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Concierge, Wellness, and Block Fee Models of Primary Care: Ethical and Regulatory Concerns at the Public–Private Boundary

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Abstract In bioethics and health policy, we often discuss the appropriate boundaries of public funding; how the interface of public and private purchasers and providers should be organized and regulated receives less attention. In this paper, I discuss ethical and regulatory issues raised at this interface by three medical practice models (concierge care, executive wellness clinics, and block fee charges) in which physicians provide insured services (whether publicly insured, privately insured, or privately insured by public mandate) while requiring or requesting that patients pay for services or for the non-insured services of the physicians themselves or their associates. This choice for such practice models is different from the decision to design an *insurance plan* to include or exclude user fees, co-payments and deductibles. I analyze the issues raised with regards to familiar health care values of equity and efficiency, while highlighting additional concerns about fair terms of access, provider integrity, and fair competition. I then analyze the common Canadian regulatory response to block fee models, considering their extension to wellness clinics, with regards to fiduciary standards governing the physician–patient relationship and the role of informed consent. I close by highlighting briefly issues that are of common concern across different fundamental normative frameworks for health policy.

Keywords Primary care ethics · Ethics of health policy · Organization of care · Medical practice design · Concierge medicine · Insured and uninsured services · Wellness · Public–private divide

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Introduction

Publicly funded health care systems around the world face the challenge of defining appropriate boundaries between goods and services funded by public payers and goods and services funded by private insurance or paid for out of pocket by patients. Ethicists often debate the resource allocation question of where the boundaries of coverage should be drawn; some argue that the challenge of setting determinate boundaries in itself places in question the legitimacy of public health systems (a charge to which I respond in [62]). We pay less attention to questions of how these boundaries should be structured and managed. In this paper, I describe three practice models that raise such questions, focusing on primary care in Canada while making comparisons to the issues as they arise in the United States [5, 6].

1. In a *concierge medicine* model, a physician typically charges an annual fee to members of their practice and in return maintains a lower patient volume and offers a level of personal attention that is impossible when care is funded by common (public or private) payers, particularly on a fee-for-service or capitation basis. Services may include annual wellness check-ups, counselling, and 24-h access without wait times, for example.
2. In a *wellness practice* model, a physician is in practice together with other health professionals who deliver related care, such as massage, physiotherapy and dietician services. Patients, or their employers on behalf of patients, pay an annual fee; this fee covers (or provides a discount on) the services of everyone in the practice. The adjective ‘executive’ may be associated with wellness clinics, indicating the roots of this model in generous insurance plans that are part of compensation packages for white collar, professional, managerial, and executive workers. They are also referred to as ‘boutique’ clinics, presumably for a different demographic.
3. In a *block fee* model, a physician identifies a number of services they provide that are not covered by the insurance plan (e.g. physical examinations required by third parties, wart removal) and offers an annual ‘block fee’ that covers these services. Patients are invited to pay this annual fee instead of paying for services on a per-use basis.

In Canada, all three models may be considered together and referred to as concierge, boutique or private clinics. During the Alberta Health Services Preferential Access Inquiry, a 2012–2013 inquiry into ‘queue-jumping’ in the health care system [54, 56], it emerged that a concierge (actually, a wellness) clinic located in a University of Calgary public–private partnership facility, Helios Clinic, appeared to offer patients not just the services of physiotherapists, dieticians, and massage therapists in exchange for a CAN$10,000 annual fee, but also expedited access to wait-listed services in the public system via the personal influence of the physician involved in referring patients for screening colonoscopies. Newspapers regularly report the confusion Canadians feel when faced with the request to pay an annual fee from clinics using the block fee model [21].

While I focus in this paper on primary care, these practice models also exist in secondary and tertiary care: an obstetrician may function on a concierge basis or charge a block fee for additional wellness services not covered by the public insurer. Closely related challenges, but outside the scope of this analysis, are the integration of uninsured goods in insured services, such as so-called premium lenses in ophthalmology [39], the provision in publicly funded hospitals of expensive cancer therapeutics of marginal benefit not covered by public drug plans or hospital formularies, and the existence of luxury care clinics catering to the medical tourism market within non-profit hospitals.

Public debate often frames these practice models as incursions of private medicine into the public system. An ethical analysis might then proceed by identifying at the heart of this debate the very basic question of liberty and its legitimate restraint in pursuit of equality or health equity (e.g. in the analysis of Gross [31]). Are the goals of health equity or of protecting the status of health care as special goods sufficient to outweigh individual liberty to purchase care on whatever terms and conditions the market decides?

In the first section of this paper, I clarify the contours of the issues raised by these practice models as they cut across the familiar public–private divide. Fundamental normative commitments about the balance of liberty and equality are relevant to the evaluation of these practice models, but these models also raise issues concerning stewardship, fair market conditions, and the fiduciary nature of the physician–patient relationship. The relevant actors (governments and professional bodies) should attend to these concerns in how they permit, promote, regulate, or forbid the practice of physicians imposing discretionary charges for patient care—whether these charges are solely for their own availability, for their own non-insured services, or for the services of other non-insured associated health professions—in a context where these charges are or may reasonably be perceived to be tied to the provision of services funded by an insurance scheme.

Public Versus Private? Liberty Versus Equality?

In Canadian public discourse, the debate around concierge, wellness, and block fee models of primary care is framed in terms of private sector intrusion into a public system and assimilated to debates about the legitimacy and desirability of Canada's distinct system of single-tier care (see [63] for a discussion of this single tier design). I argue that while such an analysis would capture some important fault lines in the debate, it would inappropriately limit analysis of the ethical issues at stake in these practice models.

Certainly, it is appropriate to place the block fee model in the long history of professional resistance to the single tier model of care in Canada. Physicians have always been resourceful in identifying opportunities to recover costs or augment their income directly from patients, despite the public policy goal of a single-payer system with no financial barriers at point of care; governments have responded by refining the terms of medicare in legislation, such as the Canada Health Act (CHA) of 1984 [3], which prohibited extra billing and user fees. Some arguments in favour

of block fee and wellness clinic models rest on the implausible idea that the CHA's prohibition on extra-billing, stated as a guarantee of 'reasonable access to care without financial or other barriers' means only a limited restriction on extra-billing for insured services under the CHA: i.e. those who work within the public system *may* erect financial barriers to the medicare-funded services they provide *as long as* there are enough other providers working in the system *not* erecting financial barriers to provide 'reasonable' access to those services. Likewise, the wellness model grows out of erosion of the single tier system by policy decisions made around private providers catering to the worker's compensation system [22, 29–31, 35]. But these practice models represent not only the resurgence of extra-billing for insured services and the consequences of past exemptions to the system's single tier design: they involve the interface between insured services and uninsured services, in the sense of services that were never intended to be part of the single tier system. Supplementary (or wellness) services exist at the border of any system of universal health coverage (UHC), and raise the substantial policy questions that are the focus of this analysis.

Furthermore, systems of UHC blend two sets of features to achieve universal coverage. They are not defined by exclusively public funding and/or delivery; rather, in each country, they consist in a blend of public and private provision and funding of care,[1] while offering the public (specified more precisely as citizens or residents or in some other way) terms of access that may be described as 'universal' or 'based in need and not ability to pay' or (more weakly) 'accessible'. The fact that these two sets of features do not map directly onto one another complicates any attempt to use 'public' and 'private' as shorthand labels for what matters normatively in policies governing UHC. Substantial private provision of care (such as characterizes physician practice in UHC in Canada) may exist in a framework of universal access without financial barriers; a system with user charges and substantial private pay (but under a public mandate and with heavy regulation) may achieve greater equity (care based on need and not ability to pay) than one with a stronger balance of public payment [23].

These points—that Canadian medicare is built on private provision of physician services and that many different system designs can achieve health equity—are often made in Canadian policy debates in order to dismiss concerns about 'creeping privatization' and innovative practice models: the primary care practices considering adopting these models always have been private businesses in the Canadian health care system. I raise them in this paper for a different purpose. I argue that in all risk-pooling arrangements—whether public or private, universal or particular, voluntary or mandatory—the public has legitimate concerns about fair terms of access to those services and about management of the boundary between those services funded and those not funded by the risk pooling scheme, including how to manage the interests and entrepreneurial activities of those who provide care funded within that scheme. While it may be inaccurate to characterize these practice models as privatization, there are legitimate public concerns to raise about these models,

[1] See [42] for a numeric accounting of the funding split in various countries and [44] for a discussion of the various roles these sectors play.

some in relation to the goals of medicare and some in relation to issues of integrity and stewardship. On a simple framing of the debate as one about public versus private health care, we miss important questions about the behaviour of individual agents within systems of UHC and about the boundaries of coverage for any system of UHC.

Equity, Fairness, and High-Value Care

Broadly speaking, equity in access to health care is achieved when access is based on medical need and not on factors irrelevant to medical need [59], such as ability to pay. Clearly, concierge, wellness, and block fee models pose potential financial barriers: patients are asked or required to pay fees as a condition of accessing care. Barring devils in the empirical detail, any financial barrier is a greater barrier for those of lower socio-economic status, who typically also have greater health care needs. That is, 'ability to pay' is not just a violation of health equity, it is *contrary* to health equity. Note that this claim does not rest on the further claim that UHC [or even UHC without financial barriers (as in the UK and Canada)] is *sufficient* to achieve full equity in access to care [48]. Other factors affect health equity—for example, geography, social capital, health services infrastructure, and the social determinants of health. Health equity is 'multidimensional', as Sen argues [51]. As a result, a given system of UHC with co-payments, deductibles, or user fees may actually achieve better outcomes in equity of access than a UHC system without direct payment. According to the Commonwealth Fund reports, Canada typically does poorly on equity in access despite its lack of financial barriers [23]. However, the balance of evidence supports that co-payments, deductibles and user fees have detrimental effects on equity in access [36, 50]: a system with user fees that achieves good equity in access to care does so despite this policy choice, not because of it.

So, prima facie, a physician contemplating adding financial barriers to access on a discretionary basis is contemplating a change that threatens equity in access to care. Such a physician may look to European systems that achieve more equitable access than Canada does despite different models of direct payment (user fees, co-payments, deductibles) and ask why they, unlike physicians in Europe, are restricted in adopting these models. However, the choice of an individual physician to adopt these practice designs is different from the choice of an insurance company or a health care system to adopt a model of health insurance that includes co-payments, user fees, or deductibles. Systems with user fees and co-payments that nonetheless achieve some degree of equity in access to care also employ safety net mechanisms to compensate for the barrier they pose to low-income and high-need patients. A system that lacks such barriers also lacks mechanisms to mitigate their effects when individual practitioners choose to impose such barriers on a discretionary basis.

When any significant number of physicians use their control of public or pooled resources to sell additional services, whether provided by physicians themselves or by their business associates, the publicly-funded services will then be available only

to those who can afford the fuller basket of care. Such a move is called "capture" in welfare state policy (e.g. [34]): resources intended (in, for example, Canada) to provide a good enough standard of care on equal terms and conditions to all would be sequestered in a marketplace for wellness care that serves the subset of the population that can afford wellness care. A given state will make policy choices about the extent to which benefits should flow to the middle and professional classes (enacting risk solidarity—which may also be called instrumental solidarity [41], rational solidarity [24], or actuarial fairness [38]) or be should used to in a manner that promotes inclusion of the worst off (enacting altruistic or 'constitutive solidarity' [24]); on the other hand, a particular government may simply succumb to the dynamics of electoral politics, which push towards capture by the classes with greater political voice [57], without any real rationale that it can expect the health care sector to adopt. Such a capture of health care resources runs contrary to goals of health equity.

Despite the obvious application of the values of health equity and solidarity to these practice models and the common claim that Canadian medicare is based in the values of equity and solidarity, there are other ethical issues at stake in these practice models. Bringing out these other dimensions of the issue generalizes the analysis beyond the specific Canadian single tier design and clarifies areas of concern that are common to those with diverse fundamental normative beliefs, from libertarian to liberal to egalitarian. It is also helpful in light of the multi-dimensional nature of health equity [52] and the resulting range of system designs that might be adopted within an egalitarian or liberal framework that values health equity. Furthermore, it broadens the range of policy responses conceivable within any system. This is particularly useful for the Canadian context because the enforcement mechanisms for Canada's policy aspiration to an equitable and solidaristic health care system are weak, indirect, and non-transparent: there is no opportunity for patients to litigate the inequities that result from executive and block fee models directly around the fundamental rights at stake as they could, for example, in the Kiryati case in Israel [31].

Fair Access

The discretionary choice of providers within a given system design to add fees and bundled services raises additional concerns. Many of these concerns arose for concierge care in the United States even before its version of UHC came into effect, despite the very weak commitment of that system to equity and solidarity. Canadian physicians may ask why they, unlike physicians in the US, are restricted in their ability to adopt these models; one part of the answer is that physicians in the US also face substantial barriers in adopting these models [5, 6]. When a system has user fees and co-payments, all participants in that system access it on uniform terms and conditions (apart from low-income subsidies or waivers); in a system where providers add discretionary charges, participants no longer access the system on uniform terms and conditions. Expectations of fairness that arise from risk-pooling as such (whether the risk-pooling is public or private, universal or partial) are recognized and enforced even in a system such as the US with a much larger role for

private funding and delivery [5, 6]: there are limits on the ability of physicians to enter into these practice models while still billing private insurance companies or public health care plans. These limits may be enforced by law—human rights law or the regulation of insurance and fair trade—or by the contracts physicians enter into with insurers, insofar as these require physicians to accept all insured persons on the same terms and conditions.

High Value Care

In concierge and executive wellness models, substantial medical resources are dedicated to lesser medical needs: this is not only an inequity but also a less efficient use of resources. Physicians and insurers—again, even in the US—increasingly recognize that consumer-driven care leads to medical practice that is unsustainable for any health system: such over-use not only threatens health equity goals, but may be medically inappropriate for the patient who is the recipient of intensive resources and unsustainable for health care as a sector of the economy. All health care systems struggle to address the overuse of medical technology [2, 28, 58]. The goal of delivering high value care is not only a system question: it is also legitimate concerns of the profession. Physicians have long been asked by the wealthy to devote substantial time to managing the 'worried well', an activity that implies opportunity costs for others in greater need and the provision of services of marginal or no benefit to patients willing to pay for them. Increasingly, physicians recognize their responsibility to provide medically indicated care backed by evidence, taking part in the development of evidence-based practice and clinical guidelines and joining the move for "high value" care [45], eschewing an older view that loyalty to individual patients is in conflict with health system sustainability. The exclusive relationship suggested by concierge medicine or enrolment in a wellness clinic is a resurgence of an older model of physician loyalty; it fosters patient expectations commensurate with the price paid. These may distort clinical judgment, resulting in misdiagnosis or inappropriate treatment (whether over-treatment or under-treatment).[2] In the US, some are raising the question whether physicians who practice concierge care should be held to a higher standard of care in the legal sphere, since they are (after all) marketing to their patients an exclusive, elevated degree of medical attention [60].

Integrity

Laws and regulations restricting concierge style medical practice in the US are not just based on concerns about fairness in terms of access. They also speak to the integrity of individual agents who control access to pooled resources and concerns about fair competition in the context of monopoly providers and monopsony payers. In an employer/employee relationship it is relatively trivial to specify that individual agents may not charge extra administrative fees directly to customers for doing their job and may not bundle services of their own associates with the services of their

[2] These issues are discussed in the context of hospital-based VIP care in [25, 32].

employer. In risk-pooling schemes, public or private, the competitive business interests of the professionals whose services are insured by these risk-pooling schemes are in play, but cannot be managed via the employer–employee relationship.

While providers have a legitimate interest in reasonable or even generous remuneration for their work, accepting or soliciting an illegitimate private inducement to provide a service that one is already paid to provide constitutes bribery, and so corruption. The case of Helios Clinic shows that such concerns extend to wellness and concierge models: it is not credible that CAN$10,000/year was the price of massage and dietary advice and had no bearing on an expectation of expedited access to public resources. Regulation must address payment on any of these models where, in effect, the payment is an illegitimate inducement for expedited access to services already paid for through a third party.

The wellness model also raises questions of fair competition within the relevant private market: a massage therapist in a wellness practice, for example, enjoys a competitive advantage from associating with someone who can bill the public purse. Furthermore, the physician role in a wellness practice can raise concerns about fee-splitting or kickbacks in referral and prescribing [7]. Prohibitions on fee-splitting and kickbacks are motivated by the concern to maintain trust in the profession, maintain the integrity of clinical judgment, and avoid conflict of interest. If the physician who practices in a wellness clinic receives space and/or administrative support without charge, this would constitute a subsidy of their practice from the proceeds of the clinic as a whole—i.e. from the health care professionals whose services are bundled with the physician's insured services. A physician in good conscience may not be aware that wellness practices arrangements are equivalent to kickbacks or fee-splitting. Some colleges have conflict of interest policies or practice management policies pertinent to wellness practices (e.g. [16]); their application to wellness practices and their enforcement should be clarified and strengthened.

In a wellness clinic in the Canadian context, the assumption would be that the physician's colleagues' practices are supported by the physician offering their publicly-funded services as an incentive to purchase their colleagues' care: wellness practitioners accepting new patients are easy to find; primary care physicians accepting new patients are difficult to find. In the US, Medicare and Medicaid fraud are substantial issues in reality and in the public eye;[3] an oversupply of specialist practitioners to whom patients may self-refer creates the opposite market dynamic. Physicians may be offering wellness bundles as incentives for patients to accept medical care that is then funded by the public payer [5, 6]. That is, the offer of the services of other health care providers (massage, physiotherapy, etc.) could be an impermissible incentive for patients to accept publicly funded care from this particular physician provider over other providers similarly funded by Medicare or Medicaid, or even to accept care that is not medically indicated at all.

Short of the question of fair competition, a given health care system may be designed to encourage, discourage, require, tolerate, or forbid subsidies to specific

[3] Such fraud exists but is less well-known in the Canadian system [40].

sectors [26]. The Australian system is structured around public subsidization of privately purchased health insurance; the Canadian system avoids such subsidies. Canada's policy choice against direct charges to patients is intended not only to increase health equity by removing financial barriers to care, but also to prevent subsidization of the private health care market by public or pooled funds [27]. Once again, where a policy level decision has been made to permit or encourage such subsidies (as in Australia), this is different from the discretionary decision of an individual provider to, in effect, subsidize specific agents in the wellness sector by tying up public resources as incentives for the purchase of wellness services.

Self-Regulation and the Physician–Patient Relationship

The physician regulatory colleges in Canada have not been successful in directly opposing block fee models and they have scarcely addressed wellness models. An early attempt by the Ontario College to ban block fees led to a legal challenge, which found that the regulator was over-stepping its remit [53]. In the wake of the preferential access inquiry, the Alberta college proposed to reference principles of the CHA in the preamble to a more restrictive policy on block fees (see draft policy at [9]); in the end, it published a policy with no stated principles [10]. In general, Canadian medicare relies on various actors in the system choosing to be guided by the principles of the CHA despite the fact that they are not legally compelled to do so; after all, health care is constitutionally a provincial matter [37]. However, the regulatory colleges may be limited by remit in the extent to which they can act as partners in extending the principles of the CHA.

While the regulator may not block this path, nothing requires the profession to promote the idea that physicians *should* use the block fee model to supplement practice income by direct appeal to patients: this is a policy path from which the profession could choose to refrain. The block fee model is in fact promoted by the CMA [4] and the company owned by the CMA that provides practice management services to physicians (MD Management): the claim to new doctors is that this is a reasonable way to add CAN$18,000 to practice income. There is no mechanism for the public to hold this practice management company accountable for the effects of its services and recommendations on equity and access. This gap in surprising in light of the public's interest in the health care system both as patients and as funders.

Typically, the colleges require that physicians not charge for 'being available' to provide services funded by the provincial health insurance plan, addressing the CHA's ban on extra billing [10–15, 18–20, 47]: it is clear under the CHA that physicians may not charge a membership fee for access to their services. This could be addressed for physician involvement in the wellness model as well. Furthermore, colleges clarify that physicians may not make payment of a block fee a condition for being accepted or remaining as a patient in the practice. Certainly, it is appropriate for the regulatory colleges to step in when physicians contemplate taking patients' need for medical care as an opportunity to coerce them into purchasing additional services, whether of the physician themselves in the block fee model, or of their associates in the wellness model. Apart from non-coercion, the colleges seek to ensure voluntariness by

requiring that physicians themselves or their designates in the practice clarify the voluntary nature of the fee and that physicians themselves 'be prepared to discuss' the fee with the patient. Several colleges also require that the physician provide to the patient a statement from the regulatory college itself clarifying that the fee is voluntary, that the services may be purchased individually, and that the choice to pay the block fee or not will have no effect on the care that will be provided. That is, in addition to the standard that physicians not coerce their patients, they set a standard that physicians should seek something like free and informed consent for the fees. Is this an adequate response? Should they go farther and prevent physicians from taking advantage of the physician–patient relationship to sell their own uninsured services in the block fee model or the services of associates in the wellness model?

Further clarity about the product on offer in the block fee model is necessary to advance this analysis. In order for it to make sense for physicians to offer a 'block fee' for uninsured services, as opposed to charging a membership fee, soliciting a donation or soliciting a gift, there must be services uninsured by the health plan that people are likely to need on a recurring basis. We have seen that the idea of access to insured services by a payment of a membership fee would be ruled out directly in Canada by the CHA and by various forms of insurance regulation in the US. Physicians are also limited both by their business models and by physician ethics in the extent to which they can act as fundraisers for their practices. Their practices are for-profit businesses or professional practices; any investment in their capital is in fact an investment in the physician's personal capital that they recover when they change practices or retire. Like other private businesses, they cannot fundraise or seek 'donations.' Furthermore, even where they work in a non-profit setting, their involvement in fundraising is circumscribed by professional ethics.[4] A blatant request for a gift from patients would of course be considered an invitation to a form of bribery, however 'optional' the gift. Regulatory colleges would not tolerate this practice. The colleges do advise physicians that the insurer will not consider it acceptable to bill for routine office expenses associated with delivering insured services or to bill a membership fee, clarifying that the reimbursement from the insurer is a reimbursement for the entire insured service, including 'being available' to deliver the service. Where, then, is the space for a block fee that is not a solicited gift, a membership fee, or a duplicate charge for services already paid by insurance? And what is in this space?

Block-fee billing exists in the space left open by decisions to de-fund minor procedures (wart removal) and doctor's notes, and by the growth of new technological means for accomplishing physicians' traditional tasks, such as faxed, phoned, or emailed prescription renewals. Now, there are only so many wart removals that people might anticipate needing in the course of a year such that they would want the convenience of paying in advance and in bulk. Something more is needed to make it plausible that a block fee is what it says it is—a convenient way of paying for something patients want, rather than the solicitation of a gift. What has left scope for a rationale for these charges is the approach of insurers, physicians, and regulators to technological change. For example, insurers could take the approach that the technology by which the physician delivers the service (in person,

[4] For a discussion of the ethical considerations involved in physicians soliciting for charity, see [46, 61].

voice, text, video—it is perhaps a measure of the slow pace of change in Canadian health care that these issues are unresolved for telephone and fax) is irrelevant to its status as an insured service; this would close an important gap that will otherwise open in the twenty-first century between those who can afford health care delivered by modern means and those who (for example) must take time away from work and/or arrange transportation to attend in person for a routine prescription renewal. For the wellness model, there is much more that patients may reasonably wish to purchase in bulk and in advance: the services of associated wellness practitioners.

Current college standards are insufficient to clarify whether the request for payment of a block fee is anything other than a request for a good-will gift or a quasi-donation. In order to distinguish the practice from a request for a gift or donation, regulatory colleges could require a tighter fit between the fees levied and the services provided. When it comes to office sales, colleges set standards such as permitting the practice only when there is a medical need that cannot be met another way and requiring that office sales be on a cost recovery basis only or minimal markup basis [12, 17]. Colleges set a weaker and more vague limit on the profit physicians may seek through block fees: the fees must have 'some plausible relation' to the services provided. The fact that it is entirely implausible that patients need repeated wart removals and doctors' notes such that bulk purchasing in advance is in their interests and the likelihood that a request will be perceived as soliciting a gift needs to guide college policy more explicitly.

How helpful are the standards the colleges set for informed consent in this context? It is important to note that the standard of informed consent is specific to the physician–patient relationship and the proposal of a medical intervention that would otherwise constitute battery. It is not clear whether the concept literally applies to a commercial transaction between physician and patient. Leaving that aside, I will test this question both with the block fee model, accepting for the sake of argument that an annual block fee payment is something other than a good-will gift, and the wellness model, where services that people may realistically desire on a repeated basis are bundled into an annual fee.

Note that the fiduciary role typically involves (among others) two elements: the physician undertakes to recommend only those services that are in the interests of the patient, and the physician respects the patient's free and informed consent or refusal of the services offered.[5] The undertaking to offer only services that are in the

[5] I understand the undertaking to act as a fiduciary to be an undertaking insofar as one is 'entrusted with power or property' to use that 'for the benefit of another' [49, p. 243]; one is expected in that role to behave 'impeccably'. It is common in physician codes of ethics to assert the aspiration to act as a fiduciary. This is in important ways a metaphor, as Rodwin points out: the law does not in fact hold physicians to the standards to which it holds fiduciaries in financial and other property matters. But, Rodwin argues, it is a metaphor that offers concrete guidance (that physicians must not use their access to patients to pursue their own interests, or anything other than the health-related purpose for which the patient has consulted the physician) and that has at its core a concept that is becoming more, not less, pertinent to physician practice even as former ideals of the physician as loyal and exclusive advocate for an individual patient is fading: accountability [49, p. 255]. The undertaking to act as a fiduciary would include not taking advantage of patient information, confidence, and attendance for purposes other than the purpose the patient brings to the medical encounter: to seek medical care. This raises question about e.g. the status of time spent in necessary administrative tasks; however, being submitted to repeated offers of special bundled deals is not a necessary administrative task.

patient's interest is a more substantial undertaking than the undertaking not to coerce patients. Informed consent may be appropriate as a means of respecting patient autonomy in the context of an undertaking to offer only goods and services that are related to the patient's interest in seeking the consultation; this does not mean it is adequate in a situation where physicians forsake that commitment. The colleges could adopt a standard higher than foregoing coercion, and also require physicians forego taking advantage of the medical encounter (both for intrinsic reasons and because it is funded by pooled resources) to market their own uninsured services or those of their colleagues. We can debate whether the offers of block fees are or are not in patients' interests: the question is whether the physician or clinic making this commercial offer is appropriately entrusted with the task of informing patients whether this is in their interests or not. This question goes beyond their medical expertise.

There are also limitations on the patient side that place in question this model of informed consent. If there were an abundant supply of primary care services well-distributed geographically, good communication could ensure voluntary choice on the model of informed consent. However, there is no such abundant supply of primary care practitioners. The reality of health services—whether in countries with UHC or in countries marked by active entrepreneurial health systems—is that primary care providers are in short supply. This is not an accident: the scarcity of primary care practitioners is over-determined, in the sense that the various actors in the system have their own reasons to create or to accept this structural scarcity. For individual physicians, those who enter the profession gravitate to areas of practice where rewards are greater than in primary care. Organized medicine sees an abundant supply of members as a threat to the price they can command for their services and so limits access to the profession via its powers over education and licensure. Governments and other payers are concerned that an abundant supply of providers would threaten system sustainability; governments, through their role in funding education and in collaboration with the regulatory colleges (who are also the licensors), act on this concern by limiting the number of care providers, preferring to pressure those providers into providing high value care rather than unleashing the numbers to provide the maximum care the market will purchase.

Even without structural scarcity, there are relational limits on voluntariness. The physician–patient relationship may involve gratitude commensurate with the depth of need and the intimacy of disclosure involved in seeking and securing health care. The beneficiary of medical attention may well interpret this gratitude as a debt to be discharged by a reciprocal gesture. The relationship is, by official aspiration (i.e. according to the primary care commitment to the value of continuity of care), a long-term relationship and not a single transaction, heightening the concern. For these reasons, regulators discourage physicians from accepting gifts from patients. Even if physicians offer convincing reassurance that they are foregoing coercion and prepared to respect patient choice not to purchase the uninsured services of physicians or their associates, patients may pay in response to other social pressures: they may feel it would appear impolite, ungrateful, or cheap not to pay. Furthermore, given public concern that health care is under-funded, the decision may be felt or indeed presented by the physician as a decision to support the health

care system [21, 55]—paradoxically, in a context where the system is designed to rule out such extra fees. Whether an appeal to consequences for all the patients in the practice constitutes stronger or weaker pressure than an appeal to personal consequences depends on the patient.

To rest content with ruling out coercion and ensuring informed consent in wellness and block fee models is to ignore the structural conditions under which patients make individual choices and the complicity of the profession in those structural conditions. It is also insufficiently attentive to relational limits on free choice in the physician–patient relationship.

Arguably, the approach of the colleges currently is to accept the practice of requesting block fee payment and to advise physicians on how to implement the practice successfully. Some of the colleges' requirements may even invite implementation in ways that run contrary to its goal of protecting the public. The requirement that the physician be prepared to discuss the fee with the patient may be intended to signal that the physician should be flexible; in practice, it may function as an invitation for the physician to pressure patients personally. College policies may lead physicians to think they can require patients who turn down the request to discuss it directly with the physician, which would constitute intimidation. There is no guidance for whether physicians may raise their block fee policy at 'meet and greet' sessions in which they decide whether to accept patients into their practice, a practice that would surely heighten the perception that it is a condition of entering the practice. The Ontario Medical Association recommends that physicians remind patients with every service for which they bill that they could avoid the trouble by paying the annual block fee [43]. One might reasonably expect the regulator to require that patients have the option to opt out of such repeated offers. The more stringent colleges require the physician to hand out a copy of the college's policy itself, but they do not prepare plain language brochures for the public, much less offer tools in the diverse languages spoken in Canada. All this raises the question whether the colleges are advancing the public's interest or advising physicians on how to successfully exploit gaps and lacunae in the CHA and Canada's insurance regulations.

If the colleges choose not to articulate the higher standard, they should take a consumer protection approach to any financial arrangements physicians propose to their patients, in light of their responsibility to protect the public interest. An assessment from a consumer rights perspective is likely to conclude that these plans are examples of well-known marketing moves, similar to extended warranties and gym memberships, that succeed by exploiting consumers' psychological vulnerabilities. The average purchaser of a membership in a gym loses $600 per year when the membership cost is compared to the services actually purchased on a per-use basis [1]. Insofar as the offer of block payments for services that can be purchased on a per-use basis is successful with (the CMA estimates [4]) 30 % of patients in a practice, this is due to well-known psychological mechanisms that lead people to neglect their economic self-interest. These mechanisms include a social aversion to saying no, the desire to save face by not appearing too cheap to pay a small fee, responding to a time pressure imposed on decision-making, and the devaluation of future interests.

In this section, I have argued briefly that the profession could do more up front to be accountable to the public for the effects of its practice models on such health system goals as equity and value in care; I have also argued that it should adopt a more robust regulatory response to the practice models in question, clarifying the line between a permissible block fee, if there is one, and clearly impermissible solicitations of quasi-donations or gifts, and by holding physicians to a higher standard of fiduciary behaviour (refraining from taking advantage of, in addition to refraining from coercing). If holding physicians to this higher standard is not feasible politically or because of regulatory remit, the colleges should position themselves as consumer advocates when physicians take advantage of the physician–patient relationship to supplement practice income by offering their own uninsured services or the uninsured services of their associates.

Conclusion: Beyond and Behind the Rhetoric of Public Versus Private Care

In this paper, I have analyzed ethical and policy issues raised by concierge, wellness, and block fee models, focusing on primary care. I have analyzed a number of issues that are of concern across the typical terms of debate (public vs. private care). These three practice models raise issues at the boundaries of insurance coverage and issues about the appropriate role of agents delivering insured care that are pertinent for 'public' (taxpayer-funded) systems, 'private' systems (i.e. risk-pooling in insurance plans), and systems in between (publicly-mandated privately-purchased insurance). The policy response one advocates to these issues will depend in part of the extent and form of one's commitment to health equity and, more broadly, where one stands on the spectrum between libertarian and egalitarian commitments and strategies. Someone committed to a liberal pluralist framework for health policy (e.g. Coggon [8]) may agree with an egalitarian on fairness and governance issues; both may agree on concerns about fair competition, rent-seeking behaviour, and corruption with one who is committed as a strategic matter to a libertarian reconstruction of welfare state institutions (e.g. Heath [33]) or who advances a libertarian "soft paternalist" approach to potential harms to the public that result from psychological vulnerabilities (e.g. Sunstein and Thaler [52]).

In addition to the regulatory short-comings for which I have argued, there is a dearth of empirical research into these practice models—their prevalence, their specific consequences for equity and access to care, and the patient experience of managing requests for block fee payment or membership in wellness clinics. The discussions of this paper should usefully guide research and policy work in the future.

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Compliance with Ethical Standards

Conflict of interest The author declares that she has no conflict of interest.

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