

## Social factors are key to eliminating health inequities

Governments have been quick to recognize that social factors are a key determinant of health, but few so far have attempted to tackle the problem head-on. WHO is creating a new commission on the social determinants of health next year to bridge that gap.

Take any of a series of social determinants such as wealth, education, ethnicity, gender, upbringing or job and the story is the same. People's health prospects worsen as they descend the social ladder.

Recognizing this is not new.

Edwin Chadwick's 1842 report on the sanitary conditions of working people in London showed the disparity in life spans between labourers and gentry, and the UK's 1980 Black Report showed that while the first 35 years of the UK's National Health Service had improved health across all classes, social status was still strongly correlated with infant mortality, life expectancy and use of medical services.

"The three main social determinants of health are income, social class and education," says Mel Bartley, Professor of Medical Sociology at University College London, who points out that the best measures of social class relate to a person's autonomy and freedom to decide what to do when.

"The link between social class and health is via the flight-fight mechanism," Bartley explains. For example, the less control you have the more insecure you feel, and the more you have others ordering you about the more times a day your heart rate goes up. Both insecurity and pressure cause increased levels of stress hormones.

These stress hormones cause peripheral arteries to narrow, thereby increasing blood pressure and triggering fats and sugars to flood into the bloodstream. Responses such as these may have aided the survival of early humans, but today they can contribute to heart disease.

Increased levels of stress hormones also suppress a person's immune system. From a biological point of view, there is no point fighting infections if you are about to be killed by an immediate aggressor. Individuals with increased levels of stress are more prone to many illnesses, including cancer, and people in vulnerable social positions experience these effects more often than the socially privileged. These and other

factors contribute to persistent socially determined inequities in health.

Governments are well aware of this situation but few have made any serious effort to tackle the social and economic determinants that underpin these health inequalities. And international comparisons expose a starker picture.

Take income, for example. While The World Bank announced in April 2004 that the proportion of the world's population living on less than US\$ 1 per day had dropped from 40% to 21% between 1981 and 2001, the progress was uneven.

In sub-Saharan Africa, for example, the numbers of people with this income had risen from 164 million to 314 million, an increase from 42% to 47% of the region's population.

Recognizing the problem, WHO hopes to engender change by setting up a new body called the Commission on Social Determinants of Health. The Commission is planned to run for three to five years starting early in 2005 and will look at the inequities within societies that create inequalities in health.

It also hopes to draw attention to examples of global, national and local policies that have strengthened health equity between and within countries.

"While the Commission will compile scientific evidence on the social patterns that generate health inequities, its main focus will be on action," says Jeanette Vega, head of WHO health equity team.

The Commission will work with political decision-makers, health planners and other stakeholders to identify interventions that really do improve the health of vulnerable populations through coordinated action on key social determinants of health.

This will include targeting issues such as early child development, nutrition, access to education, neighbourhood safety and safe working conditions. The Commission will also help mobilize expertise and resources from WHO and other partners to help countries that want to begin or expand implementation.

"Working with global partners, including other UN agencies, the Commission will also identify concrete steps to be taken at the global level to create an enabling environment for progress on social determinants," says Vega.

Looking for good practice in one part of the world and applying it to others depends on the similar factors having similar effects in different places.

Research published in the *Lancet* last month (2004;364:937-52) suggests that this may be possible.

It looked at 15 152 cases of myocardial infarction and 14 820 controls from 52 countries representing the full socioeconomic range.

The researchers found that a spectrum of nine risk factors, including psychosocial and dietary factors, accounted for 90% of the population-attributable risk in men and 94% in women. They conclude that this indicates that prevention policies can be based on similar principles worldwide.

The Commission has a few examples of success to draw on.

Beginning in the late 1990s, Sweden began a broad national consultative process involving all major political parties, as well as civil society and other stakeholders. The result has been a bold new national public health strategy that aims to create social conditions to ensure good health, on equal terms, for the entire population.

This strategy sets national health goals, targeting the determinants of disease and injury at the societal level and takes a multisectoral perspective. Instead of primarily focusing on reducing the prevalence of a specific set of diseases, it aims to strengthen conditions that broadly improve health in society that will, in turn, produce healthier individuals.

The programme includes strategies to reduce housing segregation and social isolation, as well as channelling extra resources to schools and other support structures for young people in socially disadvantaged housing areas. It fosters participation in healthy leisure

activities and creates safe and equal conditions in childhood for all children.

The strategy aims to reduce unemployment and eliminate hiring discrimination against immigrants. In addition, there is a drive to make the built environment safer and healthier, and to improve patterns of nutrition and exercise across all segments of the population.

The Commission can also look to the United Kingdom (UK), which since the arrival of the New Labour government in 1997 has not only set out to improve health for everyone, but also to narrow the gap between the worst off and everybody else.

The UK Government has set goals with numerical targets for reducing inequalities to be achieved by 2010, so it is too early to say whether they will be met.

"For the first time a government set out to develop policies aimed at reducing the gap between the best and worst," explains Sir Michael Marmot of University College London.

To do this the UK Government set up a major spending review that aimed to reduce inequalities in health.

To shift the focus of thinking from simply concentrating on health services to looking at the other social determinants the Treasury (finance ministry), not the Department of Health, chaired the review.

"I counted people from 16 different departments around the table: early child development, education, social exclusion unit, women's unit, Department of Environment, Home Office etc," says Marmot.

Issues such as stress, unemployment, social exclusion and poor transport all influence people's health.

A five-year project that ran in the socially disadvantaged Borough of Newham in east London put this thinking into practice.

Two problems in the area were high unemployment and job vacancies in the health services. A government-sponsored project called *Fit for Work* concentrated on training and employing local people. As a result it addressed some of the health service needs, tackled unemployment, and reduced unemployment-related ill health.

Lessons can also be learned from Kerala, a state in southern India, where the government in 1997 decided to let local people develop local solutions to locally important infrastructure, welfare and health issues. This is important, as being in control of your life is a potent social determinant.

"The project did succeed in a number of villages, while in others there were allegations of corruption and in yet others the political parties opposed the idea," says K. R. Nayar, associate professor at the Center of Social Medicine and Community Health at Jawaharlal Nehru University, New Delhi.

Subsequent governments have turned off the funding, closing the programmes. Nonetheless, Nayar believes the experience was valuable.

"Kerala may be considered as an expression of the democratic rights of people in an effort to counter the onslaught of globalization and centralization of governance," he says.

"To that extent, it could be considered as a lesson and a model for countries undergoing structural adjustment," Nayar says, adding that since people themselves plan for health care and the agenda is not imposed from above, it could be effectively used as a tool for strengthening primary health care.

According to Professor Barbara Starfield, the director of the Johns Hopkins University Primary Care Policy Center, Baltimore, health services are themselves social determinants and focusing on primary care, as opposed to specialty care, is critical for any government planning on reducing inequities.

"With the exception of Canada, most of the countries in the Americas don't have primary care systems," says Starfield.

In June 2000, Starfield founded the International Society for Equity in Health, which together with the Pan American Health Organization is developing specific programmes aimed at reducing inequities.

Marmot hopes that WHO's new Commission will be able to highlight best practice and enable willing governments to realize that health inequalities have their origins in social and economic factors.

"New policies should be based on a recognition that health is determined by factors other than healthcare," he says. ■

Pete Moore, *London*

### Call for papers on Maternal and Child Health

The *Bulletin of the World Health Organization* is seeking Research and Policy and Practice papers dealing with maternal and child health for a projected issue on this topic to be published in the first half of 2005. We are particularly interested in papers that deal with the following topics: why it is important to invest in the health of women and children; how care for women and children has been affected by global policy change; assessment of the public health challenge; how to meet the needs for effective care of women and children; human resources aspects of maternal and child health; economic aspects of maternal and child health; and countries' responsibilities towards the health of mothers and children. We will also consider relevant submissions on this topic to the other sections of the *Bulletin*: Perspectives, Round Tables, and Public Health Reviews. Manuscripts should be submitted to <http://submit.bwho.org> by 1 November 2004, respecting the Guidelines for Contributors, and accompanied with a cover letter mentioning this call for papers.