



## AMA Journal of Ethics®

January 2023, Volume 25, Number 1: E66-71

### **POLICY FORUM: PEER-REVIEWED ARTICLE**

#### **Why VIP Services Are Ethically Indefensible in Health Care**

Denisse Rojas Marquez, MD, MPP and Hazel Lever, MD, MPH

##### **Abstract**

Many health care centers make so-called VIP services available to “very important persons” who have the ability to pay. This article discusses common services (eg, concierge primary care, boutique hotel-style hospital stays) offered to VIPs in health care centers and interrogates “trickle down” economic effects, including the exacerbation of inequity in access to health services and the maldistribution of resources in vulnerable communities. This article also illuminates how VIP care contributes to multitiered health service delivery streams that constitute de facto racial segregation and influence clinicians’ conceptions of what patients deserve from them in health care settings.

##### **Insurance and Influence**

It is common practice for health care centers to make “very important person” (VIP) services available to patients because of their status, wealth, or influence. Some delivery models justify the practice of VIP health care as a means to help offset the cost of less profitable sectors of care, which often involve patients who have low income, are uninsured, and are from historically marginalized communities.<sup>1</sup> In this article, we explore the justification of VIP health care as helping finance services for patients with low income and consider if this “trickle down” rationale is valid and whether it should be regarded as acceptable. We then discuss clinicians’ ethical responsibilities when taking part in this system of care.

We use the term *VIP health care* to refer to services that exceed those offered or available to a general patient population through typical health insurance. These services can include concierge primary care (also called boutique or retainer-based medicine) available to those who pay out of pocket, stays on exclusive hospital floors with luxury accommodations, or other premium-level health care services.<sup>1</sup> Take the example of a patient who receives treatment on the “VIP floor” of a hospital, where she receives a private room, chef-prepared food, and attending physician-only services. In the outpatient setting, the hallmarks of VIP service are short waiting times, prompt referrals, and round-the-clock staffing.

While this model of “paying for more” is well accepted in other industries, health care is a unique commodity, with different distributional consequences than markets for other goods (eg, accessing it can be a matter of life or death and it is deemed a human right under the Alma-Ata Declaration<sup>2</sup>). The existence of VIP health care creates several dilemmas: (1) the reinforcement of existing social inequities, particularly racism and classism, through unequal tiers of care; (2) the maldistribution of resources in a resource-limited setting; (3) the fallacy of financing care of the underserved with care of the overserved in a profit-motivated system.

### **Reinforcing the Social Divide**

The very existence of VIP services allows for multiple tiers of care along racial and socioeconomic lines, thereby reinforcing patterns of racism and classism already present in the United States. Despite a decline in the overall number of uninsured nonelderly individuals across all racial and ethnic groups over the last decade, nonelderly Black, Hispanic, American Indian/Alaska Native, and Native Hawaiian/Other Pacific Islander individuals continue to be uninsured at higher rates than nonelderly White individuals.<sup>3</sup> Even among those who have health insurance, significant racial divides exist among those who have private insurance and those who have Medicaid. The Kaiser Family Foundation estimated that, in 2019, 74% of White Americans had private health coverage and that 19% were enrolled in Medicaid, whereas 52% of Black Americans had private health coverage and 37% were enrolled in Medicaid.<sup>3</sup>

A danger in recreating these racist and classist hierarchies in care delivery is that doing so can lead practitioners and learners to internalize these values. Having health care delivery systems that practice VIP care sanctions the notion that wealthy patients’ lives and their bodies are worthy of a higher level of care even in the emergency room: a chest complaint from a VIP patient should be treated first, while other patients with the same complaint should wait in line longer or deserve less attention from specialty doctors. This example of certain patients waiting longer for emergency care goes against the intent of the Emergency Medical Treatment and Labor Act of 1986, a law enacted by Congress to ensure access to emergency treatment for all people regardless of ability to pay and a guiding principle of the practice of emergency medicine.<sup>4</sup> Additionally, VIP classification and other signifiers of importance and wealth may implicitly affect clinical decision making and care delivery. As Shoa Clarke observes in a *New York Times* opinion article: “When I allow one of my patients to be labeled ‘important,’ do I implicitly label the others as less important?”<sup>5</sup>

For patients themselves, a multitiered system of care might also reinforce existing ideas of deservedness. Already, many people choose not to enroll in public programs, such as welfare, due to perceptions of being dependent on the “system” or due to shame that is reinforced when receiving social benefits.<sup>6</sup> In one study of women who use drugs and their views on welfare, one participant reflected: “I wonder about welfare. It is supposed [to] help poor folks with a place to live, food, and insurance.... I understand that there are things we have to do to show that we deserve the money.... They get into personal things, like who do you sleep with or who do you share a toothbrush with.”<sup>7</sup> As was famously stated by the US Supreme Court in *Brown v Board of Education* (1954), segregation “generates a feeling of inferiority.”<sup>8</sup> This potential impact on patients cannot be ignored.

### **Distribution of Resources**

In addition to reinforcing existing social inequities, VIP care disproportionately uses finite resources, as the increased resources allocated to the wealthy deplete the resources available to other patients. Given the shortage of primary care doctors in the United States,<sup>9</sup> the influx of physicians to concierge practices effectively works to **decrease the number of physicians available** for the rest of the population. Moreover, compared to their counterparts, physicians in concierge primary care have a smaller patient load and serve fewer Black, Hispanic, or Medicaid patients.<sup>10</sup> Thus, concierge medicine decreases access to primary care overall<sup>11</sup> and might disproportionately impact Black and Hispanic communities whose members are more likely to be uninsured or on Medicaid.

While it may seem that highly personalized health care provided via concierge primary care would result in better health outcomes, there are few studies supporting that it does so.<sup>12,13</sup> Moreover, it poses the risk of overutilization or misutilization of resources.<sup>14</sup> Thus, concierge primary care does not necessarily improve the health of those who pay membership fees while causing detriment to those who receive care under traditional health insurance programs.

An important ethical consideration for physicians considering a switch to concierge medicine is their duty to advance the health of communities and to care for the underserved, as this switch often involves keeping the wealthiest patients and leaving the poorer and often sicker patients to be cared for by other clinicians in the health system.<sup>15</sup> The American College of Physicians (ACP) released a position paper on concierge primary care that highlights physicians' ethical and professional obligations to consider the disparate impact of these service models on patients with lower incomes as well as their ethical obligation to provide nondiscriminatory care.<sup>14</sup> The ACP acknowledges the advantages of concierge care for primary care physicians (eg, less paperwork, higher compensation, and smaller patient panels), while also recognizing that its high cost to patients contributes to health care disparities. The ACP recommends that clinicians and practices that engage in concierge care consider "ways to mitigate any adverse impact on the poor and other underserved populations,"<sup>14</sup> although it does not provide guidance on what that mitigation might entail.

VIP services in the inpatient setting have not been extensively studied. One study of hospitalist physicians' perceptions regarding VIP patients and services found that a majority (63%) of physicians felt pressured by VIP patients and families to order additional testing that they felt was medically unnecessary.<sup>16</sup> This pressure to order **medically unnecessary testing** is at odds with Medicare and Medicaid regulations aimed at reducing wasteful use of resources.<sup>17</sup> The same study showed that the majority (78%) of physicians did not perceive a difference in quality of care between VIP and non-VIP care, with 17% perceiving that VIP care was worse and 6% perceiving that VIP was superior.<sup>16</sup> However, the actual health outcomes of these services have not been studied. Thus, similar to the outpatient setting, inpatient VIP care may lead to overutilization of medical resources, which, in a setting of finite resources, means less access to resources for non-VIP patients, without a clear benefit in quality of care. If VIP services were shown to improve health outcomes, then these services should instead become standard of care rather than an opt-in service for the wealthy.

### **Financial Implications**

A fundamental defense of the practice of hospital-based VIP services is that it is a financial tool to enable the provision of care to patients with low incomes—a trickle down

approach to health economics. While there is scarce literature on revenue expenditures related to VIP services, studies suggest that high earners do not pay for health care for patients with low incomes. Researchers for the Kaiser Family Foundation estimate that uncompensated care costs for uninsured individuals averaged \$42.4 billion per year between 2015 and 2017 and that nearly 80% of uncompensated care costs were covered by government payments.<sup>18</sup> They suggest that the remaining share was covered by a mix of private payers, such as philanthropic organizations and workers compensation, but do not mention whether any of these costs were supported by VIP services.<sup>18</sup> The “cost shifting” argument made by health care systems—that charging more for privately insured patients or other high-earning payers compensates for low reimbursement rates for Medicaid—has 2 main flaws: it assumes that hospital costs are fixed and that low reimbursement rates for Medicaid result in hospitals charging privately insured patients higher prices.<sup>19</sup> One study found that a reduction in Medicare payments led to a *decrease* in private payment rates—the opposite of what cost-shift theory would suggest.<sup>20</sup> This result is likely due to competition driving prices down for all payers and an individual hospital’s negotiating power in that health care market.<sup>19</sup> While there might be individual cases of hospitals using VIP care to subsidize services for patients with low incomes, this business model is not common practice. On a macro level, greater profits do not correlate with greater levels of **uncompensated or “charity” care**. One study evaluating the provision of charity care at US nonprofit hospitals found that hospitals with higher net income provided disproportionately less charity care than those with lower net income.<sup>21</sup>

While cost shifting is a popular theory employed to defend the provision of VIP care, it does not hold up in practice. Like businesses in any other profit-driven industry, health care systems are motivated to maximize services that maximize their profits (eg, concierge care) while minimizing their losses. No regulation exists that forces a health care system to balance VIP services with uncompensated care, so these services are untethered. There is no financial reason why VIP care would serve to advance health equity, and there is no evidence that health care systems use the infusion of VIP dollars to fund care for patients with low incomes.

### Conclusion

VIP health care, while potentially more profitable than traditional health care delivery, has not been shown to produce better health outcomes and may distribute resources away from patients with low incomes and patients of color. A system in which wealthy patients are perceived to be the financial engine for the care of patients with low incomes can fuel distorted ideas of who deserves care, who will provide care, and how expeditiously care will be provided. To allow VIP health care to exist condones the notion that some people—namely, wealthy White people—deserve more care sooner and that their well-being matters more. When health institutions allow VIP care to flourish, they go against the ideal of providing equitable care to all, a value often named in organizational mission statements.<sup>22</sup> At a time when pervasive distrust in the medical system has fueled negative consequences for communities of color, it is our responsibility as practitioners to restore and build trust with the most vulnerable in our health care system. When evaluating how VIP care fits into our health care system, we should let health equity be a moral compass for creating a more ethical system.

### References

1. Goldman D. Hospital care for those who can afford it helps care for those who can't. *New York Times*. August 22, 2016. Accessed February 21, 2022.

- <https://www.nytimes.com/roomfordebate/2016/08/22/hospitals-that-feel-like-hotels/hospital-care-for-those-who-can-afford-it-helps-care-for-those-who-cant>
2. WHO called to return to the Declaration of Alma-Ata. World Health Organization. Accessed July 1, 2022. <https://www.who.int/teams/social-determinants-of-health/declaration-of-alma-ata>
  3. Artiga S, Hill L, Orgera K, Damico A. Health coverage by race and ethnicity, 2010-2019. Kaiser Family Foundation. July 16, 2021. Accessed August 22, 2022. <https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/>
  4. Examination and Treatment for Emergency Medical Conditions and Women in Labor, 42 USC §1395dd (2022).
  5. Clark S. How hospitals coddle the rich. *New York Times*. October 26, 2015. Accessed July 1, 2022. <https://www.nytimes.com/2015/10/26/opinion/hospitals-red-blanket-problem.html>
  6. Orbach BY. Unwelcome benefits: why welfare beneficiaries reject government aid. *Minn J Law Inequity*. 2006;24(1):107-155.
  7. Luck PA, Elifson KW, Sterk CE. Female drug users and the welfare system: a qualitative exploration. *Drugs Educ Prev Policy*. 2004;11(2):113-128.
  8. *Brown v Board of Education*, 347 US 483 (1954). National Archives. Accessed September 20, 2022. <https://www.archives.gov/milestone-documents/brown-v-board-of-education>
  9. IHS Markit Ltd. *The Complexities of Physician Supply and Demand: Projections From 2019 to 2034*. American Association of Medical Colleges; 2021. Accessed February 21, 2022. <https://www.aamc.org/media/54681/download?attachment>
  10. Alexander GC, Kurlander J, Wynia MK. Physicians in retainer (“conciierge”) practice. A national survey of physician, patient, and practice characteristics. *J Gen Intern Med*. 2005;20(12):1079-1083.
  11. Konstantinovsky M. Many doctors are switching to concierge medicine, exacerbating physician shortages. *Scientific American*. October 19, 2021. Accessed August 22, 2022. <https://www.scientificamerican.com/article/many-doctors-are-switching-to-conciierge-medicine-exacerbating-physician-shortages/>
  12. Fernandopulle R. Learning to fly: building de novo medical home practices to improve experience, outcomes, and affordability. *J Ambul Care Manage*. 2013;36(2):121-125.
  13. McCorry D. Direct primary care: an innovative alternative to conventional health insurance. *Heritage Foundation Background*. August 6, 2014. Accessed September 19, 2022. [http://thf\\_media.s3.amazonaws.com/2014/pdf/BG2939.pdf](http://thf_media.s3.amazonaws.com/2014/pdf/BG2939.pdf)
  14. Doherty R. Assessing the patient care implications of “conciierge” and other direct patient contracting practices: a policy position paper from the American College of Physicians. *Ann Intern Med*. 2015;163(12):949-952.
  15. Carnahan SJ. Conciierge medicine: legal and ethical issues. *J Law Med Ethics*. 2007;35(1):211-215.
  16. Allen-Dicker J, Auerbach A, Herzig SJ. Perceived safety and value of inpatient “very important person” services. *J Hosp Med*. 2017;12(3):177-179.
  17. Condition of Participation: Utilization Review. 42 CFR §482.30 (2022).
  18. Coughlin TA, Samuel-Jakubos J, Garfield R. Sources of payment for uncompensated care for the uninsured. Kaiser Family Foundation. April 6, 2021.

Accessed February 21, 2022. <https://www.kff.org/uninsured/issue-brief/sources-of-payment-for-uncompensated-care-for-the-uninsured/>

19. Frakt A. Hospitals are wrong about shifting costs to private insurers. *New York Times*. March 23, 2015. Accessed February 21, 2022. <https://www.nytimes.com/2015/03/24/upshot/why-hospitals-are-wrong-about-shifting-costs-to-private-insurers.html>
20. White C. Contrary to cost-shift theory, lower Medicare hospital payment rates for inpatient care lead to lower private payment rates. *Health Aff (Millwood)*. 2013;32(5):935-943.
21. Bai G, Yehia F, Anderson GF. Charity care provision by US nonprofit hospitals. *JAMA Intern Med*. 2020;180(4):606-607.
22. What is Mass General Brigham? Our mission. Mass General Brigham. Accessed August 21, 2022. <https://www.massgeneralbrigham.org/en/about>

**Denisse Rojas Marquez, MD, MPP** is an emergency medicine resident at Boston Medical Center in Massachusetts and a co-founder of Pre-Health Dreamers, an advocacy organization for undocumented immigrants pursuing careers in health and science. She earned her MD at the Icahn School of Medicine at Mount Sinai and her MPP at the Harvard Kennedy School of Government. She is interested in promoting health justice in urban underserved settings, increasing diversity in the health care professions, and advancing the well-being of immigrant communities.

**Hazel Lever, MD, MPH** is a primary care physician at the Center for Refugee Health and Unity Hospital in Rochester, New York. She is a recent graduate of the primary care internal medicine residency at Massachusetts General Hospital and earned her MD and MPH at the Icahn School of Medicine at Mount Sinai. She is interested in advancing health equity in primary care and in creating structural change to promote health justice.

#### Citation

*AMA J Ethics*. 2023;25(1):E66-71.

#### DOI

10.1001/amajethics.2023.66.

#### Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

*The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.*