of existing activities, but found that policy implementation in Europe is far from systematic. That is a real challenge for the change within a generation which is the ambition of the CSDH.

DETERMINE is also finding, as did the CSDH, that implementation and economic research is difficult both to access and define. A project called 'Gradient', due to begin work from 2009 researching child and family social determinants and policy implications, will be co-funded by the 7th EU Research Programme.

The ground on which the report falls in Europe is partially prepared—health, welfare, education and governance systems are largely developed if not well oriented or resourced—but there is recognition that the thorniest areas are well entrenched and need sophisticated arguments.

Report of the WHO commission on social determinants of health: a French perspective

Seen from France, this report underlines how far we still have to go in our country to reduce social inequalities in health. France is not one of the partner countries of the Commission1 and the conceptions of health determinants which are developed in the report appear far removed from the paradigm which predominates in our country. We can no longer say that France is at the 'pre-contemplative' stage: data exist, the phenomenon of social inequalities in health is known and well documented for numerous states of health. But these efforts, which issue largely from the world of research, have not resulted in a system of routine statistical surveillance. Furthermore, at this 'contemplative' stage, there is no explicit public policy and no objective written down in law. In the law on public health policy of 2004, objective 34 touches on this question, but restricts it to the state of health of the most precarious populations.

Mobilizing opinion

As stated in the report, reduction of social inequalities in health is above all a political problem, but it is essential to provide evidence. In this respect, the report lends support to those who, in France, think that it is important to continue to increase our knowledge of the subject, but that the most pressing question is how we can move on to the active stage. It is strange to see how our country, always ready to give others lessons on human rights, tolerates a problem as well documented as social inequalities in health. Although the right to optimal health is laid down in a number of texts, this question of social justice and ethics does not mobilize opinion. This is so in France, but also throughout the world. The question thus remains to find out on what basis opinion and the decision makers can be mobilized. Though today it is unfortunately a fragile argument, it seems to us that the ethical imperative put forward in the report must remain central. The fact that the reduction of social inequalities can be a source of economic gain, as shown in a Canadian report,1 is an argument to be developed in order to remove economic objections, but it cannot be the central argument for mobilization.

WHO reports 2000 and 2008: very different perspectives

This report may well enjoy less popularity in France than a previous WHO report.3 In its World Health Report 2000, the World Health Organisation had no hesitation in describing the French health system as one of the best in the world. In that report, the conception of health determinants was in line with the prevailing conception in France. The health system was described as being the essential factor of the good health of a country. 'If Sweden enjoys better health than Uganda—life expectancy is almost exactly twice as long—it is in large part because it spends exactly 35 times as much per capita in its health systems.' On the basis of this analysis, since 1945 France has enjoyed a system of social protection which proclaims, among its objectives, the improvement of the population’s level of health. Within this system of social protection, the general health insurance system, completed by specific schemes for the poorest among the population, should allow widespread access to health care. The number of French people who have the benefit of insurance against ill health has constantly increased over the years and now almost the entire population is covered. In 2002, according to the Health and Social Protection survey, 91% of residents in France also had complementary coverage.4 At the same time, the mortality statistics remind us that in this country social inequalities in health are particularly marked in comparison with our European neighbours. This apparent paradox calls into question such a conception of health.

Towards fundamental policy choices

The 2008 report puts the determinants back into perspective in a most useful way. On a world-wide scale, access to drinking water, to a diet which prevents malnutrition, protection against the vagaries of the climate are the major
decisive factors in social inequalities in health. In line with this analysis, the report emphasizes actions which target determinants outside the health system and the need for a coherent policy in order to achieve health equity. A large number of spheres are involved, some of which seem a priori far removed from health: these are not only education, but also access to employment, working conditions, the age of retirement, the housing policy and lastly policies of redistribution, through taxation and direct financial aid. These are all relevant to social inequalities in health in France. The impact of investments concerning children at the very start of life and young people, in particular relating to education and training, is strongly pertinent to social inequalities in health, especially because of the links between education, qualification and health later in life. The role of unemployment and working conditions and of housing and transports are emphasized. In agreement with studies which have shown the protective influence of social networks and social support, and the role that a sense of control over one’s life can play, citizens are encouraged to participate actively in decisions related to health—and this theme is a far-reaching one. Behaviour change is not mediated only by individual approaches to health education. The prices of food products, the industrial processing of foods, institutional catering, advertising, legislative measures and regulations are all paths to be explored. We must thus be delighted that the report stresses the intersectoral aspect of the fight against social inequalities in health, as this is a key issue. For example, the report points out the contradictions which were observed in certain Northern European countries when the common agricultural policy of the European Union came to thwart the efforts of the health authorities, themselves supported by the government. It thus will help to promote an intersectoral approach to health, at a national and at a European level, a choice which involves fundamental policy choices. For example, the increase in precarious employment, obligatorily part-time work, poorly paid jobs and their detrimental effects clearly shows that what is at stake here is the choice between a potential political determination and the predominantly economic (and short term) approach which is that of the liberal ideology. Just as for the issue of climate change, the fight against social inequalities in health is clearly revealed here as a global combat implying a choice of development strategy.

From research to surveillance

Measurement and surveillance are one dimension of the solution. With the partial exception of death certificates and of a longitudinal survey of mortality based on the Permanent Demographic Sample, in France social characteristics are ignored by nearly all routine statistics, whether hospital information systems, health insurance data or registers of specific diseases. The data produced by research studies, generally based on one-off surveys or at best surveys repeated every few years, do not allow us to grasp changes in inequalities over time. The proposals for a minimum statistic system and a system which covers social determinants are important and should be developed in France. The information systems of healthcare institutions, starting with those of hospitals, are silent as to the social situation of those who use them, and this evidently restricts their ability to adapt their services to the needs of these persons.

What about the health care system?

Naturally, the report does not elude the question of healthcare and advocates universal access to quality care. At a time when health expenditure is strictly limited, it is important to examine the question of patients’ share in these expenses and its effects on care consumption and health in the light of health inequalities. The Rand Corporation study,6 carried out in the 1970s in a sample of American families, followed for 3–5 years and randomly assigned to health insurance plans which differed by levels of reimbursement and the share to be paid by the household, is still topical. The conclusions of this randomized study showed that the amount of care consumed decreased markedly as soon as >25% of the cost was borne by the patient. No difference in state of health was observed in the population as a whole. But the impact of the cost to be borne made itself felt as soon as the poor population was concerned. It is interesting to point out that the share borne by the patient in France has been around 25% during the last 20 years, a proportion which has tended to increase. But the tendency in France is to increase the participation of households in health expenses, including (particularly) persons who are in a precarious situation because of their state of health, with in due course an impact on social inequalities in health.

The report stresses the need for health systems to be proactive. Taking the need for proactivity into account is particularly pertinent in France, where the system is still widely based on a logic of offer. Issues related to secondary access to care are somewhat briefly dealt with in the report, which is strongly centred on primary access. But to ensure that this first phase is well organized is not sufficient if the system is ineffective in other respects, or if its malfunctions concern mainly the most disadvantaged patients.7

The report suggests that the role of the healthcare system goes beyond the treatment of diseases. Physicians and the other health professionals are leaders of opinion, who influence conceptions and representations of health. Finally, this is where analysis of health determinants is put together and where the directions taken by public health and research are given value. This last remark underlines the importance of giving professionals training on social determinants of health. Their commitment is undoubtedly essential to negotiate the turn towards less biological or medicinal concepts of health. The way in which behaviours are conceptualized in fact determines the way in which they will be taken into account by public health.

Towards new research methods

In agreement with what we have said above, the presentation in the report of the aims of research in public health is particularly pertinent: research on the causes of social inequalities in health, on interventions aiming to reduce them, analysis of public policies and lastly statistical measurement and surveillance. In view of the issues at stake and of the nature of the determinants, research on health should be more interdisciplinary and should integrate social determinants. Redressing the balance towards these objectives should enhance their value, unlike a primarily biological or disease-oriented approach. The complexity of the interventions and so of the methods used to evaluate them justifies not only the interdisciplinary approach, but also a reflection on the notion of proof. Going beyond randomized trials, the question is how to make use of qualitative as well as quantitative data. Evaluation of interventions and strategies to reduce social inequalities in health raises a difficult problem, particularly when these are interventions of a structural type or which aim at long-term modifications.
Assessing a research programme carried out in the Netherlands on social inequalities in health, it was found that the interventions subsidized by the programme had been specific, targeted interventions that were easy to evaluate. The projects evaluated were all of this type, to the exclusion of any wide ranging, far-reaching public policy.  

The challenge of dealing with fundamental causes

The causes of inequalities are multiple, and several levels of explanation coexist, proximal and fundamental causes. We pay tribute to the very ambitious nature of this report, which runs counter to the policies of international bodies (WTO) and so underlines the most fundamental causes of health inequalities. The main messages of the report are all the more essential as the financial and economic crisis may worsen inequalities by affecting the weakest first. Can health be the theme to mobilize us towards humane objectives, not only economic ones? The report stresses that the sector of health and healthcare professionals, including the minister or ministers responsible, could take position as defenders of wide societal objectives giving health and health equality their rightful place as a marker of progress. This supposes that professionals and politicians become aware of the importance of social determinants of health. This task is a particularly important one in France, and it is without doubt one of our primary challenges.

References


Thierry Lang¹, Monique Kaminski²
Annette Leclerc³

¹INSERM U558, F-31000 Toulouse, France
²INSERM U953, F-94000 Villejuif, France
³INSERM U687, F-94000 Villejuif, France

Correspondence: Thierry Lang, INSERM U558, Faculté de Médecine, 37 Allées Jules Guesde, 31073 Toulouse, France, tel: +33 5 61 14 59 35, fax: +33 5 62 46 42 40, e-mail: lang@cict.fr
doi:10.1093/eurpub/ckp025
Advance Access published on 11 March 2009