

The control factor: a neglected social determinant of health

About 10 years ago, the veteran social epidemiologist Leonard Syme¹ coined the term “control factor” to describe the capacity of individuals to deal with the day-to-day challenges and stresses of life without becoming overwhelmed by them. Morbidity and mortality are affected by whether people have the knowledge, skills, and motivation to work their way round their troubles,¹ irrespective of whether or not they are truly dire.

Interventions that target these so-called soft factors can therefore improve control by teaching people practical capabilities for living their daily lives.¹ Unfortunately, evidence-based strategies recommended to reduce health inequities overlook the importance of control. For example, the WHO booklet *Social determinants of health: the solid facts*² highlights the lifelong importance of social determinants in early childhood, and the negatives of poverty, drugs, poor working conditions, unemployment, and the positives of social support, good food, and transport policy. However, *Solid facts* is concerned mainly with the roles that public policy can have in creating the desired social environment in which individuals achieve better health. As such, it has little to offer in terms of what health workers can do at the microservice levels to enhance control.

After a comprehensive review of the findings from a 10-year programme of indigenous Australian empowerment research,^{3,4} we found this lack of attention to psychosocial control rather unfortunate. It results from unhelpful binary approaches to the relative importance of individual agency versus systemic structures in reducing health disparity. That healthy social policy is the key to achieving better health cannot be overstated. However, unless individuals have the capacity and reason to do something about

their situation, healthy policies by themselves are less likely to achieve the desired effects. Policy guides overlook this important factor, assuming levels of capacity for people to be responsive to the right social policy signals which might not exist, especially among socially and economically marginalised populations.^{3,4}

Broader structural factors have a crucial effect on health, but maintaining focus on these exclusively can be overwhelmingly disempowering for the average health worker and consumers of health care. It is imperative that evidence-based guides address control in its own right alongside the other structural determinants.² The emphasis on political empowerment in the final report of the WHO Commission on Social Determinants of Health⁵ is therefore a welcome development. Evidence needs to be gathered on models that successfully integrate downstream psychosocial control with upstream macropolicies that improve the social environment in a way that advantages those with the poorest health.³⁻⁵

I declare that I have no conflict of interest.

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- 1 Syme SL. Social and economic disparities in health; thoughts about intervention. *Milbank Q* 1998; **76**: 493–503.
- 2 Wilkinson R, Marmot M, eds. *Social determinants of health: the solid facts*. Copenhagen: World Health Organization Centre for Urban Health, 2003.
- 3 Tsey K, Whiteside M, Deernal A, et al. Social determinants of health, the ‘control factor’, and the Family Wellbeing Empowerment Program. *Australas Psychiatry* 2003; **11** (suppl): 34–39.
- 4 Tsey K, Wilson A, Haswell-Elkins, et al. Empowerment-based research methods: a 10-year approach to enhancing Indigenous social and emotional wellbeing. *Australas Psychiatry* 2007; **15** (suppl): 34–38.
- 5 WHO Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Geneva: World Health Organization, 2008. http://www.who.int/social_determinants/final_report/en/index.html (accessed Sept 16, 2008).

Rethinking suicide prevention in Asian countries

Justin McCurry (June 21, p 2071)¹ reports on the high rate of suicide in Japan. However, he does not consider the unique sociocultural circumstances in Asia that preclude psychiatric help-seeking.

Confucian philosophy values harmony, collectivity, and communitarianism, which are contradictory to the individualistic ethos of western psychiatry.² Increasing the number of psychiatric professionals will therefore not directly translate into a decrease in the suicide rate. To illustrate this, the suicide rate in Taiwan has increased three-fold to 17.2 per 100 000 population in the past decade despite a doubling of the number of psychiatrists.

Also, acute life stresses have a more significant role in suicide, and depression a lesser one, in Asia than in the west.³ In Hong Kong and Taiwan, recent increases in the suicide rate have been attributed to both the economic downturn and the media’s promulgation of charcoal-burning suicide.⁴ In Japan, the increase in suicide paralleled the unemployment rate and work-stressed suicide.⁵

The availability and affordability of psychiatric services in Asia have created further barriers for the community and make it less relevant in suicide prevention. Given the large number of suicides (60% of cases worldwide) and huge population sizes in Asian countries, a community-based method rather than a psychiatric and clinical approach would certainly be more relevant and cost effective.

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