NAVEC

NORTH AMERICAN VETERINARY
ETHICS COUNCIL

WORKFORCE & ACCESS RESEARCH SERIES / STRATEGY REPORT

Veterinary reform needs a voice independent of AVMA

How AVMA control of the agenda can block the changes needed to expand access to care

A reform movement cannot pursue its full agenda when the institution it seeks to change decides which reforms are acceptable.

The NAVEC strategy for an independent coalition, advanced veterinary technicians and lasting access to affordable care.

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THE CASE FOR AN INDEPENDENT PUBLIC VOICE

Summary

Gallup found that 52% of U.S. pet owners reported skipping or declining needed care in the preceding year, with cost the leading barrier.[38] Farmers, shelters, pet owners and independent practices need reform that makes care available and affordable.

The American Veterinary Medical Association (AVMA) represents veterinarians and houses programs that shape entry into the profession. Requiring its agreement gives the institution whose rules reformers seek to change the power to exclude those changes before the public can decide.

The technician crisis shows what is being lost

Veterinary technicians typically complete a two-year degree. Yet median pay for technicians and technologists is $47,380, only about $4.44 an hour above the assistant and animal-caretaker median when the annual difference is divided by 2,080 hours.[14,15] A 53-jurisdiction review found 31 without language reserving tasks to technicians.[10] This profession needs a stronger economic future.

NAVEC proposes an advanced route for registered veterinary technicians (RVTs) and technicians licensed or certified under other state titles. Additional education would earn authority to examine patients, diagnose defined routine conditions and develop treatment plans. Existing schools provide the foundation; current technicians receive bridge opportunities; assistants keep doing the support work the law already allows.

This is the practical test of independence. The proposed medical authority conflicts with AVMA's published midlevel policy.[5] A coalition that requires AVMA approval would surrender the freedom to pursue the central feature that could make the reform valuable.

An independent coalition can pursue the full solution

An $80,000 advanced-RVT salary scenario would transform the career proposition. The clinic model in this report shows how broader clinical responsibility could support that pay while increasing capacity and offering lower-priced care. Colorado's midlevel vote and California's telehealth legislation demonstrate that association opposition need not prevent public action.[16,19]

NAVEC's alternative is a coalition governed by the communities and professionals who need change, with its own expertise and the freedom to take proposals directly to lawmakers and regulators. AVMA may present evidence. It must not determine the limits of the reform agenda.

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1 / REPRESENTATION AND PUBLIC AUTHORITY

A professional guild cannot speak for everyone

AVMA is a professional guild: a membership association organized to represent veterinarians. Its own materials say members' concerns drive its priorities.[1] Pet owners, farmers, shelters, technicians and clinics unable to recruit staff need a separate voice whenever their interests require changes the association opposes.

The problem extends beyond advocacy. AVMA houses institutions that shape education and entry into practice, giving its policy preferences influence over the routes reformers need to change.

Institutional role	Why it matters to reform
Professional advocacy	AVMA promotes the interests and priorities of its veterinary membership.[1]
Veterinary education	Its Council on Education (COE) accredits veterinary degree programs.[3,4]
Technician education	Its Committee on Veterinary Technician Education and Activities (CVTEA) accredits veterinary technology programs.[2]
Foreign-graduate certification	Its Educational Commission for Foreign Veterinary Graduates (ECFVG) supplies a credential accepted by every state.[42]
Public authority	Legislatures and authorized agencies make licensing law. Association endorsement is not a substitute for their decisions.[17,18,19,20,21,22]

The conflict is structural

In December 2025, the U.S. Department of Justice told a federal court that professional accreditors face an inherent conflict when market participants regulate admission to their own profession. It described how exclusionary requirements can restrict supply, raise costs and suppress innovation.[3,4]

The filing took no position on the merits of the school's allegations. Its institutional lesson is clear: expertise does not erase the economic conflict. Public reliance on an association's standards makes independent scrutiny more necessary.

> **The people who need the rules changed must have a voice that can propose changes without the rulemaker's permission.**

Sources [1] AVMA membership · [2] AVTE: CVTEA · [3] DOJ announcement · [4] DOJ court filing · [17] Colorado HB25-1285 · [18] Colorado HB26-1198 · [19] California AB 1399 analysis · [20] California implementation · [21] California board materials · [22] New York licensure · [42] Certificate recognition

2 / THE PARTNERSHIP TRAP

Reform is narrowed before the public can decide

A coalition that needs AVMA's agreement must win two approvals: the association's and the public authority's. The first can remove an idea the second might have adopted. Farmers seeking more veterinarians, shelters seeking affordable capacity and technicians seeking advanced authority can lose their central demand before a bill is even introduced.

Figure 1. How coalition governance changes which proposals reach public decision-makers. NAVEC conceptual model.

The process can remain visibly active. Meetings occur, task forces report and a limited measure is announced. But once the agenda excludes changes that conflict with the governing partner's position, activity can channel pressure for reform into measures that leave the underlying restrictions intact.

That is the danger of AVMA-led reform. Its published opposition to nonveterinarian medical authority and its recorded opposition to California's telehealth bill identify actual boundaries, not hypothetical disagreements.[5,19] If the coalition requires its assent, those boundaries become the coalition's boundaries.

Hear the objections without surrendering the agenda

An independent coalition can test AVMA's evidence, consult its representatives and still proceed. It should negotiate concessions when they are needed to secure a public decision, rather than accept them as the price of organizing a movement.

> **Reformers should not give an association a veto that the law does not give it.**

Sources [5] AVMA midlevel policy · [19] California AB 1399 analysis

3 / THE PUBLIC RECORD

The reforms at stake conflict with published policy

A reform coalition should begin with the changes required to improve access, then identify the bodies empowered to adopt them. Beginning with measures that an incumbent association already supports reverses that order. The public record shows why the difference is consequential.

Issue	Documented position or action	What independence preserves
Advanced clinical practice	AVMA opposes legislation permitting a midlevel practitioner or other nonveterinarian to diagnose, develop treatment plans and undertake other core functions.[5]	The ability to propose a qualified advanced-RVT role with substantive medical authority.
Telehealth	AVMA and California Veterinary Medical Association jointly opposed AB 1399 in the April 2023 committee record.[19]	The ability to seek a lawful audiovisual route to establishing a clinical relationship.
Foreign-graduate entry	AVMA's board approved ending the evaluated clinical year as ECFVG Step 4 from July 2007.[23]	The ability to pursue state-supervised alternatives to the association's examination pathway.
Rural workforce	AVMA endorsed proposed tax relief for federal loan-repayment awards.[8,9]	The ability to combine financial incentives with reforms to entry, training and clinical scope.
Accreditation reform	NAVEC's federal filing seeks independent accreditor competition and evidence for restrictive inputs.[26]	The ability to challenge the structure of accreditation without requiring the incumbent accreditor's consent.

Professional expertise must answer a public question

Clinical restrictions should answer a public question: what risk do they address, and could training, supervision or a less restrictive rule address it? An association’s preference cannot settle that question. Reformers need their own expertise and the freedom to reach a different conclusion.

This is the practical value of a second voice: proposals can be assessed before institutional acceptability determines whether they are heard.

Sources [5] AVMA midlevel policy · [8] S. 1163 (introduced) · [9] AVMA rural policy · [19] California AB 1399 analysis · [23] AVMA clinical-year decision · [26] NAVEC accreditation report

4 / RURAL VETERINARY ACCESS

Rural communities need more than a repayment subsidy

Rural communities need dependable veterinary capacity. A complete strategy must address recruitment, retention, the cost of entering practice and the range of people authorized to provide care. A campaign confined to a subsidy cannot resolve all of those constraints.

The U.S. Department of Agriculture's Veterinary Medicine Loan Repayment Program offers up to $40,000 a year for a three-year service commitment in a designated shortage situation. The proposed Rural Veterinary Workforce Act changes the tax treatment of qualifying repayment assistance. AVMA publicly endorsed that legislation.[7,8,9]

Those mechanisms influence the economics of service after veterinary education. They do not themselves approve a new school, open an alternative foreign-graduate route or authorize an advanced technician to manage a defined class of cases. Recruitment assistance and entry reform address different parts of the problem.

Policy mechanism	What it changes directly	What it leaves for a separate reform
Loan repayment and tax relief	Financial incentive to enter or remain in designated service.	Accreditation, foreign-graduate eligibility and scope.
Additional education pathways	Who can train, at what cost and through which institutions.	Placement and retention in specific communities.
Foreign-graduate recognition	Whether already trained veterinarians can qualify through a fair alternative.	Local jobs, supervision and durable practice economics.
Advanced technician practice	Which clinical work a trained professional can legally undertake.	Training capacity, compensation and evaluation.

Evaluate the whole solution

Agricultural organizations should set their own workforce agenda. If they need more training capacity, permanent entry routes for qualified foreign-trained veterinarians and advanced clinical roles, a repayment subsidy cannot substitute for those changes. Accepting that subsidy as the limit of the campaign leaves the association's preferred boundaries intact.

State telehealth flexibility can improve delivery, while federal rules still govern extralabel prescribing and veterinary feed directives.[24] An independent campaign should distinguish those authorities and seek each necessary change without treating AVMA's preferred boundary as final.

Judge success by additional, sustainable access to care. Meetings, endorsements and subsidies are means, not the outcome.

Sources [7] USDA VMLRP · [8] S. 1163 (introduced) · [9] AVMA rural policy · [24] FDA drug requirements

5 / THE RVT CRISIS

A credential needs a meaningful professional role

Credentialed veterinary technicians invest in education, examinations and continuing professional obligations. The initials RVT mean registered veterinary technician; this report uses RVT to include the licensed and certified titles used by other states. The investment needs to lead to a career with meaningful authority and advancement.

Most jurisdictions did not reserve tasks to the credential

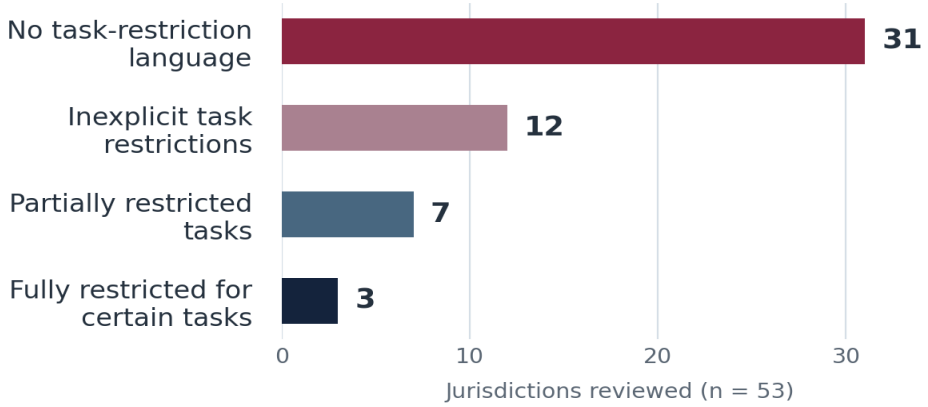

Figure 2. Technician task restrictions in the 2024 review, published in 2026. The 53 jurisdictions are the 50 states, DC, Puerto Rico and the U.S. Virgin Islands. Categories follow the published review; they are not an updated October 2026 legal census.[10]

The National Association of Veterinary Technicians in America (NAVTA) classified 31 jurisdictions as having no legal language restricting tasks to veterinary nurses or technicians, 12 as inexplicit, seven as partially restrictive and three as fully restrictive for certain tasks. Separately, 19 had no defined technician scope. The distinction between an educational credential and a legally meaningful role is therefore a documented structural problem.[10]

When education does not translate into recognized authority, graduates have a weaker basis for advancement and bargaining. An expanded clinical role would give additional training a clearer purpose and clinics a stronger reason to invest in it.

Recognition should lead somewhere

Title protection identifies a qualification. A credible advanced scope creates an additional clinical opportunity. NAVEC should connect education to greater responsibility without relying on blanket withdrawal of work already lawfully performed by trained assistants. Recognition and expansion should strengthen the team's capacity to provide care.

The proposed solution is an earned extension into advanced practice, with existing credentials preserved. Assistants retain appropriate supportive work and accessible educational routes forward. The objective is additional competence and capacity, with restrictions justified by the risks of a specific task.

Sources [10] NAVTA scope review

6 / THE ECONOMIC CASE FOR ADVANCEMENT

Underuse and low pay undermine the career bargain

The crisis is not simply a shortage of appreciation. NAVTA's 2024 survey reports concerns about pay, blurred responsibilities and incomplete use of skills. Its findings describe a workforce whose educational investment often lacks a convincing next step.[11]

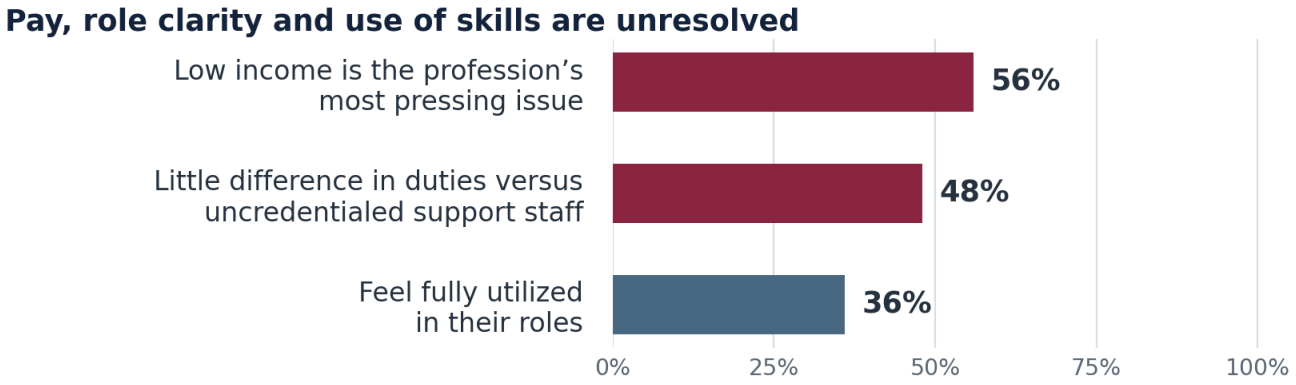

Figure 3. Selected percentages reported in NAVTA's 2024 demographic survey. These are different survey items, not mutually exclusive groups or estimates for every U.S. technician.[11]

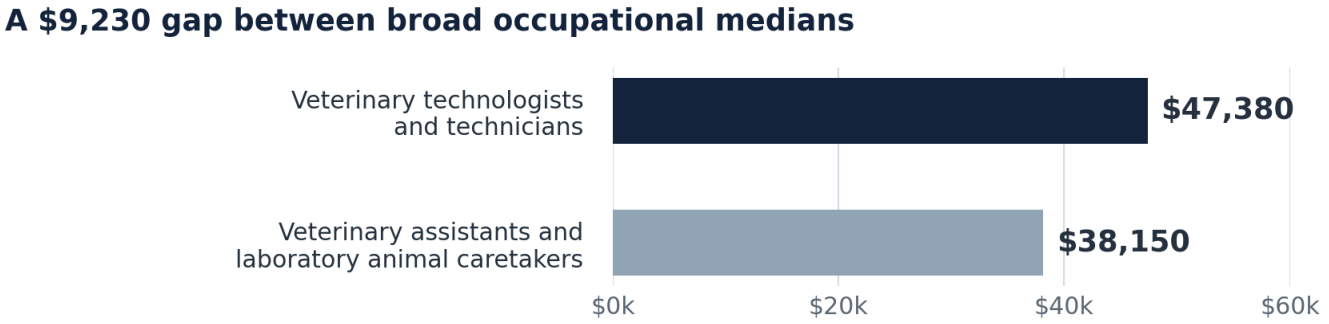

Figure 4. U.S. Bureau of Labor Statistics (BLS), May 2025 occupational medians. These broad groups do not isolate the earnings effect of an RVT credential.[14,15]

The difference between the two occupational medians is $9,230 annually. That is about $4.44 per hour when divided by 2,080 hours, an illustrative conversion rather than a reported hourly wage. A prospective student must weigh education costs, time and career prospects against that kind of earnings landscape.

Advanced authority can create a stronger economic proposition when it enables useful additional care and releases veterinarian time. Compensation must be part of the design: an enlarged job description at the same pay would reproduce the problem. Employers and training partners should document pay progression, supervision costs, client prices and retention.

Sources [11] NAVTA survey · [14] BLS technician wages · [15] BLS assistant wages

7 / THE EDUCATION PIPELINE

Students need a career worth the investment

A student considering a two-year veterinary-technology degree must weigh tuition and lost earnings against the career it makes possible.[14] If experience as an assistant can lead to much of the same daily work, the student is entitled to ask what additional education, examinations and professional fees will buy.

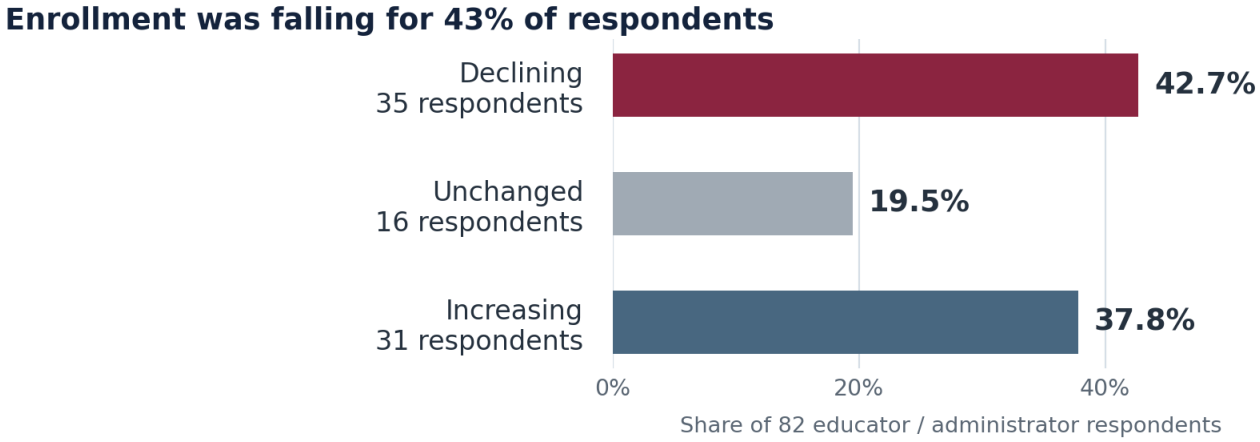

Figure 5. Kogan and Jensen (2024): 82 educators and administrators reporting 2018-2022 trends. The percentages describe respondents' reports, not the size of any national enrollment decline.[28]

In the study, 43% of respondents reported falling enrollment. Among respondents describing a decline, the leading perceived deterrents were doubts that the credential would change job duties or materially improve pay.[28]

Recruitment cannot repair a weak career proposition

The strategic problem is the gap between what education costs and what the occupation permits. A school can advertise more effectively, yet still struggle if the credential leaves graduates doing substantially overlapping work with limited earnings growth. Adding another degree without changing clinical authority would intensify that mismatch.

An advanced-RVT pathway changes the offer. The graduate would qualify for defined clinical decisions and case responsibility, with a stronger basis for compensation. Existing programs would gain a destination to recruit toward; prospective students would gain a visible route beyond the current technician pay ceiling.

> **Make the education lead to a different professional future. More schooling for the same authority is not a solution.**

Sources [14] BLS technician wages · [28] Enrollment study

8 / THE FINANCIAL INCENTIVE

An $80,000 pathway changes the education decision

NAVEC should design the advanced role around work capable of supporting substantially higher pay. An $80,000 annual salary has appeared in the midlevel debate.[29] Here it is a projected scenario to test against clinical authority and practice economics, rather than an established wage or guaranteed outcome.

A more valuable role can support a different career proposition

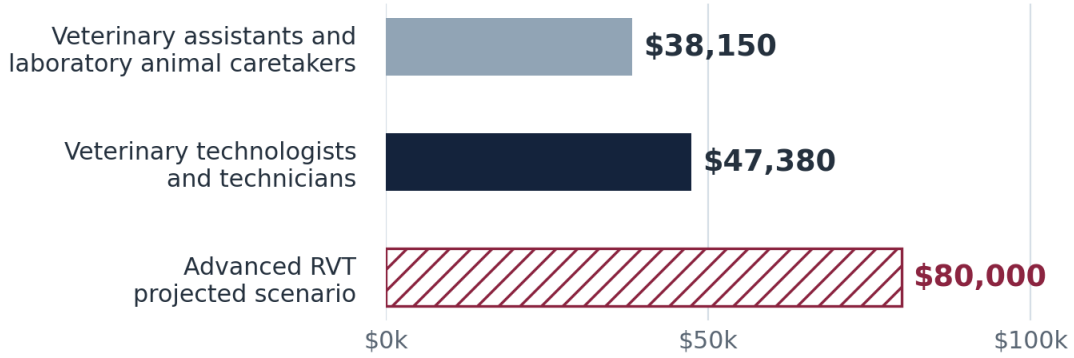

Figure 6. BLS May 2025 occupational medians versus the $80,000 advanced-RVT scenario. Hatched bar is a proposal assumption; solid bars are observed national medians. Occupational categories do not isolate credential effects.[14,15,29]

At $80,000, annual pay would exceed the technician occupational median by $32,620, or about 69%. The difference from the assistant occupational median would be $41,850. These are comparisons between a proposed salary and broad occupational benchmarks, not measured returns to a new qualification.

Higher pay must rest on greater clinical value

The route to higher compensation is the ability to manage useful clinical work that otherwise consumes veterinarian time or remains undone. A practice can then pay more for advanced skills while still spending less than it would to add another veterinarian for that defined workload. The national veterinarian median is $130,100; the advanced role would have a narrower scope.[36]

Tuition, lost earnings and financing costs still matter. Programs should publish total completion costs, offer paid clinical placements and assess prior learning. Employers should commit to pay bands tied to the advanced role. Turning a $47,380 occupation into a credible route toward $80,000 changes the incentive; making students buy expensive credentials without an authorized job does not.

Sources [14] BLS technician wages · [15] BLS assistant wages · [29] Midlevel salary projection · [36] BLS veterinarian wages

9 / THE STRATEGIC OPPORTUNITY

Make technician advancement the case for independence

The midlevel movement wants more clinical capacity. Technicians want authority, sustainable pay and a career worth entering. Schools need an offer that attracts students. An advanced-RVT route can bring those interests into one campaign. Its proposed diagnostic and treatment authority is precisely what AVMA's published policy opposes.[5]

This is why independence matters in practice. A coalition free to pursue the full proposal can join those constituencies around a larger clinical role. A campaign confined to better utilization within today's permissions cannot deliver the same change.

Constituency	Strategic advantage of an advanced-RVT route
Current technicians	An accessible progression that credits demonstrated prior learning and preserves existing credentials.
Technician schools	A reason to expand their clinical curriculum, partnerships and graduate pathways.
Access and midlevel advocates	An established workforce and educational foundation on which to build additional capacity.
Independent practices and shelters	A career structure that can improve recruitment and allocate clinical work more effectively.
Agricultural producers and pet owners	More qualified routes to care, with authority designed around actual service needs.

The two movements already have common ground

NAVTA's March 2026 statement supports technician-centered education and career progression and says the current veterinary professional associate (VPA) model does not adequately integrate credentialed technicians.[12] That creates common ground for discussion. Agreement on the advanced role's actual legal authority must still be secured.

A survey of 703 respondents found 80% supported developing an advanced-practice veterinary nursing degree.[35] Colorado has also authorized its board to develop an equivalency route from veterinary technician specialist (VTS) to VPA.[17] The ingredients for a technician-based coalition already exist.

The campaign would amend an existing credential and use established licensing, school and workforce infrastructure. It still needs state authorization for new medical functions, but it can organize around people and institutions already in place. That is a practical advantage over building a separate profession from the beginning.

Sources [5] AVMA midlevel policy · [12] NAVTA advanced pathway · [17] Colorado HB25-1285 · [35] Advanced nursing survey

10 / A ROUTE UP FOR CURRENT RVTS

Build on the workforce and schools already in place

Current RVTs should be the first people offered a practical route into advanced practice. The reform should recognize what they have learned, add the competencies their expanded responsibilities require, and let them continue earning while they qualify. An experienced technician should not have to restart an unrelated professional education.

Stage	What the pathway should provide
Assess the starting point	Review transcripts, observed skills and case experience. Give credit only for demonstrated learning; identify individual gaps.
Add clinical reasoning	Teach examination, differential diagnosis, test interpretation, treatment planning, pharmacology, communication and referral judgment.
Practice with responsibility	Provide paid, supervised placements with documented case management, direct observation and progressively greater responsibility.
Demonstrate competence	Use transparent written, practical and case-based assessments matched to the authorized scope; require remediation where needed.
Earn the advanced endorsement	Authorize defined clinical work, continuing education and professional accountability. Keep existing credentials valid for people who choose not to advance.

Use existing institutions; add the capacity they lack

Technician schools already have students, faculty, basic science instruction and clinical relationships. Those assets give the midlevel campaign a starting network. Advanced training will require additional clinical educators, case placements and assessment capacity. Colleges can share specialist instruction and clinical sites while delivering an integrated future program or a bridge for working RVTs, building on published advanced-education proposals.[35,37]

Colorado State University's VPA master's program requires a bachelor's degree for admission.[46] An associate degree and technician credential alone do not meet that requirement. NAVEC's bridge should begin with working technicians' assessed capabilities and provide an affordable route through the missing education, rather than leave them outside the new opportunity.

Assistants should also have affordable routes into the technician foundation and onward. Paid study, recognition of assessed prior learning and employer partnerships can expand the workforce over time. The profession gains a ladder that attracts entrants and retains experienced people, rather than a higher rung accessible only to those who can stop working.

Sources [35] Advanced nursing survey · [37] VIC education report · [46] CSU admissions

11 / THE PROPOSED ADVANCED-RVT MODEL

Upgrade the profession and make advanced authority earnable

The goal is to develop the existing technician profession into a career structure capable of supplying midlevel practitioners. An advanced endorsement within the credential offers a practical transition: existing technicians keep their standing, experienced practitioners receive credit for assessed competence, and future students can enter integrated programs that lead to advanced practice.

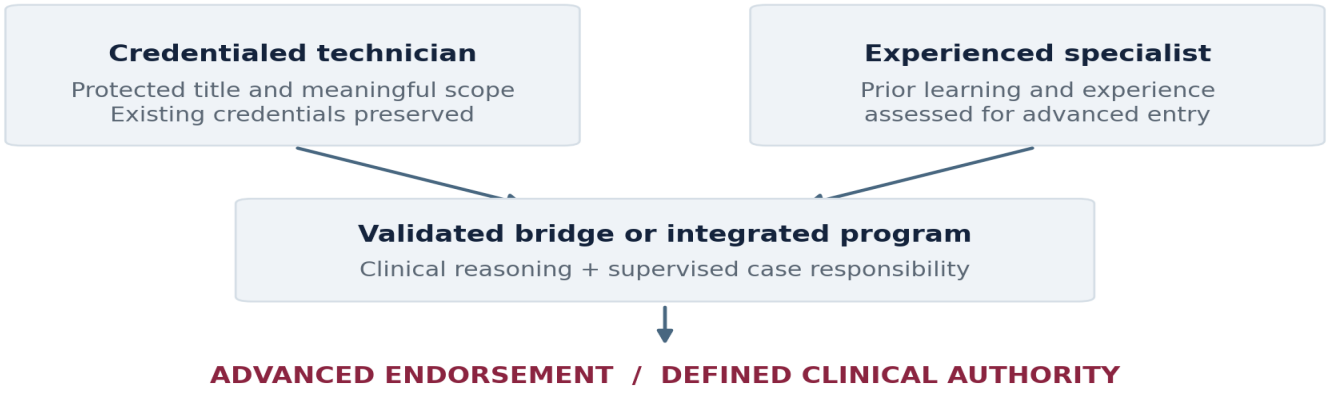

Figure 7. NAVEC policy proposal. An advanced endorsement would require new statutory authority and validated education and assessment. This is not a description of present nationwide RVT scope.

The advanced scope must include defined clinical assessment, diagnosis and treatment planning, with specified consultation and escalation. The pages that follow translate that principle into a practical clinical role, a nursing comparison and a staffing model. An endorsement confined to more delegated technical tasks would not deliver the midlevel function.

Existing schools offer a foundation, not an automatic finding of readiness to teach every advanced function. Bridge curricula should add clinical reasoning and supervised case responsibility to demonstrated prior learning. Training requirements should follow the proposed scope; a credential title or an arbitrary degree length should not substitute for validation.

Prescribing requires separate legal work. Federal law currently ties prescription animal-drug dispensing to a licensed veterinarian's lawful order. Initial practice models must respect that requirement; broader prescribing authority would require an appropriate federal strategy.[24]

Independent standards are part of the reform

NAVEC should seek a technician-led standards body independent of AVMA policy control, with public oversight and transparent competence assessment. States should recognize qualified alternative accreditors while protecting existing graduates and programs during transition. NAVTA currently favors AVMA-accredited entry education.[13] That preference should not become a veto over reform. Colorado has enacted removal of AVMA's name from its technician-program accreditation requirement, scheduled for January 2027.[18] Public law can recognize different institutional arrangements; the coalition must organize to change it.

Sources [13] NAVTA credentialing · [18] Colorado HB26-1198 · [24] FDA drug requirements

12 / DEFINED CLINICAL RESPONSIBILITY

What an advanced RVT would be able to do

The proposed core is management of defined routine cases under veterinary collaboration or supervision: examine the patient, make a diagnosis within scope, select appropriate tests, develop a treatment plan and follow the response. That is a change in medical decision authority, not simply permission to carry out more instructions.

Clinical function	Proposed authority and limits
Examination and triage	Take histories, conduct physical examinations, assess urgency and identify cases within the approved scope. Instability, uncertain diagnosis or complexity triggers veterinary review or transfer.
Routine diagnostic work	Select and interpret routine laboratory tests, cytology and approved imaging for eligible cases. Recognize unexpected findings and seek a veterinarian's assessment when they exceed competence or scope.
Common illness and prevention	Diagnose and manage defined uncomplicated conditions, such as selected ear, skin and parasite presentations; develop preventive and treatment plans. Follow explicit eligibility, reassessment and escalation rules.
Follow-up and ongoing care	Reassess healing, monitor stable chronic conditions within an agreed plan, explain treatment and coordinate follow-up. New symptoms, deterioration or major treatment changes require escalation.
Procedures and surgery	Perform validated procedures such as wound management and specified dental work. Routine surgery, including spay/neuter, would require separate procedural competence and express legal authority, initially with direct veterinary supervision.
Species-specific practice	Qualify for an identified population. Canine/feline training does not establish food-animal or equine competence; agricultural practice needs its own curriculum, assessment and legal permissions.

The curriculum should teach recognition of the boundaries as rigorously as the authorized functions. Complex surgery, unstable patients and cases beyond the advanced practitioner's demonstrated competence remain veterinarian responsibilities. Colorado State University’s VPA program already describes a supervised canine/feline role involving diagnosis, tests and routine surgery; NAVEC proposes building the pathway through the existing technician profession.[25]

Prescription orders must remain with a licensed veterinarian under current federal drug law.[24] The advanced RVT could recommend and implement a plan while obtaining the required veterinarian authorization. Broader prescribing authority would need federal as well as state reform. State legislation must expressly authorize diagnosis and treatment planning; a change of title alone cannot create them.

Sources [24] FDA drug requirements · [25] CSU VPA program

13 / THE COMPARISON WITH HUMAN MEDICINE

Adopt nursing's career structure and advanced-practice route

Registered nursing offers a profession with defined education, clinical responsibility and advancement. Veterinary medicine needs that career structure. For medical diagnosis and treatment planning, the closer comparison is a nurse practitioner (NP), an advanced practice registered nurse (APRN), rather than the registered nurse (RN) credential alone.

Human healthcare role	Function in human care	Lesson for the veterinary model
Assistant / support worker	Provides permitted support under applicable supervision and competence requirements.	Maintain an accessible support workforce; train assistants for the tasks they may safely and lawfully perform.
Registered nurse (RN)	Assesses nursing needs, plans and delivers nursing care, monitors patients and implements prescribed medical treatment.[30]	Give the technician profession a meaningful clinical identity, accountability and progression.
Nurse practitioner / APRN	Advanced education and certification support diagnosis, tests and treatment, including prescribing under applicable law.[31]	Make additional education lead to additional clinical decision authority through an advanced RVT endorsement.
Physician	Provides medical care, including complex diagnosis and specialist treatment.	Veterinarians remain essential for complexity, surgery beyond the endorsed scope, consultation and escalation.

An RN license alone does not authorize general medical diagnosis or prescribing. New York requires additional NP certification and registration.[30] The National Council of State Boards of Nursing's advanced-practice model adds postgraduate preparation for a defined role and patient population.[31]

A profession can advance without abandoning its foundation

An RVT-to-advanced-RVT route would let existing practitioners earn expanded authority through further education and assessment while preserving roles at their current level. Veterinary training should follow the clinical competencies required, without mechanically copying every degree requirement of human nursing.

The same principle supports the economic case. Federal Trade Commission staff concluded that unnecessary limits on advanced nursing can restrict competition and access.[33] NAVEC should test veterinary restrictions against demonstrated risks and permit qualified professionals to supply care within a validated scope.

Sources [30] NY nursing scope · [31] NCSBN advanced practice · [33] FTC competition analysis

14 / EXPANSION VERSUS EXCLUSION

Do not finance recognition by taking work away from assistants

The current overlap between assistant and RVT work creates a choice. Legislators can reserve more existing tasks to RVTs, or they can enable appropriately educated RVTs to assume responsibilities now reserved to veterinarians. The first approach reallocates existing work. The second can add clinical capacity.

Overlap is already lawful in many settings. NAVTA's review documented broad gaps in task exclusivity.[10] Even California, which reserves specific procedures to RVTs, allows assistants to perform other animal healthcare tasks under prescribed supervision; the veterinarian must determine competence.[32] This is not a claim that assistants may perform every RVT task in every state.

Reform choice	Effect on the clinic	Effect on access
Restrict existing assistant work	A clinic must replace, credential or reassign workers who already perform permitted tasks. Recruitment, tuition and compliance costs can rise.	No additional clinical authority is created. Without an offsetting safety benefit, capacity can fall and pressure on fees can rise.
Expand earned RVT authority	An advanced practitioner takes defined routine cases; assistants support the workflow within legal and competence limits.	More cases can be handled with existing veterinarian time, creating room for shorter waits and lower-cost care.
Protect titles and demonstrate competence	Require honest identification, task-specific training, supervision and accountability.	Patients receive clear information and enforceable standards without unnecessary exclusion from work.

Move people upward and maintain the team underneath

As RVTs advance, trained assistants can take over the routine and delegated components of their former workload that are lawfully open to assistants. Clinics must plan that backfill; relabeling a technician without replacing the support capacity would not create a net gain. Current RVTs who remain in technical or nursing roles should retain their scope and standing.

NAVEC should oppose restrictions whose only purpose is to create a wage advantage by excluding capable workers from existing lawful tasks. New restrictions should identify a specific risk and show why narrower training or supervision requirements cannot address it. A rule that adds cost without adding competence, safety or capacity is not an access reform.

Sources [10] NAVTA scope review · [32] California task rules

15 / THE CLINIC BUSINESS MODEL

Expand what each veterinarian-led team can deliver

A clinic sells care, not credentials. Its economics improve when the team can complete more appropriate care with the resources available. An advanced RVT can make that possible by managing defined cases that otherwise require substantial veterinarian time, while assistants sustain the supporting workflow.

Team member	Work in the proposed model
Veterinary assistant	Intake, handling, preparation, records, approved testing support and other permitted tasks; trained and supervised according to the task.
Advanced RVT	Owns the workflow for eligible routine cases: examination, authorized diagnosis, test selection, treatment planning, client explanation and reassessment.
Veterinarian	Handles complex or unstable cases, provides required supervision and prescribing, reviews escalation and undertakes work outside the advanced scope.

The capacity gain is saved veterinarian time

Consider 60 eligible cases a week. At 20 minutes of veterinarian time each, they consume 20 hours. If an advanced RVT can manage those cases with an average five minutes of veterinarian review each, they consume five veterinarian hours: 15 hours are released for complex care, additional patients or reduced overload. These are illustrative workflow assumptions, not measured clinical results.

The advanced RVT might spend 30 minutes per case, or 30 hours a week, with additional time for records and coordination. The gain comes from matching different parts of the work to different levels of clinical preparation. It disappears if the veterinarian must repeat the entire encounter or if essential support staff are removed without replacement.

Better staffing can improve the business without raising every fee

More completed care can spread existing rent, equipment and administrative costs over more visits. A credible advancement route can also retain experienced staff and reduce repeated recruitment and training. The clinician who earns $80,000 would be paid for a larger contribution to care, rather than the same support workload with a more expensive credential.

An observational study of 409 practices found relationships between staffing and practice revenue; nonmedical staffing was also associated with veterinarian productivity.[34] It does not establish the effect of an advanced-RVT model. It supports the underlying point that the whole team, including assistants, matters to output.

Sources [34] Practice staffing study

16 / THE CLINIC CALCULATION

An $80,000 salary and lower fees can coexist

Suppose a clinic with unmet demand adds a routine-care service. The assumptions below include an advanced RVT, an assistant, employment costs and veterinarian review. They test the model at a $100 visit fee, 20% below a hypothetical $125 fee for the same service. Every number is an illustration, not a market forecast.

Annual fixed cost	Assumption
Advanced RVT	Salary $80,000 + 25% employer costs = $100,000.
Assistant	Salary $40,000 + 25% employer costs = $50,000.
Other added costs	Training, insurance and administration reserve = $10,000.
Total fixed increment	$160,000 per year; existing premises assumed sufficient.

Assume 48 operating weeks, $20 of supplies and other variable costs per visit, and five minutes of veterinarian review valued at $100 an hour. Each $100 visit then contributes $71.67 toward the $160,000 fixed increment. Break-even is about 47 completed visits per week.

Figure 8. Annual incremental contribution at a $100 fee under the stated assumptions: visits × 48 × ($100 - $20 - $100 × 5/60) - $160,000. This is not whole-practice profit or a forecast.

At 60 visits a week, the service delivers 2,880 encounters: $288,000 revenue less $57,600 variable costs, $24,000 veterinarian review and $160,000 fixed costs leaves $46,400. No additional revenue from freed veterinarian time is included.

These are gross service-line visits. Deduct displaced visits or lost revenue elsewhere, as well as any added premises, equipment, financing or unbudgeted training costs. At 60 visits, doubling review to ten minutes reduces contribution to $22,400. Lower demand, different case complexity or inadequate training capacity can change the result. Clinics must substitute their own costs and measured workflow.

17 / CAPACITY, ACCESS AND PRICES

Make the productivity gain reach the patient

A veterinary shortage is partly a shortage of authorized clinical time in the places where care is needed. An advanced-RVT pathway can increase that time without waiting for every additional unit of service to come from another veterinary graduate. It works by expanding who can manage defined cases and allowing veterinarians to concentrate where their full training is needed.

More appointments with the existing veterinarian workforce

Routine examinations, selected uncomplicated illness, follow-up and preventive care account for work that can be organized into an advanced-practice service. Moving eligible cases to that service can release veterinarian appointments for emergencies, complex diagnosis and surgery. The relevant measure is net usable capacity after supervision and support requirements, not the number of newly issued credentials.

A lower cost of delivering a defined service

The worked example shows the mechanism: a clinic can pay an advanced professional substantially more than today's technician median and still deliver a lower-priced service if the role increases productive capacity. Salary per worker and cost per completed case are different quantities. Paying one professional more can be compatible with charging a client less when the team uses scarce veterinarian time more efficiently.

Price reductions require that some savings reach clients. Clinics can publish a lower-fee advanced-practice appointment option with clear eligibility and the same required clinical standards. Shelters and charitable partners can contract for defined service capacity. New capacity and competition can put pressure on fees, but a payroll change alone does not guarantee that any particular owner will lower prices.[33]

Reach underserved communities through deliberate design

Regional colleges and paid local placements can train people near the communities they intend to serve. Rural deployments need an appropriate species qualification, a workable supervision network, transport and referral arrangements, and sustainable case volume. A canine/feline program cannot by itself solve a food-animal shortage.[25] Advanced practice should complement fair foreign-graduate entry and affordable veterinary education, not replace those reforms.

> **The goal is more affordable, safe care and a profession people can afford to enter. Measure both outcomes, and build the rules around achieving them.**

Sources [25] CSU VPA program · [33] FTC competition analysis

18 / ENTRY AND EDUCATION

Temporary permission leaves the CPE barrier intact

Foreign-trained veterinarians need a fair route to permanent practice. A permit that expires unless they complete the same disputed examination does not replace that barrier. It postpones the point at which the barrier can remove a clinician from a community that has come to rely on them.

The examination remains the gate

The Clinical Proficiency Examination (CPE) is the seven-section practical examination used by ECFVG.[45] AVMA's August 2024 FAQ reported a first-attempt pass rate of about 25%; this does not measure eventual certification.[43] The December 2024 edition omits that figure.[47] New Hampshire illustrates the resulting insecurity: its conditional license lasts two years and can be renewed or reinstated only once; permanent licensure still requires ECFVG certification.[44] Successful supervised work does not itself remove that condition.

NAVEC's False Equivalency report documents the deeper unfairness: the CPE demands specified procedures across species that are not imposed as equivalent universal graduation requirements by AVMA's own accreditation standards.[27] A temporary permit leaves that double standard in control of the clinician's long-term future.

The danger is that a competent clinician's right to work can expire while the disputed barrier remains in place. Communities need a route that recognizes demonstrated competence and leads to lasting licensure.

PAVE does not displace the practical monopoly

ECFVG is the only equivalency certificate accepted by every state.[42] The Program for the Assessment of Veterinary Education Equivalence (PAVE), run by the American Association of Veterinary State Boards (AAVSB), remains a small alternative: 46 certificates in 2024.[41] It relies on clinical placements at AVMA-accredited schools and does not guarantee a place after its science examination.[40] Its existence does not provide a system-scale escape from ECFVG's practical gatekeeping monopoly.

Build a permanent route on demonstrated competence

New York already evaluates education directly for applicants without ECFVG certification, including specified clinical education. The North American Veterinary Licensing Examination (NAVLE) and other licensing requirements still apply.[22] NAVEC's alternative is a transparent state-controlled route based on education, fair assessment and supervised clinical performance, with an enforceable path to permanent practice.

> **Temporary work permission is not a substitute for reform of the gate to permanent licensure.**

Sources [22] New York licensure · [27] NAVEC foreign-graduate report · [40] PAVE requirements · [41] PAVE certificate totals · [42] Certificate recognition · [43] AVMA CPE pass rate · [44] New Hampshire conditional license · [45] AVMA CPE rules · [47] AVMA December 2024 FAQ

19 / THE PUBLIC CAN OVERRULE THE INCUMBENT

Colorado proved association approval was not required

The argument for independence is supported by an actual decision. In November 2024, Colorado voters approved Proposition 129, establishing the veterinary professional associate role. The American Association of Equine Practitioners' public record describes AVMA, the Colorado veterinary association and other veterinary organizations opposing the midlevel position.[6,16]

Voters approved the new role despite organized opposition

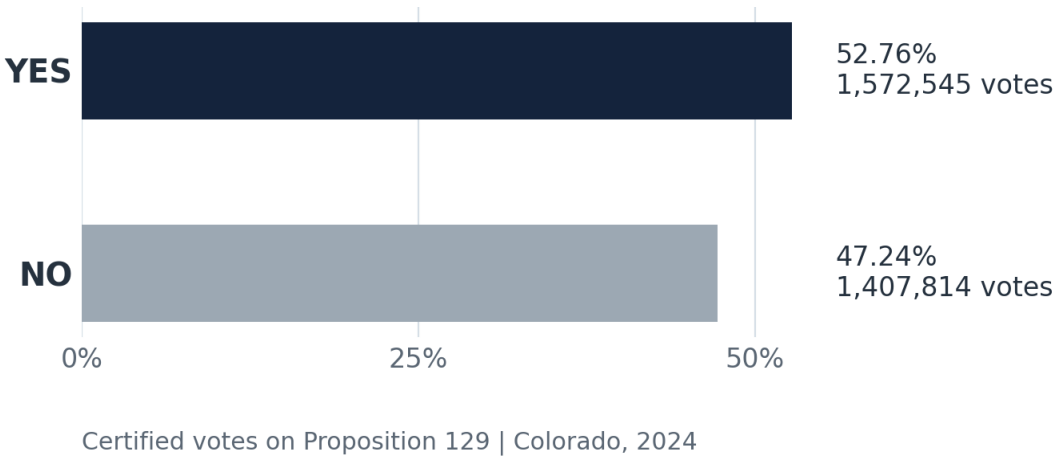

Figure 9. Certified Colorado Proposition 129 vote, November 5, 2024. Percentages use votes on the proposition, excluding ballots without a recorded yes/no vote. Source: Colorado Secretary of State.[16]

The result demonstrates a specific political fact: organized veterinary opposition did not prevent voters from authorizing a new clinical role. A campaign that had required the opposition's approval of that objective would have constrained itself more tightly than the electorate did.

Implementation also shows that new institutions can be used. AAVSB records Colorado's approval of it as the VPA examination and credentialing provider in August 2025.[39] Public authorities can choose a route outside AVMA's existing programs.

Build the pathway around the existing workforce

Colorado created a separate profession. NAVEC proposes a pathway within the technician profession, with bridge education for current practitioners and an integrated route for future students. The political lesson is that reform can pass without association approval; the educational opportunity is to build on the workforce already present.

The question for reformers is whether they can assemble enough expertise, public support and legislative sponsorship to win. Treating professional-association opposition as an automatic endpoint prevents that question from being tested.

Sources [6] AAEP opposition record · [16] Colorado certified vote · [39] AAVSB VPA examination

20 / AN INDEPENDENT COALITION IN PRACTICE

California took telehealth reform to the legislature

California's AB 1399 provides a second example, with the coalition and opposition recorded in an official legislative analysis. The April 18, 2023 Assembly committee document lists the American Society for the Prevention of Cruelty to Animals and San Diego Humane Society as co-sponsors and identifies support from other animal-welfare organizations, a veterinary welfare association and virtual-care advocates. It lists AVMA and the California Veterinary Medical Association in opposition.[19]

The legislation was enacted as Chapter 475 of the 2023 statutes and took effect January 1, 2024. The Veterinary Medical Board describes the resulting authority to establish a veterinarian-client-patient relationship through synchronous audiovisual examination, alongside other lawful methods, subject to applicable requirements.[20,21]

Step	Public record	Strategic significance
Independent sponsorship	Animal-welfare organizations sponsored AB 1399.[19]	The agenda had an institutional home outside the opposing associations.
Recorded disagreement	AVMA and California Veterinary Medical Association opposed the bill in committee.[19]	Their objections entered the public process as a position to evaluate.
Public decision	The measure became law and took effect in 2024.[20,21]	The legislature could authorize a different framework.
Implementation	State guidance addresses location, records, prescribing and other conditions.[20]	Reform proceeds through enforceable rules and professional accountability.

This was not a campaign to abolish veterinary expertise. It was a campaign to change a legal rule governing how licensed veterinarians could provide care. The associations were heard; their preference did not define the legislature's permissible choice.

Who actually has to approve a reform

The required decision-maker depends on the proposal: a legislature for a statute, an authorized board for a rule, federal authorities for federal requirements, or voters where a ballot route is available. The coalition should identify that authority precisely. It should then distinguish legally necessary approval from an endorsement that an interested organization would prefer it to obtain.

State telehealth changes do not displace federal drug requirements.[24] That division of authority illustrates the work an independent coalition should do: identify each legal constraint, assemble the evidence and take the proposal to the body that can change it.

Sources [19] California AB 1399 analysis · [20] California implementation · [21] California board materials · [24] FDA drug requirements

21 / THE NAVEC ALTERNATIVE

Build a coalition that cannot be vetoed by its opponents

NAVEC proposes an independent coalition for veterinary access with the authority to pursue reforms on their merits. Its platform should be set by the communities affected, supported by independent scientific and legal expertise, and taken directly to the public institutions empowered to act.

Constituency	Contribution to the coalition
Agriculture and rural communities	Service needs, local economic evidence and legislative relationships.
Pet owners and animal-welfare organizations	Documented access barriers, public education and constituent mobilization.
Technicians and their educators	Clinical experience, professional leadership and advanced training design.
Independent veterinarians and practices	Supervised placements, workflow design and practical standards of care.
Foreign-trained veterinarians and students	Evidence about entry barriers and viable education pathways.
Independent experts	Clinical assessment, economics, psychometrics, legal analysis and public evaluation.

Protect independence in the governing rules

No association should have a reserved veto, exclusive control over evidence or a right to block publication. The coalition must retain authority to pursue expanded clinical scope and independent education standards when a professional association objects. Technical standards should be developed transparently and tested against patient needs.

Technicians should help govern the campaign. NAVTA's support for a technician-centered career pathway offers potential common ground, but its support for AVMA-accredited education does not confer control over the coalition.[12,13] If participation is made conditional on AVMA approval, NAVEC should proceed with willing technicians, educators, practices and other organizations.

Participation by individual technicians must not depend on endorsement from a national association. NAVEC should supply research and policy capacity; state partners should organize testimony, public education and legislative support. Partners join a shared objective without acquiring the power to suppress it.

Sources [12] NAVTA advanced pathway · [13] NAVTA credentialing

22 / A PROGRAM THAT CAN BE ADVANCED

Take a complete proposal to the people who can enact it

The first campaign should join technician advancement with expanded access. NAVEC should develop model legislation, an educational blueprint and a supervised demonstration program together. Each must describe the same clinical role. A broad promise of recognition without enforceable authority would repeat the weakness the campaign is meant to correct.

Workstream	Concrete deliverable	Decision to seek
Advanced RVT practice	Task and case scope, assessment standards, supervision and escalation rules.	State authorization of an advanced endorsement with substantive clinical authority.
Education and transition	Credit for demonstrated learning, bridge courses, paid supervised practice and integrated future programs.	Approval of qualified providers and protection of existing credentials.
Fair foreign-graduate entry	Education verification, common examinations, supervised practice and transparent decisions.	A lasting state route to licensure based on competence, without mandatory ECFVG/CPE completion.
Accreditation competition	Outcome standards, independent review and continuity for students.	Recognition of qualified alternatives and amendment of exclusive statutory references.
Telehealth access	Defined clinical relationships, patient records, referral and prescribing requirements.	Changes at the correct state or federal authority.

Organize around a specific public decision

For each state, identify the statutory language that blocks the proposed role, the authority that can amend it and the lawmakers or board members who must act. Build a coalition around that decision. Provide a clear bill or rule text, a costed implementation plan and credible clinical witnesses.

Secure the coalition's own position before inviting external comment. Publish and evaluate objections. Accept a change when it improves the proposal or is necessary to secure adoption without destroying its purpose. An interested organization's refusal to endorse the campaign should not itself trigger a retreat.

The legal route depends on the reform. Where existing law permits independent education review, a board can act within that authority. Where statutes reserve diagnosis or treatment planning to veterinarians, advanced-RVT authority requires legislation. Both routes follow the same strategy: use the public body empowered to act, without making AVMA consent a precondition.

23 / THE STANDARD OF SUCCESS

Measure changed authority and access to care

A reform campaign should be judged by what becomes possible for patients and qualified professionals. The existence of a task force, a partnership announcement or a new credential does not establish that access has improved.

Public objective	Measure that tests progress
More usable clinical capacity	Additional cases managed; veterinarian time released; supervision time required.
A sustainable technician career	Compensation after training costs; retention; advancement; time and cost to qualify.
Better access	Appointment delays, travel distance, price and unmet care in the population served.
Safe care	Risk-adjusted outcomes, complications, referrals, complaints and corrective actions.
Fair entry	Completion, delay, cost and decisions by pathway; publication of assessment standards.
Independent public accountability	Accessible evidence, transparent review and enforceable appeals.

A demonstration should recruit schools and practices that can deliver the proposed training, publish the competencies in advance and use independent assessment. It should measure client access, patient outcomes, technician pay, retention and the full cost of supervision. Public reporting must include failures and revisions as well as successes.

An advanced-RVT pathway is particularly valuable because it can improve the profession's career structure while expanding the number of people able to carry defined clinical responsibility. Its success must be visible in both places. More duties without better opportunity, or more credentials without additional care, would fall short.

The decision for reformers

A professional association may advocate for its preferred rules. The people affected by those rules must be free to advocate for different ones. Veterinary reform loses that freedom when it makes the incumbent association a governing partner in a campaign that challenges the association's own commitments.

NAVEC's strategic alternative is an independent, expert-supported coalition that defines its objectives, develops enforceable proposals and takes them to public decision-makers. It can hear AVMA's arguments without asking AVMA to set its agenda. That independence is the foundation of effective reform.

READING THE REPORT

Terms and evidence notes

Term	Meaning in this report
AVMA	American Veterinary Medical Association; the professional association for veterinarians.
NAVTA	National Association of Veterinary Technicians in America; a separate organization representing technicians.
RVT / LVT / CVT	Registered, licensed or certified veterinary technician. RVT is used here as shorthand across these credential titles.
Advanced RVT	The proposed earned endorsement within the technician profession, with a defined advanced clinical scope.
VPA / midlevel	Veterinary professional associate / a role with defined clinical authority between technical support and the full veterinarian license.
COE / CVTEA	AVMA Council on Education / Committee on Veterinary Technician Education and Activities.
ECFVG	AVMA Educational Commission for Foreign Veterinary Graduates certification program.
NAVLE / VTNE / VTS	North American Veterinary Licensing Examination / Veterinary Technician National Examination / Veterinary Technician Specialist.
CPE / PAVE	Clinical Proficiency Examination / Program for the Assessment of Veterinary Education Equivalence.

Research and interpretation

Evidence reviewed through October 29, 2026. Sources include legislation, regulatory records, government statistics, organizational statements and published surveys. The report distinguishes documented institutional positions from NAVEC's policy analysis and proposed reforms.

The $80,000 salary and clinic financial model are planning scenarios. Visit lengths, costs and prices are stated assumptions, not observed results or forecasts. Occupational wage medians describe broad job groups; they do not isolate the causal return to credentials.

The advanced endorsement requires clinical education, assessment and legal authorization. Existing RVTs retain their credentials; assistants continue work allowed by law and demonstrated competence. The nursing comparison separates RN nursing practice from advanced diagnostic authority. Legal requirements vary by jurisdiction; January 2027 changes remain future provisions at the report cutoff.

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