

# Inverse and Positive Care Laws

FLORENCE Nightingale once wrote that, 'What we get into scrapes for is not for saying what nobody believes and everybody says, but for saying what everybody believes but nobody says'.<sup>1</sup> With similar thoughts in 1970, I wondered if there might be some simple and memorable phrase that might provoke more thought about what everyone knew but nobody said, for example, that communities most in need of good care were least likely to get it. Everyone remembered Newton's Inverse Square Law — at least that it existed, if not what it said. So perhaps they might remember an Inverse Care Law,<sup>2</sup> and even do something to get rid of it, for it was not a law of nature, but of our particular human society where civilisation was subordinated to market economy.

In this issue of the Journal, Mark Hann and Hugh Gravelle<sup>3</sup> confirm yet again that the Inverse Care Law still rules, in yet another field of care provision — this time the distribution of general practitioners (GPs) in relation to measures of social need. Despite more than 50 years of egalitarian effort by health ministers using the Medical Practices Committee to steer entrants away from richer and healthier overdoctored areas toward poorer and sicker underdoctored areas of Britain, a rational distribution has never been fully achieved; by 2003 maldistribution was greater than in 1974. In contrast to the United States, through planned distribution the National Health Service (NHS) greatly reduced the extreme imbalance of the care market before the Second World War, but it was never eliminated. By the 1970s progress had virtually ceased, and as this paper shows, it even went into retreat.<sup>3</sup>

Why has this happened, despite consistent policies from every government sincerely aimed at equality? The Inverse Care Law is created and sustained by market forces in the economy at large, by direct economic incentives and disincentives, and by an originally dominant professional culture accumulated around those incentives and disincentives. Devoted though governments may have been to equity in care, they have been even more devoted to profitable business — and sincerely so, for every one of them believes that this is the source of all wealth and, therefore, the foundation of civilised society. But without substantial redistribution through taxes, economic growth in a capitalist society has always, and everywhere, led to social polarisation; the creation of rich people depends on the creation of poor people. Government policies may use one little finger to encourage doctors to work where they are needed, but they use the other nine and all their toes to encourage a private economy devoted to making rich people richer, and an increasingly unequal society. The little finger is, of course, losing.

To the extent that the NHS had a planned internal economy distinct from ordinary pursuit of profit, it could manipulate some of these incentives and disincentives to encourage doctors to work where they were most needed. However, since 1979 barriers protecting the NHS

economy from the world of business have been knocked down brick by brick, whichever government people chose to elect.<sup>4</sup>

I have lost count of the papers confirming what everyone already knows: that the closer we get to the world of business, the more our distribution of resources is determined by greed rather than need. Nobody wants it, but that's what we get. It is, they say, regrettable but inevitable — the way of the world. Now, at last, we have a paper disputing that still dominant philosophy of despair. Also in this issue, Mary Shaw and Danny Dorling present evidence justifying a Positive Care Law, not by doctors but by the informal carers of sick people in their communities.<sup>5</sup> The distribution of work by unqualified people providing more than 50 hours a week of unpaid care to their relatives or friends is almost completely appropriate to need. This Positive Care Law is created and sustained by human forces — family, neighbourly, and community ties that have somehow resisted the socially divisive and dehumanising force of the market.

There is nothing inevitable about market solutions for social problems, for many (if not most) of which the market economy is itself the underlying cause. Virtually all empirical evidence indicates their failure in all respects save one — that powerful people make a lot of money out of them, regardless of the service they provide. Collaborators have no significant empirical evidence to justify their policies of appeasement. All too often, kind words about the Inverse Care Law are an apology for continued capitulation, cowardice, and avarice. Shaw and Dorling present a much more important and challenging idea: that organisation of medical care should become as rational as what patients and their families, friends, and neighbours have already achieved for informal care. The Inverse Care Law will then become a footnote to history, scarcely credible to our more civilised descendants.

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## References

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