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Multidisciplinary call for papers on:

The production of social health inequalities

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This call for papers is aimed at researchers in sociology, political science, geography, demography, anthropology, public health, economics, management, and law, as well as stakeholders in the fields of health and social medicine.

The deadline for submission is Monday 29 March 2021.

Social inequalities in health – SHI, as they are increasingly referred to – have tragically become an issue since they were brought to light by a school of epidemiology informed by the frameworks of social sciences, willing to look at social determinations, and sensitive to the biographical trajectories of individuals. From pioneering works to recent productions (Lang, 1993; Leclerc, Fassin, Grandjean, Kaminski, Lang, 2000; Aïach, Fassin, 2004; Elbaum, 2006; Leclerc, Kaminski, Lang, 2008; Lang, Kelly-Irving, Delpierre, 2009; Haut conseil de la santé publique, 2010; Lang, 2010; Aïach, 2010a; Aïach, 2010b; Lang, 2014; Lang, Kelly-Irving, Lamy, Lepage, Delpierre, 2016; Lang, Ulrich, 2017; Haschar-Noé, Lang, 2017), the literature in this long yet incomplete list shows that SHIs are biologically incorporated throughout an individual's life (Krieger, 2001; Hertzman, 2012).

Hence, it is accepted that "biological phenomena as diverse as maternal health and nutrition, various childhood infections, vaccinations, and stress factors are linked to social processes such as the socio-economic status of parents or their access to health services [...] [in such a way that,] had the whole of a life been an accumulation of disadvantages, any endeavour to repair previously done damages would require significant efforts" (Lang, 2010). This is based on the understanding that "social organization distributes advantages and privileges on the one hand and disadvantages and impairments on the other" (Aïach, 2010b). Yet what are these social processes and this likewise social organization, that so relentlessly command the dealing of advantages and privileges to some and disadvantages, damages, and impairments to others? According to what processes and rationales does this distribution of social inequalities operate in this medical sense?

1. *What is the meaning behind social inequalities in health?*

These questions clearly warrant consideration, as "the transition from the structural facts characterizing society to the observed realities of health remains relatively obscure: the analysis of inequalities does not provide the key to the mechanisms by which macroeconomic and macrosocial transformations influence risk behaviour or prevention practices, mortality or morbidity rates" (Leclerc, Fassin, Grandjean, Kaminski, Lang, 2000). It seems like the "social" quality attributed to health inequalities, as it was introduced and validated by the epidemiologists most familiar with sociological considerations, has gone largely unexamined in terms of its multiple meanings and direct implications. It appears that anything that defies the biomedical paradigm and, more subtly, the epidemiological prism, is deemed "social", which in this case means impalpable, immeasurable, and yet particularly effective. Assuming there were a somewhat mysterious and highly structuring social side to the production of health inequalities, most of the currently available literature proves both incapable of identifying it and unable to characterize its founding principles and determining factors. In this broad overview, the term "social" appears to denote an uncertain element of the indiscernible and all-encompassing "context" within which individuals exist and with which they must come to terms as best they can. This is clearly a blind spot in the prevailing analysis on the subject, that the journal *Agone* undertook to bring to attention by revealing that health was likely to "compound social inequalities" (2016).

Similarly, it is perfectly feasible and indeed imperative, to metaphysically consider that "the SHI situation raises essential issues such as life, death, or justice, that seem to have been forgotten" (Lang, 2014) and thus to invoke the values inspired by Elias' historical civilizing process (Elias, 1997 [1939]), to suggest that this omission may be interpreted as "denial of a fact that belies the myth of equality" (Lang, 2014). Undertaking to analyse the drivers of the production of SHIs is equally important, albeit more mundane and tedious. For, if "social health inequalities are the result of complex processes that occur both in the social sphere and in the biological field [...] and are the subtle product of the other social inequalities characterizing a society at a given time in its history" (Aïach, 2010b), we propose to work collectively to bring to light the social complexity and subtlety of the construction of health inequalities.

Research on SHIs has nevertheless made two major contributions over the last thirty years: the social gradient and health determinants. First, the former contends that individuals' health corresponds to their respective social positions on a continuum (Galobardes, Shaw, Lawlor, Lynch, Smith, 2006; Cambois, Laborde, Robine, 2008; Garès, Panico, Castagné, Delpierre,

Kelly-Irving, 2017; Mackenbach, 2017). Thus "most health indicators (life expectancy, healthy life expectancy, perceived health, healthy behaviour, use of the health system, etc.) deteriorate when descending from the most privileged to the most disadvantaged social categories" (Lang, Ulrich, 2017). Second, the many health determinants identified by research are divided into "three main families": socio-economic determinants; health behaviours; and the healthcare and prevention system. Considered to be inter-dependent, "they form full-fledged chains of causality and accumulate [...] over the course of a life" (Lang, Ulrich, 2017).

We consider these concepts as resources that analysis of the social construction of health inequalities can use both as steppingstones and as variables to be tested. We thus endorse Didier Fassin's argument that "beyond the identification of risk factors made possible by epidemiology, it is for social sciences to understand the processes through which a social order translates into bodies" (Carricaburu, Cohen, 2002). Moreover, "rather than a reality derived from biological, medical or philosophical definitions, health appears to be both a notion and a space defined by the relationships between the physical body and the social body" (Fassin, 2002). The social body and the social order are thus unquestionably heuristic and empirical leads which may render "the origin and the foundations of social health inequalities" (Aïach, Fassin, 2004) respectively thinkable and visible. We therefore argue that, while epidemiology can point them out, SHIs are, amongst other factors, sociologically, politically, geographically, demographically, anthropologically, legally, economically, culturally, and corporally constructed.

Hence, the fact of using the broad spectrum of social sciences calls for the concepts and schools, methods and objects, data and field surveys of various disciplines to be brought together so as to sift through the cumulative determinants of the social and territorialized production of health inequalities. We are confident that by combining and comparing analyses, especially on an international scale and at a time when stock is still to be taken of Covid-19, we will be able to characterize the general production process of domination and social discrimination in health. In so doing, we hope to reveal the conditions under which this process is perpetuated and expanded, in order to counter it more effectively. For there is one issue that remains to be addressed in order to better understand SHIs and undertake to mitigate them: the multiple, complex and embedded logics of their implacable and meticulous production.

2. The social construction of health inequalities

First of all, the social sciences under consideration here aim to confirm, through analysis, that socially constructed inequalities are indeed the issue at hand, as "being rich, educated and healthy is not an option that one could have to pick out among other possibilities. Wealth is more enviable than poverty, education and knowledge are valued more highly than lack of education and ignorance, and good health is preferable to ill health: this is why we do not speak merely of social *differences* between the rich and the poor, the educated and the uneducated, the healthy and those who are suffering or weakened, but of *inequalities*" (Lahire, 2019), be they in the area of health or any other domain, where each of them reinforces all others. While it is widely accepted that the source and breeding ground of inequalities is the structure of the social organization within which they operate, studying them entails closely inspection of the political dimension of the social relations governing their construction. Analyses submitted for this issue should therefore pay attention to the issues of power, the processes of domination, the mechanisms of stigmatization and the complex interplay of social distinctions, divisions and contradictions that make the perpetuation and aggravation of SHIs possible.

More specifically, to shed light on the workings of the production of social health inequalities is to choose deliberately to focus on the manifold situations that generate, produce and foster these inequalities. It is to study the places where means to craft, maintain and renew SHIs are patiently formed and elaborated, progressively shaped and ineluctably woven, lastingly forged and woven, skilfully ordered and rigorously arranged. It is also a question of understanding how this process takes place: according to which structuring mechanisms, under which conditions and core dynamics, which modalities and practices, which uses and behaviours, which experiences and opportunities. As such, the emphasis is placed firmly on the different processes and modes of health socialization and on the mechanisms at play in its formation. The aim is to determine how the effects of the reinforcement, remanence and reactivation of SHI can differentially mark (Bourdieu, 1979; Lahire, 2002) the incorporation of socially acquired dispositions relating to class, race, sex, gender, age and/or generation. Following the intersectional approach of Galerand and Kergoat (2014), these relations are conceived of as dynamic, consubstantial, articulated, interwoven and coextensive. Similarly, taking somatic cultures into account (Boltanski, 1971) makes it possible to critically examine the dialectical arrangement and logic of connection of social dispositions and health systems.

Moreover, the modalities whereby the government of bodies is produced (Foucault, 2008; Fassin, Memmi, 2004; Honta, Basson, Jaksic, Le Noé, 2018), and therefore of health (Basson, Haschar-Noé, Honta, 2013; Honta, Basson, 2015 and 2017), are also to be closely considered, as they tend to fuel the process of building and entrenching SHIs. The ability of the various instances of power to manage the social body's quasi-organic components helps to enrol the body of individuals as a medium and a vector for implementing public health policy. The work on oneself that this entails, through a series of objectivization and individual discipline exercises, forces each subject gradually to incorporate the rules of propriety, wisdom, reason, common sense, prudence, even restraint, established as principles of life, of self-preservation and physical safekeeping. While this process involves incorporation, that is, control over one's body and self-control in conduct as explained and described in Elias' analysis (Elias, 1997 [1939]), it does not however free anyone from external control, legal sanctions, punitive procedures and other disciplinary penalties.

Yet not all bodies are impacted in the same way, with the same intensity, urgency and force. Differentiated modes of governance in population health are emerging, in which relationships of domination are at play. Thus, by prioritizing socially, culturally, economically, and geographically vulnerable people, this corporal governmentality is socially situated and directly confronted with the dispositions of their "target audience" whose tendencies and inclinations are often stigmatized. It is in the very bodies of vulnerable people from crisis-laden working-class backgrounds that public action (in the health sector or related areas affecting the social determinants of health) finds the most fertile ground to sow its seeds, express itself in multiple ways, persistently unfold and spread as it grows. "The contemporary working classes" (Cartier, Coutant, Masclet, Renahy, Siblot, 2015; Arborio, Lechien, 2019) are regularly subjected to injunctions to eat well, exercise enough, protect oneself adequately, to "behave well in a healthy city" (Basson, Honta, 2018). These injunctions bear witness to the depth at which a strong normative and moralizing aspect is anchored in modes of government of populations. The social conditions under which the modes and regimes of justification and legitimization of these relationships to the social and political order underpinning SHIs are received and interiorized warrant further attention. The time is particularly right, as access to the health system is increasingly difficult, digital tools are developing and impacting daily life, recourse to hospitalization at home is increasingly frequent, and the Covid-19 pandemic has led to widespread confusion between the realms of health-related order and of public order.

While the social incorporation of inequalities serves the "political production of health" (Fassin, 2002), it can also give rise to alternative forms of effective contributions to the general process, even though that may involve tampering with it. Seeing health inequalities as part of the entire social question also lays the ground for politicizing them. The mechanism through which objectives assigned to actions are requalified is known: "they 'become' political in a kind of – partial or total – reconversion of the end goals assigned to them, the effects expected of them and the justifications that can be given for them" (Lagroye, 2003). This is precisely what is at play in the field of health.

3. Alternative forms of "political production of health"

While proposing to study "the social construction of reality" (Berger, Luckmann, 2012 [1966]) of health inequalities is tantamount to trying to counteract the totalizing influence of the biomedical filter on their perception and analysis, we are nevertheless careful not to contribute to erecting constructivism as a dogma that should invariably govern SHI studies. In direct reference to Berger and Luckmann's seminal work and to the variations to which it still gives rise to this day, our aim is "to acquire a dynamic conception of the actor as being subjected to multiple and contradictory socialization processes which are never completed because they are unfinishable, taking place throughout a lifetime. Without calling into question the founding elements acquired by the individual during primary socialization (early childhood), this conception opens up the spectrum of identity transformation" (Berger, Luckmann, 2012 [1966]).

However charged they may be, incorporation processes for health-related dispositions may also be kept at a distance or put on hold, and undergo phases of latency and diversions, reconversions and cut-offs, over the course of a person's life journey. The analyses submitted should therefore leave room for the individual as the bearer of a history of their own, as this history may in turn have an impact, in one way or another, on the social conditions of SHI production. This applies whether it be targeted at the individual in question, at people in their care, or at anyone to whom they offer support and company in the kind of difficult, painful or even dramatic circumstances that the pandemic is currently generating. The incorporation of a system of potentially numerous and varied dispositions that determine exposure to SHIs in various ways originates in each individual's biographical trajectory – trajectories that are composed of an intertwined, and possibly contradictory, sum of simultaneous and successive itineraries, rooted in the main

socialization environments and bodies (especially the family, school and academic environments, the professional sphere and peer groups).

Beyond powerful mechanisms of socialization and behaviour prescriptions – and in order to understand how a varied assortment of behaviours and initiatives proposes to deal with, maybe do without, and perhaps fight against SHI construction – this will be a matter of rendering and analysing a rich and complex interplay of differentiated appropriations and tinkered arrangements, incremental touches and full redesigns, random combinations and successful adaptations, haphazard compositions and bold reconfigurations, negotiated accommodations and timid workarounds, implicit diversions and overt avoidance, muted resistance and latent protest, or even direct rejection, firm refusal and frank opposition.

The SHI (re)production system has to tolerate, on its margins, distinctive forms of on-site contributions to the general process. Thus, behind the back of the dominant path that ensures the construction of asymmetries in health, the forms, modalities, and plural and heterogeneous expressions of socialization as a work in process become visible as they tentatively come into play. Being imperfectly mastered, the socializing orchestration inevitably lets slip some almost inaudible and unutterable off-tune notes, as well as resounding blunders which herald the end of the quasi-mechanical model of SHI production. For if there is indeed a construction process underway, it should also be conceived of as involving a craft. This entails a definition combining two complementary aspects: expertise, artistic ambition, mastery and meticulous work on the one hand and, on the other, a rudimentary, imperfect and eminently personal quality.

In other words, approximations are plentiful and deviations from the norm are diverse. Original and singular ways of "doing public health" (Fassin, 2008) thus appear to be unevenly successful attempts at gradual emancipation from the general process of producing health. While they allow for incremental forms of awareness of the dominations endured to be brought to light and for varyingly aggressive strategies to be put in place in order to turn the tables of stigmatization, they also remain dependant on dispositions and on the availability and concrete usability of capital, resources and support in the face of the powerful material, social and symbolic constraints imposed by inequality-generating social mechanisms.

Numerous experimental initiatives in social and political mobilization (Laverack, Manoncourt, 2016), aimed at social change, are now developing throughout the world to curtail the production of SHIs. Studies of those initiatives are welcome. They operate at local, national, supranational and international levels, advocate for a form of emancipation, claim to promote individual or global, environmental or community health (Jourdan, O'Neill, Dupéré, Stirling, 2012), define themselves as an alternative to private practice of medicine, and strive to involve the most vulnerable people in gaining and defending access to their rights and expanding their autonomy. The practices of social participation (Fauquette, 2016; Génolini, Basson, Pons, Frasse, Verbiguié, 2017; Basson, Génolini, 2021, forthcoming) and mediation in health (Haschar-Noé, Basson, 2019) that they implement should be further analysed.

Social participation in health is a lever for learning, socializing and activating a broad array of practices, which could be assessed on the international classification scale developed by Arnstein (1969), to define their gradation in terms of power(s). In the field of health, our search is for conclusive traces and tangible signs of the slow, gradual and graduated effects of the formation of a collective consciousness capable of understanding global issues and going beyond individual interests. This, in turn, brings to light specific indicators of the scope and significance of the construction of a democracy open to those most in need in the realm of health – not only in civic and civil terms, but also in a political sense.

Likewise, as outcomes of a "contractual process of building or repairing social ties" (Faget, 2015), mediation practices are based on a third party stance in which "going towards" the public, institutions and social and health professionals meets "working with" them according to individual and collective mobilization logics. Yet some civil society stakeholders show no intention of keeping mediators confined to their consensual role as local interfaces tasked with informing, guiding and supporting vulnerable people and raising awareness regarding obstacles they encounter among health system stakeholders. Using tried, tested, and renewed methods of popular education, they aim, more fundamentally, to facilitate access to rights, prevention and care for those who are dealt the worst hands, and to bolster their autonomy and capacity to act in the field health. As they refrain from imposing on the people they assist, the requirements implicit in the injunction to act responsibly, mediators can also work to counteract the general dysfunctioning in the health system. Some professionals and activists uphold their firm opposition to the idea that health mediation should be neutral, and decisively side with the people they care for in order to counterbalance the power relationship in place between them

and the institutions. As they build relationships with users and patients that are meant to be egalitarian, they engage in a contractual process of mutual trust between peers and thus emerge as having "domination savvy" (Demailly, 2014) and passing on their experience.

Focusing on health experimentation aimed at social change and social participation and mediation – all of which are major empirical fields – we propose to lay the groundwork for a framework in which to observe, analyse, interpret and objectify the rampant growth of SHIs in order to better understand and mitigate it. More generally, the papers submitted can come from all social sciences, can be multi-disciplinary, and must deal with one or more of the three main themes defined here: (i) identifying *what meaning lies behind social health inequalities*; (ii) investigating *the process of social construction of health inequalities*; and (iii) shedding light on *alternative forms of political production of health* in order to lay bare SHI production. In all cases, submissions shall necessarily be based on in-depth field studies, supported by appropriate theoretical references and served by original methods.

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