVS sanctions on veterinary surgeons’ behaviour were ‘a little heavy handed’ and ‘somewhat harsh’. One took particular issue with the notion that a veterinary surgeon should be considered guilty of disgraceful conduct if, for example,
he failed to inform clients of the availability of prescriptions on one occasion; the respondent suggested that a more appropriate means of enforcement would be action, after inspections and due warning, by the local trading standards officer. Regular monitoring by the RCVS of compliance with its Guide would, according to some respondents, put up clients’ bills because the RCVS would have to create an infrastructure to conduct audits, which would have to be financed by the member veterinary surgeons. One veterinary surgeon advocated regulation of the veterinary profession by law rather than by a professional organization, as at present.

**Timescale**

11.271. One practical proposal to emerge from this round of consultations was that:

if significant changes are to be introduced, then the more radical changes should be carried out over a period, of say 1–3 years, to allow any business to plan and change its business systems to accommodate for these ongoing changes. The greater the change the greater the introduction period required … a number of businesses will be in a process of change and restructuring … and therefore significant changes to the methods of dispensing medicines could have a serious impact on what is otherwise a viable business.

**Army Veterinary and Remount Services**

11.272. The Director of the Army Veterinary and Remount Services, Brigadier A S Warde QHVS, wrote in response to the statement recommending that, if 24(a)(v) and (vi) were implemented:

(a) veterinary surgeons in private practice be permitted to dispense their own prescriptions for POMs on request; and

(b) military veterinary surgeons be permitted to dispense POMs for the treatment of military working animals (MWAs) without prescription.

11.273. Brigadier Warde explained that the day-to-day care of MWAs was provided partly by private veterinary practices and partly by military Veterinary Officers (VOs); bills raised by private practices for the treatment of MWA were submitted by units for settlement by the Ministry of Defence; where treatment was provided by VOs, veterinary medicines were supplied from stocks procured at competitive rates by the Medical Supplies Agency; no bills arose, mark-up and profit did not feature, and in this context the issues of veterinary surgeons’ conduct did not apply. He wrote that implementation of paragraph 24(a)(v) and (vi) would involve extra costs for private veterinary services by the Ministry of Defence in terms of time, transport and the processing of a second bill; if VOs were required to issue prescriptions there would be no gain to competition and additional pharmacy costs would be incurred; on military operations, for example overseas, a VO was usually the only source of veterinary care and medicines for MWAs.

**Veterinary organizations**

11.274. The CC received responses to the statement of 17 September from the following veterinary organizations: the RCVS, the BVA, the SPVS, the BSAVA, the BCVA, BEVA and the Veterinary Practice Management Association. A joint remedies hearing was held with the BVA and the RCVS.

**Royal College of Veterinary Surgeons: written response**

11.275. The RCVS reserved judgement on the hypothetical remedies except on those directly concerning the RCVS, namely:
The Secretary of State to consider changing the law to allow a veterinary surgeon to dispense a veterinary prescription, whether or not the animal concerned is under his care. (This retains the requirement that the prescribing veterinary surgeon must have the animal under his care.)

There was no objection to this change from the point of view of the RCVS as the regulatory body.

The RCVS was prepared to consider this. It said that the Guide would also have to be revised if veterinary surgeons became free to supply medicines for animals not under their case. The present guidance reflected the provisions of the Medicines Act, only allowing veterinary surgeons to dispense medicines in respect of animals which were under their care.

The RCVS could draw attention to our recommendations. However, the Veterinary Surgeons Act 1966 only gave it power to take disciplinary action in respect of ‘disgraceful conduct in any professional respect’ or following a conviction for an offence which rendered the person concerned ‘unfit to practise veterinary surgery’. The RCVS Guide to Professional Conduct went well beyond the disciplinary jurisdiction and aimed to encourage good behaviour, as distinct from merely discouraging disgraceful conduct. If the RCVS advised veterinary surgeons to comply with the recommendations, a veterinary surgeon who failed to comply would not necessarily have been guilty of disgraceful conduct. The Veterinary Surgeons Act was currently under review. The RCVS had been considering a number of legislative improvements. One possible change would be to broaden the disciplinary role by giving the RCVS power to make conduct rules. This would confer power on the RCVS to require compliance with CC recommendations.

The Guide was not a set of rules and failure to comply with its advice could not, in itself, form the basis of a disciplinary charge. The task of the RCVS Disciplinary Committee was not to consider whether a member had contravened the Guide but whether he or she had been guilty of disgraceful conduct or had been convicted of an offence which rendered him or her unfit to practise. As explained in the Guide (Part 2.1), a charge of disgraceful conduct might be founded either on behaviour, such as false certification (disgraceful in itself), or on a series of instances of unethical behaviour—defined as ‘a departure from the standard of behaviour accepted as the norm among members of the profession’. The RCVS was open to a reconsideration of the wording of the Guide, but considered it was clear that a single instance of disgraceful conduct could be enough to support a disciplinary charge.

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The RCVS said that this would not be appropriate so long as the Guide retained its present advisory status.

British Veterinary Association: written response

In its written response to our statement of 17 September, the BVA commented that economic theory might dictate the requirements for the perfect market, but such a market was seldom achieved because of countervailing social factors. It claimed that there was a fundamental difference between medicines and other retail products: medicines were biologically active and potentially hazardous substances, and governments had a duty of care to ensure that medicines were handled and controlled in ways that ensured food safety.
since its members sold both services and products and had developed a pricing structure which did not clearly identify each component. In its response the BVA gave an overarching view, noting that its divisions and members had submitted detailed comments.

**Provisional findings and hypothetical remedies**

11.278. The BVA emphasized that the statutory constraints on the supply of POMs were imposed for sound reasons. The veterinary surgeon’s role as ‘gatekeeper’ was key and it was generally accepted that the attending veterinary surgeon was best qualified to ensure that the most appropriate medicine was selected, supplied and directed to the end-user. The veterinary surgeon took account not only of the animal’s health but also the potential for the animal or its products to enter the human food chain. The veterinary surgeon had a responsibility both to prescribe an appropriate medicine and to advise on its application, taking account of the specific management conditions on the farm and the potential to impact negatively on food safety. The safe use of these products depended upon the training and expertise of the prescriber; only the qualified veterinary surgeon had the appropriate training in pharmacology and the attendant disciplines to ensure the proper and safe use of these products.

11.279. The BVA said that the veterinary surgeon did not view the sale of a medicine as the end point of any consultation; in many situations the veterinary surgeon did not supply any medication at all but instead gave advice on a change of management, medicines being only one of the possible options and only a part of the treatment package.

11.280. The BVA believed that, whilst the dispensing veterinary practice was able to provide a 24-hour, year-round service in both urban and rural areas, commercial realities made it unlikely that a retail pharmacist would be able to match this level of service. It feared that this would reduce the availability of all medicines necessary for the maintenance of animal health and welfare.

11.281. The BVA agreed that clients should have a clear understanding of the cost of their animals’ treatments and that it was incumbent on the veterinary surgeon to ensure that this aim was fulfilled. However, it considered that some of the suggested remedies were excessive and unnecessarily intrusive into business practice in ways not required of other businesses.

11.282. In the BVA’s view, the statement erred in assuming that one solution fitted all situations. The profession was diverse both in structure and geographical location, with corporate, remote rural, single species and multi-centered practices.

11.283. The BVA argued strongly that any attempt to move away from the ‘three guiding principles’ of safety, quality and efficacy would be untenable; the basis of the Medicines Act was to remove the danger of the public being sold products that were either dangerous or of no medical value; the assumption in the statement that owners or keepers of animals kept by way of business had a corresponding expertise in medicines was unsound and was tantamount to suggesting that a human patient should choose his or her medication.

11.284. The BVA was concerned that the efficacy argument be recognized in relation to all companion- and food-animal medicines as regards generic and licensed formulations of the same active ingredient and dosage. With regard to food-animal medicines, it noted that generic equivalents and formulations of the same active ingredient and dosage had different bioavailability and withdrawal periods. This had potentially important implications for food safety. The same applied in relation to the efficacy of such products for companion animals. A distinction had to be drawn between a generic drug that had gone through the authorization process and had been licensed on the basis of essential similarity where bioavailability and withdrawal periods were known and a generic that was being used under the cascade, for example a medicine containing the same essential ingredient but only licensed for a species other than that for which it would be used, for example human drugs.

**BVA and RCVS: joint hearing**

11.285. The BVA and the RCVS made the following additional points at a joint hearing.
11.286. The BVA recalled that our inquiry was taking place against the background of tremendous structural change for veterinary practice; there was a marked swing to small-animal practice away from the farm area, principally caused by the decline in the farming industry. It commented that the narrowness of the inquiry, in dealing with POMs only, caused problems.

11.287. Both the BVA and the RCVS stressed that, for them, the paramount considerations in terms of the manufacture and supply of medicines were safety, quality and efficacy; cost was entirely secondary. The BVA recognized that, where two products seemed identical, veterinary surgeons might buy the cheaper one.

11.288. The RCVS said that it had been trying to encourage its members to improve fee transparency by estimating fees in advance and keeping clients aware of mounting fees in ongoing cases. This required changes in working practice, rather than philosophies, at veterinary practice level, but the RCVS considered that its efforts were meeting some success. It noted that the Guide to Professional Conduct stated that prescriptions should be available. It nonetheless cautioned against requiring too many notices to be posted in surgery waiting rooms—on rights to prescriptions, prices and so forth—since this could prove counter-productive.

11.289. The BVA commented that one problem veterinary surgeons might meet in issuing prescriptions was knowing the price the pharmacist would charge. This rendered it difficult for the veterinary surgeon to give sound advice on cost to a client when offering a prescription. Commenting on the term ‘cross-subsidization’, the BVA argued that the case was rather that each part of the veterinary business had to make some sort of profit and the sum total of that profit was the profit of the business. It said that we were asking for a shift in the balance of that profitability between different sectors. Whilst this system of aiming for overall net profit from different components of the business had evolved over many years, veterinary surgeons did not generally perceive the situation in such logical terms. Moreover, ‘cross-subsidization’ implied that one part of the business was making a loss, whilst another part was making a gain; in the BVA’s view this was untrue. Following a review of pharmacy costs, conducted on behalf of the BVA,1 it appeared to the BVA that some veterinary surgeons were undercharging for POMs, rather than overcharging; the survey suggested that some practices were losing money on the pharmacy part of their veterinary practice, probably without knowing it.

11.290. Whilst some specialist veterinary practices, such as poultry specialists, might derive high proportions of their turnover from the sale of medicines, because the farm units they served were so large, for most farm practices the proportion was some 40 to 50 per cent and for most small-animal practices it was about 30 per cent.

11.291. The RCVS acknowledged that there might be an element of truth in the assertion that many veterinary surgeons had made, that their professional and ethical obligations, notably the requirement to provide 24-hour cover, could not be charged at economic rates and therefore necessitated some subsidization. It recognized that an increasing number in the profession questioned the need for these requirements. The RCVS noted that the requirement was to make provision for 24-hour cover; veterinary practices were not obliged individually to undertake all out-of-hours work, and they could make rotational or other arrangements with other practices. (The BVA added that there were geographical constraints on such arrangements as well other limitations, for example related to practice specializations.) Moreover, in the RCVS’s view, the obligation reflected the general philosophy among clients of what was expected from a profession seen as having a vocational role; clients did not expect veterinary surgeons to charge extra for providing 24-hour cover. There were other services coming into this category, such as advice provided over the telephone. The RCVS Guide to Professional Conduct advised members that it was ‘unethical for the veterinary surgeon to quote a grossly excessive fee [for out-of-hours service] compared with normal charges with the intention of avoiding attending’. In the RCVS’s view, it was unlikely that the service could be provided on a full cost recovery basis; and if there were to be losses of income on one area, which caused the out-of-hours fees to rise, the profession would have to re-examine 24-hour care, which would be detrimental to animal welfare.

11.292. Neither the RCVS nor the BVA had undertaken any assessment of the economic burdens imposed by professional and ethical requirements. The RCVS was nonetheless willing to offer a rule-of-

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thumb estimate for the cost of the service of between £30,000 and £50,000 a year for a four-member practice.

11.293. Turning to the farm-animal sector, the BVA said that it was price sensitive in terms of the capital value of animals and the profitability per animal. (Price sensitivity was lower in the small-animal sector, where recent surveys had suggested that the provision of a good service was the key consideration for clients.) In the farming sector animals had a finite value; this could be low, as was currently the case for male dairy calves, which were shot at birth because there was no value in keeping them alive. Large-animal veterinary surgeons always saw that a change in the price of animals led to a change in the volume of services demanded from them. Increasingly they were trying to become involved in preventive medicine, spending more time dissuading farmers from using drugs than administering them; this offered the way forward.

11.294. The RCVS expressed considerable concern about the risk to the provision of veterinary services in the marginal livestock areas. There was already evidence that provision was declining. In the aftermath of the FMD outbreak, there were questions about where infectious disease surveillance was going to come from.

11.295. In a discussion of the hypothetical remedies proposed to reduce barriers to the writing of prescriptions, the BVA recognized that there would be an ‘incremental’ cost in terms of time and the resources of a practice in writing a prescription for pharmacists to dispense. They suggested that this would be likely to be higher in the case of farm animals where considerable detail (for example, product licence numbers) had to be included. Moreover, the concept of ‘incremental’ cost took no account of the responsibility the veterinary surgeon took in writing a prescription. Both the BVA and the RCVS took issue with the idea that prescriptions might be offered freely; in the BVA’s view, the suggestion implied that the cost would have to come from some other element of the service in the form of a cross-subsidy.

11.296. The BVA argued that, in a competitive market, pharmacists would come into the market when there was demand for their services. It recalled that pharmacists had operated in the veterinary medicines market but had left it some years ago because it was small and unprofitable for them. The RCVS drew attention to the risk that pharmacies, in dispensing veterinary medicines, would be tempted to offer diagnoses; this would be contrary to the Veterinary Surgeons Act, which stated that only a veterinary surgeon could make a diagnosis.

11.297. Commenting on the hypothetical remedies relating to frequency of examinations, the BVA said that the frequency depended on circumstances and the nature of the animal’s medical problem. The BVA had consistently steered clear of being prescriptive on this issue, although some members had advocated this, because it believed that flexible arrangements were needed. Whilst veterinary surgeons often reduced consultation fees for second visits, the BVA commented that this practice was not strictly logical and largely done as a client-friendly gesture.

11.298. In general, the BVA questioned that the level of complaints about the price of veterinary medicines was high. It noted that the 200 or so who had complained to the CC were not a statistically valid sample in relation to the millions of pet owners in the UK. Survey evidence suggested that 80 per cent of clients stayed with their veterinary practice, although there was no bar to switching practices. Nonetheless, the BVA agreed that greater price transparency would be welcome. It said that transparency would be improved by any method that encouraged veterinary surgeons to discuss prices with clients, but it believed that this should remain a voluntary process. It said that displaying the price of the most frequently-used POMs would be feasible but would be tokenism since clients would not know in advance the amount of any drug their animals would require. It would also be difficult for peripatetic veterinary surgeons to fulfil any requirement to post prices.

11.299. The RCVS suggested that the high proportion of complaints coming from owners of chronically sick animals might be explained by the introduction of the cascade. Whilst, before it was introduced, many common human generic medicines, such as phenobarbitone, could be used, the coming of the cascade had brought the need to use drugs with MA, at a significantly higher cost from the manufacturer; veterinary surgeons could no longer provide cheap medication and had to turn to more expensive ones; the cascade had not been of the veterinary profession’s making. The BVA suggested that, in quoting prices for veterinary medicines to clients, pharmacists were often quoting the price of the human generic medicine, rather than the authorized veterinary medicine, which they did not stock but would have to supply under the cascade.
11.300. The BVA welcomed the hypothetical remedy requiring manufacturers to provide information to enable veterinary surgeons to ascertain the cost, net of rebates, of POMs supplied to them.

11.301. The RCVS commented on the hypothetical remedy requiring veterinary surgeons to write prescriptions on an ‘or equivalent’ basis. It noted that its advice was that the prescriber had absolute responsibility for the use of the medicine; if a product were to be substituted by a pharmacist, it could only be done in consultation with the person who prescribed it. The RCVS believed that there were only a few cases where there was a genuine equivalent to the medicine that had been prescribed (for example, there was no substitute for the anti-flea treatment, Frontline). The BVA suggested that the Veterinary Formulary, listing the active ingredients of commercial products, should serve as a reference source in identifying possible equivalent medicines.

11.302. The BVA concluded by recommending that we might include among our recommendations the removal of VAT on veterinary drugs, in line with the tax treatment of human medical and dental drugs. This would be of immense benefit to animal welfare.

**British Small Animal Veterinary Association**

11.303. The BSAVA informed us that it was comfortable with parts of the statement of 17 September but disagreed on some issues. Veterinary surgeons should not be enabled to dispense medicines on the prescription of another practice. By spreading responsibility for the clinical case, this would at best cause confusion and at worst seriously threaten animal welfare and the course of diagnosis and treatment. Adding more professional time to the supply chain could increase expense to the animal owner.

11.304. Commercial pressure might be applied to stock a particular product as in any industry but in the case of medicines the diagnosis, not the financial consideration, drove the choice. It was offensive to suggest that members of an ethical profession would consider commercial advantage over efficacy. In cases where two equally effective but differently-priced medications were available, the vast majority of veterinary surgeons would either choose to use the cheapest for the owner or give the owner the choice.

11.305. The BSAVA disagreed with the proposal that veterinary surgeons should advise clients, immediately before dispensing POMs, of the availability of prescriptions to enable them to purchase from pharmacies; it was unaware of any other industry that invited customers to seek out competitors before making a purchase. It also disagreed with the proposed requirements for veterinary surgeons to provide prescriptions in all cases, which would add expense for clients. Clear signage and the offer to provide a prescription should be sufficient.

11.306. The BSAVA commented on possible remedies to improve price transparency. Medicines were potentially dangerous chemicals, not commodities to be bargained with, and it therefore disagreed with the proposed requirement for veterinary surgeons to inform clients on request of the price of any POM or to display in the surgery the prices of the most commonly dispensed POMs. The BSAVA objected to the proposal that veterinary surgeons should inform clients of the cost of a POM to themselves.

11.307. A requirement for veterinary surgeons to provide prescriptions at no extra cost would, in the BSAVA’s view, completely contradict the CC’s comments about businesslike conduct. A fee in line with that charged for a medical private prescription would be appropriate.

11.308. The BSAVA commented on possible remedies to reduce barriers to pharmacies competing with veterinary surgeons in supplying POMs, the BSAVA disagreed with the proposed requirement for veterinary surgeons to display details of any pharmacy requesting it. The BSAVA stated that it would want reassurance that all pharmacies complied with veterinary medicines legislation before agreeing that veterinary surgeons should write prescriptions for POMs on an ‘or equivalent’ basis.
11.310. The BSAVA disagreed with prohibiting manufacturers’ rebate schemes in relation to cat and dog vaccines; this was a competitive business practice.

Regulatory issues

11.311. The BSAVA stated that recent animal health problems had highlighted the importance of safe food, vigorous control of disease and regulation of medicines. It therefore opposed regulatory Recommendation (6). It did not believe that a brief technical training could provide the level of expertise required to safely regulate the supply of even the current PMLs, let alone new preparations currently in the POM category. On recommendations relating to the cascade, the BSAVA said that there was evidence that medicine prices would be relatively unaffected by either the use of unlicensed generics or supply by an alternative professional group.

British Equine Veterinary Association

11.312. BEVA agreed that animal owners should be educated about alternative sources of supply of POMs and that veterinary surgeons might play some role in that process, without being put into the uncommon commercial position of having effectively to advertise the existence of their competitors.

11.313. Since the provision of prescriptions on request was a requirement in the RCVS Guide to Professional Conduct, BEVA expected that all veterinary surgeons would neither discourage nor decline such a request. BEVA thought that veterinary surgeons should be able to charge for supplying a prescription, the charge being a matter for the individual veterinary surgeons and their clients. They should supply clients on request with details of the price of any component of the services or drugs and provide itemized bills.

11.314. Commenting on the pricing of medicines, BEVA said that this should reflect the global costs of running a pharmacy service, of which the price paid by the veterinary surgeon for medicines was only one input. Assuming fixed overheads, any alteration in the figure of the cost of drugs used to calculate price would need to be accompanied by a concomitant alteration in the level of mark-up, to ensure the continued viability and competitiveness of the pharmacy service. The price of the drug to the animal owner would remain similar.

11.315. BEVA observed that, although a mark-up on manufacturers’ prices was the most logical approach to pricing, it was only ‘accurate’ where information about the actual price paid by the veterinary surgeon was readily available at the appropriate time. It referred to our concern about the complexity and lack of transparency of some rebate schemes.

11.316. BEVA questioned the consistency of evidence behind our concern about veterinary surgeons using mark-ups on manufacturers’ list prices without taking account of discounts and rebates from wholesalers and manufacturers, since this statement was at variance with our later statement that rebate schemes and other promotional arrangements appeared to play a significant role in determining the price of POMs to clients.

11.317. In BEVA’s view, POMs should not be priced to subsidize professional fees provided that there was no restriction of the ability to charge professional fees, for example for appropriately timed re-examinations of ongoing cases. Prices could be compared by consumers, but they were arrived at by those selling them.

11.318. BEVA recognized that the prescribing, dispensing and administration of medicines were activities capable of separation, but doubted that separation was commonly beneficial to the animal or its owner. Many horse owners, for example, were inexperienced in administering medicines and demonstration of the necessary techniques at the time of prescription and supply was essential to the animal’s welfare and the owner’s safety. BEVA doubted whether most of the suggested alternative sources of supply had experience in administration techniques, for example intramuscular injection or oral dosing of a horse.

11.319. BEVA believed that the provision of bundled professional services with POMs offered advantages to the public interest in terms of animal welfare and the prudent use of veterinary medicines.
It stressed that prescription and supply of POMs required veterinary professional input including periodic re-examination of animals on long-term medication.

**Regulatory issues**

11.320. BEVA considered that the protection of human and animal health was the overriding consideration in discussing possible regulatory changes.

11.321. BEVA supported our welcome for the proposal to widen the categories of veterinary medicine eligible to gain MA by the centralized procedure.

11.322. On questions of classification, BEVA believed that veterinary involvement in the supply of POMs was necessary so as to ensure safety and efficacy and that both would be compromised by lesser classifications.

11.323. BEVA informed us that the availability of many equine medicines was threatened by European Commission proposals to require member states to withdraw MA for many in current use. Any changes to dispensing practices would be largely irrelevant if few products were authorized.

11.324. BEVA said that our suggested recommendation that member states should be free to control channels of distribution and supply negated the whole point of MA, which required demonstration of quality, safety and efficiency; the latter two could only be ensured by appropriate use. BEVA believed that demonstrable efficacy was fundamental to the confidence of both veterinary surgeons and animal owners in licensed medicines.

11.325. BEVA questioned our view that if an animal was kept by way of business, the owner or keeper could be presumed to have a corresponding degree of expertise. It would be wary of proposed extensions of the PML concept. It supported our suggested recommendation that the Secretary of State consider negotiating changes to the draft directive to allow MRLs for minor food-animal species to be set by extrapolation from major species data where this was scientifically justifiable.

11.326. BEVA was concerned by the proposal to allow veterinary surgeons to dispense POMs for animals not under their care. Responsibility for treating an animal sat squarely with the veterinary surgeon in whose care it had been placed. Introducing an additional veterinary surgeon in the treatment chain would diffuse what was now a clear line of responsibility, to the detriment of owner and animal.

**Society of Practising Veterinary Surgeons**

11.327. In addition to the concerns raised above (paragraphs 11.173 to 11.176, 11.187, 11.197 to 11.198, 11.201, 11.205 to 11.206, 11.210 and 11.212), the SPVS addressed some of the hypothetical remedies.

11.328. The first was the suggestion that veterinary surgeons should be required to state the cost of a dispensed POM to themselves. If this remedy were considered, the SPVS would request that veterinary practices be allowed to compete on a level playing field in the sale of POMs. That would require all persons, including pharmacists, to state cost prices. The SPVS would also request other examples of consumer goods which were treated in this way, since it was not aware of any similar precedent.

11.329. Referring to the proposed provision of prescriptions at no cost to the client, the SPVS fully understood our concerns over transparency. Itemized billing and correct charging for professional work was an issue that it had always supported. Previous surveys had shown that the majority of veterinary practices already provided itemized accounts. So as to continue to provide a high-quality level of care and service, veterinary practice had to be profitable. The charge for professional fees was intrinsically linked to the time spent on different procedures. Currently the time spent prescribing medicines and its associated cost to the practice was incorporated in the overall cost of pharmacy. Part of the margin the practice made on medicines dispensed went to cover this.

11.330. It was not the case that every examination of an animal by a veterinary surgeon would result in a need to provide medicine. When a medicine was required, a procedure had to be followed:
—— choose the correct drug bearing in mind the diagnosis, species, cascade, availability and price;

—— make a permanent entry in the clinical notes;

—— produce a prescription, either by hand or using specialized software. A prescription issued by doctors would not cover all the issues required within an animal prescription, particularly for food-animal medicines;

—— explain to the owner what could be done with the prescription;

—— explain the drug and dosage;

—— explain and sometimes demonstrate methods of dosing, particularly in cats; and

—— explain potential side effects; take responsibility for the drug and any potential side effects. The SPVS had been informed by the RCVS that the legal responsibility for the medicine lay with the prescriber, not the dispenser.

11.331. The SPVS stated that this time-consuming process was currently paid for within the margin of the medicine purchased. The prescription was also a legal document and legal responsibilities must not be dismissed. The latest newsletter from the Federation of Veterinarians of Europe (FVE) stressed the importance of veterinary prescriptions. The European Parliament Committee on the Environment, Public Health and Consumer Policy supported the FVE’s view that only veterinary surgeons should be allowed to write prescriptions for veterinary medicinal products. Prescriptions would offer additional guarantees for a rational and prudent use of antimicrobial substances, in line with FVE guidelines.

11.332. The SPVS said that the cost of time involved in the issuing of a prescription had to be covered in some form and if the CC chose to stop a veterinary surgeon charging a realistic fee for providing a prescription, the extra cost would have to be added on to professional fees. This would not be transparent and would penalize clients who attended the surgery and left requiring no medicines. Alternatively, these clients could be charged less, the difference being equal to a prescription fee. For complete transparency the cost associated with prescribing should be charged for and clearly itemized in any account.

11.333. Referring to our suggested remedy that a prescription fee should be charged at cost price, the SPVS agreed that a charge should not be so high as to force people to buy medicines at the practice (though clients in that situation were free to move to another practice).

11.334. But the SPVS objected to the proposal that veterinary surgeons should not be permitted some margin on writing prescriptions, as existed for all their other services. Veterinary practice was a business and had to make a profit.

11.335. The SPVS pointed out that veterinary surgeons had to charge VAT on all fees and medicinal products, unlike private medicine, dental or optician fees.

11.336. Finally, the SPVS could not disassociate the working and charging practices of veterinary surgeons from animal welfare and the proper availability of services. It referred also to prudent medicine use and the safety of the food produced by UK farmers. It noted that the increasing resistance to anthelmintic preparations in farm-animal medicine was an example of how ready access to low-priced PML products could encourage diagnoses based on guesswork and consequent overuse. The SPVS appreciated that the CC’s remit was economic, but said that other issues must be considered.

**British Cattle Veterinary Association**

11.337. The BCVA—representing 1,400 members, mostly practising veterinary surgeons with a special interest in cattle—said that the provision of veterinary care should be viewed as a total package within which the prescription and dispensing of medication to treat animals under the veterinary surgeon’s care was inextricably linked. Profit was taken from the dispensing of medication to clients and this contributed to the overall economic return of the business. The level of pricing was a matter for individual practices, but any reduction in profits made from medicines would ultimately result in an
increase in charges for service provision, with possibly negative effects on the welfare of animals under veterinary care. It was necessary to understand the balance required to calibrate medicine costs and the cost of service delivered to the farm client. One survey in 1996 indicated that, should the profits derived from medicine dispensing be removed from the turnover if a large-animal practice, the fees for service provision would have to increase by 400 per cent to maintain the viability of the practice. The welfare of low-unit-value livestock particularly would suffer should the cost of attendance and examination on farms increase to a prohibitive level.

11.338. In the BCVA’s view, medicines needed to be properly evaluated by way of safety, quality and efficacy data prior to being granted an MA. This was particularly important in the food-producing species to ensure the consumer had confidence that the end-product was free from residues.

Conducts

11.339. The BCVA said that the veterinary surgeon, as the only person who, by definition, might prescribe POMs, afforded a key control point in the use of such products. It maintained that it was not the case, as it believed the statement of 17 September suggested, that price sensitivity was the prime criterion for the selection of medicines by a veterinary surgeon. When prescribing a particular product, the veterinary practitioner took into account product efficacy, quality, familiarity and consistency of supply. Only then did he or she take into consideration the price of the medicine.

11.340. With regard to the ‘failure of veterinary surgeons to inform animal owners that they can ask for prescriptions’, the BCVA commented that there was often no local infrastructure for fulfilling prescriptions should they be issued. The BCVA had issued guidelines to members on the provision of prescriptions to clients. Whilst advising against actively discouraging requests for prescriptions, the BCVA recommended that the impact on overall costs of long-term provision of veterinary care should be discussed openly and frankly with the client. The BCVA expected the pricing of to be a matter for the individual practice, after taking account of practice overheads and the time taken to complete the prescriptions.

11.341. The BCVA supported the idea of discussing with the client the cost benefit of treatment prior to dispensing medicines. As veterinary surgeons involved in agriculture, members of the BCVA were well aware that the value of animals under treatment impinged on the costs of treatment, particularly in the current economic climate. However, it needed to be borne in mind that the dearest medicine was the one that did not effect a clinical cure irrespective of its initial price.

11.342. The BCVA supported the provision of itemized bills to clients, and was surprised that it was not considered normal practice. In the BCVA’s opinion, a client would have no difficulty in finding a veterinary surgeon who offered itemized billing as part of his or her normal service.

11.343. Noting that individual practices applied differing mark-ups to products, based on a wide range of business decisions, the BCVA agreed that some discount schemes were operated in ways that made it difficult to work out the net buying price of the product. The BCVA believed that this figure should be readily available to the veterinary surgeon.

11.344. In the BCVA’s view, the ‘one-stop-shop’ concept of veterinary services and the dispensing of medicines by the same veterinary surgeon offered wide advantages to members of the public. It believed that an upset in this balance would have an adverse effect on welfare.

Possible remedies to reduce barriers to obtaining prescriptions

11.345. The BCVA presumed that any sign advising clients of the availability of prescriptions would have to name the pharmacy, since they thought that not all pharmacies would wish to stock and dispense the full range of veterinary medicines.

11.346. As well as having concerns about the infrastructure among pharmacies to supply veterinary medicines, the BCVA was concerned that in some situations issuing prescriptions might lead to a lack of compliance by the owner, particularly in the companion-animal sector. For example, following an initial antimicrobial injection and the issuing of a prescription, a clinical improvement in the animal’s condition
in the first 24 hours might induce the owner to discontinue the course of prescribed medication. This situation would be less likely to arise should the medication be dispensed at the time of consultation.

11.347. The BCVA said that the generation of a prescription in every case would be an unnecessary addition to the consultation process. In its view, the cost of prescriptions was a matter for the individual practices concerned and any attempt to standardize this figure would be construed as price fixing. It saw no reason that the cost of this service should be any less than the medical profession charged for private prescriptions.

11.348. The BCVA agreed that frequency of examination was an important issue; improved guidance from the RCVS was needed, covering the quantity of medicine that should be prescribed at any one time, and the period of time during which the prescription was valid; a precedent had already been set in that MFS prescriptions could only be written for a period of 30 days. But it was vital that veterinary surgeons should continue at all times to provide control of potent POM products and not allow any change in the current situation to allow stockpiling of drugs on farms in a ‘just-in-case’ basis.

Possible remedies to improve price transparency

11.349. Whilst agreeing that the cost of POMs can often be an important consideration in the prescribing process, the BCVA emphasized that POMs should not be perceived as just another commodity. The BCVA had no problem with the suggestion of quoting a price for a POM to anyone who asked, but it noted that a veterinary surgeon could not at present prescribe or dispense to any other than a bona fide client. A price list in the surgery detailing the cost of commonly-prescribed POMs would not, in the BCVA’s opinion, serve any useful purpose; nor would a requirement to advertise the cost price of dispensed medicine.

11.350. The BCVA agreed that manufacturers should provide sufficient information to enable veterinary surgeons to ascertain the costs of POMs net of rebates. The Association also agreed with the requirement to provide itemized bills.

Possible remedies to reduce barriers to competition from pharmacies

11.351. The BCVA saw difficulty with the idea of prescriptions on an ‘or equivalent’ basis within the food-animal sector; products that might be deemed to be equivalent on a pharmaceutical basis had different kinetics resulting in different withdrawal periods being set for both milk and meat.

Regulatory recommendations

11.352. The BCVA supported the extrapolation of MRL data from major to minor species to allow an increased range of therapeutic products for these species.
Regulation of veterinary surgeons

11.355. Paragraph 41(20), statement of 17 September. In the BCVA’s opinion, there was genuine competition in most geographical areas between the many veterinary practices offering services; this competition was mainly service-led, with the client able to choose an alternative should the service prove unsatisfactory; the provision of medicines was part of that package that could be—and often was—scrutinized by the client. Regulation prohibited that supply of medication to anyone other than a bona fide client; our hypothetical recommendation to allow the dispensing of medicine by veterinary surgeons other than the client’s veterinarian, providing it was prescribed by the veterinary surgeon who had the client’s animal under his/her care, would, in the BCVA’s view, increase competition within the sector without introducing another tier of distribution.

11.356. Paragraph 42(21), statement of 17 September. The BCVA believed that advertising the price of POMs would bring no benefit since criteria other than price were taken into consideration before a veterinary surgeon prescribed a medicine.

Veterinary Practice Management Association

11.357. The Veterinary Practice Management Association (VPMA) said, in its response to the statement of 17 September, that it represented about 600 veterinary managers and aimed to promote quality management in veterinary management. It made the points below on the hypothetical remedies set out in the statement.

Displaying the practice policy on repeat prescriptions

11.358. The VPMA pointed out that it was good practice and a requirement of the RCVS that veterinary surgeons only provided repeat prescriptions for animals they had examined within a designated period of time. A significant number of veterinary surgeons already displayed their policy on repeat prescriptions; this avoided misunderstandings and ensured that clients were fully aware of the process and the reasons for it. The VPMA would welcome all veterinary surgeries displaying statements of policy.

Providing repeat prescriptions at no further cost or at a true reflection of the cost to the practice

11.359. According to the VPMA, many practices examined animals requiring a repeat prescription at no charge or a reduced charge even though the client was using up valuable consulting time. This was advantageous to the client. However, if in future all drugs must have a written prescription, the client might find it more costly than under present arrangements.

Displaying signs advising clients of the availability of prescriptions and including the price of the prescription

11.360. Whilst this requirement did not apply to any other body supplying prescriptions, for example doctors and opticians, the VPMA considered that it was reasonable to have some method of informing clients that prescriptions were available.

Providing prescriptions on request

11.361. The VPMA said that this had always been the case.

Prescription charges

11.362. In the VPMA’s view, prescription charges must be realistic, and different, competing practices should be able to charge the rate the market would bear. It was important to take care that a
prescription charge did not negate any potential saving by the client on drug costs. There was no guarantee that the client would find cheaper drugs at pharmacies or at other veterinary surgeries. But there was a danger that seeking the drugs would not only be more inconvenient for the client but would also be detrimental to the welfare of an animal if there was any delay in the purchase of the drug and consequently the treatment of the animal. Prescribing in many circumstances (for example, for exotic species) included taking responsibility for the use of unlicensed products. In these cases, the veterinary surgeon, and not the pharmacy or drug company, retained liability. Any prescription fee had to reflect this responsibility.

Informing clients of the price of POMs

11.363. The VPMA noted that there was no precedent for this in any other business and considered it an unreasonable suggestion. The price to different surgeries would vary, and the hypothetical remedy would serve only to confuse clients and stifle competition.

Itemized billing

11.364. Noting that many veterinary practices provided itemized bills, the VPMA said that it would welcome all veterinary surgeries providing this service.

Veterinary practices to display details of pharmacies which supply veterinary medicines

11.365. The VPMA believed that this did not happen in any other service or retail outlet. It thought it would cause confusion since clients would not know which pharmacy to choose, whilst actively disadvantaging the veterinary surgery. Moreover, there would be no guarantee that the pharmacy price was less than the veterinary surgery price, but the client might end up paying more for drugs, in addition to a prescription charge.

Cost net of rebates

11.366. The VPMA’s view was that, if a practice operated a good stock-control system, it was not difficult to establish the cost of POMs net of rebates.

General comments

11.367. In its general comments on the statement, the VPMA maintained that, although cost was certainly relevant to clients, it was not the most important factor in their choice of veterinary practice. They were looking for quality care, advice and treatment for their pets as well as convenience for themselves. Value for money was a subjective judgement. There were few clients who had no choice in the veterinary surgery they used and most sought their veterinary surgery on the basis of personal recommendation. Owners seeking comparative quotes on prices could readily access this information, generally over the telephone.

11.368. The VPMA had concerns that the hypothetical pricing and prescription recommendations might be disadvantageous to clients due to:

— the introduction of prescription costs;

— the unknown quality of service, opening hours and range of drugs provided by alternative suppliers;

— confusion over where to purchase drugs; and

— price taking precedence over animal health and welfare as well as public health.
11.369. In the VPMA’s view, it was accepted business practice that some items or services were sold to subsidize others, for example loss leaders and known-value items. Veterinary practices were businesses and had to operate in a modern business world. They competed with each other effectively on service and price. Only if they succeeded in producing an acceptable return on effort and investment were they able to provide the quality treatment, equipment and personnel necessary to serve their clients, protect public health and ensure the welfare of both farm animals and companion animals.

Other representations

Dr Jeremy Lucke

11.370. Dr Lucke said that he was a retired veterinary surgeon and a past-president of the RCVS. He was a member of the Marsh Independent Review Group and was currently a member of council of the PDSA. He submitted comments in a personal capacity.

11.371. Dr Lucke said that he saw the market for POMs as one market for several components of veterinary medicines for different animal types and different purposes, such as therapeutic and prophylactic. Northern Ireland was different but not really a separate market.

11.372. He said that there were good reasons for the gatekeeper role of the veterinarian as the sole person qualified to prescribe POMs, which included the protection of human and animal health and the impact of veterinary medicines on the environment. The attending veterinary surgeon was best qualified to ensure that the most appropriate medicine was issued or to advise alternatives to using POMs, such as different management and husbandry systems. The emphasis now was on using less rather than more veterinary medicines, particularly in food animals.

11.373. Dr Lucke said that in most cases there was competition between veterinary practices, except in more remote geographical regions. For the more specialized services, which now included many agricultural businesses, the small number of providers inevitably limited consumer choice. Dr Lucke also thought that loyalty to a practice or particular veterinary surgeon was a real constraint on consumer choice; there was a view that ‘in the interests of my animal, I don’t want to upset my vet’.

11.374. In Dr Lucke’s view, the trend towards increasing POM control in the EC was right. But from the prescription onwards in the distribution chain, competition should be opened up in order to allow a free market to work within reasonable constraints and drive down the price of POMs.

11.375. Commenting on our provisional finding on a complex monopoly in relation to the supply of POMs to animal owners, Dr Lucke agreed that the conducts identified existed in some cases and were factors that could distort a free market and limit consumer choice. He had sympathy with the possible remedy relating to manufacturers’ rebates.

11.376. Considering possible remedies to reduce barriers to obtaining prescriptions, Dr Lucke agreed that clients should be made aware of the option to have a prescription dispensed elsewhere, but it was for the profession itself to decide how this should be done. He agreed that clients should be made aware of the cost of a prescription. He thought that there was merit in the proposal that veterinary surgeons should provide prescriptions for POMs in every case (other than for use in emergency treatment etc). This could usually be achieved electronically, using the IT available in many practices. There might be difficulties on the farm but these might be resolved by new technology. He perceived as unnecessary the possible remedy requiring veterinary surgeons to state on prescriptions that these items could be dispensed by pharmacists.

11.377. Commenting on the possible remedy that veterinary surgeons should provide prescriptions at no additional charge beyond that for the consultation, Dr Lucke said that any costs associated with writing the prescription should be a part of the professional fee. Apart from the medicines used by the veterinary surgeon in the course of treatment, all other medicines should be prescribed using a written prescription. Where possible, the prescription should be dispensed by another qualified person, because there was merit in having a second pair of eyes checking the prescription. Charges for repeat prescriptions should be consistent and not excessive. At no time should the cost of the prescription be perceived as a hurdle.
11.378. Dr Lu cke did not sup port the suggestion that veterinary surgeons should display notices stating their policies on frequency of examining animals requiring repeat prescriptions, because the frequency was extremely variable. The prescription fee, if any, should be known to the client, who should also be informed of the number of repeat prescriptions or the date of the next review, which in most cases would necessarily involve a clinical examination and advice.

11.379. Turning to other possible remedies to improve price transparency, Dr Lucke observed that some might be seen as an unnecessary intrusion into business practice. He agreed that clients should be aware not only of the total cost of treatment but of the proportion that related to medicines and should be allowed to choose where they purchased the medicine so as to get value for money.

11.380. He disagreed with the suggestion that would require veterinary surgeons to display in the surgery the price of the most commonly-dispensed POMs, which he thought would be time-consuming and an unnecessary imposition. It would be unreasonable in his view to require veterinary surgeons to state the price they had paid for a POM when quoting its price for clients.

11.381. Dr Lucke was surprised to learn that veterinary surgeons were not aware in advance of the value of manufacturers’ rebates and agreed that manufacturers should provide this information. He agreed that veterinary surgeons should be required to provide itemized bills distinguishing the cost of services from the cost of POMs.

11.382. Dr Lucke’s view was that to require veterinary surgeons to display details of any pharmacy which asked for this would be an unreasonable imposition on any business. He also disagreed with the proposal that veterinary surgeons should be required to write prescriptions on an ‘or equivalent’ basis. It was the responsibility of the veterinary surgeon to prescribe the most appropriate preparation and, unless there was some subsequent agreement, that medicine should be dispensed. He agreed that manufacturers and wholesalers should be required to supply pharmacies, on terms that enabled pharmacies to compete.

11.383. Dr Lucke said that he found little to disagree with about our provisional finding that there was a complex monopoly in relation to the supply to veterinary surgeries of vaccines for cats and dogs; he had sympathy with the proposed remedy.

Regulation

11.384. Dr Lucke agreed that the present regulatory arrangements restricted competition to a greater extent than was necessary. He agreed with Recommendation (2) (unrestricted cross-border trade in mutually recognized products). In time there should be sufficient trust between the different authorities to allow free movement of medicines, provided labelling was sufficient for their safe use.

11.385. He thought that it would be unwise for the VPC and the VMD not to take the manufacturers’ views on classification into account (Recommendation (3)). He agreed with Recommendation (4) concerning an automatic review of classification based usually on the product’s existing dossier. He welcomed Recommendation (5) (broadening the meaning of animal welfare in the VMD’s remit) because he believed that there were too many animals in the UK that received few or no medicines at all.

11.386. Provided the necessary safeguards were in place, SQPs should dispense POMs more widely. There was a strong case for including and possibly expanding the medicines on the PML list but under a new POM category. Routinely used medicines, such as certain anthelmintics and vaccines, could be dispensed by suitably qualified staff in a wider range of outlets provided there was veterinary control over the treatment, either by a written prescription or through a written health programme for a group of animals based on veterinary advice (similar to the system in France). He did not believe that a qualification in veterinary science or pharmacy was the essential requirement to dispense veterinary POMs.

11.387. Over longer periods of time, provided a POM had been found to be relatively safe in terms of animal health, public health and environmental protection, the trend should be towards downgrading the POM to general sales, or an equivalent to OTC sales in retail outlets.

11.388. Dr Lucke said that to resist the EC’s proposal to classify all products for food-animal species as POM would go against the tide and he strongly disagreed with Recommendation (6). It should be possible for member states to determine for themselves the appropriate distribution and supply channel.
provided that that was consistent with agreed broad safeguards, and he therefore had some sympathy with Recommendation (7).

11.389. He agreed with Recommendations (8), (9), (10) and (11). Certain safeguards would be necessary for the implementation of Recommendation (12). If a new category of POM (equivalent to PML) was to be dispensed by SQPs in a wider range of retail outlets, there had to be a written health plan, for farm, stable or kennel, under which the POM was prescribed. That would involve some assessment of owner or keeper competence in the storage, administration and disposal of medicines.

11.390. Dr Lucke agreed with Recommendations (13), (14) and (15). But on the proposal that an MA be given to a product before an efficacy assessment was completed (16), he doubted that the modest savings which might be made in developmental costs would be justified.

11.391. He agreed with Recommendation (17), allowing extrapolation of MRLs for minor food-animal species from major ones. He agreed in principle with recommendations concerning relaxing the cascade ((18) and (19)) but said that this would place a responsibility on the veterinary surgeon to prescribe the best alternative. That was why it was essential that the product dispensed was that which had been prescribed.

11.392. Dr Lucke agreed that veterinary surgeons should be allowed to dispense prescriptions for animals not under their care (Recommendation (20)) and thought that veterinary surgeons should be allowed to advertise medicines (21).

11.393. Dr Lucke accepted that a code of conduct, drawn up by the profession based on our final report, should be incorporated into the Guide to Professional Conduct (22). Recommendation (23) (single breaches of the RCVS Guide to be capable of being ‘disgraceful’) would require strengthening of disciplinary powers backed up by primary legislation. Options for monitoring by the RCVS of compliance with its Guide would have to be explored and an estimate of resources made before any monitoring scheme could be justified.

**Mr Mike Nelson**

11.394. Mr Mike Nelson said that he was a retired practising veterinary surgeon who had since 1976 also been an investigative veterinary journalist. He began his career in a mixed practice in Devon, worked 18 years in the pharmaceutical industry and 20 years as the owner of a small-animal practice in London, retiring from practice in 1996. Mr Nelson said that he had undertaken research in November 2001 which showed that the average list price of medicines to veterinary surgeons in France and Holland had been in the region of 67 per cent of the average UK list price, for identical branded products. The cost of some 42 per cent of all veterinary products purchased in France, and some 50 per cent of those purchased in Holland, had been between 60 and 80 per cent of the UK price.

**Response to statement of 16 April 2002**

11.395. Mr Nelson said that the MRL requirements, designed to protect consumers of products derived from animals treated with veterinary medicines, were necessary and the science was such that there was no scope for changing the system. Safety to the consumer should not be compromised.

11.396. He did not think that the inclusion of an efficacy test in the MA procedure unnecessarily increased the barriers to introducing a veterinary medicine to market, and selling a product without proof of efficacy could compromise animal welfare. Research for more effective treatments led to increased competition.

11.397. Mr Nelson thought it would be unfair if a company were to be granted a product licence on the basis of an original manufacturer’s submission and substantial investment. Any change in the present system of requesting reclassification would stifle future development of veterinary medicines and thus reduce prospects of progress and dynamic veterinary practice.
11.398. In Mr Nelson’s view, any alleged restriction of competition due to a lack of a POM classification for medicines that could be prescribed by veterinary surgeons without prior clinical examination was irrelevant. The aspects of safety, efficacy and quality enshrined in the Medicines Act were far more important. The Medicines Act was framed so that POMs could only be prescribed by a fully qualified person for use in humans or animals. While a doctor might be able to prescribe a POM, for example over the telephone, without examining a patient, a veterinary surgeon was unable to do so because he or she could not question the patient or expect an animal owner generally to have the knowledge or expertise to recognize symptoms. However, veterinary surgeons were subject to competition from neighbouring practices and abuse of this limitation was unlikely, particularly in large-animal practice, where the herd or flock was usually seen at intervals which permitted prescribing without a visit.

11.399. If a pharmaceutical company had a candidate product for which it saw a reasonably substantial market, Mr Nelson thought the regulatory delay was unlikely to be a barrier. However, the length of time taken to progress through regulation did increase the selling price.

11.400. Mr Nelson said that lowering PMLs to GSL would not be justified, on the basis of safety, quality and efficiency. Because safeguards were necessary, SQPs should continue to be precluded from breaking up bulk veterinary medical products.

11.401. On the question of whether the European centralized procedure could restrict competition, he said that the procedure had reduced registration costs and saved time and effort. It permitted earlier marketing in those states where the manufacturer had a subsidiary or appointed a distributor and thus increased competition.

11.402. He agreed that the potential for competition from extra-EC markets had been constrained by the lack of mutual arrangements between the EC and other regulatory regimes.

11.403. Mr Nelson thought that the tying-in by manufacturers of some or all products in their ranges had minimal anti-competitive effect. Veterinary surgeons such as himself based decisions about sales on their professional opinions and costs were a secondary consideration.

11.404. In his view, rebate schemes that included contracts with veterinary surgeons assisted manufacturers in product planning, which led to greater accuracy in sales forecasts and reduced wastage. He did not believe that manufacturers’ rebate schemes had encouraged veterinary surgeons to charge higher prices than they would otherwise have done. He acknowledged that manufacturers operating rebate schemes would have an informational advantage over those that did not. However, such information resulted in a more efficient use of both the veterinary surgeon’s time and that of the company’s representative.

11.405. On the other issues relating to manufacturers, Mr Nelson did not think that their practices were anti-competitive and saw positive advantages to some.

11.406. In Mr Nelson’s experience, discounts from wholesalers were prompt payments settlements, related to total purchases. The provision of detailed sales information by veterinary surgeons to wholesalers was detrimental to neither veterinary surgeons nor consumers. Planning production and minimizing outdated stock kept prices down and increased competition.

11.407. Commenting on the issue of whether or not veterinary surgeons had failed to inform animal owners of the option to have written prescriptions dispensed by a pharmacist, Mr Nelson pointed out that it was not until 2001 that the RCVS Guide to Professional Conduct included the point that veterinary surgeons were encouraged (not obliged) to make clients aware of this option. It was reasonable for the CC to recommend a stronger line in future, but it had no grounds for castigating individual practitioners for not taking an action the RCVS did not oblige them to take.

11.408. There was no published evidence that a significant number of clients did not receive itemized invoices, nor that they wished to explore alternative dispensing options. He thought that a reasonable minimum charge for writing a prescription would be £4, which would be far less than charges made by private doctors.

11.409. Commenting on whether the treatments for companion animals were unnecessarily restricted by the regulatory regime, he stated that at issue were not simply tissue residues but the safety of the treated animals, their owners who handled them (and perhaps the medicine) and the quality of the product.
11.410. Mr Nelson’s view was that veterinary surgeons did not take steps to make it difficult for animal owners to switch from one veterinary surgeon to another. There was no reason for them to do so. On the question of whether charges for medicines subsidized consultation fees, that was a problem for those who did not have the courage to set the consultation fee at the right level. Some veterinary surgeons were less businesslike than others.

Response to statement of 17 September 2002

11.411. Mr Nelson said that our view of the market was simplistic in referring to ‘several relevant product markets primarily reflecting the therapeutic indications of the different POMs, the animal species they are licensed for and whether they are curative or preventive’. In practice, there were situations where medication might be used in a flock or herd to cure clinically affected animals and/or a preventive in those that might or might not be incubating the disease.

11.412. Similarly, some flea-control products might be used either to prevent flea infestation before any fleas were present or to eliminate an existing infestation. That did not apply to all flea products. It was not easy for a pet owner to diagnose flea infestation. Hundred of pets were brought into every surgery each year with flea dermatitis yet the owner had not noticed any fleas. Owners brought in pets that had been treated in vain over several weeks with a flea treatment bought in a supermarket, pet shop or pharmacy, where fleas were not the cause of the dermatitis. Both these instances involved animal welfare issues and justified careful consideration of channels of distribution, product by product and not blanket classification of product groups.

11.413. Mr Nelson acknowledged that we appeared to appreciate that there were differences in the vaccine markets between species, in both small- and large-animal markets. The small-animal boarding establishments demanded that any owner intending to board their pet must present an up-to-date vaccination record provided by a veterinary practice.

11.414. In Mr Nelson’s view, permitting distribution through channels other than the veterinary profession would not be in the interest of animal welfare. There was an increasing number of veterinary vaccination clinics which, due to lower overheads, provided vaccination at reduced prices and increased competition. But this was the only service they offered.

11.415. Mr Nelson said that our observation that ‘the system of regulation results in a series of national markets for POMs in the EC rather than a single European market’ applied to many different product markets other than veterinary POMs. The multiplicity of national markets for POMs in the EC partly explained the differences in cost to the end-user between different countries. However, a single market could be achieved only by agreement to changes within the EC by member states.

Conducts

11.416. Mr Nelson did not consider that discounts given to veterinary surgeons, as a result of bulk purchase and outlay of capital, should mean that the product should cost less to the public. Referring to pricing (conduct 9c), he said that many veterinary surgeons would take a lower mark-up on an expensive product that was likely to be an ongoing medication for an elderly patient. But if a medicine was very inexpensive, a minimum price was essential; otherwise the owner did not think it was effective and was unlikely to be conscientious about its administration.

11.417. Mr Nelson thought our assumption that a veterinary practice should separate dispensing fees and the price of medication in the bill was somewhat divorced from reality when the pharmacy would not be doing so. If there was to be transparency it should operate in every segment of the market.

11.418. On the provisional finding of a complex monopoly in the supply of cat and dog vaccines, Mr Nelson said that there was some doubt that competition was inhibited in the way the CC alleged. The existence of rebates based on the combined value of purchases of cat and dog vaccines did not necessarily influence the decision on which product to use. He noted that more companies marketed dog vaccines than manufactured them; that applied also to cat vaccines. The existence of discount schemes did not inhibit companies buying in vaccines to enter the market for the first time.
Possible remedies

11.419. Commenting on the hypothetical remedies to reduce barriers to obtaining prescriptions, Mr Nelson had no objection to a requirement for signs in veterinary surgeries advising clients of the availability of prescriptions, but said that those practices which already did this reported little interest. The price for issuing a prescription could also be included with this notice. He objected to proposed remedy (a)(iii) because the first priority in consultations was concentrating on the case and describing the task the client had to perform in administering treatment.

11.420. He said that a requirement for veterinary surgeons to provide prescriptions in every case would be draconian and add to costs and time, as would a requirement for all prescriptions to state that items could be dispensed by pharmacies.

11.421. In Mr Nelson’s view, it would be very difficult to prove ‘incremental cost’ for issuing a prescription (remedy (a)(viii)). On the hypothetical remedy that prescriptions be provided at no additional charge ((a)(ix)), Mr Nelson stated that one way or another an additional charge would be made, such as an increased consultation fee or prescription charge.

11.422. Commenting on hypothetical remedy (a)(x), he said that one notice could not possibly cover frequency of re-examination for repeat prescriptions in every eventuality. Each case could be different. On hypothetical remedy (a)(xi), about advising on the timing of further examinations and repeat prescriptions, Mr Nelson said that whether the animal needed re-examination would depend on response to treatment. The requirement suggested in (a)(xii) would also be unreasonable because of biological variation. He also questioned whether it was reasonable to require a business to advertise its competitors and said that it would be unfair to make the veterinary surgeons do it free.

Buying groups

11.423. The CC took evidence from four buying groups with corporate structures and dedicated staff: Vetcel, London Veterinary Forum, St Francis and Vetswest. Some 280 veterinary practices—approaching 10 per cent of all veterinary practices in the UK—were members of the four groups.

Vetcel Ltd

11.424. Mr Chris Bainton (Managing Director) said that the Vetcel group, originally six veterinary practices, was now made up of over 60 individual like-minded practices working together for the benefit of the group. It operated from its base in Fife (Scotland) and traded extensively in Scotland but with clients also in Cumbria and Bristol. It was set up in 1984 with the aim of managing the member practices’ medicinal costs without greatly increasing their stockholdings. At first the focus was wholly on reducing the cost of veterinary medicines to members without adversely affecting the choice of the individual practitioner within a practice. But over the last 18 years, it had evolved into a one-stop management service for members. The group employed five administration staff.

11.425. Mr Bainton explained that Vetcel was a limited company. Shares were wholly owned by the original directors who set up the company—basically veterinary practices as opposed to individuals, but the practice nominated an individual to represent them at board meetings. The business, as far as Vetcel was concerned, was a single entity. However, each of its members was in its own right a trading entity, usually as a partnership but possibly a single-man practitioner or potentially, since the beginning of 2001, a limited company. Vetcel did not run their businesses, but ran a joint enterprise for procurement of goods and services, separate from their individual practices. It worked on a 0.75 of 1 per cent of gross as its margin. Since the shareholders were also the customers, there was little point in generating large profit.

11.426. Vetcel could buy all goods and services within the group, but not all members wished to take advantage of that opportunity. Capital equipment servicing was one of Vetcel’s main operations. Mr Bainton said that any attempt to coerce members into buying particular medicines would be likely to lead to its break-up. Vetcel tried to establish an agreed product list, of which it maximized its purchases. The agreed list was drawn up in consultation with the other directors, taking advice from Mr Bainton on
availability, equivalent medicines and comparative prices in the market. At the beginning of the year Vetcel negotiated with all manufacturers—or with all the manufacturers willing to do business with it—a level of turnover for a return of discount. Mr Bainton negotiated as tight a deal as possible for the best possible turnover and then added some more products; if he failed to sell all the contracted volumes of medicines he had to use reserves of capital to buy up the surplus and so ensure that the turnover was achieved for the discounts negotiated with the manufacturers.

11.427. This process of selecting veterinary medicine in volume gave member practices the ability to assess products accurately and to guarantee that they paid the price Vetcel quoted them. In contrast, Mr Bainton said, many practitioners did not know the true cost of the medicines they bought and had little idea how to calculate it. The process had worked well too for the manufacturers willing to work with Vetcel; over the years, they had increased their turnover considerably.

11.428. Mr Bainton explained that specific orders from the individual veterinary surgeons went to the wholesalers in the normal way. The wholesaler had an account number for the veterinary surgeon, indicating that the practice was a Vetcel member. This applied to all its purchases from a wholesaler, but it did not get any discount from Vetcel on products ordered on its own account rather than through Vetcel. When a veterinary surgeon bought medicines directly through a wholesaler, the wholesaler passed on the details of the transaction to the manufacturer, who paid any discount direct to the veterinary surgeon. In the case of products bought under a Vetcel scheme, the veterinary practice bought the product from a veterinary wholesaler. The wholesaler supplied the data to the manufacturer. The manufacturer confirmed Vetcel’s claim of the total gross turnover of the group and agreed the discount level and paid it to Vetcel. By that time Vetcel had already given that discount within the same month. In other words, the member paid the discounted price for the product. Vetcel took no discount from the wholesaler.

11.429. Mr Bainton said that, when Vetcel first set up operations, in 1984, six of the approximately 50 major manufacturers at that time refused to do business. These were identified as: Glaxo, Pfizer, Beecham, Ciba-Geigy, MSD and Upjohn—all manufacturers with speciality products. These companies had led the way on acquisitions within the industry and had enforced their policy towards buying groups on companies they absorbed, with many of which Vetcel had formerly negotiated. Novartis, Schering-Plough and Pfizer had refused to discuss terms with Vetcel. As is the case with other buying groups, Vetcel had negotiated terms with Intervet and Merial.

**St Francis Ltd**

11.430. Mr John Hodgkin (Director) said that there were around 80 practices in the group, a limited company employing a staff of three. He explained that members paid an administration fee monthly; a separate invoice was produced for this. Otherwise, St Francis invoiced as agents for some suppliers or reinsvoiced for most others. St Francis also collected payments on behalf of most of the suppliers. Centaur invoiced and collected payments directly.

11.431. He said that members ordered and received goods directly from their chosen supplier/wholesaler. They were completely free to buy whatever they wished, with no restrictions imposed by the group. Since St Francis did not have group terms with all manufacturers, the net price differential between competing products encouraged practices to purchase products from the manufacturer offering the cheapest net price. This could be influenced, however, by other schemes outside the group. For example, a single competing product might be cheaper when bought from a manufacturer offering the group terms, but if a reduction in overall purchases from another manufacturer resulted in dropping a discount band on another range of products, the member might decide not to buy the cheaper product through the group arrangements.

11.432. St Francis confirmed that some manufacturers, including Novartis and Pfizer, refused to deal with it. From the group’s formation in July 1991, it became clear to its managers that they could not secure terms from all manufacturers. The companies often complained to the management that buying group arrangements did not encourage members to be loyal to individual companies and their entire product range, but allowed members instead to ‘cherry-pick’ from across the range of different manufacturers’ products at highly competitive prices. From the companies’ viewpoint, profits were unlikely to increase unless members switched to their products and this would be unlikely if the group benefited from terms from all manufacturers.
London Veterinary Forum Ltd

11.433. Mr Steve Beddall (Consultant) said that there were 111 member practices within London Veterinary Forum Ltd (LVF) with a total of 172 sites. LVF was a company limited by guarantee. Members paid an annual subscription as determined by the board. The board of directors were all members of the forum. The constitution of LVF would allow significantly greater scope for activity than that currently undertaken.

11.434. LVF operated by securing an arrangement with a supplier. The details of this arrangement were circulated to the membership specifying any conditions laid down by the manufacturer. Members informed LVF if they wished to take part. As long as the number of practices wishing to participate was greater than the minimum agreed with the supplier, the agreement went ahead. LVF did not purchase product directly from manufacturers or wholesalers. It never invoiced members for the supply of pharmaceuticals (having no wholesaler dealer licence). Discounts were either paid to the practice by the supplier or one payment was made to LVF who then paid individual practices.

11.435. Mr Beddall said that LVF’s aim was always to work with a limited number of suppliers who not only offered preferential terms but also worked with members in growing the market. LVF negotiated on goods and services other than medicines. Pet foods comprised, in cash terms, the single most important purchase for members. LVF was investigating the possibility of a pet-insurance arrangement, and schemes for credit card transactions; it was also in discussion with veterinary wholesalers about improving discounts on pharmaceutical supplies for LVF members.

11.436. Mr Beddall confirmed that some manufacturers did not, as a matter of principle, wish to trade with buying groups. He commented that there was a separate group of manufacturers which entered into genuine negotiations but made a commercial decision not to proceed with an offer to LVF, on the grounds that the potential for growth by dealing with the buying group was limited and offered no incentive to provide additional discount.

Vetwest Limited

11.437. David Buckley of Vetwest said that the group had 30 member practices. The company had been set up by seven founder practices and others later joined as associate members. It employed a staff of four. Vetwest purchased veterinary medicines and services on behalf of the members, at an agreed price. The members were given a list of products from which they selected their purchases. In Mr Buckley’s view, the group did more than aggregate purchases; pharmaceutical companies which supported the group saw an increase in turnover. Vetwest supplied services and other goods as well as medicines.