powers. These include the ability to cure cough—the point of the dagger is dipped into a cough syrup before ingestion. The kris has not, to our knowledge, been used on a metered dose inhaler. Pieces of jade are commonly invested with healing properties by many Chinese families, and some Indian families “disguise” their asthmatic children with make up so that avenging gods do not recognise them and cast illness on them.

Conclusions

Many of the above practices are anecdotal and hint at superstitious quackery, but it is clear that the social consequences of asthma among children in Asian communities is very different from those in their Western counterparts. Pity the small child deprived of chilled drinks and ice cream in a tropical climate. It is easy to be scathing of non-scientific traditional practices, but something can be learnt for the benefit of all patients. Psychological factors are extremely important in determining the expression of asthma, and these have received little attention during the recent push towards a greater use of drug treatment in the Western world. Eastern treatments typically take a holistic approach to the problem of asthma and do not ignore this psychosomatic component of the disorder. Interracial differences in food induced symptoms suggest unexplored, genetically determined, pathophysiological processes that cause changes in bronchial

reactivity and the expression of atopy. Commonly used herbal remedies might yet stand the rigours of double blind, placebo controlled studies and become safe, acceptable alternatives to the anti-inflammatory drugs that are currently used by Western doctors.

Illnesses affect cultures, and cultural practices have a considerable effect on the consequences of illness. The rich diversity of culture in south east Asia cannot be matched anywhere else in the world. Discovering what Asian families believe about illness is not only fascinating but is essential in reconciling the differences between what doctors want them to do, and what they think they should do, about treating their children's asthma.

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Equity issues in the NHS

Who cares about equity in the NHS?

Margaret Whitehead

This is the first of a series of five articles about equity in the health services. Margaret Whitehead will be speaking next week at a conference on equity in the NHS organised by the Society for Social Medicine and the Public Health Alliance. The conference will be in Oxford on Thursday 19 May and the fee is £25. Further information is available on 021 643 7628.

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The concept of equity in relation to the National Health Service in Britain encompasses not one but at least eight distinct principles. Until the 1980s the NHS had a good record of incorporating these principles into practice. Throughout the 1980s, however, there has been a pronounced change, with the gradual introduction of business values into the service, culminating in the market based reforms of the 1990s. Several recent policies seem to be taking the NHS away from the goal of an equitable system—for example, the new arrangements for community care and the incentives within contracting to select patients on financial grounds. To restore equity as a value demands priority for ethical values, monitoring of policies for their effects on equity, some national planning, and a new debate about the entitlement to services such as continuing care.

Over the past decade successive reorganisations of the NHS have been presented as technical adjustments, to improve efficiency, quality, and patient choice but without affecting the basic equitable foundations of the service. The impression is of noble intentions, but if we dig beneath the rhetoric is the principle of equity being upheld and protected, or is it being quietly abandoned?

Why the NHS was established

In the midst of continual reorganisation it is easy to forget why the NHS was set up in the first place. The political consensus for change grew out of a widespread realisation that the prewar system was inequitable,

inefficient, and near to financial collapse.^{1,2} In the 1930s, for instance, only 43% of the population were covered by the national insurance scheme, mainly men in manual and low paid occupations and only for general practitioner services.¹ That left 21 million people, predominantly the wives and children of employed men, not covered by the scheme. The sick carried much of the burden of payment and could be faced with devastating bills.

Across Britain services were spread unevenly, with deprived areas poorly served both in quantity and quality of service. This arose because doctors needed to make a living from private practice and only in more prosperous districts could local authorities raise enough local taxes to provide a range of high quality public services. In some places the same practitioner provided a highly visible two tier service:

Sometimes middle class patients go to the doctor's front door and working class patients to the surgery door. One class of patient comes by appointment, the other is expected to take his turn and may have a considerable time to wait.³

A highly fragmented and unplanned service added to the haphazard and inefficient use of resources.⁴ For example, 1000 voluntary hospitals and 2000 municipal hospitals were all administered separately and often competed with one another. In 1945 the National Hospital Survey reported that in some places increasing competition for dwindling charitable donations had led to wasteful duplication of equipment and high technology processes in desperate ploys to attract funds.^{5,6} Competing hospitals were also reluctant to transfer fee

Principles of equity in the NHS

- Universal entitlement
- Sharing financial costs
- Free at the point of use
- Comprehensive in range
- Equality of geographical access
- Same high standard of care for all
- Selection on basis of need, not ability to pay
- Encouragement of a non-exploitative ethos

paying patients to a more suitable hospital because of the loss of revenue.

The basis of a more equitable service

Against this background a wide consensus formed in the 1940s about the need to build a more equitable service and what the principles and values of such a service should be.¹ The concept of equity in the NHS articulated by Aneurin Bevan, the minister of health responsible for introducing the NHS, and later by the Royal Commission in 1979⁷ was multifaceted, incorporating the following principles.

A service for everyone—Everyone was to be included in the scheme as of right, without having to undergo a means test or any other test of eligibility.

Sharing financial costs and free at the point of use—In the words of Bevan: "It has been the firm conclusion of all parties that money ought not to be permitted to stand in the way of obtaining an efficient health service."⁸ The method of funding chosen, through general taxation, was linked to the ability to pay.

Comprehensive in range—There was a clear commitment to extend coverage—to preventive, treatment, and rehabilitation services, covering mental as well as physical health, chronic as well as acute care.

Geographical equality—With the intention of creating "a national service, responsive to local needs,"⁹ came a commitment to improve the geographical spread of services.

The same high standard of care for everyone—The Royal Commission emphasised that this principle must be based on levelling up, not levelling down: "The aim must be to raise standards in areas where there are deficiencies but not at the expense of places where services are already good."⁷

Selection on the basis of need for health care, not financial position in situations of scarcity. People had the right to expect that no one would be able to gain access to a service ahead of others, by money or social influence.

The encouragement of a non-exploitative ethos, to be achieved by maintaining high ethical standards and by minimising incentives for making profits from patients. As the Royal Commission noted: "We are well aware that some of these objectives lack precision and some are controversial... We are aware too that some are unattainable, but that does not make them any less important as objectives."⁷

Before the NHS the poor had to rely on charity or go untreated. Here an eminent surgeon operates for free in a church hall

What progress in putting principles into practice?

Up to the early 1980s deliberate policies were being pursued, with varying degrees of success, to move towards a more equitable service. Throughout the 1980s, however, there has been a sharp change, with the gradual introduction of business values and encouragement of the private sector, culminating in the market based reforms of the 1990s. Butler summarised the four key developments in the 1980s which laid the groundwork for a change of ethos:⁶ (a) the introduction of general management from 1984, making the NHS more open to political influence; (b) the introduction of "income generation," releasing previous inhibitions about making profits and engaging in entrepreneurship; (c) the policy of making health authorities contract out some services, establishing the principle that it was not necessary to provide a service, only to commission or "purchase" it; and (d) the international growth of interest in market solutions to cost containment problems.

Working for Patients in 1989 built on these developments to promote the idea of competition and of exposing services to market forces to a much greater degree. But by its nature competition creates winners and losers. If balancing the books becomes the overriding consideration, then it could easily lead to a health service for groups who may have less need but be more lucrative. The losers in health care could be less profitable services, areas of the country, and groups in society. Three examples of progress and retreat on these values may clarify these points.

Entitlement and pooling of financial costs

In 1948 universal entitlement was accomplished at a stroke, as was making services free at the point of use, thus opening up a wide range of services previously out of the financial reach of large sections of the population. The system of funding largely through general taxation has persisted and has recently been assessed as one of the most progressive funding systems among 10 countries in the Organisation for Economic Co-operation and Development.¹⁰ Together these components of the system broke the link between the need for health care and the ability to pay for it—removing the fear of devastating bills. This has been rated as one of the NHS's greatest achievements.⁷

The principle of free treatment at the point of use, however, has been eroded, with the introduction, firstly, of prescription charges in 1951 and later of charges for dental and ophthalmic services. This policy of charging has continued under both Conservative and Labour governments but has accelerated in the 1980s. For example, the proportion of the total cost of the NHS in the United Kingdom derived from charges (prescriptions, dental fees, and private health care) rose from 2% in 1978-9 to 2.9% in 1984-5 and to 4.5% in 1990.¹¹ A much higher burden of charges falls on specific services such as dentistry and ophthalmic care (Department of Health, personal communication). The full effect of charging on access to these services is hard to gauge because it has occurred almost simultaneously with an exodus of opticians and dentists from the NHS.

CONTINUING CARE

The most disturbing erosion of the principle of entitlement to a comprehensive range of free services has been in continuing care. The shedding of responsibility for continuing care was made possible by a change in the social security regulations in 1980, allowing social security support to people living in private residential and nursing care. As a result there has been an explosion of such provision,¹² and hard pressed NHS managers have been only too willing to

HULTON DEUTSCH

Change in regional target funding by applying reduced weighting to standardised mortality ratios in capitation based formula (1988-9 figures)

Region	% Change in funding
Northern	-1.3
Yorkshire	-0.6
Trent	-0.8
East Anglia	-0.1
North West Thames	1.9
North East Thames	0.8
South East Thames	1.1
South West Thames	1.6
Wessex	2.8
Oxford	0.1
South Western	1.9
West Midlands	-1.7
Mersey	-1.1
North Western	-2.6

Adapted from Royston *et al*²⁰

transfer patients into private homes to relieve the NHS budget. The effect, however, has been to switch patients from a free service into a means tested one. Moreover, since 1993 patients have also had to undergo eligibility tests devised by their local authority, which vary across the country.

The evidence of resulting hardship caused to some patients and their relatives is mounting.^{13 14} In a case brought before the health service ombudsman in February 1994 the ombudsman condemned the action of a health authority in transferring a stroke victim to a nursing home for which his family had to find £6000 in top up fees. This brings back the spectre of devastating bills for health care. It also raises the likelihood of an expansion of the gradual transfer of free NHS services into means tested services, particularly in the non-acute and community health sectors.

Levelling up the standard of care around the country

When the NHS came into being it inherited such enormous inequalities in the pattern and quality of services around the country that a clutch of major policy initiatives was required to tackle the issue.

THE HOSPITAL PLAN

From the earliest days the redeployment of hospital staff around the country, made possible by having a unified service with salaried staff on national pay scales, resulted in an immediate increase in the number of specialists, junior medical staff, and nurses in poorly served areas of Britain.⁴ In 1962 the hospital plan represented the first attempt in Western Europe to plan a hospital building programme strategically to improve access for the population in each region. Much of the building work was completed, providing new district general hospitals in many parts of the country, but the programme ran out of steam when the money dried up in the 1970s.

PRIMARY CARE

In primary care the distribution of general practitioners was dramatically improved in the early years by the dual strategies of negative control (prohibiting new practices in well provided areas) and financial incentives (allowances for setting up in underdoctored areas), but progress had slowed by the 1960s. An increase in the total number of general practitioners in the 1970s produced a further decline in the number of underdoctored areas.¹⁵ In 1952 more than half the population of England and Wales lived in underdoctored areas, whereas by 1980 the figure was down to 5% per cent and has continued to improve.¹⁶ There was still, however, a serious quality divide between services in deprived and affluent areas reported in 1989.¹⁷

RESOURCE ALLOCATION FORMULAS

The introduction in 1976 of a national resource allocation formula (RAWP) was the first concerted attempt to base resource allocation for hospital and community health services on the need for health care rather than on the historical pattern of services. As standardised mortality ratio was used as a proxy for need, the formula favoured the relatively poorer regions of Britain, with their higher mortality rates.¹⁸ In 1976 the expenditure per head of population in the wealthiest regions was about 30% higher than that of the poorest regions. After a decade of the RAWP formula the gap had fallen to less than 10%.¹⁹ In that respect the formula succeeded in reducing regional inequalities but as it was applied at a time of severe financial restriction, the reduction was achieved by cutting the resources to the wealthiest regions at the same time as improving those to the poorest.

MORE RECENT POLICIES

All these policies represented serious attempts to tackle geographical inequalities in health care, a commitment which seems to be lacking in more recent policies. For example, by reducing the weighting given to standardised mortality the new capitation formula introduced in 1991 has channelled resources away from the less affluent regions with high premature mortality, mainly in the north, towards those with lower premature mortality, mainly in the south and east (table).²⁰ Regions have been encouraged to use the same formula for subregional allocations, but again the effect has been to shift resources away from some deprived inner city districts with high mortality and morbidity to more prosperous, healthier districts.²¹ Such attempts have been abandoned in some areas in favour of approaches which recognise areas that are poorly served and with poorer health profiles. A revised national formula is expected any day, based on 1991 census data, but it is not clear that it will be based on principles more equitable than those in the previous version.

In primary care, the general practitioners' contract of 1990 and the fundholding scheme started in 1991 look set to widen, rather than narrow, the quality divide in general practice. No national pattern has emerged, but initial reports suggest that in some regions uptake of fundholding, attracting associated resources, was strongest among the better resourced practices in more prosperous areas.^{22 23} Likewise, the financial incentives to develop new services for patients under the general practitioner contract have proved easier to achieve in middle class areas as many depend on achieving targets for uptake of a service, which both are easier to achieve in middle class areas and swell the flow of resources to these areas.²⁴

To this list can be added the effect of new funding arrangements for community care, which seem to reinforce existing inequalities in provision, draining resources from inner city areas into more prosperous seaside locations.²⁵ None of these developments suggests that the principle of planning for equitable geographical distribution of services is being addressed seriously. Moreover, the fragmentation of the service into many separate competing units will damage the ability to plan strategically still further.

Selection on financial grounds

With much of the NHS based on salaried service, minimal fee for service arrangements, and limited private insurance coverage, until about 1980 there was little opportunity to select patients on financial grounds. Although primary and community health services and emergency secondary care scored well on this principle, queue jumping for elective surgery has always been possible, with NHS consultants allowed to have a private practice alongside their NHS work. From indirect evidence on consultants' contracts however, the opportunity for queue jumping was probably of minor importance until the beginning of the 1980s.

Consultants' contracts were then relaxed and private health insurance encouraged. Since then there has been a steady increase in commercial medicine, particularly in London, where in 1989-90 NHS consultants as a body were earning more in private fees than from the NHS.²⁶

This mixing of NHS and private work has raised questions about both equity and the efficient running of NHS hospitals.²⁶

With the introduction of the *Working for Patients* reforms in 1991 increased opportunities to select patients on financial grounds have emerged. Some fundholders have achieved improved waiting times for their patients, attention from senior specialists, quicker

response times for diagnostic tests, and other improvements.²⁷ Supporters of the scheme argue that these improvements reflect more efficient purchasing by fundholders than by district purchasers, whereas others suggest that fundholders have been more generously funded. At least one district authority has shown that fundholders within its boundaries were more generously funded than the authority itself and that this coincided with a reduction in waiting lists for fundholders' patients and an increase in those for other patients (see subsequent paper in this series by Dixon²⁸).

Surveys by the BMA and the royal colleges have shown that many hospitals are routinely "fast tracking"—giving preference to the patients of fundholders.²⁹⁻³⁰ No one knows quite how widespread these practices are but they pose a threat to the principle of selection on the basis of need, not ability to pay.

This in turn raises the question of what is happening to the ethos of the service. In the past the NHS workforce earned an international reputation for their integrity and altruism.³¹⁻³² How much the business culture of the 1980s has dented that reputation, or has led to exploitation of the workforce itself, is an aspect that has been neglected by research. There is a danger that the current low morale of health workers and commercial practices such as silencing of criticism, increasing use of short term contracts, and pressure to abandon the values that have inhibited the exploitation of patients for profit may have damaged the fragile ethos of public service.

Prospects for the future

The situation is not without hope. Many working within the NHS are determined to maintain an equitable service, and the public at large wants this principle retained. Much more active promotion of the basic principles needs to be attempted, and here four broad areas of action are suggested.

RETURN TO ETHICAL VALUES

The issue of selection on the basis of financial grounds has to be tackled as a matter of priority and requires a two pronged attack. Firstly, it needs the promotion of ethical values at all levels, not just for individual health professionals but also for managers, administrators, and policymakers in both purchasing and provider authorities. This will not be taken seriously unless the government stops sending mixed messages on the subject—one day issuing guidelines against setting preferential terms in contracts and the next defending fast tracking.

Secondly, organisational changes need to be made to cut out the opportunities to select on financial grounds, thus removing the ethical dilemma. This would involve, for example, devising more equitable methods of resource allocation in health and social care, reducing any built in bias against more deprived areas and groups.

EQUITY AUDIT

Policymakers need to audit how existing provision and proposed developments affect the provision of an equitable service. Careful monitoring needs to take place of how health status, health hazards, and health and social services are distributed across a given population. Purchasers could do worse than start by asking such questions as, Who gets what services and where? What is known about whether resources are being channelled towards areas of greater need or vice versa? The aim would be to ensure that the flow of resources and the thrust of any targets set went in the right direction, tackling rather than exacerbating current inequalities.

NATIONAL PLANNING AND ASSESSING EFFECTIVENESS

National planning is required to counteract the tendency towards wasteful duplication and over-treatment generated by competition or the sheer haphazard pattern that emerges from a fragmented system. There also needs to be strict control over the proliferation of untested high technology innovations and much more evaluation of the effectiveness of new service or managerial configurations emerging as a result of the reforms. The continuing collection of comprehensive national statistics needs to be developed and maintained.

A NEW DEBATE ON ENTITLEMENT

What is happening with continuing care is disturbing and cannot be left to drift into policymaking by default, especially with an aging population. Should those in need of continuing nursing care no longer be entitled to free NHS services and have to bear the burden of payment or be means tested? There are searching questions to be asked about the long term consequences of excluding some of the most vulnerable members of society from coverage by the NHS. What are the alternatives? Are there other service priorities which are less important? All the options need to be investigated and an equitable solution sought.

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