Hvordan kan almen praksis bidrage til at reducere social ulighed i sundhed?

Konference om den nationale sundhedsprofil

Mogens Vestergaard

PRAKSISPILOTERNE
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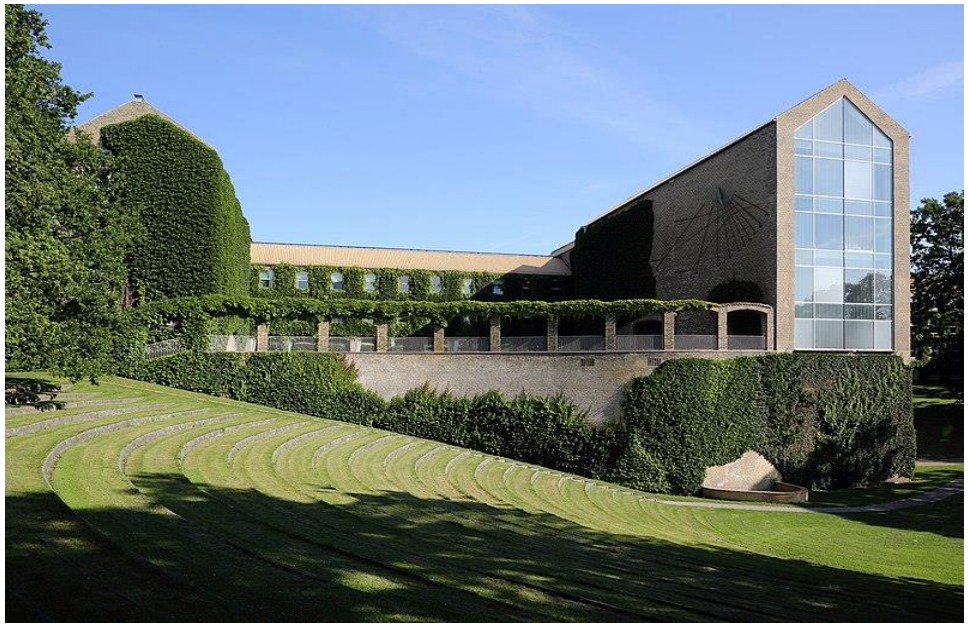
LÆGEFÆLLESSKABET

Mit udgangspunkt

Lægefællesskabet Grenå

Foto: Jesper Balleby



Forskningsenheden for almen medicin, AU

PRAKSISPILOTERNE
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LÆGEFÆLLESSKABET

The Inverse Care Law

The Lancet · Saturday 27 February 1971

THE INVERSE CARE LAW

JULIAN TUDOR HART
Glyncorrwg Health Centre, Port Talbot, Glamorgan, Wales

Summary The availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced. The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the maldistribution of medical resources.

Interpreting the Evidence

THE existence of large social and geographical inequalities in mortality and morbidity in Britain is known, and not all of them are diminishing. Between 1934 and 1968, weighted mean standardised mortality from all causes in the Glamorgan and Monmouthshire valleys rose from 128% of England and Wales rates to 131%. Their weighted mean infant mortality rose from 115% of England and Wales rates to 124% between 1921 and 1968.[1] The Registrar General's last Decennial Supplement on Occupational Mortality for 1949–53 still showed combined social classes I and II (wholly non-manual) with a standardised mortality from all causes 18% below the mean, and combined social classes IV and V (wholly manual) 5% above it. Infant mortality was 37% below the mean for social class I (professional) and 38% above it for social class V (unskilled manual).

A just and rational distribution of the resources of medical care should show parallel social and geographical differences, or at least a uniform distribution. The common experience was described by Titmuss in 1968:

> "We have learnt from 15 years' experience of the Health Service that the higher income groups know how to make better use of the service; they tend to receive more specialist attention; occupy more of the beds in better equipped and staffed hospitals; receive more elective surgery; have better maternal care, and are more likely to get psychiatric help and psychotherapy than low-income groups—particularly the unskilled."[2]

These generalisations are not easily proved statistically, because most of the statistics are either not available (for instance, outpatient waiting-lists by area and social class, age and cause specific hospital mortality-rates by area and social class, the relation between ante-mortem and post-mortem diagnosis by area and social class, and hospital staff shortage by area) or else they are essentially use-rates. Use-rates may be interpreted either as evidence of high morbidity among high users, or of disproportionate benefit drawn by them from the National Health Service. By piling up the valid evidence that poor people in Britain have higher consultation and referral rates at all levels of the N.H.S., and by denying that these reflect actual differences in morbidity, Rein [3,4] has tried to show that Titmuss's opinion is incorrect, and that there are no significant gradients in the quality or accessibility of medical care in the N.H.S. between social classes.

Class gradients in mortality are an obvious obstacle to this view. Of these Rein says:

> "One conclusion reached . . . is that since the lower classes have higher death rates, then they must be both sicker or less likely to secure treatment than other classes . . . it is useful to examine selected diseases in which there is a clear mortality class gradient and then compare these rates with the proportion of patients in each class that consulted their physician for treatment of these diseases. . . ."

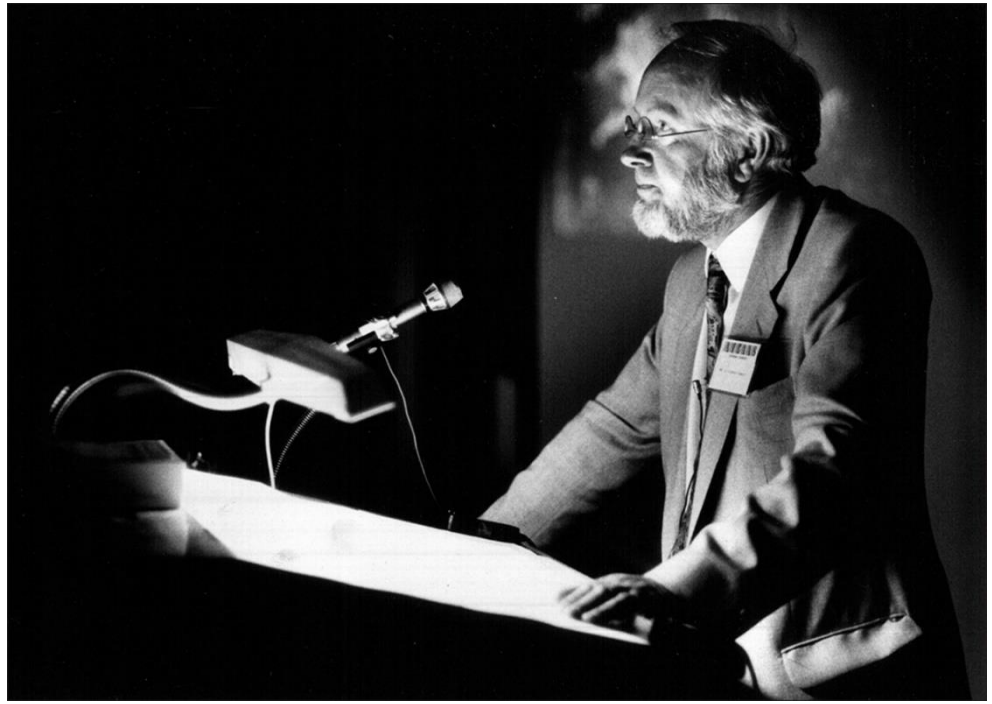
He cites figures to show that high death-rates may be associated with low consultation-rates for some diseases, and with high rates for others, but, since the pattern of each holds good through all social classes, he concludes that

> "a reasonable inference to be drawn from these findings is not that class mortality is an index of class morbidity, but that for certain diseases treatment is unrelated to outcome. Thus both high and low consultation rates can yield high mortality rates for specific diseases. These data do not appear to lead to the compelling conclusion that mortality votes can be easily used as an area of class-related morbidity."

This is the only argument mounted by Rein against the evidence of mortality differences, and the reasonable assumption that these probably represent the final outcome of larger differences in morbidity. Assuming that "votes" is a misprint for "rates", I still find that the more one examines this argument the less it means. To be fair, it is only used to support the central thesis that "the availability of universal free-on-demand, comprehensive services would appear to be a crucial factor in reducing class inequalities in the use of medical care services". It certainly would, but reduction is not abolition, as Rein would have quickly found if his stay in Britain had included more basic fieldwork in the general practitioner's surgery or the outpatient department.

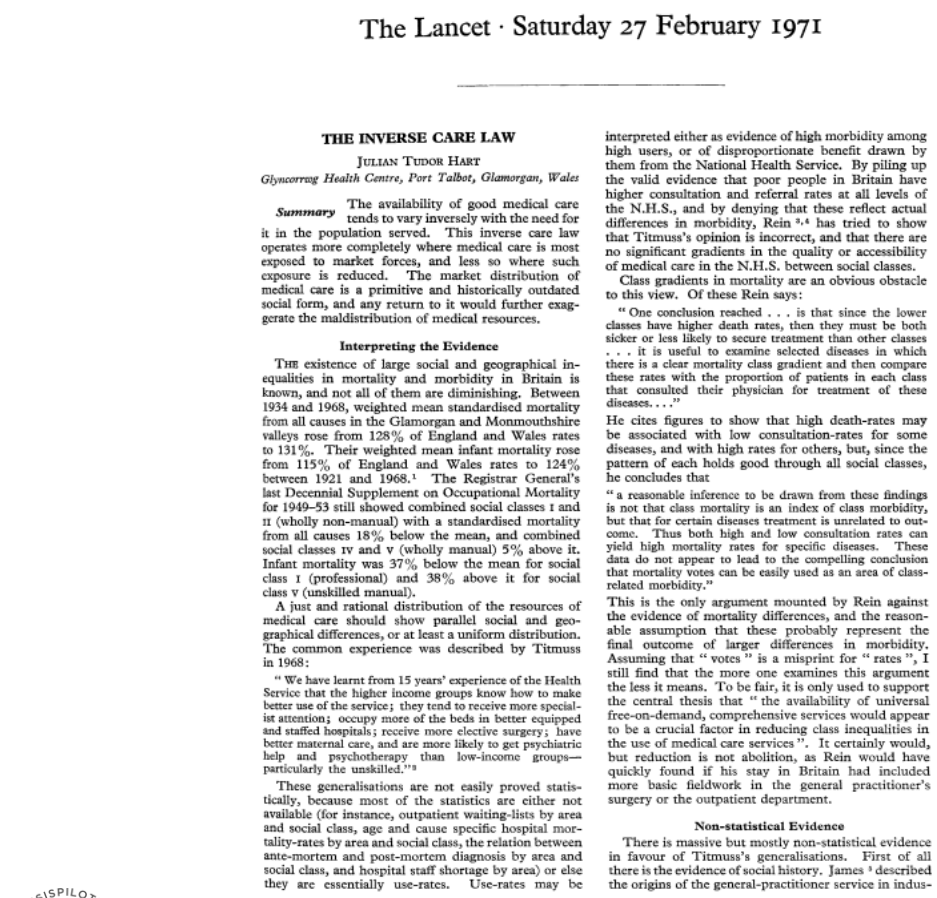
Non-statistical Evidence

There is massive but mostly non-statistical evidence in favour of Titmuss's generalisations. First of all there is the evidence of social history. James [5] described the origins of the general-practitioner service in indus-



Julian Tudar Hart

The Inverse Care Law



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The availability of good medical care tends to vary inversely with the need for it in the population served.

Julian Tudar Hart, Lancet 1971

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LÆGEFÆLLESSKABET

The Inverse Care Law

Editorial

50 years of the inverse care law

"The availability of good medical care tends to vary with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced."

These understated opening lines of Julian Tudor Hart's paper, The Inverse Care Law, are as relevant now (50 years to the day since publication) as in 1971. The paper is one of the landmark publications in *The Lancet*'s near 200-year history, and the resonance of Tudor Hart's definition of the inverse care law has global and timeless importance. Simply expressed, Tudor Hart observed that disadvantaged populations need more health care than advantaged populations, but receive less.

Tudor Hart's life and career took him from highly privileged beginnings in London and Cambridge to decades spent in the deprived and deeply socialist Welsh valleys. His experience and work has inspired a generation of influential health-care leaders including Andrew Haines, Allyson Pollock, Cesar Victora, and Graham Watt. Today's anniversary issue of *The Lancet* explores both the global reach of the inverse care law and primary care initiatives in deprived areas around the UK.

Although inequality in health and its many causes are widely understood, inequity in health-care service provision is enduring and fundamental: an intractable concept that lies at the heart of the inverse care law. The inverse care law is primarily about inequity (injustice) in health care that results in unfair social inequalities (imbalances) in health. Since the inverse care law was published, the UK's National Health Service (NHS) has strived to reduce inequity with mixed success. Notably, long-lasting progress was achieved through the 1970s resource allocation formula, which reduced geographical inequality in hospital and institutional expenditure. In the early 2000s, the NHS strengthened primary care provision in disadvantaged areas, leading to a temporary reduction in social inequality, although this progress has reversed following shifts in funding, a slowing of spending, and years of living with austerity.

Globally, letting market forces dictate health care is still a major contributor to inequity—private health care can only be accessed by those who can afford to pay. In many countries, social care and long-term care are managed by private providers too. With populations that are living longer and with more chronic conditions, families—rather than the state—bear much of the cost of long-term care. Public funding for long-term care is more means tested (based on both income and wealth) than needs tested. However, that the inverse care law continues to be seen even with integrated universal health-care systems suggests that there are other important causes. As Richard Cookson and colleagues show in a Health Policy paper, the private expenditure share (ie, private spending on health as a fraction of total health spending) in low-income and middle-income countries explains only 11% of the variation in health-care inequality—less than the share explained by poor governance, for example.

How should we reflect on the inverse care law 50 years on? Although health care is widely endorsed as a basic human right, the systems that provide it inequitably embody capitalism at its worst, where the wealthy benefit, leaving behind those most in need. Communal efforts can help. A Comment by Graham Watt and colleagues explains the Deep End Project to help improve primary care in deprived and disadvantaged communities; informal networks of primary care clinics share knowledge and activities to improve quality of care.

But it will take more than bottom-up initiatives to counter the inverse care law. Growth in health spending as a proportion of total government spending is likely to continue to increase, and with that, demand for care will continue to stretch societal willingness to subsidise services through increased taxes. As laid out in the Comment by Andrew Haines and Mayara Floss, life in the Anthropocene era, with the threats of climate change and erosion of biodiversity undermining planetary health, requires policies to protect health-care systems from future shocks. In order to do so, health systems must be designed to counter inequity, not further perpetuate it. This reality, captured by Tudor Hart's inverse care law, should be at the foreground of policy and governmental decisions when re-evaluating health-care delivery for future generations. Positioning the inverse care law as a warning could ensure advances in health equity and social justice over the next 50 years. ■ *The Lancet*

See Comment pages 773 and 775
See Perspectives page 786
See Health Policy page 828

For the original paper on the inverse care law see Articles
Lancet 1971; 297: 405–12

"The Inverse Care Law are as relevant now as in 1971. The paper is one of the landmark publications in The Lancet's near 200-year history."

Editorial, The Lancet, 2021

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LÆGEFÆLLESSKABET

Investeringer i ulighed virker

thebmj

BMJ 2017;358:j3310 doi: 10.1136/bmj.j3310 (Published 26 July 2017) Page 1 of 8

RESEARCH

Investigating the impact of the English health inequalities strategy: time trend analysis

OPEN ACCESS

Ben Barr *senior clinical lecturer in applied public health research*, James Higgerson *research fellow*, Margaret Whitehead *WH Duncan professor of public health*

Department of Public Health and Policy, Institute of Psychology, Health and Society, University of Liverpool, Liverpool L69 3GB, UK

Abstract

Objective To investigate whether the English health inequalities strategy was associated with a decline in geographical health inequalities, compared with trends before and after the strategy.

Design Time trend analysis.

Setting Two groups of lower tier local authorities in England. The most deprived, bottom fifth and the rest of England.

Intervention The English health inequalities strategy—a cross government strategy implemented between 1997 and 2010 to reduce health inequalities in England. Trends in geographical health inequalities were assessed before (1983-2003), during (2004-12), and after (2013-15) the strategy using segmented linear regression.

Main outcome measure Geographical health inequalities measured as the relative and absolute differences in male and female life expectancy at birth between the most deprived local authorities in England and the rest of the country.

Results Before the strategy the gap in male and female life expectancy between the most deprived local authorities in England and the rest of the country increased at a rate of 0.57 months each year (95% confidence interval 0.40 to 0.74 months) and 0.30 months each year (0.12 to 0.48 months). During the strategy period this trend reversed and the gap in life expectancy for men reduced by 0.91 months each year (0.54 to 1.27 months) and for women by 0.50 months each year (0.15 to 0.86 months). Since the end of the strategy period the inequality gap has increased again at a rate of 0.68 months each year (−0.20 to 1.56 months) for men and 0.31 months each year (−0.26 to 0.88) for women. By 2012 the gap in male life expectancy was 1.2 years smaller (95% confidence interval 0.8 to 1.5 years smaller) and the gap in female life expectancy was 0.6 years smaller (0.3 to 1.0 years smaller) than it would have been if the trends in inequalities before the strategy had continued.

Conclusion The English health inequalities strategy was associated with a decline in geographical inequalities in life expectancy, reversing a previously increasing trend. Since the strategy ended, inequalities have started to increase again. The strategy may have reduced geographical health inequalities in life expectancy, and future approaches should learn from this experience. The concerns are that current policies are reversing the achievements of the strategy.

Introduction

Between 1997 and 2010 the UK government implemented a comprehensive programme to reduce health inequalities in England,[1] one of the most ambitious strategies of its kind.[2] The strategy specifically focused on reducing geographical inequalities in life expectancy; with a target set to reduce by at least 10% the gap in life expectancy between the fifth of local authorities with the worst health and deprivation indicators (the Spearhead areas) and the population as a whole.[3]

The strategy focused on four themes[4 5]: supporting families; engaging communities in tackling deprivation; improving prevention, treatment, and care; and tackling the underlying social determinants of health. Several government departments made 82 commitments across these four themes (see supplementary appendix 1).[6] During the initial stages of the strategy, up to 2006, there was a broad focus across these four themes. By 2007 most of the departmental commitments had been met, at an estimated cost of more than £20bn ($26bn; €23bn) (see supplementary appendix 1).[2 7] Many actions were targeted at areas with high levels of socioeconomic deprivation, including several area based regeneration and health initiatives, and Sure Start children's centres that provided early years child care and education.[3] A new policy was introduced to allocate an increasing proportion of UK National Health Service resources to more deprived areas.[8] Other actions targeted disadvantaged individuals and families, such as the introduction of the national minimum wage, tax and benefit changes to reduce child poverty, and interventions to improve education, housing, and employment.[3] Actions that were focused on the health service included interventions to improve chronic disease management and access to primary care and smoking cessation

Figure

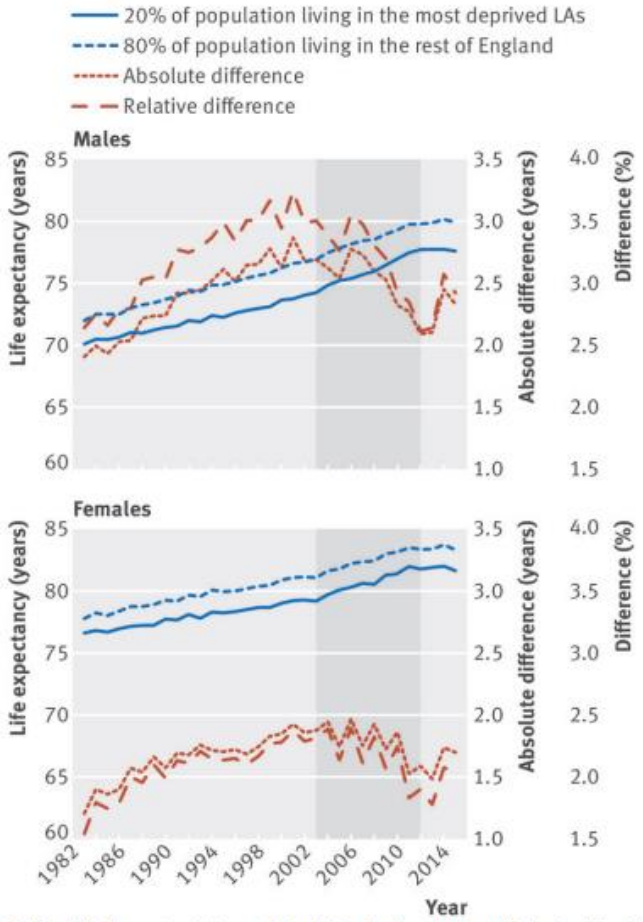

Fig 1 Trends in life expectancy in the most deprived local authorities and the rest of England, and the relative and absolute differences 1983-2015

Barr et al, BMJ 2017

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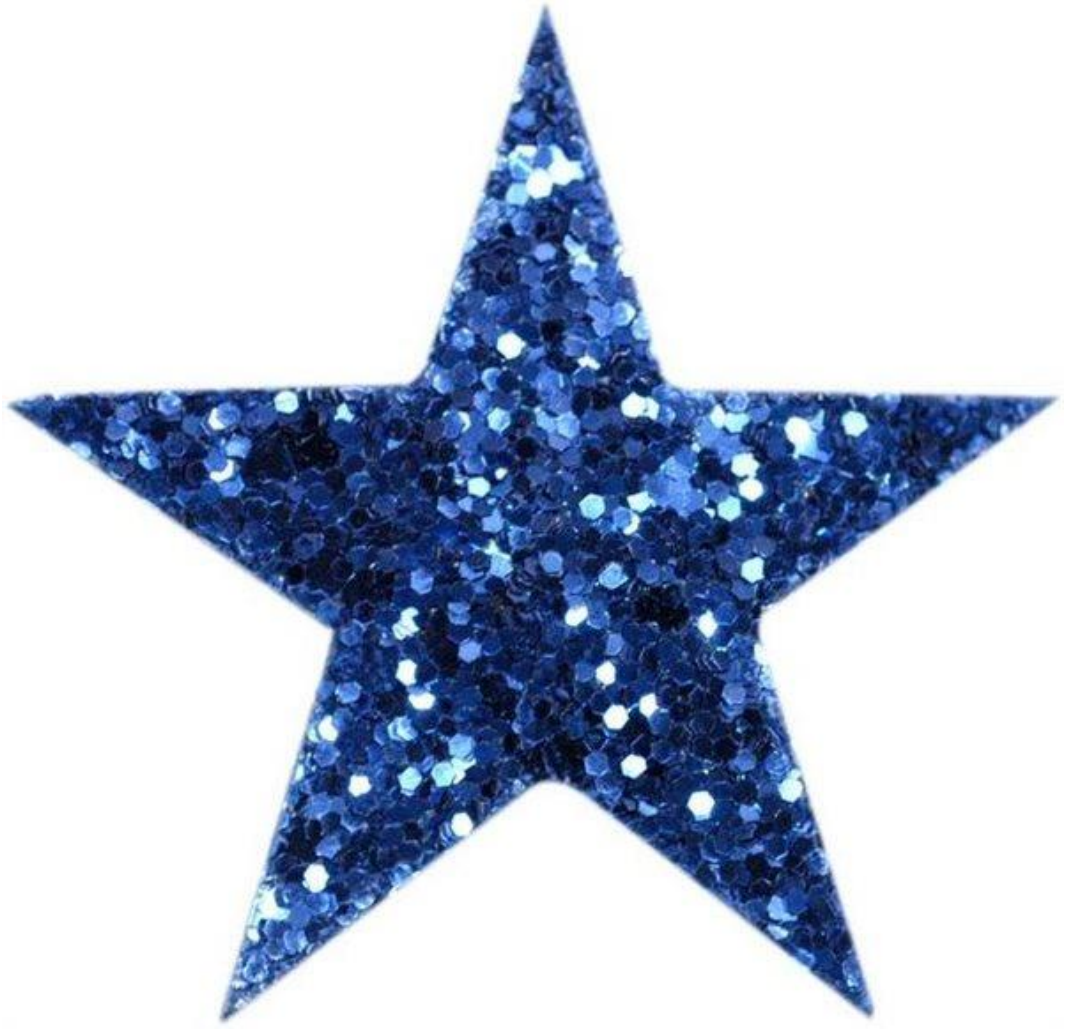
LÆGEFÆLLESSKABET

At give mest til dem med størst behov

Tegning: Rasmus Høyer, Finans

Stjernepatienter



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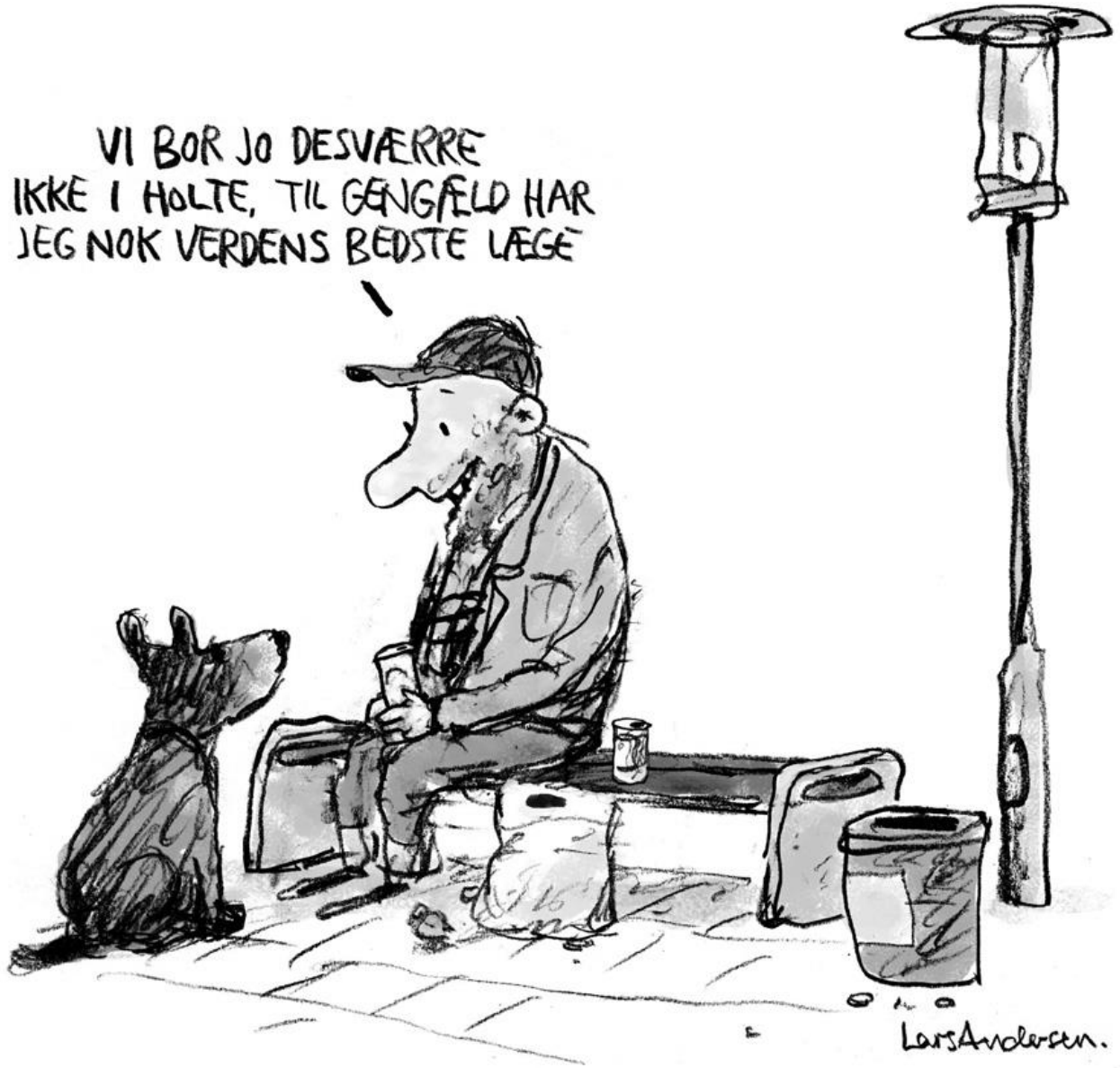
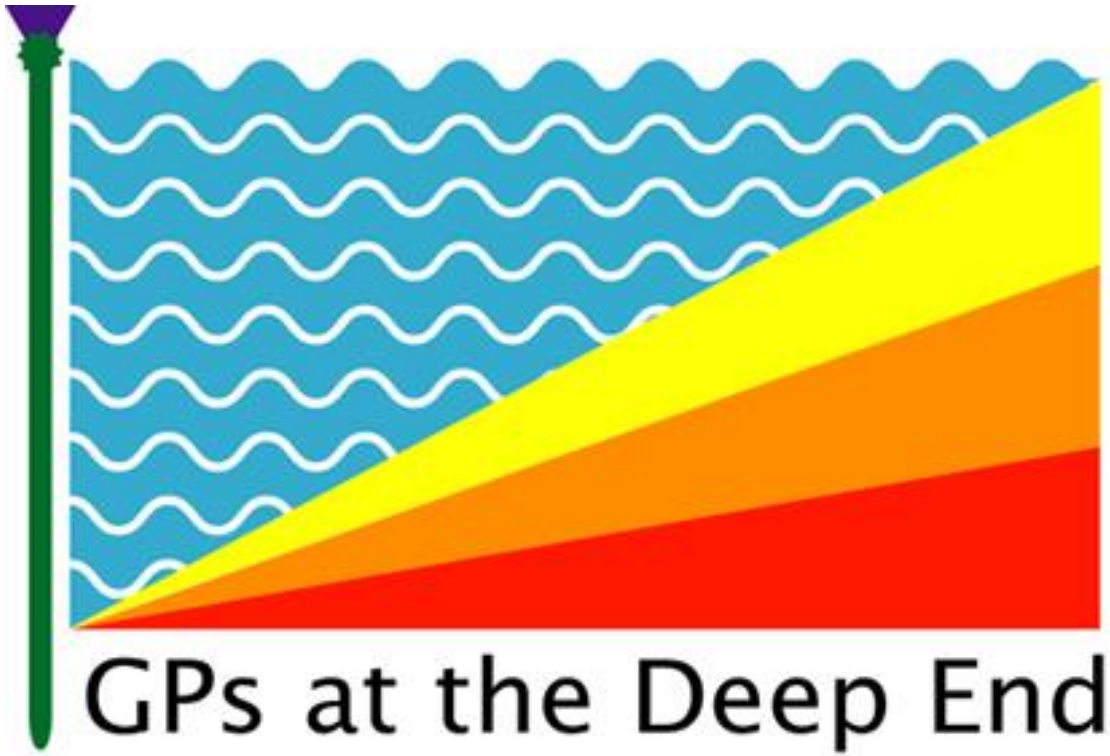


Tegning: Lars Andersen, Dagens medicin

Deep end project



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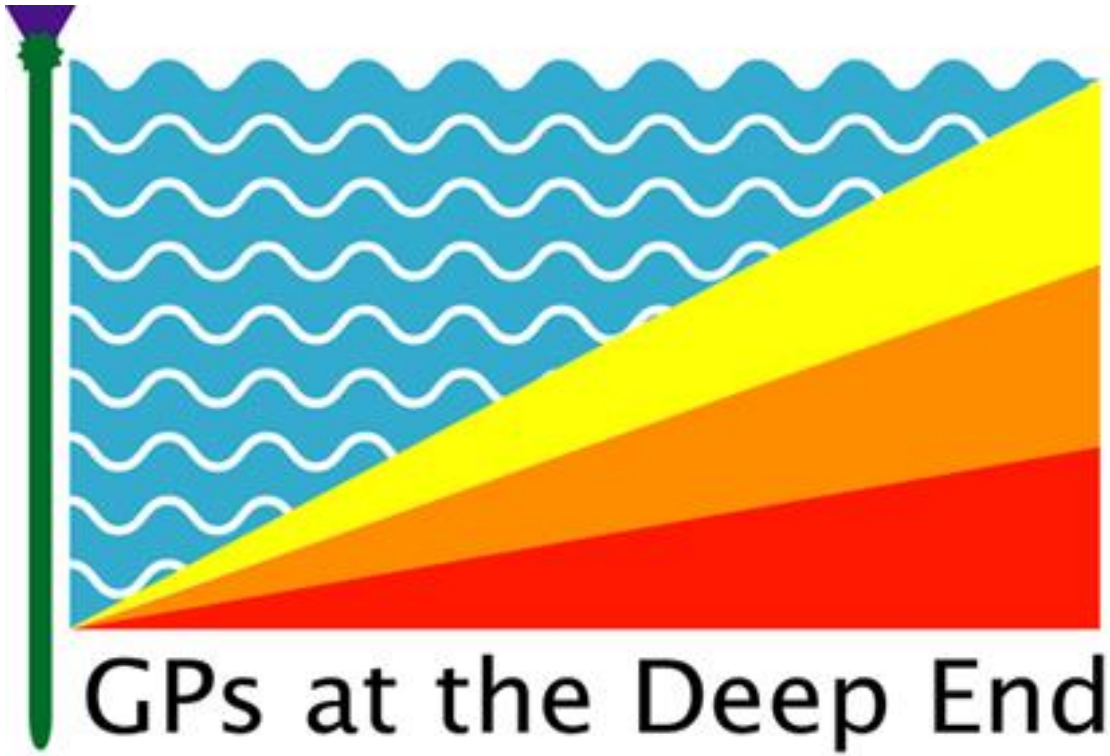

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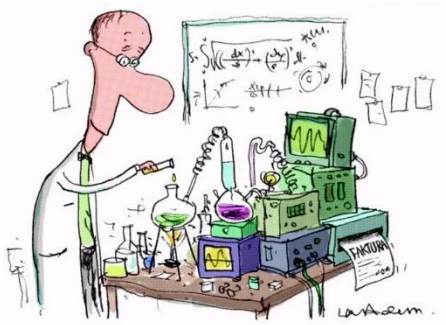
LÆGEFÆLLESSKABET

Fokus på at få noget gjort

Deep End GP's



Forskning

Tegning: Lars Andersen, Dagens medicin

International samarbejde

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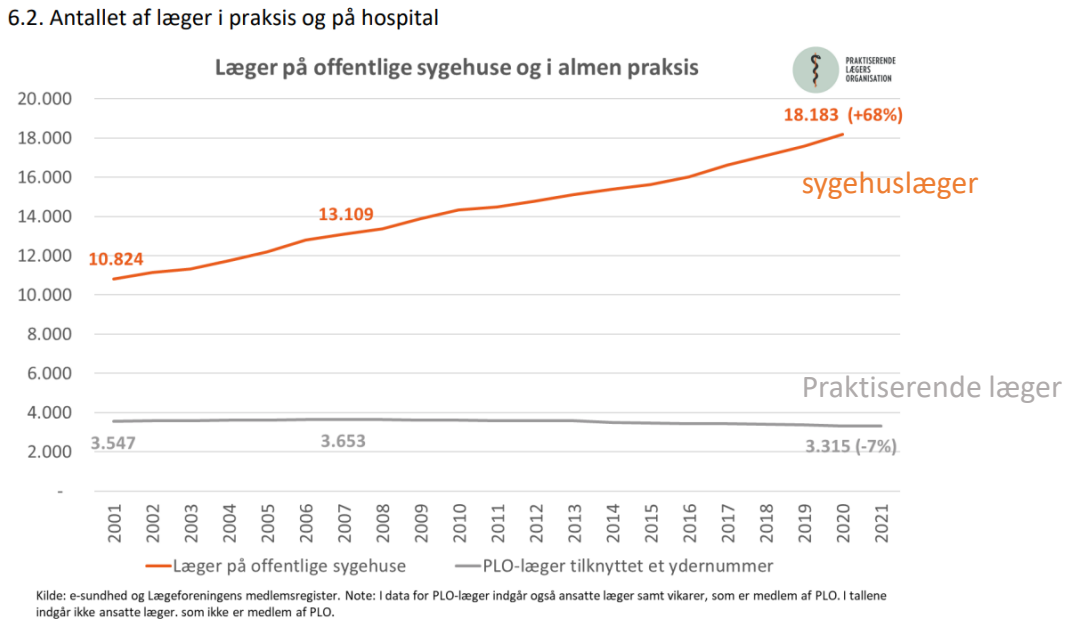
LÆGEFÆLLESSKABET

Populationsansvar

Tegning fra Jyllands Posten

Det nære sundhedsvæsen

Tegning: Lars Andersen, Dagens medicin



PLO analyse

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INDSATS I UDKANTEN

LÆGEFÆLLESSKABET

Det nære sundhedsvæsen

Tegning: Lars Andersen, Dagens medicin

”Det bør være en del af LEON-princippet, at man skaber rammer, som sikrer, at egen læge har kapacitet til flere opgaver og er fagligt sulten og serviceminded med let adgang og korte ventetider”

Frede Olesen, Dagens Medicin, Marts 2022

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LÆGEFÆLLESSKABET

Det nære sundhedsvæsen

Tegning: Lars Andersen, Dagens medicin

- 1.405 kr. pr. borger pr. år (dec 2019)
- Mere tid – ikke højere løn
- Kompetenceløft
- Protected time

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LÆGEFÆLLESSKABET

Indsats på bosteder

Modelfoto: IBG ProReact

- Plejecenter
- Socialpsykiatrisk bosted
- Voksne med senhjerneskade
- Voksne med udviklingshæmning
- Kriminalitetstruede og dømte unge

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LÆGEFÆLLESSKABET

Række ud mod lokalsamfundet

- Social prescribing
- Brobyggere
- Kendskab til lokalsamfundet og dets ressourcer
- Dialogforum for socialt udsatte

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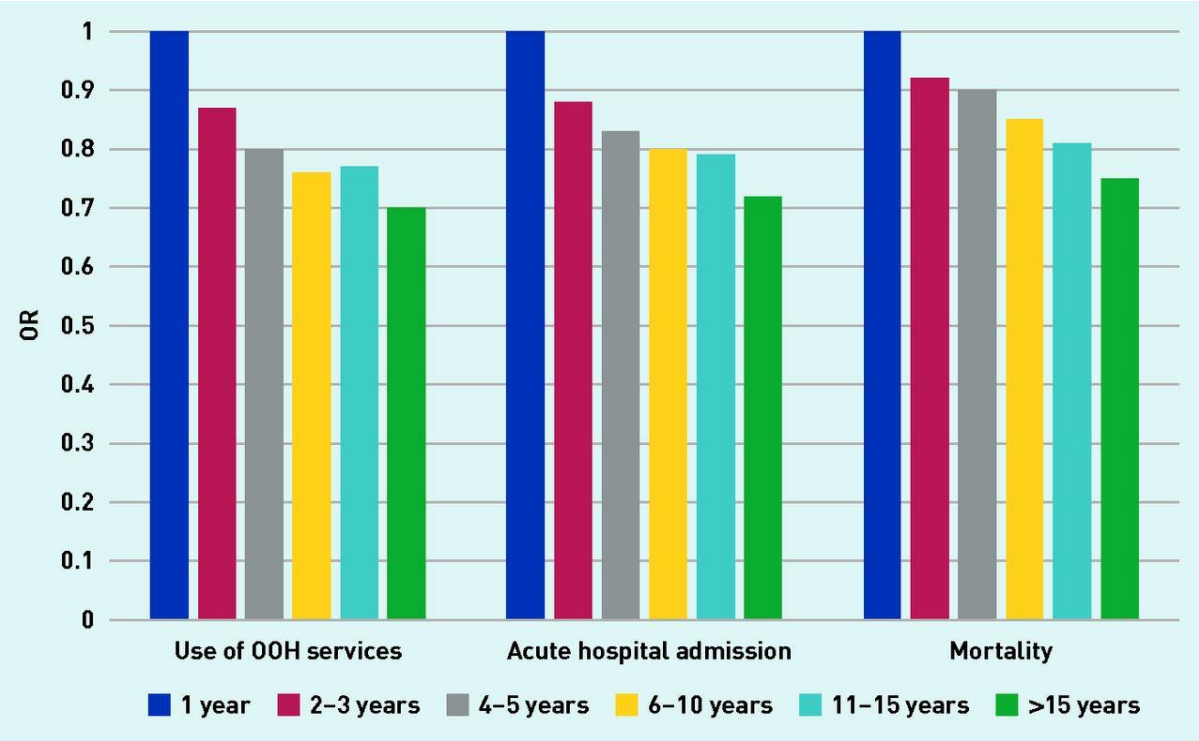
LÆGEFÆLLESSKABET

Kontinuitet er en effektivt behandling

Desto længere tid patienter er tilmeldt samme lægehus desto færre lægevagtbesøg, akutte indlæggelser og dødsfald

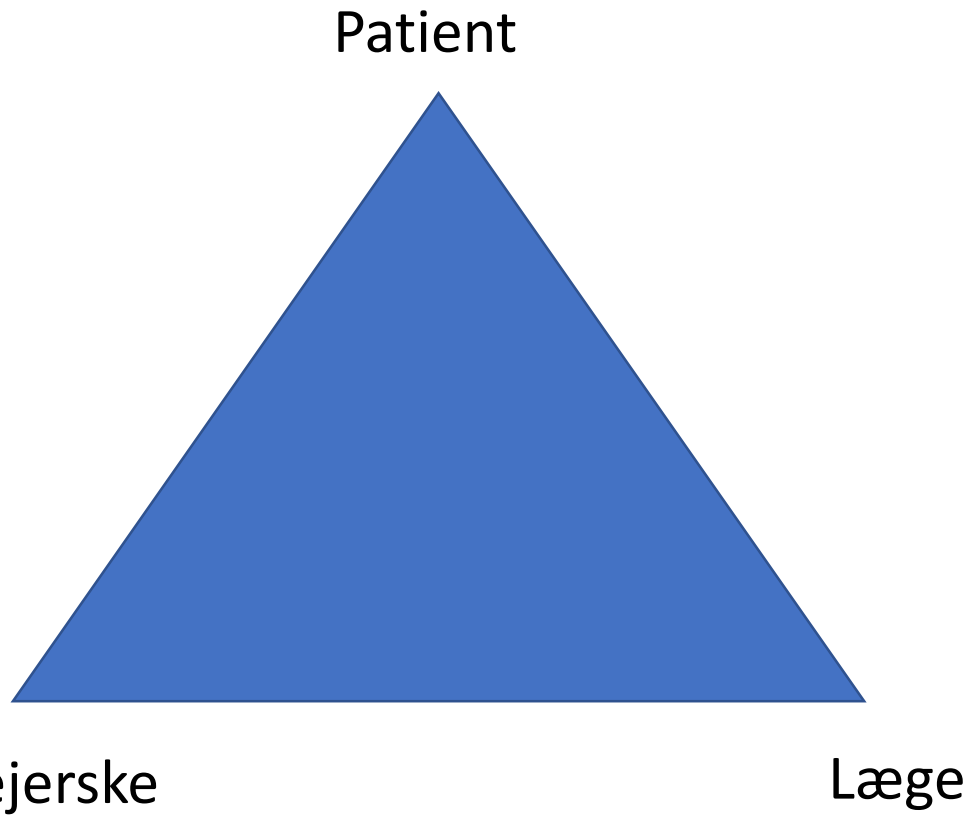


Sandvik et al, Br J Gen Prac 2021

LÆGEFÆLLESSKABET

Behandlerteam

Behandlerteam skaber kontinuitet for dem med behov for det



Tilgængelighed

- Alle patienter som henvender sig før kl 12 får ”**tid samme dag**”
- Høj tilgængelighed, få udeblivelser
- En fordel for patienter som ikke er så planlæggende

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LÆGEFÆLLESSKABET

To kvinder med diabetes

Gravid kvinde med diabetes

Kvinde med skizofreni og diabetes

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LÆGEFÆLLESSKABET