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Out of the Box: The Future of Retail Medical Clinics

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Last year, retail medical clinics seemed to be the next wave in American health care. Following the example set by banks and beauticians, dozens of cheap, convenient sites offering basic medical diagnosis and treatment, usually from nurse practitioners, opened in brand-name chain drugstores, supermarkets, and “big box” discounters.¹ Investors flocked to them. Business school professors labeled them “disruptive innovation.”² Policy experts lauded their potential.³ And, tellingly, the organized medical profession huddled together against their gathering storm in ways reminiscent of physicians’ response to managed care organizations a decade ago.

Then the wave broke.⁴ Start-up costs proved unexpectedly high, and revenues failed to meet projections. Some markets became saturated. Others ran into regulatory or staffing barriers. A few clinic chains failed; others retrenched. Retail care providers reached accommodation with established professional groups. Financing of services was absorbed into health insurance. Commentators began to analogize retail clinics to the

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¹ The first detailed health policy report on retail clinics was issued in July 2006 by the California Health Care Foundation. See MARY KATE SCOTT, HEALTH CARE IN THE EXPRESS LANE: THE EMERGENCE OF RETAIL CLINICS (2006), <http://www.chcf.org/documents/policy/HealthCareInTheExpressLaneRetailClinics.pdf>. QuickMedx, the predecessor to MinuteClinic, opened the first such clinic in 2000 in Minneapolis-St. Paul. *Id.* at 8.

² CAL. HEALTH CARE FOUND., PROCEEDINGS OF THE CALIFORNIA HEALTH CARE FOUNDATION/HEALTH AFFAIRS ROUNDTABLE, RETAIL CLINICS: DISRUPTIVE INNOVATION IN PRIMARY CARE? 4 (2008), <http://www.chcf.org/documents/policy/HARoundtableRetailClinics.pdf>.

³ See, e.g., William M. Sage, *The Wal-Martization of Health Care*, 28 J. LEGAL MED. 503, 511–17 (2007); William M. Sage, *Might the Fact that 90% of Americans Live Within 15 Miles of a Wal-Mart Help Achieve Universal Health Care?*, 55 U. KAN. L. REV. 1233 (2007).

⁴ See Daniel Costello, *Report from the Field: A Checkup for Retail Medicine*, 27 HEALTH AFF. 1299 (2008) (describing uncertainty over the future of retail clinics).

“doc-in-the-box” craze and other medical fads.⁵ The novelty, it seemed, had worn off. Perhaps more importantly, the threat to the medical establishment appeared to fade as well.

Are retail clinics the future? The answer depends, as a former President might have argued, on what “are” means. If retail clinics are merely another attempt to dazzle Wall Street with growth and profit potential by moving private health care revenue streams onto publicly tradable balance sheets, the current economic downturn will kill them quickly. If retail clinics are neighborhood sites for strep tests, flu shots, and migraine treatments, they should survive but will remain merely a niche player in the health care system. However, if retail clinics continue to anticipate and meet patients’ needs, they may represent the beginning of a movement to derive value from the connection between medical care as commonly understood and non-medical determinants of health.

This article describes the retail clinic movement, and explores both its advantages and its limitations as a model for cost-effective, accessible delivery of basic medical care in the United States. In its conclusion, the article offers the Obama administration some suggestions on how to obtain the greatest public benefit from retail clinics and similar innovations in health care delivery. The principal lesson, however, is conceptual: retail clinics demonstrate that health insurance reform is necessary but not sufficient for long-term improvement in American health care and population health.

The Business Model

Unlike the “medical home” and other aspirational models for innovative health care delivery,⁶ retail medical clinics have been organized and reduced to practice in a clear, reproducible manner.⁷ They provide basic medical services to adults and families

⁵ “Doc-in-the-box” refers to small medical offices opened in shopping malls and other retail spaces in the 1980s. These physician-run businesses, some of which survived, were oriented toward treating minor emergencies, did not offer cost savings, and failed to attract widespread demand. See Mitchell Katzman, *Freestanding Emergency Centers: Regulation and Reimbursement*, 11 AMER. J.L. & MED. 105 (1985).

⁶ “Medical home” is a phrase used to describe an accessible, reliable source of comprehensive medical care. Beginning in the 1960s, various professional groups endorsed different versions of medical homes, often focused on particular populations and services. Connotations of familiarity, empathy, and social connectedness have brought the medical home back into vogue as a policy concept, in contrast to reforms that stress commercial efficiency and advanced technology. However, significant ambiguities remain unresolved. See Robert A. Berenson et al., *A House Is Not a Home: Keeping Patients at the Center of Practice Redesign*, 27 HEALTH AFF. 1219 (2008).

⁷ For an overview of the retail clinic business model, including information on many of the points raised in this section, see Margaret Laws & Mary Kate Scott, *The Emergence of Retail-Based Clinics in the United States: Early Observations*, 27 HEALTH AFF. 1293 (2008); MARY KATE SCOTT, CAL. HEALTHCARE FOUND., HEALTH CARE IN THE EXPRESS LANE: RETAIL CLINICS GO MAINSTREAM (2007), <http://www.chcf.org/documents/policy/>

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with older children who refer themselves without appointments. They are located in compact spaces in stores that are branches of large retail chains, and they highlight the convenience that comes with geographic proximity and extended hours. They offer low, posted prices for a clearly described menu of services. Both clinical and administrative tasks are performed by mid-level health professionals such as nurse practitioners and physician assistants, who practice using written protocols with electronic recordkeeping, decision-support software, and telephonic physician supervision.

Corporate Structure. Retail clinics nonetheless display significant variation and ambiguity, only some of which reflects the disequilibrium inherent in a new business form. Corporate structure is still unsettled. A few emerging brands are truly retailer-operated, such as MinuteClinic, a formerly independent venture that is now owned by CVS. In other cases, independent clinic operators (e.g., Redi-Clinics, which does business in HEB supermarkets and Wal-Mart stores) are hosted by large chains under master agreements, often with store branding or co-branding. In still other cases, local non-profit hospitals and established physician groups are being invited to install store-based clinics with limited oversight by the corporate partner (Wal-Mart has also utilized this model). Moreover, because of state regulatory requirements and concern over consumer acceptability, many retail clinic sites are controlled by professional rather than general business entities. Staff providers have contractual but not employment relationships with the umbrella corporation. Finally, some hospitals that have built integrated delivery systems of inpatient and ambulatory care are creating store-based sites in their communities.

Services Provided. Although retail clinics share the fee-for-service incentives of existing provider settings, they have pursued a low-margin market segment often ignored by physicians and acute-care hospitals. Restricted not only by the limited licensure of their health professionals but also by lack of physical space, privacy, and even plumbing, retail clinics designed their service offerings to be quick, standardized, affordable, and uncontroversial. The clinics avoid medical problems that involve expensive specialist skills or technologies, require detailed or prolonged physical examination to overcome residual uncertainty about diagnosis, or carry risks of severe injury or death. Routine testing and treatment for common or commonly feared infections (e.g., throat, ear, eye, sinus, and urinary tract) is a mainstay of the business model, along with relief of acute discomfort (e.g., headache, allergy, minor trauma) and universal preventive care (e.g., immunization).⁸ Future demand for these services is finite, however, and may diminish if home testing or Internet consultation becomes widely available. Therefore, clinic operators are beginning to consider higher-margin services that patients might prefer receiving closer to home, such as infusions for cancer care and ongoing monitoring and treatment of severe chronic conditions (e.g., diabetes, heart disease). This may bring clinics into direct competition with established providers.

HealthCareInTheExpressLaneRetailClinics2007.pdf; Richard Bohmer, *The Rise of In-Store Clinics – Threat or Opportunity?*, 356 NEW ENG. J. MED. 765 (2007).

⁸ See Ateev Mehrotra et al., *Retail Clinics, Primary Care Physicians, and Emergency Departments: A Comparison of Patients' Visits*, 27 HEALTH AFF. 1272, 1276–1279 (2008).

Relationship to Health Insurance. Clinic operators have already altered one of the bedrock assumptions of the retail model: they now accept health insurance. Store-based medical care was originally conceived as a premium service for well-to-do consumers. Customers would supposedly pay cash for geographic proximity, convenient hours, and avoiding the hassles of managed care. It soon became apparent that a growing number of uninsured or underinsured Americans, including recent immigrant groups, also found clinics attractive because cost was predictable, time off work to obtain care was minimal, and the retail brand and setting were familiar.⁹ Low prices were essential to this population, but accepting insurance was not. Overall, the clinics believed that a cash-only trade preserved their independence, reduced administrative burdens, and improved staff productivity.

Surprisingly, this has changed and the great majority of clinic visits are now covered by health insurance. Health insurers found the cost-controlled nature of retail clinic services attractive and waived co-payments for many visits. Unlike traditional settings, an insured patient contacting a retail clinic did not invite a seemingly limitless array of expensive tests and specialist referrals. At the same time, insured patients refused to “pay twice” for medical care, and insisted that clinics bill their insurers. As clinic operators began to offer more services, established providers attempted to replicate retail convenience in their own organizations, and state Medicaid programs sought retail clinic contracts, a much closer connection to health insurance emerged than the originators of the retail clinic industry ever intended.

Value (and Values) Added

To observers, retail medical clinics seemed exciting in part because so little else was happening on the health policy landscape. Government-driven health insurance reforms failed spectacularly in the early 1990s, and employer-driven managed care followed the same path a few years later. Biomedical innovation continued, but its principal manifestation in terms of clinical practice was the aggressive marketing of pharmaceuticals and medical diagnostics to broad audiences for questionable indications. With hospitals and physicians also regaining market influence over insurers, health care costs resumed a rapid upwards trajectory, making it increasingly difficult for ordinary people working typical jobs to find and pay for basic services. Retail clinics can be seen as a market response to this challenge, aided by the large retail chains’ desires to continue their rapid growth by some means other than opening more locations. At the same time, whether by accident or design, retail clinics offer a fresh approach to three policy problems that have long plagued the American health care system.

Accessibility. For decades, access to health care has been mediated mainly by access to health insurance. Access to health insurance is poor and declining. Depending on where one lives (and not counting the recent Massachusetts reform), five to twenty-five percent of Americans lack insurance entirely.¹⁰ Roughly an equal number are

⁹ *Id.* at 1279.

¹⁰ SARA R. COLLINS ET AL., THE COMMONWEALTH FUND, LOSING GROUND: HOW THE LOSS OF ADEQUATE HEALTH INSURANCE IS BURDENING WORKING FAMILIES, FINDINGS FROM THE COMMONWEALTH FUND BIENNIAL HEALTH INSURANCE SURVEYS 1–4 (2008),

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underinsured in the event of serious illness.¹¹ For the uninsured, it is difficult to find and maintain a relationship with a physician in private practice, particularly in low-income communities without public transit. Inner-city residents can obtain care in hospital emergency departments because they are legally obligated to serve everyone, but services come from a culturally unfamiliar source at a very high price that this population generally cannot pay. Physicians and hospital clinics require appointments or long waits and often long travel times, mainly during working hours, which further decreases accessibility of care. Moreover, seemingly simple medical problems can spiral in both complexity and cost without warning or discussion as the tail of specialized medicine wags the dog of primary care, deterring the uninsured from seeking care in the first place. Unsurprisingly under these circumstances, many less affluent Americans end up going without.

Retail clinics do things differently, with accessibility and affordability constituting core business principles rather than professional afterthoughts. Suburbia and exurbia are not very compatible with the centralization of medical care in hospitals or stand-alone clinics. By contrast, roughly half of Americans live within five miles of a Wal-Mart, and a much higher percentage have convenient access to a chain supermarket or pharmacy.¹² Retail clinic services are available days, evenings, and weekends, without appointment, in places where average people gather anyway to do their weekly shopping. Prices are reasonable—fifty to seventy-five dollars on average—but even more importantly, are transparent and predictable, without the random escalation common in traditional medical settings.

One reason retail medical services are affordable is that the mid-level providers who staff retail clinics provide only routine services for straightforward problems (which one physician in conventional office practice described to me as his paid “coffee break” from seeing complex patients), rather than serving as an additional step en route to specialized care. This orientation, which may be shared by other community-based practice sites, also illustrates a new approach to understanding what constitutes “basic” medical care, at least for outpatient services. Rather than state or national government struggling to define basic care in connection with health insurance benefits, communities define it as services are sought from providers willing and able to deliver them in retail settings. Whether current clinic services such as preventive and primary acute care, or expanded services such as chronic disease management and simple surgery, providers and consumers will begin to find their own comfort zone for the point at which basic care ends and extra care begins.

Standardized Quality. Despite its huge aggregate cost, American medicine is basically a cottage industry. The majority of physicians still work by themselves or in small groups, moving at will between their private offices and the loosely shared resources of local community hospitals where they “order” tests and treatments and

http://www.commonwealthfund.org/usr_doc/Collins_losinggroundbiennialsurvey2007_1163.pdf?section=4039.

¹¹ *Id.* at 8–9.

¹² CHARLES FISHMAN, *THE WAL-MART EFFECT: HOW THE WORLD’S MOST POWERFUL COMPANY REALLY WORKS—AND HOW IT’S TRANSFORMING THE AMERICAN ECONOMY* 6 (2006).

“refer” for consultation as they see fit. Many run their practices autocratically, emphasizing loyalty from support staff and making minimal investments in professional managers or management information systems. Although physicians’ earnings depend on the disbursements of public and private health insurers, which impose substantial bureaucratic constraints on their business practices, physicians continue to enjoy relatively unfettered discretion over clinical decisions. Because causal chains are difficult to establish in such a fragmented environment, little of physicians’ clinical output is measured or benchmarked. Local reputation and the occasional malpractice suit or professional disciplinary action aside, market accountability for quality remains rare. The result is a large degree of unexplained and almost certainly unwarranted variation in practice patterns, much of which departs from scientifically established best practices and wastes scarce resources.¹³

At first blush, retail chain stores seem like an unlikely locus of medical quality improvement, but conditions in retail stores are often more conducive to quality control than they are in physicians’ offices.¹⁴ First, the clinic model depends on standardized, predictable workflow. Unlike physicians, nurse practitioners follow written protocols without objection, and clinic operators invest in electronic recordkeeping and decision support. Retail clinics refer occasional non-routine patients to hospitals or specialist physicians’ offices so as not to disrupt overall workflow. Second, clinics usually can satisfy patient demands without offering expensive but unnecessary tests and prescriptions. Patients who sacrifice less time and money to access primary care are more inclined to accept reassurance rather than insisting on active treatment. Moreover, the budgeted duration of a retail clinic visit is roughly twice as long as a physician spends with a routine patient in office practice, allowing the “talk” and “touch” that constitute professional priorities among nurses. Third, clinic operators are in the public eye, and therefore must demonstrate measurable quality while avoiding the appearance of cross-marketing pharmacy or other retail services. These dynamics are evident in the use of antibiotics, which tracks medical professional recommendations for prudent use to a much greater degree in retail clinics than elsewhere.¹⁵

¹³ See generally CTR. FOR THE EVALUATIVE CLINICAL STUDIES, DARTMOUTH MED. SCH., THE DARTMOUTH ATLAS OF HEALTH CARE 1998 (John E. Wennberg & Megan M. Cooper eds., 1998) (compiling evidence of large geographic variations in medical practice in the United States).

¹⁴ Debate over the relative merits of primary care from nurse practitioners and from physicians is purely rhetorical. A review of 11 trials and 23 observational studies in primary care settings concluded that “[q]uality of care was in some ways better for nurse practitioner consultations.” Sue Horrocks et al., *Systematic Review of Whether Nurse Practitioners Working in Primary Care Can Provide Equivalent Care to Doctors*, 324 BRIT. MED. J. 819, 819 (2002). See also Linda H. Aiken, *Achieving an Interdisciplinary Workforce in Health Care*, 348 NEW ENG. J. MED. 164 (2003) (editorial describing the quality of non-physician professionals); Mary O. Mundiger et al., *Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial*, 283 JAMA 59 (2000) (demonstrating equivalent outcomes).

¹⁵ See James D. Woodburn et al., *Quality of Care in the Retail Health Setting Using National Clinical Guidelines for Acute Pharyngitis*, 22 AM. J. MED. QUALITY 457, 459–

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Connections to Patients and Communities. A third characteristic of the health care system that presents daunting problems for policymakers is its insularity. Analysts and reformers have long noted that what we call the health care system is not fundamentally about health, but about medical care in the event of illness.¹⁶ The cost and sophistication of medical treatments have increased geometrically, but the system continues to operate in the same way it did decades ago. Sick people consult physicians, who diagnose disease and recommend treatment using a mix of invasive and non-invasive techniques in hospital, outpatient, and office settings with the assistance of various professional and quasi-professional personnel. These tools of the health system reside in professional and institutional silos, and are poorly coordinated. Third-party payment through health insurance reinforces these boundaries by entrenching categories of providers and services that are eligible for “reimbursement.”

There have been attempts to address this intransigence. Under the influence of bioethical, feminist, and consumer movements, the patient’s role has been revised from passive sufferer to (supposedly) autonomous decision-maker. However, it is difficult for patients or families to exercise their authority in a technology-driven acute care environment. In addition, practice changes to become “patient-centered” have typically been single-shot. The health system has not emphasized a continuous process of anticipating and satisfying consumer needs, which is the lifeblood of mass retailing. Furthermore, although burgeoning chronic disease has put secondary prevention for already-diagnosed individuals onto the agenda for many health care providers, primary prevention is seldom a priority. Bridges between health care and population health are still few, as are connections between the health care establishment and non-medical actors whose decisions influence community health through school, work, diet, recreation, and the built environment.

Retail clinics alone cannot do much to address these deep failings, except perhaps to integrate primary prevention of disease with consumers’ weekly non-medical routines. Nonetheless, the large retail corporations who sponsor or operate the clinics are uniquely situated to influence health outcomes at the population level through socially acceptable private processes that do not require a rapid, intrusive expansion of government. In the context of energy conservation and environmental sustainability, for example, large retailers may be able to move consumer demand into new patterns through a continual process of anticipatory innovation. Similarly, long-term improvements in population health and in medical cost-control depend on “patient activation” that integrates the receipt of medical care with healthy choices regarding diet, physical activity, substance use, sanitation, and safety. This will require much more than can be delivered in a cubicle at the front of a Wal-Mart, no matter how many stores incorporate clinic space. Still, retail clinics create bully pulpits for nurses and physicians to instill health-

60 (2007) (finding 99 percent compliance with guidelines regarding antibiotic use in retail health settings).

¹⁶ See, e.g., Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 941 (1963) (“It should be noted that the subject is the *medical-care industry*, not *health*.”) (emphasis in original).

consciousness in families that shop, and to work with store managers, corporate headquarters, and communities on more coordinated strategies.

Limits Imposed and Self-Imposed

Retail medical clinics are not yet a defining feature of how most Americans receive health care. In addition to their limited scope of service, various factors constrain the retail clinic model from both without and within. In concept, retail clinics strike a false note to a longstanding fundamentalist strain among medical educators, nonprofit advocacy groups, and grassroots professional organizations favoring comprehensive physician coordination of health care. Currently identified with the “medical home,” this movement emphasizes primary care over specialization, cognitive services over technology or invasive procedures, and professional altruism over the profit motive that supposedly drove physician “gatekeeping” under managed care.¹⁷

However, political resistance from the medical profession has been blunted by the protean quality of retail clinics. Physicians would prefer to label and hopefully control retail clinics, as they had managed care, using familiar narratives of quackery, corporatization, profit-seeking, and conflict of interest. Pediatricians, citing the vulnerability of their youngest patients and the need for continuity of care, seemed to be succeeding with this strategy, only to have the supposed enemy concede the point when retail clinics more or less renounced any intention of serving the under-two crowd.¹⁸ The American Medical Association and other physician groups have expressed reservations,¹⁹ but savvy clinic operators engaged rather than confronted them. Additionally, many AMA members would just as soon have their patients go elsewhere for simple problems at night and on weekends.²⁰

¹⁷ See Berenson et al., *supra* note 6; see also AM. ACAD. OF FAMILY PHYSICIANS, AM. ACAD. OF PEDIATRICS, AM. COLL. OF PHYSICIANS & AM. OSTEOPATHIC ASS’N, JOINT PRINCIPLES OF THE PATIENT-CENTERED MEDICAL HOME (2007), <http://www.medicalhomeinfo.org/Joint%20Statement.pdf>.

¹⁸ See Am. Acad. of Pediatrics, Retail-Based Clinic Policy Work Group, *AAP Principles Concerning Retail-Based Clinics*, 118 PEDIATRICS 2561, 2561 (2006). According to Mehrotra and colleagues, patients under age 2 make up only 0.2 percent of retail clinic visits, compared with 9.0 percent of primary care physician visits and 6.4 percent of emergency department visits. By contrast, roughly equal percentages of patients in the three settings are aged 2-5. Mehrotra et al., *supra* note 8, at 1277. Some retail clinics may not accept very young patients, who, in any event, are more likely to have an ongoing relationship with a pediatrician than healthy older children.

¹⁹ AM. MED. ASS’N, REPORT OF THE COUNCIL ON MEDICAL SERVICE: STORE-BASED HEALTH CLINICS (2006), <http://www.ama-assn.org/ama1/pub/upload/mm/372/a-06cmsreport7.pdf>.

²⁰ MinuteClinic, for example, entered into an agreement with the American Academy of Family Physicians to use the AAFP’s Continuity of Care Record standard for MinuteClinic transactions. Press Release, MinuteClinic, MinuteClinic, Inc. Announces Continuity of Care Record Project Aimed at Improving Quality, Safety and Efficiency of Care (Oct. 9, 2006), available at <http://phx.corporate-ir.net/phoenix.zhtml?c=99533&p=>

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Still, retail clinics are not immune from the conservative force of health care regulation, which often extends beyond its necessary protective role. Nurse training programs are chronically underfunded, and state licensing and disciplinary processes—often controlled by self-interested professional boards—define the permissible scope of practice for nurse practitioners. In addition, corporate practice of medicine laws ban explicit employment of health professionals by commercial entities in several jurisdictions.²¹ In terms of liability, referral and marketing practices could potentially trigger fraud prosecution, while clinics' triage capability and diagnostic accuracy eventually may attract malpractice litigation. Regulatory oversight may become a problem if states subject retail clinics to unpredictable patterns of licensure, survey, and certification. A few states have considered or adopted specific oversight mechanisms, notably the Massachusetts law governing "limited service clinics."²² Overall, however, direct state regulation of the clinic model remains light.

Finally, retail clinics are linked to retailing. In historical terms, providing health care to Americans is highly lucrative. On the other hand, many retail ventures fail, and the retailing industry is undergoing massive retrenchment as demand shrinks and credit is withdrawn in the ongoing economic downturn. As yet, there is also little evidence that the host stores have managed the supply chain as aggressively for their clinics operations as for their core businesses. Moreover, the fee-for-service basis of the retail clinic may be incompatible with emerging models of bundled payment for medical care.²³

Conclusion

Whatever their long-term commercial viability, retail medical clinics are an important metaphor for national health policy generally. To some, they are an unwelcome metaphor. Medicine out of the big-box store seems to mark the final victory of mass retailing over personal service from the independent tradesmen and small-town professionals that seemingly represent America's pioneer stock. The naked quest for profit, though itself arguably a core American value, also seems less palatable when not white-coated by physician control. Instead of shopping piecemeal at the mall, critics would argue, American patients should seek the parental embrace of an all-knowing physician in a comprehensive medical home.

rol-newsArticle_pf&ID=913559&highlight=.

²¹ See, e.g., Keith Darce, *Are Retail Clinics a Healthy Choice?*, SAN DIEGO UNION-TRIB., Nov. 7, 2007, at A1 (describing retail clinic compliance with California's corporate practice restrictions); see generally Nicole Huberfeld, *Be Not Afraid of Change: Time to Eliminate the Corporate Practice of Medicine Doctrine*, 14 HEALTH MATRIX 243 (Summer 2004) (analyzing corporate practice prohibitions).

²² 105 MASS. CODE REGS. 140.1001-1002 (2008) (establishing rules for retail clinics).

²³ See Marcus Thygeson et al., *Use and Costs of Care in Retail Clinics Versus Traditional Care Sites*, 27 HEALTH AFF. 1283, 1290 (2008) (noting that increased utilization may outweigh reduced per-service prices for the retail clinic model, raising overall health care spending).

Though the rhetorical appeal of the critical position is undeniable, it is equally possible to glimpse an attractive future in the retail clinic metaphor. Modern life is complicated, and is not likely to become less so. People form communities, exchange information, engage the marketplace, and make choices in ways quite different from half a century ago. Modern medical care is also more complex and more specialized, and requires coordination by means that befit its industrial nature. Consequently, there may be few if any physicians capable of medical parenting at an affordable price, and fewer patients than one might expect who would feel comfortable with so dependent a model of care. Moreover, as public health experts well know, health is not maintained solely, or even primarily, by medical services. The integration of health care with other, community-based determinants of health in people's everyday lives is absolutely necessary for sound health policy, and retail clinics may be a step in the right direction.

The retail clinic experience therefore offers several lessons for the Obama administration as it re-opens the can of worms called health care reform.²⁴ One lesson is to create incentives to innovate rather than to foreclose new health care delivery options simply because existing stakeholders consider them risky. Thus far, longstanding regulatory issues such as scope of practice for nurse practitioners and restrictions on corporate control are playing a larger role in the industry's development than newly enacted patient- and provider-protective rules. It may be difficult for the federal government directly to liberalize state-based legal regimes. At a minimum, however, efforts should be made to discourage specific, anti-competitive targeting of retail clinics.²⁵

Another lesson is the importance of investing in health education, which is evident on both the supply and the demand sides of retail clinics. On the supply side, the duration, complexity, and cost of professional education—as well as its high degree of self-regulatory control—have produced asynchronies between the market for medical training and the market for medical practice. Inattention by policymakers to workforce development will make it very difficult for retail clinics, or any other new health care model, to succeed. On the demand side, the best customers for retail clinics (and other cost-effective care sites) are educated patients who value healthy lifestyles and preventive care, who know what is needed to manage their chronic conditions effectively, and who can determine with reasonable accuracy whether or not their acute medical problems are life-threatening. Instilling these skills broadly in the American population should be a priority.

Finally, the retail clinic movement constitutes a lesson in an obvious fact that both the medical profession and the political process have surprising difficulty acknowledging:

²⁴ Cf. Zymurgy's Law of Evolving System Dynamics ("Once you open a can of worms, the only way to re-can them is to use a larger can.") in ARTHUR BLOCH, *MURPHY'S LAW AND OTHER REASONS WHY THINGS GO WRONG* (1978).

²⁵ See Letter from Maureen K. Ohlhausen et al., Director, Office of Policy Planning, Federal Trade Commission, to Hon. Elaine Nekritz, State Representative (May 29, 2008), available at <http://www.ftc.gov/os/2008/06/V080013letter.pdf> (competition advocacy filing urging state legislature not to disadvantage retail clinics as innovative competitors in medical markets).

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cost and convenience matter even in health care.²⁶ In 1995, Newt Gingrich wrote that American health care must “go to Canada or to Wal-Mart.”²⁷ He meant to posit a choice between bureaucratic and market control. But the distinction between Canada and Wal-Mart is also a choice between an insurance model of the health care system and a delivery model. In an insurance model, how to equitably finance care given a markedly unequal distribution of illness in the population dominates reform debates. In a delivery model, the value of the services received is as important as who pays for them. Comprehensive reform of the health care delivery system will require much more than storefront medical care. Still, retail clinics are a small but important reminder that improving the health care delivery system and connecting it to population and community health are the core challenges for access, cost, and quality in the next round of national health care reform.²⁸

²⁶ One physician, without a hint of irony, wrote the following in opposition to retail clinics: “The American public cannot have it both ways. They must decide what is more important: money and time, or comprehensive appropriate care.” David H. Schell, Letter to the Editor, *Medicine Is Not Fast Food*, USA TODAY, Aug. 30, 2006, at A12.

²⁷ Gingrich wrote:

One of the challenges I’ve made to doctors is I said you’re either going to Canada or to Wal-Mart. You can either go to a nationally controlled bureaucratic structure or you can go to the marketplace. But you’re not going to stay in a guild status where you have all the knowledge and you share none of it.

Newt Gingrich, *Newt’s New World*, FORBES, Feb. 27, 1995, at 93.

²⁸ In April 2008, the Federal Trade Commission hosted a conference on innovation in health care delivery, including retail clinics. FTC Public Workshop, Innovations in Health Care Delivery (Apr. 24, 2008) (transcript available at <http://www.ftc.gov/bc/healthcare/hcd/docs/hcdwkspttranscript.pdf>). See also William M. Sage, *Legislating Delivery System Reform: A 30,000 ft. View of the 800 lb. Gorilla*, 26 HEALTH AFF. 1553 (2007) (listing a theory of success, collective social meaning, and political support as key conditions for delivery system reform).