The inverse care law and the potential of primary care in deprived areas

The inverse care law, whereby health care favours more assertive interests and in doing so compounds the disadvantage of patients and communities with the poorest health,[1] exists in most health systems. 50 years after Julian Tudor Hart's landmark paper in which he first described the inverse care law in England and Wales,[1] it is still going strong.[2,3] In *The Lancet*, Richard Cookson and colleagues[4] provide a global re-examination of the inverse care law.

Tudor Hart's main target was the role of commerce in health care, but he also showed that the maldistribution of the health workforce and other resources limits the ability of health professionals to address patients' needs. "Medical services are not the main determinant of mortality or morbidity but that is no excuse for failure to match the greatest need with the highest standards of care", he argued.[1] The McKeown thesis[5]—ie, health care contributes little to population health—was true in the mid-20th century but now needs to accommodate the mass delivery of a wide range of effective interventions, especially in later life. If such health care is delivered inequitably, health systems will inadvertently widen inequality, a determinant which seldom features in reports on inequalities in health.[6]

Further research has complemented the evidence presented in Tudor Hart's original paper.[1] Multimorbidity typically occurs 10–15 years earlier in socioeconomically disadvantaged groups,[7] reflecting the complexity and difficulties of lives lived with physical, psychological, social, and financial problems.[8] Yet there are many challenges in the provision of primary care for patients from these groups. There are about 20% more general practice consultations per year in deprived areas than in affluent areas,[9] but consultation rates on their own convey nothing of the content, duration, quality, or consequences of clinical encounters. Unmet need is not recorded in activity data, such as consultation rates, hence the limited effect of resource distribution formulas that are based on general practice activity data as a proxy for need.[10] Consultations in general practice in the UK are typically shorter in more disadvantaged areas; yet in these settings patients often have more complex health needs to discuss, especially related to psychosocial issues.[11] These consultations generally involve lower patient expectations of shared decision making, poorer health outcomes, and greater stress among health professionals than in wealthier areas.[11,12] Patients who are socioeconomically disadvantaged generally make more use of emergency health services but less use of specialist and preventive care.[13] COVID-19 is compounding these issues through social gradients in incidence and case-fatality rate, the mounting backlog of non-COVID-19-related clinical work, increases in psychological and financial stress, and the limitations of remote primary care consultations.[14-16]

Tudor Hart not only described the inverse care law but also led the way in showing how it could be addressed, using the possibilities inherent in general practice in the UK National Health Service to pioneer a population approach to clinical care.[17] Subsequent studies in deprived areas, including many Deep End general practices—ie, general practices in places of socioeconomic deprivation—have shown the cost-effectiveness of extended consultations for selected patients;[18] the value of multidisciplinary team meetings, including social care workers, for integrated care;[19] and the importance of co-workers, including mental health workers and financial advisers, who are embedded in general practices, thus increasing the speed, familiarity, and effectiveness of referral to these services.[20] Link workers are an important addition to the generalist function, helping people with complex problems engage with multiple, fragmented, and often daunting services.[21] Focused care workers provide a flexible approach and can help reduce both worklessness and use of hospital accident and emergency services.[22] General practitioners (GPs) in east London, serving one of the UKs most diverse and disadvantaged urban communities, established a digitally enabled collaborative learning health system that improved the quality of care and achieved first place in national clinical performance rankings.[23] Together, these research studies and evaluations in the UK show that disadvantage is not a given to be endured but a challenge that can be overcome.

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Tudor Hart was a pioneer of such an approach, anticipating problems so they could be prevented, ambitious for what could be achieved in general practice, and working steadily with patients as partners to produce social value and better health outcomes.[17,24] His example inspired many, but was insufficient to lever system change.

Deep End Projects address the challenges identified by Tudor Hart on a larger scale through informal networks of general practices working together. The first Deep End Project began in Scotland in 2009, capturing the experience and views of GPs working in the country's 100 most deprived general practices. Over a decade later, the Deep End Project has given identity, profile, voice, shared learning, and joint activity to participating GPs.[25] Eight other Deep End Projects in Ireland, England, and Australia are following suit with activities spanning workforce and service development, education, research, and advocacy.[18–22] For Deep End GPs, the inverse care law is not an abstraction but the difference between what they can do under current conditions and what they could do with and for patients with more time and better connections, organisation, and support. As clinical generalists their hallmark is unconditional, personalised continuity of care, linked to community resources for health.

Whether health policy makers are prepared to match their rhetoric about inequalities in health with policies to reduce inequity in health care is still uncertain. For much of the past 50 years there has been scepticism about what could be done to address the inverse care law and who would do it. With the emergence and potential of Deep End Projects, and related initiatives elsewhere, following the path set by Tudor Hart, that is no longer the case.[26]

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