What's Not That Crazy About Making Sure Pharmacists Are Part of The Primary Care Team. But It's Crazy to Think Pharmacists Alone Can Solve the Health Care Mess

By Michael Fine

In these pages, an Op-Ed (Let Rhode Island Pharmacists Close the Primary Care Gap) by a number of trusted colleagues argued that allowing pharmacists to bill insurance directly for clinical services might close the primary care gap.

I'm not sure where I stand on letting pharmacists bill insurance directly. On the one hand, pharmacists are critical and valued members of the primary care team and provide services that greatly benefit patients. On the other hand, fee-for-service billing, billing a patient or their insurance company every time a clinician of one stripe or another sees a patient, is part of what has destroyed primary care itself, and should be shown the door as soon as possible. So letting pharmacists bill fee-for-service doesn't sound like it will fix anything.

Everyone needs a primary care clinician who they know and trust and knows and trusts them, and every primary care clinician needs a team of people supporting their patients – pharmacists, community health workers, population health and quality assurance specialists, mental and behavioral health folks, substance use disorder counselors, occupational and physical therapists, and probably a bunch of others I've forgotten (who I hope will someday forgive me for their omission.)

But we should be paying the *team* for primary care, as a team, per-patient-per-month, and paying for service delivery and public health outcomes, not paying for each "encounter."

Thus, teams should be paid to make sure everyone who is sick today is seen today. And teams should be paid to make sure people can be seen in the evening and on weekends. And teams should be paid to make sure everyone they care for is getting all the prevention they need when they need it. And teams should be paid for effectiveness at helping most of their patients quit smoking, and for their effectiveness at keeping people out of emergency rooms and hospitals when they don't need those services, and so forth. Are pharmacists a critical part of that process? You betcha. But I'd be careful about setting up another fee-for-service boondoggle, because years of experience has taught us that there

are better ways to achieve better results than we get now with insurance and fee-for-service billing.

And can pharmacists close the primary care gap? Not a chance. The primary care shortage aka gap is far too big for that.

Pharmacists help, for sure. But we are likely short a thousand or more primary care clinicians in Rhode Island today, and two to three hundred thousand clinicians across the nation, in a nation that graduates a medical school class of 22,000, of whom fewer than 5000 chose primary care, and in a state with a medical school class of 150, of whom only a few went to high school in Rhode Island and have roots here, and only twenty or thirty will end up practicing primary care, and far fewer of whom will end up practicing primary care in Rhode Island.

To close the primary care gap, we need a huge public commitment to new medical schools – we need one at URI, one at Salve Regina, and one at UMASS Dartmouth – among many other needed changes to make sure students from our communities can go to medical and other health professional schools and stay here to practice primary care (something that URI's school of pharmacy is particularly good at, for pharmacists.)

Pharmacists can and do help patients get better primary care. But it's crazy to think pharmacists alone can carry this ball. We need a huge public commitment to provide primary care to everyone, with leadership from our legislators and academic institutions, and support from our recently retired clinicians to return as teachers. Failing that, we'll keep paying twice as much as we should be paying for health care and keep having lousy public health.

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