

# Newsletter

*of the Research Committee on the Sociology of Health*



## Letter from the President of RC15

Dear colleagues,  
I have much to report in this edition of the newsletter.

We had an extremely stimulating, lively and well-attended 21 sessions at the ISA Forum in Vienna. I want to thank all the session organizers and presenters who helped make this a memorable event.

But the Vienna meeting was not even over that we began preparations for the upcoming **ISA World Congress, to be held in Toronto, July 15-21, 2018.**

The first order of business was to conduct a membership drive before the ISA cut-off date of October 31, as we were standing just under the cusp of 200 members. This was successful, and thus we have **increased our number of sessions to 24** and will receive additional funding from ISA for registration grants for the upcoming meeting as a result.

RC15 has also applied to two integrative sessions, to reach an even broader audience at the meeting and offer additional opportunities for our members to present their work. There will likely be stiff competition for those sessions, but we felt we had to throw our hat in the ring nevertheless.

This brings me to the next issue looming ahead, which is the call for session running from **February 2 to March 15, 2017**. You can now submit session proposals here: <http://www.isa-sociology.org/en/conferences/world-congress/toronto-2018/call-for-sessions/>. V.P. Guido Giarelli and myself will serve as co-coordinators of the program for the Congress, and we will look forward to your submissions to build a program as stimulating as the one we had in Vienna. While we have not set a theme for the RC15 so as to avoid unduly constraining the large number of sessions we have, please bear in mind that the theme of the meeting will be **Power, Violence and Justice: Reflections, Responses and**



**Responsibilities.** These are evidently issues that are near and dear to many of our researchers, and we would be keen to feature sessions that address these topics. Please note that, in order to maximise opportunities for our members, we **ask that session organisers be current members of RC15.**

In sum, it appears that we have much to be thankful for: we have a large, vibrant RC with dedicated members, and we are accordingly awarded a large number of sessions and a fair amount of funding from ISA. However, I am keenly aware that complacency is not an option, and, much as we have already innovated with a new student mentoring session and the LinkedIn group, I assure you that I have other exciting plans in store for our next meetings in Toronto, Canada in 2018! I also encourage you to contact me or other board member if you have suggestions of how the RC could better serve your needs.

So stay tuned for that!

Best wishes,

**Professor Amélie Quesnel-Vallée**  
**President RC15 Sociology of Health**

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#### MEMBERSHIP

Chers collègues,

J'ai beaucoup d'informations à signaler dans cette édition de l'automne 2014 !

Nous avons eu 21 sessions stimulantes, animées et très courues au Forum de l'AIS à Vienne. Mes remerciements vont à tous les collègues qui ont organisé des sessions et aux présentateurs qui ont contribué à ce succès.

Mais la réunion de Vienne n'était même pas terminée que nous avons déjà commencé les préparatifs pour le **prochain Congrès mondial de l'AIS qui se tiendra à Toronto du 15 au 21 juillet 2018.**

En premier lieu, nous avons mené une campagne de recrutement avant la date butoir du 31 octobre, car nous étions juste en deçà du prochain palier de l'AIS de 200 membres. Cette initiative a été couronnée de succès et, par conséquent, nous avons **augmenté notre nombre de séances à 24** et recevrons un financement supplémentaire de la part de l'AIS pour le Congrès.

RC15 a également proposé **deux séances intégratives**, pour atteindre un public encore plus large lors de la réunion et offrir des possibilités supplémentaires pour nos membres de présenter leur travail.

Ceci m'amène à vous annoncer **l'appel de session, en cours du 2 février au 15 mars 2017.**

V.P. Guido Giarelli et moi-même servirons de co-coordonateurs du programme du Congrès, et nous attendons vos propositions pour monter un programme aussi stimulant que celui que nous avons à Vienne. Vous pouvez dès maintenant soumettre votre projet de session ici: <http://www.isa-sociology.org/en/conferences/world-congress/toronto-2018/call-for-sessions/>

Un rappel que le thème du congrès est **Pouvoir, violence et justice: Réflexions, réponses et responsabilités**. Sans vouloir contraindre l'ensemble de notre programme autour de ce thème, il reste que ce sont des questions qui ont animé beaucoup de recherches chez nos membres. Nous vous encourageons donc à considérer l'intégration de ce thème dans vos propositions de sessions. Veuillez noter que, afin de maximiser les avantages pour nos membres, **nous demandons aux organisateurs de session d'être membres actuels de la RC15.**

En somme, nous sommes dans une situation enviable: nous avons un grand nombre de membres dévoués et dynamiques, et nous avons donc obtenu un grand nombre de sessions et un bon niveau de financement de l'AIS. Cependant, je suis très consciente que nous devons éviter à tout prix d'être complaisants. Je vous assure que j'ai maints autres projets excitants à vous soumettre pour notre prochaine réunion à Toronto, Canada en 2018. Par ailleurs, si vous avez des suggestions qui pourraient nous permettre de mieux rencontrer vos besoins, n'hésitez pas à m'en faire part.

Gardez l'œil ouvert pour nos annonces et au plaisir de vous lire!

Bien cordialement,

**Professor Amélie Quesnel-Vallée**  
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## Life of RC15 - Sociology of Health

### On the road to the ISA Congress in Toronto 2018!

#### Timeline for the submission of sessions and abstracts:

#### 2nd of February 2017 - 15th of March 2017

*Please submit your session proposals at <http://www.isa-sociology.org/en/conferences/world-congress/toronto-2018/call-for-sessions/>*

*Please note that absolutely no further sessions can be added after that deadline (as per ISA regulations), and that we require that session organizers be RC15 members.*

#### 16th of March 2017 - 7th of April 2017

*Selection of sessions by program coordinators.*

#### 25th of April - 30 September, 2017

*Online submission of abstracts on the Confex system: <http://www.isa-sociology.org/en/conferences/world-congress/toronto-2018/call-for-abstracts/>*

# FOSTERING PUBLIC DEBATE

## *Research Agenda in Medical Sociology*

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**Keywords: medical sociology, social processes, health and illness, socialized national health systems, socio- economic production of illness, transnational medical markets**

Sociology queries taken for granted understandings of the world and especially those that claim universal applicability, but that in fact support particular interests. In showing up the hidden workings of power – the interests of institutions, professions, corporations, and capital – the complex set of interests that make up modern medicine can be explored to disrupt simplistic accounts of its beneficence. By seeing health and illness as social as well as individual bodily processes, and conceptualizing medicine as a practice and profession that is entangled with governance and speculative capital, sociology offers critical insights to medicine's curative and therapeutic benefits (Bradby, 2012). The challenge for a progressive sociology of medicine is to critique the range of interests that make up medicine (as profession, discipline, business, statutory, and non-governmental institution across the world) while holding a sense of medicine's benefits and deficits at individual and population level in balance with other knowledge systems and moralities of healing.

From the height of the industrial revolution onward, the ill effects of poor living conditions on people's health have been documented (Engels, 2001; Collyer, 2015). With sociology's arrival as a University discipline at the start of the twentieth century, medicine was not viewed as a key institution, alongside religion, the law and the family, in understanding modernity. However, with the delineation of medicine's role as a social system responsible for deviance and social control (Parsons, 1991), medicine's implications in modernity's development became the research tradition we now call medical sociology. Interrogation of medical organization and processes show their implication in the nation state's technology of power (Rose, 2007), an insight which recasts medicine's relationships with patients and populations in terms of iatrogenesis (Illich, 1977), medicalization (Conrad, 2005; Conrad et al., 2010), and surveillance (Foucault, 1979). The insight that health is socially produced, and its distribution across class, gender, and generation can be measured to show inequalities in morbidity and mortality, has shaped the policy and practice of national health and welfare organizations. Bourdieu's model of social capital, conceptualizing the institutionalization of power, across statutory, market, and familial structures problematizes a simple account of tackling health inequalities through changing individual health behaviors (Carpiano, 2007).

The contradiction between public health's approach to population health and clinical medicine's focus on individual bodies is epitomized by the herd immunity conferred by mass immunization programs for infectious disease, reducing the urgency for individual immunization. Sociological investigation of the decisions that parents make regarding their children's immunization renders visible the various understandings of risk in operation (Casiday, 2007). Giving credence to nonprofessional priorities in treatment and prevention is part of the erosion of medical dominance (Freidson, 1988) that has been underway since the (possibly apocryphal) Golden Era of physician power. Sociological research has explored these various challenges to medical power, through the rise of other professions (management, nursing), other healing systems, expert patients, as well as commercial and legal interests (Williams and Calnan, 1996). Evidence-based medicine, using metaanalyses to apply systematic assessment of research results to clinical decision-making, the rise of evidence to inform practice, evaluation, and commissioning of services has become mainstream.

While sociological research has influenced the context and development of medical practice, its analyses have been largely confined to Western democracies' health and welfare systems. Sociology's slowness to engage with health and illness beyond the Global North, where medicine is differently configured and regulated, denotes a Euro-centrism that relinquishes analytic responsibility to other disciplines such as anthropology, development studies, and international public health. A partitioning off of the social processes of health and

illness in the Global South implies that different processes pertain that these might even require different sorts of medicine. While sociology has criticized the universality of medical knowledge claims, it has failed to illuminate the transnational flows of capital, labor, and ideas that create national health systems, thereby supporting the imagined community of the nation state (Anderson, 1991). The nation state has regulated health-care spending in favor of orthodox medicine such that the plurality of approaches to supporting and enhancing health is particularly apparent beyond the welfare states of the Global North. Researching plural approaches to health and illness shows how medical understandings are combined with, changed and subsumed by other models in different settings. Such research opens up a wider culture of health and illness to view, as well as illuminating the particularities of the culture of medicine.

Despite, but also thanks to sociological critique, scientific medicine has become the most authoritative source of evidence and intervention to promote health for individuals and for populations, worldwide. The provision of good quality accessible medical treatment to support health is a high priority for individuals and for societies – an ideal that people will vote for, pay for, campaign for – a highly potent force, politically, financially, and morally. The association between medicine and good health, in national health systems and in markets, is based on an idea of medicine's therapeutic efficacy for bodily and psychic suffering. The epitome of medical curative potential crystallized in the mid-twentieth century, when the research and development opportunities of two World Wars helped bring antibiotics, new surgical techniques, steroids, and insulin to the general public. The contraceptive pill was developed, while smallpox and polio vaccination programs were eradicating infectious disease. A pill for every ill: cures that work regardless of the patient's faith in the supernatural order or their social status and independent of the affect of the doctor and patient. Silver-bullet cures that are consistently and universally efficacious: antibiotics to cure blood poisoning in Scandinavia and Sumatra, regardless of the rank and association of those administering and receiving treatment, not only universally applicable but also consistently efficacious. The twentieth century's establishment of socialized national health systems and social security extended such efficacious medicine to people without means to pay, with access to medical services coming to be seen as a human right.

Despite high expectations, silver-bullet cures have not materialized for emergent (bird flu, Zika, Ebola), let alone familiar pathogens (the common cold, HIV, herpes) (Crawford, 2000). Non-communicable diseases – obesity, diabetes, some cancers, and auto-immune disorders – elude the one-shot silver-bullet cure, as do the common problems that account for days off work and health-care consultations – chronic back pain and depression.

While epidemiological methods have demonstrated exposure to tobacco and asbestos as unequivocally linked to disease, other risk factors, such as alcohol, fat, sunlight, and sedentary lifestyle, have more complex dose related and contingent effects on the risk of developing disease. And demonstrating a risk factor is not the same as establishing an effective therapeutic regime. Even when a silver-bullet cure is identified, whether it can be successfully deployed in the complex social, economic, political, and cultural context of everyday life requires other sorts of knowledge. The HIV epidemic showed us that highly effective interventions such as condom use did not work without an understanding of the priorities and values that informed people's sexual behavior. For instance, it was not only men who identified as gay or bisexual who were having unprotected anal sex and this sociological understanding pointed to the wives and girlfriends of "straight" men (who had sex with men) who were also at risk from HIV infection.

Systematic reviews of evidence to inform health care have not only illuminated the complexities of the socio-economic production of illness but also the costs and benefits of therapy and care. In establishing shared standards and guidelines for health care, anomalies stand out. Comorbidity and multimorbidity present particular challenges for standardized care pathways: with more than two conditions, treatment interactions become hugely complex. Iatrogenic problems, where medical intervention harms through error, side-effect, addiction, and drug interactions are part of the cost of medicine. Some medical treatments are aimed at neither disease nor injury: infertility, body dysmorphia, and forms of sexual dysfunction are treated through surgical and pharmacological intervention. As a professional strategy, diagnosing quotidian discontents with medical terminology offers a guaranteed stream of patients. While professional ambition and commercial gain have been part of the development of medicine's role in society, another element is the collective appetite for medical attention to our disease, both collective and individual. Medicine addresses ills – despair,

anti-social behavior, and alcoholism – that a priest or police officer attended to in previous eras, as well as problems such as insomnia and impotence that may once have remained private. Medicalization of social, psychological, spiritual, and existential problems means that medicine treats forms of suffering for which its methods are ineffective.

The monopolies that medical associations gained in the nineteenth century (despite a lack of demonstrably efficacious therapies at that time) led to the profession's influence in designing the structures of national health systems in the twentieth century. Improving population health through extending access to health services became a priority for newly enfranchised groups. The public health systems were working toward improved individual AND population health outcomes, goals which can be at odds with one another. Risk calculations enumerate the uncertain outcomes for populations and by extension, for individuals. The translation of population-based odds ratios to advice for clinical consultations with individuals has proven problematic both in terms of technical difficulties of explicating the significance of a risk calculation and the delicacy of applying it to a person's particular circumstances and values. The spread of standardized means of measuring health-care's effectiveness since the 1990s has transformed idiosyncratic and uneven clinical decision-making, using the rationale of cost-benefit analyses. This transformation has been thorough-going to the extent that the limits of evidence based methods are becoming apparent: minority populations who are under represented in trials, interventions, or surveys have no voice in these collated data. Sole reliance on systematic reviews and meta-data means compounding social exclusion of marginalized and mobile groups by covering the exclusion that they experience from the evidence base with a claim of universality. Values that are important to clinical decision-making and health policy may not be revealed by randomized control trials of interventions, as demonstrated by the role of health-care chaplains (ordained and otherwise) in contemporary national health services, to support the "spiritual wellbeing" of staff and patients.

Groups that are excluded through discrimination, poverty, migrant status, or stigma do not necessarily benefit from health systems that are designed for the average of a national population. The assumptions of the post World War II settlement about a nationally bounded, homogenous, stable citizenry have been undone by the persistence of mobility as a human strategy, alongside the increased ease of movement for capital, technology, and information. Medicine's reputation for therapeutic efficacy has been at the heart of financial speculative investment in biotechnology, pharmacology, and clinical care personnel and organizations. High tech innovations: genetic sequencing to permit individually tailored medical treatment, CT scans to detect inner lesions, and implanted defibrillators to prevent heart problems all suggest the potency of scientific medicine to fix our problems and create the necessary expectations for lucrative medical markets to flourish. These transnational medical markets can be understood in contradistinction to the nationally bounded public health systems, which explicitly exclude patients on the basis of their marginal migration status.

Medical sociology has flourished as a subspecialty of sociology with multiple constituencies in need of critical perspectives to make sense of their practice and perceptions: professions associated with medicine (radiology, nursing, physiotherapy) experience the contradictions of medicine as the dominant profession for promoting and preserving health. Decades of medical sociological research have shown us that the business of health is not the prerogative of medicine and that despite the great success of certain forms of medicine, there is much that does not work. Furthermore, the application of medical therapy and technology requires sociological understanding in order to be effective. Despite evident limitations, medical models of health and the suffering associated with illness have trouble accommodating alternative view points or experiences that do not conform to scientific standards of evidence. The practice of medicine is a human art of healing, requiring trust and empathy.

Evidenced-based medicine is a means to ration access to treatment where the evidence-base is scientific and mostly quantitative (although methods for systematic reviews of qualitative evidence are developing). The value-neutral truth of science over-rides other forms of knowledge such as intuition, tradition, or faith. The question of how alternative forms of evidence can be incorporated into or accommodated alongside modern medical practice is urgent. The widening participation agenda raises the question of making sense of non-scientific evidence and lay knowledge and are important in terms of medicine's relationship with knowledge systems from beyond the Global North. The apparent certainty of science is extremely appealing compared with the vicissitudes of suffering and illness. Humanity's desire to avoid illness and promote health means that

medicine's therapeutic reputation is a powerful marketing tool for technology, medication, and intervention to fix our problems and address our suffering in a global market. The vision of good health for individuals and populations is not only a powerful driver of commerce but also informs demands for access to health care as a human right. Biomedicine is a powerful marketing method and informs the widening provision of health care but sociological insight is needed for effective applications of medical solutions and for widespread access to the socio-economic and cultural determinants of health.

The mismatch between the complexities and diversities of human experience, on the one hand, and the certainty of scientific solutions, on the other, some of which are profitable, offers territory for an imaginative progressive sociology to explore. Sociology as a science of society has a broad remit requiring an ongoing commitment to interdisciplinary discussion covering theory, methods, and empirical material. The challenge for sociology is to continue its critical approach to interrogating the social processes of health and illness, to contribute to more humane, equitable, and effective healing that integrates scientific evidence with people's values and experience. To perform a critical role with an appreciation of medical progress alongside an understanding of how the application of medical science plays out in daily lives beyond the Global North is the demanding undertaking to which this journal aspires to contribute.

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# FACING HEALTH CHALLENGES

## *Meeting the Sexual and Reproductive Health and Rights (SRHR) of the Filipino Youth amid 21st century public health risks and sustainable development challenges*

**Satwinder Rehal**

### Introduction

The Philippines' young adult population continuously faces insurmountable health challenges. Specific health issues related to sexual and reproductive health (SRH) include induced abortion which in 2010 was estimated at 319,000 cases attributed to inadequate knowledge on preventing unwanted pregnancies (DoH, n.d.). Such cases are further compounded by unwarranted social stigma and fear brought about by unwanted pregnancy. The Philippines has the highest rate of teenage pregnancies among six major economies in the Association of Southeast Asian Nations (ASEAN) and is the only country where the rate is still on the increase (UNFPA, 2016). Since 1999, adolescent birth rates have been increasing in the Philippines. At the same time, the decline in maternal and newborn mortality has decelerated to the point that the country was unable to meet its MDG target for maternal health (Galati, 2015). Addition studies report that 7.3% of youth in the Philippines already engaged in casual sex and 3.5% had *FUBU* experiences (having regular casual sex without emotional attachment) (Natividad, 2014). The issue is further aggravated by unique barriers the country's youth experience in accessing reproductive health information and care (Reynolds, et al., 2006). For instance, prior to the passage of Republic Act No. 10354 on Responsible Parenthood and Reproductive Health (or the RH Law) on December 18, 2012, the Philippines grappled with enormous barriers towards a comprehensive SRH program in the country (Cabral, 2013). However passage of the RH Law did not in itself go unchallenged exemplified by the act of the Supreme Court issuing a *status quo ante* (or restraining) order against the Law for 120 days during which period it was to review petitions challenging the new law itself (Cabral, 2013). Challenges to mitigate unmet SRH needs still abound in the country despite passage of the Law. The effect of changing population demographics on the Philippines' highlights certain key factors responsible for the situation of the youth in the country, among which are poverty, modernization or globalization in addition to related trends in international migration (Lanuza, 2004). Given these barriers, this sub-population are unlikely to benefit from interventions targeted at the overall population. In addition, majority of this population, including children, are living in conditions of constant vulnerability to sexual exploitation and abuse. As such this sub population collectively belong to high-risk categories threatened by unprotected sex (Reynolds, et al., 2006).

Chandra-Mouli et al. (2015) note that the concepts of SRHR were adopted for the first time by governments under the aegis of the UN at the International Conference on Population and Development (ICPD) in Cairo in 1994. Key points of the final resolution included the right of young people to comprehensive sexuality education (CSE), to decide on all matters related to their sexuality; access to SRH services, including safe abortion where legal, that respect confidentiality and do not discriminate; and the protection and promotion of young people's right to control their sexuality free from violence, discrimination, and coercion (Chandra-Mouli et al., 2015). This focus is made even more critical with respect to the launching of the Sustainable Development Goals (SDGs) in September 2015. For the field of SRHR, the SDGs include several relevant goals and targets including access to sexual and reproductive health (SRH) services, comprehensive sexuality education and the ability to make decisions about one's own health (Galati, 2015). The SDGs explicitly gives attention on SRHR given the limited success of the Millennium Development Goals (MDGs) on this said issue. Kleinart and Horton (2015, p. 2355) equivocally state that "the biggest opportunity during the next 15 years and beyond is to make adolescents the human face of the SDGs. As such, more responsive policies and programs targeting the youth population in the country are



therefore needed as a basic human right. To achieve this requires a re-evaluation of ‘youth participation’ among the Filipino youth in the face of 21<sup>st</sup> century sexual and reproductive health related public health threats and challenges.

Racidon (2015) notes that even though there are at present initiatives and institutions that seek to promote youth participation in the Philippines such as the *Sangguniang Kabataan* (Youth Parliament) and the National Youth Commission (NYC), it seems that they are seldom recognized as a resource in decision-making processes and as a result their perspectives are often absent in policy-making. A lesson to draw from empirical literature is that having a youth program or youth project within an organization does not necessarily guarantee youth participation. Systems need to be in place that comprehensively ensures that youth are integrated and contributing meaningfully within organizations and these reflected in the evaluation of the projects (Gurstein et al., 2003). The few studies on the subject indicate that although there are efforts been made in the area of youth participation, the lack of strong evidence of the effect of it in the impact of SRHR interventions is still missing (Chandra-Mouli et al., 2015: S6). Ergo Galati (2015) notes that the success of key SDGs will significantly depend on the extent at which important stakeholders take seriously the specific SRHR targets and fully implement the relevant policies, services and programs to attain them. If these targets can be met, it will increase the prospects for achieving the goals of health, education and gender equality. The Philippines therefore needs the *full* participation of its youth beyond tokenism.

## Conclusion

I concur with Villa-Torres and Svanemyr’s (2015: S55) contention that understanding youth participation especially on SRHR matters is a dynamic ensemble of basic human rights that could potentially lead to what Cook (2008) asserts is the building of solid youth leadership in relation broader development agenda. This I argue is important given the global agenda set on the SDGs especially those seeking to address unmet SRHR needs of both adolescents and the youth in the Philippines. This will be in line with the point highlighted by Whitmee et al. (2015) of the unique opportunity to focus on this previously neglected age group in a way that is beneficial for adolescents and for the larger society. This is rationalized on the basis of the abilities of adolescents and young adults alike in challenging ‘the status quo, accelerate progress, and advance human potential’ (Kleinart and Horton, 2015, p. 2356). In this regard, there is need for continuous process of updating and identifying research gaps and challenges in understanding Filipino adolescents, including their sexuality, in the process of shaping a better Filipino society (Cabigon, 1999).

## Biography

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A full version of this paper was presented at the "#KabataanNgayon: A Workshop on Youth & Social Change" last May 19-20, 2016 at the Thomas Aquinas Research Complex at the University of Santo Tomas, Manila, The Philippines. This Workshop was co-organized with the Development Studies Program of Ateneo de Manila University and the Philippine Sociological Society, the Research Center on Culture Education and Social Issues (RCCESI). The workshop systematically interrogated and at the same time shed light on the relationship between the Filipino youth today and the changes taking place around them.



## FUTURE EVENTS



Working Group Health Workforce Research



### **Health professions and health human resources: making connections between public health and sociology of professions**

Health professions and workforce issues are gaining momentum as central concerns for health systems and public health. This in turn opens new opportunities to highlight the benefit of professions studies. Closer connections between healthcare and workforce issues on the one hand and professions and professionalism on the other were explored during a workshop at the EUPHA (European Public Health) Conference in Vienna in November 2016. The discussion revealed many overlaps between the two areas of research and underlined the capacity of the study of professions to better understand if and how changes in healthcare services may be facilitated by professional groups.

Professions are key to the delivery of public services and their change; they translate political programmes into concrete services for citizens. This is echoed by recent contributions to the literature that highlight the close interplay between professional and organisational projects. However, little is known about the specific strategies emerging across different countries. How do professional groups use their unique resources to contribute to reforming public policies and healthcare and to changing the organisation of services? How do professional groups exploit their roles as vertical boundary spanners and help adapt policies and organisational innovation to specific (local) contexts, making changes more sustainable?

We believe it is important to continue this debate and to come up with more complex and timely approaches to health professions; this is to counteract a past but still common assumption that professions may block innovation. The discussion will certainly be continued at the ISA World Congress in 2018 in Toronto; a session at the next Interim Meeting of RC52 (Professions) in June 2017 in Oslo provides further opportunity for discussion (Call for Papers,

<https://researchcommittee52.wordpress.com/category/news-from-isa-rc52/>).

Interested in the topic? You are warmly welcome to contact: Viola Burau (viola@ps.au.dk) or Ellen Kuhlmann (e.kuhlmann@em.uni-frankfurt.de).

### **Health workforce research**

Health workforce research in Europe is increasingly gaining momentum and ISA members are contributing to the development of this field. A Pre-conference and two

workshops have been organised by the Working Group on Health Workforce Research,

EUPHA Health Services Research section, at the European Public Health Conference

(EUPHA) in Vienna, Austria, 9-12 November 2016.

If you are working in this area and want to join the emailing list of Working Group 'Health Workforce Research', EUPHA Health Services Research section you are welcome

to send your contact details to:

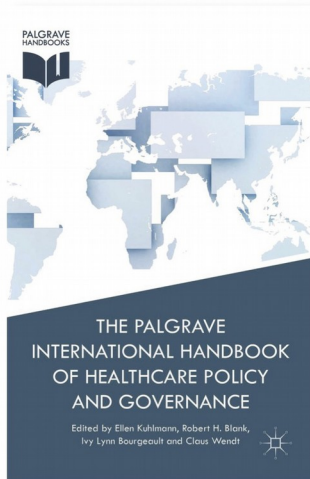
Ellen Kuhlmann, Email: e.kuhlmann@em.uni-frankfurt.de.



## PUBLICATIONS

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E. Kuhlmann, R. Blank, I. Bourgeault, C. Wendt (Eds.)

### **The Palgrave International Handbook of Healthcare Policy and Governance**

Starting with more general issues of healthcare policy and governance in a global perspective and using the lens of national case studies of healthcare reform, this handbook addresses key themes in the debates over changing healthcare policy.

Healthcare policy is one of contemporary society's most dynamic policy arenas. Heightened pressures for action and reform, such as the global economic crisis, demographic changes, and inequity, have increased interest in international, transnational, and global health policy and this, in turn, has fuelled comparative research. Yet, new concepts of healthcare may create diverse and contradictory results around the world that call for careful empirical investigation and for a systematic approach that brings the complexity of governing healthcare into perspective.

With a focus on connections, including interactions between healthcare policy and governance, international comparison and global policy, global and local perspectives, and macro- and micro-level policy using a multi-level governance approach, this Handbook handbook provides nuanced research that illuminates the intricate issues in global healthcare policy and governance.

"This Handbook arrives at a moment of intense search for ways to improve the performance of health systems worldwide, expressed mainly in the pursuit of universal health coverage. [It] offers a critical, multidisciplinary, and geographically pluralistic perspective on contemporary healthcare policy and governance issues, which will prove invaluable not only to students of the health sciences but also to health policy researchers and decision-makers around the world." (Dr. Julio Frenk, Dean of the Faculty, Harvard School of Public Health, USA)

"A monumental book covering all areas of health policy, which should be a source of reference for all researchers and policy-makers." (Naoki Ikegami, Professor and Chair, School of Medicine, Keio University, Japan)

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**Kuhlmann E, Lauxen O, Larsen C (2016) Regional health workforce monitoring as governance innovation: a German model to coordinate sectoral demand, skill mix and mobility, *Human Resources for Health*, 14:71;**

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journal homepage:

[www.elsevier.com/locate/ssmph](http://www.elsevier.com/locate/ssmph)

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**Norman Blaikie & Jan Priest, *Social Research: Paradigms in Action*, John Wiley & Sons.**

- Important introduction to social research, unique in helping readers to set the necessary philosophical groundwork to find solutions to social problems
- Works through the three most common paradigms of social research
- Includes extensive applications and examples of the paradigms in action in connection to key social problems of current times
- Written by an established and highly respected author of research methods texts

***"Norman Blaikie and Jan Priest have written a first-rate book on methodology and, as with Blaikie's previous work, it is comprehensive, clear and erudite. It will appeal both to students who want to make sense of social research paradigms and the seasoned methodologist who will find much to inspire and consider."***

Malcolm Williams, Cardiff University

***"Thoughtful, creative and groundbreaking, Blaikie and Priest have written a text that fills a core gap in many discussions of research. This is the importance of building in, from the outset, the role of explanation as much as description of social processes. A hugely informative read for those new to social research as well as seasoned professionals like myself!"***

Christina Hughes, University of Warwick

To find more information about the book, please visit the book's page at:

<http://politybooks.com/bookdetail/?isbn=9780745671840>

## Socio-economics of Personalized Medicine in Asia

Shirley Sun, Nanyang Technological University, Singapore

Series: Routledge Studies in the Sociology of Health and Illness

For more information visit:

[www.routledge.com/9781138933835](http://www.routledge.com/9781138933835)

*"This is a major contribution to the ongoing debate about the relationship between "personalized medicine" and "racialized medicine". Dr. Sun documents how in practice, the two are far more integrated than previous analysts have recognized or acknowledged. Using an international platform, Sun demonstrates how Asian geneticists (Japanese, Chinese, Singaporean, Korean, et al), in a pushback against US-European domination of human molecular genetics, are often inadvertently re-inscribing ethnic and racial categories generated in the West."*

— Troy Duster, author of *Backdoor to Eugenics*, Chancellor's Professor, University of California, Berkeley

*"A highly timely counter-weight to the dominance of works on this topic from North America and Europe, Shirley Sun's brilliant and sobering analysis of 'probability medicine' in Singapore will make even the most reflective reader think about the global implications of genomic medicine differently."*

— Barbara Prainsack, Professor at Social Science, Health and Medicine of King's College London, U.K.

*"This book addresses a critical but understudied topic: personalized medicine within the context of Asia. Asian countries are key leaders in the move towards personalized medicine, but as the author points out, historically personalized medicine has been viewed through a Western centric focus. The findings also have implications for the large Asian population residing in the US and other countries. The book is engaging*

*to read and insightful in its interpretations. I recommend it to anyone who wants to understand the global context of the emerging trend towards personalized, precision medicine and how it will change the future of health care."*

— Kathryn Phillips, Professor of Health Economics and Health Services Research at the University of California, San Francisco, and Founder/Director of the UCSF Center for Translational and Policy Research on Personalized Medicine (TRANSPERS)

### Synopsis

*This book contributes to a growing body of literature on the molecularization of identities by tracing and analyzing "personalized medicine" as it unfolds in Asia. It shows that there are inextricable transnational linkages between developing and developed countries, and examines the various social forces shaping the "co-production" of genomic science, medicine and social order in transnational settings. Theoretically guided and empirically grounded, the book provides important insights into the formation and usage of racial and ethnic human taxonomies in population-based genomic science and medicine.*

## Invitation to contribute to a book proposal on private/public healthcare

Dear Colleagues,

We are inviting contributions to a book proposal on private and public healthcare as follows:

Working Title: **Navigating Healthcare: Experiences of Patients, Doctors and Policy Makers**

Editors: **Fran Collyer and Karen Willis**

Format: **Maximum 12 chapters, 80-90,000 words (12 chapters of 6,500 – 7,500 words each)**

This edited collection concerns the global growth of private sector medicine in both developed and lesser developed countries, and the impact of this on patients, health workers, managers and policy-makers. Drawing upon experts from several countries with extensive experience in researching the field either nationally or internationally, the collection offers a unique perspective on healthcare systems: a view from those trying to access healthcare services, working inside systems, or responsible for managing and organising services or a healthcare system. Collectively, the chapters contribute an international perspective on the navigation of healthcare systems, and to the growing salience of 'choice' between public and private medicine in a variety of different systems and contexts.

**We are seeking contributions to offer insights into the book's central theme from a broad range of countries ...**

**Interested in contributing a chapter to this exciting book? Please send your abstract to us by 15th February.**

Your abstract should be approximately 200-300 words and should encompass the following

- Reflect on private/public from perspective of consumers or key players or social groups,
- (May reflect on a specific area of medicine or condition)
- Be theoretically informed and sociological in approach
- May be comparative or single country or region
- Have an empirical component.

We look forward to hearing from you! Please pass onto your colleagues who may wish to contribute.

If you would like more information about our work, please have a look at our University webpages:

- Fran Collyer: <http://sydney.edu.au/arts/staff/profiles/fran.collyer.php>
- Karen Willis: [https://corner.acu.edu.au/research\\_supervision/framework/browse.php?srperid=8200](https://corner.acu.edu.au/research_supervision/framework/browse.php?srperid=8200)

With best wishes

Karen Willis and Fran Collyer

Associate Professor Fran Collyer, PhD

Senior Editorial Advisor, Health Sociology Review

Associate Board Member, Sociology, Journal of the British Sociological Association

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