Addressing the Fundamental Problem of Primary Care

Information Sources

Google Scholar, Google search, AMA, ANA, AAFP, AAPA, news articles (BusinessWeek, Wall Street Journal, Kaiser Health Network, etc.)

Executive Summary

The number of retail clinics continues to rise, supplying evidence that their utilization as a substitution for what the primary care service system fails to deliver is becoming increasingly common. However, the expansion of retail-based health clinics is not directly addressing the problem at hand; rather, it provides substitutions that are ineffective in helping to bring change that primary care is in dire need of. There are several options for solutions that can be used to address this problem, one of which is the promotion and investment into expanding medical programs for an increase in number of medical graduates and evaluation of medical school curricula across the country to include a greater emphasis on the importance of primary care physicians.

Background

In recent years, more patients in need of simple medical care are choosing to visit retail-based health clinics rather than primary care providers. Retail clinics, which aim to provide preventative health education and services, are largely supervised by nurse practitioners that can perform various functions including the following: diagnosis, all aspects of laboratory testing, provision of drug prescriptions, and more (American Nurses Association [ANA], 2008, p.3). Since its first establishment in 2000, more than 1600 retail clinics are in operation in 42 states of the country today (Merchant Medicine, 2014). The number of these walk-in retail clinics is only projected to grow with mass merchandisers with heavy traffic such as Walgreens and CVS Caremark announcing plans to add to their number of operating clinics and expand their services. Former chief economist at the U.S. Department of Labor, Diana Furchtgott-Roth, reports that the total number of clinics is expected to double by 2016 (MarketWatch.com, 2014). Retail clinics enjoy more lenient regulations; for example, they are relieved of the financial burden of malpractice insurance that physicians' offices are subjected to, and they do not have conflict-of-interest regulations that restrict physicians (Furchgott-Roth). And research shows that though there are statewide policies that define the scope of practice, no regulations exist that will directly put a barrier to the growth of retail clinics (California Health Care Foundation, 2009).

The increasing popularity of retail clinics serves to indicate the problem that due to the deficiencies of primary care medicine in the United States, patients are left with little choice but to utilize services provided by retail clinics. Some of the factors that are fueling the problem include the cap imposed on medical schools for the number of students accepted into medical programs each year, changes in the national insurance policies due to the Affordable Care Act, and the significant difference in reimbursements and salaries between specialists and primary care physicians. This is a critical situation at hand, as diagnoses and treatment given at retail clinics are lacking the medical knowledge and authority that board-certified physicians can provide, but patients are unable to obtain appointments or high-quality care from PCPs due to the inadequate supply of doctors. This problem also has unexpected consequences regarding the scope of practice of nurse practitioners, physician assistants, and others. The realm of responsibilities and treatment of these healthcare providers is increasingly in conflict with that of

physicians, and the matter is further complicated by the fact that regulations do vary between states.

Evidence

Policy and position statements put forth by the American Academy of Family Physicians (AAFP), American Medical Association (AMA), American Nurses Association (ANA), and the American Academy of Physician Assistants (AAPA) were consulted to understand the opinions of the different stakeholders regarding the current situation. Articles from the Journal of the American Medical Association, the Wall Street Journal MarketWatch, Businessweek, and others were utilized to understand the past, current, and future of retail clinics and their impacts on the society, and synthesize solutions that would directly address the problem.

Problem

The current problem of the proliferation of retail-based health clinics is that 1) it merely serves to provide substitutions and alternatives to help patients circumvent the problems found in the healthcare system, 2) exacerbates the fragmentation and deterioration of primary care services and leave patients little choice but to utilize care from retail clinics, and 3) creates a secondary problem of the emergence of conflicts between physicians and other healthcare providers regarding scope of practice and permitted services. This problem, as defined based on the positions of the AAFP and the AMA, describe the increase of retail clinics as being invasive and harmful to the US healthcare system.

Out of the 1600 retail clinics in the country, only 172 of them are run by hospitals (Merchant Medicine). Clinics do not have access to the patients' past medical history or list of prescriptions when they see patients for what seem to be minor conditions. Lack of coordination with the physician's office will cause fragmentation of the patient's medical care to occur, and the absence of comprehensiveness in medical services might cause critical diagnoses to be missed or prevent complex medical needs from being addressed (AAFP, 2014). Though Andrew Sussman, President of MinuteClinic run by CVS Caremark, claim that it is not the company's goal to "replac[e] the primary-care physician" but instead strive to become a major "support and complement to primary-care practices" (Stock, 2014), patients utilizing those services will continue to seek lower-quality treatment from these locations hoping to avoid dealing with the broken primary care system as much as possible. The continued diversion of patients towards retail clinics will further worsen the issue of poor primary care services and PCP shortages, as the decreased demand will provide less motivation for the government and policymakers to improve primary care conditions, and less incentive for medical graduates to choose primary care as their career path.

In addition, a secondary concern that involves physicians and other healthcare providers is that the boundaries for the scope of practice among these health workers is becoming more blurred. The AMA has made its position clear regarding store-based health clinics, calling for all clinics to adhere to a specific and limited set of services, disclose fully to patients regarding the qualifications of those providing care and the limitations in diagnosing and treating certain types of illnesses, and use electronic health records to allow smooth communication between retail clinics and PCPs about patient information and continuation of care (AMA 2008). However, the ANA and AAPA continue to undermine the established territory of primary care physicians by expanding the NPs' and PAs' roles into maintenance of chronic conditions (Kaiser Health News, 2013).

Policy Options

The following are possible solutions that address the breakdown of the primary care services in the United States:

1. Prohibit all insurance plans from covering retail clinic visits and mandate plans to steeply raise the out-of-pocket fees per clinic visit
2. Invest financially into creating greater incentives for medical school graduates to enter into primary care
3. Invest financially into expanding the capacity of accredited medical programs to increase the number of graduates, and restructuring school curricula to emphasize the importance of primary care

Potential pros and cons of the above options are as follows. First, prohibiting insurance plans from reimbursing retail clinic visits and mandating an increase of user fees would be effective in decreasing the rate of utilization of these retail clinics, thereby increasing the demand for primary care services and their improvement. However, this has low feasibility due to ethical considerations and the debate over the role of the government.

Secondly, investing funds into giving recent medical school graduates more incentive to enter primary care would address the issue of shortage of physicians, unreasonable wait times for an appointment, and more. Studies show that there is a significant difference in the lifetime earnings between specialists and primary care physicians. This amount can reach up to $2.8 million on average (Leigh, Tancredi, Jerant, Romano, & Kravitz, 2012). Eliminating this gap by increasing the salary and benefits will increase the number of primary care physicians and address the problem of physician shortage. However, this option will intensify the sentiment that many choose the profession of a medical doctor purely for financial gains, and the act of seeing patients is purely for income and not for the benefit of those in medical treatment. The current reputation of primary care physicians is in need of improvement, but continuing to go against the "Appropriate Ends" section of the Hippocratic oath by using bribes and incentives to attract graduates to primary care will only further worsen its reputation, and therefore not recommended.

Recommendation

It must be recognized that the main selling point for retail clinics is "convenience," and while they may bring patients closer to medical services faster, visits with NPs or PAs with whom the patient does not have a pre-existing relationship is akin to choosing to "patchwork" only those certain areas that are obviously in need of treatment. Therefore, a solution that will improve the primary care system and bring patients back under the care of a board-certified physician should be chosen. Therefore, the third option in the previous section would be the best in terms of its feasibility and effectiveness. When the increase in program size occurs and more students are being admitted to school every day, this will naturally produce more physicians and thereby answer the problem of physician shortage. And the restructuring of courses and curriculum across all medical schools in America will increase the students' awareness of the importance of primary care services, especially in light of the aging population and the implementation of the Affordable Care Act (AAMC 2010). Students will then gain a sense of philanthropy and self-sacrifice, and this will prevent students from choosing to become specialists only based on salaries.

It is therefore recommended that the American Medical Association, the American Medical Students Association, and the Association of American Medical Colleges work with the accrediting body, the Liaison Committee on Medical Education, to lobby for increased funding for the expansion of programs and restructuring of curricula. This will effectively shift the focus back from retail clinics to the heart of the problem—on the inadequacy of primary care in the United States. Instead of spending time and resources lobbying for greater restrictions and regulations over retail clinics, those same resources can be better used in addressing the fundamental problems that caused the increase of retail clinic utilization in the first place.

Works Cited

Appleby, J. (2014). Walgreens Becomes 1st Retail Chain To Diagnose, Treat Chronic Conditions. Retrieved from http://www.kaiserhealthnews.org/stories/2013/april/04/walgreens-primary-care-services.aspx

American Academy of Family Physicians (2014). Retail Clinics. Retrieved from http://www.aafp.org/about/policies/all/retail-clinics.html.

American Nurses Association (2008). Additional Access to Care: Supporting Nurse Practitioners in Retail-based Health Clinics. Retrieved from http://nursingworld.org/FunctionalMenuCategories/AboutANA/Leadership-Governance/NewCNPE/CNPEMembersOnly/PastMeetings/Fall2008Meeting/RetailClinicspositionstatement.pdf

American Medical Association (2008). H-160.921 Store-Based Health Clinics. Retrieved from https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=%2fresources%2fhtml%2fPolicyFinder%2fpolicyfiles%2fHnE%2fH-160.921.HTM

California Health Care Foundation (2009). Retail Clinics: Six State Approaches to Regulation and licensing. Retrieved from http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/R/PDF%20RetailClinicsSixStateApproaches.pdf

Furchtgott-Roth, D. (2014). CVS, Walgreens get helping hand from Obama. *MarketWatch: The l Street Journal*. Retrieved from http://www.marketwatch.com/story/cvs-walgreens-get-helping-hand-from-obama-2014-04-11

Leigh J. P., Tancredi, D., Jerant. A., Romano P.S., & Kravitz R. L. (2012). Lifetime earnings for physicians across specialties. *Medical Care, 50*, 1093-1101.

Merchant Medicine (2014). Merchant Medicine: Taking Medicine to the Marketplace. Retrieved from http://www.merchantmedicine.com/home.cfm

Stock, K. (2014). Pediatricians See Risk—to Kids and Themselves—in Drugstore Health Clinics. *Bloomberg Businessweek*. Retrived from http://www.businessweek.com/articles/2014-02-24/pediatricians-see-risk-to-kids-and-themselves-in-drug-store-health-clinics