The looming pharmacy crisis in America

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December 04, 2023

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Merchandise aisle and Pharmacy Sign at Walgreens, Queens, New York. (Photo by: Lindsey Nicholson/UCG/Universal Images Group via Getty Images)

Pharmacists at major chain stores like CVS and Walgreens are at a breaking point.

Many workers have staged walkouts, saying they are overworked, understaffed and risking patient safety.

Today, *On Point*: The looming pharmacy crisis in America.

Guests

Shane Jerominski, practicing pharmacist. Advocate who helped organize the recent walkouts at big chain pharmacies.

Sara Sirota, policy analyst at the American Economic Liberties Project, with a focus on monopoly power in health care.

Also Featured

Dr. Craig Cox, president of the American Association of Colleges of Pharmacy.

Transcript

Part I

NEWS BRIEF: Across the country, pharmacy workers are walking off the job to protest what they call unsafe working conditions at some of the biggest retail chains.

MEGHNA CHAKRABARTI: Earlier this year, thousands of workers walked off the job at CVS and Walgreens stores in 15 states, including New York, Pennsylvania, Connecticut, Florida, Texas, and Illinois.

The action was dubbed 'pharmageddon.' A protest by pharmacists against what they say are unreasonable and unsafe working conditions at the biggest chain

pharmacies in the United States. One of their major concerns, understaffing. Protesters say the issue isn't a shortage of pharmacists or pharmacy techs.

But a shortage of workers who want to do these jobs at big chain retail stores, where they say workers are already burning out. According to the American Pharmacists Association, the industry has approximately 7,500 job openings for pharmacists and 25,000-plus openings for pharmacy tech. Now, pharmacists are highly educated and highly trained specialists who provide medications to just about everyone in the United States, which means the shortage of qualified workers could also have an impact on just about everyone in the United States.

So how did we get here? What's driving the changes that pharmacists say they're experiencing in the nation's largest corporate and retail pharmacies? That's what we're going to look at today.

And we'll start with Shane Jerominski. He's been a practicing pharmacist in Southern California for 16 years, has worked at the big chain stores like Walgreens and CVS, and now works for an independent pharmacy.

He also helped organize the walkouts earlier this year. Shane, welcome to On Point.

SHANE JEROMINSKI: Thank you for having me, Meghna.

CHAKRABARTI: Can you describe to me the worst day or one of the worst days that you had as a pharmacist when you were working at CVS or Walgreens?

JEROMINSKI: Oh, for sure. I started my career with Walgreens back in 2007.

And at that time, there was an actual real shortage of pharmacists in Southern California. So there were new pharmacists from all over the country, but all of them were immediately thrown into roles of pharmacy managers, where essentially, you're responsible for everything. You're responsible for maybe another pharmacist, as well as multiple technicians.

And during one of my first years there, during the swine flu epidemic, we, myself and one other pharmacist, did over 2,000 flu shots in the course of a few months. But that first day, we did about 150 flu shots, with 50 pneumonia vaccines, with one technician and two pharmacists there, with overlap for just a couple hours.

So we had lines throughout the door. This was in a busy pharmacy in Southern California, two lanes of drive-through. A golf cart drive-through lane. So when you have that many extra duties, along with just safely and accurately checking prescriptions, anyone can feel overwhelmed. And you just feel like a mistake is imminent.

CHAKRABARTI: Wow. That is a lot for a single day. But couldn't one come back and say that was under sort of a potential epidemic scenario, and there was this, a huge spike in demand from people who wanted vaccinations? And how does that compare to what was the norm for you at CVS or Walgreens?

JEROMINSKI: For sure.

So during those first few years, there was a flu shot season, and even during the swine flu epidemic, which did see an increase in demand, the business model has changed to all vaccinations, all day, every time. You can make appointments, you can have walk ins, and that seems to be the central focus of most of these pharmacies now, because the margins are so much better on vaccinations.

It's almost like filling prescriptions safely and accurately is now an afterthought. Because these chain pharmacies are in love with the margins associated with vaccinating.

CHAKRABARTI: Okay. Wow. Actually, now that you mentioned that, Shane, I'm just thinking on my neighborhood chain pharmacies. And there are sort of "Get your vaccine now" posters up year-round, which I guess, several years ago, I hadn't noticed that. But what about if there's a steady increase in demand or even a sharp temporary increase? I guess the real question is, did the company adjust staffing to keep up with the increase in demand?

JEROMINSKI: No. I think that the company is doing a terrible job at really staffing appropriately. And as you mentioned, there's lots of open jobs out there. And it's not a shortage of pharmacists or a shortage of pharmacy technicians, but a shortage of pharmacists and technicians willing to practice in these settings. There's a lot at risk for a pharmacist when a medication error occurs.

And after all of that education, you don't want to put your license at risk working

for a company where you don't feel like you're supported.

CHAKRABARTI: We did reach out to CVS and Walgreens and several other big pharmacy companies across the United States, and CVS sent us back a response to some detailed questions that we emailed them. And first of all, they did say that they employ more than 30,000 pharmacists and 70,000 pharmacy technicians and that revenues for the company from their pharmacy business comprised about 77% of CVS's overall revenue. So there's indication that it's a huge or the biggest part of their business.

I'm going to add another little wrinkle here for context. And those were revenue percentages I gave you. In terms of actual dollars, CVS Pharmacy and Consumer Wellness, that segment of their business, in 2022 brought in about $28 billion in revenue. So that's a dollar figure. But when you take into account their costs, their overall profit was $1.4 billion, when adjusted again for operating income.

So a significant part of CVS's business, which is why they told us in their statement, Shane, that they're committed to providing access to consistent, safe and high-quality health care to patients, and they are making targeted investments to address pharmacy teams' key concerns. What's your response to that?

JEROMINSKI: I'm sorry, Meghna. I actually lost you there for a few minutes, but I did get the end of that. So it's great. It's most of the talking points that we hear pretty regularly. That they're making these investments, but that doesn't really set well with a lot of pharmacists who are there combating this every single day.

You have, CVS has taken overlap almost out of every store. So in most places, there's a pharmacist, one pharmacist behind the counter working a 12- or 14-hour shift and everything that leaves that pharmacy is squarely on their shoulders, whether it's right or wrong. And they will not close a store if they have three call outs of technicians.

So there's a lot of scenarios in this country. And the reason why the walkout started in Kansas City was because pharmacists were working alone. It's essentially like running a McDonald's by yourself.

CHAKRABARTI: Shane are you still with us?

JEROMINSKI: Yes.

CHAKRABARTI: Okay, good. I just wanted to be sure. So no matter what's been happening, just to clarify what's happening on staffing on a given day, they keep the pharmacy open.

That's what you're saying.

JEROMINSKI: Yeah. Okay. Yes. There's no scenario where they would want that store to close, even if no one shows up except for the pharmacist. Because a pharmacist has to be there in order for the pharmacy to open. So the only way a store is closed is if that pharmacist doesn't show up.

Everyone else can call out, but they'll still stay open. We've had a ton of images of pharmacists that they decided to close the store and just have drive-through only because they were working by themselves.

CHAKRABARTI: Oh, okay. And is part of this that we have reached a place in American health care where people do expect to get a, if their doctor's calling in a prescription to the pharmacy or putting it in online, people do expect to get it in an hour or so.

So there's no imaginable scenario, which I think Americans would accept, that because of low staffing, their local CVS or Walgreens pharmacy has closed down for the day, right?

JEROMINSKI: For sure, and I think there's just a misunderstanding of what filling a prescription entails, like you hear that so often, people joke about it, that you're just putting pills from one bottle into another bottle, slapping a label on it and handing it to a patient.

But the adjudication process is not easy, when you're billing something. There's lots of things that could go wrong. Even if you get the prescription from the doctor's office, whether it's sent in electronically or a patient brings it in, you have to decipher that. You have to make sure it's correct.

You have to make sure that all the necessary details are on a prescription to be able to fill it. You have to check it against the patient's profile, bill that to the insurance.

You may find out that it's not covered. You can call the doctor's office, try to do a prior authorization, or it's a formulary switch, something that's covered by their insurance.

So there are many steps, and you can imagine that in between those steps, if you're doing COVID testing, vaccinations, counseling patients on over the counter medications, it's required to counsel on all new prescriptions, as well. So there's only one pharmacist that can do most of those tasks. That's the reason why we're being drawn in so many directions, and sometimes it takes more than an hour to fill your prescription.

CHAKRABARTI: Can you tell me a little bit more about how much time you had to spend, again, focusing on your time with the corporate pharmacies. How much time did you have to spend on the phone on average with insurance companies?

JEROMINSKI: Oh yeah. You're spending a lot of time on the phone, not just with insurance companies, but transferring prescriptions.

I'm in the Palm Springs market out here, so ... lots of snowbirds and seasonal visitors to the area. So every time you have to transfer a prescription from another pharmacy, if it's not within your own chain, you have to get on the phone and ask the pharmacist to give you a verbal transfer or fax it over.

So you're constantly on the phone, not just answering questions for patients. And then when a patient is expecting something, they might be calling 20 times a day, just to see if it's ready, as well. So there's a lot of time spent on the phone and there's a lot of things drawing you in every direction.

CHAKRABARTI: Yeah. Can you tell me what was it that finally led you to leave your jobs with the corporate pharmacies and take up work at an independent pharmacy?

JEROMINSKI: Sure, so I worked for Walgreens right out of school. I ended up in the Palm Springs area because there were sign-on bonuses to come out here.

I liked working for Walgreens, but after about five years as a pharmacy manager, I got a cold call from Target Pharmacy. Target Pharmacy was an excellent place to work for. Their business model was a little different because they didn't derive

those 70% revenues from the pharmacy, like you had mentioned. So it was more of an afterthought for guests in the store.

Plus, it was a really great working environment. You could kill an hour in Target way easier than you could kill an hour in CVS. You didn't have people staring at you and demanding that they need to get it done as quickly as possible. Halfway through my time at Target, CVS came in and acquired the Target pharmacies.

So now when you walk into Target, it's a CVS pharmacy inside there. Change the culture, change the model. At this time, I started my social media account called The Accidental Pharmacist, now has about 125,000 followers on Facebook. But we have a presence on all the social media platforms. At that time, it was my creative outlet, but I did start talking about working conditions and safety concerns. And that's when CVS said basically, "Find another job or shut the page down." So I decided to find another job.

Part II

CHAKRABARTI: Shane, hang on here for just a second because I want to introduce Sara Sirota into the conversation.

Sara is a policy analyst at the American Economic Liberties Project with a focus on monopoly power in health care. Sara, welcome to the program.

SARA SIROTA: Hey, thanks for having me.

CHAKRABARTI: So what does the monopoly have to do with this issue that pharmacists are raising about their working conditions?

SIROTA: Yeah, so the monopoly issue really exists all over the place.

It's important to look at the way that pharmacies buy drugs, and the way that they get reimbursed for drugs. And how that is driving a lot of the financial troubles that we're seeing, not just at the big retail chains, but also at the small independent pharmacies across the country. So on the buying side, that market is driven by really three major wholesalers, McKesson, AmerisourceBergen and Cardinal that dominate the industry and are driving up costs for pharmacies that are acquiring the medications.

And then on the other end is the way that they get reimbursed through entities called pharmacy benefit managers that represent the insurance industry. And they, too, are represented by three major companies. Express Scripts, Caremark, and OptumRx. And they, too, hold monopoly power and are systemically under reimbursing pharmacies, potentially even below their costs.

And so this is creating a situation where pharmacies are stuck in the middle, and they're not able to generate enough revenue and profit margin to stay in business, and that's manifesting differently depending on the kind of pharmacy you have. So the small independent pharmacies simply can't stay in business.

We see studies showing that they are being driven out. Thousands of independent small pharmacies have been forced to close, and that's driving a lot of the distress that you alluded to. At the large pharmacy chains, the way they're dealing with that is by cutting staff, by closing down stores. I think it's interesting that you said CVS responded to an email saying that they are so invested in their pharmacies, and yet they are pledging to close hundreds of their pharmacies over the next few years.

So this is part of the problem that we're seeing, this issue of monopoly and consolidation across the supply chain of the pharmacy business that are creating all of these economic problems.

CHAKRABARTI: Interesting. Just to read a little bit more from CVS's response to our questions, they said, "We're making targeted investments to address there being the pharmacy employees' key concerns, including enabling teams to schedule additional support as needed, enhancing pharmacist and technician recruitment and hiring and strengthening pharmacy tech training." They say they're rolling out these changes or they started rolling out them last month in November and will continue through to next year. So repeatedly in their statement, they assured or tried to assure us that they're listening to the concerns coming from the pharmacy employees.

As you heard Shane a little bit earlier, Shane just doesn't see evidence of that, but do you think that some of the changes that CVS, for example, says it's making are going to make a meaningful difference, Sara, in these underlying drivers?

SIROTA: Yeah, I don't see them addressing those underlying issues of the

wholesalers, the pharmacy benefit managers and also this issue generally of CVS and Walgreens closing down pharmacies and relying more on their mail order pharmacy and more on their other subsidiaries as highly diversified companies.

CHAKRABARTI: So let me ask you one quick thing. Just to be clear, because the world of pharmacy services, anything related to American health care is extremely confusing. I'm a visual learner, so I want to be sure I understood what you said. So that we've been seeing a consolidation in the endpoint pharmacies, right?

The corporate pharmacies, because as you said, they're driving the smaller independent ones out of business. Then regarding the pharmacy benefit managers, you said there's only, did I hear you right, when you said there's only three companies there?

SIROTA: There's three companies that pretty much own about 80% of the market.

CHAKRABARTI: Okay, across the United States.

SIROTA: Across the United States.

CHAKRABARTI: Repeat to me again what you said about wholesalers as well.

SIROTA: Similarly, that there are three major companies that control the majority of that market, and they're driving up costs, PBMs are driving down the reimbursements, and pharmacies are getting squeezed in the middle.

CHAKRABARTI: So there's been an overall like narrowing of the pipeline from the beginning, where wholesalers are receiving the medications, all the way to the end point, which is you, me, Shane, everyone who needs drugs.

SIROTA: Yes.

CHAKRABARTI: Okay. Wow. One more question about details here. You mentioned Caremark, right? Which I understand is actually CVS Caremark.

SIROTA: Yes. And great to point that out. So part of this whole problem is that all of these companies are very vertically integrated, as we call them. And Caremark is the largest pharmacy benefit manager, and it is owned by CVS, which is the largest

pharmacy chain. So that means that independent pharmacies are getting reimbursed by Caremark, which also has an interest in driving them out of business so that its CVS Pharmacy stores can have more business.

This is a pretty blatant conflict of interest that would not really stand in any other industry. Because health care is rather corrupt, if I must say, we allow this to happen here.

CHAKRABARTI: Oh, because I was wondering. Is Caremark also, they must be having differential pricing based on the end pharmacies that they're selling the drugs to, right?

Because I was wondering, like, why would they want to drive out their own CVS pharmacies out of business?

SIROTA: Yeah, I think part of this is also that they own a large mail order pharmacy, so that's part of the problem, too, is that through their pharmacy benefit manager, in addition to excluding independent pharmacies from their networks, they can also basically force insurance members to go to their mail order pharmacies and rely less on their brick-and-mortar stores.

CHAKRABARTI: Okay, Shane, thank you for listening along with me. Because like I said, the web here, it's hard to keep track of all of it. So I wanted to get Sara to explain stuff a couple of different times.

These are things that you already know well, I'm sure, about Shane. What did this sort of narrowing of the pipeline look like from your perspective as a pharmacist?

JEROMINSKI: I see the product of this every day, working in an independent pharmacy. Independent pharmacies are dying across the country because of reimbursements, predatory audits and the pharmacy benefits managers.

A lot of drugs, especially brand name drugs, get reimbursed below cost. So that's an unsustainable business model for any small business owner. Usually, the only way that these independent pharmacies can survive is to find a specialty niche market. The independent I work for currently services skilled nursing facilities, personal care homes, does hospice patients, some of those things that the regular chain pharmacies do not want to be involved with.

But it's very difficult to have an independent pharmacy. And that's the reason why I would say if we don't have wide scale PBM reform, 10 years from now, there'll be very little independent pharmacies left.

CHAKRABARTI: Yeah. Pharmacy benefit managers are one of the sort of less understood parts of the American health care system that I haven't gotten my head fully around yet, so I'm thinking we need to do some explainer shows about that.

But let me just play some feedback that we got from one On Point listener. Karen Hendricks of Charleston, South Carolina. Now she told us she was a pharmacy intern, a pharmacy tech, and a professional pharmacist for 37 years, and that over the past decade, working conditions at the big chain pharmacies where she was at got progressively worse, and in her opinion, it all came down to money.

KAREN HENDRICKS: Worked 12-hour days, nights, weekends, holidays. I was lucky if during the day I had time to sit, eat, or even use the bathroom. The constant barrage of prescriptions, phone calls, audits, customer questions, vaccines, and insurance problems never stopped. If I had any tech help, I was lucky. I was so burned out I left five years ago and never looked back.

It feels as if I did 30-years hard time in prison. I'm now an insurance adjuster with my husband and I live a very free and happy life.

CHAKRABARTI: Shane, can I just turn that back to you quickly? How does that land with you, what Karen said?

JEROMINSKI: That's a standard line that we hear a lot. We get thousands of direct messages to The Accidental Pharmacist page on a regular basis, whether they're pharmacists who've done 30 years, or pharmacists right out of school that don't realize that they just feel very trapped with hundreds of thousands of dollars' worth of student loans and a job that they just don't understand.

They can't even see what life is going to be like for the next 30 years, working in these conditions. And a lot of it has to do with the ancillary support staff, that the one thing that I think we haven't talked about yet is technicians are the backbone of every pharmacy in America.

And the biggest problem, why there's so many openings, is that the pay scale just is not commensurate with their skillset. And they're the ones who are, they really are the true frontline workers, pharmacy professionals. They're the ones that are dealing with angry patients. They're the ones taking in prescriptions and really putting out fire after fire.

And when you're only making 17, the Bureau of Labor and Statistics has the average pharmacy technician in America making $18.12 an hour. And it's a very stressful job for that, when you could work down the street somewhere else for the same amount of pay.

CHAKRABARTI: Now, my personal experiences with pharmacies are purely anecdotal to me.

I'm not saying that they're representative at all of larger trends in America, but over the past few years, every time I've walked into my local pharmacy, happens to be a CVS, I'm seeing a lot of tired faces behind the counter, more and more. And some of those folks just have to stay on the phone while the line for people waiting for their prescriptions gets ever longer.

But the professionals behind the counter just on the phone dealing with insurance companies or the kinds of other things you described, Shane, and even, I would say we're somewhat fortunate in my neighborhood because there are many techs and the pharmacists like working on prescriptions while all this is going on, and it's still a painful process for everyone.

Now Shane, you mentioned something which I want to just pick up on, about future pharmacists, right? And looking at working conditions right now, because, as you mentioned, it takes a ton of education to become qualified to be a pharmacist in the United States. And it just so happens that between 2011 and 2021, the number of students applying to pharmacy schools has declined by more than a third, by 36%.

Dr. Craig Cox is president of the American Association of Colleges of Pharmacy, and he says it's very concerning, and this is what he identified as the biggest driver of the decline.

DR. CRAIG COX: There really are high stress workplace conditions, and staffing

shortages in corporate community pharmacies that are discouraging young people from considering a career in pharmacy in general.

And the reason for that is that this really is the most visible sector of our profession, community pharmacy. People do this often. And I think because of it being the most visible sector, that's what our future students see. And when they see these high stress workplace conditions, I think that's having an impact on them.

And it's discouraging them from picking this career.

CHAKRABARTI: Dr. Cox told us that in 2018, There were about 15,000 pharmacy graduates in the United States, and the projection for 2026, so just a couple of years from now, is about 9,000 graduates, so a 6,000 drop for future pharmacists. Sara Sirota, I just wanted to get a sense from you, your response of this kind of downstream effect that apparently we're seeing in terms of people wanting to go into the business.

SIROTA: Yeah, I think it's very telling. Pharmacy schools were booming 20 years ago now people are not interested in going to pharmacy school. Because they see the kinds of conditions that are imposed. Both at the retail chains and also the inability of small pharmacies to survive under the current economic problems that they're facing.

And this is a huge problem. It's important to emphasize that for a lot of communities, their pharmacists are their first line of access to the health care system. Many communities don't have doctors nearby, but they do have pharmacists. And those are really important and trusted health care advisors to them, providers to them.

And they're being neglected right now. And it's important to note this.

CHAKRABARTI: Once again, we did reach out to many of the biggest pharmacies in the United States. Rite Aid did not respond to our request for comment or answers to questions. Costco did not respond either. Walmart did return our calls and told us that Walmart does not break out revenues from the 5,000 pharmacies it has.

They say most of their pharmacies are in rural areas. And Walmart also told us that their company's health and wellness business are about 11% of Walmart's total

U.S. revenue last year. So that's an interesting comparison compared to the 76%, 77% of revenues that we see from CVS.

Now, Walgreens did respond to us, sent us a statement talking about how much they're trying to they value pharmacists and what they are trying to do to assist their concerns about working conditions. They also answered a question that we had about whether there are quotas that pharmacy, pharmacists are expected to have and before I get to their response, Shane, did you experience quotas or a minimum number of prescriptions that you had to fill every day when you're working at CVS and Walgreens?

JEROMINSKI: Yes. So when I worked for the company, quotas were still tied to your pay, to your evaluation, to the bonus that you might receive. And they always had really high vaccination quotas. I worked at a store that did 2,300 vaccines, and the next year my goal was 6,000. So that gives you the perspective of how much they've ramped up what's expected and these quotas.

California just recently passed ... SB 62, two years ago, which took quotas being attached to pay and bonuses. But it's not that they don't have these metrics anymore. The metrics are used more so to put pressure on the front of the store and dangle hours, technician hours and budget hours.

So they don't tie it specifically to pay and bonuses, but those metrics are used, and quotas are used to determine how many hours you're going to get in the pharmacy. So everyone's concerned about hitting these anyway, because they want to make sure that they have enough tech support and hours attached to their pharmacy.

CHAKRABARTI: Interesting. Because Walgreens in their response to our questions about this said that in October of 2022, Walgreens announced that, quote, "We are removing task-based metrics from performance reviews for all retail pharmacy staff. A significant step is. Because we are the first and only retail pharmacy to do which helps create a differentiated working environment while supporting pharmacists' ability to focus on patient care," end quote.

And as for CVS, when we asked them about quotas, CVS said in a statement, quote, "It is inaccurate to characterize them as quotas. While we've reduced the number of metrics we measure in recent years, the information gleaned from safety and quality metrics provides us with a clearer picture of what's working and where

improvements may be needed."

And then they went on to say, "Our use of metrics mirrors what's commonly used throughout the health care industry." So we're going to talk more about what the pharmacy crisis says about the health care industry overall. And of course, we're going to try and see. Or at least explore what the potential fixes are.

Part III

CHAKRABARTI: Sara, what I'm wondering now is, we're not just talking about going to the pharmacy and buying Ibuprofen, obviously, we're talking about prescription medications. And a concern that I immediately have when I hear about the conditions that Shane and the listener Karen and other people who actually reached out to us, when they're talking about the kinds of working conditions they're experiencing is, does it not increase the probability of a mistake happening, right? And these are mistakes with prescription medications. So what kind of regulations, if any, do these major companies have to follow in order to help prevent that, if any?

SIROTA: Yeah, I think this is a good question, and I think speaks to an inherent problem of having a giant retail chains where basically executives view workers as just another cog in the machine, as opposed to the kind of personalized care that you're going to get at small, independent stores.

Certainly, there are the safety risks that we've heard about are not just about workers, but trickle to patients that are going and picking up their very necessary prescriptions. And why it's so important to protect those small independent ones, as well.

CHAKRABARTI: But so beyond that, then, can you describe if there are any federal regulations at all over the pharmacy retail business that might apply to the situation that we're seeing now. That you described that major consolidation of the business from top to bottom?

SIROTA: Sure, there are safety standards, but as we've seen across the country of CVS and Walgreens, reducing the number of staff that they have, reducing the number of hours, and then also forcing these pharmacists to take on more patients than they previously did, that creates higher concerns that are just going

overlooked.

Fortunately, there are state regulators, especially, that have been looking into this problem, especially in Ohio. I would say there's been a lot of investigations into understaffing and safety problems at the CVS pharmacies.

CHAKRABARTI: Shane, since you're there in California, you probably know this very interesting story that the LA Times had back in September.

Where they said that in a survey of California licensed pharmacists back in 2021, so a couple of years ago, 91% of pharmacists working at chain pharmacies said staffing wasn't high enough to provide patients with adequate care. And then on top of that, the state's board of pharmacy found that there are an estimated 5 million errors a year in California. And pharmacists themselves are attributing that to the staffing situation.

First of all, tell us your thoughts about that.

JEROMINSKI: For sure. I was just going to mention that the five million, and they estimated it, because there's no centralized reporting mechanism for pharmacies. So they are under no obligation to report a medication error to any regulatory body.

That just changed in California, AB 1286, which is the Stop Dangerous Pharmacies Act, was passed and signed, which now requires pharmacists, it hasn't been implemented fully yet, requires pharmacies to report those medication errors. And I think this is really important. I know everyone doesn't want to have regulation, but we need to have change here, because what's on the line for retail pharmacies versus the individual pharmacist who makes that medication error and patients, is there's a huge disparity there.

When a medication error occurs, they document it internally, but since there's no reporting mechanism right now, the only way the Board of Pharmacy finds out about a medication error is when a patient reports it.

So should a patient report a medication error, whether it's a small one or an extremely serious one, the Board of Pharmacy will come and do an investigation. After that investigation, they find out the error occurred. They might issue a fine to

the pharmacy itself for 10,000 or 50,000 on the high end if it's a serious error.

But that pharmacist, the pharmacy manager who's ultimately responsible for every prescription that goes out, could lose their license, could be on probation with the Board of Pharmacy for five years. So what's at risk for that pharmacist is so much more. And to the patients, that's why we need to have some kind of regulation here to make sure that they take it as seriously as we do.

CHAKRABARTI: Even to your point about having to document it internally, again, the LA Times reports that only 62% of chain pharmacists said the stores they were working at were following even those rules, meaning 40% of them said that those internal documentation rules weren't being followed, which is, it's quite something. Now, Sara, let me come back to you here. Because we're not strictly speaking, we're not talking about a monopoly, right?

Because there still are a couple of companies that are of major interest here, plus the remaining independent pharmacists in the United States. But given the percentage of the market that these three or four huge corporate and retail pharmacy companies have. Do you say that they're skirting some antitrust violations here or antitrust laws?

SIROTA: Certainly, and certainly in the situation of this vertical integration that I described before of having these conflicts of interest where CVS, for example, owns a pharmacy, as well as a pharmacy benefit manager, as well as a large insurer, Aetna. And we've seen cases of PBMs using their power over insurance formularies and pharmacy networks to steer patients towards their own pharmacies at the expense of independent ones.

And that certainly raises antitrust concerns.

CHAKRABARTI: It raises the concerns. Have there been any legal actions that you know of?

SIROTA: Right now, the Federal Trade Commission is conducting a sweeping investigation into the pharmacy benefit manager industry, specifically looking at those conflicts of interests.

That began last year. Right now, on Capitol Hill in Congress, there are many

different pieces of legislation that are being debated to try and rein in the excesses of pharmacy benefit managers. So there's certainly a lot of investigations going on. There's also been a number of lawsuits filed against pharmacy benefit managers.

CHAKRABARTI: Okay.

SIROTA: And pharmacies.

CHAKRABARTI: Yeah. I've read many parts from the CVS statement that they sent back to us. I just want to add something that Walgreens also told us in their response to our requests. Walgreens said, quote, "We understand the immense pressures felt across the U.S. in retail pharmacy right now.

We are engaged in listening to the concerns raised by some of our team members. We are fully committed to ensuring their contributions. And that they are acknowledged and rewarded, including competitive pay and benefits."

And they also talked about advancing their recruitment strategies and taking steps to address staffing in order to meet the needs of customers, pharmacists, experience, and to advance the profession to enable them to deliver the high value care they were trained to provide. End quote. That is from Walgreens. But Shane, you clearly don't think that is enough, that the current changes that these companies are saying are adequate. What other steps would you take, either from the company's perspective or from the perspective of workers at these pharmacies?

JEROMINSKI: So workers are taking a bold move. We just rolled out pharmacyguild.org, which is the first national push to unionize retail pharmacy workers. After the walkouts, people were looking to some of these online social media personalities in the health care field to say, "What's next? Are we going to have another walkout?

How are we going to keep?" What happens is it goes in this news cycle, and you get media attention. All these stories come out about how dangerous the working conditions are, how unsafe it is for patients. And then these companies are large enough that they just let the cycle go through and they continue with business as usual.

We decided that we were going to push for national unionization. We have the

backing of an established national international union. IAM, which is the International Association of Machinists and Aerospace Workers. They have 600,000 members. IAM health care, which is their health care component. In the past has really just been for allied medical field, hospital pharmacists, speech pathologists, but they've given us the backing and it put resources into building the pharmacy guild. The day that we launched, which was about two weeks after 'pharmageddon,' we had 30,000 pharmacy technicians and pharmacists go to the page that actually crashed the website on its first day. And the same thing happened the second day. It briefly went down. We've had thousands of people fill out the interest form, and we're about ready to start launching campaigns across the country to unionize stores.

CHAKRABARTI: So it sounds like there's a lot of business. Have you, when I say business, sorry, a lot of interest is what I meant to say. Have you received any pushback from the pharmacy companies themselves as the desire for unionization seems to grow?

JEROMINSKI: They didn't seem to think that the walkouts had that much of an impact.

So a lot of the stories that were run said, minimal disruptions in normal operations in the pharmacy. So we thought that they would respond to this. And right now, everything, it's not like the classic unionization model. Because we have this network that reaches almost every pharmacist in America. I'm working with not just The Accidental Pharmacist page, but RXcomedy.

It's another online social media advocate. Pizza's Not Working and Bled Tanoe who started that, it has a network across the country. So we're utilizing online social media to constantly engage these pharmacists and technicians. And we're just compiling data right now and making sure that we reach critical levels in every area of the country before we launch campaigns and file to have elections.

And we're just a few months out from having the first ones right now.

CHAKRABARTI: In response to our question to CVS about the efforts for pharmacists and pharmacy techs to unionize. CVS simply said, quote, "We have productive relationships with unions who represent thousands of our colleagues across the country and respect our employees right to either unionize or refrain

from doing so," end quote.

Now we wanted to, I just want to spend a minute or two talking about a really unique example of a completely different way of doing pharmacy business. And it comes from North Dakota. Because North Dakota is the only state that requires only licensed pharmacists or groups of pharmacists owning and operating a pharmacy.

Or in other words, chain pharmacies like CVS and Walgreens simply cannot exist in North Dakota, because it's all about independent pharmacies there. 171 independent and locally owned pharmacies, to be exact. Now, according to the Institute for Local Self Reliance, North Dakota prescription drug prices are more affordable than two thirds of all the other states.

They have more pharmacies per capita than their neighbor in South Dakota or in Minnesota or nationally. The law, now this is because of a state law. Which dates back to 1963. That law has been challenged several times, including in 1973, a different chain store, which is now owned by Walgreens. And in that year, the challenge made it all the way up to the Supreme Court.

So let's listen to a little bit of oral argument from this 1970s case. This is lawyer William Lucas arguing in favor of preserving North Dakota's law.

WILLIAM LUCAS: We want the people in the position of making policy to be professionals. A pharmacist has to yield to a non professional if that non professional owns the place.

He either says you do this, or you lose your job. And we don't want a professional yielding and being in that position. And we want the policymakers to be professionals so that they will offer all these services that we think are necessary.

CHAKRABARTI: So that was from a 1970s Supreme Court case that challenged North Dakota's law preventing corporate or retail pharmacies from existing in that state.

And obviously the Supreme Court ruled in favor of North Dakota. Another challenge came, interestingly, in 2014. That was brought by Walmart and put on the ballot in North Dakota. And North Dakotans defeated the ballot measure by

59%. So 59% or roughly 60/40 they wanted to keep their independent pharmacies.

Now, Sara, it's interesting to me that this law was first passed in 1963. I'm not sure I see the possibility of states taking similar action now or am I mistaken, Sara?

SIROTA: Yeah, I think that the current structure is pretty systemic, and it is difficult to imagine states copying this model, though it certainly has worked very well for North Dakota.

As you said, they have a higher number of pharmacies per capita and various metrics as shown in studies from the Institute of Local Self Reliance has shown that it works very well there. I also think that if we were to copy this model across other states and somehow get past the large corporate chains, we would still have these underlying economic problems that I spoke about earlier, that are important to address, as well.

CHAKRABARTI: The underlying economic problems of the vertical integration.

SIROTA: The vertical integration, the under reimbursement, the high cost of acquisition, these are all bigger problems throughout the supply chain that need to be addressed.

CHAKRABARTI: I see, because no matter how many independent pharmacies you have, they still have to go through the pipeline that exists now.

Okay. To that point we'll see what happens with the bill currently working its way through Congress. It seems to have bipartisan support to tackle some of these things about the pharmacy benefit management companies specifically. But in the last 30 seconds or so that we have, Shane, I'm going to give you the last word today.

What do you think the future might look like if some of these fundamental changes you've both been talking about do not happen to the pharmacy industry?

JEROMINSKI: If we don't have serious PBM reform, independent pharmacies will be a thing of the past. And just like North Dakota, independent pharmacies have a storied history of being the most accessible health care professionals in the country.

Genuine health care is going there. You have a great relationship with your pharmacist. We're trying to preserve that. So I implore every lawmaker to champion anything that deals with PBM reform. And to let patients know that we're trying our best out there, and that the situations, and when you see those long lines in the pharmacies, it's not the people behind the counter that have created this situation.

This program aired on December 4, 2023.

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