Editorials

Creating healthier societies

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When governments think about health, attention is usually on the cost of health care as that is where the money goes. The causes of ill-health tend to take second place. To the extent that causes intrude on policy-makers, a convenient, but loose, dichotomy presents itself: in the poorer countries of the world the burden of ill-health is the result of infectious disease linked to poor environmental conditions and malnutrition; the richer countries are now in the era of diseases linked to lifestyle and unhealthy choices. This simple view is not so much wrong as inadequate. The proximate causes of ill-health may, in part, be unhealthy environments or lifestyle but these have social causes in both poor and rich countries (*1*).

Social causes of ill-health have been well known to researchers for centuries. In the 19th century, writers such as Emile Durkheim in France (*2*) and William Farr in England (*3*) related suicide and patterns of mortality to features of society. In the modern era, with infant mortality among the poorest groups in rich countries at around 8 per 1000 live births, it is possible to argue that the severest problems of material deprivation have been solved. This does not mean, however, that the social environment has ceased to be important. Most babies might survive the first year of life, but there are still major social differences in life expectancy. In Britain, for example, in the 1990s there was a nine-year gap in life expectancy between the highest and lowest social classes (*4*). In the USA, the gap in life expectancy between the healthiest and unhealthiest counties was nearly 20 years (*5*).

Features of society that cause such differences have been studied by select groups of researchers, but their findings have had little impact on health policy. For this reason, the International Centre for Health and Society at University College London, at the request of the WHO Regional Office for Europe, summarized the evidence on the social determinants of health in a way that would be helpful for policy-makers. The WHO premise was that simple health messages, such as "smoking kills", had a big impact and that something similar was needed for the social determinants of health.

The result was *The solid facts*, summarizing social determinants of health in ten messages. The first edition was translated into 24 European languages and a second edition has just been published (*6*). The supporting evidence was published separately (*7*). In summary form, the ten messages are:

- Health follows a social gradient.
- Stress damages health.
- The health impacts of early development and education last a lifetime.
- Poverty and social exclusion cost lives.
- Stress in the work place increases risk of disease.
- Job security improves health; unemployment causes illness and premature death.
- Social supports and supportive networks improve health.
- Alcohol, drug and tobacco use are influenced by the social setting.
- Healthy food is a political issue.
- Healthy transport means walking and cycling and good public transport.

Governments all over Europe found *The solid facts* of help in formulating health policy. In the United Kingdom, for example, the Independent Inquiry into Inequalities in Health made a series of recommendations based on the evidence that went into preparing the text (*8*). Many of these recommendations have been adopted (*9*). The authors did all their research in rich countries and had European settings in mind when they wrote the text. How relevant are these same messages likely to be in a broader context? Might they apply to today's developing countries?

One should not assume without careful consideration that the messages are appropriate throughout the world. Indeed, it would be timely to convene researchers from rich and poor countries alike to examine this question. My own view is that they are likely to be relevant. While it is true that infectious diseases still wreak havoc in developing countries, in many of these countries cardiovascular diseases constitute the first, second or third cause of death. Injuries and neuropsychiatric disorders are major contributors to the burden of disease (*10*). If the social factors summarized in *The solid facts* influence these health problems in European countries, it is highly likely that something akin to them will be found to be relevant in the rest of the world. If that does turn out to be the case, the implications are large. Attention to the social determinants of health is likely to aid the success of programmes focusing on specific diseases, as well as dealing with a set of influences that affect disease by other pathways.

The challenge is to synthesize research findings in a way that is likely to be useful to policy-makers not only in health departments but across the range of government activities that impinge on the social determinants of health. The aim is to improve health of individuals by creating healthier societies. ■

References

Web version only, available at: http://www.who.int/bulletin

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