Social rank: a risk factor whose time has come?

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Panel: Evidence-based strategies to minimise the impact of social hierarchy on health

**Invest in children**
- Early childhood development enrichment programmes
- Intensive parent support (home visiting) programmes
- Enrolment of all children in early childhood education

**Get the welfare mix right**
- Regulate markets as necessary
- Implement income transfer policies that redistribute resources (ie, progressive tax and benefit regimes)
- Optimise balance between targeted and universal social protection policies through benefit design that minimises both undercoverage and leakage
- Eliminate child poverty through monetary and non-monetary support for families with dependent children

**Provide a safety net**
- Provide income support or tax credits
- Provide social housing
- Subsidise childcare
- Provide free access to health care (especially preventive services)

**Implement active labour market policies**
- Provide job enrichment programmes
- Democratise the workplace (involve employees in decision making)
- Provide career development and on-the-job training
- Provide fair financial compensation and intrinsic rewards
- Promote job security
- Discourage casualisation of the workforce

**Strengthen local communities**
- Foster regional economic development
- Promote community development and empowerment
- Encourage civic participation
- Create mixed communities with health-enhancing facilities

**Provide wrap-around services for the multiply disadvantaged**
- Coordinate services across government and NGOs
- Provide intensive case management when necessary
- Foster engagement of the targeted families and individuals

**Promote healthy lifestyles**
- Strengthen tobacco control and addiction services
- Improve the diet of poor families (eg, through subsidising fruit and vegetables, community gardens, purchasing co-ops, school meals)
- Provide green space and subsidised sport and recreation facilities

**Ensure universal access to high quality primary health care**
- Subsidise practices serving high need populations
- Provide additional nursing and social worker support for practices in disadvantaged areas
- Assist patients with clinic transport and childcare
- Provide services free at point of use
- Provide conditional cash transfers (to increase demand for clinical preventive services)

Strategies are collated from multiple sources.7

reverse.6 This reverse causation could not be adjusted for in a single equation regression model and could have led to overestimation of the impact of social rank on mortality. However, only a single dimension of social rank—occupational class—was captured, and that only crudely, which will have generated the opposite bias.

Whatever the exact effect and impact of low social rank on the health of individuals and populations might be, the authors’ key message is clear: social rank deserves consideration alongside the established 25×25 risk factors. In fact, intervening on social rank will itself partially address the challenge of unhealthy lifestyles. Moreover, upstream interventions (eg, earned income tax credits, universal early childhood education) are likely to be pro-equity, whereas more downstream interventions (eg, smoking cessation assistance, dietary advice) typically favour the privileged (who generally find it easier to access material and social support for behaviour change).7

Yet are not all modern societies hierarchical? Undoubtedly so, but good evidence suggests that the social gradient can vary in steepness, and its impact on health can be ameliorated, at least in part.8 Is political advocacy not, however, beyond the scope of practice of doctors? After all, doctors lack the requisite formal training to advise on opportunities for health advancement from social policies (panel).

However, the strength of evidence for the effect of social rank on mortality, as exemplified by the study by Stringhini and colleagues, is now impossible to ignore. Moreover, the UN Sustainable Development Goals,10 which have replaced the MDGs and will run from 2016 to 2030, provide a timely opportunity to go beyond the WHO 25×25 goal and place social determinants squarely at the centre of sustainable development. What is needed is strong advocacy from the health professions, led by doctors, for this wider view of risk factors. Does this mean that it is no longer enough for us, as doctors, to know about clinical medicine and human biology? Must we in the health professions also become adept at macroeconomics and sociology? Let us hope so.
As another World Tuberculosis Day passes by the outlook for tuberculosis control is far from optimistic, especially for India, the ground zero for the global epidemic. Last year, WHO declared that the tuberculosis epidemic was worse than previously thought, with an estimated 10.4 million new tuberculosis cases worldwide in 2015.1 WHO estimated that globally 1.8 million people died from tuberculosis in 2015, of whom 0.4 million were also infected with HIV.1 Although global tuberculosis deaths declined by 22% between 2000 and 2015, it is remarkable that tuberculosis today is responsible for more deaths than HIV and malaria combined, and continues to rank among the top ten causes of deaths worldwide.1

WHO estimates that India accounts for 2.8 million (27%) of the 10.4 million new cases, and 29% of the 1.8 million deaths.1 According to the Registrar General of India’s Million Death Study, which documented causes of death in 1.4 million households, tuberculosis remained one of the top five causes of death among people aged 30–69 years.2 By contrast, in China tuberculosis is no longer one of the top ten reasons for dying.3

While India has made significant progress in controlling tuberculosis, there are several factors that contribute to the high burden of disease. First, India has not adequately tackled key determinants of tuberculosis, especially malnutrition and tobacco smoking, which have been clearly linked with excess tuberculosis mortality.14 Second, India continues to underinvest in health, with governmental expenditure on health being one of the lowest in the world at 1.4% of the gross domestic product.17 This underinvestment is reflected in India’s Revised National Tuberculosis Control Program (RNTCP) that has struggled to receive budgets commensurate with the scale of India’s epidemic.

Third, implementation failures and a weak health system have led to suboptimal cascade of care in the public system. About half a million patients with tuberculosis in