

# PSNC's brief guide to Community Pharmacy Economics



Community pharmacy owners (contractors) require inclusion on a list held by their Primary Care Trust (PCT) in order to dispense NHS prescriptions. Inclusion on the PCT's list is described as holding a pharmacy contract with the NHS.

Some contractors obtained this contract prior to 1987 when control of entry for pharmacy contracts was introduced. From 1987 to 2005 potential new contractors had to demonstrate that a new contract was necessary or desirable for the PCT to grant them a contract. Alternatively they had to purchase an existing contract at considerable cost.

From 2005 contractors have been able to secure a new contract from a PCT if they satisfy one of four exemptions to the necessary or desirable test:

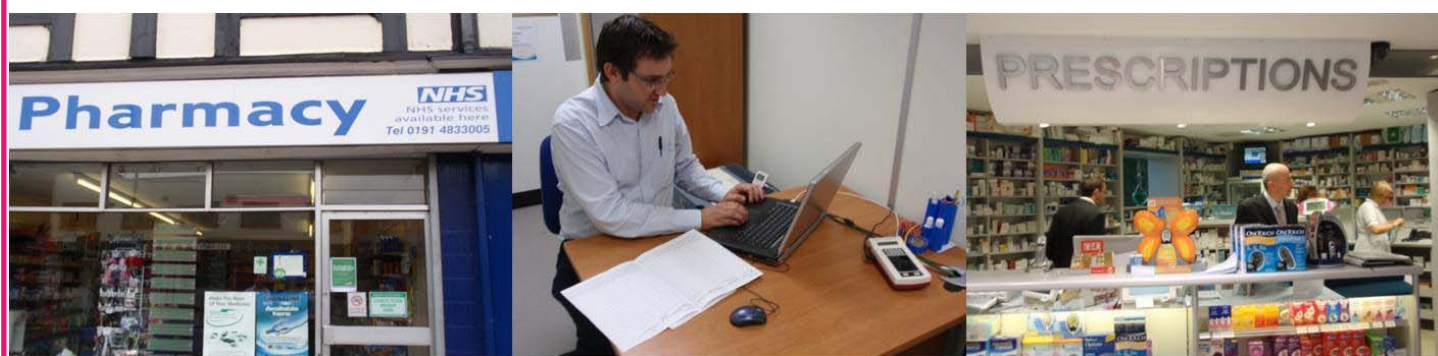
1. Pharmacies in a large retail development (greater than 15,000 sq m);
2. Pharmacies in a consortium-run primary care centre;
3. Pharmacies that plan to open for at least 100 hours per week; or
4. Pharmacies that plan to operate on a distance-selling basis (e.g. mail order).

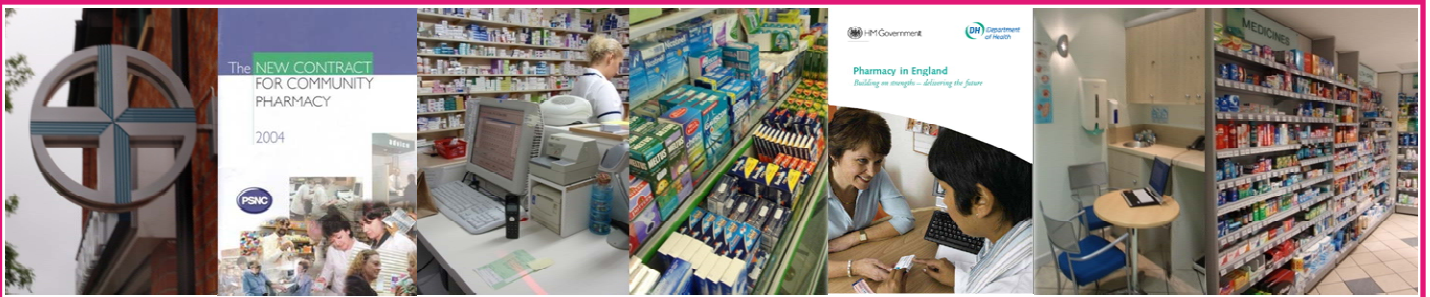
Contractors have seen their mix of business (portfolio of business streams) change over the years as NHS dispensing continues to increase, **representing over 90% of turnover** for a typical independent pharmacy.

There were **877 million prescription items** dispensed in 2010/11 and an average across the year of 10,761\* contractors, so the average contractor dispensed **6,700 items per month** generating a turnover of around £840k.

\*Estimate mid year

NHS funding is largely prescription volume based so profitability depends on securing prescription volume. The other major determinant is the composition of items dispensed: generic or branded. Margins on generic drugs are significantly higher than on branded medicines. The contractor's mix of generic versus branded drugs and thus the buying margins applied is determined by the prescribing practices of their local GPs. However PSNC and DH monitor buying margin to ensure the agreed £500m is delivered each year.





The timing of income is largely driven by the NHS Prescription Services timetable, although some cash-flow is generated by the prescription charges (levies) collected from non-exempt patients. Contractors bundle up their prescriptions at the end of the month and submit them to NHS Prescription Services by the 5th of the following month. NHS Prescription Services then make an advance payment at the start of the next month. This is calculated as 80% of the contractor's expected payment based on submitted script numbers and their average item value (average value of each prescription item dispensed) from the previous month. The final payment is made a month later.

As an example April's prescriptions are submitted by 5th May, an advance is paid at the start of June and the final payment is received at the start of July.

The major components of operating costs are salaries (circa 75%) and property costs. Although pharmacies are generally not in prime locations, rentals in GP health-centres in particular can be very high and are often accompanied by a significant lease premium.

As NHS dispensing is a zero rated activity but purchased medicines include VAT, contractors generally submit monthly VAT returns to HMRC in order to allow a speedy repayment of the VAT paid on the purchase of medicines.

## Current issues

1. The increasing number of new contracts;
2. Local prescribing policies resulting in unequal distribution of funding (eg Branded Generic prescribing); and
3. The availability of bank funding.

More information on community pharmacy funding and on PSNC's response to these issues is available at [www.psnc.org.uk/funding](http://www.psnc.org.uk/funding)

October 2011

