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## **Crocodile Tiers** (word count: 854)

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### Summary

Recent cases have highlighted the NHS policy of forcing those who pay for supplementary private treatment to also pay their NHS costs. The Health Secretary has argued that this is necessary even when the NHS cannot afford a potentially life-saving drug and the only alternative is to buy it privately; this is because the alternative would be “a two-tier NHS”. In fact, this attitude is mistaken and hypocritical. First, a two-tier NHS already exists inasmuch as some drugs are available in some areas but not in others (the “postcode lottery”). Second, the recent introduction of a revolutionary scanner funded privately and dedicated 25% of the time to employees of the funder indicates that two-tiering is acceptable in circumstances where the alternative is clearly worse. And third, the enforcement of this policy of making people pay for their NHS treatment itself creates a three-tier system: people who can afford to pay both their private and NHS costs and thus survive; those who can afford private care but not also NHS fees and will die as a consequence; and those who can only afford NHS care and will also die. It is clearly unethical for the NHS to tell people that they will die unless they pay for private treatment, and then to tell them that if they pay for private treatment they will have to pay the NHS for its independently inadequate service, particularly if people in other parts of the country are receiving all the drugs they need for the same condition on the NHS. It may also be illegal to make people pay for the NHS twice, once through their taxes and again if they go private.

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### Provenance

The author wrote this paper in response to the controversy around and lack of professional commentary on current NHS policy on “topping up” NHS treatment with private care. His expertise is in medical ethics and moral philosophy.

## Crocodile Tiers

Over the last few weeks there have been several prominent stories in the national press about people being forced to pay for their NHS treatment because they have chosen to pay for supplemental private care. One case is that of Jack Hose, who has bowel cancer and was prescribed irinotecan on the NHS, but it was not effective.<sup>1</sup> Refusing to give up, Mr Hose was privately prescribed cetuximab in combination with irinotecan with some success. His local NHS trust has now informed him that if he continues to pay for private care, he will also have to pay for all his NHS care, including repaying the cost of his original irinotecan prescription. Alan Johnson has supported this stance, claiming that to do otherwise would create “a two-tier” NHS. In fact, this attitude is unethical and self-contradictory.

First, a two-tier NHS already exists inasmuch as some drugs are available in some areas but not in others because of trusts’ individual funding decisions. It is disingenuous to claim that a two-tier NHS is unacceptable when of the notorious “postcode lottery” means that there are potentially as many tiers as there are trusts.

Second, another recent example indicates that a two-tier approach is acceptable to the NHS acceptable in circumstances where the alternative is clearly worse in terms of patient outcomes. At the end of May it was announced that the Royal Bank of Scotland has bought and will pay the running costs for 5 years of a revolutionary 3-D CT scanner at Edinburgh Royal Infirmary.<sup>2</sup> This has proved controversial because of the strings attached to the £4 million gift: 25% of the scans will be exclusively for the Royal Bank’s employees. Despite claims to the contrary, this is a clear example of priority access for a specific group that has no priority clinical need. In any case, it seems that NHS Lothian is being pragmatic here: regardless of concerns about equality of access, it would be counterproductive to insist that a two-tier system must be avoided when allowing this slight inequity will be beneficial to thousands of NHS patients, and the alternative is not to have access to the scanner at all. This pragmatism is admirable, but it is unfortunate that it is not being applied in cases like that of Jack Hose.

Third, Johnson’s anti-two-tier stance actually creates a three-tier system of its own when it is actually applied. It is a mistake to assume that all those who can afford some private treatment can also afford to fund their basic NHS care. First, we have people who can afford to pay both their private and NHS costs and thus survive. Then we have those who cannot afford both and may die as a consequence. And finally we have those (probably the majority) who cannot afford any private treatment in the first place and must simply wait to die (as Jack Hose and others in his situation were told to do before seeking private treatment). In other words, the potential effect of the NHS’s policy on preventing a two-tier system actually creates a three-tier system where the very rich can afford to pay for both private and NHS care, the well-off can afford to pay for private but not also NHS, and the poor can only rely on the NHS. In effect, current NHS policy discriminates against those who fall into this middle category in a misguided attempt to make everyone fit into the last. Not only does Johnson’s policy sacrifice utility on the altar of equality, it actually subverts the very principles of equity that it claims to defend.

It is clearly unethical for the NHS to tell people that they will die unless they pay for private treatment, and then to tell them that if they pay for private treatment they will have to pay the NHS for its insufficient service. This is all the more true if people in other parts of the country are receiving all the drugs they need for the same condition on the NHS. One final point is worth mentioning: even were it not for the existence of postcode lotteries and the flawed logic of the current NHS policy, what is the ethical

basis for denying free NHS treatment to someone who has paid taxes and national insurance contributions all their life? Even if they are rich enough to go completely private, they have paid as much as any other citizen and are entitled to NHS care. Otherwise we are left with a second tier of those who must pay twice for the NHS, but only when it lets them down. As well as being unfair, this might well be illegal.<sup>3</sup>

When we add this final charge, the case against current policy seems unanswerable. Patients who discover that they NHS care that they have paid for will not keep them alive should be able to supplement their care privately if they can afford it, without the added burden and insult of being told their independently inadequate NHS care will cease unless they pay for it too. Mired in self-contradiction as it is, the NHS's "anti-two-tier" policy must change.

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