SEEING RED

Julian Tudor Hart coined the term inverse care law, which says those who most need health care are the least likely to get it. Now aged 80, he tells **David Brindle** why he's angry at Blair's NHS, former *BMJ* editor Richard Smith, and research ethicists

Meeting Julian Tudor Hart is good for the soul. Whatever you make of his unswerving socialist line on health care in general, and the NHS in particular, his capacity at 80 to be just as angry as he surely was at 18 does much to bolster your faith in humanity.

During the course of a couple of hours' conversation at his home on the Gower peninsula in south Wales, enjoying spectacular views over Oxwich Bay, the former general practitioner and research pioneer professes himself angry or, more usually, very angry on several fronts: Tony Blair; Richard Smith, former editor of the *BMJ* and now chief executive of United Health Europe; but research ethicists? More of this to follow.

More, too, of Tudor Hart's irrepressible optimism. Although the medical profession, in common with other health workers, may in his view have failed miserably to challenge effectively the slide to a market NHS that set in, he says, with the Griffiths report in 1983, he detects in the new generation of medical students a welcome spirit of revolt. We may even be about to see protests like those in 1968, he suspects.

But first to the School of Health Sciences at the University of Glamorgan, where Tudor Hart occasionally mentors students and where he spoke last month at the unveiling of a bust of his hero, Nye Bevan. For him, he said, "the principle of a free service, developing as a gift economy rather than as trade for profit, was central so much so, that when Treasury secretary Hugh Gaitskell drove the first prescription charges through Attlee's cabinet, Bevan resigned his ministry and returned to the back benches, where he became a thorn in the flesh thereafter for every coward who flinched and traitor who sneered."

This notion of the NHS as a gift economy is as central to Tudor Hart's principles as it was to Bevan's. And such betrayals of the founding vision of the NHS seem every bit as keenly felt now as they must have been at the time. In 1951, just as Bevan was quitting, Tudor Hart was months away from qualifying as a doctor. By 1961, he was a general practitioner in Glyncoed, a mining community near Port Talbot, in which he immersed himself and his family for the next three decades. His wife, Mary, worked alongside him as he developed a full blown primary care

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unit, and his three children went to the local school: they were all, as he puts it, “captive.” For good measure, he served two terms as a district councillor.

But it was not as if he disappeared into the valleys; far from it. He has been the author of four books and hundreds of articles in medical journals, a council member of the Royal College of General Practitioners, and a leading light of the Socialist Health Association, and it was in an article in the *Lancet* in 1971 that he famously coined the “inverse care law” the proposition that those people most in need of health care tend to receive the poorest service.

Damage of market care

These days he is somewhat ambivalent about the term—“a banal truism,” as he calls it—but he is very angry, that it was appropriated by Richard Smith in support of United Health’s move into primary care. Tudor Hart has no doubt that the advance of this kind of “managed care” betokens the shift of the NHS from a public service to an industrial model. As he gets tired of pointing out, the second clause of his inverse care law, conveniently ignored by those he cheerfully calls “the enemy,” was that its malign effect was the consequence of market forces.

What attracts him increasingly is the idea that continuity lies at the heart of good care. This means not “empowering” patients as “customers”—terms he derides—but developing them as informed participants or coproducers in small, stable group work. “Continuity is coming up more and more as an important quality,” he says. “And it’s precisely that which is ignored and trampled on by marketed medicine. Shopping around is bad for everybody; it’s bad for salesmen, too.”

It was the remarkable continuity of his practice in Glyncoirwg that provided the opportunity for Tudor Hart’s groundbreaking research. It is no exaggeration to say he revolutionised general practice in the way he studied and documented his 2000 patients, screening them for treatable health risks and achieving age standardised death rates 28% lower than in a comparable community. The practice was the first to win funding from the Medical Research Council, and Tudor Hart’s research team, headed by his wife, achieved extraordinary results: imagine the degree of

trust involved in achieving 85% compliance after 12 months in a double blind trial of low dose warfarin among middle aged coal miners at high risk of coronary heart disease.

Could that be done today? Tudor Hart suspects not. Research ethicists have got it in for general practitioners and their teams who want to study their own patients, he believes. In his former practice, he says, the local research ethics committee recently vetoed a valuable piece of work on medicines compliance and hoarding. “I think that’s intolerable,” he fumes.

“If you are a new GP, from day one you are in the research business. Every practice really has a research dimension which may or may not be exploited in a sensible, imaginative way. But it’s there. These guys, it seems to me, are blocking the door to it. I think it needs very fundamental discussion.”

Tudor Hart’s conviction could be taken for arrogance, but he can be disarmingly self-deprecating. He did “silly things,” he says, like standing three times for parliament on a Communist party ticket (he left the party in 1978, joined Labour in 1981, and remains an active if disgruntled member). And he has been “quite wrong lots and lots of times, predicting great forces of resistance that don’t materialise.” Asked if he sees no positives in the NHS story post-Griffiths, he deftly adjusts the timescale but admits: “In almost all dimensions, everything is unrecognisably better than it was in the 40s and 50s.”

Before Blair can make this a footnote to his legacy, though, Tudor Hart quickly adds that such progress is attributable largely to advances in health care generally and has been achieved despite the deadweight of NHS policy and structures. Moreover, he is convinced that people are more discontented and insecure for all their better health.

Looking to the future

He has been disturbed to read in the morning paper of the death of an 11 year old boy who hanged himself after being bullied. He mentions the story several times in conversation. “My interpretation is that the disillusionment is real; the diseases of unhappiness—children hanging themselves and so on—do seem to be rising. For a long, long time we’ve been telling ourselves, reassuring ourselves, that it’s

just because we know more of what’s really happening. But I don’t think it is that. I think it’s that we are more unhappy.”

In this context, he had initially wanted to entitle his latest book “A New Path Entirely,” which is how Bevan described his vision for the NHS in a debate in the Commons in 1948. Bowing to his editors, who thought

no one would make the connection, Tudor Hart eventually opted for *The Political Economy of Health Care*. He says the title is “probably better,” although I some-

how doubt he means it and the shimmering prospect of a new path entirely continues to dominate his thinking.

Great hopes are pinned on the medical students he meets. “I think we are reaching a generation who are quite likely within the next year or two to suddenly do a 1968 on us,” he says. “We are certainly reaching a generation who are going to say to their parents, to the rest of the world: ‘What the hell have you been doing?’” Until then, or as long as he remains able, Tudor Hart can be relied on to carry on arguing for a return to unity and solidarity, a rediscovery of what he sees as the lost founding values of the NHS and, perhaps his trademark demand, creation of a salaried general practitioner service.

This last goal has been further set back, he acknowledges, by “this awful thing Blair has done to introduce a kind of fee for service system.” But doesn’t that offer sensible incentives? He snorts, pointing out there were no deaths from cervical cancer in Glyncoirwg after 1964 because he and his team had ensured that smear testing was universal. “If you want to reward practices, that’s the way to reward them for not having cancer of the cervix rather than totting up the number of smears,” he says. “But why do either of these things? For anybody who has seen the bloody disease, the reward from not having any cancer of the cervix is fantastic.”

It is reasoning that makes perfect sense listening to a master of his craft at 80. But you have to wonder how many of his juniors would understand it and not just because they might never have seen the disease.

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See also Review of the week, p 1007.

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