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Let Pharmacists Prescribe

By Marc Joffe and Jeffrey A. Singer

The United States has a worsening shortage of primary care clinicians.[1] The shortage is more severe in rural areas and medically underserved urban communities but is extending to communities throughout the country. Pharmacists are licensed health professionals with expertise in the proper dosing of medications, their interactions with other drugs, and the conditions for which they are indicated or contraindicated. In recent years, 50 states and the District of Columbia have permitted pharmacists to increase their scope of practice to varying degrees. The United Kingdom, the Australian state of Queensland, and the Canadian provinces of Alberta and Ontario allow pharmacists with appropriate training to independently prescribe medications to treat a wide array of medical conditions. Recently, in the United States, Idaho has similarly expanded pharmacists' scope of practice. Montana and Colorado subsequently implemented comparable reforms.

Pharmacies are more numerous and accessible than primary care practitioners. Many are open 24 hours. Evidence suggests that pharmacists and patients are willing to take advantage of new independent prescribing at scale, while prescribing under collaborative practice agreements, in which licensed prescribers supervise pharmacists in diagnosing and treating problems, has been less effective. Ideally, states should repeal health professional licensing laws—third-party credentialing and certification organizations can perform licensing boards' functions. If that is not politically feasible, states should allow patients to access pharmacists for a wide array of routine medical problems, which would save them time and money and improve access to primary health care. State lawmakers should expand pharmacists' scope of practice to allow them to independently treat a wide range of medical conditions.

THE PROBLEM

The United States requires more primary health care clinicians to meet the needs of a growing and aging population. The Health Resources and Services Administration uses four criteria—population-to-provider ratio, the percentage of the population below 100 percent of the federal poverty level, infant health index, and travel time to the nearest source of care—to determine what areas have


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a primary care health professional shortage in the United States.[2] As of December 31, 2022, more than 98 million US residents lived in health professional shortage areas, which means only 47.3 percent of the population's primary care needs were met.[3] A report from the Association of American Medical Colleges projects a shortage of between 37,800 and 124,000 physicians and a shortage of between 17,800 and 48,000 primary care physicians by 2034.[4] A 2020 study published in *Human Resources for Health* projects that California, Florida, and Texas will have the most significant scarcity of physicians by 2030.[5] While the shortage of primary care providers has persisted in rural areas and underserved urban communities for an extended period, leaving them unable to meet the health care demands of the population, the challenge is now extending into more densely populated areas across the nation.[6]

ONE POSSIBLE SOLUTION: LET PHARMACISTS PRESCRIBE

The shortage of physicians can be ameliorated by shifting some of their responsibilities onto other qualified medical professionals. State licensing laws erect barriers that prevent various health care professionals from practicing to the full extent of their training and expertise. Removing these barriers would increase the supply of clinician services. One such class of professionals who could take on several physician responsibilities is pharmacists, and in certain situations, they may be even more equipped to prescribe medications safely than doctors. Pharmacies are numerous. In many cases they operate around the clock. Many people in remote areas have easier access to a pharmacy than to a primary care clinician. But even people in densely populated areas with easier access to clinicians can save time and money if governments let pharmacists prescribe. Letting pharmacists prescribe would allow patients to attend a nearby pharmacy to get treatment for routine conditions without taking time off from work, traveling, and sitting in the waiting room to see a clinician when they often know in advance what the problem is and what the clinician will prescribe.

Pharmacists often have more expertise on medications and drug interactions than physicians do. When physicians see patients in their offices, they often encounter patients who have several other health conditions for which they see medical specialists who prescribe medications. In many cases, a physician sees them for a specific problem and may lack familiarity with the specialized medicines they are taking. In those cases, physicians commonly phone the local pharmacist to ask if a drug they would like to prescribe might harmfully interact with any of the other medications the patient is taking, or if they need to adjust the dose.

Physicians treating critically ill patients in intensive care units often give them multiple medications at the same time, many of them complex intravenous infusions. The critical care team makes rounds on such patients at least once daily. The hospital pharmacist is an essential member of the team. Intensivists and other hospital-based practitioners rely on pharmacists' expertise to adjust, add, or subtract drugs they administer to their patients.

Today, more than half of all licensed pharmacists have doctorate degrees, for which they receive as much classroom and nearly as much clinical instruction as medical doctors.[7] All 50 states and the District of Columbia now allow pharmacists to prescribe to some degree.[8] This includes prescribing and performing immunization, HIV pre- and post-exposure prophylaxis, hormonal contraceptives, and smoking cessation products. In Australia, Canada, New Zealand, the United Kingdom, and several European countries, drug regulators have a third alternative to the prescription and nonprescription (over-the-counter) drug categories: pharmacist-only, or "behind the counter." This third category requires patients to speak with a pharmacist before purchasing a drug.[9]

In the United States, despite calls by medical experts to allow women to purchase hormonal contraceptives over the counter, the Food and Drug Administration (FDA) will not permit women to buy any type of hormonal contraceptive but one, the so-called minipill, without a permission slip in the form of a prescription from a licensed health care practitioner.[10] To work around this, almost half the states have authorized pharmacists, who fit the FDA's "licensed health care practitioner" requirement, to prescribe hormonal contraceptives.[11] States have also allowed pharmacists to prescribe tobacco cessation and HIV prophylaxis treatments as discussed below.

Pharmacist Prescribing in Other Countries

In the United Kingdom, pharmacist prescribing has been part of a larger trend to widen the scope of practice for a variety of nonphysician medical professionals. Since the inception of the National Health Service, the nation has suffered periodic physician shortages, as British-trained doctors migrated to other countries with better compensation and working conditions.[12]

After two reports recommended nurse prescribing in the late 1980s, Parliament passed legislation implementing the practice in 1992.[13] A 1999 Department of Health review, known as the Crown Report, recommends extending prescribing authority to pharmacists, optometrists, and midwives, among others. Explaining the need to depart from the traditional model of physician prescribing, the authors note:

> Changes in the training and roles of health care professionals from all disciplines, and the widening range, potency and formulation of medicines mean that the arrangements for prescribing, supply and administration of medicines need to be re-examined, with a view to improving the effectiveness and efficiency of health care.[14]

The Crown Report differentiates two prescribing scenarios: independent prescribing, in which a practitioner is seeing a patient who has not been previously diagnosed, and dependent prescribing, in which another professional has already assessed the patient.

When the UK government implemented the Crown Report's proposals, it started with dependent prescribing but used a somewhat narrower concept it called "supplementary prescribing."[15] The role of the supplementary prescriber is "to implement an agreed patient-specific clinical management plan with the patient's agreement, particularly but not only in relation to prescribing for a specific non-acute medical condition or health need affecting the patient."[16]

In 2003, the government allowed pharmacists to gain supplementary prescribing authority by completing a course at a school of pharmacy in the United Kingdom and updating their registration with the General Pharmaceutical Council.[17] In 2006, the government allowed pharmacists to also gain independent prescribing authority.

Initially, independent pharmacist prescribers could not prescribe controlled drugs, but as of 2023, the only drugs they cannot prescribe are "diamorphine, cocaine and dipipanone for the treatment of addiction."[18]

Although pharmacists were initially slow to take advantage of these new prescribing options, registrations have accelerated in recent years. Between October 2016 and October 2023, the number of pharmacists with independent prescribing authority in England, Scotland, and Wales increased from 4,313 to 17,434. Of all registered pharmacists, 27.5 percent have either independent or supplementary prescribing authority, or both.[19]

New Zealand is another country that has implemented pharmacist prescribing, but with less impact. In 2013, the government adopted regulations allowing pharmacists who meet training requirements to prescribe from a list of 1,500 medications.[20] But prescribing pharmacists cannot practice independently. Instead:

> Designated pharmacist prescribers practise within collaborative health care team environments and within a defined clinical area of practice in which they have a required level of knowledge and competence. These teams are multidisciplinary and use the range of different professional experiences and strengths among their practitioners.[21]

This implementation has attracted limited interest from pharmacists. As of 2021, there were only 37 pharmacist prescribers in New Zealand nationwide.[22]

The Australian state of Queensland is also adopting pharmacist scope of practice reforms. In 2020, the state government initiated the Urinary Tract Infection Pharmacy Pilot. Under the pilot, women aged 18–65 with symptoms of an "uncomplicated" urinary tract infection (UTI) could seek treatment at a community pharmacy rather than visit a doctor. A Queensland University of Technology analysis of the pilot concludes that "the availability of UTI treatment by community pharmacists will increase access to safe and effective care," given that Queensland residents often must wait two or more days to see a general practitioner.[23]

In 2024, Queensland is following up with a more expansive community pharmacy pilot that includes autonomous prescribing for gastric reflux, shingles, wound management, and several other conditions. As in the United Kingdom and New Zealand, pharmacists must meet training requirements to participate.[24]

As Table 1 shows, Canadian provinces have varying pharmacist prescribing policies, with Alberta being the most advanced. Pharmacist prescribing legislation in Alberta dates to 2006.[25] Current Alberta regulations allow clinical pharmacists to prescribe drugs or blood products to "adapt" an existing prescription or in an

Table 1

Pharmacists' scope of practice in Canada

✓ Implemented in jurisdiction

P Pending legislation, regulation, or policy for implementation

X Not implemented

Prescriptive authority (Schedule I drug)		BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL	YT	NWT	NU
Initiate[1,2]	Independently, for any Schedule I drug	X	✓[4]	X	X	X	X	X	X	X	X	X	X	X
	In a collaborative practice setting/agreement	X	✓[4]	✓[4]	✓[4]	X	✓	✓	✓	X	X	X	X	X
	For minor ailments/conditions	✓	✓	✓	✓[4]	✓	✓	✓	✓	✓[4]	✓	✓	X	X
	For smoking/tobacco cessation	✓	✓	✓	✓[4]	✓	✓	✓	✓	✓[4]	✓	✓	X	X
	In an emergency	✓[6]	✓	✓[6]	✓[7]	✓	✓	✓	✓	✓	✓[6]	✓[6]	X	X
Adapt/manage[1,3]	Can make therapeutic substitutions	✓	✓	✓[8]	X	X	✓	✓	✓	✓	✓	✓	X	X
	Can change drug dosage, formulation, and regimen	✓	✓	✓[8]	✓	✓	✓	✓	✓	✓	✓	✓	X	X
	Can renew/extend prescription for continuity of care	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X
Injection (subcutaneous or intramuscular)[1,4]	Drugs[5]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	X
	Vaccines[5]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	X
	Influenza vaccines	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	X
Authority of medical labs	Can order and interpret lab tests	X	✓	P[9]	✓[10]	X	✓	P	P[9]	✓[11]	X	X	X	X
Pharmacy technicians	Province has laws granting specific authorities to pharmacy technicians.	✓	✓	✓	✓[12]	✓	X	✓	✓	✓	✓	X	X	X

Source: "What Pharmacists Can Do across Canada," Canadian Pharmacists Association, October 2, 2023.

Notes:

1. Scope of activities, regulations, training requirements, and/or limitations differ between jurisdictions. Refer to pharmacy regulatory authorities for details.
2. May initiate new prescription drug therapy, not including drugs covered under the Controlled Substances Act.
3. May alter another prescriber's existing prescription for drug therapy.
4. Applies only to pharmacists with additional training, certification, and/or authorization through their regulatory authority.
5. Authority to inject may not include all drugs or vaccines. Refer to jurisdictional regulations.
6. Applies only to existing prescriptions (i.e., to provide continuity of care).
7. Pursuant to a ministerial order during a public health emergency.
8. Applies only to pharmacists working under collaborative practice agreements.
9. Pending health system regulations for pharmacist requisition to labs.
10. Authority is limited to ordering lab tests.
11. Authority is limited to ordering blood tests. No authority is given to interpret tests.
12. Pharmacy technician registration is available through the regulatory authority (no official licensing).

BC = British Columbia; AB = Alberta; SK = Saskatchewan; MB = Manitoba; ON = Ontario; QC = Quebec; NB = New Brunswick; NS = Nova Scotia; PEI = Prince Edward Island; NL = Newfoundland and Labrador; YT = Yukon; NWT = Northwest Territories; NU = Nunavut.

emergency situation when the patient cannot obtain a doctor's prescription in time.[26] The definition of adapting an existing prescription includes changing dosages and substituting one prescription drug with another that is expected to deliver a similar therapeutic effect.[27]

Effective January 1, 2023, Ontario, Canada's largest province, authorized independent pharmacist prescribing for 13 common conditions, including UTIs and acid reflux (paralleling Queensland) as well as hay fever, hemorrhoids, and menstrual cramps.[28] During the policy's first six months, 4,233 pharmacies participated, writing a total of 255,625 prescriptions.[29] In October 2023, Ontario added six more conditions to the pharmacist prescribing envelope.[30]

Five other provinces permit pharmacist prescribing in a collaborative practice setting or under a collaborative practice agreement (CPA),[31] which is similar to the situation in New Zealand.

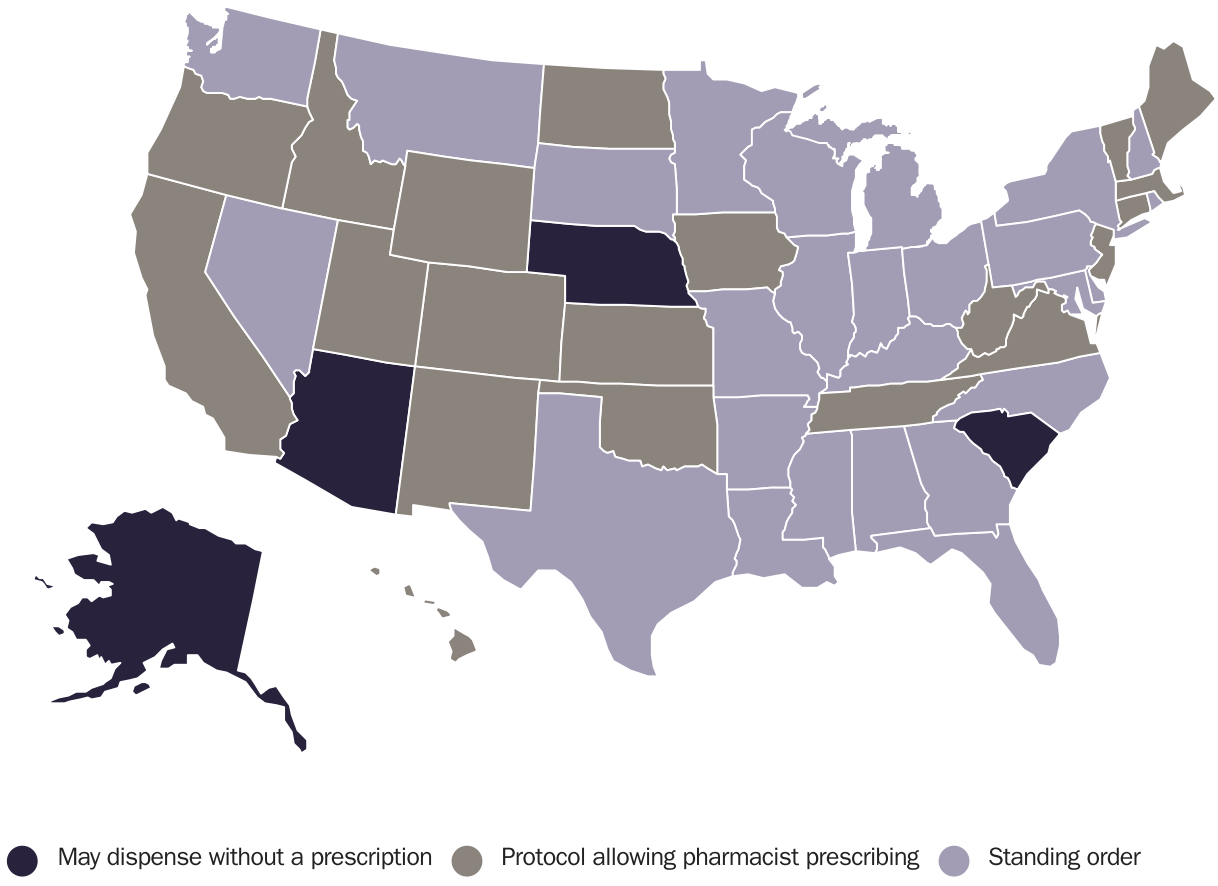
Pharmacist Prescribing in the United States

Pharmacists in all US states have at least some prescribing authority. During the COVID-19 pandemic, the FDA authorized pharmacists throughout the country to prescribe Paxlovid, emphasizing the need to administer the anti-viral on a timely basis.[32]

As shown in Figure 1, all states also permit pharmacist dispensing or prescribing of naloxone, a medication designed to rapidly reverse opioid overdoses.[33] Although states vary in the details, all 50 authorize pharmacists to

Figure 1

State rules for patients to access naloxone from pharmacists



Sources: "Pharmacist Prescribing: Naloxone," National Alliance of State Pharmacy Associations, updated March 2022; and "Scope of Practice," American Pharmacists Association.

Note: Statewide protocols are usually authorized by a state board or agency and permit pharmacists to prescribe specific medications if they meet the protocol criteria. Standing orders outline patient care for specific conditions or procedures, typically signed by a state agency physician. Pharmacists execute prescriptive authority under specific conditions. If the physician departs, a new order is necessary.

administer vaccinations.[34] Unlike in the case of Paxlovid, this prescribing authority is the result of state legislation.

Twenty-nine states and the District of Columbia allow pharmacist prescribing of contraceptives, as shown in Figure 2. The Guttmacher Institute advocates for this reform because it "can make contraceptive care more accessible and affordable by eliminating the need for a separate visit to a health care provider to obtain a prescription."[35]

Twenty-one states allow pharmacists to prescribe tobacco cessation products, as shown in Figure 3. Depending on the state, pharmacists may be able to provide the full range of FDA-approved products in this category or a subset. Three of the states allow independent prescribing, while the remainder require a CPA.[36]

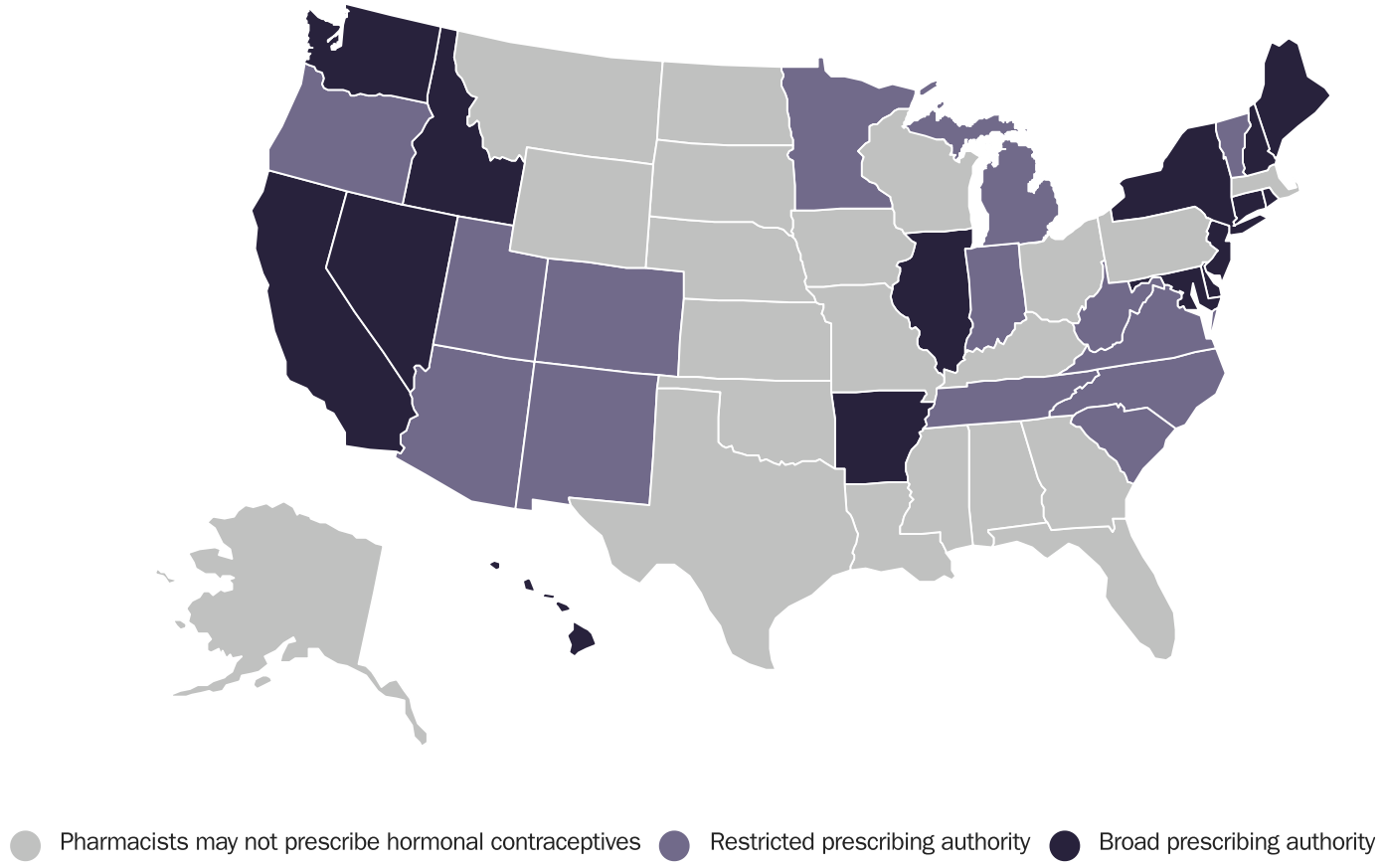
Finally, California became the first state to authorize pharmacists to prescribe HIV pre- and post-exposure prophylaxis (PrEP and PEP) to make it easier for people to access those drugs.[37] Since then, other state legislatures have followed California's example.[38] As of this writing and as shown in Figure 4, 26 states provide pharmacists with at least some level of prescribing authority for HIV prophylaxis, though some exclude PEP.[39] Because PEP must be started within 72 hours of exposure to HIV, the case for pharmacists being allowed to prescribe it is similar to that for Paxlovid.[40]

Broader Reforms

Florida pioneered the concept of broader pharmacist prescribing in 1985 but with limited success. The state's pharmacist prescribing law, which remains on the books, authorized a committee to create a formulary or list of medications that pharmacists could prescribe without a physician's intervention.[41] When the law took effect in 1986,

Figure 2

States that allow patients to access hormonal contraceptives from pharmacists



Sources: "Pharmacist Prescribing: Hormonal Contraceptives," National Alliance of State Pharmacy Associations, September 1, 2022; and Maia Pandey and Randi Selvey, "Map: Where You Can Get Birth Control from a Pharmacist without a Doctor's Prescription," NBC, July 11, 2023.

the formulary included a "shampoo for head lice, drugs that are stronger than over-the-counter medicines for ailments like colds and headaches and fluoride products aimed at preventing tooth decay."[42]

The narrow formulary and extensive paperwork requirements limited pharmacists' use of their new authority. Surveys conducted after the law's implementation suggested that between one-sixth and one-third of pharmacists were prescribing or planning to do so. Druggists interviewed by the Associated Press noted that patients could duplicate the effects of drugs "stronger than over-the-counter" medications by taking a higher dose of over-the-counter drugs.[43]

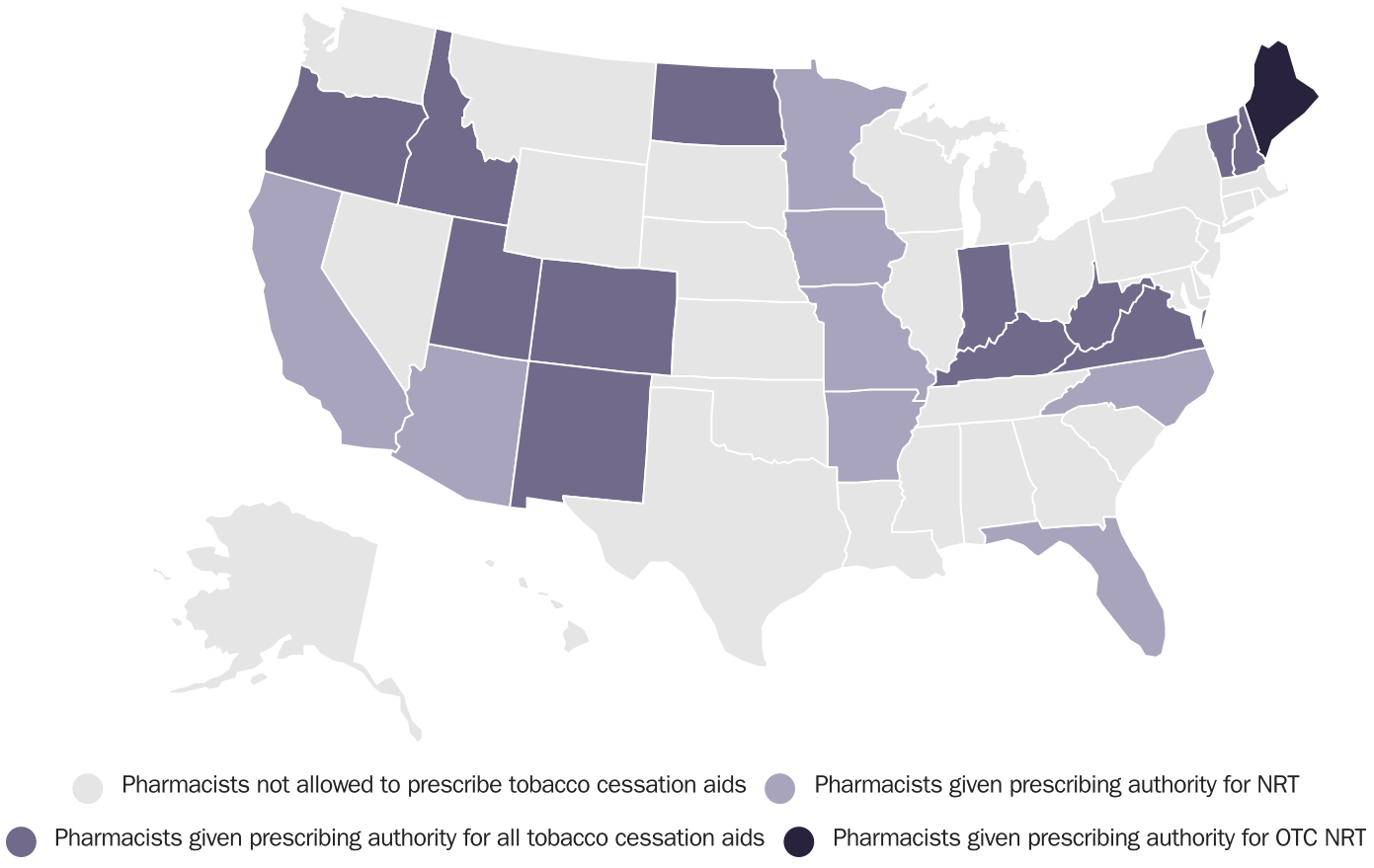
New Mexico was the next state to try pharmacist prescribing, using a different model. The state's 1993 Pharmacist Prescriptive Authority Act created the advanced designation of pharmacist clinician. These practitioners, who require additional training, can prescribe a wide array of drugs, but a physician must supervise them.[44] This requires a CPA under which a physician delegates prescribing authority to a pharmacist under specific circumstances listed in a formal protocol.

Three other states—California, Montana, and North Carolina—have followed New Mexico's lead by creating classes of advanced practice pharmacists with prescribing authority under a CPA. In all four of these states, less than 10 percent of licensed pharmacists have obtained the advanced designation. This low uptake suggests that most pharmacists do not believe that time and money spent toward achieving the higher practice level is worth the expected benefits.[45]

In 2019, Idaho tried a different approach by allowing any pharmacist to independently prescribe from a wider array of drugs than the original Florida law permitted but without the need for additional certification or a CPA as required

Figure 3

States that allow patients to access tobacco cessation aids from pharmacists



Sources: "Pharmacist Prescribing: Tobacco Cessation Aids," National Alliance of State Pharmacy Associations, updated March 31, 2022; and Landon S. Bordner and Joseph Lavino, "Pharmacist-Led Smoking-Cessation Services in the United States—A Multijurisdictional Legal Analysis," *Innovations in Pharmacy* 13, no. 1 (April 2, 2022).
Notes: NRT = nicotine replacement therapy; OTC = over the counter.

by New Mexico. Under H.B. 182, Idaho pharmacists can prescribe drugs if one of four conditions is met:

- A new diagnosis is not required.
- The condition to be treated is minor and generally self-limiting.
- The condition has a test waived under the federal Clinical Laboratory Improvement Amendments to guide diagnosis.
- There is an emergency situation in which the patient's health or safety is threatened without immediate access to a prescription.[46]

The last category could have significant implications for health care costs as well as patient well-being. Quickly receiving the right prescription in an emergency may enable patients to avoid costly and time-consuming visits to the emergency room. However, the Idaho law limits the amount of medication a pharmacist may prescribe in an emergency situation to the quantity a patient needs until he or she can see another provider.

Colorado adopted similar legislation in 2021, followed by Montana in 2023.[47] The Montana bill passed despite American Medical Association opposition.[48]

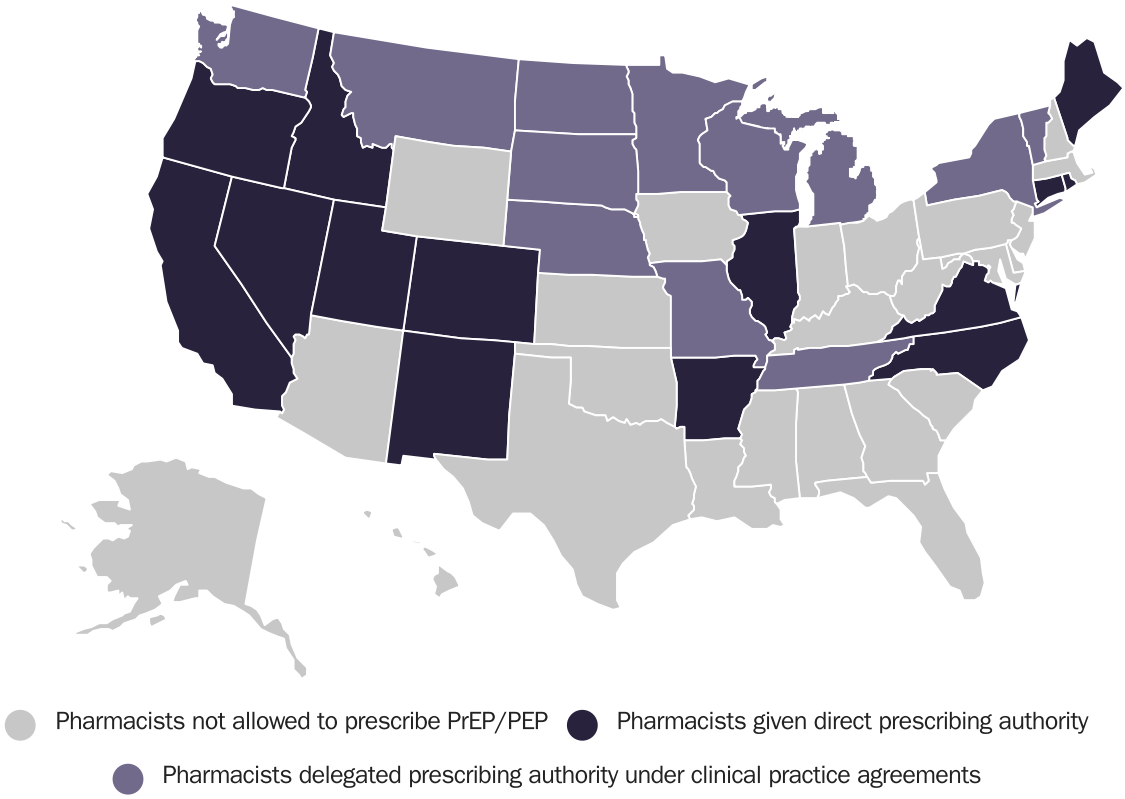
This new class of legislation appears to be having a greater impact than previous reforms. Safeway pharmacies have expanded their practices to include prescribing in several states. But only in Idaho and Colorado does the chain advertise prescriptions for medications to treat cold sores, men's hair loss, migraines, motion sickness, topical acne, and UTIs.[49] Details of state pharmacist prescribing reforms are provided in Table 2.

Impact of the Reforms

Because pharmacist prescribing reforms are relatively new, empirical findings are still limited. A literature review did not find evidence of increased prescribing errors but did

Figure 4

States that allow patients to access HIV PrEP and PEP from pharmacists



Sources: "Pharmacist Prescribing: HIV PrEP and PEP," National Alliance of State Pharmacy Associations, December 9, 2022; and Sonya Collins, "Pharmacists Expand Access to PrEP in 17 States," *Pharmacy Today* 29, no. 9 (September 2023): 22–26.
Notes: HIV = human immunodeficiency virus; PEP = post-exposure prophylaxis; PrEP = pre-exposure prophylaxis.

show increased access and convenience for patients who could benefit from prescription medications. For example, a recent study published in the *Journal of the American Medical Association* found that pharmacists prescribing medication to treat high blood pressure resulted in greater patient compliance and was less costly.[50]

Shishir Shakya and colleagues found evidence that the Idaho reform had an impact as early as 2019 and 2020. Their analysis of Medicare Part D records shows that the result of pharmacists' prescriptions of albuterol sulfate for asthma and insulin pen needles for diabetes was that "approximately three additional Medicare beneficiaries per pharmacist received time-sensitive medications."[51]

Mary Elkomos and colleagues reviewed multiple studies that analyzed pharmacist prescribing of statins to patients with type 2 diabetes.[52] They found that the availability of pharmacist prescribing increased the likelihood of patients receiving statins, but long-term health effects have not been determined. In another meta-analysis, Caitlin Kennedy and her coauthors concluded that American patients were generally willing to obtain HIV prophylaxis through a pharmacist prescription but that there was a lack of evidence on the effectiveness of this modality.[53] Similarly, Jonathan Berry and his colleagues found that individuals

Table 2

Expanded prescribing authority for pharmacists by state

State and year enacted	Type of authority	Prescriptive authority
New Mexico (1993)	CPA	• May prescribe medications (including controlled) for chronic and nonchronic conditions. • May prescribe HIV PrEP and PEP (direct prescribing authority).
California (2013)	CPA	• May prescribe the following medications: hormonal contraceptives, emergency contraception, NRT, and travel medicine. • May order and interpret drug tests (with the patient's primary care provider's coordination). • May initiate, adjust, and discontinue drug therapy upon referral from a patient's treating provider, under protocol. • May prescribe HIV PrEP and PEP (direct prescribing authority).
Oregon (2017)	Limited independent prescriptive authority	• May prescribe the following devices and supplies on the state formulary: diabetes supplies, injection supplies, nebulizers and associated supplies, spacers, peak flow meters, INR testing supplies, enteral nutrition supplies, ostomy products and supplies, and noninvasive blood pressure monitors. • May prescribe the following medications on the Protocol Compendium: emergency insulin, medications for cough and cold, vulvovaginal candidiasis, medications for preventative care, HIV PrEP and PEP, NRT, and travel medicine.
Massachusetts (2017)	CDTM	• May extend therapy for a limited time frame. • May initiate, modify, or discontinue on protocol dosages of medications prescribed by the physician for the following conditions: asthma, COPD, diabetes, hypertension, hyperlipidemia, congestive heart failure, osteoporosis, and comorbidities.
Idaho (2018)	Independent; limited to state formulary	• May treat the following minor conditions: lice, cold sores, and uncomplicated urinary tract infections. • May provide motion sickness prevention. • May treat influenza and strep throat based on a CLIA-waived test. • May prescribe the following devices: spacers, nebulizers, diabetes supplies, pen needles, and syringes. • May administer the following emergency medicine: diphenhydramine, epinephrine, and short-acting beta-agonists. • May prescribe travel medicine. • May prescribe the following medications related to clinical gaps in care: statins and short-acting beta-agonists. • May prescribe the following supplies to supplement infusion orders: flushes, devices, supplies, and local anesthetics for intravenous port access. • May prescribe Lyme disease prophylaxis. • May prescribe HIV PrEP and PEP.
Florida (1985/2020)	CPA or Test and Treat certificate	• May treat the following chronic health conditions: arthritis, asthma, COPD, diabetes, HIV/AIDS, and obesity. • May treat the following minor, nonchronic health conditions: influenza, strep throat, lice, skin conditions, and uncomplicated infections.
New York (2020)	CDTM	• May adjust or manage a drug regimen of a patient who is being treated by a participating physician for the specific disease state listed in the agreement.

Table 2 (continued)

Expanded prescribing authority for pharmacists by state

State and year enacted	Type of authority	Prescriptive authority
North Carolina (2021)	CPA	• May perform drug therapy management, including controlled substances, under protocol.
Iowa (2021)	CDTM	• May perform collaborative drug therapy management per protocol with a physician.
Colorado (2021)	Independent or CPA	• May prescribe over-the-counter medications. • May treat conditions that do not require a new diagnosis or are minor and generally self-limiting or if the patient has a CLIA-waived test. • May administer the following injections: Vivitrol and long-acting injectables. • May administer immunizations. • May prescribe HIV PrEP and PEP (direct prescribing authority).
Ohio (2021)	Consult agreement	• May manage drug therapy per protocol.
Montana (2023)	Independent or CPA	• May prescribe the following drugs and devices for conditions that do not require a new diagnosis, are minor and generally self-limiting, or are patient emergencies: influenza, strep throat, lice, NRT, prophylactic courses for family members, spacers, glucagon, and EpiPens.

Sources: Alex Evans, "Prescribing Authority for Pharmacists: Rules and Regulations by State," GoodRx Health, July 22, 2022; Matthew Murawski et al., "Advanced-Practice Pharmacists: Practice Characteristics and Reimbursement of Pharmacists Certified for Collaborative Clinical Practice in New Mexico and North Carolina," *American Journal of Health-System Pharmacy* 68, no. 24 (December 15, 2011): 2341–50; Pharmacist Prescriptive Authority Act, N.M., 41st Leg., 1st Reg. Sess., ch. 191 §§ 1–3 (1993 N.M. Laws); Pharmacy Practice, S.B. 493, 2013 Leg., Reg. Sess. (Cal. 2013); H.B. 2397, 79th Legis. Assemb., Reg. Sess., ch. 106 (Or. 2017); Or. Admin. R. 855-020-0110 (Or. 2021); 247 Mass. Code Regs. 16 (Mass. 2017); H.B. 182, 65th Leg., 1st Reg. Sess. (Idaho 2019); Idaho Admin. Code r. 27.01.04 (Idaho 2018); Diana Smith, "Florida First State in Nation to Let Pharmacists Prescribe Drugs," Associated Press, April 12, 1986; C.S./H.B. 389, 2020 Leg., Reg. Sess. (Fla. 2020); "Pharmacist Test and Treat Certification," Florida Board of Pharmacy; 2020 N.Y. Laws tit. 8, art. 137, § 6801-a (N.Y. 2020); 21 N.C. Admin. Code 46 § .3101 (N.C. 2015); S.B. 575, Gen. Assemb., 2021 Sess. (N.C. 2021); Iowa Admin. Code r. 657-8.34 § 155A (Iowa 2013); S.F. 296, 89th Gen. Assemb. (Iowa 2021); S.B. 21-094, 2021 Leg., Gen. Assemb. (Colo. 2021); "Pharmacist Services Billing Manual," Colorado Department of Health Care Policy and Financing, January 1, 2022; "Pharmacist Consult Agreements with Providers," State of Ohio Board of Pharmacy, updated March 7, 2023; Ohio Admin. Code 4729:1-6-02 (2021); S.B. 112, 2023 Leg. (Mont. 2023); and "Pharmacist Prescribing: HIV PrEP and PEP," National Alliance of State Pharmacy Associations, December 9, 2022.
Notes: AIDS = acquired immunodeficiency syndrome; CDTM = collaborative drug therapy management; CLIA = Clinical Laboratory Improvement Amendment; COPD = chronic obstructive pulmonary disease; CPA = collaborative practice agreement; HIV = human immunodeficiency virus; INR = International Normalized Ratio; NRT = nicotine replacement therapy; PEP = post-exposure prophylaxis; PrEP = pre-exposure prophylaxis; strep = group A streptococcus.

considering tobacco cessation were willing to receive pharmacist prescriptions of relevant treatments, but they did not report variations in quitting behavior between the groups of patients that had and did not have access to pharmacist prescribing.[54]

As more pharmacist prescriptions are written in Idaho and other states, we should see more studies evaluating this reform.

RECOMMENDATIONS

Ideally, states should repeal all health professional licensing laws. Licensing laws do little to protect the public from poor-quality care but serve as barriers to new entrants and innovations in the health care professions.[55] States could accredit third-party certification organizations to perform licensing boards' functions.[56] These organizations would certify professionals' scope of practice.

Christina Sandefur, Byron Schlomach, and Murray Feldstein have proposed a voluntary alternative pathway involving third-party certification that could coexist with state licensing schemes and gradually replace them.[57] Such an alternative pathway can form the foundation for a gradual elimination of professional licensing.

If repealing or reforming licensing laws is not feasible, states should develop and expand the policies already initiated by some states and non-US jurisdictions to allow pharmacists to test and prescribe treatments for a wide array of health conditions.

Specifically, states should:

- use models from Idaho, the Australian state of Queensland, and the Canadian provinces of Alberta and Ontario to increase the number of conditions

pharmacists in their states may treat;

- repeal any requirements that pharmacists enter into collaborative practice agreements and allow pharmacists to prescribe independently; and
- make independent pharmacist prescribing authority available to all pharmacists within the state rather than limiting it to those with advanced designations.

CONCLUSION

Amid a worsening shortage of primary care clinicians and a growing and aging population, state lawmakers should remove barriers to pharmacists practicing to the full extent of their training. Lawmakers should enable patients to receive treatment for minor and self-limited conditions, routine screening for common and easily detectable conditions, and preventive care from pharmacists.

NOTES

1. This brief uses the Health Workforce Technical Assistance Center's definition of a shortage, which is "not enough health care workers or not enough workers in specific professions, specialties, or settings to adequately serve patients' needs." This is different from the definition economists use for a shortage, which is a situation in which the quantity demanded exceeds the quantity supplied, and this usually arises from price controls or other conditions that prevent sellers from raising prices. "How Do You Define and Determine Shortage?," FAQs, Health Workforce Technical Assistance Center.

2. "Scoring Shortage Designations," Bureau of Health Workforce, Health Resources & Services Administration, Department of Health and Human Services, last reviewed December 2022.

3. "Health Workforce Shortage Areas," Data Warehouse, Health Resources & Services Administration, Department of Health and Human Services, February 7, 2024.

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