

Newsletter

of the Research Committee on the Sociology of Health



CONTENTS

3 - 15

LIFE OF RC15

ISA World Congress
Yokohama 2014

17 - 18

CRITICAL THINKING

Making heart disease a
women's issue

19 - 22

REPORT ON SOCIOLOGY OF HEALTH IN...

Australia

23 - 28

FUTURE EVENTS

Call for papers

29 - 30

PUBLICATIONS

31

MEMBERSHIP

Letter from the President of RC15

Welcome to the 56th edition of the Newsletter for RC 15, Sociology of Health and the first of 2013. As RC15 was established in 1963, this year marks our 50th anniversary. We are hard at work preparing events to mark this golden jubilee, so stay tuned for future announcements!

This Newsletter provides a list of all the sessions being organised by RC 15 for the next ISA World Congress in Yokohama, between 13th-19th July 2014, together with 7 co-sponsored joint sessions. If you are interested in submitting an abstract for one of these sessions you must do so between now and **30 September 2013** via the ISA's congress website (<http://www.isa-sociology.org/congress2014>). Click on to 'How to present a paper' and then follow the links for 'Research Committee' and then 'RC15'. Note that the joint sessions are listed under a separate heading.

Please do *not* send your abstract directly to the session organisers. Only abstracts submitted on-line will be considered in the selection process. You should also note that abstracts can be submitted in English, French or Spanish. Decision letters are due to be sent to those who have submitted abstracts on **30 November 2013**.

Also included in this Newsletter is an illuminating report on the fifty year history of Sociology of Health in Australia by Stephanie Short and a challenging piece by Chloe Bird on 'Making Heart Disease a Women's Issue'. We also have a number of calls for papers for special issues of journals or symposia, and information about



recent publications. There is also a request from our Secretary-Treasurer, Amelie Quesnel-Vallee, for you to renew your membership to RC15. Renewing your membership is important as it is integral to the success of our Research Committee and determines how much money the ISA allocates to our RC for travel grants and forum/congress grants. As you will see from the list of sessions for Yokohama in this newsletter, we are making progress in planning RC15's contribution to the ISA World Congress in Yokohama. We hope that as many of you as possible will be able to join us next year in order to make this a memorable occasion.

Best wishes

Jonathan

Professor Jonathan Gabe
President RC15 Sociology of Health

*Centre for Criminology & Sociology
Royal Holloway, University of London
Egham, Surrey
TW20 0EX*

Email: j.gabe@rhul.ac.uk

Mot du Président

Bienvenus à la 56e édition du Bulletin du comité de recherche 15 (RC15), Sociologie de la Santé. RC15 ayant été créé en 2013, nous fêtons cette année notre 50e anniversaire. Nous préparons une série d'événements pour marquer cet anniversaire bien spécial, donc restez à l'affût !

Ce bulletin fournit une liste de toutes les sessions qui seront organisées par RC15 lors du Congrès mondial de l'ISA à Yokohama, qui se tiendra du 13 au 19 juillet 2014. Nous avons un riche programme à vous proposer, qui inclut notamment 7 sessions conjointes avec d'autres RC. Si vous êtes intéressé à soumettre un résumé pour l'une de ces séances, vous devez le faire dès maintenant, et ce, jusqu'au **30 septembre 2013** sur le site Internet de l'ISA (<http://www.isa-sociology.org/congress2014>).

Pour ce faire, cliquez sur 'How to present a paper' (<http://www.isa-sociology.org/congress2014/how-to-present-a-paper.htm>) pour vous familiariser avec le processus de soumission. Vous pouvez ensuite sélectionner 'Research Committee' (<http://www.isa-sociology.org/congress2014/rc/>) et enfin 'RC15' pour voir toute la liste de sessions associées à notre comité. Veuillez noter que les sessions conjointes sont listées sous une rubrique séparée.

Vous êtes priés de ne pas envoyer votre résumé directement aux organisateurs des sessions. En effet, seuls les résumés soumis en ligne seront pris en compte dans le processus de sélection. Notez également que les résumés peuvent être soumis en anglais, français ou espagnol. Les décisions seront rendues au plus tard le **30 novembre 2013**.

Sont également inclus dans ce bulletin un rapport éclairant sur les cinquante ans d'histoire de la sociologie de la santé en Australie par Stephanie Short et un commentaire critique de Chloe Bird intitulé «Making Heart Disease a Women's Issue». Nous avons également un certain nombre d'appels à communications pour des numéros spéciaux de revues ou colloques, et des informations sur les publications récentes.

Enfin, notez aussi une requête de notre secrétaire-trésorière, Amélie Quesnel-Vallée, vous enjoignant à renouveler votre adhésion au RC15. Le renouvellement de votre adhésion est crucial car l'ISA se base sur le nombre de membres pour déterminer combien d'argent le RC reçoit pour en subventions et bourses de voyage.

Comme vous le verrez dans la liste des sessions fournie dans ce bulletin, le programme de RC15 à Yokohama est des plus prometteurs. Cependant, sans vous, il ne saura réaliser sa promesse. Nous espérons donc que vous serez nombreux à vous joindre à nous en 2014 afin d'en faire un événement mémorable en célébration de notre cinquantième anniversaire.

Bien cordialement,

Jonathan

Mensaje del Presidente

Bienvenidos a la edición 56 del Boletín del RC15 (*Research Committee* 15) de la Sociología de la Salud, y primera edición del año 2013. Debido a que el 'RC15' cumple este año su aniversario número 50, estamos trabajando intensamente en la preparación de este significativo evento, así que por favor esté atento a todos nuestros anuncios.

Este boletín entrega una lista con todas las sesiones que serán organizadas por el RC15 durante el próximo congreso mundial de la Asociación Internacional de Sociología (ISA), el cual será realizado en Yokohama, Japón, entre el 13 y 19 de Julio de 2014. Además de ello este boletín entrega la información correspondiente a las 7 sesiones copatrocinadas y compartidas con el RC19. Si usted está interesado en enviar un resumen a alguna de las sesiones, debe hacerlo antes del **30 de septiembre de 2013** a través de la página web del congreso ISA (<http://www.isa-sociology.org/congress2014>).

Primero diríjase al enlace 'How to present a paper' (<http://www.isa-sociology.org/congress2014/how-to-present-a-paper.htm>), ahí usted encontrará las instrucciones respectivas. Como segundo paso siga el enlace correspondiente al 'Research Committee' (<http://www.isa-sociology.org/congress2014/rc/>) y finalmente cliquee en 'RC15'. Por favor no envíe su resumen de manera directa a los organizadores de las sesiones. Solo los resúmenes enviados a través de la página del congreso serán considerados en el proceso de selección. Considere que los resúmenes pueden ser escritos en inglés, francés o español. Las decisiones serán informadas el **30 de noviembre de 2013**.

Este boletín también incluye un valioso informe sobre los 50 años de historia de la Sociología de la Salud en Australia, preparado por Stephanie Short, y un sugerente trabajo de Chloe Bird titulado 'Making Heart Disease a Women's Issue'. También tenemos una serie de llamados a la presentación de trabajos académicos para ediciones especiales de revistas o de congresos, e información sobre publicaciones recientes.

Hay también una solicitud de nuestra Tesorera-Ejecutiva, Amélie Quesnel-Vallée, para que usted pueda renovar su afiliación al RC15. Renovar su afiliación es muy importante para lograr el éxito de nuestro RC, porque esto a su vez determina cuántos recursos monetarios ISA podrá asignar a nuestro RC para la realización de viajes, congresos y/o foros.

Como podrá apreciar en la lista de las sesiones de Yokohama de este boletín, estamos ya, como RC15, contribuyendo de manera significativa a la realización del congreso mundial de ISA en Yokohama. Esperamos que cada uno de ustedes pueda reunirse junto a nosotros el próximo año, y poder hacer de este evento una ocasión memorable.

Sinceramente,

Jonathan

Life of RC15

*ISA World Congress 2014
Yokohama, 13-19 July 2014*

Facing an Unequal World. Challenges for Global Sociology

Conference co-organizers contact information

President Jonathan Gabe, j.gabe@rhul.ac.uk

Vice-President Ivy Bourgeault, ivy.bourgeault@uottawa.ca

RC Sponsored Sessions

If you are interested in submitting an abstract for one of these sessions you must do so between now and **30 September 2013** via the ISA's congress website (<http://www.isa-sociology.org/congress2014>). Click on to 'How to present a paper' and then follow the links for 'Research Committee' and then 'RC15'. Please do *not* send your abstract directly to the session organisers. Only abstracts submitted on-line will be considered in the selection process. You should also note that abstracts can be submitted in English, French or Spanish. Decision letters are due to be sent to those who have submitted abstracts on **30 November 2013**.

R1. Medicalization and Globalization

Format of the Session:

Regular Session – five 20-minute presentations [*English*]

Sociologists and others have been examining the increasing medicalization of human problems and conditions for four decades. The research suggests that the overwhelming amount of medicalization has occurred in North America, Western Europe and a few other countries. But in the past decade there has been increasing reports of medicalization of more conditions in a larger and more disparate array of countries worldwide.

This session will examine the globalization of medicalization. Papers should address issues such as the migration of medicalized categories, the emergence and/ or application of medicalized categories (e.g. diagnoses) where they previously did not exist, support or resistance to global or local medicalization, conflicts or disputes over medicalized categories or conditions, the role of advocacy groups in globalizing medicalized definitions and treatments or how particular medical systems facilitate or limit medicalization. Other topics of interest are what is the role of Western medicine (including psychiatry), the pharmaceutical industry, migration and international training of medical professionals, the access of the Internet, international aid, indigenous advocates or health workers, and other such vehicles in the global increase of medicalization. Are there examples of demedicalization in the global context? What are the social and medical consequences of medicalization? Are there cases with claims of overmedicalization or undermedicalization? Are the engines of medicalization different or similar in this global context? What is the future of globalized medicalization? Papers that cover any of these or related issues are welcome.

Peter Conrad

Department of Sociology Brandeis University (USA)

E-mail: conrad@brandeis.edu

R2: Narrative Medicine or Narratives in Medicine?

Format of the Session:

Regular Session – five 20-minute presentations [*English*]

In recent years, there has been a remarkable growth of interest in illness narratives, and the number of published studies and research findings of patients, carers and professionals' accounts of illness, disability and discomfort has grown rapidly. Since the narrative turn has become an extremely fashionable area of inquiry for various disciplines, we have also witnessed the rise of the so-called 'narrative based medicine', in which attention to illness narratives is advocated as a core interest of medical practice itself, and narrative work is placed at the heart of medical professional competence, as a form of humanistic medical practice. However, beyond a mere celebration of illness narratives as the means to gain direct access to personal experience and to the subjective aspects of illness, there is still a need to draw on empirical narrative accounts in order to construct more comprehensive and systematic frameworks, integrating formal discourse analysis with sociological perspectives on social action and interaction.

This session welcomes both theoretical studies and research-based contributions aimed at focusing thoroughly on various dimensions and theoretical and methodological issues involved in the analysis of illness narratives and in the utilisation of narratives in medicine: the kind of perspective adopted (symbolic interactionism, phenomenology, hermeneutic, etc.) and its strengths and weaknesses; the identification of the number of possible genres or types among illness narratives according to different social and cultural contexts; the kind of specific tropes (metaphors, similes, hyperboles, alliterations, puns, etc.) used in various accounts of ill-health, suffering, and embodiment; the identification of multiple social functions of illness narratives (biographical reconstitution, identity-work, political resistance, etc.); and analyses of the different ways personal experience and narrative accounts are related and used in medical practice.

Guido Giarelli

Department of Health Sciences, University Magna Graecia, Catanzaro, Italy

E-mail: guido_giarelli@tin.it Tel. +39 328 4598965

R3: Understanding 'Stigma' and HIV/AIDS: a social scientist's challenge

Format of the Session:

Regular Session – five 20-minute presentations [*English*]

'Stigma' and its relationship to health and disease is not a new phenomenon. It has been studied and examined in relation to various conditions like epilepsy, mental health and others. However, it has not been a major feature in the public discourse until the emergence of HIV/AIDS and the range of negative sentiments and responses associated with it that placed 'stigma' on the public agenda and drew attention to its complexity as a phenomenon and concept worthy of further investigation by the academic community.

As early as 1987, Jonathan Mann the former head of the World Health Organization's global AIDS programme, highlighted what he termed the '*third epidemic*' which he described as "*the social, cultural, economic and political reaction to AIDS [which] is as central to the global challenge as AIDS itself*". Some thirteen years later, 'stigma' was again placed at the top of the list of '*the five most pressing items on [the] agenda for the world community*', by Peter Piot, the Executive Director of UNAIDS, at the 10th meeting of the agency's Programme Coordinating Board in 2000. The focus on 'stigma' has steadily increased throughout the course of the epidemic, even becoming the focus of the World AIDS Campaign for the years 2002–2003. Yet despite its now prominent place in the public discourse as well as in scholarly literature, HIV/AIDS-related stigma remains intact and continues to be a serious public health concern as well as a challenge to social scientists.

This session will include papers that address this challenge of understanding 'stigma' in relation to HIV/AIDS.

Leah Gilbert

Department of Sociology, University of the Witwatersrand, Johannesburg, South Africa

E-mail: Leah.Gilbert@wits.ac.za

R4: Patient Participation and the Transformation of Professionals in Healthcare

Format of the Session:

Regular Session – five 20-minute presentations [*English*]

By exchanging information among international sociological scholars, this Session aims to explore changes in the relationship between patients and professionals by analysing patients' interaction with the professionals in the healthcare field. This goal is associated with the main theme of this conference, facing an unequal world. It has been traditionally thought that there was an unbalanced relationship between patients and professionals; however, patient participation has been changing this hierarchical status. We welcome papers from studies conducted at local, national and international levels that contribute to conceptualisation and/or methodological and empirical developments in this field. Examples include: the women's health movement, workers' health, disability rights activism, and structural initiatives in particular health systems. This session addresses issues of agency, structure, identity, and power.

Miwako Hosoda

Faculty of Life Network Science, Seisa University, Japan.

E-mail: miwhosoda@seisa.ac.jp, miwhosoda@gmail.com

Stephanie Short

Behavioural & Social Sciences in Health, Faculty of Health Sciences, The University of Sydney, Australia

E-mail: stephanie.short@sydney.edu.au

R5: Sociology of Diagnosis Session

Format of the Session:

Regular Session – five 20-minute presentations [*English*]

While diagnosis is important in identifying and curing disease, it also has a strong social impact. Diagnosis can be a source of anxiety or of relief, of hope or of despair. It structures the experience of health and illness, deciding what counts as normal, defining who is responsible for what disorders, providing frameworks for communication and structuring relationships. It presents a point around which tensions may develop, and interests collide. This session will focus on the sociology of diagnosis. It will adumbrate diagnosis as both category and process and will discuss the variable consequences of diagnoses on the experiences of health and illness. This session will explore the classificatory process of diagnosis, focusing on how diagnosis plays a role in distinguishing lay from professional, sick from bad, health from illness. It will also reflect on diagnosis as a source of power, resources, and subversion. And finally, papers in this session will analyse the impact of diagnosis on health outcomes and social outcomes. Preference will be given to papers which engage with diagnosis at meta analytic level, that is to say, which, even while focusing on a specific diagnosis, or a specific aspect of the diagnostic process, relate to the structural function of diagnosis at a more general level.

Annemarie Jutel

Graduate School of Nursing, Midwifery and Health, Victoria University of Wellington, New Zealand

E-mail: Annemarie.jutel@vuw.ac.nz



R6: Health Care Disparities and Inequalities

Format of the Session:

Regular Session – five 20-minute presentations [English]

Disparities in health care and health outcomes are important concerns for researchers, providers, and policymakers. In the United States, the Institute of Medicine defines health care disparities as differences in treatment or access between population groups that cannot be justified by different preferences for services or differences in health. As researchers, we care most about health care disparities as they result in health disparities or inequalities, meaning differences in health outcomes across population groups. While in the United States, there has been focus on differences in access and quality across racial and ethnic groups, across the world there are multiple other social characteristics that also are of great importance, such as education, income, geographical location, gender and sexuality.

Jennie Jacobs Kronenfeld

Graduate Program in Sociology, T Denny Sanford School of Social and Family Dynamics, Arizona State University

E-mail: jennie.kronenfeld@asu.edu

R7: Women, Health and Health Care

Format of the Session:

Regular Session – five 20-minute presentations [English]

Health and health care utilization vary by many social characteristics, of which gender is one. This session will focus on a variety of issues linked to gender differences in health and health care, with a greater focus on women overall. Papers could examine health outcome differences, differences in reaction to health and illness, health care issues unique to women such as issues linked to pregnancy and reproductive health issues and issues linked to health care delivery, such as issues in access to care and quality of care. The focus is on gender linked to health and health care, not to issues about women as health care providers.

Jennie Jacobs Kronenfeld

Graduate Program in Sociology, T Denny Sanford School of Social and Family Dynamics, Arizona State University

E-mail: jennie.kronenfeld@asu.edu

R8: Assisted Reproductive Technologies and the Sociological Imagination: New Conceptual Tools

Format of the Session:

Regular Session – five 20-minute presentations [*English*]

In the last three decades, the proliferation of assisted reproductive technologies (ARTs) has also given birth to renewed research interest in the intersections of the social and the technological. While this new literature has displayed rich sociological imagination, some empirical gaps and theoretical inadequacy exist. This panel calls for papers to address how sociology can offer effective conceptual tools for addressing potential pitfalls in the current literature and thereby shape the future research trajectories of social studies of ARTs. This may include: how cultural and economic sociologies offer well-developed conceptual tools, in particular the literatures on the embeddedness of the market and the interaction between cultural and economic capitals, for analyzing the mutual constitution of the cultural and the material; how sociologies of organizations and professions can provide useful theoretical perspectives that explain how global and local organizational contexts and policy environments shape the cultural norms and regulatory mechanisms in potentially controversial medical practices; how the current literature on globalization and neoliberalism can further develop more rigorous theoretical perspectives about the globalization of ARTs; how the regulatory regimes and biotechnology industry regarding ARTs are becoming a transnational network. Theoretically informed empirical studies are especially encouraged.

Ming-Cheng Miriam Lo

Department of Sociology, University of California-Davis, Davis, CA 95616, USA

E-mail: mml0@ucdavis.edu

Chia-Ling Wu

Department of Sociology, National Taiwan University, Taipei, Taiwan

E-mail: clwu@ntu.edu.tw

R9: Health, Risk and Governmentalization in a OneHealth Concept Agenda

Format of the Session:

Regular Session- 5-20 minute presentations [*English*]

The financial crisis has put uncertainty and risk over the limits of public expenditure on health mainly in Europe. This political agenda sets limits on citizens' rights, the health professionals power and the economic pressure groups that influence health politics.

The health policy process produces tensions between the actors and amplifies changes in public understandings of health, which opens a values debate on disthanasia and racionalization;

This session would like to address different viewpoints forms over the world on changes on health politics, citizens' rights and, health economics.

Papers may cover the following teaser suggestions:

1. Health Politics tensions on a social economic constraint
2. Unemployment and other social determinants of Health in a One Health Concept
3. North and South divide on Social inequities
4. Empowerment of citizens and communities on Health Dimensions
5. Social Intervention Projects and Methodologies to reduce Vulnerability and Health
6. Crisis, social mobility and Health

Vitória Mourão, ISCSP UTL – CAPP

E-mail: vmourao@iscsp.utl.pt

Jorge Torgal, FCM- UNL

E-mail: Jorge.torgal@gmail.com

Manuela Vilhena, U Évora

E-mail: mmcv@uevora.pt

R10: Religion, Body and Health

Format of the Session:

Regular Session – five 20-minute presentations [English and Spanish]

The relationship between religion and health is complex and has challenged researchers in several areas. When agents employ their healing processes they not only resort to official medicine, but also draw on various symbolic systems, building therapeutic itineraries that far from being a contradictory mosaic show up as a web of meanings that agents attribute to their practices. In this context the body presents itself as an instrument par excellence for mediation, since there is no social experience that is not experienced by dimensions of the body.

In this session we invite papers that develop this interface between religion and health, and more specifically between religion, body and health, considering the various therapeutic itineraries of subjects; the relationship between official medicine and religious practices; health and disease from the viewpoint of different beliefs; the corporeal dimension of the experience of health and disease; how various religions have positioned themselves with regard to various diseases like AIDS etc., among other possible issues that may arise within this theme, exploring the various contexts in which religion and health meet.

Amurabi Oliveira

Federal University of Alagoas, Brazil

R11: Sociology of Complementary and Alternative Medicine

Format of the session:

Regular session – five 20-minute presentations [English and Spanish]

Despite remarkable advances achieved by the biomedical model of health, there has been an exponential growth in the use and in the interest in Complementary and Alternative Medicine (CAM). The increasing popularity of CAM over the last five decades has been followed by a proliferation of sociological research on different dimensions of this phenomenon. In this context, CAM has attracted social researchers to establish the field of Sociology of Complementary and Alternative Medicine. The aim of the present session is to debate Sociology of CAM through diverse analytical and empirical research on CAM dynamics. The intended session attempts to deepen sociological debate on the re-emergence of heterodox practices of medical care and on the impact of that on contemporary Western society.



Nelson Filice de Barros

*University of Campinas, Campinas,
Sao Paulo, Brazil*

E-mail: filice@fcm.unicamp.br
and nelfel@uol.com.br

Tel: +551935219242

R12: Cross-national comparisons of health experiences

Format of the Session:

Regular Session – five 20-minute presentations [*English*]

Cross-national comparative research is increasingly recognised as important in health research as reflected by various funding streams, such as the European Commission Framework, and assessments of research excellence. The Research Excellence Framework in the UK, for example, rewards international partnerships. Cross-national comparative research enables the identification of similarities and differences across two or more countries, the development of new perspectives and offers ‘fresh’ insights not necessarily gained in single country studies. In this session we invite papers that use a cross-national comparative approach to understanding social and health inequalities. Contributors that use a qualitative approach are particularly welcome as qualitative research is less commonly used in this context. You might have used data from qualitative interviews, ethnographic observations, media discourse analysis or any other, social science informed, method. If you have studied more than one country and have observations to offer about inequalities in health experiences, or the delivery or uptake of services, we encourage you to submit an abstract. We also welcome papers with a methodological focus, reflecting on the challenges, contributions or future directions of cross-national comparative research.

The session is convened by DIPEX International colleagues, led by:

Sue Ziebland

University of Oxford

E-mail: sue.ziebland@gmail.com

Rika Sakumo Sato, *DIPEX-Japan*; **Gabriele Lucius**, *University of Freiburg*; **Susan Law**, *St. Mary's Hospital Center, Canada*; **Sara Ryan**, *University of Oxford*.

DIPEX International aims to promote the spread of accessible, well researched studies of health and illness related experiences throughout the world.

R13: Sleep, Health and Society

Format of the Session:

Regular Session – five 20-minute presentations [English]

Sociologists have only relatively recently started to pay attention to the relationship between sleep and health, partly in recognition of the growth of diagnosed sleep disorders and partly because of public debate about the demands of modern life, in today's non-stop, 24/7, 'wired' culture. Poor sleep is said to impair health and quality of life, endanger safety at work and on the road and affect family relations. This session invites papers on these issues. How is sleep socially patterned and organised in terms of, for example, age and gender? To what extent has sleep been medicalised and pharmaceuticalised? What role do commercial and professional interests play in the management of sleep? What are the social consequences of disturbed sleep in the workplace and at home? And to what extent has sleep been customised to optimise bodily productivity?

Jonathan Gabe

Royal Holloway, University of London, UK

E-mail: j.gabe@rhul.ac.uk

Simon Williams

University of Warwick, UK

E-mail: s.j.williams@warwick.ac.uk

R14: Patients' Rights in a Comparative Perspective: Emergence, Appropriation, New Claims-Making

Format of the Session:

Regular Session – five 20-minute presentations [*English and French*]

Patients' rights have been fostered by different phenomena in heterogeneous cultural contexts: biomedical research and the need to protect human subjects gave rise to patient-centered bioethics in the US in the 1970s (Shepherd, Hall, 2010); the AIDS epidemic served as a powerful catalyst in the constitution of patients as social actors in the French political arena in the 1980s (Barbot, 2002; Dodier, 2003). The mobilization of cancer patients in the 1990s, also in France, led the state to promote a patients' rights bill of law in 2002.

In this panel, we propose to examine the impact patients' rights have had within the medical realm and the public sphere at large, in an international perspective:

- Where they emerged, how do these patients' rights transform medical professions? For instance, how do they change medical professions' moral representations of their work and purpose?
- How do they modify doctor-patient relationships? Do they transform the ethics of medical practice? Does autonomy serve to isolate the patient in her decision-making (Frank, 2010), or does it promote a common deliberation process between patients and physicians?
- How have patients – either as individual or collective social actors – been appropriating those rights?
- Are new patients' rights being claimed? Where are these rights situated? It will be of great interest to examine claims for rights which cannot be realized in the social/political sphere, without having recourse to medicine, such as equal access to Assisted Reproductive Technology (access to parenthood) for all, or the right to die with dignity.

This panel will also seek to debate methodological issues, from an interdisciplinary standpoint: how can these phenomena be studied? How are they being apprehended by social scientists?

Philippe Bataille

CADIS (Centre d'analyse et d'intervention sociologiques), Ecole des Hautes Etudes en Sciences Sociales, Paris, France

E-mail : philippe.bataille@ehess.fr

Sandrine Bretonnière

CADIS-Ecole des Hautes Etudes en Sciences Sociales, Paris, France

E-mail: sandrinebretonniere@yahoo.fr

R15: Collaborative governance for healthy public policies

Format of the Session:

Regular Session – five 20-minute presentations [*French and English*]

Collaboration among multiple stakeholder sectors, crossing various policy sectors, holds much promise and continues to garner wide-spread support, especially in the field of public and population health. The objective of this session is to explore theories and practices of intersectoral collaboration towards the development of healthy public policies.

Based on the definition proposed by Emerson and colleagues (2012), collaborative governance is the processes and structures of public policy decision making and management that engage people constructively across the boundaries of public agencies, levels of government, and/or the public, private and civic spheres in order to carry out a public purpose that could not otherwise be accomplished.

The collaborative-governance approach has major implications for the health of the population. Not only is the sustainability of the health system in jeopardy, with health care expenditures increasing exponentially, but also its role in improving and maintaining health is being seriously questioned. Social inequities in health are worsening: the rise of noncommunicable diseases and the continuing burden of infectious diseases and undernutrition among disadvantaged people, in addition to the global challenges arising from climate change and unequal trade

policies. Response to this complex situation requires a paradigm shift regarding the governance of health systems, calling for attention on the concepts of integration, interdependence and collaboration. This session aims to discuss ways to develop healthy public policies for a more sustainable and healthier future: What are the experiences of successful collaboration? What theories and models are at work? What are the conditions for collaborative governance?

Louise Bouchard

Sociologie/Institut de recherche sur la santé des populations, Université d'Ottawa, Ottawa

E-mail: louise.bouchard@uottawa.ca

Téléphone: 613.562.5800 x1642; Télécopie: 613.562.5423

Joanne de Montigny

University of Ottawa, Ottawa

R16: Combining public and private health care services – better health care, more choice, or the entrenchment of inequality?

Many health care systems around the world combine elements of public and private provision and funding, and hence seem to offer a range of choices for patients and health care professionals. But the notion of choice within public and private health care systems is contested; the capacity to choose is unequally distributed and influenced by information asymmetry, the public/private mix within a health care system, and the influence of key players such as professional and industry organisations. Challenges to existing asymmetries of choice include consumer movements and new technologies providing ready access to alternative sources of information. We invite papers that present sociological research on the development, organisation, construction and experience of public/private health care systems.

Session Chair and organizer:

Karen Willis Karen.willis@sydney.edu.au

Organizers:

Fran Collyer Fran.collyer@sydney.edu.au

Kirsten Harley Kirsten.harley@sydney.edu.au

Marika Franklin Marika.franklin@sydney.edu.au

RC 17: Health Inequalities in the Global South: Challenges and Possibilities

Since its annual health statistics were published in 1976 the WHO records have consistently displayed the sharp contrast in health indices between nations in the global south and those in the north, generally referred to in the literature as low income countries and rich income countries respectively. While there has been a significant progress in health care provision among low income countries (LICs) in the last five decades, the disparity is still huge giving rise to concerns for health care provision and how best to address it, especially within the context of global economic crisis and the HIV/AIDS pandemic that has ravaged most LICs, with the highest burden being in sub-Saharan African countries. The focus of this session is concerned with the question of national and global social change, its interpretation and effects on health outcomes. Of specific interests are the historical forces that have influenced and shaped health policies among LICs as well as the various forms and dynamics of convergence between neoliberal reforms and health disparities in the global south. A general concern is how governments may mobilize, for example, social and cultural artifacts in designing appropriate health policies and providing health services for universal coverage and sustenance. We seek papers that will address these issues, either empirically and/or theoretically.

Session Organizer:

Alex E. Asakitikpi alex.asakitikpi@monash.edu

Session Chair:

Miwako Hosoda miwhosoda@seisa.ac.jp;
miwhosoda@gmail.com

RC18: Pharmaceuticalization and social inequalities: a chance to re-connect sociology with social justice? (Special session on conference theme)

Today, not only doctors are promoting the medicalization of society. There are other “engines of medicalization”: consumers, managed care, technology. Moreover, new diagnostic criteria enlarge the pathological sphere and shrink what can be considered normal. Medicine is not anymore only concerned with healing, but also with human enhancement: the enhancement of cognition, emotions and even of human species (through genetic screening and intervention). To study these new phenomena new concepts like pharmaceuticalization, biomedicalization and genetization are proposed. Even if sociology has proposed deep analysis on these new trends it has not said much about their consequences in terms of social justice and social inequalities. For instance, what is the sociological meaning of much higher rates of antidepressant prescriptions among the poor’s or unhealthy groups in Western societies? What is the relation between increasing inequality of wealth and psychotropic drug consumption? Starting from the assumption that medicalization and pharmaceuticalization leads to the individualization of social problems, which new field of analysis and investigation could sociology undertake in order to broaden the discussion on medicalization/ pharmaceuticalization and social inequalities?

Session chairs and organizers:

Antonio Maturo antonio.maturo2@unibo.it

Johanne Collin johanne.collin@umontreal.ca

RC19: Sex, health and technology (Panel session of 8 to 10 papers)

Sexual health is increasingly subject to the promise of technology. Diagnostic and treatment technologies are used to manage sexually transmitted infections, including HIV. Pfizer’s viagra.com helps couples diagnose erectile dysfunction and seek treatment. HIV self-testing – which operates with a similar logic to pregnancy self-testing – is now advocated. Chlamydia home-testing is available. Social media are used in contact-tracing: where contacts of someone with an STI are approached for testing and treatment. Education, counselling and psychotherapy are applied to such matters as safer sex, gender relations, sexual dysfunction and sexual violence. However, the technologisation of sexual health does not straightforwardly improve outcomes and there are knowledge gaps: 1) the prevalence of STIs in affluent countries has increased over the last decade and HIV transmission has begun to escalate, 2) it is not clear if technologies exercise narrow, ‘absence of disease’ or ‘rights-based’ models of sexual health, 3) the articulations of technologies with difference and inequality are under-explored, and 4) we lack knowledge of how diagnostic, pharmaceutical, social media, counselling and educational technologies inform and transform each other.

This panel, therefore, will focus on examples of sexual health technologies from around the world and ask: What form do these technologies take? How do they impact on sexual health care and education in personal experience? How do these technologies exercise different definitions of sexual health and with what effects? How do such technologies inform, transform or displace each other? Why is the promise implied in technology compromised or failing to be realised?

Co-chairs and organizers:

Mark Davis mark.davis@monash.edu

Mary Lou Rasmussen

Joint Sessions

JS1. RC11 Health and Social Care in the Context of Population Aging

Format of the Session:

Regular Session – five 20-minute presentations [*English*]

As populations age, there is, around the world, there is increasing interest in re-thinking the delivery of health care services. While much of the impetus relates to public expenditure constraint and projections about doubling of care costs within the coming decades, there is also recognition of the desire of older people to 'age in place', supported by home and community care services. At the same time, health and social care is challenged by issues of supply and demand in response to population aging. On the demand side, there be more elderly people (and more people living longer in old age) with a wide diversity of health issues, from long term disability to frailty to healthy older people with periodic acute illness, to end of life care. The capacity to provide health and social care (the 'supply' side) will be influenced by changing family structures and the availability of fewer care workers – both impacted by home and community care's typically marginalized role in health care systems.

This session invites presentations on issues relevant to the delivery of health and social care in the context of population aging, with a particular interest in home and community care. Papers may address a range of issues, from state governance of home and community care, to the intersection of public and private service provision (including informal care and 'grey' home care labour), to strategies to enhance the labour force, to considerations of quality, equity and equality, for example, of access and quality of services, between younger disabled and older people, between people in different geographic regions, between different diagnostic groups (especially physical disability vs dementia) and in relation to class/socio-economic inequalities.

Anne Martin-Matthews

Dept of Sociology, The University of British Columbia, Vancouver, Canada

E-mail: amm@mail.ubc.ca (RC11)

Ivy Lynn Bourgeault (RC15)

JS2. RC13 Leisure and the Pursuit of Health and Happiness in an Unequal World

Format of the Session:

Regular Session – five 20-minute presentations [*English*]

"Life, [Liberty](#) and the pursuit of Happiness" is one of the most famous [phrases](#) in the [United States Declaration of Independence](#), also considered by some as one of the most influential sentences in the history of the English language. To what extent are these so called "[inalienable rights](#)" of man – in pursuit of happiness – actually realised in life as it is lived today? Which is the domain which would be most conducive to their realisation?

It is not only liberty but health too needs to be looked upon as a fundamental right of all human beings wherever or in whatever kind of society they may be living in. Without physical and mental health any talk of happiness would remain an empty slogan. The fundamental question now is as to how, in today's uneven and unequal world, can we secure health and ensure happiness? To what extent is leisure, another fundamental human requirement, is conducive to realization of good health? What are the forms of leisure that could be made available to people around the world by which they can access those forms without the need to expend too many resources on them?

Organizers:

Ishwar MODI, India International Institute of Social Sciences, India.

E-mail: iiiss2005modi@yahoo.co.in

Ivy BOURGEAULT, University of Ottawa, Canada.

E-mail: Ivy.Bourgeault@uottowa.ca

Jonathan GABE, University of London, United Kingdom.

E-mail: j.gabe@rhul.ac.uk

Chairs:

Zsuzsanna Benko, University of Szeged, Hungary.

E-mail: benko@jgypk.u-szeged.hu

Klara Tarko, University of Szeged, Hungary

Email: tarko@jgypk.u-szeged.hu

JS3: RC19 Healthcare Systems and Health Inequalities.

Format of the Session:

Regular Session – five 20-minute presentations [*English*]

Healthcare systems have been established worldwide to guarantee those in need with access to healthcare and care and reforms have been introduced to improve the organization and delivery of healthcare services. Despite common interests, researchers on both healthcare systems and health outcomes have rarely communicated directly. Due to the necessity of reorganizing our healthcare systems, which is partly related to the financial crisis and to ever-increasing healthcare costs, there is a great need to improve our knowledge about the link between healthcare and health inequalities. In our joint session, we invite papers on and plan to provide a platform for discussing questions that are of similar importance for developed and developing countries: How is healthcare financed, provided, and regulated, and what are the outcomes of different national care arrangements? How should global challenges and local needs and demand be balanced? What can be learned from local solutions to global pressures? Until now, health policy papers have mainly focused on the institutional structure and not concentrated on outcomes such as health status and health inequalities. However, if we want to learn more about improved practice in healthcare, studies need to delve deeper into potential outcome measures. We therefore invite papers focussing on the interrelation between research areas such as health policy, healthcare provision, access to healthcare, take-up of medical services, and health inequalities. These papers may explore these issues either across nations and regions or within a single country.

Claus Wendt

University of Siegen, Germany

E-mail: wendt@soziologie.uni-siegen.de

Ellen Kuhlmann

Institute of Economy, Labour and Culture Goethe-University Frankfurt, Frankfurt, Germany

E-mail: e.kuhlmann@em.uni-frankfurt.de

JS4: RC52 Governing the Health Professions: Bringing Equity into Health Human Resources Policy

Format of the Session:

Regular Session – five 20-minute presentations [*English*]

Health professional governance has faced a number of new challenges over recent years, and an increasing scarcity of health human resources (HHR) is among the most urgent problems. This session aims to contribute to the debates by building bridges between two important, yet separated fields – professional governance and health human resources policy – and by reviewing the evidence through an equity lens. This includes wide-ranging topics from governing professional performance and managing skills and tasks to HHR planning and policymaking; it furthermore expands the equity agenda towards an integration of gender, age, geopolitical and cultural as well as professions-based dimensions. We invite papers that address these issues in comparative perspective or in a single area.

Ivy Bourgeault

E-mail: ivy.bourgeault@uottawa.ca

Ellen Kuhlmann

E-mail: e.kuhlmann@em.frankfurt.de

JS5: RC52 Globalization and Human Resources for Health in Japan and Asian Countries

Format of the Session:

Regular Session – five 20-minute presentations [English]

Japan has been accepting unskilled laborers from other countries since the late 1980s. Since 2008, a new trend of migration of healthcare workers from Asian countries to Japan, under bilateral agreements between Japan and Indonesia, Japan and the Philippines and Japan and Vietnam, has been observed. The inflow of health professionals, including nurses and certified care workers, is the first time Japanese society has had to accept the foreigners in the health care sectors in Japan. Due to this new globalization and the cross-border movement of health professionals, Japanese society now faces a new facet of health care management.

This session calls for papers about various sociological topics, such as cross-cultural concepts related to nursing and care, the professions and inequality of migrant nurses and certified care workers, hospital and long-term care facility management and international relations between the sending and receiving countries of health professionals.

Session Organizer:

Yuko Hirano

Nagasaki University, Japan

E-mail: hirano@nagasaki-u.ac.jp

Session Chair:

Yuka Ishii

Ritsumeikan Asia Pacific University, Japan

E-mail: yishii@s7.dion.ne.jp

JS6: RC 54 Time on the Context of Health and Illness: the Medical Control of the Body.

Format of the Session:

Regular Session – five 20-minute presentations [English–French]

Health and disease are concepts that are associated with bodies in common sense as well as in an expert discourse; the literature in this field is enormous and enormously diverse. The suggested JS is designed to focus on the importance of body time in medical treatment. Extensive mapping of the time structure of humans is presently underway as a preliminary step for the detection of the earliest changes associated with health and

disease. The importance of this time structure for normal functioning has been established in many branches of human physiology. A classic example is the dependence of a normal reproductive function on the pulsatile secretion of sexual hormones. Another is the rhythmic influence of sensory, motor, autonomic, and hormonal oscillations on normal sleep activity. More recent research has even begun to tell in detail how multiple oscillators work together to regulate blood pressure. In humans, as in less cognitively sophisticated organisms, many biological rhythms follow the frequencies of periodical environmental inputs, whereas others are determined by internal “timekeepers” independent of any known environmental counterparts. External influences are always present, but they are not simply superimposed on the endogenous rhythms generated by our biological “timekeepers.” Instead, these influences are modulated by them. This is essential to the most sophisticated tasks the brain and body perform.

Co-organizers and Co-chairs:

Bianca Maria Pirani

“Sapienza” University of Rome, Rome, Italy

E-mail: biancamaria.pirani@uniroma1.it

JS7: RC 22 & RC 31 The Relationship between Religion, Immigrants and Health.

Format of the Session:

Regular Session – five 20-minute presentations [*English*]

A growing body of evidence suggests that religiosity is typically associated with better health. The potential impact of religious involvement on health may be especially great for immigrants ; faith institutions often play important integrative roles for them and religion and ethnic identities are often intertwined. Further, opportunities may exist to leverage widespread congregational attendance already taking place by immigrants to reduce inequalities through initiatives. However, while there has been much attention in the popular as well as academic press about religion, immigrants and health individually, there has been a paucity of studies examining the intersection of all three areas: religious involvement, immigrants, and health outcomes. We invite scholars with interest in these areas to submit presentation proposals highlighting any aspect of the relationship between religion, immigrants, and health, each broadly defined. In particular, we welcome proposals that tie in with the conference and section themes of addressing inequality and with ISA's focus on diverse cultures. Therefore, proposals including implications and importance of the research for social change are encouraged.

Ephraim Shapiro

E-mail: cas97@caa.columbia.edu



Critical thinking

Making Heart Disease a Women's Issue

In the past two months, two of my friends—both seemingly healthy women—became unlikely victims of cardiovascular disease. One, a woman who by any textbook definition would be considered at low risk for heart problems, nonetheless suffered a heart attack. Thankfully, she is recovering. The other, a longtime friend and a mentor of mine, tragically passed away after suffering a stroke. These experiences left me wondering how we can accelerate efforts to reduce cardiovascular disease risk and mortality in women.

As a women's health researcher, I am concerned about how long it is taking to bring attention and resources to this problem. After all, it has been decades since we've learned that cardiovascular disease affects women every bit as much—or even more—than it does men. Indeed, since 1984, cardiovascular disease has killed [more women than men](#) in the United States. When it comes to women's health, cancer gets a good deal of the attention; somehow, it hasn't fully registered that so many of our mothers, sisters, friends and daughters are being affected by another, often silent killer.

Commonly referred to as heart disease, cardiovascular disease includes both heart disease and other vascular diseases. When tallied separately, stroke is the [third leading cause of death](#) among women. Both strokes and cardiac events are all too common in women over 40 and, sadly, so are deaths.

Consider a few statistics:

- In the U.S., women account for [60 percent of stroke deaths](#), and 55,000 more women than men suffer a stroke each year.
- Worldwide, heart disease and stroke kill [8.6 million women](#) annually—accounting for one in three deaths among women.
- Whereas one in seven women develops breast cancer, more than one in three women has some form of cardiovascular disease.



Although the American Heart Association's [Go Red for Women](#) campaign has done much to raise awareness, there is still too little attention devoted to preventing heart disease in women and improving the quality and outcomes of their care.

While we should celebrate the significant improvements in the care and survival of men with cardiovascular disease, those gains began decades ago, and the death rate among men has fallen more quickly than it has for women. Unfortunately, women continue to face lower rates of diagnosis, treatment and survival. The new [Million Hearts](#) campaign aimed at preventing a million heart attacks and strokes by 2017 has partnered with [WomenHeart](#), a national coalition for women with heart disease. This effort is essential and represents progress, but prevention is not the only challenge. Why are outcomes worse for women? Even if biomedical research on cardiovascular disease had not traditionally focused almost exclusively on men, these conditions would likely still be harder to recognize and treat in women. Women don't tend to have the "TV heart attack"—the familiar image of a man clutching his left arm or his chest in pain. Rather, for women, the symptoms of a heart attack are often more subtle and less specific. Women can present with symptoms like throat pain or a sore back. In fact,

64 percent of women who die suddenly from heart disease had no previous symptoms at all. Furthermore, tests that are mostly reliable in assessing men's cardiac risk are not as accurate in women, largely because they are aimed at identifying major coronary artery blockage. At least half of heart attacks in women are caused by [coronary microvascular disease](#), which involves narrowing or damage to *smaller* arteries in the heart. This not only makes the diagnosis challenging, but it poses problems for treatment as well. Women often go undiagnosed or incorrectly untreated after major blockages have been ruled out, and optimal treatment of microvascular disease remains unclear. Consequently, [26 percent of women over age 45](#) will die within a year of having a heart attack, compared with 19 percent of men. The deficits in women's cardiovascular care may have developed unintentionally, but our efforts to address them need to be both intentional and focused.

Fortunately, we know what it will take to close the gap and get women better diagnosis and treatment for cardiovascular disease. We can start by looking to the fight against breast cancer. Our first task is to call for increased public and private funding for public-health, biomedical and health-services research to reduce women's risk and improve their outcomes. Second, on the private side, there are many foundations dedicated to addressing cardiovascular risk in women. But they and the women they serve would benefit

from more collaboration and better coordination of effort. Finally, doctors and medical clinics need to do more to improve assessment and the quality of women's cardiovascular care.

Otherwise, women's care and outcomes will continue to lag behind men's.

Our bodies are complex systems. So, if we want to take on women's health in a way that truly moves the needle on outcomes, we need a comprehensive approach. Women's health care in general needs to become a primary focus for research *and* practice. And improving women's health and longevity will require us to expand our focus beyond sex-specific reproductive cancers and predominantly female diseases, such as breast cancer. This doesn't mean that we should divert resources from other areas of study, of course. But we need to recognize that woman-specific health care should not be confined to conditions that don't (or don't often) affect men. The stakes for women are high, but we can and must bring greater attention to women's cardiovascular health. Personally, I am not willing to let go of another friend, colleague or relative to a condition that could have been caught and treated if women routinely received appropriate preventive care, diagnostic testing and treatment. It's time for feminists to take on heart disease as a women's issue.

Chloe Bird

*Senior sociologist at the nonprofit,
nonpartisan RAND Corporation*

Report on Sociology of Health in...

Australia

by Stephanie Short

Health Sociology in Australia turns 50

I am delighted to accept the invitation from Jon Gabe, ISA RC15 Sociology of Health President, and Guido Giarelli, Newsletter Editor, to write something like a short reflection on Australian Medical Sociology to be included with the announcement of our 50th Anniversary Conference, to be held in Melbourne in late November. This is a welcome opportunity to introduce the rest of the world medical sociologists to the history, developments and 'problems' of our sub-discipline in our own country.

Given the reliance on public funding and support in a publicly funded university system the history of health sociology in Australia is inextricably linked with the history of Australian universities, as the institutional base for academic sociology, and with broader public policy developments. Australia is an island continent in Oceania with a population of 23 million, 37 publicly-funded Universities and 2 private not-for-profit Universities. The system is over 150 years old, with the University of Sydney, the oldest, established in 1850. Generally our University system was modelled on the British system and eminent Australian sociologist, Raewyn Connell, has noted that the early decades of Australian Sociology, from the 1950's to the 1970s, were characterised by 'intellectual dependence' on Western European and North American traditions. I have listed sources at the bottom of this brief history for those interested in more formal accounts of the phenomena outlined here. I see the fifty-year history in two main phases.

The Age of Aquarius, the 1960s to the late 1980s
The Aquarius Festival signifies a turning point in Australian culture and society; it was a counter cultural arts and music festival organised by the Australian Union of University Students in the rural New South Wales village of Nimbin in 1973; Australia's answer to Woodstock in the



USA and the Isle of Wight Festival in England. It is identified with the birth of the hippie movement in Australia, long associated with alternative culture, communal living and working arrangements, and the growing and consumption of marijuana.

The so-called 1968-generation, the post-war baby boomers who grew up in a time of unparalleled peace and prosperity with the growth of the Welfare State, nurtured the counter cultural social movements that provided the impetus for democratising changes in society and legislation including multiple occupancy dwellings, the softening of laws on marijuana possession, the women's liberation movement, the community health movement, liberalisation of laws on homosexuality, and the modern environmental movement.

This 'Age of Aquarius' (to quote from the sound track of the rock musical 'Hair') came to a climax

at the ballot box with the election of the first social democratic government in Australia since World War 2, led by the charismatic E Gough Whitlam, in 1972. This reformist period, 1972-1975, was a watershed in Australian public policy, economy and society. It saw the introduction of free university education, Australia withdrew all its troops from Vietnam, and Medibank, a publicly-funded universal system of health insurance was introduced.

A survey conducted by the Australian Sociological Association (TASA) identified the ten most influential books in Australian Sociology over this period. According to American sociologist, Eleanor Townsley, the survey reveals a distinctive style in Australian Sociology. She identified a '... particular brand of critical sociology'; one characterised by political analysis and engagement that relates social issues to power, public policy and reform. Typical of works influential during this period are books by Raewyn Connell, with four books in the top ten, on class, gender and hegemony, Michael Pusey's work on 'economic rationalism', and Evan Willis's book, 'Medical Dominance' on the importance of social class and gender in understanding the occupational division of labour in health care in Australia. The second phase in this brief history is marked by a turn towards neo-liberal public policies and subsequent changes in Australian Universities and Sociology.

Economic Rationalism in Australia, the late 1980s to the current day Michael Pusey's seminal sociological analysis of the Australian state 'changing its mind' dates the neo-liberal turn in Australian public policy to the late 1980s and the policies of the then prime minister Bob Hawke and treasurer Paul Keating. This turn to the Right in public policy occurred in response to the international stock market slump of 1987, and the subsequent recession in Australia in 1991-2. The Australian Government introduced most significant changes to the economic system in this period, including de-regulation of the banks, floating the Australian dollar and a more circumscribed role for trade unions.

The 1991 Wages and Incomes Accord between government and trade unions saw the introduction of enterprise bargaining at the level

of the individual organisation, rather than on an industry-wide scale. The wide-scale introduction in 1993 of enterprise agreements saw the end of nearly a century of centralised wage fixing based on a federal industrial relations system in Australia. This localised system is in place today, with round six enterprise bargaining negotiations underway in 2013 in our universities. Each University undertakes bargaining every four years through negotiation between the University-level branch of the National Tertiary Education Union (NTEU) and the university management. These negotiations are coordinated across Australia by the national office of the NTEU in Melbourne, referred to by University management as 'the Kremlin'.

This Age of Aquarius came to a definitive end in 1996 with the election of a conservative Liberal and National coalition Government in Australia led by John Winston Howard. During the Howard years, 1996-2007, public policies turned even further to the Right, with increased support and public subsidies for private health insurance, tough policies on asylum seekers and military-style interventions in Indigenous communities in rural and remote Australia, and military involvement in Afghanistan and Iraq.

Economic rationalism was realised in the late 1980s in Australian universities with the so-called 'Dawkins Revolution' (named after the Minister for Education at the time, John Dawkins), with the passing of the Higher Education Funding Act of 1988 and establishment of a unified system of higher education. The twin aims of the revolution were to increase the efficiency and international competitiveness of Australia's universities. This created cultural upheaval and fast and significant growth in the university sector, due to the conversion of former Colleges of Advanced Education and Institutes of Technology into Universities or into Universities through mergers with existing Universities.

Whilst the Whitlam policy in the Age of Aquarius emphasised equity in access to higher education, this new Act placed emphasis on economic efficiency in university management (as distinct from administration), with new public sector management principles applied to 'the provision of educational services' and support for user pays principles. This led to the introduction

of a higher education contribution scheme for students and the effective end of 'free' university education in Australia.

This Dawkins revolution coincided with the transfer of nurse education from state government-funded hospitals to federally-funded universities. Both these public policy changes led to most significant growth in health professional education in the higher education sector, and subsequent teaching opportunities and appointments in Health Sociology, as the allied health professions and nursing joined the more established health professions such as medicine and dentistry in the university system.

Australian Universities have changed dramatically since the late 1980s, with the establishment and wide-scale reorganization of disciplines and schools, staff retrenchment and cost-cutting in terms of funding per student. Since 2003 Commonwealth funding to Universities has been differentiated according to 'financial clusters' which sees Medicine in 2012 attracting over A\$21,000 per equivalent full-time student and Sociology attracting less than half that amount, with Nursing and Allied Health in between.

In this regard Fran Collyer's recent 'mapping' of health sociology identifies a 'cultural turn' in this specialist field in Australia in the 1990s. Collyer associates this cultural turn with qualitative methods and analysis, and to the influx of women into sociology. In the 1990s '... the discipline was radically and irrevocably re-oriented' towards health sociology, feminism and qualitative methodologies (Collyer, 2012: 134).

I ground this 'cultural turn' in these twin reforms: the Dawkins revolution and the transfer of nursing education to universities in particular, just as the intellectual influence of the work of Michel Foucault, Bryan Turner, Deborah Lupton and other postmodern theorists was reaching its ascendancy in Australian Health Sociology.

In the contemporary era Health Sociology is thriving. Sociology is taught in the vast majority of Australian Universities. 'Health, Medicine and the Body' is the second most common Sociology subject taught, after methodology, and the Health Section is the oldest and second most popular Thematic Group in TASA, second only to the Feminism, Gender & Sexuality Section.

In 2013 only two Universities appear to have stand-alone Sociology Departments: the Australian National University and Macquarie University. Marshall and Colleagues' (2009) study of Sociology Teaching in Australia found Sociology was most often combined with other disciplines. This trend was exacerbated by the Higher Education Reforms introduced in 2003 by the Howard government that saw student courses funded at different rates, as mentioned above. Marshall et al.'s report stated:

'This project cannot fully map how 'service' sociology is taught in our universities. In part, this is because the funding model, in which disciplines are grouped into bands for funding, may disguise some sociology teaching. Subjects called 'sociology' are funded in one of the lowest bands, so, in health sciences, for example, they may be rebadged as 'Public Health' or 'Social Determinants of Health' in order to qualify for higher funding.'

This is a double-edged sword. While the economic rationalist higher education reforms outlined here have undermined the likelihood of Health Sociology being taught as a social science subject in a less-well funded Sociology Department, the reforms have opened up greater opportunities for Sociology to be taught as an applied discipline to students in the health professions, for example as 'Sociology for Nurses', or as an integrated part of an interdisciplinary subject offering, such as 'Healthcare Resources & Systems'.

Clearly, we have seen a fundamental 'refashioning of Sociology', to use Sharyn Roach Anleu's phrase. In 1998, in a presidential address to TASA Roach Anleu outlined a case for:

'... flexibility and openness in a context marked by growing inter-disciplinarity and massive institutional reorganization.'

In retrospect, these words were prescient indeed. Health Sociology, as a sub-discipline, is flourishing in quite a different way under the current zeitgeist.

Professor Stephanie Short

*Discipline of Behavioural and Social Sciences in
Health, Faculty of Health Sciences
The University of Sydney, Australia*
stephanie.short@sydney.edu.au

Acknowledgments: I would like to acknowledge the Brocher Foundation for the residential Fellowship that provided an ideal environment in which to write whilst on study leave from the University of Sydney. <http://www.brocher.ch/en/>

References

Connell, Robert W (1977) *Ruling Class, Ruling Culture: Studies of Conflict, Power, and Hegemony in Australian Life*. Cambridge: Cambridge University Press.

Collyer, Fran (2012) *Mapping the Sociology of Health and Medicine: America, Britain and Australia Compared*. London: Palgrave Macmillan.

Germov, John & McGee, Tara Renae (eds) (2005) *Histories of Australian Sociology*. Melbourne: Melbourne University Press.

Germov, John & McGee, Tara Renae (2005) 'Australian Sociology: Recent Trends and Prospects', in J. Germov & T. McGee (eds) *Histories of Australian Sociology*, Melbourne: Melbourne University Press, 355–85.

Foucault, Michel (1973) *The Birth of the Clinic: An Archaeology of Medical Perception*. London: Tavistock.

Lupton, Deborah (1994, 2003 & 2012) *Medicine as Culture: Illness, Disease and the Body*. London: Sage.

Marshall, Helen, Robinson, Peter, Germov, John & Clark, Eileen (2009) *Teaching Sociology in Australia: A Report to the Australian Learning and Teaching Council*. Sydney: ALTC.

Palmer, George Rupert & Short, Stephanie Doris (1989, 1994, 2000 & 2010) *Health Care & Public Policy: An Australian Analysis*. Melbourne: Palgrave Macmillan.

Pusey Michael (1991) *Economic Rationalism in Canberra: A Nation-building State Changes its Mind*. Cambridge: Cambridge University Press.

Short, Stephanie & Sharman, Evelyn (1992) 'Sociology in Tertiary Nursing Education: The New South Wales Experience.' *Forum of Education*. Vol. 48, pp. 67–74.

Townsley, Eleanor (2009) Review of Germov, John & McCrae, Tara Renae (2005) (eds) *Histories of Australian Sociology*, Melbourne: Melbourne University Press. In *International Sociology* Vol. 24 (5): 669-674.

Turner, Bryan S. (1984, 1996 & 2008) *The Body and Society: Explorations in Social Theory*. London: Sage.

Willis, Evan (1983 & 1989) *Medical Dominance: The Division of Labour in Australian Health Care*. Sydney: Allen and Unwin.

Key Milestones in Health Sociology in Australia

1959: First Australian Chair in Sociology appointed at the University of New South Wales, Sydney and the first Department of Sociology created.

1963: Formation of the Sociological Association of Australia and New Zealand (SAANZ) (ISA RC15 established in 1963).

1965: Australian and New Zealand Journal of Sociology established (re-named the Journal of Sociology in 1998). Publication of Australia's first sociology textbook: A. F. Davies & Sol Encel (eds), 'Australian Society'.

1967: Health Section of TASA established. The first specialty formed.

1988: The Australian Sociological Association (TASA) established after New Zealand sociologists form an independent association

1991: Annual Review of Health Social Sciences academic journal established (re-named Health Sociology Review in 2001).

2002 TASA hosted the ISA XV World Congress of Sociology in Brisbane at the Queensland University of Technology (3 000 delegates)

2013 TASA celebrates 50 years of Sociology in Australia

Source: Adapted from Germov & McGee (2005) and Collyer (2012)

FUTURE EVENTS

Social Science and Medicine - Special Issue

CALL FOR PAPERS

The Role of civil society in healthcare systems reforms

Guest Editors:

Guido Giarelli, Ellen Annandale and Carlo Ruzza



Social Science & Medicine invites papers for a Special Issue on **The Role of Civil Society in Healthcare Systems Reforms**.

Since the 1980s in particular civil society organizations, associations, institutions and groups have become increasingly involved at various levels (planning, advocacy, delivery, evaluation, etc.) in the governance of healthcare systems around the world. However, despite the

considerable amount of published literature on international health system reform, very little has directly analyzed the part that civil society is playing beyond simple normative stances. This is of considerable topical interest at the present time as public provision is under increased pressure due to financial cutbacks and the global trend towards managed healthcare markets. Civil society organisations are a pivotal part of this mix.

Therefore we are seeking papers that address the above issues in relation to the role of civil society in healthcare systems reforms, including but not limited to the following topics:

- Theoretical development e.g definitional issues (civil society, third sector, voluntary sector, non-profit sector, etc.) and the theoretical approaches they imply for the study of healthcare
- Relationships between civil society and the State (the political functions that civil society performs) and between civil society and markets (the roles that civil society plays in relation to market functioning and failures) in different national and cross-national health contexts
- Issues of civil society's identity in healthcare advocacy and delivery (e.g risks of losing original identity due to system involvement)
- Relations between civil society involvement in health and political

protests (e.g the role of environmental movements in addressing health-related grievances)

- Deliberative democracy with patients' groups involved in assessing choices in health policy
- Analyses of actual outcomes of civil society involvement in healthcare advocacy and delivery.

The deadline for submissions is **31st July 2013**, and authors should submit online at <http://ees.elsevier.com/ssm/>. When asked to choose article type, authors should stipulate 'Special Issue: Civil Society'. In the 'Enter Comments' box, the title of the Special Issue, along with any further acknowledgements, should be inserted. All submissions should meet Social Science &

Medicine author guidelines (also available at <http://ees.elsevier.com/ssm/>). The Guest Editors of this Special Issue are:

- Guido Giarelli (University "Magna Græcia" of Catanzaro, guido_giarelli@tin.it)
- Ellen Annandale (University of York, UK)
- Carlo Ruzza (University of Trento & University of Leicester)

Webpage: <http://www.journals.elsevier.com/social-science-and-medicine/news-and-calls-for-papers/the-role-of-civil-society-in-healthcare-systems-reforms/>

Call for papers: **April 2013**

Deadline for submissions: **31st July 2013**

1st Decisions on papers: **30th September 2013**

2013 Tasa Conference

The Australian Sociological Association will be hosting its 50th Anniversary Conference at Monash University in Melbourne, 25-28 November, 2013. This will include sessions of health thematic group, including papers addressing a wide range of themes; e.g. health inequalities, new medical technologies and risk. Other sessions of interest to health sociologists will be hosted by the risk thematic group, and the sociology of emotions group. Abstract and refereed paper deadlines can be found on TASA's website: <http://www.tasa.org.au/tasa-conference/tasa-conference-2013/>

Biopolitics of science and medicine symposium

CALL FOR PAPERS

Monash University, Caulfield campus, 29th November 2013

Conveners: Alan Petersen (Monash University) and Emma Kowal (University of Melbourne)

Biomedicine and science continue to act on modern life in unexpected and uneven ways. Social scientists and humanities scholars play an important role in tracking and anticipating the effects of rapid technological change on social life, and the ways that biomedicine and the life sciences are shaped by social, political and material forces.

This symposium aims to explore the entanglements and intersections between biomedicine and science, the state, citizenship, the body, personhood, and life itself. It will bring together anthropologists, sociologists, historians, philosophers, STS scholars and others who are engaged in research on biomedicine or the life sciences across different institutions and disciplines. We aim to include a mix of established scholars, early career researchers and PhD students. Registration is free. Note that the symposium will directly follow the 2013 TASA (The Australian Sociology Association) conference to be held at Monash Caulfield.

Topics of interest include:

Emerging biomedical therapies
Outsourcing clinical trials
Drugs – illicit and pharmaceutical

Medical tourism
Organ and tissue markets
Global health
E-medicine
Complementary and alternative medicine
Post/genomics
Bioethics, research ethics
Biosecurity
Regulation of science and medicine
History of medicine and biology
Reproductive technologies and politics
Population health and policy
Other topics related to the life sciences and biomedicine

Please submit a 250 word abstract to alan.petersen@monash.edu.au by July 15th, 2013.

For more information, contact alan.petersen@monash.edu.au or e.kowal@unimelb.edu.au

Intersectionalities:

A Global Journal of Social Work Analysis, Research, Polity, and Practice

CALL FOR PAPERS - *Special Issue*

Social Inclusion and mental health: The transformation of identities and intersectional relations of power and oppression

Submission Deadline: October 1st 2013

Guest Editors:

Carol Munn-Giddings, *Professor of Participative Inquiry, Anglia Ruskin University, England*

Roar Stokken, *Researcher More and Romsdal Hospital Trust, Volda, Norway*

Reima Ana Maglajlic, *Research and Monitoring Director, Mental Disability Advocacy Center, Budapest, Hungary*

The European Context of Social Inclusion

In a number of European countries mental health services are in a process of change, in part as a result of the closure of a large number of psychiatric total institutions, in part due to the impact of the service user movement and new meaning of 'recovery' in mental health, coupled with a dominant neo-liberal governmental focus on competitive employment as the best outcome for the person and for society. This mixture entails opportunities, contradictions and conflicting directions, as well as struggles for dominance of one approach as against the other. Although European societies differ in their history, culture and understanding of mental health issues, they warrant looking at commonalities in their direction of change. All of them have developed more services in the community than was the case before 1980, all of them state that they see a place in society for people facing severe mental health issues, yet all of them still use medication as the main intervention method, applying psychological treatment less frequently and with fewer variations, with social interventions trailing a poor third. However, set against this context, in most countries there is an increasing interest in the involvement of service users in service policy and planning and in auditing services and in contributing to training and research, despite a general paucity of recorded good practice.

The Conceptual Framework

The concept of social inclusion came to the fore following the focus on social exclusion in the context of poverty and social deprivation in France, and was then adopted across the EU. Whereas social exclusion denotes the inferior social position of people with disability and their social marginality, social inclusion has come to indicate the possibility and potential for their greater inclusion within the societies to which they belong.

Exploring and critiquing social inclusion raises a number of conceptual issues not least how the rights and opportunities for participation are framed and available or otherwise for people experiencing barriers to mental wellbeing. Complex issues intersect and become relevant, such as the daily impact of stigmatisation on service users self –identity. This is also the arena in which stigmatisation due to different issues is compounded (e.g. discrimination due to minority ethnicity, gender and poverty). Less often we come across accounts of, or make use of, the ways service users handle stigma, either in their own words or in research. The internalisation of the stigmatised identity by service users requires attention too.

Within the context of mental health specifically, the key discourse on exclusion and inclusion is the cultural one, where poverty is a reflection of stigma and othering, where deprivation of citizenship rights happens frequently, and

integration is perceived in terms of expanding opportunities for social networking, meaningful activities, of which employment is a major, but not the only, or the most important, achievement on the pathway to social inclusion. The realisation of the hybrid identity of all of us, but of some groups more than others, in the context of ethnic identity, is yet to filter to the mental health field.

It is the growth of opportunities which typifies developments in social inclusion across Europe, be it in access to adult education, employment, housing, volunteering, day activities and sociability. This is coupled with stigma reduction work engaging people who use mental health services. The development of peer alternatives to medication, the Open Dialogue approach and on shared decision making in psychiatric medication management is encouraging, but is meeting resistance mainly from some service providers, and is far from becoming a mainstream intervention.

A central element in bringing about social inclusion is that of reducing the power inequality which pervades the mental health system across Europe. The success or failure of social inclusion is assessed by the ability of the community to enhance the re-entry of people who are citizens with mental health difficulties to the common spaces at most levels, and by that of the person's own contribution to taking an active role in such activities. Another key dimension of success or failure is the ability to remove structural barriers, the adoption of less stigmatising social attitudes towards this group, and enabling solidarity to develop.

This shift then from an exclusion to an inclusion discourse, which took place towards the end of the 20th century, needs to be better understood. Is it the culmination of the neo-liberal dream of putting the responsibility to become included on the individual who is facing barriers to their mental wellbeing, leaving the state, the professional service providers and the general public without responsibilities towards the reduction of stigma and deprivation and towards increasing opportunities and support for social inclusion? Is it the wish to have a stakeholders' coalition working together to achieve genuine inclusion? Does it include change at the social structural level? Does it include change in social stigma and in internalised stigma? Is it perceived as necessitating attitudinal-cultural change, which needs to be reflected also in the opportunities available and the social representation of people experiencing mental health issues? How do we

address the neglect of solidarity and community activities and service users own agency, for example through the development of peer led self-help groups and organisations.

We welcome papers that reflect the discourses and issues of the conceptual framework above (reflecting on power, oppression, privilege, identity, transformation) and will be looking to develop an issue that reflect the multiplicity of voices (service users, service providers, researchers) in the social inclusion mix.

Potential Themes of interest:

Narratives of transformation - experiential narratives which look at how engagement with peers and new learning 'spaces' have given citizens the opportunities to work towards transforming their lives.

Dilemmas focused on the transformation of identities - transforming identity and social relations and the dilemmas this provokes in power relations and identity.

Transforming services towards Social Inclusion - Accounts of co-production in services and the transformation of professional-user relations.

Transformation between and beyond services towards social inclusion - Accounts of innovative projects that transcend typical service delivery.

To ensure articles are in keeping with the journal's focus, we would want authors to ensure their articles frameworks make explicit relevant intersectional relations of power are enmeshed in processes of social justice and injustice. Please refer to the Journal policy at: <http://journals.library.mun.ca/ojs/index.php/IJ/about/editorialPolicies#focusAndScope>

We also request that authors avoid medicalized language as much as is possible.

Process for submission

All articles should be submitted via the Intersectionalities online submission process which can be accessed at <http://intersectionalities.mun.ca> articles will be subject to a formal review process according to the Journal's usual process (two double-masked peer reviews including a reviewer who is a specialist in this area) and will be evaluated on the basis of originality, quality and relevance to this Special Issue. Word-length is between 4000 to 7000 words per article. The Special Issue editors will be responsible for feedback to authors after the review process has been completed and for

making final decisions on the acceptance of papers and selection for the Special Issue. If a paper is accepted but does not go into the SI due to length restrictions it will be published in a later edition of the Journal.

Submitted papers should be formatted in accordance with the Journal style. Please note it is the responsibility of the submitting authors to ensure that the articles are correctly edited for the English language and within the journal's format. For more detailed information concerning the requirements for submission please refer to the Journal's homepage at: <http://intersectionalities.mun.ca>

When submitting please mark your article very clearly at the top of the article 'To be considered for the Social Inclusion and Mental Health Special Issue'.

of social and political dynamics. Thus evidence-based medicine is the result of an effort which, although taking the appearance of evidence, is the result of a process aiming at building its own legitimacy. Based on processes rather than given facts, evidence-based medicine is at the heart of the debate we hope to develop during this meeting. The foundations of such omnipresence of evidence-based medicine has to be studied, in that it allows the understanding of the logic of

practices associated with it in contemporary societies. The primary objective of this conference is therefore to open, or rather to broaden, the space for exchanges between anthropology of health and science studies around evidence based-medicine: what are its contributions, its limitations, but also its constraints? How does it produce, impose or recompose within its everyday activities norms and standards of care? How does it redefine our conceptions of health, body and ailments afflicting us? How does it change our system of values? How does it influence the politics defining policies implemented within our health systems?

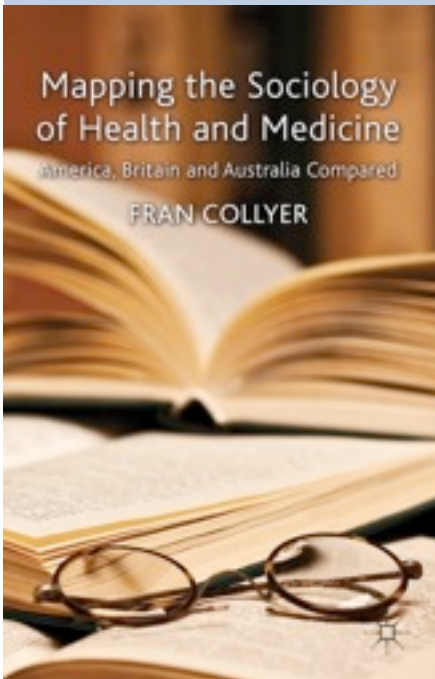
As a rough guide we suggest three main questions that will define our meeting. Although we invite papers to enroll concerning these three questions, they are far from exhaustive.

Deadline for abstract submission (500 words):
December 15th, 2012.

Notification of acceptance : March 1st, 2013
Deadline for papers : July 1st, 2013.

colloquehssa@gmail.com

PUBLICATIONS



Fran Collyer's *Mapping the Sociology of Health and Medicine* offers an unusual glimpse into the social relations of the sociologists of health, illness and medicine in Britain, America and Australia. It provides a fascinating who's who of the sub-discipline, but also a narrative of our institutional formation. The book draws on new empirical material from a content analysis of journal articles, revealing what sociologists of health and medicine 'actually do'. It tells

Collyer, F.M. (2012)
***Mapping the Sociology of Health and Medicine:
 America, Britain and Australia Compared***

Palgrave Macmillan: Houndmills, Basingstoke.
 ISBN 978-0-230-32044-4

us about the topics we study, the concepts and theories we use, the places we work within, and even the disciplinary identities we adopt. It highlights some very significant differences between the speciality field as it is practised internationally, such as the differing national relationships between sociology and fields such as nursing, psychology and epidemiology. The empirical component of *Mapping the Sociology of Health and Medicine* is grounded in a theoretical framework about the nature of disciplines. It theorises disciplines as 'social things', products of our activities but also spheres of structured social relationships. As 'social things', disciplines appear global, but are experienced in very different

ways between countries and even universities. Seeing disciplines as 'ways of life' helps us to understand why our working lives engage us emotionally and morally as well as intellectually, and why conflict and contention shape and structure our work practices. Conceiving of disciplines in this way also means understanding specialities -as not just cognitively distinct topic areas of larger disciplines, but rather arenas defined by the hierarchical social relations with parent disciplines and other disciplines. This is a book that documents our past and gives us a new understanding of ourselves. It will be read by those engaged in the sociology of health but also the broader sociological community.

Kampf, A., Marshall, B. and Petersen, A. (eds) (2013)
Men, Masculinities and Modern Medicine
 Routledge: London and New York

Aging Men, Masculinities and Modern Medicine explores the multiple socio-historical contexts surrounding men's aging bodies in modern medicine from a global perspective. The first of its kind, it investigates the interrelated aspects of aging, masculinities and biomedicine, allowing for a timely reconsideration of the conceptualisation of aging men within the recent explosion of social science studies on men's health and biotechnologies including anti-aging perspectives.

This book discusses both healthy and diseased states of aging men in medical practices, bringing together theoretical and empirical conceptualisations. Divided into four parts it covers:

- Historical epistemology of aging, bodies and masculinity and the way in which the social sciences have theorised the aging body and gender.
- Material practices and processes by which biotechnology, medical assemblages and men's aging bodies relate to concepts of health and illness.
- Aging experience and its impact upon male sexuality and identity.
- The importance of men's roles and identities in care-giving situations and medical practices.

Articles

Calvo, E., Sarkisian, N. and Tamborini, C. R.
 "Causal Effects of Retirement Timing on Physical and Emotional Health"
Journal of Gerontology: Social Sciences 68(1): 73-84, 2013



Membership

Dear colleagues,

I am writing to encourage you to renew your membership, and encourage colleagues and trainees to join!

A vibrant membership is an integral component to the success of our research committee. Indeed, not only do your dues go directly to funding exciting section events (and we have many of those in store for you come Yokohama 2014, such as a new mentorship dinner), the size of our membership also determines how much ISA allocates our RC in terms of travel grants and forum/congress grant.

We currently stand in the upper tier of RCs with 174 members. So with just a little push, we could make it into the next category of ISA funding, if we could only reach 200 members by December 2013!

If you're wondering if your membership is current, please do not hesitate to contact me at amelie.quesnelvallee@mcgill.ca.

Also, when I sent the conference program around, I reminded those of you whose memberships end in 2013 to renew sooner than later, so that we may reach this important membership milestone BEFORE December 2013!

You can renew your membership at <https://secured.com/~f3641/formisa.htm>. Please feel free to pass this along to colleagues and students who would like to join, and see you in Yokohama!

Best,

Amélie Quesnel-Vallée, RC15 Secretary-Treasurer

BOARD 2010 - 2014

President

Jonathan GABE, Royal Holloway University London, United Kingdom,
j.gabe@rhul.ac.uk

Vice-President

Ivy BOURGEAULT, University of Ottawa, Canada

Secretary/Treasurer

Amélie QUESNEL-VALLEE, McGill University, Canada,
amelie.quesnelvallee@mcgill.ca

Board members at large

Masahira ANESAKI, Nihon University School of Medicine, Tokyo, Japan

Guido GIARELLI, University Magna Graecia, Catanzaro, Italy

Leah GILBERT, Witwatersrand University, South Africa

Ellen KUHLMANN, Goethe-University Frankfurt am Main, Germany

Ishwar MODI, International Institute of Social Sciences, India

Stephanie SHORT, University of Sydney, Australia

Newsletter editor

Guido GIARELLI, University Magna Graecia, Catanzaro, Italy
giarelli@unicz.it