Concierge medicine: Ethically Concerning or a Better Care Model?

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Category: Healthcare Inequities

Case:

A hospital is proposing the implementation of a concierge primary care practice, which provides patients with a breadth of healthcare services not covered by normal insurance. This model would require patients to pay $1500 to $3000 a year for access to a physician who will be a part of the concierge group at the institution. In addition, patients will receive comprehensive healthcare services, including 24-hour physician availability, expedited appointments, longer care visits, and preventive care not typically reimbursed by insurance. Physicians will be able to volunteer to treat patients on this service. While the hospital believes this model will offer high quality, comprehensive primary care services to its patients, they are faced with the dilemma of whether the model is ethically sound. Many hospitals offer a concierge model of primary care, but this group is concerned that they may contribute to large-scale health inequities, such as limiting access to primary care to those who cannot pay the extra fees or exacerbating the nationwide shortage of primary care physicians (PCPs).

Expert Opinion:

Background

This group is not alone in weighing the ethical pros and cons of concierge medicine. Concierge primary care is defined by the American College of Physicians as "any practice that directly contracts with patients to pay out-of-pocket for some or all of the services provided by the practice, in lieu of or in addition to traditional insurance arrangements, and/or charges an administrative fee to patients, sometimes called a retainer or concierge fee, often in return for a promise for more personalized and accessible care"[1]. The first official concierge practice, MD^2, was established in 1996 in Seattle, Washington by Dr. Howard Maron and Dr. Scott Hall to provide higher quality care for a smaller panel of patients. In this practice, by paying a fee, patients are guaranteed a comprehensive, personalized care experience with access to an array of services not typically reimbursed by insurance.

Concierge medicine poses ethical questions that must be adequately addressed before this group implements the model. This model has been criticized for exacerbating inequitable healthcare access on several fronts. First, when primary care physicians transition to practicing in the concierge setting, many are concerned it will leave patients who do not wish or are unable to pay the concierge fee without a PCP[2]. The model has also been criticized for improving the quality of care for high-income individuals without making it accessible for all individuals, exaggerating class divisions in healthcare[3]. Additionally, the concierge model may make it difficult for Medicare patients to enroll since Medicare does not cover the annual concierge fees, which may further alienate this already high-need patient population[3,4]. Alternatively, other experts believe the model affords patients the opportunity to pay less on average than they would in a traditional care setting[1]. Individuals with multiple chronic conditions, for example, could benefit from a concierge model given the annual fee may be less than their care may otherwise cost with regular insurance payment models[1].

The American Medical Association (AMA) offers some guidance on the ethical establishment of a concierge practice and emphasizes that establishing such a practice is not inherently unethical. The patient's decision to enroll in the concierge model must be voluntary, with the option to opt-out of the service at any time. Physicians must also present the terms of the practice, making the implications for the patient's healthcare insurance clear, outlining which services will be covered in the new model.

However, it should be noted that physicians are entitled to part ways with patients if they are in good health and their medical conditions are under control[2]. The guidelines make clear that regardless of where PCPs practice, they must uphold their obligation of fidelity and to treat all patients with the same respect and quality of care.

Experts also argue that a physician's fiduciary responsibility to put the patient's needs above their own may be compromised when PCPs are given the option to volunteer their services in the concierge model[5]. Tempted by higher pay and smaller patient panels, PCPs may be drawn to this more manageable clinical environment. The American College of Physicians (ACP) issued guidelines for concierge practices in 2015, emphasizing that PCPs should not be ethically obligated to fix the PCP deficit, which was estimated at 17,222 PCPs in 2020, on their own, nor should they be pressured to continue practicing in a clinical environment that contributes to burn out[6]. Instead, the ACP supports physicians to practice in an environment conducive to delivering ethical, quality healthcare. By allowing PCPs the option to work in a better environment, it may in fact diminish the shortage of PCPS by making it a more attractive specialty for physicians and helping to mitigate the high rates of PCP burnout[3,7].

Recommendations

Given the group is still in the early phases of implementation planning, we propose several recommendations to aid them in the ethical establishment of concierge medicine. First, to address the ethical concern of respecting all patients on the PCP's current panel, we recommend the group thinks about how current patients may be affected in the transition to concierge services. For patients not interested in or not able to pay the concierge fee, their current PCP should make recommendations for a new PCP to aid the patient in a smooth transition of care to avoid patient abandonment. The group should be transparent about the pricing and services provided to ensure the ethical imperative of autonomy is upheld and patients can choose to participate or not participate based on good information. . To address the concern that concierge medicine can further exaggerate healthcare access disparities, we recommend the group promotes equitable access to the concierge services for those who wish to enroll by reducing financial barriers when possible and considers offering a sponsored or reduced membership fee.

To account for the concern that concierge primary care exacerbates the PCP shortage, we recommend the group consider how the concierge practice will impact their institution directly: does the institution have a PCP shortage? If a shortage exists in their institution, we offer a few suggestions. The group could first implement a pilot concierge service to determine if the model exacerbates the issue or meaningfully contributes to providing quality primary care before scaling up the model. We also suggest the group be mindful about the number of PCPs they will allow to volunteer for the concierge services to reduce the risk of limiting the number of available PCPs at the institution. Finally, and most important, we suggest that the group implement quality metrics to ensure the same caliber of care is being provided in both the concierge and regular framework. To do so, we recommend the group references the institution's mission and values, which may help to align the quality of care provided in both settings. If the group adequately considers these questions during their planning, we see no ethical objections to establishing such a model.

Summary:

Although it poses ethical questions about equitable access to care, the establishment of a concierge primary care practice is not inherently unethical. Regardless of the clinical environment, physicians have the responsibility to treat their patients with respect and to provide quality, ethical care. The group must consider how the new model my affect the surrounding community and their existing patients in order to devise an ethically sound plan. If neither the quality of care nor access to care are compromised

in their proposed model, the group should feel comfortable moving forward in their planning process for the concierge clinic.

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