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What Works

High-End Healthcare

Though they have their opponents, boutique-style services can subsidize care for the poor

By Len Costa

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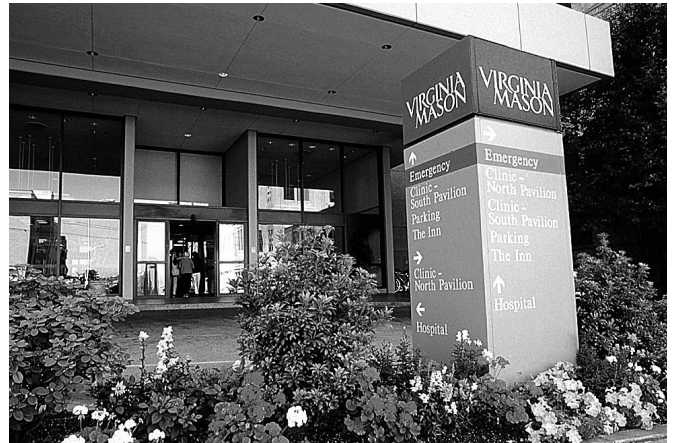
Though they have their opponents, boutique-style services can subsidize care for the poor by Len Costa

Beginning in 1996, the Seattle-based Virginia Mason Medical Center, a nonprofit hospital, was confronted with a growing competitive threat to its primary care practice. In the city's wealthy Eastside district, a number of doctors in private practice began launching "boutique" medical practices offering amenities such as 24-hour access to physicians, next-day appointments, and house calls in exchange for monthly retainer fees of as much as \$1,000, sometimes on top of insurance premiums. "Our patients wanted this and threatened to leave us," says Dr. John Kirkpatrick, a Virginia Mason physician. And not just any patients: Those demanding enhanced access to primary care doctors were baby boomers, executives and retirees who were willing to spend extra for more personalized care – just the sort of patients that Virginia Mason couldn't afford to lose.

Like other nonprofit hospitals, Virginia Mason must demonstrate a "community benefit" to maintain its tax-exempt status – for example, by offering services below cost that benefit poor and uninsured patients (such as AIDS clinics or emergency rooms that take all patients regardless of their ability to pay). When wealthy patients defect to for-profit hospitals or doctors in private practice, Virginia Mason loses a badly needed source of revenue that helps offset the rising cost of delivering charity care.

Five Star Service Now Available

To fend off the competition and meet demand, Virginia Mason decided to launch its own boutique primary care practice – the first nonprofit institution to take the plunge. In 2000, it opened the Lewis and John Dare Center, which combines "today's technology with old-style service," according to its Web site. For an annual fee of \$3,000, or \$5,000 for couples, five Dare Center physicians provide about 1,200 patients with round-the-clock access by mobile phone; next-day, no-wait appointments; home visits, when requested; and greater coordination of patients' specialist physicians. Kirkpatrick, who is one of the Dare Center's founding physicians, says that patients pay for enhanced convenience and access to their doctors, not for a superior level of medical care. On those points, the Dare Center is succeeding: Since the service launched, it has enjoyed a near 95 percent retention rate and high patient satisfaction scores.



A growing competitive threat forced Seattle-based Virginia Mason Medical Center to open its own boutique primary care practice.

The Dare Center is not alone. Healthcare industry expert Paul Mango, a director in the Pittsburgh office of management consulting firm McKinsey & Company, estimates that between 5 percent and 10 percent of the nation's nearly 3,000 nonprofit hospitals are experimenting with boutique healthcare service models, also known as "concierge" services, which typically involve primary care or luxury hospital rooms. Mango expects growth in these services to accelerate in 2005. "There will be a much more value-conscious consumer who will want them and be willing to pay for them," he says.

Not surprisingly, New York City has become something of a haven for luxury hospital accommodations, which patients pay for out-of-pocket. Mount Sinai Hospital's dedicated floor, Eleven West, is considered an industry leader. In addition to its nursing staff, it employs a nonmedical staff of 30, supervised by managers who typically have a background in the hotel industry. Eleven West offers 19 elegant rooms ranging from \$595 to \$1,600 a night, seven of which face Central Park. Its kitchen staff bakes bread daily and can prepare up to 13 different diets, according to doctor's orders. Family members can visit any time of the day or night and order their own meals. Tea is served daily at 3 p.m. Eleven West was launched in 1993 to meet anticipated patient demand. Today, it generates profits of more than \$1 million

PHOTOGRAPH COURTESY OF VIRGINIA MASON MEDICAL CENTER



annually on about \$2.5 million in revenue.

If boutique services sound controversial, they are. Critics contend that enhanced access and amenities really do translate into better medical care – and that further splits a medical system that’s already deeply divided between the haves and the have-nots.

Additional Revenues for Charitable Mission

By segmenting their customers and providing premium services to those individuals who are willing to pay for them, however, nonprofit hospitals have hit on a solution for driving incremental revenue. Both the Dare Center and Mount Sinai transfer profits into their general operating budgets, where the funds can be used to support emergency care, community outreach, and other programs.

The Dare Center, for instance, uses its profits to benefit the Seattle community at large. In 2003, it earned about 25 percent profit margins on annual revenue of about \$1.7 million, funds that Virginia Mason Medical Center used to offset the cost of paying for patients without insurance, hospital services that lose money, and community-related services such as the hospital’s free clinic and its heart and cancer programs. With the Dare Center hitting its five-year anniversary in January, “Hospital administration is happy,” says Kirkpatrick.

The potential market for boutique services could be significant, according to a national consumer survey conducted by McKinsey. As outlined by Mango and Maria Gordian in a recent issue of the firm’s publication, *The McKinsey Quarterly*, “The average 600-bed nonprofit hospital, in a city of 1 million people with average incomes, could generate meaningful incremental revenues by offering boutique services for access, integration, and comfort and convenience.” And with margins of 30 percent to 55 percent, the authors added, boutique services could add as much as \$6 million in incremental profit annually.

Selling It Internally and Externally

Nonprofit hospitals considering some form of boutique care must tread carefully. The risks and considerations aren’t just ethical and reputational; on a practical level, they also involve startup costs and span the legal, regulatory, marketing, and staffing disciplines. Most importantly, a nonprofit hospital with a market for boutique care must weigh the benefits of extra revenue and patient retention against potential internal

and external criticism that boutique healthcare favors the wealthy at the expense of the poor and uninsured. This issue is particularly acute when it comes to launching boutique primary care practices. “There was a lot of debate among the powers that be,” recalls Kirkpatrick, who could speak for many of his colleagues in the nonprofit medical community who have launched such practices. “The question was, ‘Should a medical center with a mission statement differentiate its services for a different population?’ The debate was heated at times.”

Internally, Kirkpatrick adds, it’s important to let physician-specialists and other hospital stakeholders know that the bou-

Eleven West offers 19 elegant rooms ranging from \$595 to \$1,600 a night, seven of which face Central Park.

tique primary care practice isn’t creating an expectation of faster or better service for patients throughout the institution. To help reconcile boutique services with the charitable mission, says Kirkpatrick, an institution needs an internal champion and a management team that’s looking for innovative ways to deliver care and help the bottom line. “An institution has to get employees to see why it’s good for the business,” adds Mango. External communications are also critical – in particular, learning how to market boutique ser-

vices so that nonprofit hospitals can find a customer base. In that regard, consistently high patient satisfaction can help power word-of-mouth marketing, perhaps the most powerful and cost-effective way of finding new patients.

Serving the Core Mission

Still, safeguarding an institution’s reputation is paramount. That’s why some nonprofits have taken steps to diffuse the most searing criticism of boutique medicine: that doctors who convert to a boutique primary care practice end up dumping patients who can’t afford their retainer fees. The Encina Practice, a two-doctor boutique primary care service of the nonprofit Palo Alto Medical Foundation in California, hired more physicians to take on patients that didn’t wish to follow their physician to the boutique service when it launched in 2003, says Dr. David Druker, the foundation’s president and CEO. The Encina Practice uses about \$500,000 of its annual revenue to subsidize healthcare for lower-income patients in the community.

Tufts-New England Medical Center in Boston has gone even further. Doctors who joined the Pratt Diagnostic Center, its boutique primary care practice that launched in 2003, kept all of their patients by splitting their time between the

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center and the parent institution's general medical practice. "The biggest challenge is balancing the two clinics," says Dr. Brian Cohen, Pratt's general medical director. The center intends to begin transferring roughly \$350,000 to \$400,000 in annual revenue to Tufts-New England Medical Center's primary care practice within a year or so. This practice loses more than \$1 million annually – about on par for a major teaching hospital.

Treating Patients like Customers

Nonprofits contemplating jumping into boutique services must also contend with high fixed costs and business process enhancements. To launch luxury hospital wings, institutions such as Mount Sinai's Eleven West must commit substantial capital for renovations and enhancements. Christi Knee, director of guest services, says the floor spent roughly \$50,000 last year just to repaint, replace china, and cover other recurring maintenance expenses that many hospitals may choose to ignore. And to make projected revenue,

Eleven West must book 11 of its 19 rooms at all times (typically not a problem). For both boutique hospital accommodations and primary care practices alike, hospital staff must learn how to combine medical and nonmedical services to create an overall differentiated experience while also treating paying patients like customers – something that can't be taken as a given in an industry that often gets low marks for service.

Boutique medicine may be controversial, but critics and supporters alike can agree on one thing: It's a practical response to broader pressures in the healthcare industry that are driving up costs and eroding the quality of care. Boutique care won't help heal the injured American healthcare finance system, but the Dare Center and other such innovators are proving that segmenting services for patients who are willing to pay for them can enhance care for everyone. For nonprofits, after all, there can be no mission if there's no money to pay for it. □