Chapter 7
Worksite Clinics

ABSTRACT

In this chapter, the evolution and growth of worksite clinics is discussed. Worksite clinics are not a new phenomenon. Prior to the 1980s, many large employers operated onsite company clinics to treat work-related injuries. However, many of these clinics closed in the 1980s and 1990s because of the decline in heavy industry and manufacturing sectors and the reduction in workplace hazards. Recently, there has been a significant resurgence of worksite clinics. The new generation of clinics is markedly different in that their main focus is on primary care, health promotion, and wellness rather than occupational injuries. The authors discuss in-depth the operations, stakeholders, and outcomes of care in worksite clinics. They predict that worksite clinics seem to be well positioned to thrive in a post-reform healthcare environment.

INTRODUCTION

One of the unique aspects of the U.S. healthcare system is employer-sponsored insurance (ESI). Most Americans under the age of 65 obtain their health insurance coverage through an employer, whether that is their own employer or the employer of a family member to whom they are related as a dependent. Companies have traditionally offered healthcare coverage as a benefit to attract and retain top talent. The latest estimates suggest that about 159 million Americans are covered by employer-sponsored insurance (Robert Wood Johnson, 2013). However, the costs of providing that coverage to employees have steadily
increased in the last ten years. Costs have grown faster than inflation and now constitute 15% and 40% of the average single and married employee’s total annual compensation, respectively (Fuld & Company, 2009). As a result, many employers have dropped or reduced coverage to their employees, while some employees have declined ESI even when offered due to high premium costs. Average annual premiums for employee-only coverage more than doubled from $2,490 in 2000 to $5,081 in 2011. Family premiums have also increased from $6,415 to $14,447 in the same time period. Consequently, the percentage of Americans receiving health insurance through their employer has fallen from 69.7% in 2000 to 59.5% in 2011 (Robert Wood Johnson, 2013).

Facing the hard realities of increasing costs, decreasing profits and reduced overall global competitiveness, American companies have looked for solutions, such as shifting the risk of healthcare coverage to employees through the provision of high-deductible health plans (HDHP) and health savings account (HSAs) (discussed in Chapter 2). Other solutions have emphasized viewing employees as company assets and providing them with valuable alternatives for seeking primary care and other types of services. In that direction, employers are offering worksite clinics that promise to deliver cost-effective healthcare services. The main rationale for these clinics is to help control costs of ESI. Other reasons include improving access and convenience for employees; reducing lost time and absence; improving productivity; improving health outcomes; promoting wellness and encouraging use of screening and preventive services; providing higher quality of care than that received in the community; boosting employee retention, recruitment and morale; redirecting care from expensive, sub-optimal and time consuming settings such as hospital emergency rooms; and serving as the primary locus of healthcare delivery for employees and their dependents (Hochstadt, 2010). A recent report suggested that “[b]y far the strongest motivation for implementing workplace clinics is to contain direct medical costs. In the short term, exerting greater control over direct costs, such as specialist visits, non-generic prescriptions, emergency department (ED) visits and avoidable hospitalizations, is a key employer objective. In the long run, improving population health by preventing and managing chronic conditions is a major objective” (Tu, Boukus & Cohen, 2010), p.2). A survey of employers by the human resources consulting firm Mercer, found that among those offering worksite clinics, 82% were motivated by reducing lost employee productivity, 75% by controlling overall healthcare costs, 73% by managing employees’ health risks and chronic conditions, and 50% by attracting and retaining talent (Mercer, 2012). Another survey by Tower Watsons (2012) found that 62% established them mainly to enhance worker productivity, 56% to reduce medical costs, 52% to create a center of health to better integrate all health productivity efforts, 38% to improve access to care, 32% to address occupational health and safety needs, 27% to improve quality of care, 8% to reduce pharmacy costs and 8% to provide concierge service as a perk.

Evolution

It is important to note that worksite clinics are not a new concept. As far back as the 1800’s, large railroad and coal mining firms had company physicians that provided occupational health services to workers. These firms were located in remote sites and workers would otherwise have no access to any kind of care. In the 1940’s, the Kaiser Steel Company of
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