

Boutique Medicine: Good medicine with a bad taste or just bad medicine?

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Boutique medicine is a term that is more and more coming into our popular lexicon. By most definitions boutique medicine is used to describe a type of physician practice which has a few distinguishing characteristics that separate it from conventional physician practices. Typically a boutique practice is set up to cater to a limited number of patients who pay a premium, often times, an up-front enrollment fee ranging from \$1,500 to \$20,000 a year, in exchange for unlimited and unfettered access to the practice's physicians. A boutique practice is usually comprised of two or three physicians who limit the number of patients they each treat to approximately 600 – 800 patients.¹ By limiting the number of patients under their care the physicians are able to spend more time with their patients, offer same day appointments, and usually increase their net income in the process. From the patient perspective the annual premium is money well spent in exchange for this personalized and prompt care.

Taken at face value, the boutique concept of a physician practice is American capitalism at its very best, free enterprise at work. At its very worst, the boutique concept is an elitist, unethical and immoral business practice which further divides the haves from the have nots. And therein lies the rub. Perhaps there is a greater truth in some yet undiscovered middle ground.

Imagine for a moment an economically depressed area with a desperately underserved patient population, hundreds and thousands of patients in fact, all needing a surgical intervention that would save them from a lifetime of blindness through a simple cataract procedure, yet none of these patients having the means to pay for such an operation. Now imagine in that same country the wealthiest of the wealthy being given red carpet treatment in the plushiest of facilities for the

very same cataract affliction using state of the art equipment, technology and methods, a boutique practice, if you will. The only thing separating these two groups of cataract patients is the ability to pay. Now imagine further a scenario whereby the profits from the boutique practiced were used to finance a second practice that provided the same service, same world-class technology and cutting edge methods, minus a few of the red carpet frills to the population of poor patients. A fantasy? Hardly, it exists right now, in India in a practice founded by Dr. Govindappa Venkataswamy over twenty five years ago. His Aravind Eye Hospital is now, " ... performing 180,000 cataract operations a year, 70 percent of them for free".²

Does anyone question the morals, ethics or elitism of providing free care to 70 percent of a practice's patients? Probably not. However, before one jumps to the seemingly obvious point that the current model of most boutique practices in the U.S. do not use any of their profits to subsidize a portion of their practice to providing free care to a slice of patients who cannot afford to pay we need to look at few more issues.

Let's first look at what is the effect on the U.S. healthcare system and a given community where a boutique practice is underway. Clearly the physicians operating the practice by all reports are well satisfied and well compensated. The patients being treated are certainly more than willing to pay a premium for their care and are also well satisfied with the quality of their care. So what effects do well paid, well satisfied doctors and well satisfied patients have on their local community's health and healthcare system? Surely we have high income physicians paying a commensurate rate of income taxes, making those dollars available for redistribution based on the priorities set by legislators and policy makers, to include establishing avenues for obtaining healthcare by those unable to pay. Surely the patients paying the boutique premium do so because by definition they are high income persons, who also pay taxes. Moreover, the more time the high income patients spend working versus waiting in an overcrowded clinic the more

income they are producing and of course, the more taxes they are paying. So in the end the reader is left to ponder, what's different between the U. S. and India example except for a third party intermediary (government tax collection) in the U.S. versus direct transfer in India?

The next issue beyond simple dollars is to look at what is happening as a result of health care being delivered to this select part of the population, the boutique patients, here in the U.S. It is well documented in the literature that satisfied patients enjoy better health and satisfied physicians practice better medicine, both of these positive affects contributing to the overall improved health of the community at large. Perhaps a practical example might further illustrate this important point. As a result of a patient's wealth he is able to quickly get a necessary flu shot before winter sets in. Clearly this has a direct and immediate benefit to this patient. But is there not also a community benefit? The patient does not get sick, continues to work, frees up health care resources for others, prevents the spread of the flu, etc., etc. While the patient who remains without a flu shot because of his inability to pay or get access to a flu shot remains at risk, is it not true that for every patient who does get a flu shot the overall community risk is lowered?

Yet, it is understandable that our instincts tell us that it is precisely disparities such as these, which must be eliminated. But the focus on the disparity itself is one that often times further confuses the issues. This instinct is succinctly explained by David Mechanic in a recent essay. He writes that, "...enhancing overall population health and reducing disparities are different objectives and are sometimes in conflict".³ Indeed. We must ask ourselves, are we upset about the boutique concept, or are we upset at that fact that some patients get treatment while others do not? Uwe Reinhardt, a respected health economist and Professor at Princeton University, recently wrote on the subject of boutique practices in the U.S., "...like the United Kingdom – but unlike Canada and much of continental Europe – the United States accords its upper income

classes economic, legal, and social privileges that are distinct from those accorded the rest of society. Boutique medicine is merely a part of this class based social order”.⁴

Perhaps even more significant than Professor Reinhardt’s social order argument is an even more fundamental one which validates the boutique practice as an acceptable and legitimate component of an entire continuum of a health care system. That fundamental argument is that our understanding of what determines one’s health is much more than a matter of simple resources, especially financial ones. In their seminal work on Life Course Health Development, Haflon and Hochstein offer convincing evidence that an individual’s health is determined by a complex set of systems and pathways that cannot be considered in isolation. They write, “...our efforts to reduce health disparities can no longer be confined only to providing better access and more resources to address the needs of the underserved”.⁵

Surely any of us in the health care arena can appreciate the seeming unfairness, if not unjustness of a society that allows two populations of its citizens to enjoy or suffer such very different levels of health care. At the very worst, the advent of boutique practices is only yet another manifestation of a free and democratic society at work. Yet, attacking the concept does nothing for reducing disparities between one segment of the population and another. If anything it simply furthers the philosophical, social and economic divide between these groups when only side is shouting and the other side is not listening.

Taking away boutique medicine will do nothing to decrease disparities in a community’s health. While boutique medicine may admittedly have a distinctly bad taste for some people, it is nevertheless distinctly good medicine for some people.

¹ Romano, Michael (2002). If you have to ask, you can't afford it. *Modern Healthcare*. Vol 32, No. 12, p.17.

² Magretta, Joan (2002). *What management is*. New York. The Free Press.

³ Mechanic, David (2002). Disadvantage, inequality, and social policy. *Health Affairs*. Vol 21, No. 2, p. 50.

⁴ Reinhardt, Uwe. (2002). Doctors are more interested in having higher incomes than providing better health care. *British Medical Journal*. Issue 324, p. 1335.

⁵ Halfon, Neal and Hochstein, Miles (2002). Life Course Health Development: An integrated framework for developing health, Policy, and research. *Milbank Quarterly*. Vol. 80, No. 3, p. 435.

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