science with eagle-eyed scrutiny by readers. Calderon-Larrañaga *et al* highlighted the important association of deprivation with hospital admission rates and asserted that markers of primary care quality, such as GP supply, were lower in deprived areas. Dr White makes some valid points when questioning the data suggesting that the quality of services in areas of deprivation is inferior.

Having written the accompanying editorial³ to the paper by Calderon-Larrañaga *et al*, I accept that the evidence underpinning the inverse care law is now subject to debate. Whether or not primary care services are better or worse in deprived areas, what is not in debate is that deprivation is the nursery of many chronic diseases, including COPD, vasculopathies and cancer.⁴ The theme of the editorial remains sound: investment in primary care services in areas of deprivation is needed if we are going to improve management of long-term conditions and reduce the impact on stretched hospitals and stretched commissioning budgets. Effective strategies linking health, social care and education in our deprived populations are needed to address the roots of this modern non-communicable plague.

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Primary healthcare factors and hospital admission rates for COPD

Dr White's interesting observations¹ on the paper by Calderon-Larrañaga *et al*² show the real benefit of peer-reviewed