



Editorials

Unequal access to health care in England

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Women, elderly people, and those in deprived areas continue to be worse off

In the linked study (doi:[10.1136/bmj.c4092](https://doi.org/10.1136/bmj.c4092)), Judge and colleagues assessed the geographical and sociodemographic factors associated with variations in access to total hip and knee replacement surgery in England. They found inequity in access to both types of surgery by age, sex, deprivation, area of residence, and ethnicity.¹

The 1989 report *Working for Patients* set out the responsibilities of health authorities.² These included assessing the health needs of their populations and ensuring that an appropriate range of services was available to meet them. It led to the development of a new set of methods, termed health needs assessment,³ which was backed up by a substantial body of research. The process of methodological development provided a major stimulus to research into health services, and it brought together clinicians, epidemiologists, and a variety of social scientists. It led, among other things, to the publication of a multi-volume textbook that offered guidance to those commissioning health care.⁴

Assessing need and monitoring whether it has been met remains a core function of primary care trusts, the successors of those health authorities. Yet despite the work that went into methodological development in the 1990s, the task remains challenging. Firstly, we need to agree on the threshold for intervention. This can be difficult because much of the research on effectiveness is conducted in atypical subjects, few of whom have complex comorbidities. Secondly, we need to assess the need for health care in a way that can be measured in the population. A screening test that requires invasive investigations is of little value in this situation. Thirdly, we need to measure these indications in the population. And finally, if need is to be related to use, we need to determine the treatment rate in the population.

Judge and colleagues have tackled this challenge in an imaginative way.¹ They looked at disparities between the need for and use of total hip and knee joint replacement surgery—cost effective procedures that are undertaken for common problems, which can transform patients' lives by reducing pain and increasing mobility. They began by implementing and validating a simplified scale developed in

New Zealand to identify patients who need major joint replacement. By applying this scale to subjects in the English Longitudinal Study of Ageing they developed a model that could be used with census data to estimate how many people in different parts of the country would need surgery and compare this number with how many operations were undertaken. Obviously, this approach has many limitations, as the authors recognised. Among the most important are the inability to determine whether everyone in need wants the operation and the absence of data on the 20% or more of procedures undertaken in the private sector. The limitations are unlikely to change the key findings, however.

Crucially, the study showed that, should you need joint surgery, the probability of getting it varies according to who you are and where you live. In particular, older people, women, and those living in deprived areas seemed to be disadvantaged, although the role of other characteristics varied between the two types of joint replacement.

These findings are consistent with existing research, especially studies showing that doctors in primary and secondary care are less likely to investigate and treat women and elderly people.⁵ This is important because promotion of mobility and thus independence must be a core element of our response to population ageing.⁶ The undertreatment of people in deprived communities is doubly unjust because they already face a greater burden of disease.⁷

Some findings are relevant to ongoing debates about hospital reconfiguration. Distance from hospital did not seem to be important, but the capacity to provide orthopaedic surgery (such as numbers of consultants and training status) did increase provision, strengthening the case for greater centralisation.

Although this study provides a major methodological advance, the implications of its findings for current policy are limited because the data are from 2002. Investment in the NHS has increased since then, and although health expenditure in the United Kingdom is still less as a share of national wealth than in other industrialised countries,⁸ the level of provision has improved greatly. Hence the considerable under-provision recorded here is likely to have been alleviated to some extent, although we cannot be sure of this.

The authors should be congratulated for blazing a trail in conducting these analyses, but the NHS must now take on this task. In future, private sector data should be included that will build, for example, on the pioneering collaboration between the private sector and the London Health Observatory⁹ or the growing number of national procedure registries that contain both NHS and private sector data. Without such analyses it is not possible to know whether the health needs of the population are being met and ask why any inequalities exist and how they can be tackled. This, however, raises one final question. So far, health needs assessment has been the responsibility of primary care trusts and strategic health authorities. Now that the Department of Health in England has signified its intent to move to general practice commissioning, who, if anyone, will have the skills or interest to take on this important role?

Notes

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Footnotes

- [Research, doi:10.1136/bmj.c4092](https://doi.org/10.1136/bmj.c4092)
- Competing interests: All authors have completed the Unified Competing Interest form at

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