# Few Retail Clinics Found in Underserved Areas

BY MARY ANN MOON

Retail clinics tend to be located in "advantaged" neighborhoods rather than in the medically underserved areas that they are purported to serve, according to researchers.

In a study that matched the geographic locations of 930 retail clinics across the country with census data on the populations living in those locations, 123 clinics (13%) were found to be situated in underserved areas, according to Dr. Craig Evan Pollack and Dr. Katrina Armstrong of the University of Pennsylvania, Philadelphia.

Proponents of retail clinics contend that these venues can increase access to care, particularly for the uninsured, and can serve as an entry point into the health care system for those who do not have a primary care provider.

"A recent report … states that the placement of the clinics is determined in part by 'physician shortages and higher uninsured populations,' " Dr. Pollack and Dr. Armstrong noted.

But their analysis showed that these clinics are much more likely to be located in census tracts characterized by high incomes and low levels of poverty; high percentages of white residents and low percentages of black and Hispanic residents; and higher rates of home ownership and fewer rental units.

This disparity is not due to the "advantaged" location of the chain stores that house these clinics. Nearly one-third of such chain stores are located in medically underserved areas, but these are not the locations where the retail clinics are placed.

Moreover, counties in which there were retail clinics had the same number

## Paperwork for Insurers Costs $31 Billion a Year

Physicians and their staffs spend the equivalent of weeks—and $31 billion—each year processing health insurance paperwork, according to a study funded by the Commonwealth Fund and the Robert Wood Johnson Foundation.

The survey of 895 physicians and practice administrators nationwide asked respondents about the amount of time their practice's staff spent on various administrative activities, including prior authorization, drug formularies, claims and billing, credentialing, contracting, and collecting and reporting quality data.

The researchers found that physicians spent an average of 3 hours a week—or nearly 3 weeks a year—on administrative activities. Nursing staff spent more than 23 weeks per physician per year, and clerical staff spent 44 weeks per physician per year, interacting with health plans. More than three in four respondents said the costs of interacting with health plans have increased over the past 2 years (Health Affairs doi:10.1377/hlthaff.28.4.w533). Overall, the cost of these interactions amounts to $31 billion annually.

"While there are benefits to physician offices' interactions with health plans—which may, for example, help to reduce unnecessary care or the inappropriate use of medication—it would be useful to explore the extent to which these benefits are large enough to justify spending 3 weeks annually of physician time … on physician practice–health plan interaction," the study's lead author, Dr. Lawrence P. Casalino of Cornell University said in a statement. Physicians in solo or two-person practices spent many more hours interacting with health plans than did those in practices with 10 or more physicians; this was especially true in primary care, the researchers found.

"Administrative costs will never be zero, but we need to make sure that administrative interactions improve the quality of care by working to make care safer and more efficient, and rewarding health care providers who successfully reduce excessive care and provide the right treatment at the right time," Dr. Risa Lavizzo-Mourey, president and CEO of the Robert Wood Johnson Foundation, said in a statement.

**—Joyce Frieden**

of per capita hospital beds (approximately 2.3 per 1,000 residents) and the same number of general practitioners (2.8 per 10,000 residents) as did counties in which there were no retail clinics.

And despite the known shortage of physicians in rural areas, 96% of the counties in which retail clinics are located are classified as metropolitan, the researchers said (Arch. Intern. Med. 2009;169:945-9).

"If retail clinics are determined to be a valuable and effective source of care, rethinking the distribution of these clinics may be an important avenue for improving their potential societal benefit," they noted.

The investigators cautioned that their study was limited by its area-level assessment, which could not examine the individual clients who attend retail clinics nor measure other aspects of accessibility such as hours of operation or available public transportation.

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DR. ARMSTRONG

The funding for this study was provided by the Robert Wood Johnson Foundation.

In an invited commentary, Dr. Mark D. Smith of the California Healthcare Foundation in Oakland, and his colleague, Margaret A. Laws, noted that retail clinic operators generally do not portray their services as comprehensive primary care, nor do they claim to focus on underserved populations (Arch. Intern. Med. 2009;169:951-3).

"The major operators have positioned their offerings as meeting mainstream customer needs for convenient, timely access to basic care for a subset of needs rather than as an alternative to comprehensive primary care," they wrote, noting that "most consumers do not have access to basic, acute care after hours and on weekends through their regular providers." Consumers, therefore, have turned to retail clinics to meet these needs. ■