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Commentary

As a moral concept equity embodies ideas of fairness as justice.[1] As a word it is related to the morally neutral idea of equality, and most attempts to assess equity begin in a search for inequalities. Inequalities are not necessarily inequitable, and the definition of equity will vary with cultural values. Since 1948 British health and social services have been seen in part as instruments of social equity, but the last decade has imposed significant changes on the cultural assumptions underlying their design and operation. It is timely to examine the concept of equity to which health professionals should be working.

Equity transcends specialty frontiers. In restricting examples of 'vertical' equality to the field of paediatrics, Reading avoids the issues of assessing equity in the total social context.[2] The community paediatrician will not necessarily solve problems of equity by improving the take up of vaccination if this is achieved at the expense of services for stroke patients. Technical and ethical problems in the equitable commensuration of the wellbeing of different individuals have yet to be satisfactorily resolved.[3 4]

Inequities may be detected in inequalities in service provision, access, use, and outcome. Inequalities of provision must be evaluated in their relation to inequalities in need, bearing in mind that if services are effective they should in time remove the needs they address. The concept of need raises its own problems of definition[5] but is nowadays seen primarily as a measure of ability to benefit; it seems poor logic to define people as being in need of something that would do them no good if they obtained it. We know little about the parameters of effectiveness of most of the services that health and local authorities offer and the public expect. How much does a 15% difference in pertussis vaccination actually matter? What are the opportunity costs of correcting it? One of the problems for the Black report was the lack of sufficient evidence that the interventions it proposed would actually work.[6] An unexpected benefit of inadequate resources may be a new paradigm for research by making it ethical to carry out randomised controlled trials of withholding interventions.[7]

Reading exemplifies concern about equity in the ability of fundholding general practitioners to enable their patients to jump queues[2]; we might fear more the incentive in fundholding for general practitioners to prevent the access of their patients to expensive forms of secondary care. Any effects of this will fall most heavily on the less educated and less demanding classes. Personal opportunity costs will also contribute to differential use of services and raise what may be a crucial dimension to the contemporary concept of equity, that of perceived desert. The opportunity costs of a bus fare and of a missed episode of 'Neighbours' may be large and equivalent to an indigent mother who decides for one reason or the other not to take her child to an immunisation clinic; they may not be seen as equivalent by the providers and purchasers of immunisation services, nor by the majority of middle class taxpayers who fund them. When Reading[2] writes of 'increasing the value that poorer families place on comprehensive preventive health care' he is working to a traditional model. Is it still the public view that the state has a right and duty to protect children against the cultural values of their parents? Where do we now stand in the general case about freedom of choice and multicultural autonomy if they cause inequalities? In an affluent and civilised nation the major preventable factors in illness lie with lifestyle and personal choice. The 'new order' of the 1980s began from the notion of personal responsibility 'rolling back' a paternalistic state. Personal responsibility and choice may have little meaning for the poor (who are still with us) but does equity require that they alone remain wards of the state?

In a democracy the public must accept ultimate responsibility for the equity of its institutions and so we must divine what the public expects of its servants in the health and social services. Presumably the result of the last general election implies public acceptance of the market ethos claimed to underlie the new NHS. In a perfect market 'good consumers'[8] with money, choice, and knowledge can obtain at efficient cost the services they demand, and these will be, by implication, the services they deserve. Moreover, the tradesman's principle of 'caveat emptor' removes moral responsibility from those who furnish, whether as 'providers' or 'purchasers', poor quality services. Unfortunately for the consumers of British health services, they are not the emptors of the idealised

market model for they do not hold the money, they have even less choice under the new NHS than under the old, and very few have sufficient knowledge to assess the quality of the care being offered.

In the same tradition as that espoused by Reading, it has been suggested that 'provider' health professionals should inherit the moral responsibility for the welfare of an unsophisticated public that suffused the old NHS.[9] This role might now be depicted as anachronistic paternalism and would not be easy to maintain against opposition from management. It would also not survive professional groups competing with each other. But where else are the knowledge and commitment necessary to guard the public interest? In the *realpolitik* of the new NHS, health authority 'purchasers' are primarily the agents not of the customers of health services but of the purveyors in central government.

Equity could prove a treacherous concept if it means different things to different people; 'inequity' is a conventional but still potent battle cry for people with axes to grind. As injustices, inequities are not to be tolerated, but their removal may require a privileged and possibly inefficient use of public resources that could generate new inequities. As a society we need a more explicit ethical system. As health professionals we owe the public a unified appreciation of how the costs and benefits of adjusting inequalities for one group of the population will affect others.

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