Many Doctors are Switching to Concierge Medicine, Exacerbating Physician Shortages

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Michelle Konstantinovsky

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Mid-pandemic, Texas resident Marilyn Santiesteban came down with a bad cold. The illness left her severely dehydrated, and at the suggestion of a friend, she received an intravenous infusion from a local concierge medical practice. Santiesteban was so happy with the convenience and personalized experience, she switched from her traditional health care provider to concierge care, which allows patients unusually unfettered access to a physician for a fee. The practice she uses charges an annual membership fee ranging from $600 to more than$1,000, depending on the plan, but patients will still be on the hook for certain medical services that are not covered by the fee.

Concierge medicine has come under scrutiny since its inception more than two decades ago. Yet there is still plenty of confusion over what it really is and what implications its various forms may have on the state of U.S. health care. Traditionally, concierge physicians still bill private insurance or Medicare for certain services, so patients pay two fees: one for their concierge membership and one for insurance. The cost of the membership fee can range

significantly, however, and the type of access granted to patients also varies wildly between practices. According to information put out by Harvard Medical School,the average monthly price tag for concierge care is $200 with a potential maximum of as much as $30,000 *per month*.

While there are variations on the model that come at a lower monthly cost (and cut insurance out of the picture altogether), skeptics question why physicians and patients feel the need to circumvent the traditional U.S. health care model at all. Those providing and receiving concierge care say it is the only feasible way to access value-based care in a system that has historically rewarded quantity over quality. But some experts say the shift toward the concierge model points to inherent flaws in the nation's long-standing approach to health and wellness and could exacerbate existing gaps in access to primary care.

The Rise of Concierge Care

Accordingto a 2020 poll conducted by NPR, the Robert Wood Johnson Foundation and the Harvard T. H. Chan School of Public Health, more than one in five wealthy people (the top 1 percent of those with the highest incomes in the U.S.) pays an extra fee for direct access to their doctor. But that estimate may not paint a full picture of who is actually paying for personalized health care in the country or how fee-for-service medicine is impacting those in lower tax brackets.

Part of the problem is that "concierge medicine" is a vague term. According to the Harvard Medical School report, the model arose in the 1990s as an alternative to traditional care under the fee-for-service structure, allowing patients to sidestep traditional obstacles to care, such as accessibility, and to develop closer relationships with their providers. Direct primary care (DPC) emerged as a distinct model in the mid-2000s, when physicians who liked the concierge model sought practical ways to improve quality of care for those who could not afford the hefty out-of-pocket costs. DPC, as its name suggests, strictly covers primary care, whereas concierge care can run the gamut of specialties.

One of the first concierge medical providers was MD², which began offering personalized care and 24/7 physician availability for an annual membership fee of thousands of dollars starting in 1996, explains Terry Bauer, CEO of Specialdocs Consultants, a firm that provides support for concierge practices. "As the health care landscape began its shift to volume-based care in the early 2000s," he says, "physicians became increasingly frustrated—challenged by rising operational costs, an intensified administrative burden and sharp cuts in reimbursement." Bauer says the paradigm was equally frustrating for patients, who typically had to wait weeks to see their physicians only to encounter 10-minute visits with no time to address anything but acute issues.

Jewel Mullen, associate dean for health equity and an associate professor in the department of population health at Dell Medical School at the University of Texas at Austin, says that many still use the terms "concierge" and "DPC" interchangeably, generating confusion about

their nuances. “DPC practices do not bill insurance,” she explains. “Instead they charge people a monthly fee [or one with some other frequency] for general medical care, offering patients more ready access to appointments [and] phone and online communication.”

DPC membership fees cover visits, lab work and some other services. And DPC practices rely solely on such fees from patients, meaning they do not accept insurance or participate in government reimbursement programs. Concierge practices, by contrast, typically cater to higher-income populations, charging pricier membership fees that cover an in-depth physical exam and screenings. These practices often *do* accept insurance and take part in government programs. Proponents say that both models allow physicians more time with patients and a reduced administrative burden and that they give the patients more personalized, comprehensive care—at a cost.

Russell Phillips, director of Harvard Medical School’s Center for Primary Care, says that while concierge medicine has gone a long way in helping physicians manage their workload, earn more money and provide better access, it is not a perfect system. “That reduction in the number of patients—often from nearly 2,000 to 500 to 600—means that many patients are left without primary care physicians at a time of increasing shortages in primary care clinicians,” he says. “Additionally, concierge medicine creates a two-tier system of care, where patients who can’t afford the cost of concierge care are excluded.” Phillips adds that a lack of peer-reviewed studies on care outcomes in concierge practices, compared with more typical primary care, makes it hard to know if the concierge model is really as effective as claimed.

Experts say the number of DPC or concierge practices in the U.S. has historically been hard to track, although the trade publication *Concierge Medicine Today* puts the number of concierge physicians at around 12,000. In an interview with NPR last year, Erin Sullivan, an affiliated faculty member at Harvard Medical School’s Center for Primary Care and a co-author of the aforementioned Harvard paper, noted that there were “approximately 1,000 [DPC] practices in 48 states serving approximately 300,000 U.S. patients.” If the practices saw an equal number of patients, that would mean each one would cater to approximately 300 individuals.

“We know that we do not have enough primary care providers in the U.S., so having more physicians seeing fewer patients is not ideal,” Sullivan told *Scientific American*. “However, the other question I think about is ‘Does a physician with a smaller patient panel provide higher-quality care or more preventive care? And if they do, does this generate significant cost savings for patients and health systems over time?’ I don’t have the answer to this.”

The Pandemic’s Effect

The COVID pandemic altered the trajectory of concierge care in the U.S., and experts say the effects could be either concerning or promising, depending on your perspective.

“I’m worried about how this pandemic is going to impact the physician shortage,” Sullivan says. “That might have a much bigger impact … than DPC or concierge. Prepandemic, I would have said, ‘We don’t have enough physicians choosing to practice primary care.’ And if those physicians who *do* choose primary care elect to practice in models such as concierge and DPC, then you could see how that would exacerbate a shortage. On the other hand, if these models prove [to be] more attractive or sustainable ways for physicians to practice primary care, then can we increase the number of physicians electing to practice primary care? And can we learn from these models to build something better and accessible for all patients?”

Mullen says that the pandemic “set off alarms” as people recognized how underfunding of public health has impacted the attraction and retention of primary care providers, in turn threatening the collective well-being of Americans. “The crisis from underinvesting was festering before it erupted,” she says. “Evaluating DPC and concierge care should lead us to answer bigger questions, such as ‘How will we eliminate the disincentives that drive medical students and physicians away from primary care?’ A counterpart to that is: if we believe that health care is a right and not a privilege, we need to build a system that makes primary care accessible.”

Even Santiesteban, who has been happy with her concierge experience, sees limitations with the model. “For everyday testing, bloodwork, even physical therapy, I loved the convenience,” she says. “But when I needed a specialist or x-rays or other sophisticated testing, the concierge doc was of limited value.” Nevertheless, she adds, “sometimes you just get tired of being another cog in the machine. You want someone fully focused on you and your issue—no interruptions.”

ABOUT THE AUTHOR(S)

Michelle Konstantinovsky is a San Francisco-based freelance journalist and UC Berkeley Graduate School of Journalism alum. She's written extensively on health, body image, entertainment, lifestyle, design, and tech for outlets like Vogue, Teen Vogue, O: The Oprah Magazine, Cosmopolitan, Marie Claire, Seventeen, and more. Learn more at michellekmedia.com.