
Commentary
As a moral concept equity embodies ideas of fairness as justice. 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' equity to the field of paediatrics, Reading avoids the issues of assessing equity in the total social context. 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 remuneration of the welfare and knowledge can obtain at an 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 emporers 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. 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.

J GRIMLEY EVANS
Department of Geriatric Medicine,
Radcliffe Infirmary,
Oxford OX2 6HE