

STAT

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OPINION

Community pharmacies are in crisis. Three things need to change Walgreens' chief pharmacy officer proposes fixes to a system that broke long ago

By Rick Gates

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Earlier this year, the second largest independent pharmacy chain in America, Rite-Aid, [filed for bankruptcy](#). While many were caught off guard, I wasn't. After 30 years in community pharmacy, I saw this coming. Financial pressure has been building for years. Burnout among pharmacists exploded during the pandemic. Now, access to care is deteriorating before our eyes.

This isn't just an industry trend; it's a system failure. The alignment of incentives around generics that once benefited the entire health care system is no longer in place. And the industry left holding the bag is community pharmacy.

Pharmacists are the most accessible health care providers in America. [Nearly 90% of Americans](#) live within 5 miles of a pharmacy. Patients interact with their pharmacist [12 times more](#) often than their primary care provider. Chronic care patients, who account for [90% of U.S. health care spending](#), often engage with their pharmacy [35 to 50 times per year](#).

If we don't act now, we won't just lose pharmacies. We'll lose one of the most efficient, cost-effective access points in the U.S. health care system. Here's where the change must start:

1. Reimburse for care, not just pills

Let's be blunt: Pharmacies are regularly reimbursed below cost. In some states, Medicaid pays less than \$1 per prescription, not even enough to cover the label and

bottle, let alone a licensed professional's time.

Meanwhile, pharmacists deliver care every single day: immunizations, test-and-treat services (where a provider conducts a diagnostic test and provides treatment in the same visit, often without requiring a separate doctor's appointment or lab processing), chronic disease management, medication adherence programs. But the current payment model only recognizes pills, not the professional judgment or clinical expertise behind them.

Between 2009 and 2015, roughly one in eight pharmacies closed, with closures disproportionately impacting independent pharmacies and low-income neighborhoods, according to a [study](#) published in the Journal of the American Medical Association. Within a matter of weeks, Rite-Aid closed at least 150 stores in Pennsylvania — a sizable percentage of the state's approximately 2,600 licensed pharmacies.

Fixing this problem means establishing:

- Minimum dispensing fees that reflect pharmacies' actual operating costs
- Patient freedom to go to the pharmacy of their choice without interference by PBMs who steer them toward affiliated pharmacies.

The economics of pharmacy are upside down. Without structural reform, we'll lose the infrastructure that fills [more than 6 billion prescriptions each year](#).

2. Build smarter systems that actually support pharmacy

Today's pharmacy model is labor-intensive, fragmented, and inefficient.

Pharmacists spend 40–60% of their day on administrative tasks: prior authorizations, insurance paperwork, chasing down refills.

That's not a workforce problem. That's a systems problem.

It's time to scale clinical pharmacy and offload the rest. That means:

- Micro-fulfillment and central fill for high-volume scripts
- Remote verification and centralized operations across enterprise systems
- AI-driven tools to handle refill reminders, adherence programs, insurance adjudication, and even inventory optimization.

Technology isn't a threat; it's the only way we scale personalized care without burning out the people delivering it.

3. Let pharmacists practice — everywhere

Pharmacists are health care providers. They complete six to eight years of clinical training, yet outdated state laws and federal policies often tie their hands.

Some states allow test-and-treat. Others don't. Some payers offer reimbursement for care. Others don't. The result is a fragmented system where access depends more on ZIP code than need.

Other countries like the U.K. and Canada already empower pharmacists to test, treat, and prescribe for common conditions such as strep throat, urinary tract infections, and seasonal allergies — resulting in clear benefits to access and outcomes. The U.S. is falling behind.

Fixing this requires:

- Federal recognition of

pharmacists as health care providers and reimbursement consistency across state lines

- Full integration of pharmacy into care teams under value-based models and accountable care organizations.

Some states — like Alaska, Florida, Idaho, Iowa, and New Mexico — are moving forward, but federal policy must catch up, especially in programs like Medicare.

And it must catch up soon.

According to the American Association of Colleges of Pharmacy, pharmacy school applications have dropped nearly 60% over the past decade. Loan debt is up. Morale is down. And students are being told, explicitly or implicitly, that community pharmacy is dying. If we don't fix the system, that prophecy will fulfill itself.

This isn't just about the profession. It's about public health. Who's going to administer flu shots, manage blood pressure, or help patients stay on track with their diabetes medications if half the nation's pharmacies shut their doors? Who will manage chronic care for aging Americans if we decimate one of the only health care access points they consistently rely on?

And yes — pharmacists are asking: What are pharmacy chains doing about it? What's Walgreens doing?

We hear you.

What's Walgreens doing? We hear you.

At Walgreens, we know we have to lead differently. That's why we're investing in programs like PharmStart, which helps pharmacy technicians become pharmacists — with fully funded education and real career pathways. We've expanded centralized services and micro-fulfillment centers to reduce operational strain in stores. And we're advocating for payment reform that finally reimburses pharmacists for care, not just pills.

Are we where we need to be yet? No. But we're making changes because the profession — and the people in it — deserve better.

I've seen the soul of this profession. Pharmacists stay late to help patients. They deliver meds to homebound seniors. They do more than they're paid for, because it matters. We can't afford to lose that.

Fix the system. Fund the care. Let pharmacists deliver care to their patients.

States have made real progress modernizing pharmacy practice and advancing some pharmacy benefit manager reforms. But at the federal level, we've been here before, almost crossing the finish line on critical reforms only to see key provisions stripped from broader legislation and postponed once again.