Mind the Gap: ethical issues of private treatment in the public health system

Elizabeth Fenton

Abstract

The funding of expensive new cancer treatments is a difficult health policy issue in New Zealand and around the world. Since the public health system cannot afford to fund every new treatment, complex decisions must be made about which treatments to fund publicly, and whether and how to make unfunded treatments available to people who may wish to fund them themselves. One recent proposal is that unfunded treatments be made available to patients privately through the local public hospital. Although ultimately declined by the health minister, this proposal merits serious debate, since it is likely to continue to attract attention as a policy option.

While the integration of public and private delivery systems has clear benefits for patients with the means to purchase additional treatments, its overall effect may be to exacerbate existing inequities in the New Zealand health sector. This paper briefly explores the wider ramifications of such schemes as part of the ongoing public discussion that should inform the development of health policy on this issue.

The Southern District Health Board recently proposed a pilot scheme in which patients seeking treatments that are approved for use but not funded through the public health system can receive those treatments in a public hospital, provided that they pay for the treatments, and any additional incurred costs, with their own funds. The goal of this scheme was to “bridge the gap” between the treatments that the public health system can afford or decides to fund, and the treatments that patients want to receive.

Given the recent surge of extraordinarily expensive cancer drugs on the pharmaceutical market, it is not surprising that the primary focus of this scheme (as of similar “top up” schemes in Canada and the United Kingdom) was the provision of cancer treatments, which are, in many cases, outside the reach of publicly-funded health care systems. Since schemes like Bridging the Gap propose novel partnerships between the private and public health systems, and are likely to continue to emerge in policy discussions, care must be taken to explore the ethical issues they raise, particularly issues of fairness and equity.

Bridging the Gap

The scheme proposed for the Otago-Southland region was motivated by the unavailability in the public health system of new and often expensive cancer treatments. There are two principal reasons for this unavailability. First, some of these treatments are not government funded and so are not available through the public health system in which these patients may already be receiving treatment. Patients who want to access these treatments pay the cost of the drugs themselves and the
costs of administering the drugs in a private setting. Second, private facilities in the relevant geographic area are unable to administer the treatments, so that patients who wish to receive them must travel away from home. For those patients for whom the drugs are an addition to the regimen they are already receiving, travelling to another centre is not only costly but may lead to fragmentation of care; for other patients their health may make such travel impossible or very difficult.

Bridging the Gap proposed that currently unfunded drugs be made available to patients willing to fund them in a designated ward in the public hospital. The principal benefit of such public-private integration of care is that it obviates the need for patients who are already receiving treatment in the public system to fragment their care and incur the full costs of treatment in order to receive drugs that they are willing to fund themselves. In addition, it addresses what proponents see as one of the principal equity issues in access to this form of care, namely that patients who live in areas well served by private facilities have access to additional self-funded treatments without needing to travel, while those living in rural or less populated areas have to go without or travel long distances.

The argument in favour of such schemes assumes that patients ought to have access to the currently unavailable drugs; it is claimed that their unavailability represents an “unmet need” for patients. This argument assumes that patients’ lack of access to these drugs is in some way unfair or unjust, but it is not clear that lack of access to these treatments is always an issue of justice. To see why this is the case I will consider two arguments in support of the case that lack of access is unjust. I hope to show that these arguments are unpersuasive and that attempts to rectify the supposed injustice through schemes like Bridging the Gap could exacerbate rather than address existing inequities in the health system as a whole.

Availability and public funding of expensive cancer treatments

The first argument that lack of access to unfunded cancer treatments is unjust locates the injustice in the government’s failure to fund the treatments through the public health system, thereby making the treatments available to everyone. On closer inspection, however, the reasons for this lack of funding make it far from clear that it is an issue of justice. Public health systems have limited resources, and cannot afford to fund every treatment that is available on the market. They must try to ensure that the resources they have are used to produce as many health benefits as possible, while striving to distribute those benefits equitably throughout the population. To this end, agencies like PHARMAC evaluate new treatments to ensure that, if purchased by the government, they are getting good value for money.

While this strategy is open to criticism, both moral and political, it is important to remember that no health system can afford to pay for every treatment that every patient may want. In order to be fair to all users, the system must evaluate not only the financial costs of a new treatment, but also its opportunity costs—those treatments that must be foregone in order to fund the new treatment.

It is sometimes argued that the failure to fund new cancer treatments puts New Zealand out of step with other countries, and places the patients in the public health system at a disadvantage. This argument assumes, however, that availability in other
countries is a matter of settled consensus, when in fact it may mask significant controversy about whether these treatments ought to be available.

In the United States for example, where government health programs are legally prohibited from using cost or cost-effectiveness measures as a factor in decision-making, oncologists and others have questioned whether many of the new cancer drugs offer sufficient health benefits to justify the prices patients, insurers, and the government are being asked to pay.\textsuperscript{2,7,12,15}

There is no doubt that New Zealand could spend a higher proportion of its GDP on health, and a higher proportion of its health budget on cancer care. Such increases might temporarily provide funds for a specific service or treatment, but are not a permanent solution for difficult resource allocation problems. No matter how large the health budget, if it is limited at all, as it must be to ensure sufficient public funds for other social goods, there remains the problem of deciding how to allocate that budget fairly.

In order to be fair to all users of the health system, treatments that are less cost-effective, or too costly, sometimes have to be foregone. The alternative is to provide all treatments, no matter how small their benefit or how high their cost, to all patients who want them. Since this alternative is neither rational nor ethical when resources are limited,\textsuperscript{2} the unavailability of certain treatments is not unjust.

**Availability and impact of private health services**

Since the unavailability of expensive cancer treatments in the public health system is in some cases justified, we can now turn to the second argument claiming that lack of access to unfunded treatments is unjust. This argument might concede that the government cannot and ought not to fund every available drug, but argues that it is unjust that patients willing to pay for additional services are unable to access those services for reasons that are outside their control, such as a lack of access to private facilities.

This argument takes the existence of the private health sector for granted, and is concerned with the way in which access to that sector is distributed. To be sure, when access to a good is determined by factors that are arbitrary or morally irrelevant, questions of fairness are rightly raised. But there is an important prior question about whether the existence of private health care, which is accessible only to the wealthier members of the community, itself raises issues of justice that might be exacerbated by programs that seek to integrate private health care into the public system.

In New Zealand, as in many other countries, a private health care system exists alongside the public system. In favour of this two-tier arrangement it is argued that provided everyone has equal access to an adequate package of core health care benefits, allowing some to pay to access more and better care is not unfair or unjust. In fact, this protection of people’s liberty to spend their own “legitimately held” wealth on beneficial goods or services may itself be a requirement of justice.\textsuperscript{10} Moreover, since governments cannot afford to pay for every possible drug or intervention, some health services simply will not be available in the public sector. The private sector provides those with greater wealth the ability to purchase what they cannot receive in the public sector.
On the other hand, it can be argued that a two-tier health system is fundamentally inequitable, since it allows some to access more and potentially better health care based on ability to pay, rather than on morally relevant characteristics such as medical need or capacity to benefit from treatment. This may result in health inequalities between rich and poor. Importantly, however, some inequalities are more morally troubling than others.

If the public health system is maintained at a sufficiently high level, ensuring that everyone has access to at least a “decent minimum” of health care, then the inequalities engendered by the existence of a private health care system will occur at the “top” rather than at the “bottom”—i.e., above rather than below the point of access to a “decent minimum” of health care. These inequalities are less worrisome from the point of view of justice than inequalities between those who have access to no or very little health care and those who have access to full health care.

Nevertheless, two-tier health systems do raise important moral concerns. In particular, it is misleading to characterise private services as merely an “add on” or “top up” to what is offered in the public sector. Rather, the interaction between the two tiers of the system is complex and can negatively affect the viability of the public sector, either by draining resources or by reducing pressure on the government to maintain the core benefits package at an appropriately high standard. In addition, where a private system exists, use of the public system by the wealthier classes may decrease, which not only reduces support for the public system, but also threatens the stability of its funding and the extent to which improvements in services are lobbied for.

Allowing the purchase of additional private health care is not simply an innocuous bow to personal liberty, but a potential threat to the integrity of the public health system as a whole. A further concern is that in dual private-public health delivery systems the public system inevitably underwrites and subsidises the private system, as happens when patients opting for private care require further services that only the public system can provide. In such cases private patients do not pay the real cost of treatment in the private system, with those costs being passed on to the public, tax-funded system.

New Zealand’s ongoing support for or tolerance of a two-tier health system suggests that it is willing to tolerate the inequalities that are part and parcel of that system. It is not clear, however, that tolerance of a largely separate private health care system extends to the provision of private health care wherever and whenever is most convenient for the patients. It is important to ask, then, whether the integration of private care into the public system, through schemes like Bridging the Gap, introduces particular forms of harm or disadvantage that exacerbate levels of inequality that people have previously been willing to tolerate.

**Equity between patients**

With respect to individual users of the public health system, it might be argued first that public patients are disadvantaged by such integration schemes to the extent that they receive fewer health benefits than private patients. This is not necessarily the case, however, since the treatments the private patients are paying for may not deliver more or better health benefits.
Second, it might be argued that public patients will be harmed by the diversion of important resources to private patients, particularly resources such as bed space and nursing care that carry opportunity costs. This is an important harm, but one that could be limited by the way in which the scheme is arranged. For example, the scheme could be limited to patients already receiving treatment in the public system, such that additional treatment requires no resources that would not have been used anyway.

Alternatively, private patients could be admitted only when bed space permits, or, in principle at least, the treatment could be priced far enough above cost to ensure that resources are not removed from the public system, and may even be added to it. While this is possible in principle, in practice charging too high a fee would defeat the purpose of the scheme, creating a potential gap between the cost to the system of providing the service and the fees patients are charged to use it. A risk thus remains that this scheme will harm other patients in the system by diminishing resources available to them.

Third, it might be argued that public patients being treated for cancer will be psychologically harmed by the knowledge that other patients in the hospital with the same illness are being treated differently simply because they have the financial resources to purchase additional treatments. This is a significant source of potential harm. Commentators on a similar scheme in Canada noted that such differential treatment within the public system “could be considered an insult to human dignity.”

In the United Kingdom a commissioned report on the proposed “top up” scheme for the National Health Service (NHS) argued that allowing differential care within an NHS hospital, while the most convenient and inexpensive option for the private patient, is “by far the most overtly inequitable option” for other patients in the hospital receiving standard NHS care. It is principally for this reason that the report recommends against integrating private care into NHS hospitals.

A potential solution to this equity issue, suggested in the Bridging the Gap proposal, is that patients receiving self-funded drugs be treated in a separate ward in the hospital. Under this arrangement patients receiving different treatment for the same condition would not confront each other in the same ward, thereby, it is suggested, lessening the extent to which the non-paying patient will feel “let down” by the public health system.

It is not clear, however, that the visibility of private fee-paying patients is the principal equity issue raised by such schemes. As has already been noted, in all public health systems resource limitations mean that some treatments must be foregone when they have been judged to be not good value for money compared with other possible uses of resources, or are simply unaffordable for the health system. These are difficult judgements to make, which is why they are entrusted to agencies like PHARMAC in New Zealand and NICE in the UK that strive for careful, objective and transparent decisions.

While sometimes unpopular and controversial, these decisions are in one important sense fair: they take into account the needs of all users of the health system, and so effectively share the burden of health care rationing across all users of the system. When private health care is integrated into the public system, the fairness of this
rationing process is undermined, since not all users of the system share equally the burden of limited resources.

Patients who self-fund additional treatments that they then receive in the public system receive the benefits of that system, but they do not share in its costs—that is, its opportunity costs, what it must sacrifice in order to provide a good level of service for everyone.

The unfairness and inequity between private and public patients receiving different care in the public system is not that one sees the other receiving different care; rather, it is unfair that the fee-paying patient enjoys the benefits but does not bear the burdens of public health care. Although treating private patients in a separate ward may reduce the psychological stress on non-paying patients, it does little to remove the inequity created by their differential treatment.

**Health system implications**

In addition to the disadvantages for other users of the public health system, schemes like Bridging the Gap have important implications for the health system as a whole.

First, such schemes could increase health sector costs. In part this is because patients who want these additional treatments are often willing to pay high costs for relatively small benefits. This both disincentivises pharmaceutical companies from pricing their drugs in line with their value,¹ and undermines the ability of agencies like PHARMAC to negotiate with drug companies for lower prices.¹¹

If pharmaceutical companies know that patients are willing to pay their high prices privately, they may be tempted to bypass the public sector altogether. Since PHARMAC’s negotiating power generates significant savings for the New Zealand health sector,⁶ such schemes could lead to higher costs without increased health benefits. Moreover, the increased availability of the treatments, and the perception that their use in the public sector is an endorsement of their effectiveness¹¹ may increase pressure on the government to fund high-cost cancer treatments that have been judged, by a careful deliberative process, to be not cost-effective for the public health sector. Such spending increases will mean less money available for other important health services.

Second, the existence of a private health care system can provide governments with a reason not to expand or even to reduce the package of core benefits available through the publicly funded system. It is important, then, that when new treatments become available schemes like Bridging the Gap do not act as disincentives for inclusion of those treatments into the publicly funded system.

These concerns thus pull in different directions, emphasising the complexity of the interaction between the two tiers of a public-private health system. On the one hand, integrating private health services into the public system might force the government to spend money on additional, possibly unaffordable, treatments for one disease, thereby exacerbating inequities in the system between disease groups and potentially reducing the efficiency of the health system as a whole. On the other hand, such integration might push advanced cancer treatment into the realm of private health care, thereby creating or exacerbating inequalities between rich and poor patients with the same disease.
This last point is an especially troubling one. As the background material for Bridging the Gap noted, cancer is the leading cause of death in New Zealand. It is also true, but was not mentioned in the document, that cancer affects some population groups more than others.

A recent study showed significant differences in mortality from colon cancer between Maori and non-Maori, due in part to unequal access to health services for Maori. To the extent to which schemes like Bridging the Gap will further increase those differences, both in access to services and in health outcomes, by making more treatments available to those who can afford to pay, their claim to be meeting “an unmet need” for patients is unpersuasive.

The greater unmet need that public hospitals should be striving to meet is that of equitable access to their services for everyone, but particularly for those who are disadvantaged and at risk of worse health outcomes. To this end, making room for the provision of treatments that are distributed on the basis of ability to pay should be given lower priority than addressing those unjust health disparities that already exist.

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Author information: Elizabeth Fenton, Visiting Scholar, Institute for Practical Ethics and Public Life, University of Virginia, Charlottesville, Virginia, USA

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Correspondence: Dr Elizabeth Fenton, Institute for Practical Ethics and Public Life, University of Virginia, PO Box 400800, Charlottesville VA 22904, USA. Email: emf7u@virginia.edu

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