

Corrigendum to: Equity in primary health care provision: more than 50 years of the inverse care law

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Australian Journal of Primary Health, 2023, **29**(2), i–ii.
doi:[10.1071/PY23062](https://doi.org/10.1071/PY23062)

The authors wish to add the following reference to the reference list:

Goodyear-Smith F (2023) Equity in primary health care: the legacy of Julian Tudor Hart and a personal journey he inspired. *Australian Journal of Primary Health* **29**, 126–130. doi:[10.1071/PY22081](https://doi.org/10.1071/PY22081)

The new reference should have been cited on page i, the text should read “In this special issue, we have a first-hand account of Tudor Hart and his work from Professor Felicity Goodyear-Smith, who worked with him in his practice and saw his commitment to research embedded within clinical practice that aimed to improve people’s lives (Goodyear-Smith 2023).

Equity in primary health care provision: more than 50 years of the inverse care law

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Professor Julian Tudor Hart was a Welsh general practitioner who meticulously documented the inequity in healthcare access and outcomes that he saw for the patients in his disadvantaged community. In this special issue, we have a first-hand account of Tudor Hart and his work from Professor Felicity Goodyear-Smith, who worked with him in his practice and saw his commitment to research embedded within clinical practice that aimed to improve people's lives. It's been just over 50 years since Tudor Hart published his seminal paper outlining the Inverse Care Law, 'the availability of good medical care tends to vary inversely with the need of the population served' (Hart 1971). This paper has influenced healthcare within many systems and highlighted the need for consciously advocating for appropriate levels of access for at-risk groups and as a driver for universal healthcare.

Primary care is recognised as the best way to provide equitable, effective and efficient healthcare services to populations. There have been some gains made since Tudor Hart first wrote about the inverse care law, most significantly in the conceptualisation of inequalities and health equity with more recognition of intersectionality, the acceptance of the impact of the social determinants of health and the increasing recognition of the commercial determinants of health. Yet, Harris and Harris (2023) remind us of the second sentence of the Inverse Care Law, 'This inverse care law operates more completely where medical care is most exposed to market forces and less so when such exposure is reduced (Hart 1971)' and outline the market forces that currently shape primary care access in Australia, that sometimes do not lead to more equitable outcomes (Harris and Harris 2023).

This special issue highlights programs, policies and approaches to comprehensive primary health care that are influenced by the spirit of the Inverse Care Law. The issue includes a number of papers outlining primary care issues for First Nations peoples, emphasising the foundational and critical inequality facing Aboriginal and Torres Strait Islander peoples. One narrative review outlines educational interventions for healthcare workers in Australia, New Zealand, Canada and USA, highlighting the need for more focus on the effectiveness of such interventions (Rissel *et al.* 2023). Tane *et al.* (2023) outline a culturally appropriate smoking cessation program for Aboriginal and Torres Strait Islander women. Burgess *et al.* (2023) explored the appropriateness of Patient-Reported Outcome Measures for diabetes with Aboriginal people and found them wanting.

The issue also includes two papers on the primary health care needs of the trans- and gender-diverse community with a case study of model of primary healthcare to improve access to gender-affirming care (Clune *et al.* 2023), and an overview of psychotherapeutic strategies in primary care with trans and gender-diverse clients, which highlights power dynamics within the therapeutic relationship (Waldron *et al.* 2023). These papers are timely with the needs of the trans- and gender-diverse community for safe and effective healthcare being increasingly recognised.

Access and quality of care are long recognised needs for culturally and linguistically diverse communities within Australia. Chua *et al.* (2023) outline an evaluation of an innovative approach for healthcare coordination that is nurse-led and co-located in general practice. 'M-ChooSe' assists patients from CALD backgrounds to access the health system more efficiently and effectively (Chua *et al.* 2023).

Primary health care practice, research and training have a critical role to play in understanding and redressing the inverse care law. The Deep End GP Pioneer Scheme from Scotland aimed to improve recruitment and retention of GPs in areas of the

Published: 20 April 2023

Cite this:

Harris-Roxas B and Sturgiss E (2023)
Australian Journal of Primary Health, 29(2), i–ii.
doi: [10.1071/PY23062](https://doi.org/10.1071/PY23062)

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greatest socioeconomic disadvantage (Dhanani and Blane 2023). Reath *et al.* (2023) outline the need for appropriate resourcing of PHC and general practice University departments so that they can lead research and teaching on equity to inspire future primary care workforce. Welsh colleagues outline practical solutions to improving research engagement with more disadvantaged communities to ensure their needs are represented in primary care research (Yu *et al.* 2023). These examples demonstrate the key role that PHC can play in realising the Inverse Care Law in our communities.

Significant gains have been made in health care delivery and the development of health systems over the past 50 years. The countries and jurisdictions described in the papers in this special issue generally have excellent health systems by international standards. Despite this, barriers to affordability of healthcare persist and there are increasing challenges for many population groups to have access to the care they need, in particular to preventative care.

There are still significant gaps in research, including how the inverse care law affects different groups of patients and their carers within specific settings. The papers in this issue make an important contribution, but we cannot assume that the importance of the inverse care law in determining health outcomes has been demonstrated, is known, and is accepted in all settings. A strength of Tudor Hart's original research was its clear clinical relevance, and demonstrating the nature and the impact of the inverse care law in clinical settings should remain a priority.

Systems of care, and individual practitioners and researchers, do not always recognise the intersectional nature of disadvantage (Bowleg 2021). The impact of multiple forms of disadvantage and stigma over the life course is complex and compounding, affected by discrimination based on culture, sexuality, gender identity, mental health, addiction, work and unemployment, and housing and homelessness, amongst other factors (Bowleg 2021). Although this issue does not specifically address poverty, we cannot forget the importance of income inequality as one of the primary manifestations of disadvantage. Poverty remains one of the principal determinants of how the inverse care law plays out in primary health care and it is a cross-cutting issue that affects all disadvantaged groups to varying degrees. All approaches to improve the access to primary care would benefit from specific attention to how the needs of those living in poverty are served.

Comparative studies have found that the Australian health system continues to score relatively highly on measures of

health equity (Tikkanen *et al.* 2020) [ref]. We owe Tudor Hart and the many others who have tackled the inverse care law for many of these gains; however, meaningful threats to the sustainability of services and the health system proliferate. We cannot assume that gains will be sustained, or that the inverse care law has been 'solved'.

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Conflicts of interest. The authors declare no conflicts of interest.

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