Concierge Care: Money Is Not the Sole Motive

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BALTIMORE — Some physicians who embrace concierge care are ideologues who want the government and insurance companies to stop interfering in the doctor-patient relationship. And others? They're in it for the money and the lifestyle, John R. Marquis said at a meeting of the American Society of Law, Medicine, and Ethics.

"A large portion of these doctors have as their primary motive that they want to earn more money," said Mr. Marquis, a partner in a Holland, Mich., law firm. However, while money plays a big role, other factors also influence the decision, said Mr. Marquis, who helps physicians set up concierge practices.

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One other big reason for the move to concierge care is lifestyle, he said. "If [I've] heard the analogy to the hamster wheel once, I've heard it a million times. 'I get up every day, I get on the hamster wheel, I run for 10 hours, I get off, and I hope to God I've seen enough patients to pay the light bill.' Concierge medicine does offer them some degree of better lifestyle as they perceive it."

Another reason physicians give is to improve patient care. "You'd be surprised at the number of physicians who list [improving patient care] as their top priority," he said. But there are two levels to the patient care issue. "Some say, 'I could practice better medicine if I spent more time with patients.' But there has been no proof of that whatsoever. I think that is bogus," said Mr. Marquis. He added that from an ethical perspective, physicians are not supposed to imply that concierge care will mean better care for their patients.

Others profess the desire to provide better preventive care, Mr. Marquis said, noting that, to him, this seemed like a legitimate reason for moving to concierge care.

"Physicians don't get paid for doing preventive care, generally speaking. You'd be surprised at the number of physicians who say, 'I really would love to see healthy patients, because I have a lot to say to them. I'd like to plan their diet, their lifestyle, get them on nonsmoking programs, and I want to be part of their lifestyle.' It sounds hokey, but I think they're being sincere when they tell me that," he said at the meeting cosponsored by the University of Maryland.

According to Mr. Marquis, there are two basic models of concierge practice. The first, practiced by the ideologues, is a "fee-for-care" model, in which the physician charges a set fee—say, $100 per month—in exchange for giving patients access to all the primary care they need, including sick visits, physicals, immunizations, and lab work. These physicians opt out of Medicare and don't bill insurance, although they may remain on some managed care panels.

The second model, used more by physicians interested in increasing their incomes, is a "fee-for-noncovered-service" model, in which the doctor charges patients a per-visit fee but also charges an annual fee for services not covered by Medicare, such as a yearly physical. "These people are driven more by money," said Mr. Marquis. "They just want to game the system a little bit, and get a little more money out of it."

Proponents also say that the type of intensive medical care provided is very good for sick people with chronic illnesses, and that the increased income ultimately will make medicine more attractive and lead more people toward a medical profession. Frank Pasquale of the Seton Hall University School of Law in Newark, N.J., agreed. Mr. Pasquale noted that concierge practices provide preventive care; "directly therapeutic" care, in which patients have the ability to jump the line and be seen the same day; and nonmedical amenities such as fluffy exam robes or a private waiting room. "The [critics] are attacking concierge care as a unitary phenomenon," Mr. Pasquale said. "I say, don't attack preventive care, but the other two [directly therapeutic care and nonmedical amenities] are a problem."

Concierge care has "amazing benefits" for the doctors and patients who participate, such as more income for the physicians and more attention for the patients, he continued. But there are also problems, such as a disruption of care relationships for patients who can't afford or don't want to join the concierge practice.

"There's the worry of the 'death spiral,' where all the better physicians will go into concierge practice and everyone who can't afford a concierge practice will be left with physicians who don't have quite as good a reputation," Mr. Pasquale said.

Proponents of concierge care say that such a disaster scenario is not likely, because concierge medicine is not apt to spread. "It's just a new product," he said.

Rather than regulating concierge care out of existence, Mr. Pasquale suggests that, instead, lawmakers tax directly therapeutic care and nonmedical amenities, and use the tax proceeds to help provide access to care for the poor.

Sandra J. Carnahan of the South Texas College of Law in Houston suggested that private insurers consider dropping concierge practices from their networks. In the case of physicians who treat Medicare patients, because taxpayer money is used to pay for the physicians' medical education, "that ought to [dictate] that they have a reasonable patient load … and physicians should not be able to use the system to choose the wealthiest, healthiest patients." ■

POLICY & PRACTICE

Dermatologists and Statistics

Apparently, dermatologists are lacking when it comes to appropriately using statistical methods and interpreting results—but not any more so than physicians in other specialties, according to a recent review of studies in the Archives of Dermatology and the Journal of the American Academy of Dermatology by researchers at Wake Forest University. They found that 38% (59) of 155 articles that used statistical analyses either had errors in the methods or omissions in reporting of results. They reviewed original studies from January through December 2003. Twenty-two studies erred in use of a statistical test, thus possibly changing the validity of results; 41 presented results incorrectly, and 4 had errors in both test use and presentation. Thirty-eight were in the Journal of the American Academy of Dermatology and 21 were in the Archives of Dermatology. To reduce errors, perhaps all papers should be reviewed by a statistician before submission, and statistics training should be added to dermatology residency programs, suggested the authors. The paper was published in the June 2006 Archives of Dermatology.

Supplement Side Effects

Dietary supplement makers and producers of over-the-counter drugs would be required to report serious adverse events to the Food and Drug Administration within 15 business days, under the Dietary Supplement and Nonprescription Drug Consumer Protection Act (S. 3456), currently pending in the U.S. Senate. Events would include death, a life-threatening experience, hospitalization, disability, or a birth defect. Retailers would not be required to report the events. The bill was introduced by strange bedfellows: Sen. Orrin Hatch (R-Utah), who crafted the 1994 Dietary Supplement Health and Education Act (DSHEA), which is widely seen as a loophole for the products, along with two frequent critics of DSHEA: Sen. Tom Harkin (D-Iowa) and Sen. Richard Durbin (D-Ill.). The proposal also has the backing of consumer advocates such as Consumer Reports and the Center for Science in the Public Interest, and of industry groups, including the Consumer Healthcare Products Association, the American Herbal Products Association, the Council for Responsible Nutrition, and the National Nutritional Foods Association. The bill could be on a fast track to approval; it was accepted and reported out of the Senate Health, Education, Labor and Pension Committee earlier this summer and now will go before the full Senate.

Postmarketing Study Failure

The Food and Drug Administration is doing a poor job of ensuring that pharmaceutical companies live up to postmarketing study commitments, according to a new report by the Department of Health and Human Services' Office of Inspector General. Among the findings: that the FDA can't easily identify if the studies are progressing or what stage they are in; and that monitoring postmarketing studies "is not a top priority at FDA." The IG reviewed new drug applications from 1990 to 2004; 48% of those applications had at least one postmarketing study commitment. Drugmakers are required to submit annual status reports. The IG found that 35% of the reports that should have been submitted in fiscal 2004 were missing or had no information on the study commitments. The IG noted that the FDA has limited enforcement power in this area, but suggested that the agency require more, and more relevant, information from drugmakers. In response, FDA said it could not do that without additional regulations, but agreed that it needed to do more to improve its monitoring and to ensure that commitments are honored and that annual reports are thorough.

Part D Drug Price Increase

The advocacy group Families USA says almost all the plans participating in Medicare Part D drug coverage raised prices from November 2005 to April 2006 for pharmaceuticals frequently used by seniors. The data are compiled from pricing reports submitted to the Center for Medicare and Medicaid Services. All the plans raised prices for Zocor (simvastatin), and most did so for Fosamax (alendronate), Actonel (risedronate), Nexium (esomeprazole), and Norvasc (amlodipine). The median price increase for the top 20 drugs used by seniors was 3.7%, said Families USA. Increases for Celebrex (celecoxib), Lipitor (atorvastatin), and Aricept (donepezil) were 6%. During the November-April time period, the median price increases for the Part D plans "were virtually identical to changes in manufacturer prices as measured by average wholesale price (AWP)," according to the report. "This means that Part D plans are doing essentially nothing to contain the fast-rising prices by the drug industry," said Ron Pollack, executive director of the group, in a statement. CMS, however, said that its analysis showed that Part D plan prices rose 3.6% on average while AWPs rose 4.1%, resulting in savings to taxpayers.

Physicians' Income Drops

The average net income for physicians dropped by about 7% from 1995 to 2003 after adjusting for inflation, even as incomes for other professionals increased, according to a survey conducted by the Center for Studying Health System Change. Primary care physicians have experienced the biggest decline, with average net incomes dropping 10.2% after adjusting for inflation. Surgical specialists also saw a significant decrease in inflation-adjusted earnings, with an 8.2% drop in net income from 1995 to 2003. Medical specialists had a 2.1% decrease, but this change was not statistically significant.

—Alicia Ault