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BOOK REVIEWS

Nicolas Duvoux and Nadége Vezinat (eds) (2022). *La santé sociale*, Paris: Puf.

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Following its outbreak in early 2020, the SARS-CoV-2 (Covid-19) pandemic has undoubtedly revived the interconnection between the spheres of health and social care. Recent research has shown how the spread of the virus follows a social gradient whereby it is more prevalent among communities of the vulnerable and socially marginalised (Azria et al. 2020, Burdett and Knight 2022, Burström and Tao 2020, Mishra et al. 2021, Da Mosto et al. 2021). Not only does the virus itself follow the gradient of inequality, but the consequences of resulting containment measures also have a differentiated impact on the population. In addition to both revealing and exacerbating social and health inequalities, the pandemic has highlighted a number of critical weaknesses in health systems, including the organisation of health services at a local and territorial level, namely primary care; the accessibility and affordability of health services for social groups living with economic, employment, housing, social and health uncertainties, and the failure to address the social determinants of health (CSDH 2009). A common thread connects these fragilities, namely the relationship between the spheres of health and social care and how this, in turn, affects both individual and collective health. However, it is clear that despite their connection in several countries, a significant gap exists between these two spheres generally. This disjuncture is the result of a process of autonomisation seen during the twentieth century and it can be traced across most European health systems.

La santé sociale, edited by Nicolas Duvoux and Nadége Vezinat, both of whom are professors of sociology at the University of Paris 8, focuses on the relationship between the spheres of health and social care. The book seeks to conceptually and theoretically re-establish the link between the social and health spheres by applying the concept of *social health* in the context of the French system. The authors approach this by reconstructing the historical processes that have given rise to the current French health system and by providing a critical reading of the organisational and regulatory forms of health organisations. They also examine the role of local and territorial contexts in the health field, analysing collective experiences and existing dispositions of healthcare, and they hold the incorporation of social factors into medical practice as a common goal. Therefore, the concept of social health emerges as a ‘connector’ between theoretical perspectives and concrete initiatives. Another characteristic of this concept is its understanding of the tensions, contradictions and ambivalences that exist between social and health spheres and social actors in the health field. To analyse the concept of

social health, the book brings together contributions from different researchers: Mauricio Aranda, Jean-Charles Basson, Nicolas Da Silva, Maryse Gadreau, and Igor Martinache.

The book contains an extended introduction by Duvoux and Vezinat and five chapters written by the abovementioned authors. The introduction outlines the concept of social health, presenting a socio-historical view of the evolution of social health as a public action category. It begins by addressing the weak connection between social issues and health, which requires reconsolidation. It goes on to explore the concept of social health, presenting its main characteristics and ambivalences, and distinguishing it from both public health and social medicine.

The first two chapters in the book then focus on two central themes in order to discern the potential and appropriateness of engaging the concept of social health when assessing the relationship between health and social spheres. In the first chapter, Da Silva and Gadreau propose a historical reconstruction of the development of the French health system by considering the processes of regulation that has occurred between the public and private sectors and the conflicts that have arisen as a result. The second chapter sees Martinache and Vezinat question the role of local governments and municipalities in the health field. This is particularly relevant to the book as, first, it draws attention to the idea of local context, which is an essential component of the concept of social health. Second, it identifies the areas of political decision-making on health in the local governance processes.
The next three chapters explore existing social health organisations to identify key principles of social health. In the third chapter, Vezinat discusses the case of the *maisons pluriprofessionnelles de santé*, local care structures that bring together various primary care services provided by the likes of doctors, midwives, dentists and nurses. Notably, Vezinat reflects on how the liberal practice of medicine is not necessarily incompatible with social health principles. In the fourth chapter, Aranda and Duvoux examine the PASS (Permanence d'access aux soins de santé) system, which has been in force since 1998. It aims to guarantee the right to health by providing medical consultations and social support to those who do not have access to the health system owing to the absence of health coverage. Jean-Charles Basson contributes the fifth and final chapter on community health centres (*Centres de santé communaitaires*), which are multidisciplinary clinics that operate with a prevailing politically focused idea of health and in which doctors are salaried by the state. Basson investigates the role and structure of these clinics using the Case de Santé in Toulouse, France's first community health centre, as a case study.

This review will discuss the book *La santé sociale* by considering three central themes: the concept of social health, health as a political and conflict space, and the concretisation of the concept of social health.

Santé Sociale: A recompositive concept

Social health can be conceptualised in two ways: first, as a new relationship between the spheres of health and social care; and, second, as an emerging norm of public action. This dual meaning is derived from the fact that social health suggests two challenges with regard to its application to healthcare organisations. The first challenge concerns the reintegration of social issues into the medical sphere and the creation of new connections between social rights and healthcare. By means of such an integration, the medical act is transformed into a caring activity, using a holistic approach to patient care by taking into account their pathologies and medical and social issues. Thus, accessibility to healthcare must be comprehensively addressed, taking account of such things as accessibility in financial, institutional, territorial, organisational, linguistic, cultural and bureaucratic terms. The second challenge incorporates practical aspects of people's daily lives into the care pathway (for example, a cooking workshop for diabetes patients, a language school, a social hairdressing salon or tooth-brushing workshops for children). These two challenges contribute to the practice of a more holistic approach by taking broader social aspects into account and integrating a health

promotion approach (Labonté 2008) rather than focusing solely on therapeutic and pharmaceutical interventions.

The concept of social health aims to find points of connection between dichotomous semantic domains and actors, which are often presented as mutually incompatible. The first set of 'opposites' concerns individual and population approaches. In this respect, social health reinserts primary care into a dynamic population, while simultaneously taking individual conditions and relative living circumstances into account. A second dichotomy exists between the public and private sectors. According to editors, social perspectives such as access to social rights, the fight against medical desertification, continuity of care, and access to prevention (e.g. cancer screening) can be included in the actions and objectives of both collective medical clinics of public and private sector.

The essays in this book also explore contradictions within the concept of social health in their analyses. Social health proposes a universalistic approach to care; in other words, care is targeted towards the whole population, not only those who have been socially marginalized. At the same time, and on the contrary, initiatives that concretely develop the concept of social health in an often non-voluntary manner actively participate in the stratified management of health and care. This interpretation is critical to the premise of the entire volume, particularly in the chapters that recount the experiences of collective medicine. In fact, on the one hand, these initiatives criticise the exclusionary dynamics of the health system and the persistence of social and health inequalities. However, they are a component of this health system and participate in the governance of the population.

Health as a field of conflict and political space

The first topic of interest in the book highlights the conflictual nature of the historical processes that led to current healthcare systems in France, characterised by a combination of state regulation, social health insurance and private doctors. This combination results in contradictions caused by the coexistence of universalists and liberalists principle (Steffen 2010).

The perspective proposed in the book also emphasises the roles of different actors across various historical periods. For instance, the role of social actors such as trade unions, their social struggles in the expansionary phases of public spending and access to care and their contribution to the construction of a public health system is investigated in Chapter One. This is discussed alongside the role of private actors, such as private insurance companies or the sector of the medical profession that defends private practice, both of which have played a prominent role in public expenditure contraction phases. De Silva and Maryse Gadreau centre their analysis around the 'médecine de ville' in France, that is, medicine practised outside the hospital—this field has a marked tendency towards private practice in France.

The question that guides the two authors' considerations concerns the processes used by the public authorities to integrate liberal medical practice and public health goals. Accordingly, the authors propose an investigation of the history of the regulation of private practice, which is closely associated with the evolution of the French welfare state. This historical timeline is characterised by conflicts and oppositions between the liberal practice of medicine and the principles of national solidarity; indeed, the authors consider there to be a 'forced marriage' between these two poles. Such a forced union began in the late 1920s with the inception of social insurance laws. There was fundamental conflict between these laws and the principles of liberal medicine from the outset, for instance in relation to the principle of the direct payment agreement between doctor and patient and the absence of constraints and regulatory intervention by third parties, such as the government or insurance companies.

The post-war era saw the emergence of the second phase of regulation, in which public policy aimed to provide the greatest possible access to healthcare in response to increasing pressure from various social movements. The Securité Sociale (the French social security system) was established during this time. However, despite its creation in 1945, it did not come into effect in the field of health until 1960 owing to resistance from doctors in private practice who sought to defend their autonomy.

The 1980s saw the instigation of the third phase. The state lost its 'social' connotations and instead adopted neo-liberal ideology, which was characterised by the importance of competition between public and private sectors, and of reduction in public expenditure. During this period, supply-oriented policies replaced demand-oriented policies in the welfare sectors of several European countries. In the French healthcare sector, complementary private insurance gained space and power.

The authors suggest that the final phase (in the 1990s and 2000s) has signaled a further paradigm shift: the movement away from price control towards control of medical performance. The aim has been to improve healthcare through the use of resources and shared professional standards. In practical terms, this has involved standardising clinical practice through shared guidelines. Thus, physicians' remuneration has begun to be defined by performance standards.

Focusing on the regulatory and conflictual processes between different social actors allows the volume to examine two issues. The first is mentioned in the final section of Chapter One and concerns the relationship between the medical category and the 'financing' actors. The historical evaluation proposed demonstrates that the role of healthcare financiers is not immutable; rather, it is decisive and restrictive, in both the public and private sectors. In the post-war period, the Fordist welfare state was the leading funder, but this was replaced during the 1980s by the neo-liberal state in tandem with the private insurance sector. The dynamics of the market and for-profit system have thus become viable and, in some cases, desirable options. These dynamics also permeate the public, third, and non-profit sectors, in which mutualist principles are being side-lined to meet efficiency and profitability standards. The authors argue that market logic is supplanting the original principles of the healthcare system as it was conceived in the post-war period.

The second area of interest concerns health as a significantly political area, and it is this that forms the focus of the second chapter by Igor Martinache and Nadége Vezinat. The authors discuss the role of local institutions, namely municipalities, in the governance and organisation of healthcare services. They highlight the peculiarities of municipal health action by focusing on its apparent political dimension. Municipality action has garnered increased relevance as a result of the Covid-19 pandemic, in particular when considering the interventions that were organised and implemented directly by municipalities to cope with the emergency. This aspect is particularly relevant if we understand territories as a level where different forms of urban health regulation and governance are formed, understood as multi-level coordination between different actors, institutions, associations, and informal social groups for the achievement of collectively defined objectives and which develop in fragmented decision-making and organisational contexts and different types of regulation are structured (Les Galès 1998)

Over the past century, particularly in the post-war period, the relationship between local government and healthcare has progressively weakened, with central government taking a more central role. This process has increased the distance between the social and health spheres, whereby matters of the former have been delegated to municipalities and the latter to the state. This has therefore meant that municipalities have limited agency regarding the distribution of competencies and financing. The national framework and management determine significant constraints for local health organisations. Nevertheless, the municipalities have retained some power of intervention: encouraging health facilities with community health practices ; coordinating city services, both social and health; implementing initiatives in the field of prevention, education and health promotion; using devices such as the Atelier Santé Ville (Molas Gali 2014), to implement collective diagnostic plans; training local actors in the field of health; promoting initiatives to guarantee access and the right to health for all. Furthermore, networks of cities have been formed to address health issues and to action environmental and urban health interventions that aim to reduce pollution or improve the management of public spaces, for instance.

Da Silva and Gadreau suggest that in order to understand the political dimension of the choices made at the municipal level, it is necessary to consider the areas in which there is agency and the coexistence of two mutually contradictory principles in the French health system (Steffen 2010). These are the liberal principle of private practice and the state principle, which is embodied in the organisation of the hospital network and the management of the national medical insurance funds. Considered through a political lens, the coexistence of

these two principles makes the choices by local governments regarding health services intelligible. For instance, which regulations do local governments prioritise? Do they favour free market principles or the public principle, for instance, by means of the presence of publicly employed doctors?

The authors argue that in services managed by municipalities, the liberal principle may, for instance, be embodied in the provision of 'residual' services that are dedicated to populations who have been socially marginalized. On the other hand, the state principle may be embodied in quality services of a universalist nature, i.e. those intended for the entire population. This is not just an administrative issue or a question regarding the division of responsibilities and competencies between different levels of government. Instead, it concerns the interpretation and implementation of proximity health in primary care and the principles that are to be promoted.

This is an issue that has recently returned to the fore. De Silva and Gadreau note that the local and community context is a 'fragile ecosystem' in which territorial specificities make it impossible to construct a universally applicable model. Consequently, municipalities play perhaps the most appropriate role in developing services adapted to the needs of the population and the specificities of different urban and territorial contexts in connection with the national plan.

Realising the principles of social health

The third, fourth and fifth chapters explore the health facilities of collaborative medical practices defined as attempts at a 'collective correction' of asymmetries in the health and social system. The authors emphasise three tensions in the implementation of these services. First, they discuss the tension between state and free-market principles. Second, they consider the conflict between residual benefits for specific categories of the population and universalist services. Finally, the authors detail the tension between addressing inequalities and simultaneously being an integral part of the health system. These chapters discuss three types of care facilities: the *maisons de santé*, the PASS facility and the *centres de santé communautaire*.

Vezinat is the author of the chapter on *maisons de santé*. Since 2007, the *maisons de santé* have been places for the joint exercise of the liberal medical profession in the field of primary care in France (Vezinat 2019). The services provided by the *maisons de santé* act as a bridge between the hospital and the local area. These facilities are universally accessible and operate on both a social and a health level. This type of healthcare institution is of particular interest because it provides opportunities for group practice of the liberal medical profession and allows for the incorporation of some principles of social health. This coexistence is not without contradictions. For some time, the *maisons de santé* were presented as the answer to the 'medical desertification' problem in certain geographical contexts, particularly rural areas or those on the urban periphery. However, the author astutely points out that this line of argument is perhaps overstated because professionals in the maisons de santé are essentially independent practitioners and thus do not have any obligation to comply with such methods or with directives on where a service should be opened. However, because they are liberal practitioner facilities in which specific restraints are not imposed, it is also challenging to make a general statement regarding all maisons de santé, as the experiences may vary and the French landscape is fragmented.

The PASS facility (*Permanences d'accès aux soins de santé*) has been in place since 1998 and is one of the programmes that aims to guarantee the right to health to those excluded from the health service.

PASS is a social and health service initially created to address the lack of medical coverage for the unemployed. Owing to recent changes in migration patterns, the system has changed to accommodate its users (Geeaert 2017). It is possible to gain an insight into the development of the French social welfare system and its contradictions by studying facilities such as PASS. For instance, the authors Aranda et Duvoux state on the one hand that the State combats exclusionary processes through instruments such as PASS, which are dedicated exclusively to helping groups of people considered vulnerable. At the same time, it might also be perceived that the State implements policies that exacerbate social inequalities and processes of social marginalisation.

The latest 'corrective' is in the chapter written by Jean-Charles Basson and is the case study of the *Centres de Santé communautaire* and, in particular, the "Case de Santé" in Toulouse, the first community health centre

in France. The Case de Santé is one of the only health centres that responds to social exclusion processes and health inequalities. It was established in 2006 in one of the last-remaining working-class neighbourhoods in the centre of Toulouse (Basson et al. 2021). It counted social justice, emancipation, social mobilisation, and active participation practices among its founding principles. The Case de Santé pursues 'militant' goals for social and political change. At the same time, the health centre is financed by the Agence Regionale de Santé, the Casse primaire d'assurance Maladie and the departmental council. The socio-medical staff are salaried, but the management works on a self-organisation basis in planning activities and distributing resources. The political nature of this centre's work is based, first and foremost, on the connection between the health and social spheres. The *Centres de Santé* are services with universal access. But, in many centres, the users are the inhabitants of the neighbourhood, namely people who are marginalised and racialised and who are often resident in the country illegally, and thus lack health insurance and presenting a cumulation of inequalities and experiences of discrimination. As a result of their political and militant approach, these health centres possess an ambivalence that stems from their efforts to tackle the mechanisms of reproduction of inequalities. On the other hand, they remain an integral component of the health system. They constitute a kind of service that operates both with and against the system as a whole.

The case studies reported in the book follow some of the principles of primary healthcare and health promotion expressed in the Alma-Ata Declaration (1978) and the Ottawa Charter (1986) (Talbot and Verrinder 2017). However, all three health organisations described in the book have a limited capacity to correct the distortions and exclusion processes of the French healthcare system as a whole. Just as the maisons de santé may respond to the principles of the liberal profession rather than to those of social solidarity, the PASS facilities produce specific forms of support for vulnerable populations. The *Centres de santé communautaire*, on the other hand, propose a universal service of a community nature but, at the same time, must respond to constraints imposed on them by public authorities.

The constraints may concern issues such as the location of the centres. In this regard, public authorities would benefit from locating such services in peripheral and deprived urban neighbourhoods, de facto converting them into 'residual' services for marginalised groups. A central consideration of this book thus concerns how these actors oppose the process of liberalisation of the health system and, at the same time, are part of this process. This contradiction makes them particularly interesting in the framework of the concept of social health.

In the book's introduction, the editors present two critical questions in light of the three case studies analysed in the chapters. First, they consider whether these actors exercise control over vulnerable populations or instead promote processes of emancipation. Second, they ask whether or not these actors contribute to improving the provision of healthcare facilities or increase the segmentation of services in an already highly fragmented healthcare system.

Social health: Within or beyond France?

Having reviewed the core contents of the book and discussed the main topics, the focus of this review now shifts to its contribution to the field of health studies and its main limitations. As mentioned above, the book aims to analyse the concept of social health as a means of contributing to a wider debate on the interdependence between the social and health spheres and on forms of solidarity. To this end, the volume editors offer a broad overview of historical processes and three case studies from France, the '*fabriques des inegalites'*. On the one hand, the persistence of social and health inequalities in France makes it a relevant case study for assessing the forms of solidarity and responses to the processes of exclusion that arise in the healthcare sphere. On the other hand, social health is a concept that fits into the gap between the social and health spheres. The Covid-19 pandemic has highlighted the widespread need to reduce the distance between these two spheres, not just within the French context but across Europe and the world more widely. Indeed, one of the central areas of reconciliation between the social and health spheres is primary healthcare, the development of which favours an improvement of the population's health (Starfield, Shi, Macinko 2005). The

aim of making the concept of social health usable beyond French borders is partly pursued by Duvoux and Vezinat in the Introduction. The absence of a concluding reflection, however, is a critical point. For the book to be truly cohesive, it would have required a conclusion to synthesise the numerous arguments raised.

A second issue relates to the refocusing on the relationship between the national and local levels of government through the analysis of local and community healthcare services in the last three chapters. This focalisation moves beyond a top-down dynamic in the organisation of health services. The authors attach particular importance to the territories, understood as spaces of creation, and to the impact of processes of exclusion, stigmatisation and isolation. At the same time, these territories can give rise to alternative and solidarity-based communities. The concrete initiatives analysed in the last three chapter of the book lie between the social and the health sphere, and they participate in the territorialisation of public health action. Despite the attention given to the ambivalences in the case studies, the absence of a focus on the relationships between the various actors involved and, thus, on the different interests and the related conflicts weakens the analysis (perspective that is instead present in the first two chapters).

This point gives rise to a further potential research question, which would investigate how the reconnection between the social and health sphere occurs concretely; the organisational arrangement, the priorities, the disputes and the conflicts in governance, understood as non-linear and discontinuous (Le Galès and Vitale 2013). In this perspective, the concept of social health can contribute to the debate on what role the social sciences, and sociology in particular, can play in the research field of urban health (Fitzpatrick and LaGory 2003, Kelly and Green 2019; Battisti, Marceca and Iorio 2020), starting with crucial research such as the work of Fassin (1998) on 'urban figures' and the dynamics of local production of public health or studies on public health action at metropolitan level (Honta and Basson 2017). The local and urban dimensions of health and healthcare can also highlight the relation between social conflict, collective action, and political innovation (Vitale and Podestà 2011) in the health field, through recognition of the coexistence of different experiences that develop outside health institutions, for example, within social movements and, more generally, experiences of health activism (Musolino et al. 2020). In some countries, such as Italy and Greece, both mobilisations in defence of public health claiming the reopening of public health services (Vallerani 2022a) and self-management initiatives of health - 'social clinics' - have developed as a response to the processes of exclusion from health systems and as spaces for the construction of different forms of health-making on different levels and different topics (Cabot 2016, Pecile 2017, Kokkinidis and Checchi 2021, Vallerani 2022b).

Furthermore, the authors seek to eliminate the ‘confusion’ between the public and private spheres. The book shows how associative experiences, including those of liberal medical practice, can deliver comprehensive patient care that extends beyond simply healthcare. However, a factor that has not been addressed, and that could be interesting to explore further beyond the historical phase in the 1980s, is the impact of commodification of health systems and of incorporation of principles from the private sector and free market in the public system (Sajay et al. 2005, Ferreira and Mendes 2018, Krachler et al. 2021). The presence of market dynamics in the public and third sectors, including the health sector, is a crucial issue that deserves more attention.

The book examines the differences between the concept of social health and that of public health and social medicine as understood by Fassin (1996, 2008) and Foucault’s (1994). However, the notion of social health should confront the extensive literature on primary healthcare (Muldoon, Hogg and Levitt 2006, Talbot and Verrinder 2017), community health (McKenzie, Pinger and Seabert 2016) and urban health (Battisti, Marceca and Iorio 2020) so as to identify potential areas of interaction and overlap and the distinctive elements between the various approaches.

The book’s limitations as presented here may reinforce the heuristic aims of the concept of social health. Nevertheless, this concept has much potential for the analysis of European health systems in the post-pandemic phase in which the link between the social and healthcare spheres, health and territory and the interdependent relations between members of societies assume relevance and centrality in both the scientific and the public debate.

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