6-2015

Undergraduate Student Attitudes on Concierge Medicine

Sushane Gupta
Union College - Schenectady, NY

UNDERGRADUATE STUDENT ATTITUDES ON CONCIERGE MEDICINE

By:

Sushane Gupta

Adviser: Professor Melinda Goldner

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Submitted in partial fulfillment

Of the requirements for

Honors in the Department of Sociology

Department of Sociology

Union College

May 2015

Abstract

The purpose of this thesis was to examine the opinions of undergraduate students on a field of personalized primary care known as concierge medicine, as well as assess their satisfaction with their current non-concierge healthcare providers. Concierge medicine aims to provide patients with a high level of customer service and satisfaction, and in exchange for an annual fee, they receive benefits such as lower waiting times for appointments, access to the physician by phone or e-mail, and a stronger patient-physician relationship focused on preventative care. The current literature on non-concierge healthcare reveals several deficiencies including poor insurance coverage, poor patient and provider satisfaction, and low ratings of the United States on several measures of healthcare. The literature on concierge medicine shows that it has grown since its inception nearly 20 years ago and has both supporters and opponents, but no data on student opinions of the field exist. In this study, I interviewed 12 students at an undergraduate college in the Northeast, and found that the majority of students were satisfied with their existing non-concierge care and were not interested in concierge medicine. Students described their current physicians as trustworthy, and never felt rushed or inconvenienced by their physicians. These opinions contrasted with the literature, which exemplifies patients being refused certain care or feeling rushed during their visits. Students also stated that concierge medicine would not be practical for them, as they would not need the benefits of convenience or personalized care it offers. Some felt that it is unethical as well, as it denies care to those who cannot pay the monthly retainer fee. The findings suggest that concierge medicine is not practical for healthy, nonelderly individuals, and that it presents an issue of ethicality by refusing care to those who cannot afford it. Despite the demand and growth of concierge medicine, it is not for the masses, and increasing non-concierge care should be a priority for the future.

Acknowledgements

I would like to thank my adviser, Professor Melinda Goldner, for spending countless hours in helping me construct my thesis as well as guiding me from my first day at Union. I would also like to thank the sociology department, especially all of my former sociology professors, for helping me become the thinker I am today. I would not be where I am today without the support from these individuals.

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Introduction

The United States has a history of administrative and proficiency issues in medicine that began in the early 1800s, shortly after the country's inception. It was first flooded with quackery and an absence of regulating bodies, essentially meaning there was no standard of care to be expected (Gutierrez and Scheid 2002). Improvements were made in the mid-1800s as the American Medical Association was formed, and in the 1900s as incompetent medical schools were shut down and residency programs for medical specialties were created (Gutierrez and Scheid 2002). However, the U.S. began facing a shortage in primary care physicians, a chronic problem that it continues to face today, instigated by lower compensation and prestige in primary care in comparison to specialty care (Gutierrez and Scheid 2002).

In addition to low compensation and prestige, primary care doctors have been unsatisfied because of pressure from managed care organizations to follow specific protocols that constrain physician autonomy (Warren et al. 1999). Low physician compensation has also forced physicians to see more patients, which has reduced the time allotted per patient and interfered with strong patient-physician relationships. The weakening of the patient-physician relationship led some doctors to conceive concierge medicine, a form of primary care delivery characterized by small patient panels, longer visit times, fast access to the doctor over email or telephone, shorter waiting times, and in some practices, unlimited office visits. The model is structured on improving the patient physician relationship, thus being beneficial to both patients and physicians. Concierge medicine has grown steadily since its inception and estimates place the number of practices at 5,000, up from 756 in 2010 and 146 in 2004 (Gavirneni and Kulkarni 2014; Clark et al. 2010).

In this thesis, I studied whether this model of care would appeal to students, as existing data showed it to be preferred by an older clientele. Student interest in the field could help it financially in both the short and long-term, so if there was interest detected, it would be beneficial for concierge physicians to advertise to students. I interviewed 12 premedical students on their opinions regarding their current physicians and whether they would be interested in concierge medicine. I interviewed premedical students specifically because I felt they would have a greater interest and knowledge in their healthcare since they would be future healthcare professionals.

The first chapter of this thesis outlines the current literature on the state of primary care, patient and provider opinions on the field, and state of concierge medicine. The second chapter outlines the methods I used to conduct this study. The third chapter explains my results and how they relate to the literature described in chapter one. Lastly, chapter four consists of a discussion of the significance of these results, solutions to improve the primary care shortage, limitations of this study, and future directions for research on concierge medicine.

Chapter 1: Literature Review

Primary care is a fundamental part of the U.S. healthcare system. It provides patients with a physician who provides non-specialty preventative care such as physicals, vaccinations, and blood tests, and it attempts to keep patients from developing the more serious problems that would subsequently require expensive care from a specialist. Primary care also provides curative care aimed at curing acute illnesses, such as by prescribing antibiotics for bacterial infections. Preventive care requires both the physician and patient to take responsibility for the patient's health; the physician recommends the action necessary and the patient implements it. This requires a strong patient-physician relationship, one in which the physician regularly communicates with the patient and has time to fully explain components of the patient's health. This relationship is disrupted by several factors in our existing healthcare system, and a new form of primary care delivery known as concierge medicine has surfaced in the last two decades as a solution. In this preliminary chapter, I look at the development of the current system of primary care. Next, I describe the specific problems with the current system, a major one being physician and patient complaints with insurance. Finally, I introduce concierge medicine, look at its characteristics and growth, and examine whether it appeals to the general patient population.

A Brief History of Primary Care

The United States is a world leader in providing the most advanced healthcare possible for those who can afford it, despite its relatively poor health outcomes in comparison to other countries (Commonwealth Fund 2014). Among 11 advanced countries, the U.S. was the least efficient in delivering healthcare, the worst in providing equal levels of care, and the worst in achieving measures of healthy lives. A significant contributing factor to these results, particularly the lack

of equity of care, is the large income differences amongst the U.S. population and lack of a universal healthcare system (Commonwealth Fund 2014). Inadequacies in healthcare are not unfamiliar to the U.S.; U.S. healthcare in the early 1800s was unorganized and lacked quality control (Gutierrez and Scheid 2002). There were no standards for healthcare since there were no medical schools with standardized academic curriculums, residency teaching programs, or even regulating bodies to oversee doctor qualifications (Gutierrez and Scheid 2002). As a result, doctors were often unqualified and had simply picked up the skills from observing others, much like an individual learning to repair cars from working at a car shop (Gutierrez and Scheid 2002).

Primary care began to improve in the mid-1800s as the American Medical Association (AMA) was formed in 1846 to regulate medical education and the profession, and in 1910 when the Flexner report, a report prompted by the AMA amid perceptions of the U.S. lagging behind other countries in medicine, set strict standards for medical education and began to clear the field of medical practices considered to be quackery (Gutierrez and Scheid 2002). Specifically, the report exposed several schools exaggerating the scopes of their curriculums, prompting them to close (Starr 1982). Additionally, the Federation of State Medical Boards was created to license medical graduates and acted as a formal authority to accredit medical schools (Starr 1982). The Flexner report was just the beginning in the series of changes made by a developing medical bureaucracy, supported largely by the AMA and the American Board of Medical Specialties (Gutierrez and Scheid 2002).

By the mid-1900s, medical procedural specialties began to command more prestige as specialty residency training programs were instituted and specialists gained a monopoly on the use of medical technology (Gutierrez and Scheid 2002). Hospitals began to grow with advancements in medical knowledge and technology, as equipment was too expensive for

individual physician offices (Rosenberg 1987). Medical technology also focused care towards specific diseases, indicating a shift from holistic care performed by primary care physicians (Rosenberg 1987). From an economic standpoint, the medical tests utilizing the new technology would cause increases in healthcare costs, leading to higher insurance reimbursements for hospitals. This would motivate hospitals to emphasize procedures utilizing this technology, which would be performed by specialists rather than primary care physicians. This is exactly what happened, as primary care practitioners were excluded from hospital work and assigned lower prestige and pay in the medical community, which caused them to decrease in number (Gutierrez and Scheid 2002). Rising medical education costs made primary care even less attractive to potential students, increasing the motivation to pursue specialty care. These changes led to a shortage of primary care physicians and caused medicine to become more depersonalized, meaning that primary care physicians were unable to provide enough attention to the increasing U.S. population (Gutierrez and Scheid 2002). Primary care also became more difficult to access, particularly in rural areas because there were not enough physicians to meet healthcare demand (Gutierrez and Scheid 2002).

In response to the decline of primary care, the AMA held The Citizen's Commission on Graduate Medical Education to try to restore primary care (Gutierrez and Scheid 2002). This in turn led to the Folsom Report in 1966, which stated "every individual should have a personal physician who is the central point for integration and continuity of all medical services to his patient," thus highlighting the importance of the primary care physician (Folsom Report as quoted in Gutierrez and Scheid 2002:9). Another report similarly stated, "The American public does want and need large numbers of qualified Family Physicians" (Willard Committee as quoted in Gutierrez and Scheid 2002:10). These reports reinvigorated primary care, and in 1969

the field of family practice was approved, with a stated goal of creating physicians who provide "continuing and comprehensive healthcare for the individual and family" (American Academy of Family Physicians as quoted in Gutierrez and Scheid 2002:11). It is appropriate to consider family practice as representative of primary care, because it is the largest primary care field, it is designed to perform the functions of primary care and, in the words of Geyman (2010), was created to address primary care needs for "comprehensiveness, continuity, and accessibility" (Geyman 2010:593). This specialty proceeded to flourish, and today it is the backbone of primary care, as it boasts the largest medical board and the most delegates in the AMA (Gutierrez and Scheid 2002).

In the midst of the primary care rejuvenation process, the U.S. experienced a rise in healthcare costs in the 1960s with increases in specialty care and advances in technology (NCD 2015). This prompted the U.S. government to enact the Health Maintenance Organization Act of 1973, which provided funds to develop health maintenance organizations (HMO), a type of managed care insurance plan (NCD 2015). The term "managed care" refers to a system that both finances and provides healthcare for its members (Feldman et al. 1998). HMOs provide their members with care from any of the doctors in the HMO's network, but patients must usually see their primary care physicians before they can be referred to a specialist (Fox and Kongstvedt 2007). The reason for this requirement is that specialist visits are expensive and often unnecessary, and can be avoided by first consulting a primary care physician. A second type of managed care plan, though more expensive, is the preferred provider organization, which is similar to the HMO except it allows members to see physicians outside of the network for an additional fee and does not require patients to see their primary care physicians first (Fox and Kongstvedt 2007). The purpose of the HMO Act was to restrict costs by focusing on outpatient

care and prepaid costs, thus limiting the use of medical services. Additionally, because healthcare in the U.S. is predominantly provided through employers, the Act mandated employers to offer HMOs to employees as a potential healthcare option, thus increasing the public's access to managed care plans (NCD 2015). Managed care grew significantly in the 1980s and 1990s, a consequence of the HMO Act and its ability to reduce hospital visitations and negotiate low rates with participating physicians (NCD 2015). From 1976 to 1995, plans grew in number from 175 to 591 and enrollment from 6 million to 51 million (Warren et al. 1999). The industry promoted its benefits such as offering preventive services like vaccines, which both kept individuals healthier and reduced costs associated with preventable diseases (Fox and Kongstvedt 2007). Physicians had little choice but to work with these managed care plans, as employers increasingly began offering only managed care plans to employees (Fox and Kongstvedt 2007). While managed care cut costs, it experienced significant opposition from the medical community to the point of threatening the existing system of primary care; this will be explored in detail later.

As McWhinney (1981) writes, the role of the family practice physician has changed from dealing with acute illnesses to helping patients maintain a standard of health. McWhinney writes that physicians today are more likely to help patients manage chronic disorders by studying a patient's personality and environment, and less likely to deal with "acute life-or-death situations" (McWhinney 1981). This conclusion is logical because medical advancements have made it far easier to treat and prevent fatal infections that in previous centuries, led to death. Additionally, Geyman (2010) states that the goals of family medicine are maintaining health, preventing disease, and managing chronic illness. This indicates a shift from curative to preventive medicine, as acute and infectious illnesses are no longer a significant threat to society (Reeder

1972). In economic terms, the shift from curative to preventive medicine indicates a transition from selling medical procedures and emergency care to providing preventive services such as physicals and checkups (Reeder 1972). Reeder (1972) calls this a shift from a "seller's market" to a "buyer's market," as instead of patients predominantly paying for emergency care during calamities, physicians will need to convince patients to come in for checkups even when they are seemingly healthy. These are indicators that doctors need to have close relationships with their patients in order to assist them with taking responsible actions regarding their health. However, this close relationship is threatened today by several factors, which will be explained in the following pages.

Despite the growth of primary care in the 1960s and its increased access with managed care, primary care is at risk. The patient-physician relationship is in decline as described previously, and in addition, the number of students selecting primary care residencies such as family practice has declined in the last decade (Bodenheimer et al. 2009). The main causes behind the lack of students are medical education favoring non-primary care, and lower incomes compared to procedural specialties like ophthalmology, which result in high stress for the paygrade (Bodenheimer et al. 2009). Bodenheimer et al. (2009) states that government funding for medical education is directed towards hospitals instead of residency programs, which favors training in hospitals over non-hospital ambulatory settings; the latter is necessary for training primary care physicians, and thus primary care training suffers. Dr. John Goodson argues that medical schools and residency training programs need to support primary care residencies, but claims that this will be difficult as they do not always support workforce needs (Goodson 2010). For instance, there is a shortage of primary care physicians in rural areas and to correct this, medical schools could accept more students from underserved areas (Bodenheimer and Pham

2010). This is based on the finding that students from rural areas are four times more likely than urban students to practice in rural areas (Bodenheimer and Pham 2010). Secondly, Goodson (2010) states that the reimbursement levels for primary care physicians are not high enough to stimulate interest in the field, despite the Affordable Care Act raising reimbursement by 10% for primary care. In addition, specialists will continue to receive significantly higher reimbursements than primary care physicians and thus it is difficult to see the 70% specialist vs 30% primary care distribution of practicing physicians in the U.S. becoming more equal, as in similar countries, any time soon (Goodson 2010). A contributing factor to the low incomes is the resource-based relative value scale, which is used by Medicare and private insurers, and disproportionately compensates specialists for medical imaging and procedures (Bodenheimer et al. 2009). The reason for this is that spending on imaging and procedures has increased more so than spending on evaluation and management services, and because the latter two constitute the majority of a primary care physician's duties, these physicians are paid less (Bodenheimer et al. 2009). This lack of students is expected to create a shortage of 35,000-44,000 physicians in the future, which will be an issue particularly in rural areas where there are already shortages in physicians (Bodenheimer and Pham 2010).

Problems with Current System of Care

Healthcare in the United States has been plagued by an assortment of issues ranging from insurance coverage, high deductibles in insurance, complaints from physicians and patients, and several other factors corroding the physician-patient relationship. The current system is ineffective, as studies in 2006 placed the U.S. behind other industrialized nations in clinical outcomes, such as mortality from diseases preventable by healthcare (Schoen et al. 2006). Eight

years later, the U.S. continued to lag behind other similar countries such as Australia and Canada in outcomes, as determined by the Commonwealth Fund (2014). The main issue with health-care is potentially the insurance component, which does not serve the U.S. population adequately and does not allow physicians to practice effectively.

Insurance Coverage

The United States lags behind other first-world countries such as the United Kingdom, Australia, and Germany with its lack of insurance and, for the insured, high deductibles (Schoen et al. 2006). In comparison to these other countries, U.S. physicians report more patients that have difficulty paying for healthcare and medication, which leads to a stratification in health between the rich and the poor, with the poor experiencing worse clinical results (Schoen et al. 2006). Schoen et al. (2006) points out that the U.S. differs from other similar first-world countries in that it does not have a universal healthcare system, it has high cost-sharing in its insurance plans, and it does not utilize primary care as much. Each of these shortcomings increases costs, making healthcare in the U.S. expensive. Even those that are insured find it difficult to pay because of cost sharing and high deductibles, which makes it difficult for them to afford regular visits or for physicians to give more complete care, such as the appropriate medication and exams (Schoen et al. 2006).

The issue of high-deductible insurance plans reducing access to care has become more prominent since employers, in an attempt to reduce spending in response to rising costs of healthcare, have enrolled employees in health-savings accounts and high-deductible health plans (Lee and Zapert 2005). These plans cause individuals to pay out of pocket until they reach their deductibles, resulting in annual costs of at least $1,000 for individuals if they regularly utilize

health services (Lee and Zapert 2005). The idea behind these cost-sharing plans is they put consumers in charge of making decisions about their healthcare as to when they should utilize it, though this raises concerns as to whether their decisions will result in poor health outcomes (Lee and Zapert 2005). Studies show that these high-deductible plans reduced the likelihood of low-income individuals to seek healthcare by 39%, resulting in poor management of blood-pressure (Lee and Zapert 2005). They show that individuals in high-deductible plans are less likely to fill prescriptions than individuals in lower deductible plans, citing the reason as costs (Lee and Zapert 2005). Additionally, 77% of non-public administration employers providing healthcare plans agree that plans with high cost-sharing, such as high-deductibles will cause employees to skip important care (California Healthcare Foundation 2005). This reveals that patients will be reluctant to seek healthcare when costs are high and although they may forgo unnecessary care, they will also forego necessary care. Secondly, high-deductible plans are designed to make patients more conscious about the care they are seeking by expecting patients to use doctor and hospital quality grades (Lee and Zapert 2005). This idea is based on the similar concept of individuals reading reviews on services that they pay for, such as dining at a restaurant or staying at a hotel, in order to get the most out of their money. However, surveys show that patients are not utilizing these, further discrediting high-deductible plans (Lee and Zapert 2005). All of these findings suggest that insurance plans contribute to the United States having poor clinical outcomes and high mortality from preventable diseases.

However, in response to some of these claims and to encourage patients to seek care despite the high-deductible, insurance plans have started to exempt several types of services such as preventative care visits and certain exams from the deductible (Reed et al. 2009). The free preventive services provision matches the ACA requirement of ACA Marketplace plans to

include free preventive services such as flu shots, and thus it is possible that this action was more to allow insurance companies to sell their plans on the ACA Marketplace (Healthcare.gov 2015). This provision results in insurance companies covering these services and patients only being responsible for the copays, or fixed fees associated with any visit that are paid even after the deductible is normally reached (Reed et al. 2009). Despite these services being exempt, Reed et al. (2009) found that certain patients in high-deductible plans did not understand which services were exempt and, compared to patients without these plans, still took cost-related actions regarding their healthcare. These actions included delaying care, avoiding care, or seeking unspecified medical care out of the Kaiser Permanente health plan (Reed et al. 2009). Thus, these results show that in order to improve clinical outcomes, it is not enough to simply make changes to healthcare plans but to properly inform patients about them.

The United States government attempted to increase access to healthcare through the Affordable Care Act (ACA), which would reduce the number of uninsured Americans by 55% (American College of Physicians 2009). The ACA increases coverage by allowing individuals that do not have employer-sponsored insurance to buy it directly from state-run healthcare exchanges. However, to accommodate this increase in coverage, at least 14,000 additional primary care physicians would be necessary, and a previous experience on the state level with instituting such a plan initially created problems (American College of Physicians 2009). In 2006, the state of Massachusetts instituted health reform which increased access to patients in the state, but this caused a shortage of physicians and led to patients waiting an average of 31 days for an appointment in 2008, nearly double the waiting time of 17 days before the act in 2005 (Bodenheimer and Pham 2010). The ACA has succeeded in lowering the number of uninsured Americans, as polls suggest that from July 2013 to May 2014, the percentage of uninsured

individuals dropped from 18% to 13.4% (Blumenthal and Collins 2014). It also succeeded in lowering insurance premiums by 10% in 2014 (Blumenthal and Collins 2014). However, these newly insured Americans are still facing coverage issues because the provider networks included in the insurance packages are small (Blumenthal and Collins 2014). For some patients, this means driving unreasonable distances to receive care, which was the case with a patient in Manhattan who had to drive to Stamford, CT to see an orthopedist for a broken ankle (Rosenthal 2015).

Insurance: Physician and Medical Community Complaints

It is not just the patients that are limited by insurance companies in utilizing healthcare services, but also the physicians in providing them. Managed care, as explained previously, was introduced by the U.S. government to curtail rising healthcare costs by making healthcare more efficient and utilizing fewer resources. However, physicians are dissatisfied with it, claiming that managed care limits physician autonomy, as physicians feel they must act according to what the managed care organization expects (Warren et al. 1999). The views of the physicians surveyed parallel those of researchers, who state that managed care has a set of protocols that physicians must follow (Warren et al. 1999). These protocols limit the types of medications physicians may prescribe and force them to receive approval for care they give, such as receiving approval from the managed care organization prior to surgical procedures. These strategies aim to minimize healthcare utilization and keep costs low, though limit physician autonomy and cause frustration. Additionally, since physicians must sign managed care contracts to receive new patients, patient loyalty decreases as well, as the patients are not seeing them after hearing positive reviews but only because the physician is in their insurance network (Warren et al.

1999). A second study by Diamond et al. (1993) had the same findings, that family practice physicians were dissatisfied with regulations and copious amounts of paperwork imposed by insurance companies and governmental agencies.

Apart from issues of regulation, insurance and managed care pose several issues regarding compensation and administrative issues for physicians. A study by Berman et al. (2002) found that in states with low pediatric Medicaid reimbursements, pediatricians had lower rates of accepting pediatric patients on Medicaid. The same study found that physicians are less likely to accept Medicaid patients since payments are capitation based and there are significant amounts of paperwork involved. The survey by Warren et al. (1999) found that physicians are not satisfied with the compensation they receive in managed care contracts, nor the influence managed care has on their work schedules. The study by Diamond et al. (1993) found that physicians cited lack of leisure time and low income as consequences from regulations and paperwork; low income was dissuading students from going into primary in 1993 at the time of the study and appears to be an ongoing problem as it continues to do so today. Cykert et al. (1997) found that physicians dislike the capitation payment system associated with managed care, stating among many reasons that it increases physician tension, risk of being sued, decreases income and does not have financial benefits for their practice, and limits the power they have in their practice. The capitation system differs from fee-for-service payments because it only pays providers a specific amount per patient regardless of the amount of healthcare utilized, thus forcing providers to constrain costs. However, constraining costs has the effect of reducing care given, which can cause physicians to rush patients in appointments, causing the physician stress and the patient unhappiness. The capitation system also limits power that

physicians have in their practice because it forces them to treat patients with a low budget, thereby not allowing them to always take the best course of action.

Finally, physicians believe that managed care severely compromises the quality of care they give to patients, particularly by harming the patient-physician relationship. Hall (1997) writes that managed care organizations employ several unethical strategies to contain costs including limiting the use of medical services, treatment, follow-up visits, expensive medications, life-preserving devices such as ventilators, and specialist visits. Additionally, managed care organizations encourage physicians to drop sick patients when their contracts expire (Hall 1997). These requirements not only reduce the patient's trust in the physician but also lead to lawsuits, common suits being the refusal of treatment and premature discharges on the basis of protocol (Hall 1997). A study by Feldman et al. (1998) surveyed patients on their opinions regarding the effect of managed care on the patient-physician relationship, on the physician's ethical obligations, and overall care quality; this study found that overall views on managed care were negative. Physicians expressed negative opinions of managed care on the patient-physician relationship, stating they had inadequate time with each patient because of efficiency requirements (Feldman et al. 1998). Because managed care reduces reimbursements, physicians must see more patients, which shortens visit times and consequently, patient trust in the physician (Feldman et al. 1998). Mechanic (1975) reasons that physicians under a capitation system, which is characteristic of managed care programs, have no incentive to increase the amount of time they spend per patient since they would not be getting paid any differently. Those under a fee-for-service system would, however, benefit from the additional time since they could bill for more hours (Mechanic 1975). Mechanic (1975) found that fee-for-service physicians devote more time to patient-care activities, which supports previous findings that

patients under fee-for-service doctors are more responsive to them. Therefore, in accordance with the structural expectation of managed care organizations, it would be more logical to reduce the amount of time per patient and see more patients in the same time frame. Feldman et al. (1998) state that shorter patient visits combined with the treatment of physicians as economic commodities by managed care organizations will do significant damage to patients' trust in physicians. As one physician in the survey stated, "Both physician and the patients have contracts with [the] insurance company, but not with each other" (a physician as quoted in Feldman et al. 1998:1629).

This concept of managed care harming the physician-patient relationship can often be caused by parties other than the managed care organization or physician and patient. Flocke et al. (1997) found that employers looking to provide healthcare for their employees must bid for managed care contracts, often annually. This has the potential to disrupt continuous care for patients, as it could cause them to switch physicians every year and thus disrupt their relationships. Flocke et al. (1997) first standardized their results by showing no differences in healthcare delivery between the types of managed care providers, including preferred provider organizations/independent provider associations (PPO/IPA) and fee-for-service healthcare. Next, they showed that 25% of patients in a PPO/IPA were forced to change their physician in the one-year period of study. They found that these patients had much lower opinions of their primary care provider, such as less knowledge of their medical history and healthcare needed. These patients also indicated a lesser desire to see their physicians, indicating lower utilization and potentially worse health in the long run. In addition, Flocke et al (1997) believe that since the families of these patients are typically on the same health plan as them, this disruption in care would be magnified and dissatisfaction would be more common. These results agree with

previous studies by Davis et al. (1995) and Kahana et al. (1997), who also found forced disruption of care among patients and subsequent frustration, indicating that managed care has an abundance of problems plaguing the physician-patient relationship.

In addition to physicians, other healthcare professional groups with a stake in healthcare include medical students, residents, and faculty. A study by Simon et al. (1999) shows that these individuals are against managed care as well, finding that these individuals generally preferred a single-payer health system that would provide universal coverage. Several countries like Great Britain and Canada have such a system in which the government provides universal healthcare to the public. Individuals in residency training programs such as faculty and program directors believed that managed care reduced faculty time for research and teaching, particularly for those in specialty programs (Simon et al. 1999). Managed care organizations have reduced reimbursements for hospitals, causing hospitals to pressure these individuals to spend more time in a clinical setting to bring in revenue (Mechanic and Dobson 1996). Faculty members and deans reported a lower quality of life caused by lower income, job security, and poorer relationships with colleagues (Simon et al. 1999). The lower income is caused by lower reimbursements from managed care contracts, and the lower job security is a consequence of pressure from managed care organizations on physicians to adhere to guidelines and expectations. Additionally, physicians are also under pressure from their institutions to bring in clinical revenue as stated previously, and because they face reductions in time for research and teaching, it is logical that their relationships with colleagues would also decline. Finally, medical students and residents stated that their faculty members were the biggest influences on their views of managed care, but that these influences were negative (Simon et al. 1999). This study is concerning, as it reveals widespread scorn for managed care that does not show signs of

disappearing with the next generation of doctors. If doctors and patients alike continue to remain unhappy with managed care, which is a significant component of the healthcare system based on patient volume and influence, satisfaction in medicine will decrease and both parties may look for alternatives to the current system.

Insurance: Patient Complaints

It is not just the physicians who are speaking out against healthcare insurance but patients as well. A survey in 1998 by the Kaiser Foundation and Harvard University found that, from the previous year, more Americans believed managed care to not be effective in providing quality healthcare to patients, and that managed care organizations were more interested in profits than patient wellbeing (Kaiser Foundation 1998). The results were thought to be influenced by skeptical views of managed care shown by the media, which had been highlighting the issues with managed care described previously, as well as by patients' experiences with managed care (Kaiser Foundation 1998). Many of those surveyed stated that they had been denied care by their HMO, despite it being recommended by their doctors (Kaiser Foundation 1998). This denial exemplifies the lack of autonomy that physicians face in managed care, as managed care organizations have strict cost-constraining policies and do not always approve care that doctors recommend.

Secondly, patients have been skeptical of managed care, particularly its cost-controlling mechanisms. For instance, managed care organizations give bonuses to physicians when these physicians keep healthcare costs low and refrain from providing unnecessary treatment (Gallagher et al. 2001). These bonuses have attracted criticisms that quality of care is being comprised, although Gallagher et al. (2001) argue that there are no data to support this claim.

The results of the Alternative Quality Contract, a cost-control program in Massachusetts that rewards providers if their costs are below assigned budgets, supports the idea that quality of care is not compromised with cost-control bonuses (Song et al. 2001). Specifically, in its first year, the program led to lower healthcare costs but an improvement in healthcare quality (Song et al. 2001). However, in response to these criticisms and even class-action lawsuits, managed care plans have adjusted the bonuses to reflect not only low costs but also patient satisfaction (Gallagher et al. 2001). However, patients do not need evidence to come to conclusions, and data collected by Gallagher et al. (2001) support the theory that any indication of physicians possibly being negligent in their duties will reduce patient trust in their physicians. Gallagher et al. (2001) found that 66% of patients stated cost-control bonuses would lower their trust in their physicians, and 85% of respondents supported healthcare plans without bonuses over those with bonuses. Support for a combined bonus that incorporated patient satisfaction in addition to lower spending was higher amongst patients, although 68% stated they would select a plan without any type of bonus over one with the combined bonus (Gallagher et al. 2001).

In the last 15 years, criticisms of managed care itself have lessened, possibly from reluctant acceptance of the system, though the health insurance crisis continues. Patient frustration today is more directed towards insurance plan coverage, such as the problem the aforementioned Manhattan patient faced. Another patient reported that her doctors left her ACA marketplace plan during the course of treatment, causing her to postpone surgery while she switched to a plan that accepted her previous physicians (Rosenthal 2015). Several others have reported difficulty in determining whether certain primary care physicians are in network, as many physicians cycle in and out of their networks (Rosenthal 2015). The list of cases goes on, suggesting that health insurance problems have not disappeared but just changed in form.

Other Factors Harming Healthcare

The negative effects of insurance on healthcare have already been discussed, but there are several other factors that harm quality of care. These causes may be rooted in insurance but may also stem from other causes, such as inefficiency on the physician's part.

A common complaint patients have is the waiting times they must endure for seeing their physicians. In their study of waiting times, Anderson et al. (2007) found patient satisfaction scores to be lower when patient waiting times were long and when visit lengths were short. Put together, the study showed that patients with the longest waiting times and the shortest visit lengths were most dissatisfied. However, they also found that patients receiving visit lengths of 10 minutes or longer were more satisfied than patients receiving visits of 5 minutes or shorter, regardless of waiting times. In other words, a patient waiting more than 60 minutes for a 10 minute or longer visit was more satisfied than a patient waiting less than 15 minutes for a 5 minute or shorter visit. A nearly identical study by Camacho et al. (2006) found the same results that higher waiting times lead to greater dissatisfaction, though longer visit times can help compensate for the wait times. These data signify that doctors trying to see more patients, whether it is due to managed care constraints or personal reasons, cannot both reduce visit lengths and have longer waiting times. They also signify the importance patients place on visit lengths; physicians can increase patient satisfaction by spending more time with them.

Morrell et al. (1986) found that shorter times for surgery consultations lead to lower patient satisfaction and less accurate care. Specifically, the study conducted an experiment with consultation lengths of 5, 7.5, and 10 minutes and found that consultations only 5 minutes long led to lower patient satisfaction scores, shorter visit times, and missed patient health problems (Morrell et al. 1986). For the sessions allotted 5 minutes, physicians had difficulty ending the

sessions on time and the average length was 5.2 minutes; physicians did not run late for the 7.5 and 10 minute sessions (Morrell et al. 1986). In the longer 10 minute sessions, physicians were also able to perform more tests such as measure patient blood pressure multiple times, which correlates with the ability to perform multiple tasks in a non-experimental setting (Morell et al. 1986). This study is insightful because it indicates that even increasing visit times by a few minutes can make a significant difference in healthcare outcomes. It also sheds light on the negative effects that can occur when physicians work under time constraints.

Apart from patient satisfaction, time spent with patients is a determinant of physician satisfaction and malpractice claims (Dugdale et al. 1999). Physicians do not enjoy short visit times with patients any more than patients do, and studies show that patient-physician relationships are one of the most significant contributors to physician satisfaction (Dugdale et al. 1999). A Commonwealth Fund survey of physicians found that 29% of physicians explicitly specified that they were unhappy with the amount of time they spend with patients, and just 31% indicated that they were satisfied (Collins et al. 1997). These results support the discussion previously on managed care, which made it clear that lack of time with patients was a major concern for physicians.

Finally, time spent with patients is correlated to physician malpractice claims. A study of primary care physicians in Oregon and Colorado showed that physicians giving patients longer visit lengths had fewer malpractice claims than physicians offering less of their time (Levinson et al. 1997). Despite the fact that the average difference in time lengths was just three minutes (18.3 minutes vs 15 minutes), the consequences were severe. Additionally, physicians in this study who were more emotionally attached to the patient and communicated more diligently with the patient had lower malpractice claims (Levinson et al. 1997). Physicians who asked patients

their opinions about taking a particular medication and listened to patient concerns, a strategy termed "active listening," were also less likely to have malpractice claims (Levinson et al. 1997). A similar study by Hickson et al. (1994) had the same result, finding that obstetricians with malpractice claims were more likely to have patients indicating feeling rushed in their appointments in comparison to those without claims. Hickson et al. (1994) found that physicians without any claims had a history of high patient satisfaction, which patients characterized as high accessibility, strong communication, and concern for their wellbeing. In contrast, doctors with claims were characterized as not only rushing patients, but also showing less interest and being reluctant to answer patient questions. Thus, it must be stressed that visit time lengths are not just important to preserve patient-physician relationships, but to keep the standard of care high enough to avoid malpractice suits.

Concierge Medicine

Overview and Benefits for Patients and Physicians

These inadequacies have prompted several physicians to consider a new form of care delivery known as concierge medicine. Concierge medicine, also known as retainer medicine is a type of personalized medical care that, analogous to other service industries, aims to provide the patient with a higher level of customer service and satisfaction. Theoretically, in exchange for an annual fee, patients are given lower, if any waiting times for appointments, longer and unlimited appointments with the physician (45-60 minutes at a Tufts practice), prompt access to the physician by phone or e-mail, and essentially, a stronger patient-physician relationship focused on preventative care (Kamerow 2012; French et al. 2010; Lucier et al. 2010). Some concierge physicians will even accompany their patients to referred specialist visits, thus helping to bridge

the gap between primary and specialist care (Clark et al. 2010). Alexander et al. (2005) found that concierge physicians were more likely than standard physicians to offer house calls, 24 hour access to physicians, same day appointments, and coordinated hospital care. A Seattle practice with several physicians and 850 patients recorded 150 house calls by one physician alone in its financial year (Kirkpatrick 2002). Concierge medicine practices vary in their willingness to accept insurance, but the annual fee tied to all practices is paid out-of-pocket and not covered by insurance companies (McDonough 2013). Other, more expensive procedures requiring specialist referrals or hospital stays require insurance coverage, and therefore patients of concierge medicine practices are encouraged and required by concierge physicians and the Affordable Care Act, respectively, to not forego health insurance but instead opt for a high-deductible plan (Page 2013).

A criticism of concierge care is that its clientele tends to be of certain demographics; in comparison to patients of non-concierge doctors, they are less likely to be African-American, or Latino, or on Medicaid, and more likely to be older than 65 (Alexander et al. 2005). Another study by Ko et al. (2009) supports these results, finding that in comparison to non-concierge medicine patients, concierge medicine patients are older and less likely to be of a minority ethnicity. The same study also found concierge medicine patients to have higher levels of education; the majority of concierge medicine patients had graduate school education while non-concierge medicine patients tended to have a college degree or less. This suggests an ethical problem since concierge care is only possible for those who can pay, thus resulting in physicians denying access to care for many (Stillman 2010). While these data may suggest that concierge medicine is attractive to a wealthier clientele, it can be and has been made more affordable for middle and lower class individuals, as will be discussed later.

For physicians, the benefits are manifested in lower overhead costs and increased efficiency stemming from a reduction in insurance processing, increased satisfaction and lower stress from seeing fewer patients, and for physicians affiliated with concierge care networks like MDVIP, lower billing and malpractice insurance costs as these are handled and negotiated by MDVIP staff (French et a. 2010). According to Alexander et al. (2005), compared to non-concierge physicians, concierge physicians have a patient panel a third of the size, see half as many patients daily, and provide more than 1.5 hours more of charity care each month. It can be argued that concierge medicine not only provides the physician with a better standard of living, but also the public which receives charity care.

Alexander et al. (2005) also found several differences between concierge and non-concierge physicians. First, both concierge and non-concierge physician populations show similar average age and gender distributions, though concierge physicians tend to have been practicing medicine for a shorter period. This latter statistic of practicing period may indicate that newer physicians are more receptive to concierge medicine, while older physicians are more accustomed to traditional medicine styles. A key difference Alexander et al. (2005) found, however, was in specialty distributions; the majority of concierge physicians were internists while non-concierge physicians were more evenly spread out amongst internal medicine, internal medicine subspecialties, and family practice. Although there are no studies analyzing this distribution, experts claim that specialists in concierge medicine would face several issues that would bring down revenues. Specialists rely heavily on patient referrals from primary care physicians but by advertising to these patients directly, they would cause patients to avoid seeing primary care physicians beforehand, reducing primary care revenues (Lipton 2013). The loss of patients could anger primary care physicians, and they would be less likely to refer additional

patients to those specialists in the future (Lipton 2013). This would not be an issue for concierge-only specialists with full patient panels, but would be for physicians that offer a hybrid model consisting of both concierge and non-concierge patients. Secondly, specialists perform procedures, some of which may be surgical or require physician teams. For concierge patients, the fees for these procedures can be very high, and the procedures would either require insurance payments or very high retainer fees that would only be feasible for the wealthy. A benefit of concierge medicine is to reduce insurance billing for physicians, and expensive procedures would be counterintuitive to this. Some specialists may also do procedures for non-recurring patients seen only once, and adopting a concierge-only practice would involve either discontinuing services for these patients or practicing both concierge and non-concierge medicine (Lipton 2013). Discontinuation of these services would reduce revenue, and thus a hybrid model would be most practical; this however, leads back to the first issue of referrals from primary care physicians. A third issue is time; specialists such as oncologists see patients with fatal illnesses who require significant amounts of attention (Lipton 2013). Though a concierge model advertises increased time with patients, the potentially exorbitant amount of time and visits required by these patients could drastically lower the number of patients seen by the physician, critically lowering revenues. Finally, potential patients would still need primary care to manage their overall health apart from the specialist care they receive. Some specialty concierge practices work with internists to provide primary care to the patients, but this complicates the concierge practice by adding more parties to the relationship (Otero 2010). For instance, if the patient were to contact the doctor during non-business hours, would he/she contact the internist or specialist? Essentially, the combination of expensive procedures, non-

recurring patients and patient referrals, intensive care, and requirement of primary care make concierge specialty care far more difficult to manage than primary care concierge care.

History and Growth

Concierge care was first proposed in 1996 by a Seattle based practice known as MD^2, which gave each of its physicians responsibility for 100 patients and in turn, patients paid an annual membership fee to the practice (French et al. 2010). The idea sprung from one of the co-founders of the practice, who had once served as the team physician for the Seattle Supersonics professional basketball team and wished to offer the same personalized care that athletes received to the general public (Clark et al. 2010). MD^2 has grown significantly since then, as it now has nine offices throughout the U.S. and has taken on a family based approach by limiting each physician to only seeing 50 families as opposed to 100 patients (MD^2). Apart from MD^2, several other concierge care practices have started, including small practices with just one branch as well as larger companies that contract concierge care physicians. One such company is MDVIP, which was started in 2000 and proved to be successful, as it was acquired by Proctor and Gamble in 2009 (MDVIP 2014). MDVIP contracts concierge physicians around the U.S., matching them to potential patients in their area but limiting them to a total of 600 patients (MDVIP 2015). Like MD^2, patients enrolled with MDVIP pay an annual fee depending on their region that covers all included primary care service and offers them the concierge medicine experience, giving them 24/7 access to the physician and more personalized care (MDVIP 2015). There are other companies like MDVIP including SignatureMD, Concierge Choice, and Specialdocs Consultants, Inc., indicating that the concierge medicine networking concept is in high demand. Though they have similar purposes, these companies use different approaches to

attract patients to their own networks. For example, instead of requiring its physicians to be readily available for patients, SignatureMD takes calls 24/7 to match enrolled patients with physicians on call (French et al. 2010). SignatureMD also offers several types of memberships, including some with physicians offering house-calls (SignatureMD 2015). The companies try to attract physicians through different strategies as well; SignatureMD and Concierge Choice allow affiliated physicians to practice both concierge and non-concierge care in their practices, thus not limiting them to the concierge model which may not be as popular in specific regions of the U.S. (French et al. 2010).

The growth of concierge medicine has been strong, as rough estimates put the number of concierge physicians at over 5,000 up from 756 in 2010 and 146 in 2004 (Gavirneni and Kulkarni 2014; Clark et al. 2010). A national survey of more than 20,000 physicians in 2014 found that 7% of physicians practice concierge medicine (Physicians Foundation 2014). For comparison, the total number of physicians as of 2014 in the U.S. was 893,851, and 425,032 were primary care physicians (Kaiser 2014). MDVIP reported over 700 affiliated physicians in 2014, up from 380 in 2010 and 130 in 2006 (MDVIP 2014; Clark et al. 2010). MDVIP also reported 215,000 enrolled patients in 2014, up from 40,000 in 2006, indicating rising patient interest in the field (MDVIP 2014; Clark et al. 2010). These numbers indicate that, though concierge medicine is a new field, it is gathering support amongst both the physician and patient community.

Physician Opinions

The growth trends indicate that both physicians and patients alike support concierge medicine. There are several studies on physician opinions regarding concierge medicine that detail the

aspects they like and whether concierge medicine is a viable field. Interviews with physicians at a Tufts academic retainer practice state that their concierge medicine practice not only offers concierge patients a more convenient service, but also allows the practice to offer subsidized primary care for those who cannot afford it (Press 2011). Two of the physicians in charge of the program, Dr. Salem and Dr. Cohen, state that their program is a hybrid concierge care program, meaning that they offer both concierge and non-concierge care. The proceeds from the concierge program are used to subsidize the non-concierge program, and the doctors state that some of their concierge clients specifically chose their program for this reason; some of these concierge patients have even donated to the non-concierge program. In addition, the doctors state that the two divisions of the practice do not differ in the medical services offered, but just in their convenience and appointment durations. Appointment length does contribute to care quality according to patients as described previously, and the doctors admit that individuals paying more will receive a better experience, but they state that this is justified because the concierge practice has improved care for all individuals through the subsidy program. Additionally, they state that differences in care will always exist since VIP patients, such as high-ranking government officials, may demand a greater quality of care than the average individual. When asked about the potentially negative aspects of concierge care, such as the high annual fee that could drive up healthcare costs in the U.S. or tests not covered by insurance, the doctors showed no concerns. They claimed that the increased attention provided by concierge care would lessen the need for unnecessary exams given in a rushed clinical setting, one in which the physician would not have time to explain a patient's condition and would order unnecessary exams to convince patients of their conditions. Additionally, the physicians stated that longer appointments would permit adequate communication time and thus prevent these

unnecessary exams, and inexpensive tests would be included in the retainer fee. Paradoxically, the concierge practice increased the number of patients the group sees by 5,000 since the proceeds from the concierge practice have helped to subsidize care in the non-concierge practice. Overall, the physicians are very satisfied with their decision to switch to a hybrid model of concierge care.

There are other concierge physicians who do not have such a humanitarian hybrid model but instead, focus on the economic benefits. Dr. John Kirkpatrick states that his motivation for switching to concierge care was too many of his long-time patients leaving him for more personalized care in concierge practices (Kirkpatrick 2002). After switching, Dr. Kirkpatrick reports satisfied patients and physicians at his practice, indicating a win-win situation for both. He states the practice has annual revenues of $2.5 million and a net-margin of 30%, which has resulted in higher profitability and physician salaries than before their switch. Furthermore, the program has 850 patients, 98% are very satisfied with the program, and there is less than a 5% attrition rate, signifying patients are truly happy with the results regardless of what the practice's motivations are.

Concierge medicine faces criticism, however, from non-concierge physicians who have voiced their opinions on the field. Dr. Michael Stillman gives several incidents of patients leaving his practice for a concierge one, including a patient who wanted a same-day medical imaging exam, another who was insistent on a MRI that Dr. Stillman would not order, a third who was not satisfied with a diagnosis, and a fourth who wanted more personal care but described by Stillman as "throwing money at a problem to buy a solution" (Stillman as quoted in Stillman 2010:391). Stillman disapproves of the majority of concierge physicians, even citing Kirkpatrick who was described previously, since they only treat wealthy clients who can pay the

retainer fee. He continues by claiming same-day exams and aggressive, unnecessary imaging ordered by some concierge physicians is not demonstrating evidence-based care. Finally, he claims there is no evidence for concierge medicine truly offering more positive clinical results than non-concierge primary care. However, this previous statement is refuted by an MDVIP sponsored study published in the *American Journal of Managed Care*, showing that MDVIP patients were less likely to be hospitalized than non-members (Klemes et al. 2012). Stillman (2010) does offer evidence potentially invalidating the finding above, stating that concierge care practices have patients with lower rates of diabetes, heart disease, and hypertension. Although this evidence comes from a single study in 2005 and does not include all concierge practices, Stillman's voices the opposition to concierge care and makes valid contentions. It appears that doctors are divided on the morality of concierge medicine and further studies are necessary to judge the effectiveness of concierge care. Regardless of these studies, the capitalistic market of the U.S. legally allows concierge care to persist and since there is currently a market for it, it will continue. As Matt Jacobson, CEO of SignatureMD, states, "Should we send our kids to private school if that's something we value? Some people put value on healthcare, and want to put investment in healthcare" (Jacobson as quoted in McDonough 2013:3).

Secondly, despite the criticisms, the aforementioned Tufts concierge medicine program subsidizes primary care using proceeds from its concierge service. There is nothing unethical about this program because patients are not excluded from the non-concierge division if they cannot pay the concierge fee; they are simply not given the additional benefits of convenience and longer appointment times (Lucier et al. 2010). The medical expertise and resources, excluding time, are identical across the practice indicating that all patients, regardless of socioeconomic status, are cared for adequately across the practice. This agrees with the creed of

the American College of Physicians, a national organization comprising of internists, "to care for patients from all socioeconomic means" (American College of Physicians as quoted in Lucier et al. 2010:962). Not only does this program comply with their creed, it increases access for patients, as the subsidies allow for more primary care physicians to be hired. Thus, if all concierge practices were to practice a hybrid model and saw any patient, even if they did not subsidize the non-concierge service, they would be practicing ethically. This, of course is up to the physician, since many physicians would prefer not to handle insurance claims and reduced reimbursement from Medicare and Medicaid in the non-concierge division of the practice.

The idea of subsidizing care in concierge practices has been suggested by Gavirneni and Kulkarni (2014) to be mathematically beneficial for both physicians and patients. Gavirneni and Kulkarni (2014) model a concept of concierge care in which patients are given the option of becoming elite members by paying additional fees to be seen by the physician sooner. Patients can also choose to be regular members, in which case they will be subjected to standard waiting times but would still receive all other concierge benefits. Gavirneni and Kulkarni (2014) predicted that individuals with higher incomes, or high opportunity costs related to waiting, will sign up to be elite members. They reasoned this off of analysis they conducted showing that concierge practices are generally located in high income areas. Their model was applied to two zip codes, one in which incomes are above the U.S. average and the other in which they are below, and the results show that implementing such a system would increase revenues for providers relative to those from a non-concierge practice and would be cost-effective for both elite and non-elite members. Elite members would be experiencing lower income-based opportunity costs by waiting less, and non-elite members would offset their opportunity costs by

the lower fees they pay. Thus, this is another potential business strategy for concierge physicians, one that is both ethical and economically lucrative.

Patient Opinions

It may be assumed from the success stories of concierge physicians that concierge patients feel equally satisfied. Several studies show this to be true. Ko et al. (2009) compared patients' views on non-concierge and concierge physicians and found that the latter scored higher than the former on every indicator of physician-patient interaction quality, care coordination, access to care, office staff interactions with patients, and overall satisfaction. This suggests that concierge care remains true to its word on giving patients enhanced service. Personal accounts from patients highlight these differences in service. An orthopedic patient in Virginia changed to an insurance free concierge service because his previous doctor had crowded waiting rooms, appointments that felt rushed, and no positive effect on his health problems (McDonough 2013). With his new concierge doctor, he has an empty waiting room, appointments that are four times longer and faster to schedule, and follow-ups after his appointments with specialists that help him understand his conditions (McDonough 2013). In his own words, the patient feels that the concierge physician typifies "old times when the family knew the doctor" (Campagna as quoted in McDonough 2013:1). Members of the Access Assured concierge medicine program at Oregon Health and Science University reported several pros as well when asked about the program. Patients appreciated the benefit of choosing and remaining with a single doctor while at the program, were pleased with the respect they got, were happy to be able to contact the physician by email or telephone, and were impressed by the quality of care (Saultz et al. 2011).

However, some patients at the Access Assured program voiced several confusions about the program. Some were confused as to why they needed to be a member of the program during periods of time that they were not utilizing any services (Saultz et al. 2011). These patients believed that paying only at the time of utilizing healthcare, or month-to-month, was more appropriate than paying a subscription fee that was wasted in months they did not utilize care (Saultz et al. 2001). However, this is similar to the continuous payments of healthcare insurance; one cannot only pay for healthcare insurance only when it is needed for a procedure. However, this is a valid concern for those who have potentially never had health insurance and/or are trying to save money, and thus the program's management concluded that they would need to explain this concept more clearly to patients with fewer economic resources. Others did not understand the program's guidelines as stated in the description when they enrolled, such as the program's policies and benefits. This could have been due to patients having poor literacy skills, since the program accommodates individuals who cannot afford healthcare insurance and potentially have lower levels of education (Saultz et al. 2011). Essentially, since the Access Assured program has a goal of providing healthcare to the uninsured, several of the concerns that were voiced may not be applicable to patients actually paying for concierge services. However, their concerns are important to consider in concierge programs offering subsidized care, as these programs may draw clients from a lower socioeconomic background and/or with lower education.

It appears that concierge medicine has the potential to correct many of the problems with the current system of primary care, has support from a small but growing number of physicians, and appeals to at least a certain demographic of individuals. Concierge medicine can be viewed as an improved version of the initial state of healthcare in the United States when doctors made house calls and had more personalized relationships with their patients. Studies on concierge

medicine patients are limited but show that it attracts older individuals, as these individuals require and utilize more healthcare than younger ones and potentially have more financial resources. Because concierge medicine gives unlimited access and in some cases, unlimited visits, as part of the retainer fee, it is practical for those who utilize large amounts of healthcare, such as the elderly. However, in order for concierge medicine to gain a larger clientele, it must appeal to other groups such as the younger generation of individuals. My research question is to understand what younger individuals, specifically college students, think of the current healthcare they receive and whether they would support concierge medicine. I am unsure if students are even aware of the concept of "concierge medicine," and if this is the case, concierge medicine needs more advertising. If students do support it, then the goal of current concierge physicians will be to make it more popular, possibly by lobbying the government and insurances companies to include it under the Affordable Care Act as a primary care option. The next chapter will cover the methods I used to conduct my study, including details on my sampling population, data collection, and data analysis.

Chapter 2: Methods

The purpose of this study was to understand the views of college students towards concierge medicine, a relatively new type of healthcare delivery. Several studies show that concierge medicine appeals to an older clientele, but in order for concierge medicine to gain ground, it must gain popularity amongst others, particularly amongst the next generation, and there are currently no such studies. I conducted interviews with 12 students at an undergraduate college in the northeast to understand their thoughts on their primary care experiences, as well as whether they would be interested in concierge medicine. I obtained approval from the Human Subjects Review Committee at Union College to conduct these interviews.

1) Sampling Population

I needed a sample of younger generation individuals for this study, but also some who would have a basic knowledge of healthcare in order to understand the questions I would be asking. Thus, it made sense to first limit these individuals to college students, especially to premedical students, as they would have an extensive knowledge of healthcare care, including information on providers and payment as well as their own plans. However, these students were not necessarily familiar with concierge medicine, as it was not a component of their required undergraduate curriculum. I interviewed an equal proportion of students from each class year (3 freshmen, 3 sophomores, 3 juniors, and 3 seniors) to analyze trends by seniority. Seniors in college will be under pressure to seek healthcare for the following year, as they will no longer be entitled to health services on campus. Additionally, seniors may be more aware of their healthcare requirements than younger cohorts by virtue of their maturity. The students in the

study were recruited by asking them if they wanted to take part in a short interview on concierge medicine and their healthcare experiences consisting of a series of open-ended questions.

2) Research Instrument

I chose interviews because they would allow me more flexibility to phrase and clarify my questions, especially since my topic was most likely unfamiliar to subjects. An interview would allow me to add details as I wished to make it easier for the subject to answer my questions. Interviews would be face-to-face as well, so I would have a better idea of what respondents truly felt from their tones and facial expressions. In contrast, a mass survey sent out to the school would pose several issues. First, it would potentially have a low response rate because of the intricacy of the topic. Second, it would be difficult to phrase questions that could be answered on a scale. Third, individuals may not give me complete answers to the questions, and I would not have the added benefit of tones and expressions to guide my notes.

In all interviews, subjects were asked to consent to the interview by signing the consent form. In addition, the subject was informed that his/her identity would be kept confidential. No names would be recorded (pseudonyms would be used), and the only identifying information recorded would be class year and a number assigned to the student (i.e. student #1). Subject responses would be recorded on the interview sheets and not shared with anyone except my thesis advisor. Finally, I notified subjects that responses could potentially be used, possibly quoted in their exact form, in my thesis but that the response sheets would be discarded at the conclusion of the study. The interviews were 10-20 minutes and took place in public settings on campus that had privacy, such as study rooms in the library and isolated spots in other campus buildings.

The 13 interview questions asked were identical for all subjects. Prior to beginning the interview, concierge medicine was quickly explained and the subject was asked if he/she knew about the field before the interview. Next, a series of questions about the subject's current healthcare provider were asked, including the type of insurance plan he/she had, the frequency of visits to the primary care physician, waiting times for appointments, and a description of the relationship he/she had with the physician. The final two questions were whether the subject embraced the idea of concierge medicine and whether he/she would pay an annual fee for it. The full list of questions and the consent form are included in the appendices.

3) Analysis

I analyzed the interview responses qualitatively by looking for common themes in primary care plans, experiences in care, and views on concierge medicine. I did this by comparing responses for each question, looking for similarities and differences. Secondly, I looked for patterns among each subject's responses, examining if there were correlations between responses within each interview. For instance, I examined whether a subject's ideal primary care physician qualities influenced his/her decision to support concierge medicine. Thirdly, I connected my data to the information I found in my literature review and analyzed whether concierge care is viable for a younger population of individuals. Finally, based on the critiques I found of concierge care, I made recommendations on what steps could be taken to increase the popularity of concierge care to younger individuals.

Chapter 3: Results and Discussion

The goal of this study was to understand the reception of college students to concierge medicine, an up and coming method of healthcare delivery. Existing studies found that elderly populations supported concierge medicine, a logical conclusion since the elderly are expected to need more medical care and would thus support a model of unlimited visits and longer visit times without additional fees. The sample for this study was a group of 12 premedical undergraduate students at a small college in the Northeast; nine students were male and three were female, and there were three students from each class year. Premedical students were chosen because they were thought to have the requisite knowledge to understand the questions asked, though they were not expected to be familiar with concierge medicine.

The idea for this study came from a TV show on concierge medicine, *Royal Pains*. However, in the interviews, only one student had seen this show indicating that the show is not advertising concierge medicine to a considerable degree. Additionally, one student was familiar with concierge medicine from one of his undergraduate courses, and one another had encountered it in leisurely reading. Therefore, only three out of twelve students had even heard of it, indicating that the field needs more exposure if it is to garner support.

Additionally, an internet search was conducted to understand existing concierge practices. These data would give an indication on the field's status today, as well as any differences between individual practices.

Health Insurance

To understand students' health insurance plans, they were asked: "Do you have a high-deductible or low-deductible health insurance plan? High-deductible is when you have to pay out of pocket

for all visits until you reach a certain amount paid. If you don't know, can you describe your insurance plan briefly?"

Although every student interviewed had health insurance through their family members, only two were aware of the type of plan they had. Most students therefore were not informed on whether their insurance plan was a high-deductible or low-deductible one. Of the two individuals that knew, one had a low-deductible plan with excellent coverage in regards to which doctors he could see, citing it as a benefit of a governmental plan. The other stated he had a high-deductible plan that his father's company had recently switched to in order to cut costs, as high-deductible plans shift costs over to patients. As mentioned in chapter one, employers are increasingly enrolling employees in health-savings accounts and high-deductible health plans to reduce company spending (Lee and Zapert 2005).

Several students mentioned that they received free wellness checks as part of their health plans, while others stated that their insurance covered parts of their wellness visits. No student claimed to pay the full amount for wellness checks; this agrees with the new policies of managed care plans to offer preventive healthcare visits at no cost, as well as services such as flu vaccinations at convenient commercial pharmacies (Reed et al. 2009). Additionally, unlike the sampled individuals with high-deductible plans in Reed et al. (2009) who were unaware of free visits and often skipped them, the students in this study were aware of this benefit, which suggests that the students have a greater understanding of their health plans. Finally, students did not voice any disapproval of their insurance plans or of managed care, a sharp contrast from the findings of Feldman et al. (1998).

As will be described in the next section, most students only visit their physicians for wellness checks and in rare cases, for illnesses, and if they receive the majority of these services

conveniently and at no cost, then concierge medicine will not appeal to them. The inclusion of these services, as well as the fact that all students receive care through their primary care physicians, makes concierge medicine less appealing for individuals with infrequent physician visits because they receive all of the services they need at no additional cost. Essentially, students are spending negligible amounts on their health care and though switching to concierge care would give better care, it could also incur significantly higher and unnecessary costs.

Current Forms of Healthcare Delivery

To determine students' experiences with long-term and regular primary care, they were asked: "Do you have a regular primary care physician (the same physician on every visit)? If not, did you have a long-term relationship with a pediatrician as a child? How many years did you see him/her? How many times do you see a primary care physician per year, whether it is for physicals, routine checkups, or a sickness like the flu?"

Each of the 12 students had a healthcare provider and of the 12 students interviewed, three had a family member who acted as their primary care physician. The fact that all students had a primary care physician supports the Folsom Report of 1966, which highlighted the importance of the primary care physician by stating "every individual should have a personal physician who is the central point for integration and continuity of all medical services to his patient" (Gutierrez and Scheid 2002:9). Nearly all of the students had primary care physicians who they saw regularly; only one student stated having an insurance plan that did not give her the same physician on every visit. Since eleven out of twelve students have been seeing the same physician since childhood, this study reveals that students are receiving continuity of care and have strong relationships with their physicians. The concept of patients receiving long term

primary care agrees with the goal of primary care, as stated by the American Academy of Family Physicians in 1969, to provide "continuing and comprehensive healthcare for the individual and family" (Gutierrez and Scheid 2002:11).

Frequency of healthcare visits was low, as the highest number of visits reported per year was just 4-5. Only one student reported this number, and one other stated 3-4 visits. Ten out of twelve individuals stated seeing their physicians just once or twice per year, one for their wellness check and once for any instance of sickness. Those with family members acting as their doctors reported calling their family members whenever they needed healthcare, such as for a sore throat or cold, but also indicated that they saw their family members for their physical once a year. Thus, the average number of visits for the entire group was roughly two. Only three students reported visiting the on-campus health center, and only one out of the three reported visiting more than once in the previous year, suggesting that on-campus resources did not significantly reduce potential visits to their regular primary care physicians.

Costs

To determine if health care costs held students back from seeking health care, they were asked: "Do you ever refrain from seeing your physician or are hesitant to because of costs, such as a fee that your insurance won't pay?"

Costs can be a potential reason for individuals to switch to concierge services. If an individual has frequent visits to the physician, then concierge care would make more sense financially since it allows for unlimited visits for a fixed fee. As stated previously, high-deductible plans can result in individuals paying annual costs of at least $1,000 if they frequently visit their physicians, and at this level of usage, concierge care would be more financially

prudent (Lee and Zapert 2005). No students stated that costs affected their healthcare usage but instead expressed that they visited their physician whenever they needed healthcare. However, it is unknown whether interview subjects did face issues with costs and were uncomfortable admitting that they were an issue, or if they indeed had low co-pays, if any. Despite the seemingly irrelevance of cost, one of the main justifications given by every subject for lack of current interest in concierge medicine is the cost, which is not justified given the low physician visit frequency. This indicates that, although costs do not deter students from seeing their physicians, students are still restrained by costs to sign up for a service that they would not fully utilize. These findings also indicate that concierge medicine is not cost-effective for students, especially because it does not take the place of legally required health insurance (Blumenthal and Collins 2014). A provision of the Affordable Care Act is that all Americans are required to be on an approved health insurance plan unless they have been granted an exemption, and those who are not will face fines (Blumenthal and Collins 2014). The experiences of these students are in direct contrast with the findings of Schoen et al. (2006) that insured Americans find it difficult to pay for health care because of high co-pays and deductibles. At least one student in this study had a high-deductible plan, but unlike the findings of Lee and Zapert (2005) that high-deductible plans reduced the likelihood of individuals to seek healthcare, this student was not hesitant to seek health care. However, the sample of Lee and Zapert (2005) consisted of low-income individuals and it is possible that the students in this study were of a different socioeconomic status. If this is the case, socioeconomic status would explain the effect of health care costs on likelihood of seeking care.

Waiting Times

To determine students' experiences and opinions on their waiting time in primary care, they were asked: "How long do you typically have to wait for an appointment with your primary care physician? Do you ever have trouble getting an appointment exactly when you want it? How long do you typically have to wait to be seen once you are in the waiting room? Do you consider this length of time to be acceptable?"

There were two types of waiting times recorded; the first was days/weeks until the appointment and the second was minutes in the waiting room, which included time in both the waiting and exam rooms. Those with family members acting as their physicians did not have waiting times for appointments or at the physician's office. The majority of the other respondents had wait times for wellness checks of at least a week, and upwards of 2-3 weeks. Two students were the exception to this trend, stating just three days to secure appointments. One student indicated scheduling his appointments in advance when he left his previous appointment, so he effectively had no wait time. Urgent appointments were uncommon, but students stated receiving either same day or next day appointments when scheduling them. One student stated that for urgent conditions, he would not see his primary care physician and would instead go to the emergency room. In any case, no student had trouble receiving appointments and wait times were never extreme, such as the average of 31 days for Massachusetts residents in 2008 (Bodenheimer and Pham 2010). Students were also not bothered by the time it took to obtain an appointment, and one student understood why there was a long wait, stating that his doctor "is popular with a large patient panel." These results show that although there is a wait time for wellness checks, non-concierge care, like concierge care, offers same-day appointments for urgent care (Alexander et al. 2005). Students did not mind the waiting period for wellness

checks, and this is another indicator that the benefits offered by concierge care do not significantly outweigh those of standard care for these students; this once again lowers the appeal of concierge medicine.

Waiting times in the physician's office were affected by time spent in the waiting room as well as time taken for the physician to arrive after the nurse departed the examination room. The lowest total time for these two activities was 15 minutes but the majority of students claimed times of 20-40 minutes. One student reported an exceptional waiting time of 1-2 hours, claiming that "the waiting time was unacceptable, especially because of the short amount of time with the physician." Apart from that student, others accepted the wait times and understood that "the doctor was just very busy." Other students understood that "the doctor has to go from patient to patient" and indicated that "the wait time isn't too long." One student stated he would "occupy himself with his phone," which indicates that the advent of mobile technology has potentially reduced our perception of wait times, more so than the traditional magazines or information pamphlets found in offices that may not necessarily appeal to patients. Additionally, students' checkups were primarily non-urgent wellness checks and as one student indicated, the wait is "not too big a problem because I am not actually sick when I see the doctor." Patients with chronic conditions or illnesses may be in pain and thus more bothered by long uncomfortable waiting times, especially if they are visiting the doctor on a regular basis and have to experience the waiting times more often. These experiences contrast with those of individuals that switched to concierge care, particularly those that complained of crowded waiting rooms (McDonough 2013). Additionally, Anderson et al. (2007) found that patient satisfaction decreased as waiting time increased, but waiting time was offset by time with the physician, as will be described next.

Appointment Visit Lengths

To determine students' experiences and opinions on their appointment visit lengths, they were asked: "How much time do you typically spend with your primary care physician per visit? Do you ever feel rushed by your physician during your appointment, or believe he/she didn't take enough time to diagnose you properly?"

Students with family members as doctors enjoyed as much time as they desired with their physicians. Of the remaining nine students, three stated visit times of 10 minutes or less and six stated times of 20-40 minutes. One of these three students indicated that because she had spent two hours waiting for an appointment, 10 minutes of time with the physician was not adequate. Every other student was satisfied with the visit lengths and no one indicated feeling rushed or not diagnosed properly. A second student that received just 10 minutes or less was also content, stating that "I don't feel rushed and my doctor gets everything done." Several students mentioned that after the physician finished the examination, he/she allotted time for questions and discussion. The time allotted for questions gave students the feeling that their physicians listened to their concerns and were attentive to them. Answering questions also showed that physicians did not dismiss students' concerns about their own health. Students expressed this as a desirable trait in physicians, as it shows that their physicians care for them; this will be further explained in the next section. When the waiting time and visit time results are put together, they constitute high patient satisfaction, similar to Anderson et al.'s results (2007). Specifically, Anderson et al. (2007) found that patients who waited less than 60 minutes for appointments lasting 10 or more minutes were very satisfied with their care, even more so than patients who waited less than 15 minutes for 5-10 minute appointments. In this study, the single student who waited 2 hours for a 10 minute appointment had low satisfaction, but this is expected according

to the model shown by Anderson et al. (2007) since patient satisfaction decreased with increasing wait time. Essentially, the results of waiting time and appointment length time in this study indicate that the benefits of low waiting times and long appointment times in concierge care do not appeal to students because they are not bothered by the current wait times and are content with the time they have with physicians.

Desired Traits

To determine students' opinions on their ideal primary care physicians, they were asked: "What qualities do you find most important in a primary care physician?"

Students expressed a variety of traits that they find important in a primary care physician. A trait expressed by four students was the combination of empathy and compassion, which indicate that the physician cares about the student and that the student's wellbeing is important to the physician. One student said that the ideal primary care physician would care about interactions and would engage in small talk with patients. He went on, stating that even if this interaction is as simple as the physician asking him how school is going, he would feel more comfortable during his visits. In the student's words, "primary care is about interactions because a great deal of wellness information can be determined from these interactions."

A second trait, also expressed by four students, was approachability and friendliness as this contributes to the doctor-patient relationship. In the words of a student, if a physician is approachable, patients will feel as if they are being "convinced by the doctor rather than ordered" in regards to health advice. This reflects Reeder's (1972) description of medicine changing from a seller's market to a buyer's market, since physicians will need to convince patients to see them for preventative care, such as wellness checks, even when patients feel they are seemingly

healthy. Reeder (1972) mentions that patients have more power today as a result of medicine shifting from curative to preventative care, which no longer forces consumers to seek care for otherwise life-threatening illnesses. Therefore, it is important for physicians to act friendly in order to entice patients to their services. Patients are also more satisfied when physicians respect them by speaking to them kindly and not in a condescending manner. This idea is supported by reviews of the Access Assured program at Oregon Health and Science University, whose members praised the program because of the respect they received from the program's physicians (Saultz et al. 2011). Approachability also allows patients to discuss health care in more depth with their physicians, which is important for effective treatment. In other words, patients will open up more to physicians that are approachable. A second student also echoed these traits, and stated that a physician once visited an undergraduate class she had and told the class that physicians should focus on "being liked" by their patients, as this will increase patient satisfaction and lower the likelihood of patients questioning their physicians' abilities. The student stated that "being liked" comes from being approachable and friendly.

Thirdly, on the topic of physician capability, five students stressed the importance of physician competency. This included being knowledgeable on the subject matter and not guessing in any diagnoses, considering all possibilities in a situation and not jumping to conclusions, and explaining everything to the patient. A student stated that a physician who looks at his stress, genetics, lifestyle, and factors in his environment would be more likely to successfully diagnose any problems he had. A second student stated that physicians who explain their diagnoses to the patient are more convincing to the patient, as this indicates that the physician knows what he/she is claiming.

Other desired traits were organization skills (mentioned by one student), patience (two students), and honesty (one student). A student stressed the importance of organization in the sense that the physician "has my file, knows my name, and knows my medical history," as it is a sign of professionalism. Patience in a doctor was considered important, as it would allow doctors to not rush patients in their appointments and listen to concerns they had. Honesty in a physician was considered a prerequisite to being able to trust the physician, and will be covered in more depth next.

Trust and Honesty

To understand students' opinions on their relationships with their physicians, specifically regarding the components of trust and honesty, they were asked: "Please describe the relationship you have with your general physician. What level of trust do you have in this provider? Do you feel that your physician listens to your concerns? Do you think your doctor cares about you and is completely honest with you about your health? Do you feel he/she ever refrains from giving you certain details about your health?"

All students stated that their physicians were honest about their health, and that their physicians did not hide anything or refrain from disclosing details. All students therefore trusted their physicians with their health. One student described how his physician hypothesized that he had a calcium deficiency and ordered a test for calcium. The test confirmed the physician's guess, and the student started taking calcium supplements. The student was very impressed at the physician's level of detail in his examinations, and stated that he has complete trust in his physician to manage his health. This relates to the idea of the primary care physician as a maintainer of health, and the shift in medicine from curative to preventive care (Geyman 2010;

Reeder 1972). Similarly, a second student stated he switched physicians in the previous year because his pediatrician did not treat individuals 18 years and above. The student had great trust in his previous physician and although he had only seen his new physician twice, the new physician listened to all of his concerns and gave him sound responses; he therefore trusted his physician because of his superb knowledge.

A second student was pleased at how relaxed his doctor was with him, exemplified by the doctor's history of making the same jokes since the student's childhood. The same student also stated that his physician was not afraid to talk about sensitive topics, such as sexual health or drug use, which further showed how close their relationship was. The fact that his physician talked about these sensitive topics increased the student's trust in him, as he felt that the physician never hid any details or topics from him.

On the topic of honesty, students were also asked about their physicians' possible reluctance to provide care because of the costs of these services. No student mentioned any instance of physicians taking cost-cutting measures, such as limiting the use of medical services or treatment (Hall 1997). One student mentioned that his doctor always recommended preventative care before utilizing medications, but only because this would be easier and less costly for the patient. In other words, his doctor was not against prescribing medication and was only hesitant because he was looking out for him. However, one student pointed out that although his physician had never taken cost-cutting measures, he had never required any expensive procedures and was unsure if his physician would act differently if he did require such a procedure.

All students agreed that their physicians cared for them, whether it was because the physician was a family member or out of honesty and compassion. These results indicate one of

two things. One possibility is that the backlash against managed care described by the Kaiser Foundation (1998) is declining, a result of managed care organizations improving their policies. For instance, managed care organizations and insurance companies may no longer be stressing the strict cost-cutting measures they once did, or restricting physician autonomy as significantly. The other possibility is that the study sample did not include individuals who had issues with their health care providers, such as feeling rushed or experiencing poor network coverage, as no individual reported any serious problems; this will be discussed in greater detail later. In essence, the students had high levels of trust in their physicians and there were no signs of efficiency requirements imposed by managed care organizations, such as limiting services and visit time, which in the past caused a reduction of trust in physicians (Feldman et al. 1998).

Views on Features of Concierge Medicine

To understand students' opinions on the main benefits of concierge medicine, students were asked: "Would you want a physician who you can talk about anything health-related, for as long as you want and whenever you want?" The costs of concierge care were not brought up, since the question's focus was just to understand views on concierge medicine.

Nine out of twelve students preferred having a single, long-term physician that they could continue seeing year after year and in the words of a student, this long-term relationship would "make my physician more familiar with me and understand me more effectively." One student stated that if his physician ever had something serious and unfortunate to say to him, doing so would be far simpler if he and his physician had a history and their relationship was relaxed. Other students stated that having the same physician over a long period of time would allow the physician to relate to them and diagnose them more effectively, as the physician would be more

familiar with their health history. This relates to the words of an individual in McDonough (2013:1) who switched to concierge medicine, that the new physician typifies "old times when the family knew the doctor." Most students did not show support for the feature of unlimited visits for no additional fee; only one student liked this idea, as he would never have to visit the ER for urgent primary care and would always see the concierge physician before considering any specialist care. He felt that such a system would save him money and time, as he would not be visiting the ER or specialists as much. This idea of seeing a concierge physician prior to specialist care relates to the idea of HMOs requiring patients to see primary care physicians before specialists in order to reduce costs (Fox and Kongstvedt 2007).

Students with family members as physicians stated that they had been accustomed to receiving this concierge-type care for the entirety of their lives, so it was very appealing to them. These students liked the idea of contacting their physicians by text message or phone, as they have become accustomed to doing so. One of these students also stated that because she "tells [her family member] every aspect of her health," it would be important to have a single long-term physician in the future that she could do the same with. Collectively, these findings indicate that the majority of students are in favor of several features provided by concierge care, but not all.

However, three students indicated they would not be interested in this type of care because they did not have chronic conditions and would not need the amount of care offered. One of these students indicated that he views his physician as a source of healthcare only for severe health issues and "not as a counselor;" he would not want to spend time discussing private matters (e.g. unhappiness, relationships) or seeing his physician for insignificant matters, such as the common cold. In other words, the student felt it was only appropriate to see his physician for

wellness checks and illnesses he was not familiar with. The second and third students both stated that they do not have any chronic conditions requiring "constant care," and the third student also said that she does not need the benefits of concierge care, such as longer appointments and convenience in scheduling.

Willingness to Pay for Concierge Medicine

To determine if students were not only supportive of concierge medicine, but were also willing to pay for it, they were asked: "Instead of your normal physician, would you be willing to pay an annual fee of $1,000, which is not covered by insurance, for a private primary care physician who would provide additional services (e.g. available to you 24/7 by cell phone and offer house calls, accompany you to any potential specialist visit, and give you as many appointments desired for no additional cost, as well as visit times of at least 30 minutes)?"

Despite their support for some concierge care services, all students stated that as of now, they would not be interested in paying for concierge medicine. Students stated that the service made economic sense for those who visited their doctors often, but no student was currently visiting his/her physician frequently enough for concierge care to make sense. A student who received concierge-type care from his family stated that he was just taking advantage of the current situation but would not likely pay for it in the future. Several students expressed that they may be interested in concierge medicine in the future as it "offers a high number of benefits for the cost" and because of its commitment to continuous care, "a feature important for my health care," as one said. However, these same students also claimed that this type of model would only be useful for those seeing their doctors often, since they would utilize the benefit of unlimited visits. Their initial responses therefore imply that they would only be interested in

concierge care in their senior years or if they develop a need for ongoing care. This supports the finding of Alexander et al. (2005), who stated that concierge physicians are more likely to be older than 65 years of age, as the elderly are more likely to need frequent health care. Additionally, the legal requirement of health insurance resulting from the Affordable Care Act and the failure of concierge care to fulfill this requirement makes concierge medicine even less desirable, as students would essentially have to pay twice for the same service (Blumenthal and Collins 2014).

One of the students said that in the future, he would choose his physician based on reviews from people he knew, and he would not be likely to choose concierge care because he would be "less likely to find a concierge medicine doctor being used by people he knows." The idea is similar to a service such as Netflix or social networking platform such as Snapchat; if an individual is not familiar with it and no one in his/her social circle has it, he/she would be less likely to use it.

A third student felt that the system of concierge care is unethical because it gives better care to affluent people and is wasteful because it encourages overutilization of health care. This criticism voices those of the opponents of concierge medicine mentioned in chapter one, specifically those who claim that concierge medicine physicians act unethically by not providing care to those who cannot afford it (Stillman 2010). Stillman (2010) also stated that concierge physicians order unnecessary medical imaging tests, which does not agree with evidence-based care. Although concierge medicine has the potential to be charitable and increase access to standard care, as shown by the Tufts concierge program and the analysis of Gavirneni and Kulkarni (2014), the majority of programs are not. Thus, in its current state, concierge care does present an ethical dilemma.

Other Themes

Separating the results by class year showed that seniors appeared to be stronger in their opinions towards concierge medicine, as they opposed it and were not open to potentially utilizing it in the future. One of the seniors stated that he would never use it because it provides better care to those who can pay, an ethically incorrect practice. In his words, "even if I could easily afford it, I would not utilize it." A second disliked its high cost and stated he would never be interested in it. The third senior preferred the idea of seeing multiple doctors for any conditions he had, and therefore only liked concierge medicine for wellness checks. However, wellness checks would be infrequent and thus it is deduced that he would not utilize this service in the future either. This pattern may signify that seniors are more knowledgeable and decisive about their health care options than other students because of increased maturity and responsibility, especially as they near the age limit for staying on their family members' plans. Also supporting this statement is the observation that two out of three seniors knew what type of health care insurance they had, but only one out of nine of the non-senior students knew their plans. This gap in knowledge suggests a lack of interest in and need for health care insurance, which may be a further driver of current lack of interest in concierge medicine.

The finding that nine out of twelve respondents in this study were not familiar with concierge medicine indicates that it is not being advertised effectively. The results of this study contrasted with those of previous studies, as no student was interested in concierge medicine as an alternative to his/her current medical care. The reason given was that utilization would be low, as no student had any ongoing medical conditions needing continuous care from a physician. Additionally, no student visited his/her current physician frequently enough to view concierge medicine as being more sensible from a financial standpoint. However, nine out of

twelve students expressed an interest in the concept, stating it may be relevant for them as they age.

Concierge Practice Information

The internet search on concierge practices was performed by conducting a Google search for concierge practices in Oregon, California, New York, and New Jersey, and subsequently selecting practices that both appeared early in the search results and displayed details of their models on their websites. Although the search only focused on practices in these states, concierge practices do exist in other states. The search indicated that concierge medicine practices exist across the U.S., both in populous states such as California and New York as well as less densely populated states such as Oregon. Findings show that concierge practices generally offer the same benefits of greater access and convenience, but differ in regards to fees and included services. Several providers include all primary care services and unlimited visits in the retainer fee, some only include a predetermined number of visits in the fee, and others charge a fee per visit in addition to the retainer fee. Some practices offer several categories of concierge care, with the more premium categories offering features such as unlimited visits and more comprehensive physical exams. While this is neither a comprehensive nor a representative sample of practices, it gives insight into specific practices and shows how practices can differ.

SendantHealth is a concierge medicine practice located in West Linn, Oregon and started in 2011 with the goals of offering high patient involvement and customer service, the most technologically advanced and up to date care, and comprehensive preventive care (SendantHealth 2015). It believes that proper care cannot be given in 10-15 minute appointments, implying that appointments are longer than this duration of time. The practice

offers house calls on a limited basis if the physician deems them appropriate, and offers 24/7 access to its physicians by phone. It also holds a smaller patient panel that is limited to "several hundred patients," whereas non-concierge practices average over 2,000 patients. SendantHealth offers three levels of service, including a basic program at $99 per month, advanced program at $149 per month, and premium program at $499 per month. There is also a one-time fee of $100 per patient at the time of registration to set up online portal access to health information. The advanced program offers extensive services for cardiovascular health, such as detailed cholesterol measurements and blood panels. The premium program, in addition to the services provided by the advanced program, offers greater physician involvement in the patient's health. Some of these services include access to the physician by cell phone, assistance with scheduling specialist visits, coordinated care if out-of-town with physicians in the area, and air ambulance access.

MD^2 is a concierge practice that started in 1996 as the first concierge practice and has 10 offices across the U.S (MD^2 2015). It boasts the benefits of personal attention, as it limits each physician to just 50 families, as well as convenience in scheduling with 24/7 unlimited access to a physician. It believes in "shepherding" patient health, signifying that its physicians will be very knowledgeable about patient health history and will be comparable to having a doctor in the family. Its exceptional service is captured by the action taken by one of its physician to help a patient complaining of abdominal pain, who was diagnosed with appendicitis (Ruiz 2009). The physician accompanied the patient to the emergency room and helped him bypass the long wait for the operating room, essentially helping the patient receive VIP care (Ruiz 2009). However, MD^2 is expensive and its fees depend on location, with fees of $15,000 per patient at its Bellevue, WA location and $6,000 at its Tucson, AZ location (Ruiz 2009).

PersonalCare is a concierge management service founded in 2008 that contracts with physicians offering concierge care in three regions in California (PersonalCare 2015). Physicians sign up with the service to become affiliated providers, and the service matches patients interested in concierge care with them. The service also performs much of the administrative work, such as billing and scheduling. Physicians may practice both non-concierge and concierge care, but are limited to 350 patients each in order to spend more time with patients, emphasizing PersonalCare's mission statement of personal attention It emphasizes preventive care to reduce sick days, reduce medical bills, and increase productivity at work. Members get access to their physicians 24/7, "generous time" with physicians, and house calls if necessary. However, unlike MD^2 and SendantHealth there is an office visit fee and some preventive services such as vaccines require additional payments that may be covered by insurance. Therefore, the access fee simply provides more personal care and extended visit times during office visits, but patients must still pay additional fees for the visits themselves.

MyMD Personal Medicine is a concierge practice located in Bend, Oregon and was started in 2006 (MyMD 2015). The practice offers a small patient panel for personal attention and has four categories of services, including basic, "live well," "age well," and "custom." The basic level offers several benefits including 24/7 access to the doctor, two 30-minute office visits per year, same-day or next day appointments, and coordinated care with hospitals; it is recommended for individuals in good health but wanting personal, convenient care. The "live well" level is recommended for individuals needing monitoring of their health, and includes unlimited 45-minute office visits, access to the physician by cell phone, and more comprehensive health management. The "age well" category offers longer office visits, up to 60 minutes, as well as care tailored towards those over 70 years. Finally, the "custom" level offers house calls,

as well as other services at the discretion of the patient. Fees range from $3,000-$24,000 per year depending on the patient's age as well as level of care desired.

Beverly Hills Concierge Doctor is a concierge practice located in California (Beverly Hills Concierge Doctor 2015). It has a large emphasis on house calls, which it provides 24/7. The practice has a hybrid model, offering both concierge and non-concierge services. It does not offer unlimited visits, and instead offers members 12 office visits and 4 house visits per year in the monthly fee as well as 24/7 access to the physician. The monthly fee depends on age, and is $100 for ages 18-39, $150 for ages 40-65, and $200 for those above 65. Reviews for the practice on Yelp indicate that many members have used the service just once while they were on vacation and were very impressed by the house call option; this highlights the success of the hybrid model in concierge care (Yelp 2015).

Healthy Aging Medical Centers is a concierge practice located in New Jersey but unlike other practices, it offers unlimited office visits to all of its patients, including 24/7 access to the doctor through cell phone (Healthy Aging 2015). The practice emphasizes the concierge care values of personal care but does not specifically state that it has a small patient panel. It has two categories of care, including a basic ($150 per month) and executive plan ($299 per month); the executive plan offers more comprehensive care such as additional testing. However, there is a steep registration fee of $599 for the basic plan and $3500 for the executive plan, which is for a "comprehensive wellness assessment." Therefore, an argument can be made that although this practice offers unlimited visits to the office, it has steeper registration fees and monthly fees than practices not offering this service, such as SendantHealth.

This information reveals that concierge medicine is flourishing, as several practices have been open for more than four years. The practices stress that personal care and small patient

panels are important characteristics of concierge medicine. Patient panels generally average less than 500 patients per doctor, and care is personal through extended time and features like house calls. Care is also more convenient in concierge care through lower waiting times and faster appointment scheduling. Therefore, these findings support Alexander et al. (2005), which found that concierge physicians were more likely than non-concierge physicians to offer house calls, 24-hour access to physicians, same day appointments, coordinated hospital care, and patient panels one-third the size. However, studies by French et al. (2010) and Kamerow (2012) claimed that concierge medicine provides unlimited visits in the fee, but this was not seen in this survey of practices. Some practices did not offer unlimited visits and those that did offered it as a part of their premium packages, or were costly (e.g. Healthy Aging Medical Centers, MD^2). This is an important point, since the possible lack of unlimited visits in the basic plan makes concierge medicine a more expensive option for those who would see their physician often. It also indicates that there is misinformation in general studies and articles on concierge medicine, since not every feature described applies to all practices. However, every practice offers 24/7 access to the physician by phone, indicating that some form of medical assistance would be available to patients even if they did not schedule a visit. Finally, these practices do not appear to be hybrid models in which non-concierge care is subsidized through the concierge practice. By failing to do this, physicians in these concierge practices are missing the opportunity to decrease the unethicality of concierge medicine; this unethicality will be explained in chapter 4.

Chapter 4: Conclusion

Concierge medicine is an up and coming field, evident by an upward trend since 2002 in articles cited containing the terms "concierge medicine," and an upward trend since 2004 in Google searches for the term "concierge medicine" (Web of Science 2015; Google Trends 2015). There have also been increases in the total number of concierge physicians over the past decade, with just 146 in 2004 and 756 in 2010 but over 5,000 as of 2014 (Gavirneni and Kulkarni 2014; Clark et al. 2010). There is clearly a great amount of support for the field, both by patients and physicians since neither exist without the other. Thus, the purpose of this study was to understand whether students, a patient group, are supportive of concierge medicine.

This study found that the majority of students were satisfied with their current primary care physicians and would not be interested in concierge care at this time. No students expressed disapproval of their health care insurance plans either; several students were instead satisfied with the complimentary services included, such as wellness checks. Most students stated having a long-term primary care physician who they visited infrequently once or twice a year, but were satisfied with the amount of care received. Students were not dissatisfied with the waiting time to receive appointments nor with the waiting time in the office, but instead understood the reasons for the wait. Most students were content with the amount of time they had with their physicians and some stated having appointments lasting 30 minutes or more, which is similar to appointment lengths at MyMD in Oregon, a concierge practice (MyMD 2015). Finally, students also agreed that they could trust their physicians to provide them with adequate care, so the physicians themselves were not an issue in the current system of care. For instance, physicians may practice cost-cutting measures and resist providing certain care or prescribing certain medications, which would reduce patient trust. However, no student indicated any instances of

this, and cited their physicians as trustworthy. Essentially, these interviews revealed that the majority of students had no problems with the care they received.

A striking result from this study was the majority of students were not familiar with concierge medicine, despite them being premedical students and having constant internet access. Although several concierge care features stood out to students, such as the emphasis on the physician-patient relationship, most did not show interest in the potential for unlimited visits or convenience in scheduling and waiting. Students were not currently interested in paying for the service and felt that it would be more appropriate for the elderly or those with chronic conditions requiring regular care. One student even brought up the unethicality of concierge medicine, as practices do not accept insurance to cover the retainer fee and thus exclude those who cannot pay. These results show that most students were either uninterested in concierge medicine, or in the case of one student, were bothered by its ethics.

The results of the online search of concierge medicine practices in the U.S. indicated that practices have been successful, as several have been running for over four years. However, there are discrepancies between information on concierge practices in the literature and at actual practices, both in regards to price and services offered. The pricing differences may be attributable to rising health care costs, as several studies cited in chapter 1 were from the early 2000s. In regards to services offered, the most significant difference was the lack of unlimited visits in certain practices. For instance, MyMD in Oregon only offers two office visits per year in its most basic plan (MyMD 2015). It is possible that these practices stopped offering unlimited visits in their non-premium plans because of rising costs, or never offered them as part of their approach to concierge care. Several practices such as PersonalCare in California have simply added the benefits of convenience that concierge care offers to the standard primary care

model, meaning patients would bill insurance for any office visits or tests but would pay the retainer fee out of pocket. It is possible that the concierge care models vary widely to reflect different market types and regional consumer preferences. Some markets may have excessive demand for care, which would hinder the doctor's ability to spend time with each patient, leading him/her to not offer unlimited care in the cheapest plan. On a similar note, some doctors may not find offering unlimited visits cost-effective, regardless of patient usage. Another possibility is that not all individuals may be looking for unlimited visit plans, and in certain practices, doctors may have introduced cheaper plans due to low usage by patients. The ethicality of this is questionable, as access in concierge care is already diminished because of its retainer fee that prevents some from joining, but decreases further with measures potentially designed to make practices more lucrative. The topic of ethicality in concierge medicine is examined more closely later in this paper. Without an analysis of income levels and age distributions in the locations of concierge practices, as well as the financial reports of the practices, it is difficult to say whether this model of care that is tailored to specific individuals will be viable in the long-run. However, as stated previously, some of these services have been open for several years, and the luxurious service MD^2 that can charge upwards to $15,000 per patient has been open since 1996. This suggests that there is a stable market for concierge medicine and that it will continue to exist as a model of care, regardless of whether certain practices fail.

Significance

The significance of this study is that among students, non-concierge primary care and managed care are not experiencing backlash but are instead providing excellent care. These opinions contrast with those of unsatisfied patients in previous studies, who were unhappy for several

reasons such as being denied care and feeling rushed by their physicians (Kaiser Foundation 1998; Dugdale et al. 1999). These patients from previous studies were also unsatisfied that physicians were leaving their insurance networks, which made it difficult for patients to consistently see the same doctors (Rosenthal 2015). It is difficult to imagine from this study's results that the U.S. ranks below similar countries in health care delivery and health outcomes (Commonwealth Fund 2014). Specifically, the U.S. ranks below similar countries for equity of care and healthy lives, indicating that U.S. health care is poor for those with low incomes (Commonwealth Fund, 2014). However, according to this study, cheaper non-concierge care is fulfilling student needs in health care and keeping them satisfied; this will deter students from choosing concierge care. It appears that concierge care may not be suited for individuals visiting their physicians infrequently and only for annual checkups, since these annual checks are offered as complimentary preventative care under insurance plans. Additionally, in students' existing non-concierge health care plans, a small number of additional visits would be a negligible cost in comparison to the monthly retainer fee of concierge care. These results also contrast with the demographics of concierge care patients as found by Alexander et al. (2005) and Ko et al. (2009), specifically that patients are older than 65 and less likely to be of a minority ethnicity. Thus, this study supports previous studies that concierge medicine attracts older patients, and does so by providing new data on student opinions regarding the field.

For concierge physicians, these findings suggest that students are not a group to specifically target in advertising, as they do not appear to be sold on the concept. Healthy students are less interested in close management of their health by virtue of their young age, and will biologically be prone to fewer illnesses than older aged people. It can be assumed that they would be less interested in constant management of their health, as this type of care is

appropriate for those with or at risk for health problems. This lack of interest stems from the U.S. system of healthcare historically focusing on curative rather than preventive care (Reeder 1972). The old proverb, "an apple a day keeps the doctor away" exemplifies this ideology of reluctance to see a physician. The proverb exemplifies the fact that the U.S. historically disliked preventive care and individuals would only see their physicians when they needed to treat an illness (Freymann 1975). Even thinking about constant health care can be depressing for younger individuals, since they have a "present orientation" mindset (Brannen and Nilsen 2002). Brannen and Nilsen (2002) found that 18-20 year old individuals exemplified this orientation by focusing on enjoying life through social activity and leisure, and thinking less about the future. Crocket et al. (2009) found that future orientation comes with age, and that future oriented individuals are likely to schedule health screenings and actively maintain their health. This is not to say that younger individuals will not see physicians, but the idea of paying a premium to receive higher quality of service in health care is less likely to register with younger individuals than older ones, since older individuals are more future oriented and have accepted their vulnerability to poor health and need for more personal health care.

As a student, I am skeptical of concierge medicine being the right choice for nonelderly, healthy individuals. The model does not uphold ethical guidelines by the American College of Physicians that doctors must not refuse treatment to patients, but instead objectifies doctors as economic commodities that can be bought for their services (Lucier et al. 2010). Although the goal is to provide a higher quality of service, the model places a disturbing emphasis on payment from the consumer and implies that people who are capable of paying the retainer fee deserve care that is more personal. The model's refusal to accept patients who do not pay the retainer fee suggests that concierge physicians only believe in improving the wellbeing of those with

monetary resources. According to Marmot et al. (2008), access to health care is correlated with higher life expectancy, and health care itself is considered a common right rather than a commodity. The concierge model of selectively treating patients suggests that certain lives are of higher value than others, which is a human rights violation and in direct contrast with the United Nation's stipulation that "all human beings are equal in dignity" (UN 2015). Despite the fact that concierge physicians treat members of the public, they do so selectively, which is arguably a violation of the UN's human rights declaration. While its ethicality is questionable, I support concierge medicine for the elderly who may require the extra convenience and attention, especially if they do not have family to assist them. I also support it for younger individuals requiring close monitoring of their health per medical concerns. These individuals can benefit from concierge medicine, such that the potential increase in their health would offset the unethicality of their support for the model. Finally, I support hybrid models consisting of both concierge and non-concierge care, such as the Tufts practice discussed earlier, as these practices do not refuse care to those who cannot pay the retainer fee.

The current status of concierge medicine appears to be aimed towards two types of patients, those who want a higher quality of service in their medical care and those who can afford it. Student income was not measured in this study, but cost was not an issue in their existing care, suggesting that students were not struggling financially. Students with physicians in their family, who were likely somewhat affluent, did not support concierge medicine either. This reasoning supports the idea that people need to desire higher quality of service to be interested in concierge care. For students whose parents pay for their health care, the question is whether the students' parents desire higher quality of service for their families. However, service comes at a cost as illustrated by services such as pizza delivery, first-class airline tickets,

and hotel bellhop service. Those who do not opt for the premium level of service in these situations can pick-up their pizzas from restaurants, travel economy class on flights, and transport their luggage themselves. Concierge medicine is arguably no different, apart from the ethical dilemma that doctors must treat all, since non-concierge care is available to the public. As mentioned previously, some practices accept insurance to cover office visits, therefore only charging patients for the enhanced concierge service. Since the ethical dilemma surrounding concierge medicine does not appear to be getting resolved and practices continue to only treat those who can afford the retainer fee, interested patients must treat concierge medicine like any other service and decide whether health care is important enough to warrant the premium service.

Solutions to the Primary Care Shortage

Despite its arguable unethicality and selective audience, concierge medicine is a form of primary care and can help alleviate the primary care shortage in the U.S. (Bodenheimer and Pham 2010). It is a potential primary care option for younger individuals suffering from chronic conditions and those who are very old and physically incapable of waiting for appointments or require longer appointments, both which are not offered in non-concierge care. However, concierge medicine needs to become known, and this study showed that the majority of students were unfamiliar with the field. The field will not grow rapidly until more of the U.S. population becomes aware that it exists. In the following two paragraphs, two solutions are given to increase its popularity to younger and older populations.

It is possible that receptiveness to concierge care will change if the field becomes more popular and people succumb to the herd mentality of trying a new product (Huh et al. 2014).

Huh et al. (2014) state that if individuals are uncertain on a matter, they are likely to mimic the actions of those around them. This action is known as behavioral mimicry, a concept that pervades the field of sociology. For instance, in social settings like a dinner table, the social context may dictate the amount of food an individual consumes (Huh et al. 2014). A student in this study stated that he chooses his doctor based on recommendations from others, which exemplifies the herd mentality. Thus, a possible goal for concierge care is to increase its popularity, possibly through social media or product placement in television. Services such as Instagram and Facebook have large followings, especially by the younger generation, and would be good places for companies to advertise their services to students with chronic conditions. Older individuals above 65 may also be targeted through social media, although the approach may not be as effective towards them since they use social media less than younger populations. Research shows that only 49% of those above 65 use social networking sites, but over 80% of individuals between 18 and 49 use them (Pew Research Center 2014).

Concierge medicine can be advertised to older patients through product placement, a strategy of advertising certain brands or products in visual media (Cowley and Barron 2008). Individuals over 65 have been found to watch more television than younger populations, so this advertising strategy may be more effective towards them in comparison to advertising on social media (Depp et al. 2010). For instance, a character in a TV show may drive a BMW or use a Samsung phone, both of which would be conspicuous to the watcher. It differs from TV commercials because viewers are more focused on TV shows and therefore see the advertising, whereas in TV commercials advertisers do not know if viewers have muted the TV, are paying attention to the TV, or are even present in the room (Cowley and Barron 2008). Studies also show that product placement does not have a negative effect on the brand being advertised,

whereas standard commercials could have that effect if consumers feel they are being forced to watch a TV commercial and learn about the brand (Cowley and Barron 2008). Concierge medicine is the topic of a TV show called *Royal Pains*, but the result of this study showed that nearly no students were familiar with it. The field needs to be advertised in shows or media that are more commonly seen by older populations, possibly shows that are on public television channels like ABC. One possibility is large concierge care networks with sufficient capital, such as MDVIP, can advertise in TV shows or movies to attract patients. This idea would be exemplifying product placement, as viewers focused on a scene in a TV show or movie would see the MDVIP logo and potentially enroll. Increasing popularity through these methods would not only attract the direct audiences of the media, but also individuals in their social circles based on the idea of mimicry discussed above.

A second change to improve the receptiveness of the public to concierge medicine would be for the U.S. government to change its health insurance policy to include concierge care. The issue with concierge care currently is that it does not fulfill the insurance requirement of the Affordable Care Act (ACA), so patients not only have to pay the retainer fee out of pocket but must also pay for a health insurance plan that is deemed eligible under the ACA. The downside of concierge care is that it does not cover specialized care, which can create catastrophic bills, thus necessitating insurance. A possible idea is for insurance companies and the U.S government to offer plans on the ACA healthcare exchange that include coverage of the concierge medicine retainer fee but with higher premiums, higher deductibles, and no complimentary preventive care. There would be no need for complimentary preventive care, since concierge practices would offer several office visits free of charge per year as evident from the results of the online concierge practice search. These plans would be beneficial to insurance companies because they

would not have to cover any wellness checks or vaccinations, which were found to be included in the majority of students' plans in this study. The higher premiums and deductibles would help offset insurance costs as well. The idea would require a cost-benefit analysis for insurance companies, which they have likely already done with the rise of concierge care, but may be beneficial if high numbers of patients continue to enroll. For the patient, this plan would be financially sensible if the annual premiums would be less than the sum of the annual retainer fees and the cost of their existing insurance plans. I support this idea since it would increase access to concierge care for those who need it but would not be able to otherwise afford it. These plans may have higher premiums than other plans, but the cost would be similar to other plans on the healthcare exchange that offer more healthcare coverage.

If insurance companies refuse to cover the monthly retainer fees for concierge patients, a third idea is for concierge physicians to lower the costs of care through subsidies from the government. Primary care is a neglected field as explained by Bodenheimer and Pham (2010), and there will be a shortage of primary care physicians in the future. To prevent this, the government can subsidize concierge physicians since they provide primary care, thus reducing the monthly annual retainer fee for patients. Patients would still be required to obtain health insurance, but their costs for concierge care would be significantly lower. The subsidies would vary from region to region, depending on the need for primary care physicians in the area as well as the costs of living, and it would be up to the concierge physicians to decide whether the subsidies would be cost-effective. This would motivate physicians to choose primary care fields as well, since they would be well reimbursed for their services.

Although the previous option appeals to physicians and increases primary care, the U.S. government has finite resources and may not be able to subsidize primary care in this manner.

Additionally, I do not believe it is ethically correct to subsidize concierge physicians who selectively treat their patients, especially if these physicians will refuse to practice in rural areas where incomes are low but primary care shortages are high (Bodenheimer and Pham 2010). There are other methods of increasing primary care in the U.S. that do not involve concierge medicine. Two significant issues with primary care, as described previously, are the low compensation and lack of primary care training programs, which motivate students to specialize (Bodenheimer et al. 2009). According to the National Institute for Health Care Reform, there are several ways in which the government can address these issues. In order to address low compensation, primary care physicians can receive higher payments through Medicare and Medicaid, as well as loan forgiveness if they practice in selected underserved areas (Carrier et al. 2011). Medical education costs are high, often amounting to more than an entire year of post-training physician salary, so the loan forgiveness option would be intriguing. Carrier et al. (2011) also show that in contrast to scholarships, loan forgiveness results in higher student satisfaction. However, loan forgiveness would need to have strict stipulations, such as the time duration of practice in the rural environment in order to prevent physicians from leaving the area. In order to address a shortage in residency training programs, Carrier et al. (2011) state that three-fourths of new primary care residencies funded by Medicare be in primary care. This idea is logical; as the number of doctors increases from graduates of new U.S. medical schools and the influx of international graduates, the number of new primary care doctors relative to specialists will increase in Medicare sponsored residencies. Considering that Medicare is the largest sponsor of U.S. residency programs, this idea would significantly aid the primary care shortage (Iglehart 2013). I support these ideas over concierge care subsidization, as they increase primary care access for all patients, not just for those who can afford concierge

medicine. Ideally, the government should include concierge care in its insurance plans and support non-concierge primary care, as this would increase primary care coverage for all clienteles.

Limitations

This study had several limitations. The first is that all students were satisfied with their insurance plans and none complained of any issues, such as lack of coverage. This study would have been more effective had it contained students who were having issues with their insurance, as it would have given a more complete view of the current state of primary care. The second limitation is that students in this study did not have any chronic conditions and did not visit their physicians often. The idea of concierge care is for patients to maintain regular communication with their physicians to stay healthy. This is accomplished through unlimited access to the physician via phone, as well as unlimited office visits in some practices. The concept of unlimited access eliminates a barrier to entry, and with this advantage students would not think twice about seeing their physicians because of cost. However, the students had no need for the greater access, thereby eliminating their interest in concierge care. These limitations partly arose from a lack of random sampling and the shortcomings of a convenience sample, which prevented this study from recruiting a diverse group of students that may have had the experiences described above. Thus, this study does not represent the student population as a whole, but only those who do not have problems with their health insurance and do not require regular access to health care. Regardless of the sample's limitations, this study was a small-scale measure of students' views on concierge medicine, the first of its kind.

Secondly, there were limitations with the online search on concierge practices, specifically that the search was not representative of the U.S. or random in its selection. Another limitation was the lack of specific details on practices, such as the demographics of their patients and patient satisfaction. The information found could not be used to infer on concierge medicine as a field, but was used instead for comparison with the literature and to gauge interest in the field.

Future Directions

Future research on concierge medicine views among the student population should be conducted with different student populations. For instance, students of different backgrounds should be selected, potentially those with chronic diseases and who see their physicians often. Another group could be those who are unhappy with their insurance plans, as this would give an idea of the current state of the healthcare system and if low satisfaction with non-concierge care would lead to more support for concierge care. Finally, it may be beneficial to interview students who are not on their parents' insurance plans because these individuals would be responsible for their health care and thus more interested in options. By virtue of their financial situations, these students may also be on plans with less coverage, fewer included services, and higher deductibles, and interviewing them would give a more comprehensive understanding of views on health insurance and health care experiences.

Other, more general studies should focus on whether concierge care offers more effective health care than non-concierge care. Specifically, these studies should aim to confirm the benefits of concierge medicine, such as a stronger patient-physician relationship, and see whether they translate into a healthier lifestyle measured by fewer illnesses and better physical shape.

Currently, there are no objective studies on this topic, and the single study that exists was sponsored by a concierge care provider, raising the question of bias (Klemes et al. 2012). If objective studies can prove the efficacy of concierge care, the field will gain credibility from the public and policy makers, leading to an increase in popularity and acceptance. The increase in credibility could also lead to more acceptance of the field as a form of health care, leading government officials to allow it as a health plan under the ACA and insurers to cover it.

The outlook for concierge medicine appears promising because existing data on concierge practices show that there is a demand for concierge physicians, despite the fees being very high. If there are no policy changes on concierge care, such as insurance coverage or qualification as an ACA plan, or changes in its popularity, it will continue to exist as a form of healthcare for a niche audience. However, the growth of practices suggests that it is becoming more popular, so it is likely that in the long run, this model will increase in its patronage. It is doubtful that increases in users will be from students, as this study showed that students are not receptive to the field. If this popularity improves the field's image and elicits widespread demand for concierge doctors, then it is possible that policy makers will include it under the ACA and insurance providers will support it. No concept is destined to fail, and the hugely popular iPhone, which was predicted by several large news outlets such as Businessweek and Bloomberg to fail because of its shortcomings (e.g. lack of innovation and features), serves as a testament (Wildstrom 2007; Lynn 2007). It may be beneficial for concierge practices to advertise to older individuals or younger people in need rather than to healthy populations, as this would emphasize that the retainer fee is paying for the extra service required to treat these populations. Essentially, this approach would reduce negative attention towards the retainer fee and reduce criticisms directed at its unethicality. The debate on its ethicality is persistent and

physicians are divided on its ethicality, though further studies are necessary to determine patient views on its ethicality. With the correct marketing and appeal, concierge medicine can catch the attention of the older population or those who require close monitoring of their health, and become even more successful than it is today.

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Appendices

Appendix 1- Student Interview Questions

In the last 20 years, some physicians have started practicing concierge medicine, a private form of health care without insurance. Research shows that older, educated individuals (above 45) are attracted to this practice for a variety of reasons, such as increased time with physicians. For my thesis work, I am interested in knowing if this type of medicine appeals to the younger generation of college students. This interview will give me an idea of whether you support it and would potentially utilize it.

1) Before this interview, were you familiar with the term "concierge medicine?" If so, how did you first hear this term?

2) a) Do you have a regular primary care physician (the same physician on every visit)? This could be in your hometown or in Schenectady. If you do not, what did you think of your pediatrician as a child? How many years did you see him/her? Did you like the continuity of this relationship?

b) How many times do you see a primary care physician per year, whether it is for physicals, routine checkups, or a sickness like the flu? This does not include specialist physicians such as those who perform surgeries, perform cancer therapy, or treat you for a specific condition that your primary care physician may have referred you for. This can include visits to health services at Union College.

3) How long do you typically have to wait for an appointment with your primary care physician? Do you ever have trouble getting an appointment exactly when you want it? Please explain.

4) Do you have a high-deductible or low-deductible health insurance plan? High-deductible is when you have to pay out of pocket for all visits until you reach a certain amount paid. If you don't know, can you describe your insurance plan briefly?

5) Do you ever refrain from seeing your physician or are hesitant to because of costs, such as a fee that your insurance won't pay? Please explain.

6) How long do you typically have to wait to be seen once you are in the waiting room? Do you consider this length of time to be acceptable? Why or why not?

7) How much time do you typically spend with your primary care physician per visit? Do you ever feel rushed by your physician during your appointment, or believe he/she didn't take enough time to diagnose you properly? Please explain.

8) Please describe the relationship you have with your general physician. What level of trust do you have in this provider? Do you feel that your physician listens to your concerns? Please explain.

9) Do you think your doctor cares about you and is completely honest with you about your health? Do you feel he/she ever refrains from giving you certain details about your health?

10) Would you want a physician who you can talk about anything health-related, for as long as you want and whenever you want? You might go in to see your physician for a specific symptom, but then realize you have questions about other health issues or concerns, such as diet or stress.

11) When do you typically communicate with this physician? For instance, does your physician ever call you to ask about your health, or do you schedule a visit when you need healthcare?

12) What qualities do you find most important in a primary care physician (e.g. short waiting times, long appointment times)?

13) Instead of your normal physician, would you be willing to pay an annual fee of $1,000, which is not covered by insurance, for a private primary care physician who would:

- be available to you 24/7 by cell phone and offer house calls
- talk to you about any health issues, or personal problems causing those health issues
- check up on you regularly by calling you and inquiring about your health
- give you as many appointments desired for no additional cost, as well as visit times of at least 30 minutes
- provide significant discounts on exams and medications. Examples of the costs of care in non-concierge practices: tetanus shot ($28), cholesterol test ($72), and flu vaccine ($25).
- accompany you to any potential specialist visit (e.g. orthopedic surgeon, dermatologist, oncologist)
- reduce paperwork
- not require any insurance except a cheaper high-deductible plan (required by law) if referred to a specialist or for hospital care

Additionally, for your reference, unless you are on a low-deductible health plan, you are probably already paying upwards to $1000 annually if you see your physician often and have tests and injections administered. The average price of a visit is $104 without any such tests.

Appendix 2- Consent Form

INFORMED CONSENT FORM

My name is Sushane Gupta, and I am a student at Union College in Schenectady, NY. I am completing this thesis as a requirement for my major in Sociology under the direction of Professor Melinda Goldner. I am inviting you to participate in a research study. Involvement in the study is voluntary, so you may choose to participate or not. A description of the study is written below.

I am interested in learning about student views on concierge medicine. Concierge medicine is a type of personalized medical care that, analogous to other service industries, aims to provide the patient with a higher level of customer service and satisfaction. Theoretically, in exchange for an annual fee, patients are given lower, if any waiting times for appointments, longer appointments with the physician, prompt access to the physician by phone or e-mail, and essentially, a stronger patient-physician relationship focused on preventative care. You will be asked to provide your opinions on the healthcare you receive from your primary physician, as well as if you would support features of concierge medicine. This will take approximately 10-20 minutes. The risks to you of participating in this study are minimal and limited to you providing information about your health care that you may feel is private. These risks will be minimized by allowing you to answer only what you feel comfortable answering, and keeping all answers confidential. Pseudonyms will be used, and any identifying characteristics will be omitted."

I consent to participate in this interview about concierge medicine. Sushane Gupta, the project researcher, has explained the purpose of the study, how the interview will be conducted, and the expected duration of my participation. I have had the opportunity to ask any questions that I may have regarding the study and I have received answers that meet my satisfaction. I understand that I am free to discontinue participation in this interview at any time without penalty. I understand that my participation will be kept confidential. I have read and fully understand this consent form. I sign it freely and voluntarily. A copy will be given to me upon request.

Date: _____

Signed: _____ (Participant)

Signed: _____ (Principal Investigator)