

Extra \$75 a month helps medicine go down,
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CHAMPAGNE HEALTH CARE AND CAVIAR DREAMS: BOUTIQUE MEDICINE IN THE UNITED STATES

By Phyllis Griffin Epps

And so it has come to this. In Boston, Seattle, and the states of Florida and Arizona, persons with private medical insurance or Medicare may pay an additional premium – beyond medical costs covered by insurance – in exchange for prompt and direct access to their physicians. "Direct access" includes house calls, a physician's mobile phone number, and more, for anywhere from \$700 to \$12,000 per patient each year. Dubbed "boutique" or "concierge" plans, such practices restore the doctor-patient relationship to a level not seen since the advent of managed care.

Concierge practices are a response to what some describe as the decline in the quality of medical care under health maintenance organizations and other vehicles of managed care. Managed care is based on the proposition that the rationing of medical services will not only slow the increasing cost of medical care but also generate a profit for the managed care company and shareholders. Critics point to the continued increase in the cost of medical care despite the prominence of managed care. Physicians who contract with the managed care company complain of a reduced income and pressure to increase volume by restricting time spent with each patient. The vehicles of managed care dictate the limits of treatment with less regard for the judgment of the physician. By most accounts, managed care has contributed to a general deterioration of the relationship between doctor and patient as well as decreased patient satisfaction.

Because a doctor in a boutique practice carries a smaller patient load – down from several thousand to 50 or 100, that doctor has more time to develop the relationship with patients more common under conventional practices. The patient pays the additional fee directly to the physician, and retains private insurance to cover hospital stays and prescription drugs. The direct payment of such fees make concierge practices more lucrative than a conventional practice.

Critics argue that physicians should be obliged to provide quality care to every patient. The prevalence of physicians who do not accept Medicaid patients is cited as an example of greed and improper attention to financial rewards. But those who tout the bottom line as the primary factor in the administration of medical services must welcome indications that physicians have taken the lessons of managed and rationed care to heart. Cries of altruism are neither appreciated by administrators nor fair to physicians who labor under the pressures of managed care.

Perhaps the most meaningful criticism of concierge practices is that they highlight failings in the delivery of health care in this country. Boutique medicine effectively creates a new tier in the hierarchy that exists within the current system of the delivery of health care. In addition to those persons with private insurance, those with Medicaid and/or Medicare coverage, and the uninsured, subscribers to boutique plans constitute the "superinsured". This concept is not foreign to the United Kingdom, Sweden, or Canada, where superinsurance exists alongside a national health care delivery system that excludes none of its citizens. By contrast, the United States is famous for the gaps and inequities in its health care system relative to the concentration of wealth enjoyed by its citizens. The growth in boutique plans is consistent with the concept that "better" care should be available to those who are willing to pay extra for it. But is the further stratification of health care a positive development or is it a crescendo of the death rattle emanating from the current system? Assuming that morality is relevant to a discussion of the availability of medical care, what do boutique plans say about the morals of a society that declines to ensure affordable medical care to its citizenry?

Boutique medicine is a mixed blessing. The market should provide an outlet for those who are willing to pay extra for better service, particularly if one is inclined to associate better service with better quality care. Perhaps boutique medicine will shift a greater portion of the high costs of care onto the consumer most able to pay for it. Or maybe boutique medicine will shrink ultimately the number of providers available to populations of lesser means (and, usually, more expensive care). For more information, see Julie Appleby, Extra \$75 a month helps medicine go down, USA Today, Oct. 30, 2000, at <http://www.usatoday.com/life/health/hcare/lhhca133.html>; Michael J. Pulaski, Medical Care in a Boutique Setting, *Medicine & Behavior*, viewed on Feb. 4, 2002, at <http://medinfosource.com/mb/mb991038.html>; Editorial, "Boutique Medicine," N.Y. Times, Jan. 17, 2002, at A 28; Liz Kowalczyk, "Tufts Health Raises Concerns on 'Premium Practice' by Doctors," Boston Globe, Dec. 20, 2001, at E6; Michele Chandler, "Gold-card Medicine," Milwaukee J. & Sentinel, Sep. 17, 2001, at 1G; and Margaret Ann Miille (not a typo), Business & Money, Sarasota Herald-Tribune, Sep. 9, 2001, at D1.

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