A solution to the doctor shortage already exists in most neighborhoods

Summary

The United States faces a projected shortage of up to 124,000 physicians by the mid-2030s, exacerbating existing access issues. However, pharmacists, trained in patient assessment and treatment, are often legally restricted from providing care they are qualified to deliver. Modernizing outdated practice laws to allow pharmacists to diagnose and prescribe within their training could expand access to care, reduce unnecessary emergency room visits, and alleviate the primary care shortage.

Pharmacists in many states remain legally prohibited from providing care they are trained to deliver.

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For millions of Americans, gaining timely access to basic medical care is a familiar struggle. The United States is projected to face a shortage of up to 124,000 physicians by the mid-2030s, according to the Association of American Medical Colleges. Nearly 30 percent of Americans do not have an established primary care physician. For many patients, even routine medical needs now mean protracted waits, long drives or emergency rooms filling in for primary care.

Expanding physician-training pipelines alone cannot resolve this access gap in the near term. Medical education takes years, residency positions remain constrained, and recruiting clinicians to many communities has proven persistently difficult. In much of the country, the lack of physician capacity is already shaping where and how patients seek care.

At the same time, health care infrastructure already exists in most neighborhoods. The U.S. has more than 300,000 licensed pharmacists practicing in nearly 60,000 community pharmacies. Roughly 90 percent of Americans live within five miles of a pharmacy. These are physical health care sites that do not need to be built, staffed or licensed — they are already operating, with extended hours and walk-in access.

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Pharmacist education includes patient assessment, differential diagnosis, laboratory testing, drug administration and prescribing. But outdated statutes often limit pharmacists to testing without treatment or require referral even when clinical care is straightforward and well-established. Some state legislatures are considering proposals to modernize these laws and expand access to care. Yet pharmacists in many states remain legally prohibited from providing care they are trained to deliver.

This gap is most visible in conditions that frequently drive urgent care and emergency department utilization. In places with modern practice laws, pharmacists diagnose and treat uncomplicated urinary tract infections, influenza, strep throat and covid-19 — the same conditions that now account for millions of urgent care and emergency visits each year. When treatment can be provided immediately at the pharmacy counter, patients avoid unnecessary escalation and hospitals preserve capacity for more complex cases.

Pharmacist prescribing authority also improves access to preventive and some chronic disease services, including smoking cessation therapy and cardiovascular disease. These are not peripheral services. They are among the most common and costly drivers of long-term morbidity, and they require frequent monitoring, medication adjustment and patient follow-up — precisely the kind of access community pharmacies are well-positioned to provide.

The need for expanded access is especially clear at the state level. In South Carolina, the state is projected to face a shortage of more than 3,200 physicians by 2030, including more than 800 in primary care. Forty-one of the state's 46 counties are designated Health Professional Shortage Areas, and the physician-to-population ratio is approximately 23 percent worse than the national average. Similar dynamics are emerging in many states where appointment backlogs, hospital closures and workforce attrition are converging.

Some states have already modernized how pharmacy practice is regulated. Idaho and Iowa shifted away from rigid task-based statutes and toward a standard-of-care regulatory model, the same framework that governs physicians and nurse practitioners. Under standard of care, clinicians are authorized to provide services consistent with their education, training and

experience. They remain fully accountable to licensing boards and the courts when they fail to meet professional expectations. Oversight is not reduced; it is applied through clinical judgment rather than static permission lists.

This approach does not turn pharmacists into physicians, nor does it eliminate referral or collaboration. It allows pharmacists to practice to the full extent of their training while preserving the ability to escalate when conditions require physician management. It also aligns pharmacy rules with how every other clinical profession is already regulated.

Federal and state policymakers are making progress. The Centers for Medicare & Medicaid Services' new Rural Health Transformation Program explicitly rewards states that modernize scope-of-practice laws, including pharmacist prescribing authority. Momentum is also building at the local level. South Carolina is considering a proposal to authorize pharmacists to prescribe medications for certain conditions. New Hampshire lawmakers are attempting to modernize pharmacist prescribing authority statewide. These reforms are gaining support because they offer a practical bipartisan way to expand access using the workforce and facilities already in place.

States do not need to invent a new health care delivery model to ensure more Americans have access to timely treatment. A clear and proven framework already exists: Modernize outdated practice laws, allow pharmacists to diagnose and prescribe within their education and training, and let existing health care infrastructure operate at full capacity. Doing so would expand entry points into care, reduce unnecessary emergency room use and help close the widening gap in American primary care.