EXECUTIVE SUMMARY
Healthcare disparities are a growing concern for the U.S. healthcare system. These disparities are found at all levels of quality, access, and cost and greatly affect those segments of the population that most need affordable, quality, and accessible healthcare. The populations most in need are rural, ethnic, racial, and minority populations, who do not usually receive the highest quality of care. A new healthcare delivery model has recently emerged—retail medical clinics. This article describes current disparities in the healthcare system and presents one possible solution: the use of retail medical clinics.

Editor’s Note: Please see pages 228 and 230-31 to view the correct sources of the information included in this article.
The United States has struggled for decades to provide adequate healthcare coverage to all of its citizens, particularly to the most vulnerable. As with other governmental services (education services, for one), who you are and where you live seem to make a great difference in the quality of healthcare services you will receive and the accessibility of those services. For the majority of the U.S. population, quality healthcare is almost unattainable and certainly unaffordable. The emergence of a new healthcare delivery model—retail medical clinics—may be an answer to eliminating some of the healthcare disparities and improving the overall healthcare system in the United States.

**BACKGROUND OF RETAIL MEDICAL CLINICS**

In 2004, retail medical clinics, often referred to as “docs in a box,” appeared as pilot projects in Minneapolis–St. Paul, Minnesota, and Baltimore, Maryland. The premise behind retail medical clinics is to house a medical clinic together with a commercial retail entity to provide acute care and diagnostic services through the use of advanced practice nurses or nurse practitioners at significantly discounted market rates. Those first clinics treated a very limited number of illnesses and conditions and only accepted cash for their services. Today, more than 200 clinics are operating in commercial retail shopping centers, retail pharmacies, and mega retail chains throughout the country. The major companies behind most of those clinics—MinuteClinic, Take Care Health Center, and RediClinic—have announced plans to open hundreds, perhaps thousands, more by the end of 2007 (Champlin 2006). The attractiveness of these clinics is their accessibility and affordability, as they are mainly situated in commercial strip malls and other retail locations where they are convenient for consumers. Given the use of nurse practitioners or physician assistants to provide the medical services, in addition to other efficiencies discussed later, costs for services are significantly reduced. Retail medical clinics hope to fill a gap and make healthcare accessible to unrepresented and uninsured populations in the United States.

**HEALTHCARE DISPARITY**

In the United States a great healthcare disparity exists on racial and economic lines. There is clearly a distinct and marked difference in the utilization, accessibility, and quality of healthcare between groups or classes of people, specifically among lower-income groups, racial and ethnic minorities, women, children, the elderly, and the disabled (Siegel, Moy, and Burstin 2004). With the Healthcare Research and Quality Act of 1999, Congress mandated the Agency for Healthcare Research and Quality (AHRQ) to produce reports—the National Healthcare Disparities Report (NHDR)—on healthcare disparities and healthcare quality.

The goals of the NHDRs were to capture the status of the quality of healthcare provided to all Americans, while emphasizing major subgroup populations, and to focus on personal

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healthcare rather than public healthcare (Poker, Hubbard, and Collins Sharp 2004). Since 1999, the AHRQ (2003; 2004; 2005) has issued three reports on national healthcare disparities, and they have proved instructive in the fight to close the disparity gap. The findings of these studies often bring attention to actions that must be taken to improve the healthcare of vulnerable priority populations and the overall U.S. healthcare system.

AHRQ’s first NHDR, issued in 2003, looked at performance measures to show the nation’s progress toward improving the quality of care provided to all Americans, and it laid the foundation for creating solutions to these emerging problems (Poker, Hubbard, and Collins Sharp 2004). The second NHDR, issued in 2004, focused on access-to-care measures and healthcare utilization from the perspective of providers and insurers (AHRQ 2004). The third NHDR, issued in 2005, highlighted four key facts: (1) disparities still exist, (2) some disparities are diminishing, (3) opportunities for improvement remain, and (4) information about disparities is improving (Hand et al. 2006; Moy, Dayton, and Clancy 2005). Our disparities are as vast and extensive as our healthcare system. According to the 2005 NHDR, disparities still exist in all aspects of quality, including patient safety, timeliness, and effectiveness; all aspects of access; all levels and types of care; all clinical conditions, including cancer, diabetes, and heart disease; different care settings; and many subpopulations (Hand et al. 2006; Moy, Dayton, and Clancy 2005). Findings of the 2005 NHDR showed that minorities and the poor receive the lowest quality of care and have the worst access to care, compared with white and high-income populations. The inability to receive high-quality care and to have open access to care can be attributed to many factors, including geographic location, medical insurance coverage, and economic status. Many minorities and the poor cannot afford proper insurance coverage and, instead, rely on state-funded (Medicaid) healthcare facilities where they are generally frustrated with the long waits, shoddy care, and rundown conditions.

Since the AHRQ started tracking the progress toward improving healthcare disparities, the most recent NHDR shows that some of these issues are getting better. For instance, disparities in quality of care are becoming smaller for most racial minorities, except for Hispanics. About 59 percent of the quality-of-care disparities for Hispanics are becoming larger, while disparities for blacks, Asians, and the poor are becoming smaller by an average of 50 percent (Hand et al. 2006; Moy, Dayton, and Clancy 2005). The fact that no significant improvement is showing for Hispanics is troubling, as it is estimated that nearly 67 million people of Hispanic origin will be added to the nation’s population between 2000 and 2050. That is a population increase of 188 percent, which means that this population group will account for more than half of the nation’s total population by 2050 (U.S. Census Bureau 2006). This underscores the importance of reducing healthcare disparities as much as possible now.
Again, geographic location, lack of medical insurance coverage, and economic status are factors in creating healthcare disparities in the Hispanic population. Culture could also be a factor. Many Hispanics do not have access to physicians and healthcare facilities in their native countries and commonly use their pharmacist or spiritual healer to prescribe remedies. Language is often a barrier, too. Although some racial groups have seen improvement, there is still much work to be done to provide quality, accessible, and affordable healthcare to all ethnic and racial groups. Retail medicine, together with patient education and awareness, may be the answer to achieving this goal.

**USE OF RETAIL MEDICINE TO ADDRESS DISPARITIES**

Many mega retail chains are including retail medical clinics as part of their consumer offerings. Retail medical clinics are appearing in many high-traffic retail outlets in major metropolitan cities, suburbs, and rural America, through such retailers as CVS/pharmacy, Walgreen’s, Target, and Wal-Mart. These clinics are legally distinct and separate entities from the retail chains from which they lease space. They offer consumers medical care in the easiest, most convenient, and most affordable manner and are run by licensed physician assistants (PAs) or by nurse practitioners. PAs and nurse practitioners may provide patient care and treatment, but the scope of their authority is regulated and varies in all states.

In a general sense, a PA is academically and clinically prepared to provide patient care in collaboration with and at the direction and responsible supervision of a physician of medicine or osteopathy (AMA 2006). The extent of a physician’s direction and oversight is also regulated and varies in each state. Some states permit PAs to provide patient care independently, and others require collaboration with a licensed physician or hospital system. The clinical role of PAs includes primary and specialty care in medical and surgical practice settings. A PA’s practice is centered on patient care and may include educational, research, and administrative activities (AMA 2006). Nurse practitioners are advanced practice nurses who possess graduate-level degrees, provide high-quality healthcare services similar to those given by a physician, and have the ability to diagnose and treat a range of health problems (AANP 2006). As with PAs, some states permit nurse practitioners to provide patient care independently, and other states require them to collaborate with a licensed physician or hospital system.

PAs and nurse practitioners are licensed and qualified to do the following:

- diagnose and treat common illnesses and minor injuries,
- prescribe medication,
- obtain medical histories,
- perform physical assessments and examinations,
- perform and interpret diagnostic and laboratory studies.

• counsel and teach nutrition,
• screen and refer patients to specialists and other healthcare providers, and
• provide education to allow patients to make decisions about their own health.

The appeal of these new clinics is the fact that they are usually open in the evenings and on weekends, when a physician office is typically not. Prices are also relatively low, compared with a physician’s office visit, an emergency department visit, or a visit to an urgent care facility. In addition, they are located in local neighborhoods, and this, again, indicates that they cater to patient convenience.

The evolution of retail medical clinics is not without issues. Many state and national medical societies question whether PAs and nurse practitioners are unlawfully engaged in the practice of medicine; in all states, only licensed physicians, doctors of osteopathy, and chiropractors may lawfully practice medicine. However, an October 2005 poll conducted by Public Opinion Strategies indicates that patients seem open to the idea of retail health clinics; of the 800 adults polled, 59 percent said they would be likely to use a retail health clinic (Sullivan 2006). An October 2005 Harris Interactive online poll of 2,245 people found that 7 percent had used the services of a retail clinic. Of those 7 percent, 92 percent were satisfied with the convenience, 89 percent were satisfied with the quality of care, 88 percent were satisfied with the staff's qualifications, and 80 percent were satisfied with the cost (Sullivan 2006). Could this be part of the solution to reduce healthcare disparities?

So far, retail medical clinics have demonstrated an ability to improve cost, quality, and access. Many of the larger chains use electronic medical record systems to prevent medical errors. Also, retail medical clinics are decreasing costs by substantially reducing prices for many basic medical treatments. For example, a flu vaccination at a retail medical clinic may cost as little as $25, compared with the prices charged by physicians and emergency departments. In addition, retail clinics are collaborating with insurance companies to waive patients' copayment obligations if they use retail medical clinic services, as treatments at retail clinics are less expensive than a comparable visit to an emergency department or urgent care center.

Other positive results emerge from use of these retail clinics. First, third-party payers will be removed from the patient–doctor relationship (Chapman 2004). Second, there will be less confusion about what will be covered and what will not be covered by insurance, as retail medical clinics put all the responsibility for payment into the patient’s hands. This, in turn, will lead to more proactive patients as they will be directly paying for the services rendered. Third, most retail medical clinics are able to offer lower treatment fees for cash payments because they avoid insurance billing fees. Fourth, fewer billing and coding errors are likely to occur because of the decrease in paper billing.

With the surge of retail medical clinics, the American Academy of Fam-
ily Physicians (AAFP) sought to create uniform standards of framework of operations. The AAFP, in collaboration with the three leading medical clinics—MinuteClinic, Take Care Health Center, and RediClinic—compiled the following list of desired attributes that all retail medical clinics should possess (AAFP 2006):

1. Scope of service: [The] clinic must have a well-defined and limited scope of clinical services.

2. Evidence-based medicine: Clinical services and treatment must be evidence based and quality improvement oriented.

3. Team-based approach: The clinic should have a formal connection with physician practices in the local community, preferably with family physicians, to provide continuity of care. Other health professionals, such as nurse practitioners, should only operate in accordance with state and local regulations, as part of a team-based approach to healthcare, and under responsible supervision of a practicing, licensed physician.

4. Referrals: The clinic must have a system for referral to physician practices or to other entities appropriate to the patient’s symptoms beyond the clinic’s scope of work. The clinic should encourage all patients to have a “medical home.”

5. Electronic health records: The clinic should include an [electronic health record] system sufficient to gather and communicate the patient’s information with the family physician’s office, preferably one that is compatible with the continuity of care record supported by AAFP and others.

THE LEADING RETAIL MEDICINE PROVIDERS

MinuteClinic, Take Care Health Center, and RediClinic are the leading retail medicine providers. Retail medical clinics are more affordable and convenient for common, everyday services than traditional medical outlets. All three were formed on the same foundation of offering affordable, fast, and quality healthcare.

MinuteClinic first appeared in a Cub Foods grocery store in May 2000, after founder Rick Krieger experienced a two-hour wait for a strep-throat test at his local urgent care center. Rick Krieger believed there had to be an easier and faster way to receive basic healthcare services, and from this, MinuteClinic was formed. Today, MinuteClinic operates out of 18 locations in Target and CVS/pharmacy stores, and the company hopes to aggressively add more locations in the near future. These clinics are run on a walk-in basis, and the staff see patients age 18 months and older. Treatment for common illnesses, such as a bladder infection or strep throat, costs $59–$69. Vaccines offered range from flu vaccines at $30 to meningitis vaccines at $110. Minor skin conditions, burns, and rashes cost $59 to treat.

Take Care Health Centers currently operate in 33 locations, exclusively in Walgreen’s pharmacies in Chicago, Kansas City, St. Louis, and Pittsburgh.
At Take Care, the cost for a visit is the same as an insurance copay, or $59–$74 for those patients who choose to pay in cash.

RediClinic, part of InterFit Health, has been providing quality, accessible, and convenient healthcare since 1989. The clinic offers many of the same services as Take Care and MinuteClinic, for the same low, affordable prices.

Of course the prices for services will vary at each clinic in all states. The bottom line is that as of right now, these retail clinics have the lowest prices out on the market.

**CONCLUSION**

Retail medical clinics are the newest healthcare delivery model. Scheduling a necessary health service around the available times of a physician or waiting for an extended period of time in an emergency department is slowly becoming a thing of the past. It may not have happened yet, but retail medical clinics will catch on more than they already have. The goal of serving quality, affordable, and convenient healthcare to all populations of our nation is attainable. Adequate healthcare service that is blind to race, ethnicity, economic status, geographic location, and insurance coverage is not only a possibility but is also urgently needed. Retail medical clinics, in conjunction with educating patients about them and continued use of such clinics, can be one solution to reducing healthcare disparities.

**Notes**

1. According to the Medical Expenditure Panel Survey (2006), in 2003, the median cost of an emergency room visit was $299, while the average emergency room visit was $560.

2. Information about the prices and services offered by these three retail medical clinics may be found on their websites: www.minuteclinic.com, www.takecarehealth.com, and www.rediclinic.com.

**References**


Chapman, G. 2004. “Will You Be Ready for Retail Medicine?” [Online article; re-


