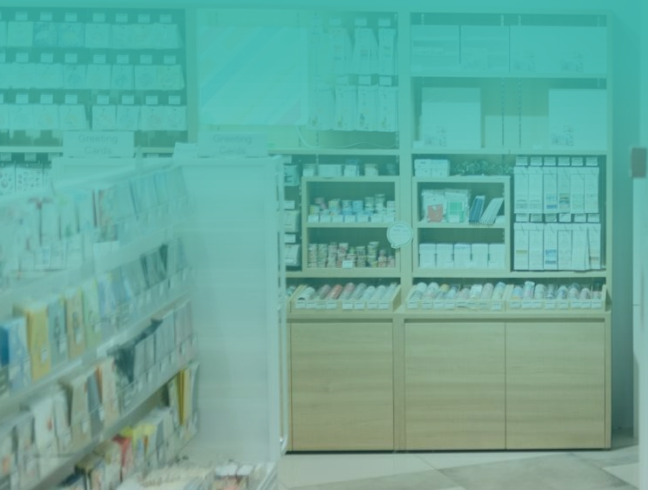
Money's too tight to mention?

Lessons from the NHS England-commissioned Independent Economic Analysis of Community Pharmacy Finances

May 2025



Contents

Executive Summary

The National Pharmacy Association welcomed the independent Economic Analysis of NHS pharmaceutical services in England by Frontier Economics and IQVIA, commissioned by NHS England. It is an extremely important contribution to ongoing discussions about community pharmacy funding. This independent analysis was committed to as part of the year 4 and 5 contract settlement in September in 2022 to inform future negotiation of the Community Pharmacy Contractual Framework (CPCF). We thank all the contractors who gave their time and data (with no recompense).

This independent economic analysis is uncomfortable reading for both those reliant on their local community pharmacy for life-saving, life-prolonging and pain-relieving medicines and government/commissioners with a duty to provide access to medicines for the population of England.

It does not include the effect of the Autumn 2024 budget impacting pharmacy businesses from 1 April 2025.

It tells us that

1. NHS pharmaceutical services provided by all types of community pharmacy have been very significantly underfunded when Full Economic Cost is compared to payment.
2. The overwhelming majority of NHS community pharmacy businesses are unsustainable under this funding model in the short run and virtually all are unsustainable in the longer-term meaning NHS services are at significant risk of interruption.
3. Existing or new clinical services commissioned from community pharmacy could, in some cases, be substitutes for other more expensive NHS activities.

The Full Economic Cost of providing NHS pharmaceutical services in England in 2023/24 extrapolating data provided by 1,166 (11%) pharmacies was found to be between £441k and £573k per pharmacy, depending on type of pharmacy. Across England the Full Economic Cost (inclusive of over-the-counter sales of health care products, the provision of which supports the self-care element of the pharmacy contract) was £5.063 billion (range £4.397 to £5.730 billion). 97.7-100% of pharmacies were estimated to have Full Economic Costs greater than funding and around 47% were operating at a loss in their last accounting year as measured by EBITDA[1] (this measure does include beyond scope services such as private services). It is unsustainable for community pharmacies to effectively lend to and subsidise the NHS.

If the status quo continued, based on the current items and services growth, the Full Economic Cost of providing NHS pharmaceutical services by the year ending March 2030 was estimated to be £8.106 billion (modelling clinical services growth at twice the rate of dispensing growth the resulting Full Economic Cost would be £8.303 billion).

The recently announced funding deal moves funding in the right direction but it remains clear that the government and NHS need to act urgently to retain access to medicines and provision of other

[1] EBITDA- Earnings before interest, taxes, depreciation amortization (does not include centralised, hub or structural costs which would result in more pharmacies appearing unprofitable if included).

pharmaceutical services for the population of England and to manage the predicted growth in prescription items and associated costs by 2030.

Our members want to provide high quality NHS care in their communities, but running a community pharmacy must be a financially viable proposition, contractors must be paid a fair rate of return for the provision of NHS services.

Urgent reform is needed so patients can access the medicines and care they need. We are already seeing deaths related to the interplay of complex factors associated with the availability of medicines, including community pharmacy contractual terms and funding.

There are a number of issues which this analysis highlights but does not fully address:

1. Pharmacies may well be trading as insolvent although they have no way of knowing if this is the case because of a lack of transparency regarding their income and retrospective clawbacks (see Table 1). Businesses are faced with a real challenge of breaching their contract and professional duty or potentially committing the offence of knowingly trading whilst insolvent.
2. The report shows increases in defaulting on direct debits to a major wholesaler, the very last option for pharmacies in financial failure. We are also hearing that wholesalers are increasingly tightening credit terms for individual contractors and in some cases requiring up-front payment, meaning pharmacies are holding reduced stock or, for some lines, no stock.
3. The report states that out-of-scope services, such as private and locally commissioned services, may be subsidising provision of nationally commissioned NHS pharmaceutical services or in larger chains more sustainable pharmacies may cross subsidise provision in less sustainable pharmacies.

The National Pharmacy Association is cognisant of both the wider financial position, the predicted forward costs in this report and the very significant efficiencies our members have made over the past 10 years. We stand ready to work with government on contract reform, so that small businesses providing the majority of NHS pharmaceutical services have transparency and certainty of income, receive a fair rate of return and can contribute their clinical and independent prescribing skills fully to the problems facing the NHS outlined by Lord Darzi of an aging population with increasing morbidity and need for NHS care. We call for government and the NHS to act now to recognise that community pharmacy is critical to delivering the 10 Year Health Plan big shifts: hospital to community; analogue to digital; and sickness to prevention.

Recommendations

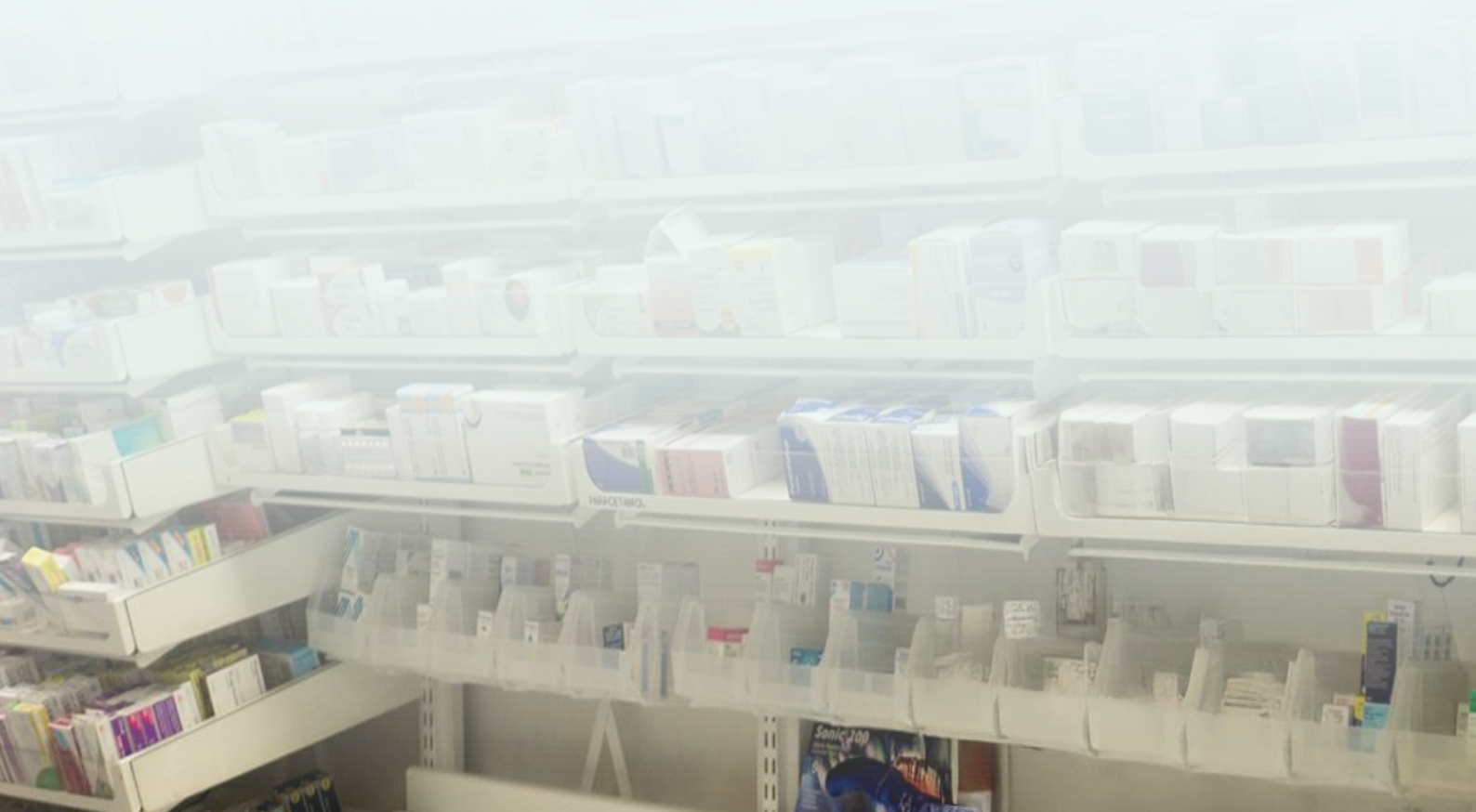
We recommend:

1. **NHS England and the Department of Health and Social Care** (DHSC) work with **Community Pharmacy England** to model the effect of the 2024/2025 and 2025/2026 CPCF settlement on the financial sustainability of community pharmacies in the short and long term and publish this analysis, to inform the consultation on the CPCF for 2026/2027.

2. **All community pharmacy bodies** help to develop and propose ideas for reform of the CPCF alongside the work on substantive reform of the GP contract.

3. **NHS England and the DHSC** fully engage all stakeholders in urgent reform of both the pharmacy and GP contracts, with a focus on sustainability, affordability and supporting the government's strategic shifts and NHS 10-year plan.

4. **NHS England** urgently commission further work to answer research question 3 - *Which clinical services can be most efficiently delivered from community pharmacy as compared with general practice or the wider NHS?* which was not fully answered by this analysis, with a focus on the economics of future clinical services and the opportunities created by independent prescribers in community pharmacies in England.



Introduction

1. The National Pharmacy Association (NPA) believes this independent economic analysis of the community pharmacy sector in England is a vitally important contribution to the debate on community pharmacy services upon which millions of people rely. The analysis was commissioned by NHS England as part of the Community Pharmacy Contractual Framework 5-year deal: year 4 (2022 to 2023) and year 5 (2023 to 2024) and announced on 22 September 2022 to "help inform negotiation and the future contractual framework for community pharmacy".

2. Both Frontier Economics and IQVIA bring significant expertise to this independent analysis. Their work has been informed by Community Pharmacy England, NHS England and Department of Health and Social Care (DHSC) officials as well as volunteer contractors. They have confirmed through this analysis very significant historic underfunding of the community pharmacy sector by a government/NHS that has a legal duty both to pay a fair rate of return for services commissioned by a monopsony commissioner and to make arrangements for the provision of proper and sufficient drugs, medicines and listed appliances and additional pharmaceutical services for the population[2].

3. This is the first comprehensive assessment of the costs of providing pharmaceutical services commissioned by government/NHS since the 2011 Cost of Service Inquiry (COSI) commissioned by the Department of Health from Price Waterhouse Coopers. The results of this economic analysis broadly triangulate with the 2011 COSI uplifted to March 2024.

4. In September 2020 the National Pharmacy Association published Impacts of current funding, policy and economic environment of independent community pharmacy in England an independent report commissioned from EY. This report concluded that although community pharmacy contributes to UK medicines spend (>£19 billion in England) being 16% lower per capita than the Organisation for Economic Co-operation and Development (OECD) average, 28-38% of the network were in financial deficit with 52% of owners planning to sell their business and projecting that this would rise to 64-85% in 2024. We have subsequently seen the highest ever levels of pharmacy sales including the sale of Lloyds Pharmacy branches as they exited the UK market as well as significant divestments from other multiples such as Boots and Rowlands. Between January 2021 and November 2024 there was a 7% net reduction in the number of pharmacies in England. There has also been a reduction in opening hours. In 2024 pharmacies in England were open for 551,000 hours a week, down from 620,000 in 2022. This is a reduction of around 7 million hours in the last 2 years.

[2] NHS Act 2006

5. We would like to thank all of the community pharmacy contractors who against the background of significant funding cuts[3], and whilst struggling to keep their businesses afloat and find medicines in short supply for their patients, gave considerable time, at no recompense from government or the NHS, to provide significant data and expertise to inform these analyses.

NPA commentary on the Independent Economic Analysis of the Community Pharmacy Sector in England

Research Questions

6. The three research questions the analysis sought to answer are shown below.

    1. *What are the Full Economic Costs of delivering NHS pharmaceutical services and how do these costs vary across and within different types of pharmacy; different mix of dispensing activity and services and different locations?*

    2. *Are community pharmacy businesses sustainable under the current funding model and including the current trajectory of the sector? To what extent are NHS services at risk of interruption?*

    3. *Which clinical services can be most efficiently delivered from community pharmacy as compared with general practice or the wider NHS?*

Data Collection

7. This economic analysis was informed from publicly available data such as from the NHS BSA, proprietary data from IQVIA and data provided from community pharmacy businesses both specifically collated to inform this analysis and from their submitted accounts for 2023/2024.

[3] 24% real terms funding cut between July 2019 and August 2024 on top of previous funding reductions from £2.8 billion to £2.592 billion from 2016.

8. It should be noted that since this data was collected, the autumn budget in 2024 announced increases in employer National Insurance Contributions[4] (eNICs) and to the national living wage (NLW) (estimated by Community Pharmacy England to create a further cost pressure of £115-152million NLW and >£50m eNICs for community pharmacies from 1st April 2025) and a reduction in business rates relief impacting contractors. These increases have been taken into account in this published analysis only in the forward projections of future costs.

9. This economic analysis combined a Bottom-Up and Top-Down approach to data collection. The final sample included analysis from data provided by 102 parent companies for 1,166 pharmacies. Only seven of these were distance selling pharmacies which limited the ability to robustly analyse costs associated with this model of provision. For the Bottom-Up analysis a sample of 35 parent companies provided data at a pharmacy level. The sample included deliberately different archetypes of pharmacy; single (1), small multiple (2-5), medium multiple (5-200) and large chain (>200 branches). For the Top-Down analysis 67 parent companies provided less detailed data which was subsequently used with some re-weighting to extrapolate to a picture representative of the whole of England.

Main Findings

10. 97.7-100% of pharmacies were estimated to have Full Economic Costs greater than funding; this supports the evidence we have consistently presented to the DHSC and NHS England including the commissioning of our own **independent review from EY** in 2020. This also evidences what our members have been telling us, that they cannot provide NHS pharmaceutical services for the amount the NHS pay. It is unsustainable for our members to effectively lend to and subsidise the NHS.

11. 99.9% of pharmacies reported that financial pressures in the last three years have led to significant changes in management of both staff and operations. This sadly will have inevitably caused pressure on staff and means that quality of provision will have suffered with pharmacy staff having less time to spend on prescription-linked interventions and helping patients/carers to understand how to take medicines with subsequent increased costs to the NHS in terms of reduced **medicines optimisation and adherence**.

12. About 47% of pharmacies were operating at a financial loss in their last accounting year (as measured by EBITDA[5], including beyond scope -private and locally commissioned - services). Even more concerning is liquidity, for about half of pharmacies (24% of parent companies) current liabilities exceeded their current assets meaning they may struggle to meet their debts over the next year which could lead to financial difficulties and closure.

[4] NLW has already risen once since March 24 and rose again in April 25, Employer NICs rose from 13.8% to 15% from April 25 with a reduction in secondary threshold from £9,100 to £5,000, employment allowance increased from £5,000 to £10,500 and the eligibility threshold has been removed.
[5] EBITDA- Earnings before interest, taxes, depreciation amortization (does not include centralised, hub or structural costs which would result in more pharmacies appearing unprofitable if included).

13. This chimes with what our members are telling us. They are struggling to raise further finance and are in the position of breaching covenants relating to existing borrowing. We are concerned that pharmacies may well be trading as insolvent although they have no way of knowing if this is the case because of lack of transparency regarding their income and retrospective clawbacks (see Table 1). Businesses are faced with a real challenge of breaching their contract and professional duty or committing the offence of knowingly trading whilst insolvent. This also impacts the appetite of financial institutions for both short- and long-term lending to the sector. If lending is pulled wholesaler bills cannot be paid and pharmacies cannot fill prescriptions. The report shows increases in defaulting on direct debits to a major wholesaler, the very last option for pharmacies in financial failure. We are also hearing that wholesalers are increasingly tightening credit terms for individual contractors and in some cases requiring up-front payment.

14. Large chains of >200 pharmacies seemed to benefit from economies of scale compared to medium chains of 6-200 or 2-5 but not compared to independent contractors running a single pharmacy. The National Pharmacy Association are aware that single independents may not monetise or account for hidden time spent running their business, at least in part driven by desire to mitigate what would be accounting losses in reporting to banks and other financial institutions which might in turn risk a breach of facilities covenants. Hidden costs of single contractors were considered but may not have been fully reported for this reason.

15. 37% of pharmacies reported being deterred from closing due to costs of doing so; redundancy costs, lease commitments, loss of asset to support pension, (this ranged from a high of 94% for small chains (2-5 pharmacies) to a low of 28% for medium chains (5-200 pharmacies)).

16. Regional variation was seen when Full Economic Cost per 10,000 items/month was modelled, with London 5.4% above national average and the Midlands 3% above and South West 7.1% below. Although London appeared to have the highest pharmacy costs in the descriptive analysis, costs for pharmacies in London were not found to be statistically significantly different, once the location effect is isolated from other pharmacy characteristics. When other factors were modelled, only two regions North West and South East are associated with costs that are statistically significantly higher.

17. Pharmacies co-located with general practices appeared to have lower costs in the descriptive analysis but higher costs when other factors such as location and pharmacy characteristics are taken into account showing that care is needed in interpretation of these findings.

18. If not out of scope (private and locally commissioned) services were carried out the analysis estimated that between <1% (for large 201+) and 12% (for singles) of costs would be saved. This means that between 88% and nearly 100% of a pharmacy's cost are related provision of NHS pharmaceutical services and pharmacy sustainability is controlled by NHS funding.

19. The report states that out-of-scope services, such as private and locally commissioned services, may be subsidising provision of nationally commissioned NHS pharmaceutical services or in larger chains more sustainable pharmacies may cross subsidise provision in less sustainable pharmacies. This is not acceptable; community pharmacy must be paid a fair rate of return for the provision of NHS pharmaceutical services.

20. There are significant exit barriers to closing for some pharmacies and short-term financial fixes may not be possible to maintain.

21. If nothing changes in the funding or delivery model, and items growth continues at same trajectory as for past 5 years (increase by March 2030 of 17% relative to March 2024), the economic analysis estimates the Full Economic Cost would grow from £5.063 billion in March 2024 to £8.106 billion in March 2030, (or £8.303 billion if clinical services activity grows at twice the rate of dispensing activity).

Clinical Services

22. There is considerable variability in the proportion of pharmacies offering each clinical service: New Medicines Service (NMS) (provided by 91%), Pharmacy First (provided by 81%), Flu vaccination (provided by 77%), Blood Pressure (BP) Checks (provided by 73%) and Discharge Medicines Service (53%), Contraception Service (23%). The highest number of consultations per pharmacy (excluding appliance use reviews) was for NMS (273) followed by flu vaccination (227) and BP checks (115). Very few pharmacies offer fewer than three services or more than seven clinical services. The majority offer between four and six services (inclusive).

23. Whilst this analysis suggests that community pharmacy may be a more cost-effective provider of other clinical services, we do not consider question 3 to have been fully addressed by Frontier Economics and IQVIA. There is also notably no consideration of the economics of future clinical services optimising medicines or managing long term conditions; or opportunities created by the increase in independent prescribers in community pharmacies in England.

Limitations

Inclusion of reclaimable over delivery in funding calculation

24. The analysis is based on funding for 2023/2024 that was above the fixed sum available to pharmacy during that year. It includes over delivery of the fixed sum of £46.2m and over delivery of medicines margin of £39.6m. It also includes £41.4 million of Pharmacy First (Primary Care Access Recovery Plan) funding including set up fees and £36.2m for flu vaccinations (NHS vaccination budget). This analysis therefore used a 6% uplifted sum of £2.755 billion.

25. £85.8m of this was recoverable from contractors in England retrospectively at the time of the analysis and this does not appear to have been adequately taken into account.

26. One of the biggest problems contractors have in provision of NHS pharmaceutical services is the lack of transparency of payment and rate of return. Table 1 shows potential sources of income and the variability in funding delivery.

Table 1. Variability of funding and factors outside of control of contractor.

Funding stream	Factors	Outside contractor control
CPCF fixed sum	Decreased from £2.8bn to £2.6bn, absorbed items growth and new services	Subject to retrospective adjustment
Medicines Margin (part of CPCF fixed sum)	Pitches contractors against each other to earn their share. Drives down prices. See Table 2.	Not equally accessible to all pharmacies impacted by local prescribing. Retrospective adjustment, reclaim not from those who earned. Complex smoothing over time.
Clinical services which are paid from fixed sum	Disincentive to deliver, squeezes SAF etc.	Reliant on others for referral e.g. Discharge Medicines Service (DMS), Pharmacy First - including urgent meds and minor illness) not paid without referral.
Advanced services outside of CPCF	Flu - reduction in eligible cohort. Primary Care Access Recovery Plan (PCARP) Pharmacy First - approx. £82m delivered of allocated £645m.	Flu pitched against GPs. Reliant on referrals. Thresholds can act as disincentive.
Locally commissioned NHS services	Commissioner decision. Piecemeal and short term.	Too risky and short term to invest in.
Local Authority (LA) commissioned services*	LA funding reductions. LA contracts, payment, and assurance.	Decommissioning of services and static funding that isn't covering costs.
Private services*	Necessary to subsidise NHS services, reduced capacity for NHS service provision.	Deprived areas limited scope for income.

***Not NHS pharmaceutical services.**

Assumption of margin being earned equally by contractors across England

27. Medicines margin makes up around a third of income to contractors. For the purpose of this economic analysis medicines margin has been calculated at an average of £0.755 per item (£800m + £39.6m over delivery divided by 1.11 billion items) which has been applied evenly to every item dispensed. The analysis recognises that distribution of medicines margin is complex and uncertain. For half of pharmacies this will have led to an overestimate of income.

28. Table 2 outlines issues with medicines margin and reasons why it is not equally accessible to all contractors. Crude sensitivity analysis within the report acknowledges that some of the least sustainable pharmacies would become even less sustainable if their actual margin retained was taken into account.

Table 2. Issues with allowed medicines margin.

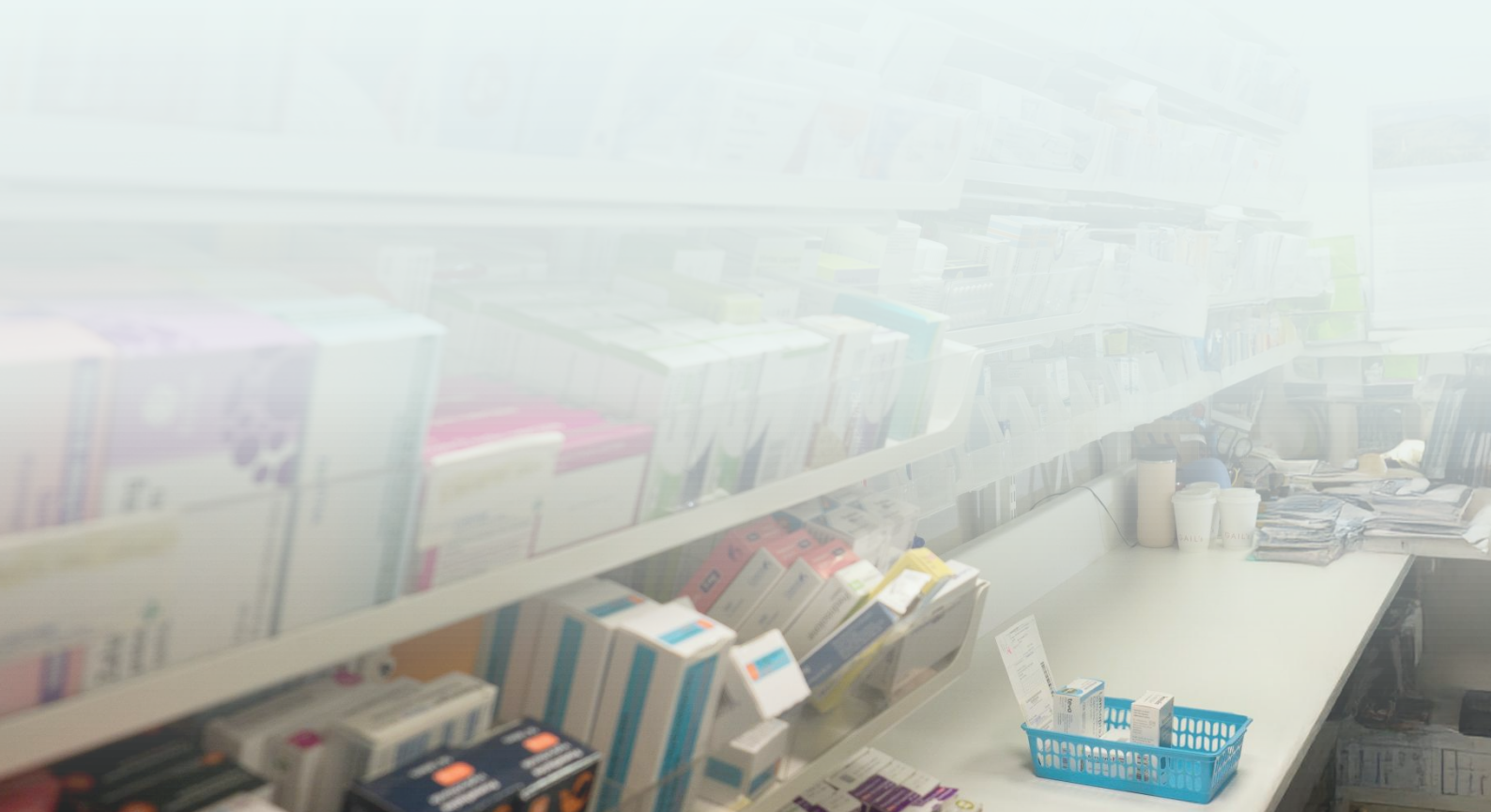
Issue	Why it's a problem
Average	Contractors have inequitable access to margin. It is delivered at sector level — many contractors get under amount modelled in these analyses. £800m was set in 14/15 and items have grown considerably since, meaning less margin per item is earnable. This leads to more items being reimbursed at a loss to the contractor, harder to balance out losses and gains. Big off-patent impact of some medicines has a distorting effect.
Local prescribing decisions	Formularies, prescribing policy e.g. branded generics, rebates (local and national), disproportionate impact of some items on ability to earn margin. For example, an NPA member contractor analysis shows just 6 prescription items accounted for 22% profit on 21K item basket.
Wholesalers	Not always responsive enough to change in manufacturer pricing. Liquidity impacts ability to buy from short line wholesalers, credit availability and contractors falling foul of minimum order thresholds.
Shortages	Lowest medicines prices - not attractive market for Pharma. Price concessions and longer-term impact of these, potential quarantining. Damages Community Pharmacy/GP relationship always asking to reissue scripts. Negative patient outcomes when alternative available but not issued due to current regulations.
Closures	Surrounding pharmacies absorb sudden increase in items, little/no increase in profit, take staff away from clinical services or they resign due to pressure. More work for reduced income or domino closures as pharmacy businesses fail and cannot pay increased wholesaler bills.
Retrospective adjustments	Quarterly adjustments with smoothing — lack of transparency re income for business decisions. Clawback impact not always pharmacies who received over-delivery as depends on items dispensed.

Distance Selling Model excluded from analysis

29. The Distance Selling Pharmacy model of provision was effectively excluded from the analysis with significant uncertainty associated with the results because only seven took part in the data collection. This makes comparison of the distance selling model to the other archetypes in terms of Full Economic Cost impossible. We also understand that this category of pharmacy is amorphous and we respect the need to maintain confidentiality of data collection. This did however result in an important model of provision (the only one where an exemption to market entry rules currently applies) being excluded – there were 380 distance selling contractors at the time of the analysis.

Impact of pharmacy closures not accounted for

30. The impact of closures was not accounted for but is having a very real negative impact on our members who must very quickly pick up large volumes of items when a neighbouring pharmacy closes, with pressure on staff, facilities, and liquidity impacting the ability to deliver clinical services. This may lead to increased costs due to rapid expansion to meet additional demand, reduced income from clinical services and significantly increased wholesaler bills. The 2030 projection does not model how costs could rise in a non-linear way e.g. need to make major capital investment once demand surpasses a certain threshold.



Did not consider quality or economic value as opposed to cost

31. The economic value of community pharmacy provision of NHS pharmaceutical services was not included in this analysis. The value of 12 pharmaceutical services to the NHS (£1.352m), patients £612m), other public sector (£452m) and wider society (£575m) was calculated in 2015 in The value of community pharmacy, Price Waterhouse Coopers report. Quality of provision was also not considered; this is important because high quality pharmaceutical care improves outcomes and reduces cost elsewhere in the NHS[6].

No future policy changes have been modelled.

32. There are well known policy developments, such as better utilising the clinical skills of community pharmacy teams and changes to Pharmacy Undergraduate Education and Training which will mean new pharmacists will enter the register of pharmaceutical chemists with an independent prescribing qualification from 2026. The government pledged in their manifesto to create a community pharmacist prescribing service and NHS England is running a pathfinder programme to test implementation of independent prescribing in community pharmacy. NHS England is also testing early diagnosis of cancer through community pharmacy and vaccination programmes are increasingly commissioning community pharmacy providers to deliver a wider range of vaccinations. Evolving policy in this country and globally will impact future costs for the community pharmacy sector. It is recognised that the impact of future policy is very difficult to include in these analyses.

Clinical services

33. The research question regarding which clinical services can be most efficiently delivered by community pharmacy compared to other parts of the systems is not fully addressed in the published analysis aside from a cursory comparison of costs of provision by different members of the primary care workforce suggesting that existing or new clinical services commissioned from community pharmacy could, in some cases, be substitutes for other more expensive NHS activities. Factors such as workforce capacity, clinical skillset, facilities investment and reduction in costs elsewhere would need to be taken into account.

[6] https://pmc.ncbi.nlm.nih.gov/articles/PMC5774321/#sec6

Goodwill premium

34. Accounting for goodwill is also critical to balance sheets and in turn allows financial institutions to take a longer-term view to lending to pharmacy businesses rather than just against tangible assets. With negative goodwill valuations this prevents pharmacies from borrowing to fund major capital investment (such as refit or refurbishments).

What Does this Economic Analysis Tell Us?

What are the Full Economic Costs of delivering NHS pharmaceutical services?

35. For 2023/2024 these costs were estimated at £5.063 billion, significantly higher than the income provided by the NHS of £2,592bn + non-recurrent remuneration for flu vaccination (around £50m + PCARP funding (around £130m).

36. This categorically tells us, (even allowing for a huge margin of error and allowing for OTC healthcare sales) that a fair rate of return is not being paid for the provision of NHS pharmaceutical services in England. The recently announced funding agreement of £2.698 billion for 2024/2025 and £3.073 billion for 2025/2026 moves funding in the right direction but does not mean the costs of providing NHS pharmaceutical services are being adequately met by the government.

37. The prediction of Full Economic Cost of delivering NHS pharmaceutical services in England rising to £8.106 billion by March 2030, a mere 5 years hence, shows the urgent need for contract and funding reform. (Assuming a linear progression this would be £6.1 billion rather than £3.073 billion for March 2026).

38. This prediction factors in a 17% increase in prescription items and against a known background of

    a. an aging population with increased morbidity and need for NHS care outlined by Lord Darzi in his Independent investigation of the NHS in England in September 2024

    b. significant new drug developments and advances such as recent NICE recommendations around GLP1-receptor agonists and

    c. increasing medicines usage globally

    d. a rapid review of the Voluntary Scheme for Branded Medicines Pricing and Access in the UK.

39. It is evident that urgent action is required to maintain access to medicines and broader pharmaceutical care for the population of England, a duty of the Secretary of State. The National Pharmacy Association, stands ready to work with the government and NHS and our partner pharmacy bodies on urgent radical reform of the way community pharmacy is remunerated and reimbursed for the provision of NHS pharmaceutical services.

How do these costs vary across and within different types of pharmacy; different mix of dispensing activity and services and different locations?

40. Although regional variation in costs is addressed in the report, we cannot see how the analysis considered how costs vary with different mix of dispensing. As a third of pharmacy funding is made up from medicines margin and as variation in access to medicines margin was not factored into this analysis then this can only be a partial picture of the (un)sustainability of community pharmacy going forward. Table 2 outlines considerations that need to be taken into account in terms of access to medicines margin. The commitment in the 23/24 and 25/26 contract settlement to gain a better understanding of the impact of local prescribing activities on community pharmacy medicines margin and to consider actions as a result is critical to our members and this work must be expedited.

Are community pharmacy businesses sustainable under the current funding model and including the current trajectory of the sector?

41. This question is clearly answered by the economic analysis. 97.7-100% have funding which is lower than Full Economic Cost. Without a shadow of doubt, this independent analysis confirms that most community pharmacy businesses are not sustainable under the current funding model including the current trajectory of the sector.

To what extent are NHS services at risk of interruption?

42. The risk of service interruption is not quantified in the economic analysis but the finding that 97.7-100% of pharmacies were estimated to have Full Economic Costs greater than funding gives a clear indication that NHS pharmaceutical services are at significant risk of interruption. Places like West Berkshire have already become pharmacy deserts with residents telling us they are sometimes queuing for two hours at the remaining pharmacies. The knock-on impact of closures creates, at times, intolerable pressure on neighbouring pharmacies risking both patient safety and access in the future.

Which clinical services can be most efficiently delivered from community pharmacy as compared with general practice or the wider NHS?

43. The National Pharmacy Association does not consider this question to have been adequately addressed in the publication of the economic analysis.

44. Comparison of costs of other settings lead to a conclusion that the opportunity costs associated with certain other primary and secondary care activities are high compared with the cost of providing services in community pharmacy settings. Existing or new community pharmacy services could, in some cases, be substitutes for other more expensive settings.

Next Steps

45. This independent analysis, by leading experts in the field, commissioned by NHS England, provides irrefutable evidence that a reasonable rate of return for NHS pharmaceutical services is not being paid. It clearly finds that the supply of medicines and access to other pharmaceutical services is unsustainable within the current financial envelope and there is a clear risk to access to medicines for the population of England.

1. NHS pharmaceutical services provided by all types of community pharmacy have been very significantly underfunded when Full Economic Cost is compared to payment. Costs vary considerably between pharmacies both within and across the archetypes studied.
2. NHS community pharmacy businesses are unsustainable under this funding model now and in the future meaning NHS services are at significant risk of interruption.
3. Existing or new clinical services commissioned from community pharmacy could, in some cases, be substitutes for other more expensive NHS activities.

46. We understand that the findings have been used, as agreed in September 2022, to "inform the negotiation of the future contractual framework for community pharmacy" and particularly future funding decisions. The recent funding announcement for 2024/2025 and 2025/2026 must be just the first step to future sustainability of the pharmacy sector.

47. Further research should be commissioned to answer the questions regarding clinical services that this independent economic analysis failed to answer, particularly in light of the policy direction towards provision of clinical services through community pharmacy and increasing availability of independent prescribers in community pharmacy.

48. We welcome the recent contract announcement and uplift to funding. However, we call for the government to work with us on putting an end to the situation where

    a. patients are needing to go from place to place to seek the medicines they need, sometimes because of genuine supply shortages, but also because the finances of the sector have made it increasingly difficult to maintain stock levels, particularly for loss-making drugs

    b. pharmacies cannot purchase the medicines their patients need as they do not have credit with certain wholesalers

    c. prices of NHS medicines are being pushed up because of lack of liquidity to purchase from short line wholesalers, lack of credit with mainline wholesalers selling at the most competitive price and minimum order thresholds preventing purchasing at the most competitive price

    d. businesses are no longer able to secure up-front working capital and financial support to provide clinical services in advance of receiving payment from the NHS in arrears.

49. Current and future predictions of costs of providing pharmaceutical services in this report are sobering. Both pharmacy businesses and the government/NHS have a shared aim, to ensure communities get the medicines and other pharmaceutical services they need now and in the future.

50. Our members need transparency and certainty of income and to receive a fair rate of return so that they can contribute fully to the problems facing the NHS. They will be critical in delivering the 10 Year Health Plan big shifts; hospital to community, analogue to digital and sickness to prevention through optimising medicines, reducing overprescribing, supporting safe transfers of care, providing capacity, where appropriate, for urgent care and minor illnesses, prevention and long term condition management supported by digital interoperability to enable holistic, patient centred care.

Recommendations

51. Our recommendations following this report are outlined in the Executive Summary (page 3).

May 2025

The National Pharmacy Association is a not-for-profit membership body which represent independent community pharmacies in the UK, from regional chains through to single-handed independent pharmacies.

Contact Neil Bhayani

n.bhayani@npa.co.uk

01727 800 402

npa.co.uk

Version 2.0