

# Class-Based Healthcare

*by Nadège Vezinat*

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**Far from lessening inequality between social groups in France, the organisation of the healthcare system and the practices of healthcare professionals actually serve to increase disparity. The sociology of social relations shows that the health system is not used or organised in the same way depending on the social class to which patients belong.**

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Reviewed: Maud Gelly, Baptiste Giraud, Laure Pitti, “Quand la santé décuple les inégalités” *Agone*, N°58, 2016, 208 pp., €20.

The special report published in the *Agone* journal, entitled “Quand la santé décuple les inégalités” (When healthcare increases inequality) and coordinated by Maud Gelly, Baptiste Giraud and Laure Pitti, presents eight articles exploring the question of inequality through the lens of healthcare. Based on evidence of serious healthcare inequalities in France, Gelly and Pitti chose to study the role of the healthcare systems in creating – as well as fighting – social inequality, by analysing the health system not only as a product of social inequality but also as its cause.

# Incorporating a sociology of social relations into a study of health systems

Although the French healthcare law that was enacted on 26 January 2016 seeks to make healthcare “accessible to all”, not all social classes use the system in the same way. For the coordinators of the special issue of *Agone*, this difference “remains the main frame of reference for healthcare inequality, which structures health policy” (p. 10). And yet, access to care according to a patient’s resources alone (financial as well as geographical, linguistic and social) cannot adequately explain health inequalities. In addition to this first factor, we must also consider the provision of care and medical practices from the perspective of healthcare quality as a “factor on which to act in order to correct those inequalities” (p. 10): in other words, the variations proposed in the provision of care according the social groups to which it is made available. Bearing in mind that medical care is of lower quality when the patient has difficulty interacting with caregivers, explaining symptoms or simply verbalising, an analysis of the quality of care enables us to go beyond the question of access. The “differentiation of the quality of care according to a patient’s social group” (p. 13) indeed forces us to take into account doctor-patient interaction as well, based on the relations of power, class, gender and race that overlap, reinforce each other and influence that interaction.

The key question explored in the special report is whether the organisation of the healthcare system and the practices of professionals serve to exacerbate or improve inequalities between social groups. This question is implicit in all the contributions made, which study the medical practices that change “according to the healthcare environment and system in which they are practised as well as the power relations in force there” (p. 14). The eight articles that comprise the special issue aim to “understand how and why the health system is unable to compensate for social health inequalities, and actually contributes to them” (p. 17). They can be presented in two sub-axes: one studies the social relations that affect health inequality, while the other looks at the evolution of the healthcare system – which the authors claim is moving towards privatisation – that is causing the organisation of healthcare to shift accordingly.

## Class, sex, gender, race: intersectionality and health inequalities

In the first axis of analysis, four papers focus on the question of social inequality through the lens of the overlapping categories of class, gender and/or race, enabling an examination of power relations and the conditions of class-based medical prescription, medical racialisation and gender-based care of patients.

Maud Gelly, Caroline Izambert and Claire Richard provide a French translation of the introduction to the English-language book *Body and Soul: The Black Panther Party and the Fight Against Medical Discrimination* (University of Minnesota Press, 2011), in which Alondra Nelson examines the mobilisation of the Black Panthers in the United States around the issue of healthcare and social justice. The politicisation of healthcare by the Black Panthers led them to implement “community-based healthcare” (p. 22) and develop what the author calls “social health” driven by the biomedical civil rights movement. The Party’s activism increased in the late 1960s and early 1970s, when the crisis in the healthcare system in the United States led to a healthcare shortage and support for whites-only hospitals. Alondra Nelson shows how the black communities asserted their right to healthcare and thereby opposed “invidious forms of biomedical racialization” (p. 21).

In line with this approach, Helena Bretin and Laurence Kotobi focus on the contraceptive situation in France by studying the conditions under which the contraceptive implant is prescribed: “In fact, women from the working classes seem to be far more pressured into accepting prescriptions for this contraceptive method, while women from wealthier classes tend to choose it for themselves (p. 127). The authors reveal that “other forms of social inequalities impact the way in which women are led to “choose” their method of contraception and control their fertility” (p. 126). In an analysis of two biographical trajectories, two different experiences of contraception and the relationship with the contraceptive implant emerge:

In the first, contraception is part of a controlled construction of existence. [...] In the second, contraception is the marker of a series of constraints. The institutions – social, medical – that support and accompany its introduction require a pledge of good behaviour, of which fertility control is a part. (p. 133)

Maud Gelly, meanwhile, studies the higher incidence of illness among women (“increased female morbidity”) who have HIV or AIDS. The author first shows that the theory of women’s over-interpretation of their physical symptoms is ineffective since they die earlier than men. She goes on to explain that being diagnosed does not necessarily mean being treated, and the time lag between diagnosis and treatment varies, but is longer for men and women from sub-Saharan Africa. Finally, faced with the evidence that identical treatment has varying benefits, Maud Gelly questions the socially differentiated effects of patient care policies, with inequalities resulting in reduced access to care, “inequalities by construction” and “inequalities by omission” (p. 144). In contrast with what is generally observed, her research in the case of AIDS reveals that treatment given to women is less effective. By studying this epidemiological exception, the author highlights the differentiations “in which racial categories outweigh categories of class, gender and sexuality in practices of classifying the public, and in the organisation of consultations” (p. 148).

Lastly, Pascal Marichalar focuses on the working classes, a social category that largely bears the weight of health-related physical and psychosocial risk factors in the workplace despite the availability of occupational medical services, which are more ineffective than inactive. Given that a correlation must be established between workers’ activity and their health problems by

doctors who make a diagnosis, establish a protocol of care and treat workers as patients, Marichalar believes that the social relations established during face-to-face appointments between doctors and workers can be understood as a power relationship. The author looks at the case of the former glass-blowers of Givors who developed cancer. He concludes:

Some of the doctors' provisions (fear of administrative or judicial troubles, ignorance of conditions for workers or indifference towards them, sometimes a belief that the system should be protected against "profiteers") lead to workers being denied access to the level of prevention, compensation or treatment to which they have a right. (p. 108)

In effect, doctors are essential for initiating the procedures required for the recognition of occupational illnesses, for beginning a course of treatment and for accompanying patients and their families. For the author, however, their central role constitutes a flaw in the provisions for preventing, compensating and treating occupational cancers in so far as the individualised, complex nature of the procedures often makes it difficult to recover medical records or obtain the original medical certificate that confirms the pathology and suggests a link with the work performed. Caregivers become unavoidable, which reinforces the power relationship as well as preventing workers from accessing their rights and being recognised as victims when sick.

## **A multi-speed healthcare system**

In four separate articles, the second axis focuses on the social selection that is practised within the healthcare system in France. According to the texts, the distinct criteria (social class, solvency, addressing networks) used by medical providers, hospitals, clinics and even the Institute for Public Health Surveillance (INVS) are not the same, even if they do partly overlap. These practices, which identify certain strata of the population as being preferred over others, serve to reinforce rather than reduce health inequalities by creating a two-tier healthcare system.

By looking at the career path of a committed general practitioner, Audrey Mariette and Laure Pitti analyse how some practitioners choose to settle in problem neighbourhoods (he works in Saint Denis) and practice in a different way. They show how some doctors "seek to create a link between liberal medicine and taking into account (and even taking responsibility for) the social question" (p. 51). The professional career path of the doctor in question may be analysed as part of a "class-based healthcare system" in terms of his high levels of political socialisation and civic involvement. He was not from a family of doctors. He earned his baccalaureate in May 1968 and from a young age was aware of the problems with social healthcare. As a supporter of the far-left, he believed that medicine based on fee-for-service payments was tantamount to "slaughter medicine" (p. 60), and saw group doctors' practices as a solution for developing a form of medicine based on "listening". Ultimately, the authors' careful reconstruction of his career shows that "investment in health issues at local level (city or neighbourhood) has not always been the result of national guidelines and policies" (p. 71).

Sylvie Morel, meanwhile, examines how access to emergency services produces social inequalities. By carrying out social selection, the services create socially differentiated access to

emergency care. That access is organised according to active medical addressing networks. Sylvie Morel presents a number of access pathways: 1/ private for-profit clinics whose aim is to “capture and retain solvent clients” (p. 77) in order to increase profitability; 2/ public hospitals offering specialisms considered unprofitable, with profiles of patients who do not have full coverage (healthcare and mutual insurance); 3/ the “socio-sanitary” services, which do not refer patients in the same way depending on their pathology and social background; 4/ and the “bypassing” of the emergency services by patients who consult their doctor directly and thereby receive faster care. These four access pathways highlight the fact that a homeless person who has a general “health problem” (linking a pathology or medical complaint to lifestyle) is less desirable (and therefore less likely to be referred) in private clinics than a patient with full coverage and a specific “health problem” (involving only one organ, for example) that can be treated more quickly. In this sense, for Sylvie Morel these access pathways exacerbate social inequality.

Caroline Izambert focuses on public hospitals in order to study how patients are selected according to inequalities in social protection. Solvency is becoming a concern for hospitals, and their “obsessive fear of unrecoverable bills” (p. 95) can sometimes take precedence over patients’ well-being or need for care, and undermine the universality of access to hospital care. The author compares two periods, the early 1990s and the early 2010s, showing how poor or foreign patients are penalised on two counts: their exclusion from naturalised social protection (when it is the result of a political decision) and the barrier of medical costs (the “cost of therapeutic innovations” (p. 102) is set by the laboratories) make certain illnesses difficult to treat. In this context, although discrimination is not a new phenomenon, the fact that caregivers are being made to accept (and ensure) the exclusion of certain patients for financial rather than medical reasons certainly is.

Finally, François Buton focuses on epidemiological surveillance, one of the public health missions of the Institute for Public Health Surveillance (INVS). Epidemiological surveillance promotes acts of disease prevention and health promotion by establishing a link between a risk and risk “factors”. It uses probabilistic mathematics to legitimise its knowledge and expertise, bring epidemiology out of the scientific sphere of infectious diseases and detect health threats as early as possible. However, this approach tends to marginalise social health determinants by rendering them invisible.

This special report, which proposes to depart from a sociology centred on the medical professions, renews analyses of health sociology by incorporating them into a sociology of the social classes and social relations. This approach was much needed, and it is right that this way of sociologising healthcare and patients has been given expression in this special report. However, one might wonder to what extent it was put together as a kind of prosecution file, given that each text (with the exception of the article by Audrey Mariette and Laure Pitti) systematically concludes that, at best, the French health system or method of organising healthcare is powerless to correct social inequalities and, at worst, actually exacerbates them. While this observation does not detract from its relevance, this report would undoubtedly have

gained from showing that, in some areas, measures and initiatives (whether local or marginal), healthcare professionals are determined to offer holistic medical care that is more territorialised and more social. Its demonstration of the link between social health inequalities and power would only have been strengthened by mentioning these counter-examples.

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