Editor's Choice

Stroke — for poorer not richer

It has long been known that poverty has a negative impact on health. In this issue of the Journal, Heeley and colleagues (*page 10*) show that people living in socioeconomically deprived areas in Australia and New Zealand experience higher rates of stroke. They tend to be younger, more likely to have hypertension and diabetes and, not surprisingly, are more likely to smoke.

The magnitude of the difference was startling. When comparing the most deprived with the least deprived groups, the age standardised incidence rate for stroke per 100 000 person years was 70% higher. After adjusting for age, they found that almost one in five strokes could be attributed to living in the most socioeconomically deprived areas compared with the least deprived areas.

In developed countries, stroke is the second most common cause of death after heart disease, and it is predicted that by 2020 this will be the case worldwide. Stroke is a leading cause of disability and results in the loss of at least 49 million disability-adjusted life-years annually throughout the world. Stroke in later life has been linked to socioeconomic deprivation in early life, and even to prenatal factors that have socioeconomic determinants, such as low birthweight and short birth length (*Lancet Neurol* 2006; 5: 181-188).

The effect of socioeconomic status on health is multifactorial. Income, environment, education level and social support are important, as are lifestyle factors such as diet, exercise and smoking. Service provision and access also matter.

The Marmot Review (http://www.marmotreview.org/reviews/english-review-of-hi) was undertaken to put forward evidence-based strategies for reducing health inequalities in England from 2010. Its key message was that health inequalities result from social inequalities and that the reduction of inequality is a matter of fairness and social justice. The Review also identified a "social gradient" for health in England: people living in the poorest neighbourhoods have a life expectancy that is 7 years less than those living in the richest neighbourhoods.

In addition to the health benefits for an individual, the Marmot Review also points out the economic benefits of alleviating health inequalities. These include reduced productivity losses and forgone tax revenue, and reduced treatment costs and welfare payments — all especially relevant to stroke.

In Australia, belatedly, we are aware of the survival difference between Indigenous and non-Indigenous people and there are now calls to "close the gap". There is less awareness of the difference in survival rates across socioeconomic groups.

As a profession, we have a responsibility to the community as well as our individual patients to ensure that the treatments we employ are cost-effective. By extrapolating the message of Heeley et al and Marmot, it's also part of our role to promote health by advocating for policy that diminishes socioeconomic inequality.

The "debate" of the moment is about plain packaging of cigarettes. Smoking has a strong inverse relationship with socioeconomic status and is a major risk factor for stroke. We should continue to advocate for any measure that will reduce it — not nanny state, but Nanny knows best.

Annette Katelaris
Editor, *Medical Journal of Australia*
akatelaris@ampco.com.au