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“Clawback” in Community Pharmacies in Northern Ireland

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This briefing explains how discount deduction (or “clawback”) operates within Northern Ireland’s community pharmacy funding system. It outlines the mechanisms that govern reimbursement, retained margin and tariff setting, and highlights the implications of potential changes to deduction within a fixed financial envelope.

This information is provided to Members of the Legislative Assembly (MLAs) in support of their duties, and is not intended to address the specific circumstances of any particular individual. It should not be relied upon as professional legal advice, or as a substitute for it.

1 Key Points

Community pharmacies in Northern Ireland are privately owned businesses delivering General Pharmaceutical Services under contract with the Department of Health. Their funding sits within a single financial envelope made up of three interacting components: the Global Sum for core dispensing and practice costs; the Non-Global Sum for additional commissioned services; and the planned retained purchase profit (RPP), which reflects the margin pharmacies collectively earn by purchasing medicines below the prices they are listed in the Drug Tariff. Discount deduction (or “clawback”) is the mechanism used to recover assumed wholesaler discounts so that reimbursement aligns with actual procurement costs and the planned sector-wide margin is achieved.

Clawback applies only to the NHS-funded part of a pharmacy’s business. It does not affect private sales or over-the-counter (OTC) activity. It is applied as percentage deductions to aggregated reimbursement totals by product group, rather than reflecting the actual discount on each individual item. In Northern Ireland the deductions are now set as fixed percentage rates by product group. They are taken “at source” from payments made by the Business Services Organisation (BSO), based on the claims which pharmacies submit for the items they have dispensed.

Historically, clawback operated on a sliding scale under which pharmacies with higher total reimbursement faced a higher deduction percentage. In Northern Ireland the sliding scale has recently been replaced with fixed rates by product group. In Scotland, by contrast, the current discount deduction rate has been set to 0%. This position reflects a fundamentally different funding architecture, with a large, annually negotiated global sum, income supports, and a strategically managed pharmacy network, in which discount deduction is no longer the primary lever for cost-containment or for distributing the RPP.

Within Northern Ireland’s framework, RPP is not treated as incidental commercial gain. It is a policy-planned component of remuneration, intended to reward efficient procurement across the sector while ensuring that the Department of Health meets its statutory duty to provide fair and reasonable remuneration for a commercial network that purchases medicines on its behalf. RPP accounts for a substantial share of

community pharmacy income (around one-fifth of remuneration under the contract). It sits alongside the “global sum” and “non-global sum” elements of funding within a single financial envelope. Changes to clawback, reimbursement prices or professional fees therefore need to be considered together as parts of a system, rather than as separate adjustments.

The system is designed to operate at sector level. It aims to ensure that, in aggregate, pharmacies are reimbursed for the medicines they purchase and that the sector retains the planned level of RPP.¹ It does not guarantee a profit on each individual item dispensed. In practice, pharmacies dispense a “basket” of items, some at a profit and some at a loss, with the expectation that, over time, overall reimbursement and RPP for the sector will be aligned with policy. Because the system does not operate in real time and the generics medicines market is volatile, there are timing gaps between changes in purchase prices and changes in reimbursement. Mitigations include concessionary prices for specific medicines and targeted cash-flow support payments.

Assurance that pharmacies are being remunerated as intended, and that the planned level of RPP is being delivered, comes from the Ongoing Margins Survey (OMS). This survey was introduced following earlier disputes and judicial reviews about the basis of remuneration, including previous use of the Scottish Drug Tariff as a reference. Northern Ireland now follows the English Drug Tariff, with the OMS providing Northern Ireland-specific evidence on actual purchase costs and margins.² Where the survey shows that the sector’s RPP is above or below the target, the Department can realign the system by adjusting other elements (e.g. Drug Tariff prices) within the system.

The later sections of this paper move from describing the mechanics to considering what they mean in practice. While evidence indicates that, at sector level, reimbursement and RPP are broadly delivering what they are designed to deliver, community pharmacies have made representations to the Committee for Health describing severe financial pressure. This raises questions about how a system

¹ Reference to the ‘planned’ level of RPP relates to the ‘guaranteed minimum margin threshold’ in Northern Ireland.

² In general, Northern Ireland aligns with the England Drug Tariff and does not routinely adjust prices independently, aside from limited local adjustments.

designed to work at aggregate level interacts with very different contractor-level circumstances, and about the distribution of risk within the network. It also explains why clawback has become a focal point in a much wider debate about under-funding, volatility and the balance between margin-based income and commissioned clinical services.

The briefing concludes by highlighting some points for consideration. These include: how well clawback settings reflect Northern Ireland's actual purchasing conditions; how quickly concessionary pricing and other mitigations respond to market shocks; whether the planned level of RPP remains appropriate; and how far changes to clawback alone, including proposals for a move to 0%, would address underlying concerns about stability, equity and the future role of community pharmacy.

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2 Purpose and Scope of this Briefing

This briefing explains how discount deduction (or “clawback”) operates within Northern Ireland’s community-pharmacy funding framework, why it exists, and how it interacts with wider contractual arrangements and market conditions. It does not assess the adequacy of funding levels, only the operation of the system. It is intended to support Members in scrutinising a complex, technical system that has implications for the stability of the community pharmacy network and for access to medicines.

The paper has four main objectives:

- to explain the rationale for clawback and how it operates in Northern Ireland;
- to situate clawback and retained purchase profit (RPP) within the wider community pharmacy remuneration framework;
- to assess whether the system is delivering its intended sector-level outcomes; and
- to explore the tensions between sector-level design and contractor-level experience, including why clawback has become a focal point for including why clawback has become a focal point for reform.

3 Background and Key Concepts

3.1 The community pharmacy contractor model

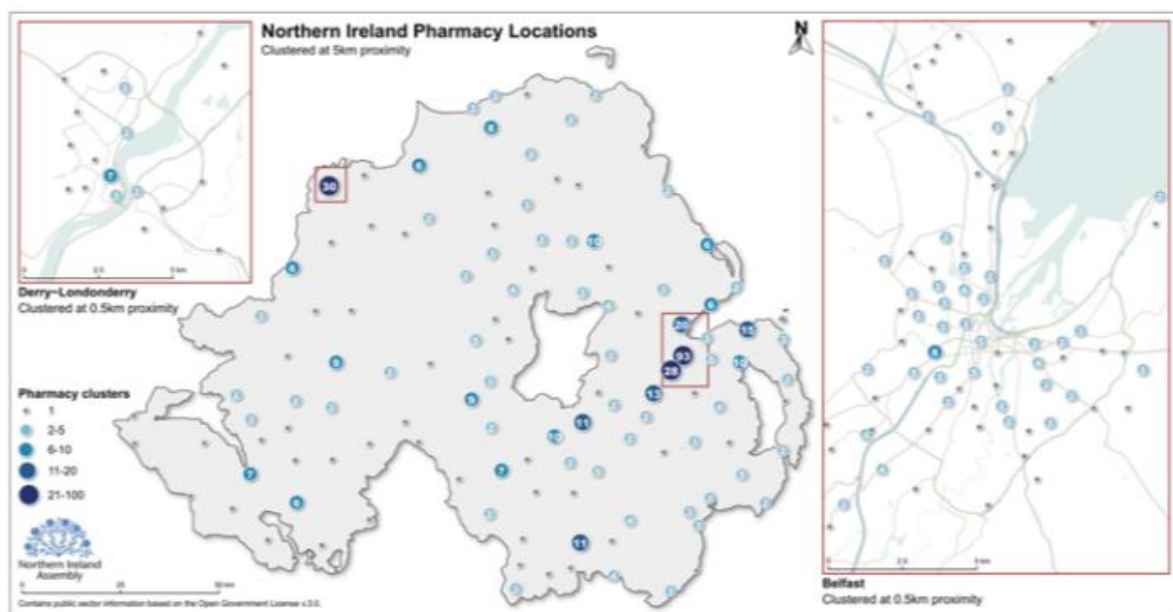
Community pharmacies in Northern Ireland are privately owned businesses that hold contracts with the Department of Health to deliver General Pharmaceutical Services. They employ staff, lease or own premises, purchase medicines, and bear commercial risks. At the same time, most of their income comes from the public purse via the Health and Social Care (HSC) system.

This hybrid position is central to understanding clawback. From the Department’s perspective, the contract is a way to secure safe, accessible, cost-effective supply of medicines within a fixed budget. From the contractor’s perspective, it is a business framework that should provide sustainable remuneration for supply, professional services and investment.

In Northern Ireland, pharmacies dispense approximately 45-46 million prescription items annually across just over 500 contractor premises.³ This equates to around 90,000 prescription items per pharmacy on average, although activity varies considerably by location, size and service profile. Approximately 123,000 people visit community pharmacies in Northern Ireland each day, and an estimated 99.4% of the population lives within five miles of a pharmacy.⁴ The network is therefore both extensive and geographically well distributed.

Northern Ireland has higher pharmacy density than the UK average (26.6 vs 19.2 per 100,000) (Figure 1). Alongside larger urban contractors, many small rural pharmacies operate at lower volumes with less purchasing leverage, increasing exposure to price and cashflow pressures.

Figure 1: Community pharmacy network in Northern Ireland



Source: Research and Information Service (RaISe), Northern Ireland Assembly.
 Mapping data: [BSO](#). Contains public sector information licensed under the Open Government Licence v3.0.

³ [Community Pharmaceutical Services Statistics for NI, Q4 2023/24 - GOV.UK](#)

⁴ [Community Pharmacy Strategic Plan 2030](#)

3.2 The funding envelope and main components of remuneration

Community pharmacy remuneration in Northern Ireland is managed within an overall financial envelope. Within that envelope, three broad components interact:

- **Global sum** (core funding for dispensing and associated practice costs)
- **Non-global sum** (payments for additional and enhanced services)
- **Retained purchase profit (RPP or 'margin')**, the planned sector-wide profit arising from the difference between reimbursement prices and the net cost at which pharmacies can purchase medicines from wholesalers, after discounts.

The first two components are more visible to contractors as line items on their payment schedules. The third, RPP, is less visible day to day but is a deliberate and significant part of the remuneration package. It is *not* treated as incidental profit; rather, it is viewed by the Department as integral to meeting its statutory obligation to remunerate fairly a commercial network that procures medicines on its behalf.

It is also important to distinguish between two key elements - payment for services/supply activity, and the reimbursement of medicines and appliances purchased by contractors on behalf of the Department. Reimbursement is distinct from remuneration in principle, because it repays the contractor for the cost of stock supplied. However, in the pharmacy contract it also functions as the main mechanism through which the planned RPP is delivered, so the two are closely connected in practice.

The Global Sum provides the core, recurrent funding for dispensing and practice-related activity. It includes dispensing fees, paid per item, and practice allowances that support the infrastructure, staffing and overheads required to deliver pharmaceutical services. Fees vary by product type and prescription characteristics to reflect differences in workload.

The Non-Global Sum covers payments for additional commissioned services, including enhanced or advanced services and time-limited initiatives. These are typically activity-based or programme-specific and fluctuate as services are introduced, expanded or withdrawn in line with strategic priorities.

The third component is the **planned level of RPP**, the collective profit contractors are expected to earn by procuring medicines below Drug Tariff prices. This margin is monitored through the Ongoing Margins Survey (OMS), which assesses whether actual margins align with planned levels. If margins deviate, tariff prices may be adjusted in future periods.

For 2025/26, the opening financial envelope was set at **£158.7 million** (excluding DDRB-related pay adjustments), an increase of around £11.7 million compared with the previous year's opening position. Subsequent confirmation of Health and Social Care pay awards added £4.72 million, bringing the total to approximately £163.4 million, the highest nominal funding level to date.⁵ This includes uplifts to reflect employer National Insurance Contributions, an increase in the guaranteed minimum level of retained margin, and changes to the treatment of discount for appliances as part of a phased move to a 0% deduction rate for that product group.⁶

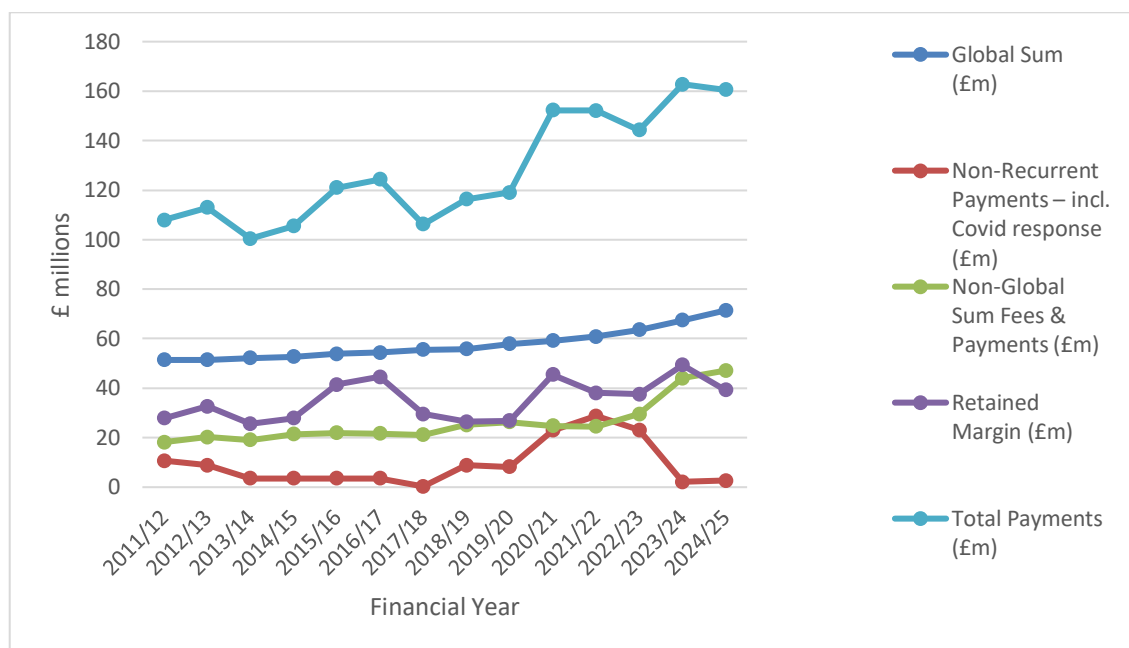
While the 2025/26 increases support short-term stability, they do not create additional long-term capacity within the envelope. The envelope must accommodate both service development and the remuneration mechanisms that underpin the supply of medicines, which places importance on how tariff prices, deduction rates and margin expectations interact over time.

Figure 2 below shows how the components of the community pharmacy financial envelope have changed over time, illustrating change in total payments and the relative contributions of the Global Sum, Non-Global Sum services, non-recurrent payments and retained margin.

⁵ Department of Health, Letter to the NI Assembly Research and Information Service on Community Pharmacy Funding 2025/26, 11/03/2026

⁶ Department of Health, Letter to the NI Assembly Research and Information Service on Community Pharmacy Funding 2025/26, 11/03/2026

Figure 2: Closing position of Community Pharmacy Funding 2011/12 to 2024/25⁷



While the guaranteed minimum retained margin for 2025/26 is £34 million (up from £31.5 million in 2024/25), recent OMS findings indicate that actual retained margin has tended to exceed this figure (Table 1). Northern Ireland does not currently operate a routine mechanism to recover excess margin once realised, meaning that final expenditure may be higher than initially planned.

⁷ Department of Health, Letter to the NI Assembly Research and Information Service on Community Pharmacy Funding 2025/26, 11/03/2026

Table 1: Guaranteed minimum margin v actual retained margin (Source; DOH)⁸

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Guaranteed minimum margin	£26.5m	£26.5m	£26.5m	£26.5m	£26.5m	£31.5m
Actual Retained Margin	£26.8m	£45.4m	£38.1m	£37.6m	£49.3m*	£39.3m

** includes £4.8m impact of the temporary suspension of discount clawback in November and December 2023*

The approximate scale of RPP is important for context. It accounts for a substantial share of community-pharmacy income under the contract (around one-fifth of total remuneration). The planned level of RPP is set through policy and is monitored over time. If assumptions about discounts or pricing are wrong, the sector will retain more or less RPP than intended, with consequences for both contractors and the public purse.

3.3 A system, not separate levers

The funding envelope, reimbursement prices, professional fees, RPP and clawback all form part of a system. Changes in one area have implications for others.

For example, if the clawback percentage were reduced without any other change, pharmacies would be expected to retain more purchase profit. In the absence of offsetting adjustments, such as lowering Drug Tariff prices, reducing other fees, or increasing the overall funding envelope, this would increase the total remuneration paid to the sector and therefore increase costs for the HSC. Conversely, if clawback were increased or Tariff prices reduced, RPP would fall unless the funding envelope were expanded.

This interdependence is important when considering proposals for change. Calls to reduce or abolish clawback are, in practice, calls either to increase the planned level

⁸ Department of Health, Letter to the NI Assembly Research and Information Service on Community Pharmacy Funding 2025/26, 11/03/2026

of RPP or to increase the overall funding envelope, unless other parts of the system are adjusted to compensate.

4 How Clawback Works in Northern Ireland

4.1 Policy rationale

Clawback exists because community pharmacies typically receive commercial discounts from wholesalers when purchasing medicines. If the HSC reimbursed pharmacies at full Drug Tariff prices without recognising those discounts, the public sector would systematically overpay for medicines, and contractors would retain profits above the level deemed fair and reasonable for the sector.⁹

Clawback is therefore intended to:

- reflect, at sector level, the discounts pharmacies can reasonably secure;
- prevent systematic overpayment by the public purse; and
- help deliver the planned level of RPP across the network, rather than leaving it to emerge incidentally.

It is important to note that clawback is only one part of the mechanism by which the HSC manages medicines spending.

4.2 Scope and application

Clawback applies only to the NHS-funded part of the community pharmacy business.

It does not apply to:

- private prescriptions;
- over-the-counter sales; or
- other non-NHS retail activity.

⁹ [Publication of General Pharmaceutical Services for Northern Ireland, Annual Statistics 2024/25 | Department of Health](#)

Within the NHS-funded portion, clawback is applied as follows:

- It is calculated on the aggregate monthly reimbursement total submitted by each contractor, not on each individual dispensed item.
- It is applied to groups of medicines and appliances, typically by product category such as generics, branded medicines and appliances.
- It is taken “at source” by the BSO when processing the pharmacy’s monthly schedule of payments.

In practical terms, a pharmacy dispenses items, submits its prescriptions, and BSO prices each item according to the Drug Tariff (or, where applicable, a concessionary price). For items that are subject to deduction, BSO then applies the relevant percentage rate for that product group to the total reimbursement amount. The resulting deduction appears as a separate line on the payment statement.

Certain items are exempt from deduction, such as medicines on the Zero Discount List and concessionary lines in the month for which a concession applies. These exemptions aim to avoid inappropriate deduction where discounts are not realistically available or where reimbursement has already been adjusted to reflect higher acquisition costs.

4.3 From sliding scale to fixed rates

Historically, Northern Ireland operated a sliding-scale discount deduction, similar to the model used elsewhere in the UK at that time. Under the sliding scale:

- contractors with lower total monthly reimbursement faced a lower percentage deduction;
- contractors with higher reimbursement totals faced higher deduction rates.

This approach recognised that larger-volume pharmacies might be able to negotiate better discounts from wholesalers. However, over time, several concerns arose:

- the sliding scale was complex and not easily understood by contractors;
- it did not always reflect the discounts actually available in Northern Ireland; and

- it contributed to volatility in net income, particularly for contractors close to band thresholds.

In response, and in line with broader UK-wide moves to modernise discount deduction arrangements, In Northern Ireland, discount deduction is implemented through three product-group rates applied to monthly reimbursement subtotals:¹⁰

- **Generics:** 18.48%
- **Branded medicines:** just over 5.27%
- **Appliances:** 0%

These rates reflect differences in how medicines are purchased and the availability of discounts in each category. Under the fixed-rate model:

- each product category (for example, generics, branded medicines, appliances) has a set deduction percentage;
- the same rate applies regardless of the contractor's overall monthly volume; and
- concessionary items are treated differently for deduction purposes, typically being exempt in the period covered by the concession.

This change is intended to improve transparency and predictability, while still allowing the Department to use deduction as a lever to align sector-wide RPP with the planned target.

4.4 Worked example (very simplified)

This worked example is deliberately simplified and illustrative. It does not represent typical prices, discounts, margins or the experience of any individual pharmacy, and is intended solely to explain how discount deduction operates at sector level within the current system.

A contractor dispenses a basket of generic medicines with a total Drug Tariff reimbursement value of £100.

¹⁰ [Business Services Organisation \(BSO\) Discounting arrangements](#)

- The applicable generic deduction rate is, for illustration, 18.48%.
- BSO applies this rate to the £100 total, deducting £18.48 and paying £81.52 for that basket.

If the contractor's net purchase cost after discounts for those items is £75, they have retained £6.52 of purchase profit on that basket. If their net purchase cost is £92, they have effectively dispensed at a loss of £10.48 on that basket. The system does not adjust the deduction for each line; it relies on the assumption that, across the whole mix of items and over time, the sector's actual discounts will broadly align with the assumed rate, so that the planned level of RPP is delivered.

This example illustrates why the system can feel misaligned for individual contractors whose purchasing terms, item mix or timing of purchases differ significantly from the assumed average. Later sections return to these distributional and timing issues in more detail.

4.5 Relationship with RPP

Clawback is one of the main levers used to manage RPP. When the Department sets deduction rates, it does so with a view to the planned sector-wide level of RPP and the evidence it receives from the Ongoing Margins Survey (OMS) about actual margins being achieved.

In broad terms:

- if the survey shows that the sector is retaining more purchase profit than planned, deduction rates or Tariff prices can be adjusted upward to bring margins back toward target over time;
- if the survey shows under-delivery of RPP, rates or prices can be adjusted downward to allow more margin to be retained.

These calibration mechanisms operate at sector level and over time, rather than targeting individual contractors or specific items. They also sit within the constraints of the overall funding envelope. Any proposal to reduce clawback therefore needs to be considered alongside the planned level of RPP and the affordability of the funding envelope as a whole.

Note: The explanation provided focuses solely on the process by which clawback contributes to the sector-wide RPP. It does not express any view on the level of RPP or its adequacy for contractors.

5 Drug Tariff, Market Volatility and Concessionary Pricing

5.1 Role of the Drug Tariff

The NI Drug Tariff ¹¹ is the main reference used to determine reimbursement prices for medicines and appliances dispensed under the community-pharmacy contract. It draws on the structure and prices of the English Drug Tariff, with Northern Ireland-specific arrangements layered on top. It sets:

- the basic reimbursement price for each listed medicine or appliance;
- the rules for fees and allowances; and
- the categories to which discount deduction applies, including exemptions.

Because the Tariff is updated periodically rather than in real time, it cannot always keep pace with movements in the underlying medicines market, particularly for generics. Discount deduction and concessionary pricing work together with Tariff updates to manage this gap.

5.2 Volatility in the generics market

Generic medicines are subject to frequent price changes. Manufacturers and wholesalers may alter prices in response to changes in raw-material costs, regulatory requirements, supply-chain disruptions or market competition. In some cases, prices rise sharply and temporarily.

When the market price for a generic medicine rises above its Tariff reimbursement price, pharmacies can face a situation where the net acquisition cost exceeds the amount they are reimbursed, especially once clawback is applied. If this persists, contractors may be dispensing certain items at a loss, even if the overall system remains on target at sector level.

¹¹ [Business Services Organisation \(BSO\) - Drug Tariff](#)

5.3 Concessionary prices

Concessionary prices are the main tool used to address specific instances where Tariff prices are out of line with market acquisition costs. In broad terms:

- where evidence shows that pharmacies cannot obtain a medicine at or below the current Tariff price, a higher temporary “concessionary” reimbursement price may be agreed;
- once a concessionary price is in place, pharmacies dispensing that medicine within the concession period are reimbursed at the higher rate;
- in Northern Ireland, concessionary lines are generally exempt from clawback for the period covered by the concession.

This mechanism is intended to reduce the risk that pharmacies systematically lose money on particular items during periods of price spikes. However, it operates with a lag:

- time is required to collect evidence on actual purchase prices, consider representations and agree concessionary prices;
- during this period, pharmacies may be purchasing at higher cost but still being reimbursed at the lower Drug Tariff price, with clawback applied.

The exemption of concessionary items from clawback once a concession is granted reduces, but does not eliminate, the impact of this lag, especially where price volatility is high or sustained.

5.4 Timing, cash-flow and mitigation

Because the Drug Tariff and concessions process work on cycles, there is an inherent timing mismatch between changes in market prices and changes in reimbursement.

This interacts with clawback in two main ways:

- **timing of margin realisation** – even if the sector achieves the planned level of RPP over a year, there can be periods where contractors experience reduced margins or losses on specific lines;

- **cash-flow pressure** – if the cost of stock rises rapidly and reimbursement has not yet caught up, pharmacies may have to finance higher outlays while waiting for concessionary prices or Drug Tariff updates.

To ease acute cash-flow pressures, the Department has at times provided targeted support payments (for example, a flat cash-flow payment to each contractor). Such measures are designed as temporary relief rather than structural changes to the funding model. They sit alongside, rather than replace, the core mechanisms of Tariff pricing, concessionary adjustments and discount deduction.

6 The Ongoing Margins Survey (OMS)

6.1 Purpose and origins

The Ongoing Margins Survey (OMS) is the main tool used to monitor whether the sector as a whole is achieving the planned level of RPP. It was introduced, in part, in response to earlier disputes and judicial reviews^{12, 13, 14} about the basis of community-pharmacy remuneration, including concerns about:

- the use of non-Northern Ireland reference data;
- how discounts and margins were estimated; and
- whether the Department could demonstrate that it was meeting its obligation to remunerate fairly.

As a result, Northern Ireland moved to a model in which the NI Drug Tariff is aligned with the English Tariff, but the level of RPP is informed by data collected from Northern Ireland contractors through the OMS. This provides jurisdiction-specific evidence on actual purchasing conditions and margins.

¹² [Judicial review \(No. 1\) CPNI v Department of Health \[2010\] NIQB3](#)

¹³ [Judicial review \(No. 2\) CPNI v Department of Health \[2011\] NIQB132](#)

¹⁴ [Judicial review \(No. 3\) CPNI v Department of Health \[2016\] NIQB14](#)

6.2 How the survey works

In outline, the OMS proceeds as follows:

- a sample of community pharmacies is selected to represent the sector;
- for a defined period, these pharmacies submit detailed invoice data for a basket of medicines and appliances;
- for each sampled item, the survey compares the Drug Tariff reimbursement price with the net invoice cost after all wholesaler discounts;
- the observed margins on the sample are then extrapolated to estimate the total retained purchase profit across the sector.

The output is an estimate of how much purchase profit the community pharmacy sector has retained in the period, expressed in monetary terms. This estimate is compared with the policy-planned level of RPP.

6.3 Strengths and limitations

The OMS has several strengths:

- it uses real invoice data, rather than assumptions alone;
- it focuses specifically on Northern Ireland, reflecting local purchasing conditions;
- it allows the Department to demonstrate, with evidence, whether the system is over- or under-delivering on the planned level of retained margin.

However, it also has important limitations:

- it is necessarily retrospective, looking at past periods rather than current market conditions;
- it operates at sector level and does not show how margin is distributed between individual contractors, locations or business models;
- its accuracy depends on the representativeness of the sample and the completeness of the data collected.

These limitations mean that a finding that the sector has, in aggregate, achieved the target level of RPP does not imply that every contractor is in a similar position. Some may be systematically above the average and others below.

6.4 Realignment when margins diverge from target

When OMS results show that the sector's actual RPP is materially above or below the planned level, the Department can realign the system. This is done not by invoicing contractors for past periods, but by adjusting parameters going forward. In broad terms:

- These adjustments are usually implemented over time, with the aim of bringing the cumulative RPP back toward target without sudden shocks.
- They are also constrained by the overall funding envelope and by the need to maintain reasonable stability for contractors.

The OMS therefore plays a central role in the calibration of discount deduction and Tariff prices. It provides the evidence base for adjusting the balance between public-sector cost containment and the planned level of sector-wide profit. Later sections consider how these sector-level adjustments interact with the very different circumstances individual contractors may face.

7 Sector-Level Design and Contractor-Level Experience

7.1 Basket effects and item-level losses

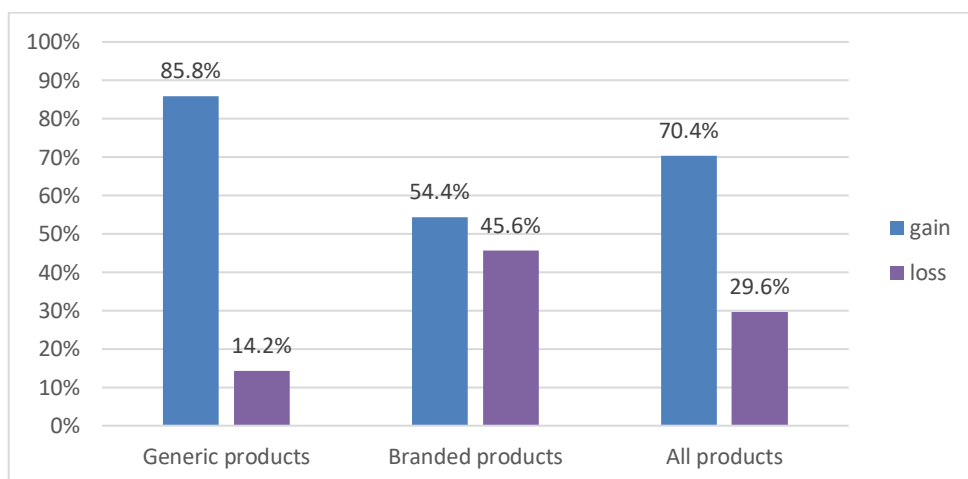
Clawback and the Drug Tariff system is designed to work at sector level. It aims to ensure that, in aggregate, pharmacies are reimbursed for the medicines they purchase and that the sector retains the planned level of purchase profit. It does not guarantee that every individual item, or even every basket of items, will generate a positive margin for each contractor.

In practice, each pharmacy dispenses a basket of medicines. Within that basket:

- some items may be dispensed at a profit, where the Tariff price (after deduction) exceeds the net acquisition cost;
- other items may be dispensed at a loss, where the net acquisition cost exceeds reimbursement after deduction;
- across the whole basket, the intention is that the gains and losses balance out in a way that contributes to the sector-wide RPP target.

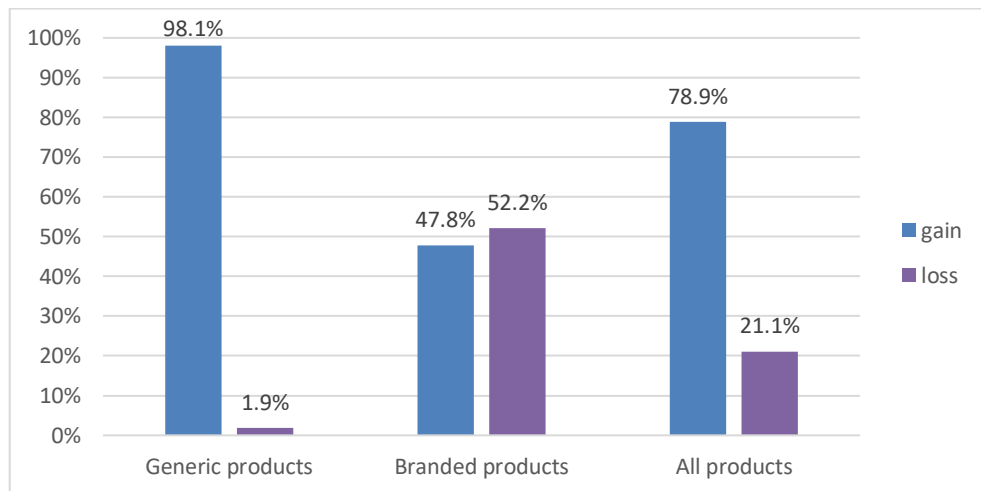
This “basket effect” is central to the design but can be difficult to reconcile with individual experiences. Contractors may focus on lines where they are persistently below water, particularly when these lines are high-volume, when concessions are delayed, or when they perceive that discounts assumed by the system are not realistically attainable in their circumstances. Tables 2 and 3 below provide evidence from the OMS regarding the proportion of products generating a margin gain or loss, and the proportion of cost attributable to margin gain or loss.

Table 2: Proportion of products generating a margin gain or loss (2024/25 margin survey). Source, DOH ¹⁵



¹⁵ Department of Health, Letter to the NI Assembly Research and Information Service on Community Pharmacy Funding 2025/26, 11/03/2026

Table 3: Proportion of cost attributable to margin gain or loss (2024/25 margin survey).

Source, DOH ¹⁶

7.2 Timing and why “real time” alignment is not possible

Even if the system delivers the planned level of RPP over a year, it does not operate in real time. There are several reasons for this:

- reimbursement is based on monthly Tariff schedules and periodic concessionary decisions, not live market prices;
- Clawback is applied to monthly totals based on fixed rates, not continually adjusted to daily changes in discounts;
- the OMS, which underpins calibration, is retrospective and periodic.

In theory, a fully real-time system might track the actual invoice price of each of the roughly 45 million items dispensed annually, adjust reimbursement prices immediately and tailor deduction to each contractor’s realised discount. In practice, such a system would be administratively complex, costly and burdensome for both contractors and the Department. The current arrangements represent a compromise between accuracy, administrative feasibility and predictability.

¹⁶ Department of Health, Letter to the NI Assembly Research and Information Service on Community Pharmacy Funding 2025/26, 11/03/2026

Because of these timing issues, it is possible for contractors to experience periods of acute pressure even if, by the end of the year, the sector-wide figures look close to target. This is particularly likely during episodes of generic price spikes, where concessions lag behind market movements and cash-flow pressures build.

7.3 Sector-level balance vs contractor-level hardship

Representations to the Committee have described severe financial pressure among some community pharmacies in Northern Ireland. At face value, such accounts may appear difficult to reconcile with a system that, on paper, delivers the planned level of RPP at sector level.

Several factors can help explain this tension:

- **Variation in purchasing power** – larger contractors or those belonging to buying groups may secure better discounts than smaller, independent, rural or lower-volume pharmacies. A single average deduction rate will inevitably be closer to the circumstances of some contractors than others.
- **Differences in item mix** – pharmacies with a high proportion of low-margin or loss-making lines, or serving patient populations with particular prescribing patterns, may experience structurally lower margins than others.
- **Exposure to timing effects** – contractors whose stock purchases or prescribing patterns coincide unfavourably with periods of Tariff lag or delayed concessions may experience disproportionate cash-flow strain.
- **Fixed costs and local context** – high premises costs, staffing pressures, locum rates or rural service requirements can mean that the same level of RPP translates into different levels of overall viability.

The system is not designed to achieve distributional equity between contractors. Its primary function is to ensure that, in aggregate, the sector is not systematically over- or under-paid. As a result, it is a relatively blunt instrument in terms of targeting support to those in greatest need.

7.4 Why clawback has become a focal point

In this context, clawback has become a visible point of pressure for contractors. It is:

- a clearly identifiable line on payment schedules;
- directly linked, in contractors' minds, to the experience of dispensing items at a loss; and
- seen as a lever that could inject liquidity quickly if reduced or suspended.

However, as earlier sections have explained, clawback is not a stand-alone element. It is one of the key levers used to deliver the planned level of RPP within the existing funding envelope. Reducing or abolishing it without compensatory adjustments elsewhere would change the balance of the system. The next section considers what this means in comparative context, particularly with respect to Scotland.

8 Comparative Context and the Feasibility of 0% Clawback

8.1 Position in other UK jurisdictions

Clawback is a common feature of community pharmacy funding across the UK, but its role and settings differ:

- **England and Wales** – clawback arrangements continue to operate, using fixed rates by product group. RPP is managed across the national contract through periodic surveys and adjustments.¹⁷
- **Scotland** – the current deduction rate on many community pharmacy items has been set to 0%, within a framework that includes a large, annually negotiated global sum for community pharmacy, mapped service-based income and formal income supports.¹⁸

¹⁷ [Discount Deduction - Community Pharmacy England](#)

¹⁸ [Update to Drug Tariff Part 11 Clawback Rate | Community Pharmacy Scotland](#)

Scotland's move to 0% deduction has attracted attention in Northern Ireland, with some stakeholders asking why Northern Ireland cannot adopt the same position. To assess this, it is necessary to consider the differences in funding architecture and risk allocation.

8.2 Scottish funding architecture

Scotland's community pharmacy contract is anchored in:^{19, 20}

- a large overall “global sum” for community pharmacy, agreed annually and designed to provide a high degree of income stability for contractors;
- a managed network, in which the number and distribution of pharmacies is actively shaped through contractual levers and services planning;
- extensive service-based funding, including nationally commissioned clinical services, with income mapped to defined pathways and activity levels;
- tighter national tariff price setting and margin control mechanism, which help control costs without relying heavily on contractor-level discount recovery.

Within this framework, clawback is no longer a primary tool for cost containment or RPP distribution. Setting the deduction rate at 0% does not mean that Scotland ignores purchase discounts; rather, margin control is exercised through other parts of the system.

8.3 Northern Ireland's position

Northern Ireland operates within a different set of constraints and design choices:²¹

- the overall funding envelope for community pharmacy is smaller and more constrained;

¹⁹ [Community Pharmacy Scotland - Financial Package 2024-25 for Community Pharmacy](#)

²⁰ [Community Pharmacy Scotland announces first part of funding deal for 2025/26](#)

²¹ Department of Health, Letter to the NI Assembly Research and Information Service on Community Pharmacy Funding 2025/26, 11/03/2026

- RPP is an explicit, planned component of remuneration, accounting for a significant share of sector income;
- Clawback is the main mechanism for ensuring that the sector-wide level of RPP remains close to the planned target;
- the network has developed more organically, with a relatively high pharmacy density in some areas and lower average dispensing volumes per contractor;
- new investment in pharmacists' clinical roles has been directed into salaried posts in general practice.

Against this backdrop, a move to 0% clawback in Northern Ireland would have different implications compared with Scotland.

8.4 Why an immediate move to 0% would not be cost-neutral

If Northern Ireland were to set clawback to 0% while leaving Drug Tariff prices and the planned level of RPP unchanged, the effect would be to:

- increase the amount of purchase profit retained by the sector above the current planned level;
- increase total remuneration paid to community pharmacies for medicines supply;
- increase the cost of the community pharmacy contract to the Department unless offsetting reductions were made elsewhere.

Based on current parameters, a full removal of clawback would potentially require an uplift in the order of around £20 million, if the rest of the framework remained unchanged. In a constrained fiscal environment, this would require either additional funding, reductions in other parts of the contract, or both.

Moreover, because clawback is a sector-level lever, reducing it to 0% would not, in itself, target support toward those contractors in greatest difficulty. It would provide additional income to the sector as a whole, including those already better able to secure discounts, without addressing distributional issues or structural pressures such as workload, location or fixed costs.

8.5 Longer-term aspirations

Over the longer term, many stakeholders envisage a system in which community-pharmacy income relies less on procurement-based margin and more on commissioned clinical services, aligned with broader “shift-left” and neighbourhood healthcare policies. In such a system, clawback might play a reduced role, with margin control achieved through other mechanisms.

However, moving toward this model would require:

- a different funding architecture, including more stable, mapped service income;
- decisions about network design and access standards;
- investment in the infrastructure needed to support expanded contractor-delivered clinical services;
- a re-balancing of risk between contractors and the public sector.

An immediate move to 0% clawback in the current framework would not, on its own, deliver that transformation. It would change the distribution of income within the existing model without necessarily aligning with the profession’s aspirations for a more service-based contract.

9 Points for Consideration

The following questions may assist the Committee in exploring the operation of clawback further and its place within the wider community pharmacy funding framework.

9.1 Calibration and evidence

- How is the planned level of RPP set, and how frequently is it reviewed in light of changing market conditions and workload?
- What does the most recent Ongoing Margins Survey (OMS) show about the sector’s actual RPP, and how does this compare with the planned target?

- How representative is the OMS sample of the different types of contractors in Northern Ireland (for example, rural vs urban, small vs large, independent vs multiple)?

9.2 Timing and volatility

- What is the typical time lag between significant changes in generic acquisition prices and the implementation of concessionary prices or Tariff adjustments?
- How many concessionary price lines have been agreed in recent years, and what trends are visible over time?
- What short-term mechanisms are available to manage acute episodes of volatility and cash-flow pressure, and how are decisions made about their use?

9.3 Distributional effects and contractor experience

- What information does the Department hold on the distribution of realised discounts and margins across different types of contractors, beyond sector averages?
- To what extent is the Department concerned with distributional equity between contractors, as opposed to aggregate sector-level balance?
- Are there options for more targeted support to pharmacies that are critical for access (for example, last-pharmacy rural sites) within the current funding envelope?

9.4 Alignment with policy aims

- How does the current balance between procurement-based margin and service-based funding support, or hinder, the strategic aim of expanding community pharmacy roles in neighbourhood care and “shift-left” models?
- What would be required, in practical terms, to reduce the system’s reliance on RPP and clawback over time?
- How is the Department ensuring balance between investment in GP-based pharmacists and the development of contractor-delivered community pharmacy services?

9.5 Modernising clawback: the evidence base

- Has modelling been undertaken to explore the impact of different discount-deduction settings (including 0%) on:
 - the sector-wide RPP;
 - the distribution of income between contractors; and
 - the overall HSC budget
- If additional funding were available, what are the relative merits of using it to reduce clawback versus expanding service-based funding or targeted support mechanisms?
- How would any significant change to clawback be phased and monitored to avoid unintended consequences for network stability and patient access?

These questions are intended to help the Committee move beyond a binary debate about clawback being “fair” or “unfair” and toward a more nuanced understanding of how clawback functions as part of a wider system, where the real points of leverage lie, and what trade-offs would be involved in pursuing different policy options.