The Walmart Effect: Retailing of Health Care

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ABSTRACT

Health care delivery began as a cottage industry and then transformed into an industrial model of care delivery dominated by large for-profit, non-profit, and governmental bureaucracies. In recent years, with the growing health care labor shortage, the aging of the population and the ever-changing demand for health care services, there have been a host of innovations in the delivery and financing of health care services. This article will focus on the emergence of retail based clinics and will critically evaluate these clinics using a stakeholder perspective.

INTRODUCTION

In a move that could have profound effects on the health care system, the king of "always low prices" has announced its aim to conquer car infections and sore throats. Wal-Mart Stores, Inc., already has opened a pilot program of 76 in-store medical clinics in 12 states, and plans to increase that number to 2,000 over the next five years (Maestri, 2007). Other retailers, such as CVS/Caremark Company's MinuteClinic and Walgreens, are joining health care's retail revolution. Business tycoons are jumping into the delivery of health care; former AOL Time Warner chairman Steve Case has launched RediClinic, a retail division of Revolution Health Group. Even the non-profit Aurora Health System is operating in-store clinics in grocery stores and in Wal-Mart itself.

The introduction of retail clinics into the health care landscape is nothing less than a disruptive innovation. Christensen, Bohmer, & Kenagy (2000) raise the prospect as to whether disruptive innovation addresses the central challenges of health care as captured by the title of their Harvard Business Review article--"Will Disruptive Innovations Cure Health Care?" Malvey and Fottler (2006) assert that retail clinics which represent a disruptive innovation will be one of the cures for health care as described below:

"We believe that the revolution will likely be led by retailers such as Walmart because they exhibit the strategic attributes and behaviors necessary for radical change. For example, Walmart embraces change and aggressively pursues new market opportunities, whereas HCOs [Health Care Organizations] tend to be averse to change (page 169)."

Given that health care is part and parcel of any social system, social scientists suggest that new industries are to be considered as emerging social systems (Van de Ven & Garud, 1989). Seeking health care services and the financing of such services are part of the social system of nations as well as the economic system. Retail clinics not only represent a disruptive innovation but possibly a change in societal expectations regarding health care.

Wal-mart was not the first retail clinic to enter this pioneering new market. The first retail clinic opened in 2000 in Minneapolis-St. Paul and was operated by QuickMEDS. Since that time, many more have opened to the point that the Convenient Care Association (CCA) was established as the trade group for the emerging industry. CCA launched in 2006 the premier edition of The Retail Clinician-the magazine for the industry. The executive editor writes in an opening column entitled-Vive’ le revolution-that, "...the based clinic lowers the cost and increases accessibility to health care in America...You can call it a Retail Clinician Revolution (page 3)." According to some estimates, the end of 2007, there will be 1,500 retail clinics operating under twelve different organizational banners (Frederick, 2006).

Retail clinics are not the only innovation in health care delivery. Other innovations include concierge medical practices, credit cards for health care services, and other novel reimbursement approaches. Although not the focus of this article is it important to briefly describe concierge medicine and the convergence of finance and health care.

First, the business model of concierge medical practices is designed around an annual retainer fee structure in which a primary care physician limits the number of patients ranging in size from 50 families to 500 individual patients (DeMaria, 2005) for an annual fee ranging from $1,200 to $20,000 per patient per year (Ackerman, 2007). This type of practice offers physicians more time to spend with each patient and offers patients "...more convenient
health care with more amenities (DeMaria, 2005, page 377).” Some critics have suggested that this type of practice has created a two-tiered economic system within medical care (Leidig, 2005). Similar to retail clinics, concierge medical practices are supported by their own professional society-The Society for Innovative Medical Practice Design. Patients pay for concierge medical services in two ways: out-of-pocket payment for the annual retainer and health care insurance for those services covered by the insurance carrier.

Second, employer-sponsored health insurance and state-sponsored health insurance is gradually disappearing in its entirety or in its benefit levels in the United States (Knott, Ahlquist, & Edmunds, 2007). As such, as health care moves toward a retail model and as insurance benefits continue to decline and then the financing of health care will have to depend upon patients. Emerging innovations include debit cards, credit cards, and health savings accounts (HSAs) which function like a 401(k). According to Bessler, Leisey, and Saxena (2007) in an article entitled “Health Meets Wealth”, retail based health care represents part of the convergence between health care and financial services as described below:

“As the two industries converge, they can capitalize on at least three types of opportunities: technological integration, which could, for example, lead to credit cards that are embedded with the holder’s electronic health record; new financial arrangements, such as collection services for doctors and other providers, including assumption of bad-debt risk; and unique blended products. Under the last category, we’ve already seen the emergence of consumer-directed health plans (CDHPs), which typically pair high-deductible major medical policies with tax-advantages health savings accounts (HSAs) or health reimbursement arrangements/accounts (HBAs) (page 2).”

Notable illustrations of the convergence between health care and financial services is the federal approval of Blue Cross Blue Shield Association launch a bank to administer HSAs (The Associated Press, 2007) and the offering of the VISA HSA card. There are also credit cards to be used only for health care services like Care Credit, which is endorsed by organizations like The American Society of Plastic Surgeons. Even mutual funds like Fidelity are migrating into this space as evidenced by Fidelity’s online Retirement Health Care Cost Calculator which allows pre-retirees, retirees, and financial advisors to plan for retirement health care expenses as part of an overall financial and retirement plan.

Many of these innovations have come into existence due to reports of declining quality (Kaiser Family Foundation et al., 2004), estimates ranging from 44,000 to 98,000 hospital deaths resulting from medical errors each year, and reports of “Patient care suffering from depersonalization (Kimball, 2005, page 8).” To this point, many innovative business models of health care including both retail clinics and concierge medical practices are attempts at addressing the fundamental challenges within U.S. healthcare today. For example, it has been noted that concierge care is designed around “…the fundamental concepts of quality and personalized care, a reduced patient base that ensures greater access to service, and enhanced continuity of individual care (Lintz, Haas, Fallon, & Metz, 2005, page 515).” These innovations in business models, delivery models, and financing models are in direct response to the growing recognition that health delivery is not immune to the open-market economy of the U.S. which “…provides choices for consumers and promotes competition among providers of goods and services (Lintz, Haas, Fallon, & Metz, 2005, page 518). Furthermore, assuming that quality of care and quality of service are outputs of medical services, it has been argued that “…the availability of these options provides an incentive for increased or improved output by producers (Lintz, Haas, Fallon, & Metz, 2005, page 518).”

Latkovic and Singhai (2007) comment that “…U.S. health care is going retail, from the growing interest in health savings accounts (HSAs) to the proliferation of minute clinics and other convenient settings for delivering care (page 1).” This trend is also emerging within Latin America and Europe. The Mall Pasco Estacion in Santiago, Chile houses a bus terminal and a medical clinic in addition to 450 stores. Teseo, the United Kingdom retail giant, launched Healthy Initiatives which does not include a retail outlet yet but includes a pharmacy, optical services, and nutritional services. According to Knott, Ahlquist, and Edmunds (2007), the goals of this retail revolution are described below:

“...to improve health and health care and to transform an annually evaporating asset- traditional health insurance-into a lifelong benefit with real wealth-building potential for consumers over and above any near-term risk management features (page 4).”

Wal-Mart’s retail clinic business model consists of contracting with hospitals and other independent organizations, such as RediClinics and Aurora. The company may use its “one-stop” shopping model to include...
primary care services at a lower cost than more traditional delivery models. Wal-Mart is seizing on the trends of corporate medical practice, a market economy, and a consumer culture that values self-service and self-direction.

“We think the clinics will be a great opportunity for our business,” says Wal-Mart CEO Lee Scott. “But most importantly, they are going to provide something our customers and communities desperately need — affordable access at the local level to quality health care.” (Maestri, 2007). Wal-Mart is a low-cost operator that leverages technology and other efficiencies to bring lower prices to consumers. Consumers could see other benefits as well. Wal-Mart’s abilities to manage information could improve coordination of care. And because Wal-Marts are located in many medically under-served areas, from rural Mississippi to Chicago’s west side, disadvantaged patients could find health care more accessible.

As the number of aging baby-boomers and the uninsured and underinsured increases, Wal-Mart and other retailers are betting on an increase in market demand. These companies likely will benefit from an increased labor supply as well, since the number of physician assistants is expected to rise. Moreover, U.S. consumers have grown accustomed to convenience and these retail clinics optimize convenience. The convergence of these forces, along with other legal, regulatory, and socio-cultural factors, all make it likely that the primary medical care system will experience the Wal-Mart effect — for better or for worse.

**WAL-MART EFFECT**

The Wal-Mart effect has the potential to transform the delivery of medical care at a faster pace than any government-sponsored health care reforms. But prudence is in order, given the known impact of the Wal-Mart effect. Charles Fishman describes it this way in his book The Wal-Mart Effect: How the World’s Most Powerful Company Really Works -- and How It’s Transforming the American Economy:

“Wal-Mart changes the world like that every day, and has been for forty years. A wasteful routine, often long entrenched, is detected and eliminated, establishing a new standard of efficiency, lowering costs for everyone, especially ordinary customers. And in the wake of the change comes a ripple of unintended consequences. Or if not quite unintended, at least unrecognized. That is the Wal-Mart effect -- the ways both small and profound that Wal-Mart has changed business, work, the shape and well-being of communities, and everyday life in the United States and around the world.” (2006, page 3)

The Wal-Mart effect is an illustration of commoditization in private markets. The current delivery of primary medical care includes private markets, in the form of for-profit medical groups; quasi-private markets, in the form of providers who accept a high proportion of Medicare and government-sponsored insurance; and public markets, in the form of federal and state-employed providers, such as federally qualified Community Health Centers. Is Wal-Mart different from individual providers and medical groups that function in private markets? This question dips into the age-old debate as to whether medical care is a right or service to be bought and sold. Clearly, medicine today is largely organized as a service to be bought and sold. As a company, Wal-Mart has discovered time-tested approaches of creating greater value for consumers of both goods and services and is now ready to enter the delivery of primary medical care services.

An analysis of the Wal-Mart effect on the delivery of primary medical care in the United States must critically examine the expected benefits and risks to patients and providers.

**Patients as Stakeholders**

Patients may benefit from increased access to limited primary care services, cheaper health care and pharmaceutical services, and more satisfaction in the delivery of health care services. Empirical data regarding the experience of patients is limited. However, the polling firm Harris, in concert with The Wall Street Journal, conducted an on-line survey of 2,441 adults in March of 2007.

One in twenty (5%) respondents reported visiting a retail-based health clinic. Among the users, 83% reported being somewhat/very satisfied with its convenience; 90% by quality of care, 85% by the quality of provider staff and 80% by cost. Clinic users gave their top reasons for seeking services there as: vaccinations (44%); treatment for minor infections, such as ear, sinus, and throat, and illnesses, such as colds and rashes (33%); preventive screening tests for high blood pressure, high cholesterol, allergies, and diabetes (19%); and physical
exams for school, camp, and work (5%). In terms of reimbursement, 42% reported that their insurance covered the full or partial amount for the visit. This report concludes that “these findings bode well for the future of in-store clinics, suggesting that as their availability increases, more people will be willing to use their services.” (page 1)

The anticipated risks for patients may include uncoordinated care, the delivery of inappropriate care at retail-based clinics, and the invasion of privacy and confidentiality, as well as the commoditization of the health care encounter. Balancing anticipated benefits and risks rests on the shoulders of policy makers, regulators, physicians, and patient advocacy groups. Evidence-based criteria ought to be used to determine if the benefits outweigh the costs. The Convenient Care Association (CCA) promulgated 10 mandatory Quality and Safety Standards for retail clinics that are members of CCA with the overriding goal to assure the “highest quality of patient care and safety (2007, page 1).”

Providers as Stakeholders

The provider community, as represented by leading medical groups, is divided on whether Wal-Mart should deliver primary medical care services. The American Academy of Pediatrics is unequivocally opposed, favoring the medical home model. The American Medical Association says the growth of retail clinics parallels the AMA’s policy stance on pluralism in health care and free market competition. The AMA has set eight principles, listed in Table 1, by which retail health clinics must operate. Like the AMA, the American Association of Family Practice released a policy statement in June 2006. This policy statement entitled “Desired Attributes of Retail Health Clinics” identifies five factors to help physicians decide whether to work with a retail health clinic.

Provider benefits include increasing access of health care to the more vulnerable segments of the United States population, easing the burden on U.S. emergency rooms due to the lack of access to community-based care, further correcting the geographic maldistribution of primary care services in rural and urban communities, contracting with Wal-Mart to serve underserved markets, and increasing referrals to primary care physicians and specialists who decide to participate in this growing phenomena. Moreover, increasing employment and contracting opportunities will be made available for mid-level providers.

The possible risks for physician providers are the threat of substitution of labor by mid-levels, the shift in medical provider roles to a more direct role in leadership, management and supervision, the exchange of one provider for another during episodes of care and during benefit enrollment change dates, and the squeezing of compensation for all labor in the retail-based labor supply chain. Another risk, although it may benefit patients and payers in the short term, is that Wal-Mart wins the race to the bottom, delivering ever-cheaper care. This race to the bottom is driven in part by the well-constructed operational model first deployed by McDonalds, in which “the services listed are highly standardized interventions and require no physician evaluation.” (Bohmer, 2007, page 766) Will lower prices for patients result in downward pressure on income and wages for physicians and mid-level providers?

CONCLUSION

The Wal-Mart effect will transform the delivery of primary medical care. The critical issue facing medicine is the degree to which medical associations, health care delivery organizations, and individual physicians will collaborate with Wal-Mart and other retailers to ensure that patient care is improved, while at the same time preserving the ever-evolving profession of medicine. Malvey and Fottler (2006) argue that “[T]hese retailers are expected to have a profound impact on the delivery of health care services by providing an alternative site for basic medical care (page 168).”

The challenge for health care and medicine is to be able to move with both speed and deliberation in the face of Wal-Mart’s infrastructure and size. Will primary care physician offices disappear like the mom-n-pop retailers of small downtowns? Will Wal-Mart serve as the catalyst for the transformation of the delivery of primary medical care services? Will Wal-Mart commoditize the clinical encounter? Will Wal-Mart become the template for the future design of primary care delivery (Bohmer, 2007, page 767)? Will the profession of medicine and providers, including institutions and individual practitioners, collaborate with Wal-Mart to leverage Wal-Mart’s core competencies, while at the same time providing patients the best that medicine has to offer from a scientific, professional, and ethical point of view? Will Wal-Mart’s next strategy be to move up the value-chain and provide not just simple primary services, but also more complex procedures and specialty services? These questions must be addressed soon. With 2,000 clinics in the works, Wal-Mart is coming soon to a clinic near you.
Table 1   AMA’s Principles of Retail Based Health Care

1. Have a well-defined and limited scope of clinical services, consistent with state practice laws.
2. Use standardized medical protocols derived from evidence-based practice guidelines.
3. Establish arrangements by which their healthcare practitioners have direct access to and supervision by those with medical degrees (MD and DO).
4. Establish protocols for ensuring continuity of care with practicing physicians in the local community.
5. Establish a referral system with primary physicians in appropriate facilities.
6. Inform patients of the qualifications of the healthcare practitioners who are providing care, and the types of illnesses they can diagnose and treat.
7. Establish appropriate sanitation and hygienic guidelines.
8. Use electronic health records as a means of communicating patient information and facilitating continuity of care.
9. Encourage patients to have a primary care physician to ensure continuity of care.

REFERENCES


Frederick, J. (2006). Inside the Retail Clinic. The Retail Clinician, 1, 6-9.


