Impact of Concierge Care on Healthcare and Clinical Practice

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The emergence of a small but increasing number of physicians choosing to provide a nontraditional high-end, or luxury, style of healthcare known as concierge care—also often called boutique medicine or retainer practice—is raising important medical, ethical, and legal questions. In concierge care, which was originally developed in Seattle, Wash, in the mid-1990s, patients pay physicians annual retainer fees, usually hundreds or thousands of dollars, in exchange for improved access and services. Typically among these services are same-day appointments, longer examination times, home delivery of medications, physician coordination of specialty-care referrals, and around-the-clock telephone, pager, and e-mail access to physicians.1 Concierge care is designed to provide the “highest quality and greatest availability” of healthcare to a market niche of the “most discerning and limited number of patients.”2 Concierge care has recently been characterized as an excellent business opportunity;3 but, so far, it has attracted only approximately 200 physicians nationwide.4 There is currently no reliable estimate as to the number of osteopathic physicians involved in concierge care.

Responses to this new model of patient care have been mixed. Those physicians and public health advocates who are skeptical about concierge care claim that such “selective rationing” of healthcare services will exaggerate class distinctions by reducing the resources available to uninsured and underinsured individuals—while accentuating the shift of the best care to the privileged few.5 Other physicians, however, argue that class distinctions have long existed in the United States and that concierge care is “just another portion of class-based social order” that already allows upper income classes to have economic, legal, education, and social advantages that are inaccessible other socioeconomic groups.6

Various legal issues have been prominent in the debate over concierge care. The New Jersey Department of Health and Senior Services asserted in 2003 that concierge care agreements are inconsistent with the state requirement that network healthcare providers not discriminate against any person.7 An official document released by the department in August 2003 warned, “Carriers are on notice that agreements that require members or covered persons to pay a fee, other than the cost-sharing of the health benefits plan (whether referred to as an ‘access fee,’ ‘retention fee,’ or ‘service fee,’ or some other name), to gain access to a network provider are not acceptable and should be terminated immediately.”7 In April 2004, the New York State Department of Health issued an official statement condemning concierge medicine among enrollees in health maintenance organizations (HMOs).8

Physicians involved in concierge care often defend their practices by stating that their patients receive more personal time, special amenities, greater preventative services, and increased provider availability.9 However, critics maintain that concierge practices may not improve patient healthcare or increase preventive services.8 Furthermore, these critics claim, concierge care might be unethical or even illegal, with possible violations of Medicare and state insurance regulations.1,7,9

Concepts of Concierge Care

Concierge care is typically based on fundamental concepts of quality and personalized care, a reduced patient base that ensures greater access to service, and enhanced continuity of individual care. Traditional insurance plans do not cover or pay for the added amenities or services that are sometimes desired by patients using concierge care.1 The current business model for the practice of concierge care requires charging patients an annual membership or retainer fee in exchange for guaranteed, heightened access to standard healthcare services, as well as access to unique, personalized physician services. Membership costs for patients using concierge care vary, ranging from a $50 annual “access fee” to retainer fees of between $900 and $20,000 per patient per year.4,10

Physician Dissatisfaction

Physician dissatisfaction with the typical selective contracts used in HMOs, or managed care programs, have emerged as an impetus in the development of the concierge care model.11 Standard contracts often impose discounted fees that require physicians to rapidly increase their number of patient visits per...
day, compelling brief visits that are typically limited to an average of 5 to 10 minutes per person. The number of patients over age 45 that physicians see every day has increased by more than 20% over the past 10 years, according to the US Centers for Disease Control and Prevention’s National Center for Health Statistics in Hyattsville, Md. Many physicians note that the managed care contracts cause much frustration for them as they attempt to deliver competent care to their growing number of patients, counteract rising financial costs, preserve personal and family time, and cope with the legal constraints and malpractice threats that are common with managed care.

Some physicians see an antidote for these frustrations in the concierge care business model, which they believe offers opportunities to avoid the restraints of managed care, see fewer patients, spend more time with each patient they do see, and have more time to spend with their own families. Physician concerns regarding managed care’s alleged delivery of inadequate healthcare were highlighted by McGlynn et al, who reported that adult patients in the United States receive only about half (54.9%) of the recommended healthcare outlined by the US Preventative Services Task Force (USPSTF), an independent panel of experts in primary care and prevention that develops recommendations for clinical preventive services. McGlynn et al also observed that healthcare quality varied substantially and was dependent on the particular medical condition being treated. The researchers concluded that evidence of health system inadequacies, along with a lack of adherence to USPSTF recommendations for basic care, could pose a serious threat to public health in the United States.

St Peter et al found that managed care programs were a major cause of physician dissatisfaction. The investigators reported that these programs, in an effort to control costs, often force primary care physicians to exceed the scope of care they are capable of providing. In addition, the researchers found that physicians face the inability to fully bill their usual fees under managed care contracts—at the same time that they must absorb increasing overhead expenses.

Some studies seemingly contradict the research that purports to document causes of physician discontent with managed care, however. Mechanic reports that, contrary to common perceptions and expectations, the growth of managed care has not been associated with a reduction in the length of office visits. This conclusion raises the question of whether reduced patient contact time can really be a prime cause for physician dissatisfaction and entry into concierge care practices.

Weeks and Wallace evaluated physician dissatisfaction in a retrospective study of inputs, outputs, efficiency, and physician income from 1987 to 1998. Although a great deal of dissatisfaction among physicians was recognized, the study also found that physician input (ie, the average number of hours spent in professional activities) showed little absolute change across specialties between these years. Furthermore, physician output (ie, total number of patient visits per week) actually decreased, and efficiency (determined as the amount of time actually spent with patients) remained unchanged from 1987 to 1998. Thus, these findings refute the assumption that physicians are working harder and longer while their incomes are declining.

**Patient Dissatisfaction**

Another often-stated cause for the emergence of concierge care is that it satisfies certain consumer demands for a different approach to healthcare. Many patients have expressed dissatisfaction with impersonalized care that includes long waits; short appointments; and shuffling to middlelevel caregivers, such as physician assistants or nurse practitioners. A nationwide survey of US residents in late 2004—by Harvard University, the Agency for Healthcare Research and Quality, and the Henry J. Kaiser Family Foundation—found that 55 percent of the respondents were dissatisfied with their healthcare, and 40 percent agreed that the quality of care had worsened in the previous five years. Yarnell et al reported that basic preventative services at recommended frequencies are commonly missed or delayed in the traditional primary care setting due to time constraints that limit compliance with accepted clinical guidelines.

Advocates of concierge care claim that the new type of medical practice will result in extended outpatient visits and improved physician compliance with recommended guidelines. Whether this promise can be realized, however, remains unclear.

Furthermore, appropriate evidence-based studies have yet to be completed to determine the effectiveness of the healthcare offered in the concierge care model, compared with that in managed care. However, Ware et al were able to demonstrate that individuals who were elderly, poor, or chronically ill had worse health outcomes when treated in HMO settings than when treated in fee-for-service systems. Younger patients and higher income patients, on the other hand, tended to fare equally well under both HMO and fee-for-service models.

**Institutional Perspectives on Concierge Care**

Hospitals, medical centers, and other healthcare institutions have responded to concierge care in various ways. Some institutions opposed to concierge care have attempted to use “economic credentialing” in evaluating physicians’ qualifications. In this process, economic criteria unrelated to quality of care or professional competence is used to determine a physician’s qualifications for initial or continuing hospital medical staff membership or privileges. Economic credentialing has been used by some hospitals to deny hospital privileges to physicians practicing concierge care.

For example, in 2003,
OhioHealth Group, an organization of hospitals and healthcare services in that state, removed hospital privileges from physicians who invested in a new hospital specializing in concierge care.25

The OhioHealth case generated a great deal of reaction from the medical community in Ohio. The Ohio State Medical Association voiced strong opposition to hospital economic credentialing, stressing that the association continued to support conventional methods of granting privileges, which are based on physician education, training, and professional competence.25 Jon F. Willis, the executive director of the Ohio Osteopathic Association (OOA), notes that a number of inquiries about concierge care have been received from the association’s members. Although the OOA has the same position as the Ohio State Medical Association regarding specialty hospitals and economic credentialing, the association has not yet adopted a specific policy regarding annual retainer fees (J.F. Willis, written communication, November 3, 2005).

Administrators at other healthcare institutions, including Tufts-New England Medical Center in Boston, Mass, and the Virginia Mason Medical Center in Seattle, Wash, have expressed support for concierge care, arguing that this form of medical practice could provide financial support for hospitals and clinics that care for patients from all economic strata.26 A recent study27 of US nonprofit hospitals concluded that fee-based services, such as concierge care, have the potential to result in the subsidization of money-losing healthcare facilities by wealthy persons choosing to pay for the personal amenities of these services. Such subsidization would help those facilities to survive.27

Ethical Controversies and Legal Obstacles
Concierge care has been described as both an attempt by physicians to maintain a high-income ratio and an attempt to provide patients with higher quality healthcare services. Medical ethicists and consumer advocates have voiced ethical concerns regarding the creation of a two-class system of medicine based on willingness and ability to pay.28 In 2003, however, the Council on Ethical and Judicial Affairs of the American Medical Association (AMA) concluded that there is “nothing inherently unethical about entering into a contractual relationship with a patient.”28 The AMA also established ethical guidelines in 2003 for concierge care practices and other groups offering selective medical services.29

At the annual meeting of the American Osteopathic Association (AOA) House of Delegates in July 2004, the AOA Division of State Government and International Affairs adopted a paper that discusses professional concerns about concierge care but states no official position on the subject.30 At the July 2005 meeting of the AOA House of Delegates, the Committee on Socioeconomic Affairs voted not to recommend an official AOA policy on concierge care. However, the committee did vote to review the Ohio State Medical Association’s position statement as an educational tool (Y. Doss, written communication, November 3, 2005).

Legal opinions regarding concierge care have been mixed, but most legal experts agree that risks of violations of law arise when a clinical practice continues to seek reimbursement from Medicare and private insurance companies for services already paid for by retainer fees.31 Medicare rules state that if a physician accepts Medicare reimbursement, then he or she cannot charge extra fees for those services covered by Medicare.32 Because of these rules, physicians must justify the extra fees obtained in concierge practices as separate from services provided under Medicare benefits.30 Private insurance companies have imposed sanctions, including threatened expulsions from health plans, against physicians who charge extra fees for services covered by managed care contracts.30

There have been some legal and regulatory actions taken against physicians engaged in concierge care. In 2004, the US Department of Health and Human Services warned that physicians who charge patients extra fees for services covered by Medicare are subject to fines or expulsions from the Medicare system.30 The Office of Inspector General has halted some contracted services that were reimbursed by Medicare.30 The state of New Jersey prevents insurers from contracting with physicians who charge extra fees for their services.30 Other states, including Florida and West Virginia, have conducted investigations of concierge practices.30 Despite these regulatory actions and investigations, most concierge practices offer only prepaid programs that have not yet been determined to be unlawful.10

Support for Physicians in Concierge Care
Established concierge practices have founded a national organization to support clinicians adopting this type of practice model. Following its first national meeting in May 2004 in Denver, Colo, the initial name of the organization, American Society of Concierge Physicians, was changed to the Society for Innovative Medical Practice Design.33 Topics discussed at the group’s Denver meeting included how to start a practice, marketing strategies, legal concerns, and ethical guidelines.30 The Web site34 of the organization details plans that include creating a forum in which physicians share their collective wisdom and experience, evaluate industry trends, prepare policy arguments to reshape potential public discourse, and participate in dialogue regarding the regulation of concierge-style practices. At the group’s 2005 national meeting in New York City in March, several legal aspects and issues regarding concierge care were discussed.35

Expectations for Concierge Care
Supporters of concierge care expect that it will result in a number of measurable outcomes as this patient model con-
continues to spread. These anticipated outcomes include improvements in services provided and in continuity of patient care; increases in the amount of time that physicians have available for community and humanitarian work, as well as increases in the amount of personal and family time; and the generation of desperately needed income to support affiliated hospitals and clinics.

The anticipated continuity of patient-physician relationships in concierge care contrasts with traditional primary care practices, which may be fraught with uneven or intermittent coverage delivered by physicians or nonphysician providers who may not be familiar with all the patients cared for within the practice. Concierge practices seem well positioned to provide an environment in which medical care is more proactively focused on wellness and prevention than on disease diagnosis and treatment. One might expect future outcome studies to evaluate the amount of preventive healthcare services occurring in concierge practices.

With fewer patients to see and less paperwork—related to such issues as insurance, billing, and managed care—to fill out on any given day, concierge care has the potential to provide physicians with more time to engage in altruistic activities beneficial to public health, say proponents. Such activities might include volunteering services to community clinics and increasing humanitarian or charity care. Future studies will be necessary to accurately document the extent to which the transitioning of practitioners from traditional practices to concierge practices contributes to community services and public health activities.

Proponents of concierge care believe that this model of care may help salvage the careers of those physicians who have become increasingly frustrated with overbooked schedules, managed care restraints, lack of personal and family time, and other problems associated with traditional medical practices. According to these proponents, the option of concierge care might cause such physicians to defer considering early retirement or seeking employment opportunities in other fields. Future surveys of physician attitudes and career satisfaction are likely to shed additional light on this subject.

Comment

Concierge care continues to trigger various philosophical, emotional, ethical, and legal responses. Nevertheless, it is clear to us that concierge care represents an economic alternative that is viable in the current healthcare environment. We suggest, however, that concierge care will have a limited influence on medicine and healthcare in the United States—mainly because of the small number of physicians likely to pursue this option.

Normative judgment regarding improved consumer (ie, patient) and supplier (ie, physician) satisfaction in concierge practices can be favorably argued. Although factual reviews of outcomes regarding satisfaction parameters are currently lacking, survey results indicate that patient-physician renewal rates in concierge care agreements are as high as 99%. Concierge care physicians’ responses to survey questions concerning job fulfillment and contentment also strongly support the assumption of improved physician satisfaction. Such reports lead us to believe that concierge care is most likely to satisfy a small portion of the physician workforce who might otherwise opt out and leave medical practice.

The effects of concierge care on public health measures, prevention goals, and health outcomes remain uncertain. Nevertheless, evidence suggests that concierge care satisfies consumer criteria for value, based on an individual patient’s willingness to pay extra for some measure of healthcare and status. Concierge care’s effectiveness, defined as a measure of the ability of an intervention to bring about a desired outcome (such as an increase in patient-physician satisfaction), is also suggested by evidence.

Some people might object to the ability of wealthy individuals to purchase additional healthcare benefits beyond those available to less fortunate individuals on the grounds that it would be inequitable. However, one needs to ask whether such an approach would be any more inequitable than our current system of healthcare. Furthermore, to the extent that physicians use any added personal time to support public health efforts and low-income patients, healthcare equity among different socioeconomic groups might actually improve.

As long as different methods of supplier reimbursement exist, the role of payment will influence provider behavior and, thus, exert an impact on the quality and quantity of healthcare provided. We suggest that a reasonable compromise to concerns about inequities in today’s healthcare system might be to offer society a standardized amount of health benefits as part of a universal healthcare program. In such a program, provisions could be adapted to provide individuals with opportunities to purchase additional benefit access using their own resources—similar to the concierge care model.

Affluent consumers who choose concierge care do not represent a large portion of the overall healthcare consumer population. Thus, they should not be expected to disrupt society’s economic equilibrium as it relates to providing healthcare services.

The open-market economy of the United States provides choices for consumers and promotes competition among providers of goods and services. A competitive economy ensures the existence of a mechanism for people willing to pay for unique goods and services. First-class airline tickets versus standard coach seating, luxury versus economy automobiles, sky boxes versus general seating at sporting events, and private versus public schools are all accepted options that are compatible with our market-based society. Often, the availability of these options provides an incentive for increased or improved output by producers. Similarly, concierge care
should remain a viable option for consumers as long as it does not drain resources devoted to the mainstream healthcare system.

Many people would probably agree that healthcare and medicine fall into a much different economic paradigm than the airline industry or baseball tickets. After all, healthcare and medicine incorporate humanistic factors and values that are far removed from materialistic, competitive decision making. Nevertheless, in healthcare, there does exist a dichotomy involving patients’ essential needs and nonessential demands. Fuchs claims, “it is the patient rather than the physician who has a major influence on his health” while “the opposite is true regarding the cost of medical care.”

Fuchs also points out the importance of selection at individual and societal levels, asserting that people cannot have all the health or all the medical care that they would like to have, so they inevitably must make choices. Ethics and value judgments must guide individuals as they make decisions and choices about using available healthcare resources.

Many people believe that healthcare is a basic right, rather than a privilege. Yet, not all of these people may be willing to increase their personal out-of-pocket expenses or to approve tax increases for improved healthcare services. Concierge care allows individuals to devote more of their personal resources to their own healthcare. An argument can be made that concierge care is an attempt to permit discretionary space for a small, consumer-driven market niche, while not interfering with the rights of all persons to have access to basic healthcare.

Concierge care programs have shown success in providing needed financial support for some primary care services, such as those at Tufts-New England Medical Center and the Virginia Mason Medical Center. Thus, it is reasonable to conclude that concierge care offers a mechanism to maintain a limited number of programs that are necessary for healthcare access for all citizens—programs that might face elimination without some form of economic subsidization.

Until more complete evaluative analyses of several critical issues are examined, we conclude that normative judgment supports the creation and use of concierge practices within a small, consumer-driven medical market. Quantitative as well as qualitative results, including local health surveillance data recently released by the CDC, may contribute to these important analyses. Additional investigations should also help determine whether improvements in overall quality of care and health outcomes will actually occur for those individuals able to afford the services of concierge care.

References


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