Urgent care centres

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Although the growth of urgent care centres in the past 5 years has been phenomenal (180 urgent care centres in 1980; in excess of 3000 urgent care centres in 1985), they have been in existence since the early 1970s. Astute physicians, many of them involved in emergency medicine, saw that a significant percentage of the patient population utilizing hospital-based emergency departments consisted of people with relatively minor, but urgent, complaints. It was also obvious that the primary mission of hospital-based emergency departments was to provide medical intervention in life threatening or incipient life threatening situations. These new health care facilities, sometimes called freestanding emergency centres, were physically separate from hospitals and directed themselves to patients with ambulatory medical problems which were not truly life threatening. The success of these centres thus far can be attributed to: (1) the use of business techniques such as advertising and marketing to attract patients with episodic urgent care problems to the centre; (2) the relatively high cost of hospital-based emergency care and the lack of insurance coverage for many medical ambulatory problems; (3) the planning in these facilities to meet the patient convenience needs and the public perception that the hospital emergency department environment does not serve these personal needs.

Urgent care centres began to proliferate 11 years ago with the current prototypes being founded in Rhode Island and Delaware in 1973. Emergency physicians, family practitioners and others have, in many localities, built and staffed such facilities. Their purpose was to achieve a personal degree of autonomy and self-esteem. They described themselves as being involved in 'the private practice of emergency medicine'. Hospitals have built such facilities in order to expand their patient base and to 'feed' admissions to the base institutions. The hospital will frequently utilize the services of the hospital-based emergency group to provide professional staffing. Profit-making organizations such as 'Humana' staff and operate dozens of such centres throughout the US.

The typical urgent care centre is open 15 hours per day from mid-morning to mid-evening 7 days a week. The case-load consists of ambulatory patients almost exclusively and no appointments are necessary. Typically, there is an intensive marketing effort aimed at the insured patient seeking 'faster, cheaper, quality care in an environment more hospitable than the average hospital emergency room'. Where appropriate, marketing is also directed towards other patient groups such as industrial workers

(typically 100% insured) and white collar corporate employees. Although many facilities are equipped to stabilize the acute emergency patient (for example, the patient in cardiac arrest), no marketing is done to encourage the seriously ill patient to come to these units.

The medical process within urgent care centres is planned for patient satisfaction. As such, the process is highly stylized so as to provide convenience, caring and cost effectiveness as well as high quality for patients. Patients usually find convenient free parking adjacent to the centre. They enter a quiet, well-appointed office environment and are greeted by the nurse or doctor. Evaluation by the doctor usually follows within 15 to 30 minutes. Payment or proof of insurance is expected at the time of visit. There is a basic charge plus additional charges for services such as x-ray or laboratory. The typical urgent care centre has 'x-ray and laboratory facilities on the site'. Follow-up care may be by a private physician or the patient may be asked (or may ask) to return to the freestanding unit. From a standpoint of practice style, those physicians working in urgent care centres manage patient flow using the same type of systems management provided in emergency departments. There is a strong emphasis upon time management and the effective supporting role of ancillary medical personnel.

Some urgent care centres probably deserve to call themselves true emergency facilities (the American College of Emergency Physicians has published a set of guidelines which defines what essential policies, personnel and equipment should exist in a facility providing emergency care). All of these facilities are open 24 hours per day and are staffed, organized and equipped to provide true emergency services. Generally these facilities are owned and operated by hospitals, and are placed in locations which are remote from any other hospital. They provide for the transport of critically ill patients and participate in the local regional emergency medical services system. These 24-hour facilities provide little or no continuity of care, but like true emergency departments offer only emergency or urgent primary care as needed.

Physicians and others interested in urgent care centres formed the National Association of Freestanding Emergency Centers (NAFEC) in 1980. The trade organization represents the interests of physicians and/or hospitals owning or staffing these facilities. It developed standards of operation, relationships with government and insurance carriers and courses on how to set up units for those physicians and hospitals interested in developing such a project. Because of increasing marketing emphasis on ambulatory and primary care in addition to urgent care, NAFEC changed its name to the National Association for Ambulatory Care (NAFAC) in 1984 saying that the name change more clearly reflected the nature of their practice.

While the number of urgent care centres was growing, economic pressures from government, business and insurers acted to decrease reimbursement for emergency visits. Large business corporations, for example, are now acting to reduce the cost of medical insurance for workers by requiring employees to pay a co-payment or deductible portion of their health care before private insurance begins to pay for medical services. These forces produced a decrease in emergency visits from 83 million in 1981 to 79 million in 1983.

The phenomenon of urgent care centres has produced several interesting responses within the medical community. The advocates of 'pure' emergency medicine (that is, hospital-based emergency physicians) reacted to this competitive economic threat by

asking for state and local government regulations for any urgent care centre using the word 'emergency' in its title. Physicians working in freestanding centres countered with the argument that patients are discriminating enough to determine if they need the services of a hospital or an urgent care centre. As time has passed, this argument has cooled, though it is partially reflected in the organizational name change from NAFEC to NAFAC.

Private physicians' offices have reacted by keeping longer office hours, especially on weekends and evenings, to maximize their convenience for their patients. Hospitals have built their own urgent care centres to compete. Most recently hospitals and emergency department physicians have begun to lower prices for emergency care patients. Some hospitals are even developing an urgent care section of their emergency departments to offer essentially the same service as their freestanding urgent care centres.

The urgent care economic story is not one of inevitable success. With the burden of site development, site construction, labour costs and materials coupled with reduced charges for services, many freestanding centre owners have sold out to large health care corporations or gone bankrupt. The rosy pictures of economic success painted between 1980 and 1982 have been tempered with harsh reality. Still, the role for the urgent care facility in the provision of episodic care remains both real and important. The ability of American physicians to adapt rapidly and efficiently to a changing health care environment is exemplified by the urgent care centre phenomenon, and emergency physicians can be proud of their innovative role in the development this new dimension of the American health care system.

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