SUPPLEMENT

TALKING POINT

Social class inequality in access to primary care: a critique of recent research

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Despite the substantial deployment of public funds to health care, no appraisal is made of this investment in terms of the routine collection of information designed to monitor the effectiveness of services. So ingenious manipulation of data designed for other purposes takes place, but such data inevitably provide a poor basis for evaluation. Thus we find the health of communities interpreted through consideration of their death rates, and the quality of antenatal care interpreted through crude perinatal mortality figures that make no allowance for maternal age, parity, or social class distribution or for rates of abortion and low birth weight, let alone the satisfaction of the users. Furthermore, health authorities frequently show more concern over durations of hospital stay and lengths of waiting lists than over what happens to the health of those receiving or awaiting hospital treatment.

The greatest anomalies are undoubtedly in primary care, where most doctor-patient contacts occur and where no routine statistics are collected on the quality, or even the quantity, of care. The statistical vacuum in this important sector of the NHS necessitates the closest scrutiny of all new information brought forward. This is especially so in the contentious area of social class equity in health care provision and is emphasised in the widespread concern over the Government's negative response to the Black Report.¹ This paper applies such a scrutiny to the most recently published research on social class equity of access to primary care,² in which Collins and Klein analyse previously unavailable data from the General Household Survey (GHS). Their findings contradict the conclusions of previous studies³⁻⁴ that for given levels of need there is a direct relation between social class and use of primary care services, and they claim that their analysis shows "that the NHS has achieved equity in terms of access to primary health care."

The additional information made available to Collins and Klein in their analysis of 1974 GHS data permits them to analyse the use of primary care services in four health categories: those reporting no morbidity; those reporting acute sickness; those reporting chronic sickness without any limiting effects on activity; and those reporting chronic sickness with limiting effects on activity. The more limited information available to previous researchers³⁻⁴ permitted only cruder overall comparisons of those reporting morbidity with those reporting use, with no

indication of the actual extent of the assumed correspondence between the two populations. Collins and Klein make certain qualifications concerning the validity of their data, but their conclusions disregard the constraints that these qualifications impose. There are three important objections to their conclusions that social class equity of access to primary care exists in the NHS.

Frequency of contact

Collins and Klein acknowledge that they fail to distinguish between one-time and multiple users of primary care in the two-week GHS reference period. They justify this in terms of their aim, which is to analyse access to health care not frequency of contact. But if a systematic social class differential is hypothesised in this variable—for instance, people of higher social class being more likely to revisit the doctor—then clearly frequency of contact becomes a relevant aspect of access.

The GHS question on which the attribution of "use" is based is: "During the two weeks ending last Sunday, apart from visits to a hospital, did you talk to a doctor for any reason at all?" Defining all affirmative answers to this question as equal "units of access" begs several questions. Are there systematic social class differentials in the "opportunity cost"—that is, the benefit foregone—of making a visit to the doctor? Do such differentials also exist with respect to the length and quality of the consultation? Previous evidence⁵ suggests that such differentials do indeed exist; and they are clearly relevant aspects of access when conclusions are being drawn about equity.

The GHS question used to classify the "acutely sick" is: "During the two weeks ending last Sunday, did you have to cut down on any of the things you usually do because of (this illness/disability or some other) illness or injury?" Clearly a positive answer to this question cannot necessarily imply the need for a visit to the general practitioner and cannot therefore be related with any validity to the "use" data. Even if (as is probable) a partial relation exists it could well be subject to a systematic social class bias. In the same way the GHS question used to define "chronic sickness without limiting effects on activity" would, for instance, include the healthy diabetic with no need to visit routinely the general practitioner, and in whom any use:need relation would be spurious. This morbidity group could also carry systematic social class bias—for instance, if the chronic conditions of its higher social class members were more "doctor autonomous," such as diabetes, and the lower social class conditions more "doctor dependent"—for example, chronic bronchitis in a cigarette smoker.

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Armed Forces doctors' pay

BMA Secretary writes to Prime Minister

The Review Body on Armed Forces Pay based its recommendations for Service medical officers on the actual levels of remuneration of general medical practitioners that had been implemented as a result of the Government's decision to reduce the recommendations of the Doctors' and Dentists' Review Body (DDRB) to 6% (8 August, p 454). The Secretary of the BMA, Dr John Havard, has asked the Prime Minister to reconsider this decision so as to ensure that serving officers receive the full 9% increase. Dr Havard's letter is set out here.

"A key factor in our reaction to your decision to cut the recommendations of the Doctors' and Dentists' Review Body this year, and in the restraint which has been shown by the professions, was the assurance you gave us that with the exceptions of the armed Forces and the police, the Government was determined to limit salaries in the public sector within the 6% cash limit.

"You explained to us that the exceptions mentioned were based on the risks which are incurred by the armed Forces and the police, and this appears clearly in the agreed notes of the meetings which took place with yourself, and afterwards with the Secretary of State for Social Services.

"The restraint exercised by the professions was in large measure due to the belief that the Government was acting in good faith in a determined attempt to reduce inflation, and I have little doubt that the restraint which the professions have shown has been a major factor in enabling settlements to be reached in other parts of the public sector within cash limits.

"At the time it had not even occurred to us that our restraint might be used against the interests of doctors and dentists serving in the armed Forces as they incur the same risks as

other serving officers. However, this has been the consequence of your having accepted the recommendations contained in the *Supplement to Tenth Report* of the Review Body on Armed Forces Pay (Cmnd 8322).

"The decision to exclude serving doctors and dentists in this way will have an adverse effect on the good faith with which the professions based their restraint in accepting for this year the cuts imposed on the recommendations of the DDRB, and I must request that

you urgently reconsider your decision so as to ensure that these serving officers receive the 9% increase which they are entitled to receive by virtue of their analogue with increases recommended for general medical practitioners by the DDRB.

"In view of the special position of serving officers I must make it clear that the representations in this letter are made on behalf of members of the BMA and BDA serving in the armed Forces and do not therefore have the support of the Medical and Dental Directors General in asking for a review of this year's award. Meanwhile, the professions as a whole will be deeply concerned at the adverse effect of this discrimination against their colleagues in the armed Forces."

DHSS planning guidelines 1981-2

The DHSS has set out national guidelines for planning by health authorities in England for 1981-2. The guidelines (HC(81)10) are divided into three parts: capital and revenue assumptions for 1982-3 (see table); manpower assumptions for operational planning; and planning in 1981-2.

Regions have been asked to state their needs for medical posts additional to their 1981-2 establishment in the consultant, senior registrar, and registrar grades. The guidelines state that the requests should reflect the regions' firm plans to implement posts in the period 1 April 1982 to 31 March 1983. The DHSS has said that up to 60 new posts will be authorised in anaesthetics and up to 45 in radiology. Up to 20 new posts will be authorised in geriatric medicine. Community medicine is a shortage specialty and authorities have been authorised to create up to a total of 30 special supernumerary senior registrar posts on the basis of an average of two per region in England and

Wales on a purely temporary basis while the NHS is being reorganised. Authorities are also asked to increase recruitment of SHOs and registrars where possible.

Capital and revenue assumptions for 1982-3

Region	Capital assumptions (£m)	Revenue assumptions (£m)
Northern	33.68	448.9
Yorkshire	39.98	501.7
Trent	43.41	593.4
East Anglian	19.36	252.2
North-west Thames	28.26	550.5
North-east Thames	33.90	604.8
South-east Thames	32.60	577.3
South-west Thames	25.83	465.6
Wessex	35.72	358.2
Oxford	20.00	285.8
South Western	32.70	438.4
West Midlands	54.40	699.0
Mersey	25.70	368.4
North Western	59.02	618.3
Total	484.56	6762.5

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Inability to match use with need

The first problem (though not the others) raised in the previous paragraph is acknowledged by Collins and Klein, "... within any health category group we have not been able to identify the precise reason why individuals consulted their general practitioner: thus someone within the 'acute' group may have consulted about their acute sickness or about something else. This constrains us to draw general conclusions about equity in terms of access as between socioeconomic groups, rather than precise conclusions about the matching of use and need in the case of individuals within them." If this constraint had been observed the findings of Collins and Klein would have been much more circumscribed and tentative than they are. Their acknowledged inability to match use with need within individuals is no different in principle from the inability in previous studies^{3,4} to match use with need between individuals of similar social class. In the same way, no conclusions on equity of access can be drawn without the risk of committing the ecological fallacy.

Despite their acknowledgment that use and need cannot accurately be matched, Collins and Klein go on to match them and to use the one (self-reported morbidity) to standardise the other (use of general practitioner services). Their analysis of

these inappropriately standardised use data results in firm assertions that "if there are continuing social inequalities in health there are no similar social inequalities in access to primary care" and that "we can confidently conclude that Britain's primary health care system does not speak with an upper-class accent." Without the support of these untenable data, however, such conclusions carry no greater weight than do those of the earlier work, whose methodological limitations Collins and Klein claim to have overcome, and can in no sense be said with any certainty to alter the existing state of knowledge on social class inequality in access to primary care.

References

- 1 Department of Health and Social Security. *Inequalities in health*. London: DHSS, 1980.
- 2 Collins E, Klein R. Equity and the NHS: self-reported morbidity, access, and primary care. *Br Med J* 1980;281:1111-5.
- 3 Forster DP. Social class differences in sickness and general practitioner consultations. *Health Trends* 1976;8:29-32.
- 4 LeGrand J. The distribution of public expenditure: the case of health care. *Economica* 1978;45:125-42.
- 5 Cartwright A, O'Brien M. Social class variations in health care and in the nature of general practitioner consultations. In: Stacey M, ed. *The sociology of the National Health Service*. Keele: University of Keele, 1976:77-98.

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