Ignoring psychosocial risk factors might indeed increase social disparities through a biased estimation of true cardiovascular risk, resulting in divergence between the true and the estimated cardiovascular risk. Let us consider two patients who consult for mild hypertension, with the same level of clinical and biological cardiovascular risk factors. Based on their cardiovascular risk estimate, the same decision concerning the treatment of hypertension would be taken. Let us now suppose that these two patients have very different lives. Mr A is a manual worker, has a low level of education, is socially isolated and his occupation is characterized by low job control and high demand. Mr B is a highly educated professional. Considering their psychosocial factors, the true cardiovascular risk of Mr A would in fact be much higher than the true risk of Mr B. Since BP increases with age in our society, at a given time both Mr A and Mr B would meet the criteria for treatment, based on their estimated risk. It is easy to see that, given the underestimation of the true risk of the disadvantaged patient, Mr A, he would start treatment later than a patient with no adverse psychosocial factors such as Mr B. The actual decision threshold for treatment would thus be higher for lower socioeconomic classes, among which psychosocial factors are more prevalent resulting in delayed access to effective care.

Introducing a more comprehensive picture of a patient’s life for estimating his/her absolute cardiovascular risk thus appears as an urgent task in order to avoid perpetuating yet another cause of social health inequalities. This means that social, economic and psychological factors that predict long-term risk should be taken into account when assessing the patient’s future health status. In other fields, such as rheumatology, the rules of prescription of costly drugs such as tumour necrosis factor blockers might be based, in the future, on the estimated progression of the patient’s disability (A. Cantagrel, personal communication). Again, neglecting social factors with a negative impact on disability might increase health inequalities, since patients with adverse factors would have a true risk of disability higher than their calculated risk, and would be denied access to effective health care. It therefore seems important to examine clinical decision rules and see whether those that ignore social context may in fact contribute to increase social inequalities in health. Avoiding social health inequalities by design through clinical decision making would appear to be one of the tasks on our public health agenda.

References

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