Perspectives

Extortion and the Ethics of "Topping Up"

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In November 2008 Professor Mike Richards issued his much awaited review of the British Department of Health's policy on out-of-pocket payments (''top-ups'') for drugs not approved as cost effective by the National Institute for Health and Clinical Excellence (NICE). The policy stated, or had been construed as stating, that those who top up thereby became ineligible for further National Health Service (NHS) treatment for the condition targeted by the drug.[1] For instance, if a lung cancer sufferer bought Avastin, which is not NICE approved, she could no longer receive free treatment for her cancer on the NHS's tab. Richards, the National Cancer Director, recommended that the policy be repealed. From an ethical point of view, this change should be enthusiastically welcomed.

This is not to doubt, as some have, whether unfettered access to unapproved drugs will lead to increased inequalities in healthcare access between the rich and the poor. Rather, one should question whether ethics permits the use of a penalty on topping-up in order to prevent such inequalities. Supporters of the penalties on topping-up policy make two main points in its favor.[2] First, tiered healthcare systems in which some healthcare is available only to those able to pay are unjust. Second, injustice aside, the private purchase of drugs should be disincentivised in order to prevent deterioration of the NHS's ability to deliver high-quality healthcare. For instance, it stands to reason that a robust private market in drugs will drive up the price of currently existing drugs and discourage the development of drugs that meet NICE's cost-effectiveness standard. This would leave the NHS handicapped in its effort to provide cost-effective drugs. Furthermore, there is a legitimate concern that the NHS will be stuck footing the bill when those who buy unapproved drugs end up needing treatment for the side effects of those drugs. In addition, there is the worry that too much topping up will cause support for robust, comprehensive public provision to wane. The idea is that if the wealthy are permitted to pay for drugs, without penalty, when they need them, then they will be less likely to see themselves as needing the NHS. At the same time the less wealthy will be sapped of *their* enthusiasm for the NHS as they begin to perceive that they are not receiving the highest quality care available.

With regard to the first point, it is not entirely obvious that a two-tiered healthcare system, in which everyone has free access to NHS care and some have the opportunity to top up with private care, would be unjust. In such a system, either the NHS delivers all the healthcare to which citizens are entitled to as a matter of justice, or it does not. If it does, then those who

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cannot afford to top up have no basis for complaint. If it does not, then those who cannot afford to top up have a valid complaint regardless of whether others top up. After all, top-ups by the affluent do not make the less affluent any less healthy.[3]

To avoid this dilemma, it would have to be claimed that the entitlement is not to any absolute level of healthcare, but rather to equal provision of healthcare *at any level*. This proposal seems to be egalitarian, but is it really? We know quite well who is favored by a system that mandates that everyone have access to the exact same health services: the people who, for whatever reason, are less apt to get sick. There is, of course, nothing we can do to eliminate variations in susceptibility to disease and injury. Nevertheless, it seems positively *inegalitarian* to exacerbate the problem by putting out of reach the one remedy that the more illness prone would otherwise have: the option to add private medical care to their NHS coverage.

Taking up the second point, some have questioned whether easier access to unapproved drugs will undermine support for the NHS in light of the fact that there is already a thriving private healthcare market in Britain.[4] Others doubt that drug prices will rise as a result of increased topping up,[5] and still others are optimistic that a tiered healthcare system can be designed such that the public tier can be insulated from additional costs owing to the presence of a private tier.[6] Suppose, however, that topping-up penalties really were necessary to prevent these harms to the NHS. Is the preservation of a robust NHS so crucial that it would then be right to impose such penalties? Ironically, it is the very importance of the NHS that suggests that the answer is no. Presumably, the NHS is important because it delivers to citizens something to which they are entitled as a matter of justice: comprehensive healthcare at no charge. But if this truly is something to which one is entitled, then threatening to withhold it unless certain demands are met (i.e., no topping-up) constitutes extortion. If, on the other hand, quality state-sponsored healthcare is not an entitlement, then one can hardly object when others behave in ways that lead to reduced support for it.

The case for tiering—and, by extension, topping up—is simple. Every citizen of a relatively wealthy country has a claim, based in justice, to a comprehensive set of health services.[7] In addition, however, each citizen also is endowed with a broad liberty to use her money as she wishes, as long as doing so is compatible with the securing of justice. Consequently, there should be a private healthcare system in addition to a public system. In the British context, it has been argued that a penalty for topping up is necessary to protect the public system. This may very well be the case, but protecting the public system by threatening to revoke access to it for those who top up seems perverse. Such a radical response to the problem would be ethically justifiable only if topping up were itself intrinsically unjust. But the arguments for this claim are weak. The sense that the poor are in some way victimized by the private purchase of drugs seems to lack a foundation. And so it is the now defunct policy that may rightfully be condemned as unjust. Moreover, because it never made anyone any healthier, the policy made the NHS appear less "caring and compassionate,"[8] thereby feeding the very distaste for the NHS that it was supposed to avert.

Notes

1. Department of Health. A code of conduct for Private Practice. London: Crown; 2004; available from http://www.dh.gov.uk/en/

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8. See note 6, The King's Fund 2008.

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