Concierge Care and the Future of General Internal Medicine

The report by Alexander et al.¹ on the characteristics of concierge practice in the United States has some good news and some bad news. The good news is that the practice of luxury primary care is not very prevalent. The authors could find only 152 retainer physicians to survey, after a very thoughtful search process. Their estimates are correlated by recent reports from the industry that there are probably less than 200 such practices in the United States today.² Concierge care does not appear to be an approach that is gathering momentum.

The bad news is that every unfortunate, yet predictable, side effect of the concierge practice has come true. The concierge doctors do tend to build their practices by shipping those who cannot pay off to other doctors. Those transferred patients are more likely to be Medicaid recipients. What was not necessarily predicted might be even worse news. The concierge doctors are getting rid of their sicker patients (at least those with diabetes). And they are not as likely to care for patients of color, raising concerns about worsening racial disparity in care. If it were to grow in popularity, concierge medicine would likely push more patients of color, poorer patients, and sicker patients into the remaining primary care practices.

Fortunately, it has not caught fire. But we cannot be complacent as the field of primary care appears to be set for a conflagration. The decline of interest in primary care internal medicine demonstrated by residents is striking,³ although not surprising. Long practice hours with relatively poor reimbursement, lack of significant exposure to primary care in training programs, and fewer mentors capable of exciting interest in the field are all factors that contribute to this sense of malaise. The result is that while other areas of medicine are growing and practitioners thriving, primary care internal medicine is moving toward crisis. If this decline in interest persists, most primary care practices will be completely reliant on the pool of foreign educated physicians to find replacements, and that supply may be tenuous as well.

Like many other areas of concern in health policy, reimbursement forms the foundation of the problem and indicates some possible solutions. While many conciergists are no doubt made very happy by the amount of time they are able to spend with patients, chances are they are even more attracted by the prospect of relatively higher income without the need to grind through 4,000 or 5,000 relative value units each year. The popularity of other fields is likely related to a compensation/effort ratio. Radiology may have become more intrinsically in-

teresting, but the upsurge of interest in radiology residency almost undoubtedly has more to do with climbing incomes based on very generous reimbursement. It seems very possible that primary care internal medicine could demand resurgent interest if the payment for evaluation and management codes was improved; or better yet, if methods could be identified for reimbursement based on number of patients in a panel.

The latter idea is not new—it would be capitation without the financial risk for utilization that proved to be so divisive. It is also like concierge payment, only available to all without regard for ability to pay. If pay for performance notions become more widespread, the health care system will require someone to manage a panel of patients—the primary care doctor is the only real candidate. Improved payment, and incentives to manage and improve care, as well as a central role in the health care system, all could be potential steps toward the revitalization of primary care internal medicine.

But that is just a prospect. For now, the symptoms of malaise are widespread: concierge medicine is one of them. It is a bad symptom, worse in many ways than could be predicted. Its potential for distributive injustice appears to have been fully met, adding race to the anticipated problems surrounding discrimination based on socioeconomic status and ability to pay. We can be happy, and perhaps take some solace in the fact that luxury care is not becoming rapidly prevalent. Yet the potential for this and other unattractive developments will remain unless general internists take the political initiative to seek changes in reimbursement policy. Both patients and physicians deserve reform of our current approach.—**Troyen A. Brennan, MD, JD, MPH**, *Department of Health Policy and Management, Harvard School of Public Health and Department of Medicine, Harvard Medical School and Department of Medicine, Brigham & Women's Hospital, Boston, MA, USA.*

Address correspondence and requests for reprints to Brennan: Department of Medicine, Brigham & Women's Hospital, 75 Francis Street, Boston, MA 02115 (e-mail: tabrennan@partners.org).

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