Equity or equality?

We must be grateful to Dr Shaw [1] for drawing attention to the College's Report on equity and equality of care for older people [2]. Its condemnation of discrimination against people on the basis of old age has been endorsed by the Department of Health and the Health Committee of the House of Lords. Dr Shaw, it seems, has other views.

He begins by tilting at a windmill. When the authors of the College Report wrote of equal access to care they assumed their readers would be intelligent enough to recognise that a call for equal access must presuppose equal need. Any other meaning, as Dr Shaw is at pains to point out, would be nonsensical.

The rest of his article is a critique of the ethical values underlying the Report, but which the authors, concentrating on the practicalities of service delivery, did not make explicit. There are two issues: the treatment of individuals on the basis of their membership of a group rather than on their individually assessed capacity to benefit; and the distribution of resources on the basis of benefit as perceived by the purveyors rather than the users of health services.

Age is linked with health care outcomes not because of any causal role but because of a statistical association with the prevalence of physiological impairments that modulate outcome. There is a high variance for most physiological variables around the mean at any age, and the variance increases with age because individuals senesce at different rates. The theme underlying the College Report is that the likelihood of benefit from interventions should be calculated from physiological and other relevant variables for each individual and not assumed to be identical with the average of his or her age group. The calculated probable benefit and hazard are used to enable the patient, not the doctor, to decide what should be done. Age will drop off the end of the equation predicting benefit from an intervention if enough is known about the physiology of a patient. (This raises the practical issue of the inadequacy of much medical research, as deplored in a recent publication by the Medical Research Council [3]). Dr Shaw's statement that 'a lot more life is saved by treating *a* fit 50-year old than *a* fit 80-year old' (my emphasis) might or might not be true; it depends on which 50-year old and which 80-year old, and what fate has in store for them, but it exemplifies his confusion between the group and the individual.

This section in his paper also makes the assumption that x years of life for A is necessarily better than y years of life for B if x is greater than y. This is the health care purveyor's view of benefit and begs the question of what the ethical basis of the British National Health Service should be. Ethics are not freestanding universal truths; they are merely logical deductions from ideological premises. Nor is there anything absolute or universal about such premises. They may arise during revelatory experiences on the Damascus road, or from the resentful broodings of Marx or Hitler. To most of us, our own ideological premises seem to be self-evident principles but are usually the residents of the inaccessible 'read-only-memory' of our early cultural programming. In common with most other amateur ethicists, and indeed many professionals, Dr Shaw does not tell us what ideological premises he is working from. He seems to consider a statement of his own views and an occasional appeal to popular sentiment a sufficient exegesis. He opines, for example, that it is a greater misfortune to die young than old. The opposite view is part of our culture [4] and it certainly does not strike me as something that is either self-evident or even generally true. Would not my psychopathology be as valid a basis for an ethical system as Dr Shaw's? His appeal to the general agreement of the public is at variance with his admonition that 'gut feelings' should be subjected to 'rigorous ethical analysis'. The assertion that presented with two drowning people and only one lifebelt 'we would throw it to the 25-year old not the 75-year old' is of doubtful authenticity and relevance. Supposing the two individuals were the same age but one was black and one was white? Would Dr Shaw find the choice equally self-evident? After all, blacks and whites have different life expectancies. I will urge the view that the ethical means of choice in such a situation would be by tossing a coin. Those at hazard are both citizens; we do not know how they value their lives; we have neither reason nor right to discriminate between them.

As Dr Shaw implies, the common man, whether of Oregon or Britain [5], is ageist. We may suspect the latter abstraction would also favour capital punishment, flogging and the repatriation of foreigners. We do not bow to these opinions because they conflict with what we believe English society to be about. (I can only speak for England.) We have no written constitution, but the last 400 years of our history and the common rhetoric of our political parties imply a general goal of society based on the equality of citizens before the institutions of society and on the subjective uniqueness of the individual. The fact that this latter idea has outlived the Protestant doctrine of the soul that spawned it is immaterial. We have our inheritance. We can go elsewhere to enjoy living under the premises of Marxism or Islamic theocracy. We have also inherited from ancient Athens the obligations of logic and the examined life. This is why we are obliged

J GRIMLEY EVANS, MD, FRCP, FFPHM, *Professor of Clinical Geratology, University of Oxford*

to be explicit about our ideology and logical in moulding our ethics.

This cultural ideology provides the schedule to the social contract between the users and purveyors in the National Health Service. The essential value of a life in English society can only be assessed by the unique person who lives it. Young Mr A *may* value his remaining years of life more or less than old Mrs B values her probably fewer years, but we can no more measure those perceptions than we can compare what Mr A experiences as 'green' with what Mrs B experiences as 'green'. The values of individual human lives are incommensurable; we cannot distinguish between them nor can we make logical sense by multiplying non-finite values by a number representing life expectancy or quality [6]. The fair innings argument is no more than a dubious analogy let out of its cage. The fairness of an innings lies less in its length than in the quality of the bowling [7], but the non-linear complexities of the area under the time-pleasure curve would surely defy meaningful mensuration.

The ideological principles of English society demand that the benefits that we seek in deploying our health care resources should be the benefits as assessed by the patients, not some putative return on investment as seen by the purveyors. If resources are insufficient to provide for all, the principle of equal access calls, at the clinical level, for randomised allocation.

It is important not to let this sort of debate distract us and our politicians from remembering that health care resources are only limited because government limits them. With a few more resources and rather more efficiency the issues of rationing might prove surprisingly marginal. The image of the bottomless health care bucket is a useful myth for those who prefer to water other gardens.

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Address for correspondence: Professor J Grimley Evans, Division of Clinical Geratology, The Radcliffe Infirmary, Oxford OX2 6HE.