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Policy Memo – Retail Clinics

Executive Summary: As retail clinics become an increasingly accessible and popular means of treating non-urgent, minor medical conditions, some physicians groups have expressed concern inducing policy-makers to take steps to address any risks. Regulators and policy-makers must review the existing data and move forward with an appropriate strategy that meets the FTC’s commitment to protecting both competition and the quality of care consumers receive as well as preventing unfair or deceptive practices by business retail clinic business owners, while considering physicians’ concerns about the impact on the doctor-patient relationship and management of care.

Background: Retail Clinics, healthcare clinics located in retail locations such as grocery stores, retail pharmacies and big-box discount stores, have become an increasingly popular method for consumers to seek out preventive care and care for non-urgent minor health issues by providing services at convenient locations and typically at a lower cost and with shorter wait times. Deloitte’s 2008 report *Retail Clinics: Facts, Trends and Implications* calls this shift “an important and growing part of the U.S. primary care delivery system.” Though the economic downturn has slowed the rate of growth of these clinics, the growth rate is expected to increase again during the economic recovery. Another important trend is that insurance companies are increasingly starting to cover services offered by these retail clinics, while clinics are expanding the kinds of services offered. Other hosts are entering the market including hospitals and employers. Another factor that differentiates these clinics from other clinics like urgent care clinics, emergency departments and other physicians’ offices is that often the care provided at retail clinics is provided by registered nurses or physician’s assistants as opposed to physicians. Some physician’s groups are staunchly opposed to retail clinics citing that the quality of care provided by non-physicians is subpar. Additionally, they argue that the doctor-patient relationship as well as patient care management may be compromised when patients visit these clinics. They cite that affiliates at the clinics are making decisions without the full scope of the patient’s medical information which can result in lower quality of care and duplicate tests leading to higher health care costs. As the convenience healthcare landscape continues to change and as forecasts continue to anticipate industry growth, many states have begun to consider regulation of these retail clinics. Legislation considered includes limiting the scope of services, requiring certain reporting procedures,

requiring permits or licensure, advocating for different levels of supervision for PA's, NP's and other non-physicians typically employed at clinics or granting permission to open clinics in Massachusetts where the political landscape was hostile towards expanding clinics.

Evidence: According to the Mehrotra study, retail clinics are serving a population that is typically underserved by primary care physicians. Only 39% of retail clinic visitors had a primary care physician compared to a national average of 81%. However, the Ashwood study did not show an association between retail clinic use and available primary physicians such that retail clinic use was not greater in areas with fewer physicians. Additionally, ten health issues, including respiratory, eye and ear infections and immunizations, make up 90% of retail clinic visits, indicating that there is a very specific market and need for these clinics. The percentage of visits for these conditions at PCP's or emergency rooms is much less concentrated. Though Weinick found that about 30% of urgent care visits were for respiratory illness, the proportion to overall care was much lower than at retail clinics. Musculoskeletal injuries were a large proportion of these urgent care visits but rarely seen at retail clinics. Only 2.3% of retail clinic patients were referred to an emergency department, though there is little evidence to show a reverse trend – one that alleviates stress on emergency rooms. However, given growth projections, more access to convenient and lower-cost care point to the potential to see a shift from emergency department care to retail clinic care for non-emergency care. Regarding the doctor patient relationship, the Mehrotra study found that three-fifths of patients did not report having a PCP. This indicates that for a large proportion of those patients using retail clinic services, there is no relationship to disrupt. Similarly, continuity would not be adversely affected if there is no primary physician. The Weinick study further points out that a smaller percentage of uninsured patients seek care at an emergency facility than at a retail clinic, a statistic which seems to follow the difference in price. Among insured, the strongest indicator of retail clinic use is proximity to a location. As retail clinic growth increased, so did use by those near a retail clinic location at a much higher rate. Another strong indicator of retail clinic use among the insured is income level. People in a higher income bracket are more likely to use a retail clinic. Ashwood suggests this could be due to putting a higher value on their time.

Problem: Given the changing landscape of healthcare and the emergence of a new kind of health care provider, policy-makers must consider three options toward regulation, considering the needs of the user, the business climate and any third-party impact:

1. Regulate: Implement some kind of regulation, the magnitude and reach to be

determined.

2. Do not regulate: Leave the industry as is and allow the market to regulate itself.
3. Table regulation until a clear need emerges: As limited research exists on the benefits and drawbacks, wait to see if a pattern emerges that requires a legislative intervention.

Policy Options:

Option 1 – Pros: Regulation will attack some of the issues related to the increase of retail clinics. First, it will provide consistency across retail clinic locations. Users will know what services they are able to get at any retail clinic location. It will also provide consistency across which industries can host a retail clinic. The consistency and transparency of how these retail clinics are allowed to behave provides protection to the consumer and evens the playing field for the industry. Regulation of the non-physicians working in retail clinics can provide consistent oversight, hopefully resulting in consistent quality of care and health outcomes. Regulation of the practices at retail clinics, particularly involving information flow between physician and retail clinic, will also help to eliminate extra tests and misdiagnosis due to lack of patient history.

Cons: The main issue with legislation at this point is that it is not entirely clear what the trend will be. Though the evidence projects continued growth, it may be pre-emptive to implement regulation without having the full picture. Unintended consequences may emerge that might be counterproductive to the legislation. In contrast to protecting consumers and competitors from industry entrants who champion potentially unsafe practices, regulation may also create barriers to entry. If the implemented regulation is too rigid or specific, this may hinder innovation and restrict growth of a space that potentially fills an unmet need of low-cost, convenient healthcare for non-emergencies. Implementing legislation too early may be perceived as biased towards the medical associations and may tarnish a perception of neutrality.

Option 2 – Pros: The services provided at retail are most often routine and easily treatable. Evidence shows that patients are often referred to other facilities in the event the condition cannot be cared for in the retail clinic. There is no evidence for adverse health outcomes from care received at retail clinics. As the industry stands, the evidence does not point to a cause for alarm. To the contrary, some evidence points to retail clinics providing increased access to affordable and timely health care for many populations who may not have received the services before due to convenience or cost. Additionally, the data does not show that health care utilization with physicians is impacted.

Cons: Not regulating from the beginning could become problematic down the line. Growth

of the industry could expand to include not just location growth but also an increase in services provided. Regulation could be crucial to maintaining a standard of safe practices. Without it, clinics may begin to provide services that are best left to other kinds of clinics, which may lead to negative health outcomes and overspending. In addition, not taking any steps to regulate could alienate powerful physicians groups like the AMA.

Option 3 – Pros: Because this an emerging industry with patterns of growth that aren't yet fully identifiable, we need more research and concrete data to see if retail clinics are in fact a cost-effective option, for who and for what services. We need good research on the effectiveness and quality of treatment. In addition, we need evidence for the AMA claims that retail clinics are disruptive to primary care. Effects on third parties must be considered as well. As retail clinics grow along with insured users of those clinics, it is important to note the impact of lower costs of care on insurance companies. However, given the increased convenience of these clinics, the growth could also result in increased healthcare consumption, costing more. Waiting for a fuller picture to emerge provides a strong basis to make the best policy decision.

Cons: Waiting to implement regulation runs the risk of not intervening quickly enough if problems of disconnectedness from primary care does emerge. In addition, there is the same risk from the second option of alienating powerful physicians groups like the AMA. Finally, data may be difficult to collect. Certain outcomes, such as adverse health effects, may be difficult to attribute specifically to care at retail clinics. Enough sufficient data may never exist. Policy-makers may always have to make decisions from inconclusive evidence and waiting to take action only prolongs the inevitable.

Recommendation: We recommend the third option which calls for waiting for more data. From the data that currently exists, projections suggest that growth of the industry will only continue. The usage trends are still only speculation. Creating legislation at such an early stage may be misdirected as well as difficult, costly and time consuming to refine. Much of the evidence points to retail clinics as a cost-effective alternative for a subset of minor, non-emergency procedures and care and increases access to health care for certain populations. The data does not show reduced primary care with physicians. The industry still requires more data to validate concerns of physicians associations. It is important that if, eventually legislation is required, that it is evidence based and maintains neutrality with regard to different stakeholders.

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