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Ontario Walk-In Clinics: A Preliminary Descriptive Study

SUMMARY

Little has been reported about Canadian walk-in clinics. The authors identified and surveyed 34 Ontario walk-in clinics in a preliminary descriptive study. A walk-in clinic was operationally defined as "a clinic that is separate from a hospital, has extended hours, and normally accepts patients without an appointment or a referral." Results showed that most Ontario walk-in clinics are not identifiable by name, have increased in number dramatically in the past two years, have laboratory, X-ray, and electrocardiographic facilities, and have varied practice patterns. Implications for rising health care costs and changing views on family practice were noted and suggestions made for future research. (*Can Fam Physician* 1989; 35:2013–2015.)

RÉSUMÉ

On ne connaît que peu de choses de la version canadienne des cliniques sans rendez-vous. Au cours d'une étude descriptive préliminaire, les auteurs ont identifié et procédé à une enquête auprès de 34 cliniques ontariennes sans rendez-vous. A des fins opérationnelles, on a défini la clinique sans rendez-vous comme étant "une clinique séparée de l'hôpital, qui offre une couverture horaire prolongée et qui accepte normalement des patients n'ayant pas de rendez-vous ou qui ne sont pas référés." Les résultats de l'enquête ont révélé que la plupart des cliniques ontariennes sans rendez-vous n'ont pas de nom précis, que leur nombre a augmenté de façon dramatique au cours des deux dernières années, qu'elles possèdent des facilités de laboratoire, de radiologie et d'électrocardiographie et que les modèles de pratique y sont variés. Les auteurs parlent des implications qui en découlent quant à l'augmentation du coût des soins de santé et aux changements des perceptions de l'omnipratique. Ils émettent enfin des suggestions permettant d'orienter la recherche future.

Key words: family medicine, practice patterns, walk-in clinics

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UNTIL RECENTLY, there have been no attempts to study the growth of medical walk-in clinics in Canada has been poorly studied. In 1987 a five-member Ontario Health Care Committee was formed to identify and survey walk-in clinics in Ontario. Although little has been reported about Canadian walk-in clinics, literature on their American counterparts may apply to the Canadian situation.

The evolution of commercial walk-in clinics in the United States has been traced to the early 1970s in the form of free-standing emergency clinics or urgent care centers (UCCs).[1,2] These UCCs were viewed as bridging the gap between fully scheduled family physician offices and overburdened emergency departments. They provided non-appointment services and after-hours care without the longer waits and higher medical costs associ-

ated with emergency departments.[3,4] The growth of UCCs in the U.S. has been dramatic; one source estimated a 10-fold increase of known clinics in a four-year span.[5] Nevertheless, it is questionable whether UCCs have actually reduced emergency department visits.[5]

Although some family physicians have had a no-appointment system for many years, there has been a recent upsurge in the number of new walk-in clinics, often part of large commercial organizations. For Canadian patients, there is no financial difference between visiting an emergency department, a walk-in clinic, or a physician's office, and no studies have assessed the impact of another level of primary care on the overall cost of the health system.

We report a preliminary descriptive survey of Ontario walk-in clinics. A walk-in clinic was operationally defined modifying the definition of Schaffer,[1] "a clinic that is separate from a hospital, has extended hours, and normally accepts patients without an appointment or a referral."

Method

Procedure

The committee chose a three-level search. The chiefs of family practice of 243 hospitals in Ontario, the Ontario representatives of the Ciba-Geigy pharmaceutical firm, and personal contacts of the Ontario Health Care Committee were contacted through mail for any information on locations of known walk-in clinics in their areas. By the cut-off date (November 1987), 54 clinics had been identified. The surveys and an opening cover letter explaining the purpose of the study were then mailed to potential clinics. A small group of clinics were mailed surveys in January because of late identification as walk-in clinics. All clinics were mailed two reminder letters before the cut-off date for replies in April 1988.

Instrument

The survey instrument consisted of two pages of 13 main items in addition to clinic name, address, telephone number, and an open-ended question asking for general comments. Item formats were forced-choice, yes or no questions, with blank items to be filled in. Item contents were designed through discussion by the committee to determine whether the clinic met the definition of a walk-in clinic and to determine the extent of its operations.

Respondents

Respondents were 42 representatives of the 54 medical clinics surveyed (77.8% response rate). Of these, 34 clinics met the operational definition of a walk-in clinic and had usable data. It was not known what position the respondents had in the clinics, or who physically completed the survey.

The list of walk-in clinics continued to be updated by the committee until the end of May 1988, when the total had risen to 105. Data for only 34 clinics are reported here.

Results

All usable data from the 34 walk-in clinics were entered into a microcomputer, and descriptive statistics were determined. The data are organized under five headings: background information, clinic in-services, clinic out-services, business administration, and respondents' comments.

Background Information

Clinic Names. Of the 34 walk-in clinic names, 18 (53%) clinics contained the word "medical" or "clinic" in the title, often with the name of the area in which the clinic was located. Of the remainder, nine (26%) used the name "doctor's office." Only five (15%) contained the phrase "walk-in clinic," and two (6%) contained the phrase "after-hours clinic."

Clinic Addresses. The largest number of clinics were in the Toronto area. Twenty-six clinics (76%) were within a 50-km radius of downtown Toronto, 11 (42%) of which were in metropolitan Toronto itself. Smaller cities tended to have one or two clinics each. The data did not allow further analysis of distribution of clinics per population or area.

Clinic Location. The most common locations for walk-in clinics were strip plazas (44%), malls (26%), and doctor's offices (18%). Other locations, mostly specialty medical buildings, accounted for 12%.

Duration at Clinic Location. It is important to note that this survey item determined duration at clinic location, and not duration of the clinic's existence. For the 24 clinics reporting duration at clinic location, the mean duration was 60 months (five years). A small number of these clinics, however, were family physicians' offices that had offered extended hours on a no-appointment basis for as long as 30 years before the current commercial trend for walk-in clinics began. To get an indication of current trends, we eliminated the three clinics reporting to be open for 10 years or more from the calculations. The remaining 21 clinics had a mean duration at the clinic location of 17 months, with a range of one month to four years.

Clinic In-Services

Appointments. All (100%) clinics accepted patients without appointments because accepting patients without scheduled appointments was one of the criteria used in defining a walk-in clinic. Twenty-seven (79%), allowed patients to make scheduled appointments if they wished.

Hours of Operation. Four clinics were after-hours clinics only. The other 30 clinics were open a mean of 7.64 hours daily before 5 p.m. All 34 clinics were open after 5 p.m., but because some closed as early in the evening as 5:30 p.m., they could not really be defined as having "evening hours." Clinics were assumed to have evening hours if they were open for at least two hours after 5 p.m. Thirty clinics met this criterion, and the mean number of evening hours for these clinics was 4.4 hours, with a range of two to six hours.

Twenty-nine clinics (85%) were open on weekends and holidays. Mean total hours per weekend were 14.62, with a range of 2.5 (Saturday morning only) to 24 per two-day weekend. The most extensive hours were reported by clinics belonging to commercial chains.

Services. The most common services offered were laboratory analysis (82%), X-ray examination (79%), electrocardiographic testing (79%), minor operations (68%), pulmonary function testing (53%), pharmacy (29%), and physiotherapy (18%). Other services mentioned included sports medicine, nuclear medicine, social services, optometry, massage

therapy, chiropractic, electrolysis, and tanning salons.

Clinic Out-Services

Hospital Privileges. Of the 34 clinics, 19 (56%) had hospital privileges. The remaining 15 clinics arranged hospital admission through emergency departments, through specialists, or through family physicians.

Practice Pattern. Of the 34 clinics, 12 (35%) offered obstetrics and 20 (59%) offered home visits.

Follow Up. Twenty-four clinics (71%) offered follow up, of which 20 gave the choice of follow up either by the clinic or the family physician. Twenty-seven clinics (79%) sent copies of the encounter to the family physician, although 16 did so only at the patient's request.

Business Administration

Clinic Ownership. The distribution of clinic ownership revealed that 19 (56%) were physician-owned. Nine (26%) were physician- and business-owned, four (12%) were business-owned only, and two (6%) were publicly funded. Thus 28 (82%) of the clinics had some physician involvement in ownership. Of the clinics that reported membership in a chain, 18 (53%) belonged to seven identifiable commercial organizations.

Medical Director. Although all clinics identified a person in charge, four did not have identifiable medical directors.

Respondents' Comments

Most respondents offered general comments describing their clinic's philosophy or their perception of the role of walk-in clinics in primary health care. Most respondents believed that there was a definite consumer demand for walk-in clinics, and most assumed that walk-in clinics would result in a decreased load on emergency departments. Many perceived the patient population as wanting immediate service, and there were several comments that the use of walk-in clinics was a result of failure of family physicians to respond adequately to patient demand for urgent care.

Discussion

We attempted to identify and survey walk-in clinics in Ontario. Our major findings were:

- walk-in clinics could not be identified by name alone;
- the number of operating walk-in clinics has increased greatly during the past two years;
- clinic services and hours of operation varied, although the majority of clinics reported having laboratory, X-ray, and electrocardiographic facilities and facilities for minor operations;
- clinic practice patterns varied for hospital privileges, obstetrics, home visits, and follow-up; and
- a slight majority (56%) of walk-in clinics were owned completely by physicians; 38% were owned at least in part by non-physician entrepreneurs; and 6% were funded by the public.

Limitations and cautions for interpretation of this study include a broad definition of walk-in clinics and possible sample bias. The definition did not distinguish commercial walk-in clinics from family practices with extended hours and a no-appointment system. As a result of the lack of standardization of clinic names, walk-in clinics were not easily identified or located, and thus the small sample size may have biased results. Finally, this was a preliminary study, and the results cannot be generalized beyond the sample.

One implication of this study is the effect of walk-in clinics on health care costs. Many respondents surveyed in this study stated their belief that walk-in clinics would ease the load on the emergency departments. This belief, however, has been contradicted in the U.S.,[5] where Ferber and Becker found no decrease in emergency department use despite a dramatic increase in the number of walk-in clinics. No studies have been published yet in Canada to confirm or refute this finding, and initial reports[6,7] give conflicting results.

The Scott task force has recently stated that there is a lack of quality information on demand for medical services.[8] Studies are urgently needed to examine the patient population of walk-in clinics. It will be important to know whether patients would otherwise have gone to the emergency departments or their own family physicians, or whether they are an "add on" population, in which medical problems would have resolved spontaneously without medical care.

A second implication is a possible change in patients' perception of illness, with an increasing demand for instant health care. This in turn may raise concerns about the continuity and quality of "walk-in" care, as well as adequacy of follow up.

Conclusion

Research is urgently needed to determine the impact of Canadian walk-in clinics on primary care and to determine whether increased health care costs may result from the growth in number of these clinics. Studies may also be needed on the changing perceptions of patients regarding primary care and on whether these changing perceptions may be directly related to the growth of walk-in clinics. ■

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