

# The Emergence Of Retail-Based Clinics In The United States: Early Observations

Will these clinics remain niche players, or can they lead the way to an extensive range of affordable, convenient services?

by Margaret Laws and Mary Kate Scott

**ABSTRACT:** Retail-based clinics have proliferated rapidly in the past two years, with approximately 1,000 sites in thirty-seven states representing almost three million cumulative visits. Clinic operators have evolved from a dispersed group of privately financed concerns to a concentrated, largely corporate-owned group. A major development has been the move to large-scale acceptance of insurance, deviating from the initial cash-pay model. Consumers' acceptance and the fact that the clinics appear to increase access for both the uninsured and the insured has encouraged providers and policymakers to consider this approach to basic, acute care while seeking a better understanding of these clinics. [*Health Affairs* 27, no. 5 (2008): 1293-1298; 10.1377/hlthaff.27.5.1293]

RETAIL-BASED CLINICS ARE SMALL PLAYERS in the health care arena, yet they have received a great deal of recent attention from consumers, the health care industry, regulators, and the media. This paper provides an overview of the emergence of retail clinics and highlights some of the operational and policy questions this model of care introduces. In the absence of independent research and empirical data, our study relies heavily on consumer survey data and interviews with eleven clinic operators and several industry experts, and it suggests areas that would merit more formal exploration.<sup>1</sup>

The retail clinic model is straightforward: offer a limited menu of mainly acute medical services on a walk-in basis; provide care through nurse practitioners (NPs) or physician assistants (PAs) with lower salaries than those of physicians; and locate in small, relatively inexpensive retail spaces for easy consumer access. Although these clinics have existed for more than eight years, in the past twenty-four months their number has grown from approximately sixty to close to 1,000 sites, managed by more than forty different clinic operators.<sup>2</sup> One operator,

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MinuteClinic (owned by the drugstore chain CVS), accounts for more than half of all clinic sites.

### **Clinic Operators/Ownership Models**

Early clinic operators such as MinuteClinic (originally QuickMedx), Take Care, and RediClinic were independent of both the health system and retail store "hosts" and were financed by venture capitalists, including Bain Capital (MinuteClinic); Beecken Petty O'Keefe and Company (Take Care); and Revolution Health (RediClinic). Almost a decade later, the landscape has shifted: most clinics are owned by either drug-store retailers or hospitals, and only about 20 percent are run by independent operators.<sup>3</sup> Several independent operators, including Wellness Express, with three sites in Longs Drugs stores in California, and CheckUps, with twenty-three sites in Florida Walmart stores, have closed down.

■ **Motivations for operating clinics.** Clinic owners and operators interviewed expressed different motivations: retailers that own clinics are interested in increasing revenues through stronger consumer relationships, increased sales of prescription and over-the-counter medications, and increased sales of general merchandise (retailer-owned only); hospitals that own clinics are pursuing strategies to either keep patients in their networks, attract new patients, or reduce inappropriate emergency department (ED) use. Independent clinic operators are focused on creating a strong business, with an eye toward either long-term operation or acquisition.

■ **Services and payment.** The initial service focus of the clinics was acute episodic rather than preventive care. Acute care has remained the focus, with 69.4 percent of visits being for five common acute conditions.<sup>4</sup> Immunizations, at close to 20 percent of all visits, are the most common type of preventive care visit. These proportions of common conditions and acute versus episodic care visits were consistently cited by clinic operators across the country in interviews.

Payment was initially made directly by consumers, with no participation by insurers. This was a key element of the early retail clinic business model; by not accepting insurance, clinics avoided the expense of working with insurers. This resulted in higher out-of-pocket payments for consumers, however: two years ago a consumer paid approximately \$60 for a visit for pharyngitis at a retail clinic—at least \$40 more than the national average copayment of \$19 at a primary care physician's (PCP's) office.<sup>5</sup> Approximately 85 percent of clinic sites now accept insurance and copayments, and most national and regional insurance carriers are working with clinic operators.<sup>6</sup> A recent survey found that 62 percent of all visits derived some part of the payment from an insurance carrier.<sup>7</sup> This important development has enabled the clinics to enter the mainstream health care system with the benefit of inclusion in insurance coverage, the credibility conveyed by the carrier, and a price that consumers find affordable. One notable exception to this trend is California-based QuickHealth, a physician-staffed model that does not contract with or accept payment from insurers.

## Consumers' Response

Policymakers, health plans, and health systems are eager to understand how consumers will make decisions in a consumer-driven health care environment, and retail clinics have provided an opportunity to explore this behavior in the marketplace. As health researchers and policymakers have observed the emergence of clinics, they have raised several questions that merit further study: Would services at retail clinics replace visits to EDs or PCPs, or would they simply be additive? Would retail clinics disrupt the PCP relationship? Would consumers prove smart enough to shop for health care services and choose appropriate venues of care for their conditions and overall health? Would consumers prefer this venue, or would they consider it to be an inferior substitute choice of locations or providers? Would price transparency prove to be a powerful force in the market?

■ **Overall satisfaction.** National, independent surveys indicate that consumers have responded quite favorably to retail clinics to date, with nearly three million clinic visits and ratings of around 90 percent satisfaction in the areas of quality of care, convenience, and cost.<sup>8</sup> Three segments have emerged as the major users: younger consumers, children, and (overlapping these two categories) consumers who report that they do not have a relationship with a PCP. Thirty percent of respondents reported having no PCP relationship, and 22 percent reported being uninsured at the time of their retail clinic visit.<sup>9</sup>

■ **Appropriateness of venue.** Interviews with and data presented by several clinic providers reveal that to date, consumers have selected retail clinics for appropriate uses, with approximately 95–98 percent of patients presenting to clinics with conditions that can be treated by the clinic staff.<sup>10</sup> One 2006 survey of 800 consumers identified as key features the price-transparency of services with “menus” of treatments, a preference to be seen by an NP rather than a physician, and convenience of location with an assurance of an appointment time.<sup>11</sup>

■ **Quality of care.** Although little analysis of clinical quality at retail clinics is available, one early study analyzing 57,331 patient visits for pharyngitis documents better than 99 percent adherence to clinical guidelines.<sup>12</sup> These results compare extremely favorably with other documented rates of PCPs' adherence to guidelines in the care of acute pharyngitis.<sup>13</sup> This study was conducted with one clinic operator; data should now be available to support more extensive studies of adherence across retail clinic models and operators.

## Industry's Response

■ **Physician organizations.** Some groups from organized medicine have responded to the emergence of retail clinics with conditional support (the American Academy of Family Practice [AAFP] issued a list of desired attributes for retail clinics, and RediClinic, MinuteClinic, and Take Care Health Systems have all signed an agreement to adhere to these guidelines). The American Medical Association

(AMA) issued principles very similar to those of the AAFP.<sup>14</sup> The American Association of Pediatrics (AAP) issued a formal opposition to retail clinics as sites of care for infants, children, and adolescents and “strongly discouraged their use” but, recognizing the likely spread of the model, also issued principles for retail-based clinics treating pediatric patients.<sup>15</sup>

■ **Health systems.** Several health systems have entered the retail clinic marketplace, either with their own branded offerings inside retail stores (for example, Sutter Express Care in Rite Aid) or with a cobranded venture (the Clinic at Walmart by Memorial Hermann Medical Center, operated by RediClinic). Walmart has indicated its intent to launch 400 clinics with local health systems across the country by 2010.<sup>16</sup> Systems indicate that these alliances enable them to offer their members simpler, more convenient access to basic care. These relationships also offer the potential for the health system, clinic operator, and retail host to collaborate on an information system that allows patients’ data from the retail clinic visit to be integrated with the health system’s electronic medical record—if it has one.

■ **Regulatory response.** Most regulations affecting retail clinics—licensure, staffing, and facilities requirements—are under the jurisdiction of the state in which the clinic is located; thus, there is much variation across the United States.

Several states have responded to the emergence of clinics with regulatory concerns or actions, led both by health care industry interests seeking to prevent clinics from opening in the state and by groups looking to retail clinics to help offer improved access to basic care in states seeking to expand health coverage. Issues raised have included ownership of clinics, providers’ prescribing authority, oversight of nonphysician clinic staff by physicians, physical characteristics of the clinic facilities, and potential conflicts of interest where patients fill prescriptions in pharmacies housing a retail clinic. In January 2008 the Massachusetts Public Health Council issued rules governing operation of “limited care clinics” and appointed a new medical director to oversee care in the clinics.<sup>17</sup>

Oversight of NPs has been one of the biggest issues of contention in regulatory discussions around retail clinics. Twenty-three states now require no physician involvement, four require physician involvement without written documentation, and twenty-four require physician involvement with written documentation.<sup>18</sup> There are factions both pushing to make these state-level rules stricter and wishing to see these regulations relaxed.

### Potential Effects Of Clinic Proliferation

■ **Reduced demand for PCPs.** As clinics proliferate and their use increases, PCPs may see reduced demand to treat minor conditions. This issue merits further study, and a few retail clinic markets are becoming mature enough that data to test this hypothesis should be available. Although this development might allow physicians to concentrate on care that requires their more extensive level of training, there are several potential effects worth noting.

*“Clinics’ move into the mainstream health system has quelled some of the early opposition from the medical community.”*

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Losing shorter, simpler visits could have a financial impact on PCPs’ practices. Although the remaining PCP visits are likely to be appointments for more-complex conditions and chronic disease management, both of which are reimbursed at higher rates, they might also result in more unreimbursed care (for example, case management and counseling) for the practice outside of the physician visit.

■ **Advances in technology and shifts in care delivery.** This shift in care delivery suggests that there are diagnoses and treatments that, with advances in medical science and technology, have become sufficiently routine and rules-based to move from a physician to a health care professional with lesser but appropriate training. If so, what are the criteria for these conditions, diagnoses, and treatments? This is a critical issue, because it appears likely that this set of conditions will increase with advances in technology. As primary care evolves, the question of what care is provided by physicians and what can and should be provided by health care professionals with less intensive training (or by patients themselves) will continue to be a topic of much debate. Given concerns about current and pending shortages of PCPs, this is also an area that merits further exploration and dialogue.

■ **“Good enough” or better?** Initial response to the clinics has raised the question of whether they are a “disruptive innovation” in health care. That is, do they make available to consumers a more affordable, “good enough” option for health care—at least for a segment of patients’ care needs? In keeping with the disruptive-innovation paradigm, one major question for researchers, policymakers, and industry observers is whether these clinics can “move up the value chain” and provide a more extensive range of services in the same affordable, convenient fashion. Some clinic operators have indicated plans to do so—most notably RediClinic, emphasizing services such as wellness and prevention that have traditionally been offered by costlier health care providers.

**A**NALYSIS OF RETAIL CLINICS’ IMPACT on patients and the broader health care system has just begun, but important issues for further exploration include quality of care in clinics, including adherence to evidence-based guidelines by providers in these clinics as compared with those in other primary care settings; contribution to providing basic access to those without insurance or a PCP; effectiveness in connecting consumers with other providers where appropriate; and the extent to which clinic visits are replacing inappropriate ED visits. In the meantime, clinics’ move into the mainstream health system, through participation in insurance and alliance with local health systems, has quelled some of the early opposition from the medical community.

**NOTES**

1. Authors' interviews with executives from the eleven largest clinic operators, collectively representing 85 percent of all clinic sites, November 2007 through January 2008.
2. Merchant Medicine, monthly retail clinic market summaries, available at <http://www.merchantmedicine.com/Home.cfm>. Note that these numbers are updated regularly.
3. As of 1 March 2008, 492 of the 921 clinics in operation were owned by CVS/MinuteClinic; hospitals owned 15 percent, and approximately 35 percent were independent. *Ibid.*
4. A. Brower, "Retail Medical Clinics Draw Patients and Payers," *Managed Care Magazine*, June 2006, <http://www.managedcaremag.com/archives/0606/0606.minuteclinic.html> (accessed 18 June 2008).
5. G. Claxton et al., "Health Benefits in 2007: Premium Increases Fall to an Eight-Year Low, while Offer Rates and Enrollment Remain Stable," *Health Affairs* 26, no. 5 (2007): 1407-1416.
6. See Note 1.
7. Harris Interactive, "New WSJ.com/Harris Interactive Study Finds Satisfaction with Retail-Based Clinics Remains High," 21 May 2008, <http://www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=1308> (accessed 18 June 2008).
8. *Ibid.*
9. *Ibid.*
10. Authors' interviews with representatives of MinuteClinic, RediClinic, the Little Clinic, and QuickHealth, March 2008.
11. Scott and Company, "Consumer Preferences and Use of Retail Clinics," 2006 (slide presentation), [http://www.marykatescott.com/docs/Consumer\\_Preferences\\_and\\_Uses\\_of\\_Retail\\_Clinics\\_2006.ppt](http://www.marykatescott.com/docs/Consumer_Preferences_and_Uses_of_Retail_Clinics_2006.ppt) (accessed 23 July 2008).
12. J. Woodburn, K.L. Smith, and G.D. Nelson, "Quality of Care in the Retail Health Setting Using National Clinical Guidelines for Acute Pharyngitis," *American Journal of Medical Quality* 22, no. 6 (2007): 457-462.
13. R. Gonzales et al., "Excessive Antibiotic Use for Acute Respiratory Infections in the U.S.," *Clinical Infectious Diseases* 33, no. 6 (2001): 757-762.
14. American Academy of Family Physicians, "Desired Attributes of Retail Clinics," June 2006, <http://www.aafp.org/online/en/home/publications/news/news-now/professional-issues/20070201retailhealth.html> (accessed 18 June 2008).
15. Retail-Based Clinic Policy Work Group, "AAP Principles concerning Retail-Based Clinics," *Pediatrics* 118, no. 6 (2006): 2561-2562.
16. "Wal-Mart Plans to Open Health Clinics," *Baltimore Business Journal*, 7 February 2008, [http://www.cpnonline.com/cpn/content\\_display/regions/southeast/e3i61954dce5d766db34fec4dd690659c1e](http://www.cpnonline.com/cpn/content_display/regions/southeast/e3i61954dce5d766db34fec4dd690659c1e) (accessed 1 June 2008).
17. Regulatory language available at Massachusetts Department of Public Health, *Licensure of Clinics*, <http://www.massleague.org/CHCManual/105CMR140.pdf> (accessed 18 June 2008).
18. T. Hansen-Turner et al., "Convenient Care Clinics: The Future of Accessible Health Care," <http://www.convenientcareassociation.org/WhitePaperforDistribution.pdf> (accessed 18 June 2008).