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Might the Fact that 90% of Americans Live Within 15 Miles of a Wal-Mart Help Achieve Universal Health Care?

William M. Sage*

I. INTRODUCTION

The subject of this Essay is the retail medical clinic movement. Retail medical clinics—a few hundred exist at the time of this publication—are typically located in national or regional chains of discount stores, pharmacies, and supermarkets.¹ News articles describing this new phenomenon in American health care tend to examine its viability as a business. The symposium for which this Essay was prepared is devoted to the “Massachusetts Health Plan,” that state’s pioneering effort (in the current political cycle) to achieve near-universal health insurance for its residents. Accordingly, this Essay situates the retail medical clinic movement in overall “health policy,” with particular emphasis on its implications for access to medical care.²

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1. Mainstream media are beginning to cover retail clinics as medical innovation. See, e.g., Rachel Donadio, *Walk-In Health Care*, N.Y. TIMES MAG., Dec. 10, 2006, at 82, 82, 84 (describing initiative by Quick Health to place health clinics in Wal-Mart, featured in special issue on the “year in ideas”); Milt Freudenheim, *Attention Shoppers: Low Prices on Shots in the Clinic Off Aisle 7*, N.Y. TIMES, May 14, 2006, at A1 (describing walk-in health clinic trend); Jane Spencer, *Getting Your Health Care at Wal-Mart*, WALL ST. J., Oct. 5, 2005, at D1 (same); Daniel Yi, *Latest Retail Niche: Clinics*, L.A. TIMES, July 18, 2006, at C1 (reporting on Quick Health).

2. The first detailed health policy report on retail clinics was issued in July 2006 by the California Health Care Foundation. MARY KATE SCOTT, CAL. HEALTH CARE FOUND., HEALTH CARE IN THE EXPRESS LANE: THE EMERGENCE OF RETAIL CLINICS (2006), available at www.chcf.org/documents/policy/HealthCareInTheExpressLaneRetailClinics.pdf. According to Scott, the first in-store clinics appeared in Minneapolis-St. Paul in 2000, and were operated by QuickMeds, the predecessor business to MinuteClinic. *Id.* at 8. See also DEVON M. HERRICK, NAT’L. CTR. FOR POLICY ANALYSIS, CONSUMER-DRIVEN HEALTH CARE SPURS INNOVATION IN PHYSICIAN SERVICES 1–2 (2006) (describing telephone consultations, retail clinics, and other customer-friendly models). Medical professional journals and trade magazines have approached the topic gingerly, though not negatively. See, e.g., Richard Bohmer, *The Rise of In-Store Clinics—Threat or Opportunity?*, 356 NEW ENG. J. MED. 765, 765 (2007) (describing in-store clinics and possible implications); Drew Sullivan, *Retail Health Clinics Are Rolling Your Way*, FAMILY PRACTICE MGMT., May 2006, at 65, 66, available at www.aafp.org/fpm/20060500/65reta.pdf (observing the impersonal nature of the

For an author whose formative career experience in health policy was helping formulate the Clinton administration's Health Security Act, it is disconcerting to state in print that Newt Gingrich was right. Here is Newt Gingrich's column in *Forbes* magazine on February 27, 1995:

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, you share none of it.³

Gingrich's comparison between Wal-Mart and Canada has an explicit and an implicit component. His explicit distinction is that physicians' professional hegemony is again subject to attack by both governmental bureaucracies and commercial enterprises, challenges that the medical profession successfully resisted for many decades. His implicit distinction, which is critically important to understanding both the Massachusetts health plan and the retail medical clinic movement, is between insurance coverage and health care services. In the United States, an expanded government role in health care is nearly always framed as access to insurance. The commercial marketplace has no such requirement, although it has been conventional for private businesses to seek health insurance for their workers rather than medical services. But expanding access to health care services, often in the absence of health insurance, is where retail medical clinics—what is sometimes described as the “Wal-Martization” of health care—comes in.⁴

Why is insurance coverage assumed to be the optimal approach to accessing health care in America, as it is now in Massachusetts? There are obvious attractions to an insurance model. One reason is the intuitive compatibility of an insurance model given the unequal financial burden of illness in the population. Another reason is the familiarity that Americans have with employer-based health coverage. A third reason, at least in some parts of the country during some decades, was the success of HMO-based models for delivering both insurance and medical care in one prevention-oriented package. Finally, periodic attempts over many

clinics).

3. Newt Gingrich, *Newt's New World*, FORBES, Feb. 27, 1995, at 92.

4. Wal-Mart itself appears to be making a major push to identify its retail brand with health care. See Rob Eder, *Customer Connection All About Health Care*, DRUG STORE NEWS, Dec. 11, 2006, at 21, 21–22 (discussing Wal-Mart's marketing efforts to expand its pharmacy business). Its first health initiative offered generic prescription drugs for \$4. See, e.g., Christopher Bowe & Jonathan Birchall, *Wal-Mart Cuts Cost of Generics*, FIN. TIMES, Sept. 22, 2006, at 26 (reporting on Wal-Mart's new four dollar generic prescription program).

decades to enact a European-style national health insurance program in the United States have kept policymakers focused on coverage notwithstanding the political failures that have resulted.

II. CLINTON HEALTH REFORM REVISITED

Examining the failures of that last dynamic can shed light on the policy potential for the retail medical clinic movement. Revisiting the “Clinton Health Plan” of 1993–1994 arouses mixed emotions, but after roughly a ten-year hiatus the analytics for evaluating that effort have again become relevant. The Clinton administration’s reform opportunity needed to be directed at three fundamental problems: insurance reform, financing, and health care delivery.

Insurance reform was fairly successful. The goal was to create reasonably stable, accessible risk pools, emphasizing the “small group” market. It was largely accomplished at the state level in the early 1990s, and was made applicable to self-insured employers through the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). The principal shortcoming of insurance reform was that it never induced health insurance companies to compete based on the efficient delivery of health care services rather than on efficient selection and pricing of risk. Notwithstanding a brief attempt at “risk adjustment,” both existing businesses and the public turned out to be more comfortable with insurance companies that acted as insurance companies, not as health care providers.

Financing reform was attempted with a vengeance but was unsuccessful. It turned out that nobody wanted to pay for someone else’s health insurance, at least not when the cross-subsidy was explicit rather than a byproduct of common employment. Resistance was heightened by the perceived fragility of the economy in the early 1990s, as desire for the government to replace health insurance lost and the preceding, short-lived recession gave way to hope that recovery unburdened by government mandates would maintain or restore private coverage. Concern over deficit reduction, a major political issue in the 1992 presidential election, compounded the difficulty of funding an expansion of federal health insurance. Although financing reform was framed as “purchasing reform” in the 1993–1994 debate—invoking “managed competition” theory to argue that large, quasi-public organizations would drive hard but smart bargains with insurers—the (unsuccessful) strategic objective of making “health alliances” the centerpiece of Clinton health reform was to persuade the public overseers of the federal budget that coverage could be universalized without a massive increase in taxation

and redistributive spending. A caution based on this experience is relevant today for states seeking universal coverage. It *may* be possible for Massachusetts, with a tradition of high taxation, to reduce the percentage of uninsured residents from 10% to 5%. It is impossible for states like Texas, with 25% uninsured and no state income tax, to attempt a similar approach.

The third need of health reformers was to remake the health care delivery system, meaning the ways in which doctors, hospitals, other health professionals, and health care suppliers do business. It is virtually meaningless to say that delivery system reform was unsuccessful in 1993–1994—it was simply not discussed. It was not even on the agenda. There was widespread rhetoric regarding how the United States could get more for its health care dollar, but no stomach (or cerebral cortex) for substantive restructuring of the health care delivery system. All sides inveighed against rampant “waste, fraud, and abuse.” Lamentations were heard about lack of preventive services and overuse of emergency departments in connection with the large amount of money already being spent on uncompensated care. But what to do about it eluded both policymakers and politicians.

So nothing happened—except exacerbating the problem during the managed care backlash that followed the failure of national health reform. Kaiser-style HMOs were impossible to replicate broadly, given that both providers and consumers were unfamiliar with that delivery model. And network-based managed care organizations found themselves unable to organize the provider community without using tools that were unpalatable to the average consumer.

III. A NEW DIRECTION?

The retail medical clinical movement focuses on health care instead of health insurance coverage.⁵ Why is this an opportune historical moment for such an approach? Winston Churchill once quipped that “[you] can always count on Americans to do the right thing—after they’ve tried everything else.”⁶ A similar phenomenon underlies the

5. The specific legal implications of retail clinics are not discussed in this Essay. These include anti-kickback and self-referral concerns, corporate practice issues, scope of practice restrictions, insurance billing practices, and medical liability. The scale of Wal-Mart and other host stores creates additional legal issues. On the latter point, see generally Lea S. VanderVelde, *Wal-Mart as a Phenomenon in the Legal World: Matters of Scale, Scale Matters*, Univ. of Iowa Legal Studies Research Paper No. 07-08, 2006, available at <http://ssrn.com/abstract=971836>.

6. Winston Churchill Quotes, <http://www.Funnyquotes.com/quotes-Winstonchurchill.shtml> (last visited June 1, 2007).

sudden proliferation of primary care clinics at discounters such as Wal-Mart and Target, drug chains such as CVS and Rite-Aid, and supermarkets such as HEB and Cub Foods.⁷ The failure of both government cost control through national health insurance (Gingrich's Canada) and private cost control through insurer-driven managed care has created a vacuum—a lack of countervailing pressure on health spending that retail clinics attempt to fill within their niche.⁸

From the 1960s through the 1990s, annual per capita health care spending in the United States increased persistently, but generally tracked the experience of other developed countries. The United States diverged to the upside in the early 1990s, briefly reversed direction in the late 1990s, but then accelerated again after 2000. American health care consumers, both employers as sponsors of private health coverage and individuals as recipients, see the situation as increasingly desperate. The former have defined their contributions and increased their cost-sharing requirements, placing greater financial burden on the latter. Having squeezed most available discounts out of hospitals and physicians, insurers meanwhile continue to look for cheap ways to deliver covered services that will not provoke a market or political backlash similar to what followed the severe restrictions on choice, perverse physician incentives, and direct interference with clinical practice of 1990s-style managed care.

Simultaneously, an aggressive, ideologically driven, politics of “consumer-directed health care” attributes unbridled cost growth primarily to the attenuation of information and incentives that accompany third-party coverage.⁹ Reformers of this ilk believe that reducing moral hazard and increasing transparency at the point of care will lower health care expenditures, and therefore prefer service-oriented approaches to low-deductible insurance sponsorship models such as “managed competition.” Beginning with HIPAA, with a significant expansion as part of the Medicare Modernization Act of 2002, this preference has been reflected in the Internal Revenue Code, which

7. Wal-Mart, unsurprisingly, has attracted considerable attention from public observers of all types. *See generally* JOHN DICKER, *THE UNITED STATES OF WAL-MART* (2005) (describing the highs and lows of interacting with a company that if it were a country would be one of the twenty largest economies in the world); CHARLES FISHMAN, *THE WAL-MART EFFECT* (2006) (describing how the company's single-minded fixation on low price affects producers, consumers, and society).

8. I owe this interpretation to a conversation with Columbia health economist Sherry Glied.

9. *See, e.g.*, Greg Scandlen, *Consumer-Driven Health Care: Just a Tweak or a Revolution?*, 24 *HEALTH AFF.* 1554, 1555–57 (2005) (describing the potential connection between increased consumer financial responsibility and more cost-effective care delivery models).

increasingly allows consumer-directed health purchases to be made with before-tax dollars through health spending accounts.

The exact scale and scope of the retail clinic enterprise are moving targets, but the basic features seem established.¹⁰ Clinics are located in mass retail centers associated with familiar consumer brands. Space is leased by the host store to contract parties who basically act as franchisees, although some clinics are attempting to develop their own goodwill. Clinics tend to be small, with low overhead and limited technology; miniaturization of basic medical diagnostics is a key facilitator of clinic operations. Hours tend to be expansive, including nights and weekends. No appointments are necessary. Prices are openly posted at the sites and often on the Internet.

Only selected services are available, not amounting to what one would typically consider “urgent care.” The most frequently provided service is strep throat testing. Services tend to divide between what one clinic chain calls “get well services” for simple ailments such as flu or conjunctivitis, and “stay well services” such as immunization-based services. Almost all retail clinics are staffed by supervised mid-level providers, either nurse practitioners or physician assistants, and therefore have expanded most rapidly in states that allow broader scope of practice to non-physicians. These professionals use explicit practice protocols, typically with computerized decision-support, and maintain electronic medical records. Retail clinics tend to be scrupulous about not encroaching on established physician relationships, communicating information about off-hours services they provide to patients already under treatment and developing referral networks both for additional outpatient care and for hospitalization. They do not provide emergency services as traditionally defined.

IV. HEALTH POLICY IMPLICATIONS

What are the implications of the retail clinic model for the three major dimensions of American health policy: cost, quality, and access? Commitment to posted, affordable prices is a defining characteristic of

10. For representative stories on the expansion of retail clinics, see Emily Fredrix & Marcus Kabel, *Basic Care While You Shop*, HOUSTON CHRON., Feb. 6, 2006, at D4; Felice J. Freyer, *Quick Care—Now Offered in 10 States, One-Stop Clinics at Pharmacies Promise to Fill Health-Care Needs*, PROVIDENCE J., Aug. 1, 2006, at A1; Dorsey Griffith, *Walk-in Health Care*, SACRAMENTO BEE, Jan. 14, 2007, at A1; Sandra Jones, *Walgreens Plans to Expand Clinic Service*, CHI. TRIB., Jan. 11, 2007, at 1; Pallavi Gogol, *Drugstore Clinics Are Bursting With Health*, BUS. WK. ONLINE, July 17, 2006, http://www.businessweek.com/investor/content/jul2006/pi20060717_240148.htm?chan=search.

the movement, and is achieved partly through aggressive input cost control and, one would eventually expect, supply chain management. This is in keeping with the business model of the host stores, fits the profile of the consumers who patronize them, and justifies the use of scarce sales space for medical services rather than other revenue-producing activities. For example, Wal-Mart not only demands very low prices from its suppliers but it often works closely with them to accomplish it by providing capital and acting almost as an internal management consultant.¹¹

The focus on price in the retail clinic model rather than utilization is significant because high price typically distinguishes the United States in international comparisons of health expenditures. Also interesting with respect to cost is the clinics' focus on administrative simplification through standardization, electronic information, and transparency. This has allowed retail clinics to become incorporated in various insurance models, not just ones based on cash payment. The first clinic operators assumed that many people would pay for the convenience of getting basic medical care without appointment during shopping trips, and did not accept insurance. Now, however, most insurance plans readily pay for care at retail clinics, in part because lower prices have not been accompanied by higher utilization of clinic or referral services (prescription drugs being the only readily available additional covered item in most clinic settings). To make insurance coverage practical, the clinics must keep their administrative systems simple and compatible with those of insurers.

Turning to quality, retail clinics reflect to some degree the absorption by the American public of a host of studies done over the last twenty years or so showing the tremendously uneven quality of American health care. By and large, the cottage industry that we call "health care country" generates high cost but still fails to practice according to established science, leaving large areas for improvement. At least for basic services that they can understand, patients seem to be responding to clinics' standardized practices and value-for-money proposition in a way that was not true a generation ago, when physicians' knowledge and skill were unquestioned.

The technical quality of care in retail clinics depends primarily on the fit between the services they provide and their constituent professionals. Decades of experience and considerable research on

11. See FISHMAN, *supra* note 7, at 79–109 (casting "The Squeeze" Wal-Mart exerts on suppliers in a less favorable light).

advance practice nurses and physician assistants leave little doubt that those providers are as qualified as physicians to deliver services of the sort retail clinics currently offer.¹² The business model of the typical clinic allows mid-level providers to spend more time with each patient than would occur in many physician offices, which is additionally reassuring. There are also good indications that retail clinic chains are adopting information technologies that backstop clinical decision-making and allow electronic communication with other health care providers.¹³

Retail clinics depend on patients to self-identify need for particular services, and problems might arise if screening and treatment protocols were channeled for business reasons in directions that undercut quality, such as not taking time to make an appropriate referral. Concerns about excessive diagnostic testing or prescription of medications obtainable in the host pharmacy, while plausible considered against ideal clinical practice, seem slight when one takes into account the imperfections of the established primary care delivery system.¹⁴

12. A recent review of eleven trials and twenty-three observational studies in primary care settings concluded that patients were more satisfied with care by a nurse practitioner, that nurse practitioners had longer consultations and ordered more tests, and that no differences were found in prescriptions, return consultations, or referrals. 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). The review concluded that “[q]uality of care was in some ways better for nurse practitioner consultations.” *Id.*; see also Linda H. Aiken, *Achieving an Interdisciplinary Workforce in Health Care*, 348 NEW ENG. J. MED. 164, 165–66 (2003) (describing the quality of non-physician professionals); Mary O. Mundiger et al., *Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians*, 283 JAMA 59, 64 (2000) (demonstrating equivalent outcomes).

13. For example, MinuteClinic recently entered into an agreement with the American Academy of Family Physicians (AAFP) to use the AAFP’s Continuity of Care Record standard for MinuteClinic transactions. *MinuteClinic, Physicians Group Announce Agreement for Secure Exchange of Patient Information*, BIOTECH BUS. WK., Nov. 6, 2006.

14. Among organized medical groups, the American Academy of Pediatrics has been most opposed to retail medical clinics, generally citing concerns over comprehensiveness and continuity of care. See Retail Based Clinic Policy Work Group, *AAFP Principles Concerning Retail-Based Clinics*, 118 PEDIATRICS 2561, 2561 (2006) (stating opposition but recognizing clinic movement as irreversible); see also Ranit Mishori, *Is Quick Enough?: Store Clinics Tap a Public Need, but Many Doctors Call the Care Inferior*, WASH. POST, Jan. 16, 2007, at F1 (quoting a recent American Academy of Pediatrics director as saying “[t]hese [clinics] are not appropriate for children”). The American Medical Association issued an internal report that took a cautious approach. COUNCIL ON MED. SERV. AM. MED. ASS’N, *STORE-BASED HEALTH CLINICS* 5 (2006) (expressing concern for patient care and the physician-patient relationship); see also Jonathan Nelson, *Redi or Not, Here Come Retail Health Clinics*, TEX. FAM. PHYSICIAN, Apr. 2006, available at www.tafp.org/news/tfp/2006tfp2/5.asp (describing AAFP’s concerns about retail clinics).

Undoubtedly, medical errors will occur in retail clinics, and there is no reason to believe that clinic operators will be more forthcoming about revealing and addressing errors than physicians in traditional settings. However, it is interesting that the anecdotal reports assembled by a Washington, D.C., pediatrics group as ammunition against clinics focused on two patients who, the group believed, had not been prescribed antibiotics for conditions that warranted them. *Id.* Overuse, not underuse, of prescription medications available at the host retailer is the quality problem that

Today's retail clinics are also noteworthy for their focus on customer service.¹⁵ This contrasts sharply with American hospitals, which for decades treated the physician rather than the patient as the customer because physicians controlled both admission and services received. As one physician, without a hint of irony, wrote *USA Today* 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."¹⁶

Moreover, the amenities clinics emphasize are convenience, accessibility, and predictability rather than luxury.¹⁷ The patient is indeed the customer, who also typically associates these qualities with the trusted brand of the host store and expects the same reliability from clinic services as from other mass-produced and mass-retailed products. In this respect, the difference between a care-based system and a coverage-based system is again important. Contrary to the hopes and expectations of managed competition theorists in the 1980s and early 1990s, managed care organizations could never build brand-based trust among consumers because they were insurance companies and were presumed to maintain an adversarial position with respect to people who sought benefits. By contrast, retail clinics have the potential to enjoy widespread customer confidence as long as prices remain low and scandals are avoided.

Access presents an equally interesting set of possibilities. As any economist would acknowledge, low prices alone recruit new buyers along the demand curve and improve access to care at the margin. The low prices do, of course, as any economist would say, improve access at the margins. The convenience associated with receiving these services at familiar retail locations also avoids the "take-up" problem that besets health reform proposals based on tax credits or other insurance subsidies.

most clinic critics have forecast.

15. In a recent Harris Interactive survey, 5% of people surveyed had used a retail clinic. Of these, 83% reported satisfaction with the convenience of the clinic, 90% were satisfied with the quality of care, and 80% were satisfied with the cost. Becky Bright, *Most Are Satisfied with Care at Retail-Based Health Clinics*, WALL ST. J. ONLINE Apr. 11, 2007, <http://online.wsj.com/article/SB117509709709251933-search.html?KEYWORDS=adults+satisfied+care+COLLECTION=wsj/6month>.

16. David H. Schell, Letter to the Editor, *Medicine Is Not Fast Food*, USA TODAY, Aug. 30, 2006, at A12.

17. In late 2006, twelve retail clinic chains created a quality-oriented trade association, aptly named the Convenient Care Association. Michael Johnsen, *CCA Emerges as Face, Voice of Booming Retail Clinic Industry*, DRUG STORE NEWS, Nov. 6, 2006 at 1, 1. New delivery models to provide house calls are also surfacing. See Victoria Colliver, *Their Patients Really Feel at Home*, S.F. CHRON., Jan. 31, 2007, at C1 (discussing the rising trend in house calls). Like retail clinics, house call businesses employ miniaturized clinical and information technology. *Id.*

Whether or not one dignifies the analysis by citing risk perceptions, risk valuations, or similar cognitive biases, the fact remains that people unaccustomed to insurance often fail to purchase it, even when it is affordable by any objective analysis.

Put services at a fair price where people congregate, and the situation is different. This argument supports placing health care, and public health services, in places such as schools as well as retail clinics.¹⁸ While urban sprawl in growing areas of the United States, particularly the southwest and west, distance much of the population from large, center-city medical centers, 50% of Americans live within five miles of a Wal-Mart store and 90% live within fifteen miles.¹⁹ Pharmacy and supermarket chains track population growth and follow population even more closely, with little need for centralized planning. Low overhead in retail clinics also allows them to locate in economically disadvantaged, ethnically diverse neighborhoods, even though the original business model contemplated a relatively affluent patient base.²⁰

A final point about access confronts the potential irony of looking to Wal-Mart as a health care provider when it, and many other mass retailers, do not provide health care to their own workers.²¹ It is a reasonable assumption that once health care is readily available to customers in these stores, it will be made available to employees as well. Among other things, the health professionals and ancillary staff employed in these settings will demand it for themselves and their co-workers. An additional selling point for retailers installing clinics is the boost to productivity from having on-site medical care. Properly structured, the retail clinic model therefore can improve access to care for large groups of currently uninsured low-wage workers.

Innovation is sometimes subsumed in quality and sometimes identified as a separate health policy metric. Regardless of its characterization, it takes shape in retail clinics in unusual ways. Health

18. See Onora Lien et al., *Getting Medicine to Millions: New Strategies for Mass Distribution*, 4 *BIOSECURITY & BIOTERRORISM: BIODEFENSE STRATEGY, PRAC., & SCI.* 176, 178–81 (2006) (exploring the feasibility of mass distribution of vaccines and antibiotics through retail grocery and wholesale stores in event of public emergency).

19. FISHMAN, *supra* note 7, at 6.

20. See, e.g., Michele Chandler, *Medical Care and Shampoo*, *SAN JOSE MERCURY NEWS*, Jan. 6, 2007, at 1C (describing a clinic in a Hispanic drugstore).

21. See DICKER, *supra* note 7, at 83–88 (describing the catastrophic health insurance package that Wal-Mart, at best, provides its workers); see also *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 198 (4th Cir. 2007) (affirming district court decision that Maryland law obligating Wal-Mart to pay for health insurance is preempted by ERISA). According to a 2006 book, Wal-Mart has 1.6 million employees, making it the world's largest private employer, with another three million people dependent on Wal-Mart purchases for their livelihood. See FISHMAN, *supra* note 7, at 7.

care innovation is usually associated with technological advances in medical diagnosis and treatment, often in the hospital setting. Retail clinics share this form of innovation in limited but important ways, such as compact diagnostics and informatics. But the essence of the retail clinic is innovation in accessibility and service, innovation that, moreover, must be continuous. All successful mass retailers regularly reinvent their offerings, an unaccustomed practice for health care providers. Unlike most professional services, which change largely with generational washout or major alterations of public funding models, mass retailers expect to adopt new approaches every two to four years, and pursue them explicitly.

In addition to being self-conscious, service design in retail clinics is local. As a matter of political necessity, mass retailers entering communities assess conditions on the ground and act accordingly. This process may not be pretty, pitting personalities and their parochial interests against one another, but it is adaptive. Accordingly, one can expect retail medical clinics to follow paths that vary not just with state law regarding scope of practice but with the demands of the local chamber of commerce and the local provider community.

V. CAVEATS AND CONCLUSIONS

The retail clinic model is still undeveloped, and may or may not play out as hinted at above. Its scalability, and even its survival, remain matters of speculation. For the time being, however, its potential to dislodge the U.S. health care system from certain entrenched practices is worth noting. Also deserving attention are questions that retail clinics raise for the national health reform enterprise in its efforts to provide for the underserved through changes to insurance, financing, and—most importantly—health care delivery.

In terms of insurability, consumer-directed health care as a whole poses problems for the stability of risk pools, which the ready availability of primary care in retail clinic settings may heighten. Retail clinics as currently constituted are most attractive to healthy people seeking preventive services or treatment of acute moderate illness. The great majority of health care dollars are not spent by this population, but by people with multiple chronic conditions such as heart disease and diabetes. Uniform funding of these two very different groups by employers as insurance sponsors, and federal tax policies that shelter both health spending accounts and traditional coverage equally, will tend to draw dollars away from the pools that cover the sickest individuals.

Adverse selection of this sort is always the risk of expanding insurance choice to consumer-directed models as a partial solution to moral hazard.

In terms of financing, retail clinics exist to make money and therefore cater to people with money, even if many clinic customers have less money than the people who are best served by the existing system. The very poor cannot afford care through retail medical clinics any more than they can afford traditional medical providers. The efficiency and customer service focus of retail clinics, therefore, needs to be replicated within the primary care safety net, which may currently lack both the clinics' infrastructure and their incentives.

Still, their sensitivity to local conditions and their standardized service delivery may enable retail clinics to make a very large and innovative contribution to American health insurance. For decades, politicians and policymakers attempting to finance "basic" health care from the top down have been unable to answer a deceptively simple question: "Where does basic medical care end, and where does more-than-basic medical care begin?"²² Retail clinics approach this question from the bottom up. At least with respect to primary care, retail clinics are likely to draw different lines in different communities as more or fewer services become subsumed in their business model. Some clinics may offer x-rays and minor surgery. Others will stick with immunizations and acute sinusitis. Chronic disease management may exist in some clinics and not in others. Observing this process as it plays out across the nation may have important implications for insurance design and public entitlements as well as for service delivery.

With respect to health care delivery and national health reform, the retail clinic model challenges longstanding beliefs about the health care workforce and the structure of primary care. Corporate America changed the nature of health insurance in the 1980s and early 1990s by supporting managed care, which destabilized a political settlement in favor of Blue Cross-style coverage that was within the comfort zone of organized medicine. Through large retailers, it is now poised to change the health care workforce, again upsetting equilibrium conditions with respect to professional hierarchy and scope of practice that medicine has maintained under state law. If this model succeeds, and if our system of

22. In the 2006 reform in Massachusetts, this question was held captive to the politics of benefit mandates under state law, resulting in a three-year moratorium on additional mandates but no rollback of the many existing ones. The result is a less affordable benefit package. See generally Gail A. Jensen & Michael A. Morrissey, *Employer-Sponsored Health Insurance and Mandated Benefit Laws*, 77 *MILBANK Q.* 425, 441-54 (1999) (discussing the cost of benefit mandates to employers and beneficiaries).

professional education keeps pace with market demand, the future American “doctor” may be an advanced practice nurse or physician assistant rather than a physician.²³ It will be difficult for small physician practices to achieve the efficiencies of retail medical clinics even if they embrace the clinics’ customer-service philosophy. Purchasing and storing vaccines, for example, is far costlier and riskier in the small office setting, limiting patient access to these services.²⁴ And with direct supervision of mid-level providers receding in importance because of improvements in electronic information and decision support, many primary care physicians (and specialist physicians who currently provide primary care) may turn to team-based management of serious chronic diseases.

Finally, what will happen to hospitals as primary care diffuses into the community? Emergency departments may be relieved of treating many non-urgent problems, but will still need to maintain reserve capacity and develop funding streams to support it. As nurses expand their community role, physicians are likely to consolidate into specialist groups focused on serious illness and injury, often aligned with inpatient facilities. The complement to the nurse-based practice model in retail clinics is the hospitalist movement among physicians.²⁵ Taken to its logical conclusion, this process may create a uniquely American version of the health care delivery system that prevails in most European countries, with office-based primary care medicine strictly separated from hospital-based specialty care. That model was poorly adapted to the American continental expansion, which favored community hospitals with open medical staffs in emerging population centers, with predictable consequences for cost. In the best case scenario, dividing primary from specialty care through retail clinics could reduce cost in the former and improve quality in the latter. This is not a solution to the compelling problems of the underserved in America, but it is a ray of hope.

23. The Governor of Pennsylvania recently proposed an overhaul of state professional licensing laws to allow non-physicians to provide basic care. Martha Raffaele, *States Driving Health Reforms*, BOSTON.COM, Apr. 1, 2007 http://www.boston.com/news/nation/articles/2007/04/01/states_driving_reforms?m.

24. My family experienced this phenomenon during our first year in Texas as academic visitors. Every pediatrician we called regarding flu shots for the kids either had reserved their supply of vaccine for existing patients, or ran out as soon as a new batch arrived. Visiting relatives in Minnesota over Thanksgiving, however, we all received flu shots in fifteen minutes at a retail clinic in a Cub supermarket.

25. See Christopher Rowland, *New Specialists Are Ready to Help—Inpatients, That Is: In-Hospital MDs Take Pressure Off Physicians*, BOSTON GLOBE, Oct. 30, 2006, at E1 (describing hospitalists); see also Herbert S. Diamond et al., *The Effect of Full-Time Faculty Hospitalists on the Efficiency of Care at a Community Teaching Hospital*, 129 ANNALS INTERNAL MED. 197, 202 (1998) (concluding that hospitals may improve the quality of inpatient care).
