Haute Ecole de Santé Vaud

Inégalités sociales de santé et physiothérapie
Problèmes et perspectives

Mathieu Arminjon
HESAV

Symposium romand de physiothérapie et d'ostéopathie

12.11.2024
Lausanne

Inégalités sociales de santé (ISS)

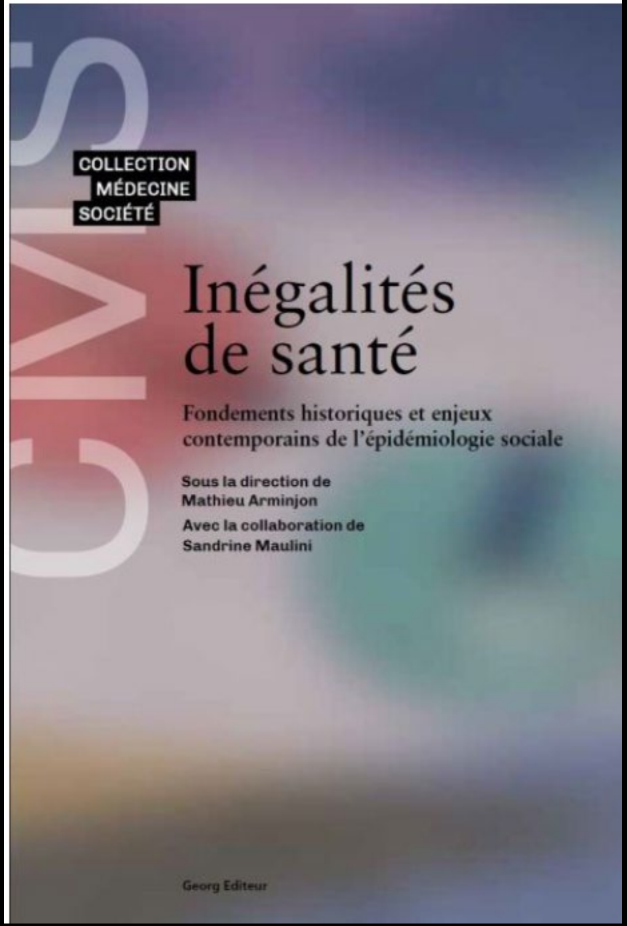
Histoire et philosophie de la médecine et du soin.

Sous quelles conditions (intellectuelles, sociales, etc.) on produit ***ou pas*** des savoirs.

La lombalgie ?

Enseignements des ISS et de l'éthique à HESAV.

… Un défi compte tenu de l'état de la recherche dans les soins et en physiothérapie.



COLLECTION
MÉDECINE
SOCIÉTÉ

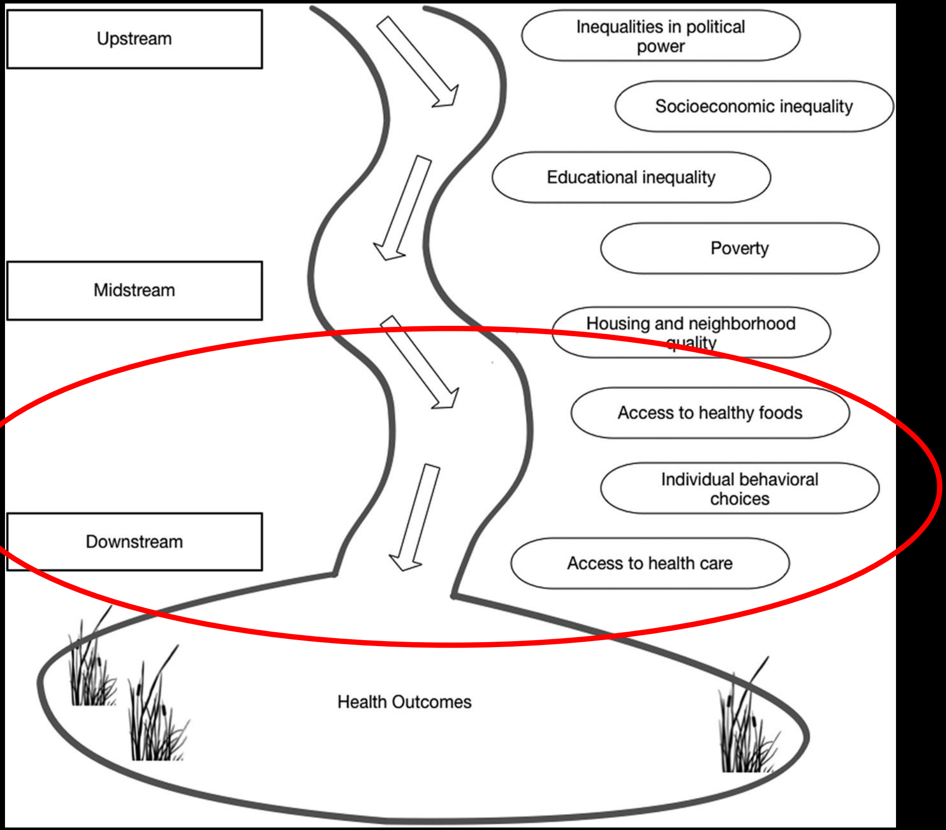
Inégalités de santé

Fondements historiques et enjeux contemporains de l'épidémiologie sociale

Sous la direction de
Mathieu Arminjon
Avec la collaboration de
Sandrine Maulini

Georg Editeur

Les inégalités sociales de santé recouvrent les différences d'état de santé entre individus ou groupes d'individus causées par des facteurs sociaux, qui sont inéquitables et potentiellement évitables.



En aval : le renoncement au soin

Selon l’OFSP le renoncement aux soins concerne 23,6 % des personnes nées à l'étranger, et 18,6 % chez des personnes nées en Suisse.

Ces écarts sont encore plus marqués entre classes supérieures et populaires dans le recours aux spécialistes et aux dentistes.

La littératie en santé

« la connaissance, les compétences, la motivation et la capacité d’un individu à repérer, comprendre, évaluer et utiliser des informations sur la santé ».

(Sørensen et al., 2012)

Health Literacy Survey Schweiz 2019-2021 :

49 % de la population suisse fait état d’un faible niveau de littératie en santé.

72 % de la population fait état d’un faible niveau de littératie en santé numérique.

74 % de la population a un faible niveau de littératie en santé liée à l’orientation dans le système de santé.

Inégalités éthnoraciales dans le soin

Aux USA, croyances erronées des étudiants en médecine sur les différences biologiques entre les personnes Noires et les Blanches.

Préjugés raciaux dans 58 % de l’échantillon : les personnes noires ont une peau plus épaisse, leurs nerfs sont moins sensibles.

La douleur est minimisée chez les personnes racisées ce qui entraîne une sous-prescription d’anti-douleurs .

(Hoffman, K. M., Trawalter, S., Axt, et al., 2016).

Racisme et santé, comment agir ?

Colloque et ateliers
Lundi 18 mars 2024
17h30-20h
Hôtel de Ville, pl. de la Palud 2, Lausanne

Inscription : www.lausanne.ch/racisme-colloque

Ville de Lausanne
Bureau lausannois pour les immigrés

unisanté
Centre universitaire de médecine générale
et santé publique · Lausanne

Inégalités ethnoraciales dans l'accès aux soins physiothérapeutiques

Aux USA, les Hispaniques et les Noirs américains sont respectivement 26,5 % et 44,8 % moins susceptibles de se rendre au moins une fois dans un cabinet de physiothérapie au cours d'une année pour des problèmes d'arthrite autodéclarés.

Armstrong S, Wong CA, Perrin E, Page S, Sibley L, Skinner A. Association of Physical Activity With Income, Race/Ethnicity, and Sex Among Adolescents and Young Adults in the United States: Findings From the National Health and Nutrition Examination Survey, 2007-2016. JAMA Pediatr. 2018 Aug 1;172(8):732-740. doi: 10.1001/jamapediatrics.2018.1273. PMID: 29889945; PMCID: PMC6142913.

Bilan

Toutes les professions de santé sont concernées par les problématiques d'inégalités sociales d'accès aux soins.

Perspectives de recherches spécifiques au contexte Suisse, aux différentes professions dont la physiothérapie et aux différentes minorités (classes, éthnies, genres etc.).

Les problématiques sont invisibilisées par les représentations sociales et les stéréotypes sociaux :

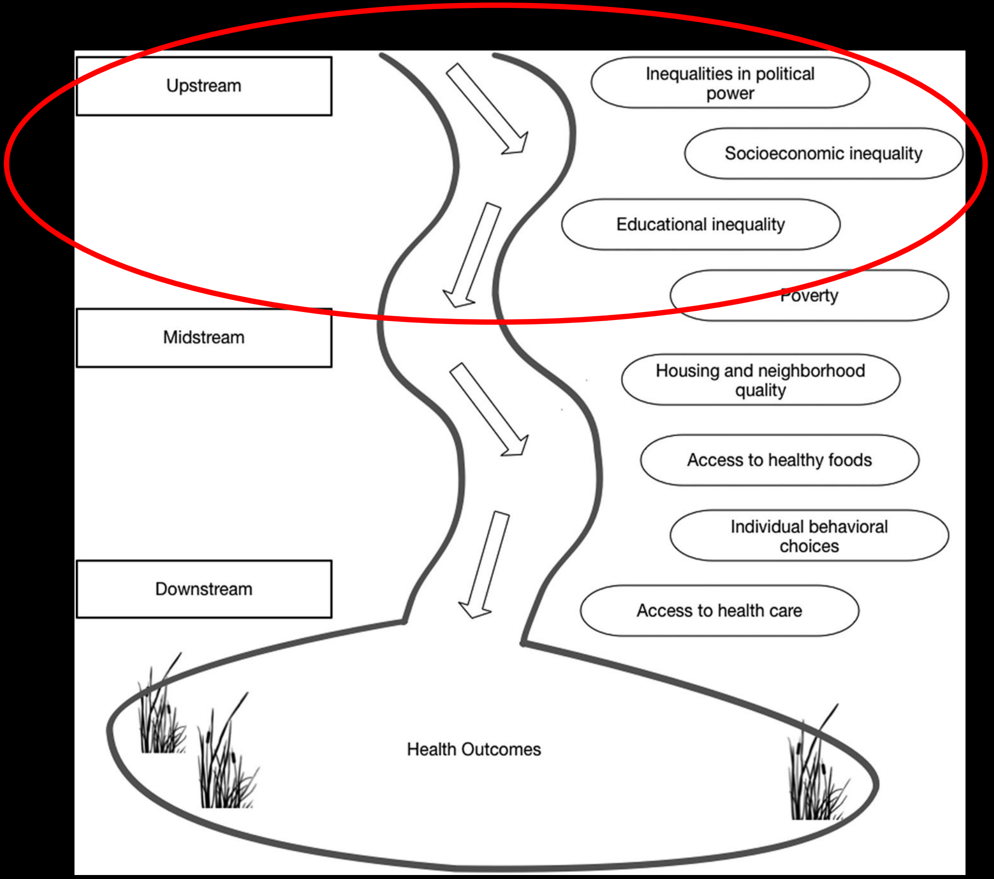
La Suisse est un pays riche et éduqué avec un accès universel au soin…

… on suppose donc qu'il n'y a pas d'inégalités de santé, ni d'inéquités de traitement envers les minorités.

Sans recherche dans le champs on ne documente pas les problématiques.

Ces lacunes de savoirs produisent des **inégalités épistémiques** :

les savoirs manquants ou partiels relatifs à certaines populations (classes sociales ou minorités) contribuent à reproduire et/ou à renforcer les inégalités sociales d'accès au soin.

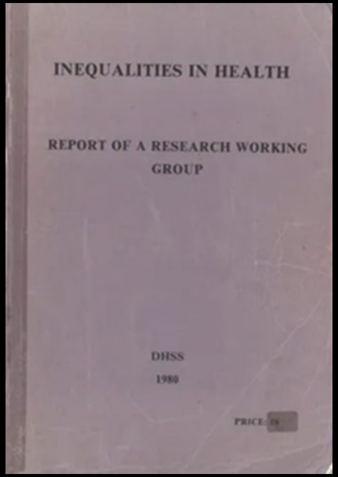

Upstream
Midstream
Downstream
Inequalities in political power
Socioeconomic inequality
Educational inequality
Poverty
Housing and neighborhood quality
Access to healthy foods
Individual behavioral choices
Access to health care
Health Outcomes

Le rapport Black, 1980

Au Royaume-Uni, le gouvernement est tenu de publier tous les 10 ans les statistiques de morbidité et mortalité selon 5 catégories socioprofessionnelles.

Développement économique (Trente Glorieuses) et accès universel et gratuit = égalité de santé?

L’écart entre les taux de mortalité des classes sociales supérieures et inférieures est deux ou trois fois plus important aujourd’hui qu’au début des années 1930, et il s’est creusé depuis les années 1950.



INEQUALITIES IN HEALTH

REPORT OF A RESEARCH WORKING GROUP

DHSS
1980

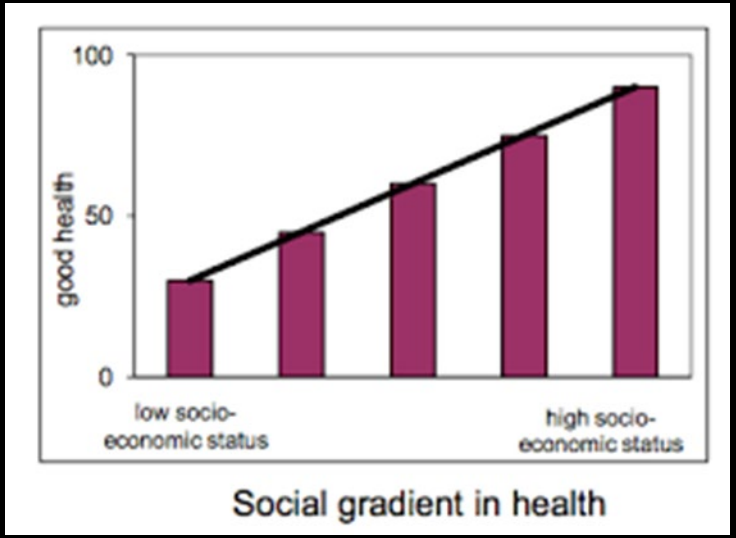
PRICE

Michael Marmot et la Whitehall study

Étude de cohorte mise en place en 1967, impliquant 1’800 fonctionnaires et jugée représentative de la hiérarchie sociale propre à la société britannique.

Michael Marmot met au jour un gradient social de santé pour toutes les maladies :

«The higher the position, the higher the health».



Social gradient in health

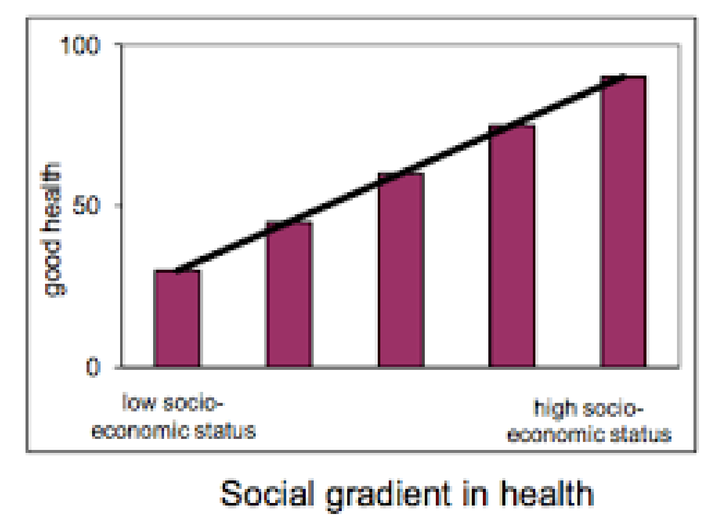
Dans la hiérarchie, il y a toujours quelqu’un au-dessus de vous dont le risque de maladie est inférieur au vôtre.

Modèle explicatif psychosocial : plus le statut est élevé, plus on a d’amis (social support), de vacances, de hobbies, d’autonomie dans son travail, de recompenses sociales, etc.

Ces facteurs réduisent le stress.

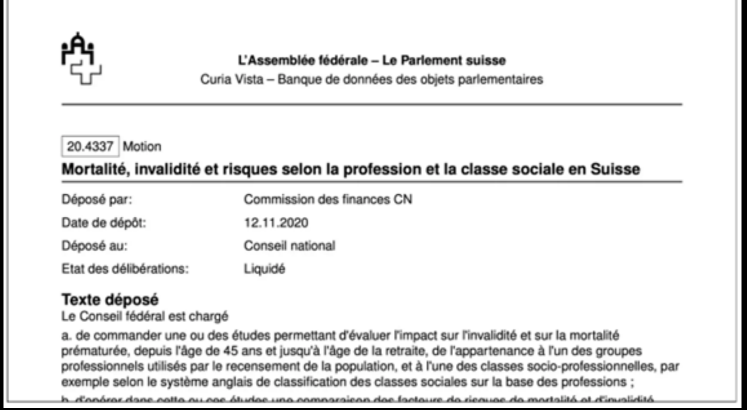
Les ISS ne disparaissent pas au-delà d’un certain niveau
De confort matériel.

Elles sont consubstantielles aux hiérarchies sociales. Au mieux, on peut réduire leur magnitude en réduisant l’écart entre les plus riches et les plus pauvres.



Social gradient in health

Les données des institutions publiques suisses :



L'Assemblée fédérale – Le Parlement suisse
Curia Vista – Banque de données des objets parlementaires

20.4337 Motion

Mortalité, invalidité et risques selon la profession et la classe sociale en Suisse

Déposé par: Commission des finances CN
Date de dépôt: 12.11.2020
Déposé au: Conseil national
Etat des délibérations: Liquidé

Texte déposé

Le Conseil fédéral est chargé

a. de commander une ou des études permettant d'évaluer l'impact sur l'invalidité et sur la mortalité prématurée, depuis l'âge de 45 ans et jusqu'à l'âge de la retraite, de l'appartenance à l'un des groupes professionnels utilisés par le recensement de la population, et à l'une des classes socio-professionnelles, par exemple selon le système anglais de classification des classes sociales sur la base des professions ;

b. d'opérer dans cette ou ces études une comparaison des facteurs de risques de mortalité et d'invalidité

En 2020, la Commission des finances du Conseil national a déposé une motion demandant que des études soient menées pour évaluer l'espérance de vie en fonction du revenu (pas seulement l'âge et le sexe).

Motion rejetée !

Les inégalités sociales de santé : un sujet à forts enjeux politiques… AVS?

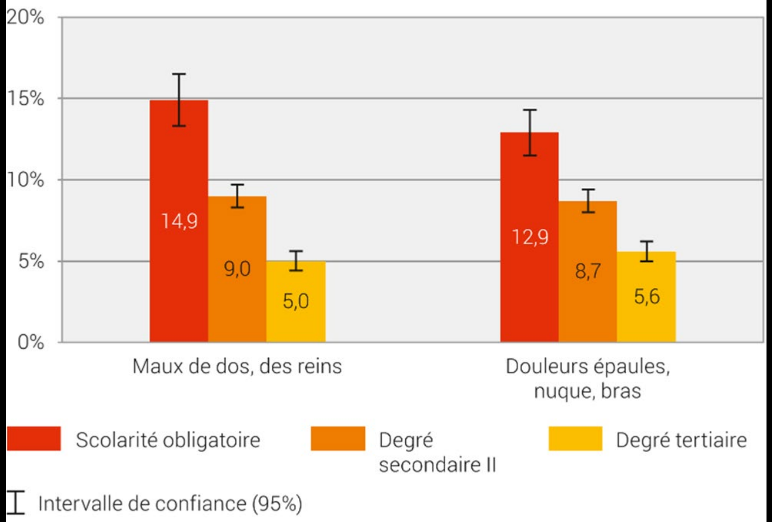
Enquête Suisse sur la santé 2017 : quelques bons « proxy »

Gradient social pour la santé auto-évaluée, maladies cardio-vasculaires, diabète, etc.

Les personnes qui n’ont pas de formation post-obligatoire souffrent plus souvent de maux de dos (15%) que celles avec une formation de degré de secondaire II (9%) ou celles avec un degré tertiaire (5%).

Les femmes plus que les hommes (10% contre 6%).

Les personnes locataires d’avantage que les propriétaires (9% contre 6%).



Beaucoup de douleurs au cours des quatre dernières semaines selon le niveau de formation, en 2017

Population de 25 ans et plus vivant en ménage privé

Source: OFS – Enquête suisse sur la santé (ESS)

Lombalgie et ISS

Lombalgie invalidante et situation sociale, résultats issus de l'enquête HID (Handicap-incapacité-dépendance), France

Annette Leclerc (annette.leclerc@st-maurice.inserm.fr)[1,2], **Jean-François Chastang**[1,2], **Isabelle Regnard**[1,2], **Jean-François Ravaud**[3,2]

1 / Inserm, U687, Saint-Maurice, France 2 / Université Paris 11, IFR69, Saint-Maurice, France 3 / Inserm U502, Villejuif, France

Résumé / *Abstract*

Objectifs – Décrire les relations entre lombalgie invalidante et situation sociale en France.

Méthodes – Les données utilisées ont été celles de l'enquête nationale HID menée en 1999 auprès des ménages, pour la tranche d'âge 30-64 ans, et celles de l'étape longitudinale menée en 2001 ; la catégorie « lombalgie invalidante » a été construite à partir des réponses en clair données par les sujets.

Résultats – Les sujets souffrant de lombalgie invalidante sont relativement plus nombreux dans les catégories ouvrières ; un lien avec la situation sociale dans l'enfance est aussi observé. En dépit des limitations dont ils souffrent, une grande majorité des lombalgiques est en activité, les professions ouvrières étant sur-représentées parmi les actifs. Les évolutions socialement défavorables, telles que la perte d'emploi, sont plus fréquentes parmi les lombalgiques que dans la population française.

Discussion-Conclusion – Les résultats documentent des inégalités intervenant tout au long de la vie, depuis l'enfance jusqu'à l'âge adulte, avant que la maladie n'existe et dans les conséquences une fois qu'elle est survenue. Des interventions utiles pour réduire les inégalités peuvent être identifiées, qu'il s'agisse en particulier de la prévention précoce en milieu de travail, et de l'aide au maintien en activité de travailleurs souffrant de limitations.

Disabling low back pain and social status, results from a national study in France

Objective – *Describe the relationships between disabling low back pain (LBP) and social status in France.*

Methods – *The data were issued from the HID survey, a national survey on disability and handicap. Data from the two waves, 1999 and 2001, were used, for the age group 30-64 years. The definition for cases of disabling LBP was based on the description of health problems at the survey interview.*

Results – *Subjects suffering from disabling LBP were over-represented in the working-class categories: a relationship with the social status in childhood was also observed. Despite the limitations, a large majority of cases were employed, more often (than in the general population) as manual workers. Over a two year period, negative changes in employment status were observed for cases more often than in the general population.*

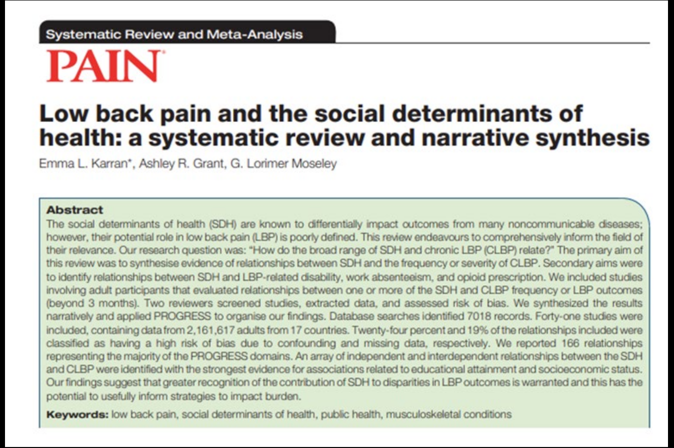
Discussion-Conclusion – *The results show inequalities occurring during childhood and adulthood before the onset of the diseases as well as their consequences once the disease appears. Different types of useful interventions could reduce inequalities in this field such as early prevention at the workplace, and policies aiming at keeping at work disabled subjects.*

1 289 sujets qui souffrent de lombalgie invalidante.

Les ouvriers sont sureprésentés parmi les lombalgiques. Les cadres sont sous-représentés.

Avoir eu un père cadre ou exerçant une profession intermédiaire est relativement rare parmi les lombalgiques, qui sont à l'inverse plus souvent fils d'agriculteurs.

Résultats de la revue de littérature vont dans le même sens (41 études, incluant 2,161,617 adultes de 17 pays).



Systematic Review and Meta-Analysis

PAIN

Low back pain and the social determinants of health: a systematic review and narrative synthesis

Emma L. Karran*, Ashley R. Grant, G. Lorimer Moseley

Abstract

The social determinants of health (SDH) are known to differentially impact outcomes from many noncommunicable diseases; however, their potential role in low back pain (LBP) is poorly defined. This review endeavours to comprehensively inform the field of their relevance. Our research question was: "How do the broad range of SDH and chronic LBP (CLBP) relate?" The primary aim of this review was to synthesise evidence of relationships between SDH and the frequency or severity of CLBP. Secondary aims were to identify relationships between SDH and LBP-related disability, work absenteeism, and opioid prescription. We included studies involving adult participants that evaluated relationships between one or more of the SDH and CLBP frequency or LBP outcomes (beyond 3 months). Two reviewers screened studies, extracted data, and assessed risk of bias. We synthesized the results narratively and applied PROGRESS to organise our findings. Database searches identified 7018 records. Forty-one studies were included, containing data from 2,161,617 adults from 17 countries. Twenty-four percent and 19% of the relationships included were classified as having a high risk of bias due to confounding and missing data, respectively. We reported 166 relationships representing the majority of the PROGRESS domains. An array of independent and interdependent relationships between the SDH and CLBP were identified with the strongest evidence for associations related to educational attainment and socioeconomic status. Our findings suggest that greater recognition of the contribution of SDH to disparities in LBP outcomes is warranted and this has the potential to usefully inform strategies to impact burden.

Keywords: low back pain, social determinants of health, public health, musculoskeletal conditions

Sureprésentation des personnes pauvres et racisées.

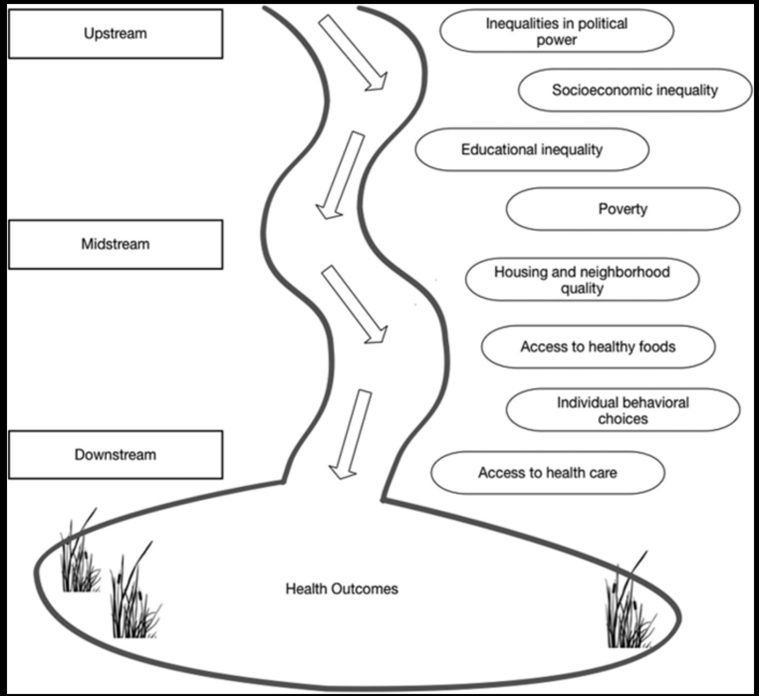
Connecter les ISS en amont et en aval

Minorités ethnoraciales et personnes au statut socio-économique faible : d'avantage de douleurs dorsales et des niveaux d'incapacité plus élevés.

On leur associe pourtant des douleurs moins intenses, on les soupçonne plus de simuler, on leur prescrit moins d'imagerie et de traitement.

« La disponibilité de soins médicaux de qualité est inversement proportionnelle aux besoins de la population desservie ».

Julian Tudor Hart (1971)



Bilan et perspectives

Un champ en développement et à développer dans le soin en général, en physiothérapie en particulier.

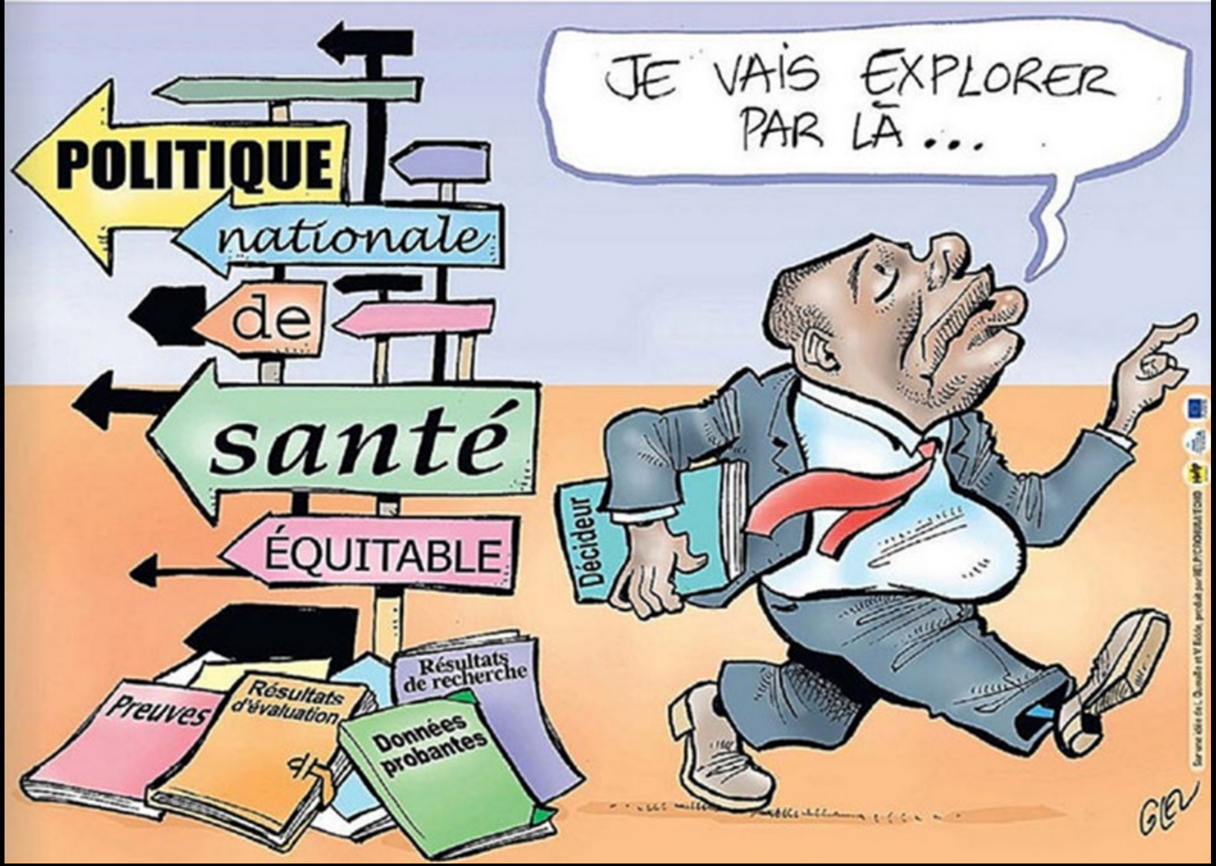
Un gradient social de santé pour toutes les pathologies mentales et somatiques.

Aucune raison de ne pas le retrouver dans les troubles musculo–squelettiques (ce que confirment les études).

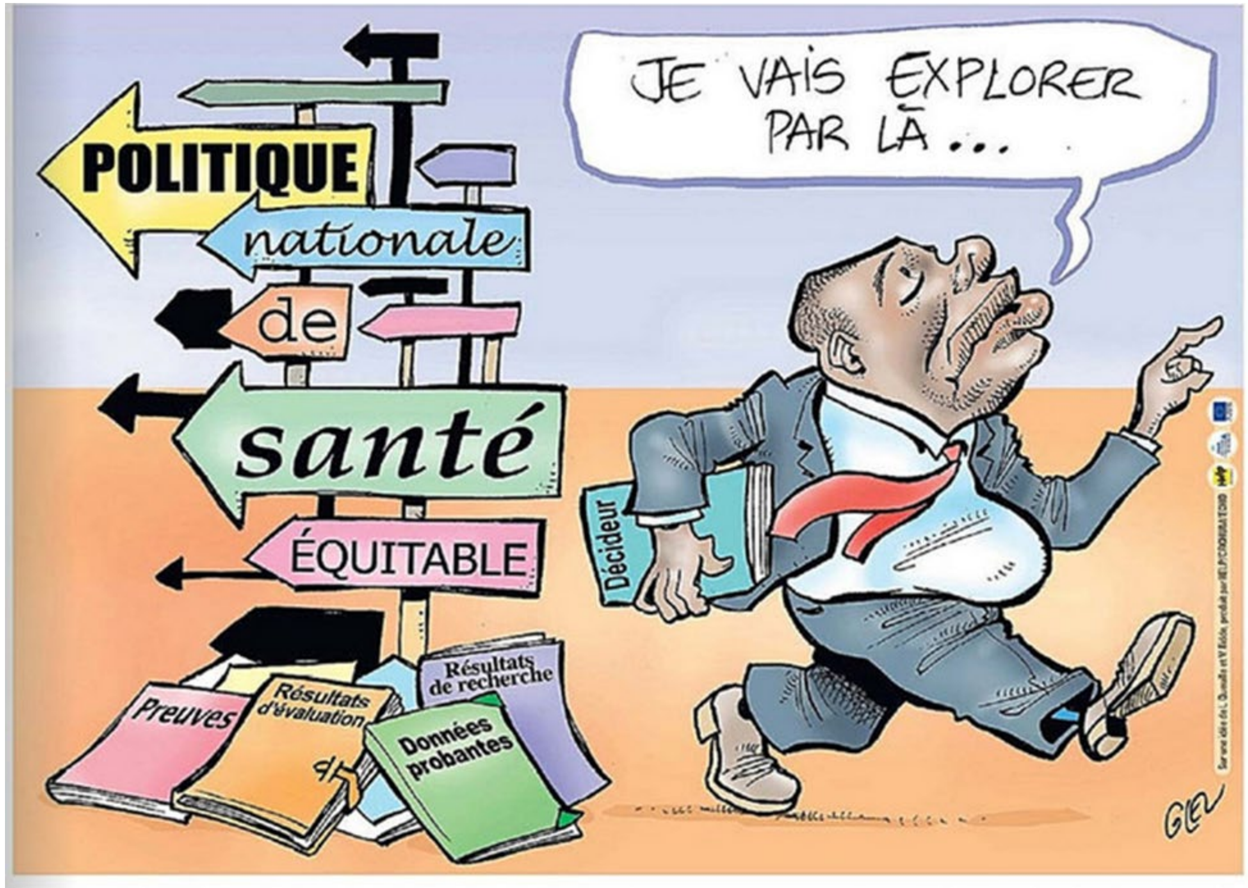
Opportunités de recherches à partir des données Santé Suisse, mais aussi des études de cohorte (CoLaus).

Merci de votre attention !

https://fns-iss.hesav.ch/le-projet/



In fact, participants with low socioeconomic status had a higher prevalence of cardio-metabolic risk factors, risk behaviors, sleep disturbances, and higher inflammatory markers compared to the more socio-economically advantaged participants in the study. In most cases, these inequalities are similar to those found in the neighboring cantons and countries.



Plan :

1 - History of public health, social medicine and social inequalities in health : An old story.

2 - The rise and fall of social medicine.

3 - Social inequalities in health: the birth of social epidemiology.

The rise of moderne medicine

The birth of modern medicine is spontaneously associated with the development of scientific and laboratory medicine, which in turn is associated with the treatment of individual patients :

- Robert Koch discovers tuberculosis is caused by a bacillus in 1882.
- Pasteur discovers of the rabies vaccine in 1885.
- Frederick Banting and Charles Best carried out the first human administration of their pancreatic extract (insulin) in 1922.
- Etc.

Since the 1970s, this depiction of the birth of modern medicine has been criticized by historians and philosophers.

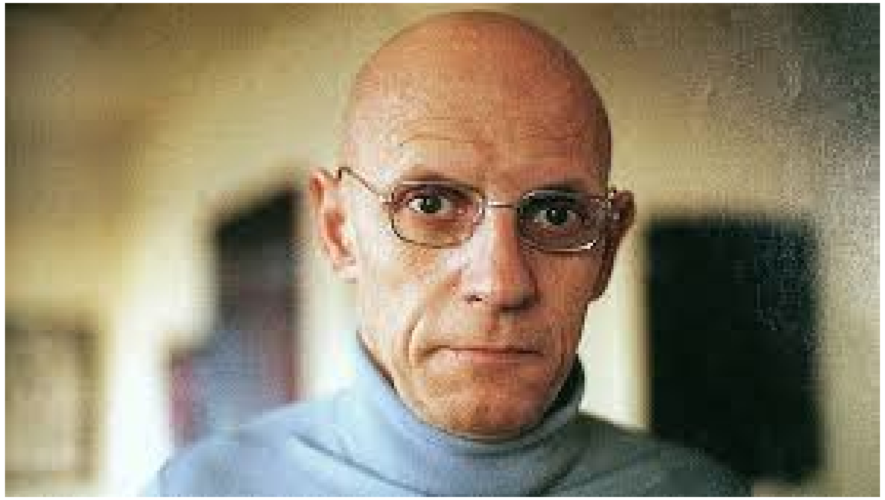
Michel Foucault : Biopolitics

«capitalism has not led to a shift from collective to private medicine [...] precisely the opposite happened. »

Foucault, M. (2001).

Biopolitics: With modernity, health and life in general have become the object of governance (hygiene, prevention, medicalization, etc.).

Medicine focused on individual behaviors is only secondary to social, population-based and epidemiological medicine.



The rise of public health

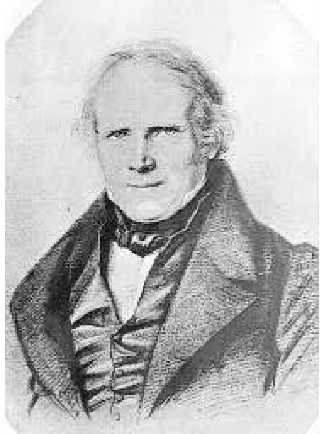
At the turn of the 19th century, in a period of relative pandemic calm, urbanization and industrialization call for the gradual development of the first sanitary technologies, namely sanitation and immunization (hygienism).

Industrial development in its infancy calls for political and social administration to contain epidemics and epizootics that might slow down trade.

measuring the population's state of health using epidemiological tools is becoming a central mission for the state

Population’s health becomes the measure of the wealth and strength of modern nations.

Growing concern for the poor's health



Louis René Villermé (1782-1863) correlates mortality rates with taxes paid per household in a dozen of neighborhoods in Paris. He finds a correlation between poverty and mortality rates.

Edwin Chadwich (1800-1890), publishes the *Report on the Sanitary Conditions of the Laboring Population of Great Britain.* He recommends to the Royal Commission the implementation of sanitary measures to eradicate the diseases of poverty (poor health of workers is not good for the economy).

Rudolf Virchow (1821-1902) conduces a study on behalf of the Prussian government. He demonstrates that typhus is not a contagious disease, but an infection caused by the deplorable sanitary conditions in poor neighborhoods.

The rise of social medicine

"Medicine is a social science, and politics nothing but medicine at a larger scale".
(Virchow, 1848)

Virchow's ambitions to revolutionize medicine failed as revolutionary movements swept through the German Confederation in 1848.

However, at the turn of the 1880s, Bismarck set up a social insurance system and compulsory health insurance (1883) to prevent future workers' revolts and the rise of socialism.

The nationalization of social medicine in USSR

Lenin creates the Commissariat for Health Protection in 1919.

The social hygiene program (statistics, anthropology, demography) aims to study how sociological and historical variables (class, urbanization, occupation, culture and lifestyle) impact health.

Disease and premature mortality is considered as caused by social inequalities, and therefore by capitalism. They can be controlled by socialism, then eradicated by communism.

Social hygiene refers to a program of research into health inequalities, a comprehensive reform of the medical profession and medical training, and the implementation of a social health policy.

The nationalization of social medicine in the USA

In 1926, in the USA, the American Medical Association (AMA) invites the Commission on Medical Education (CME) to consider ways of improving the healthcare and educational systems. The initiative is funded by the Carnegie, Macy and Rockefeller foundations.

The final report is published in 1932, in the context of the economic crisis of 1929. The project for creating a social insurances is rejected by liberals hostile to the “socialization” of medicine.

The Rockefeller International Health Board is set up to finance the international development of social medicine.

The nationalization of social medicine in Switzerland ?

1885: the Federal Council draw up a compulsory insurance plan covering accidents, loss of earnings during illness and medical expenses. The constitutional amendment is ratified in 1890, and the bill is put to referendum in 1900. It is rejected...

1949: Tuberculosis Act rejected.
1974: Health Insurance Act rejected.
1996: basic health and accident insurance becomes compulsory.
2012: Health Promotion Act rejected.

Historical tensions between cantonal and federal authorities.

Left-wing initiatives are counterbalanced by a liberal conception of health, based primarily on individual responsibility.

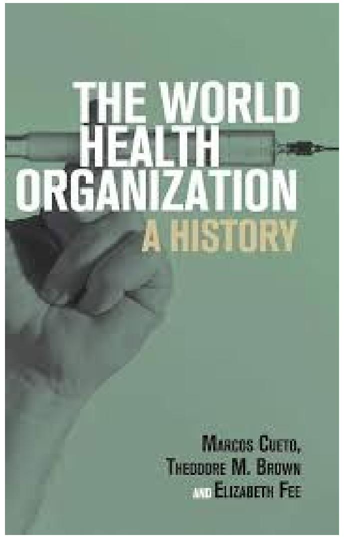
History of public health and social inequalities in health : An old story.

Modern medicine emerges as populational practice.

Poverty/inequalities is a central issue for both human and economic reasons.

This social dimension was to dominate the pre-war period, and can be spotted in the WHO Constitution (1946) :

« Health is a state of complete physical, mental and **social** well-being and not merely the absence of disease or infirmity. »



This sociomedical ideal will come into tension with the biomedical ideal: an individualistic conception, focused on curative medicine.

Plan :

1 - History of public health and social inequalities in health : An old story.

2 - The rise and fall of social medicine.

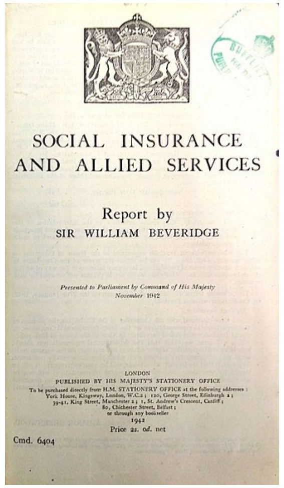
3 - Social inequalities in health: the birth of social epidemiology.

Public health in the post-war era: the birth of the welfare state

France: the Resistance Council adopts an “immediate action plan” including the creation of a social security system with universal health insurance.

United Kingdom: William Beveridge recommends the establishment welfare state. The National Health Service (NHS) is created in 1948.

Free access to healthcare is becoming widespread in many countries.



SOCIAL INSURANCE
AND ALLIED SERVICES

Report by
SIR WILLIAM BEVERIDGE

Presented to Parliament by Command of His Majesty
November 1942

LONDON
PUBLISHED BY HIS MAJESTY'S STATIONERY OFFICE
To be purchased directly from H.M. STATIONERY OFFICE at the following addresses:
York House, Kingsway, London, W.C.2; 120, George Street, Edinburgh 2;
39-41, King Street, Manchester 2; 1, St. Andrew's Crescent, Cardiff;
80, Chichester Street, Belfast;
or through any bookseller
1942
Price 2s. 0d. net

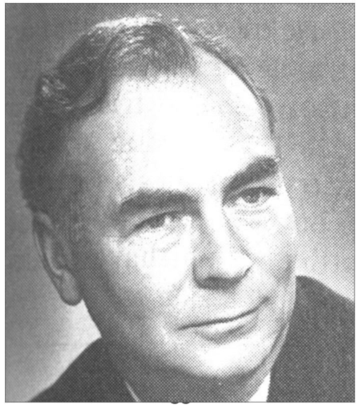
Cmd. 6404

The Mckeown Thesis

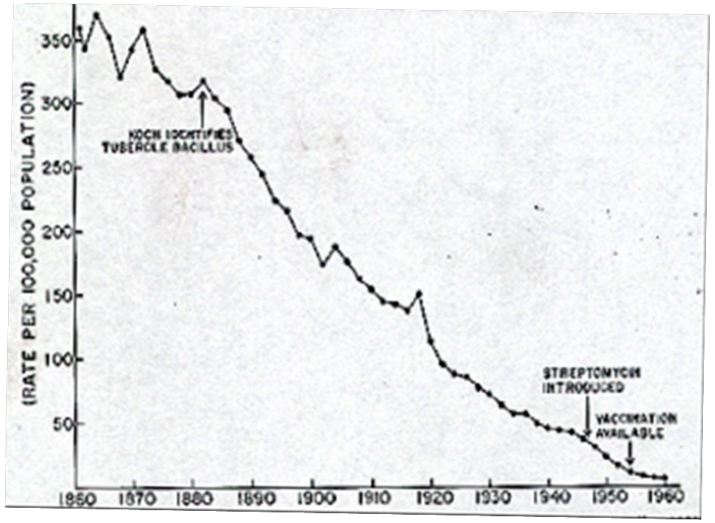
Thomas McKeown shows that tuberculosis mortality in the UK began to decrease at the turn of the 20th century. Vaccination and treatment played only a minor and late role.

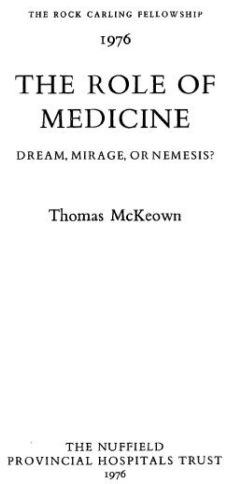
Curative medicine do not explain the improvement in health at the turn of the 20th century.

Economic development is solely responsible: More food of better quality, more comfort and hygiene
Social inequalities in health will disappear with economic development.



McKeown, T. (1976).
The Role of Medicine.
Dream, Mirage, or Nemesis.
London: Nuffield Provincial Hospitals Trust.





THE ROCK CARLING FELLOWSHIP
1976

THE ROLE OF
MEDICINE

DREAM, MIRAGE, OR NEMESIS?

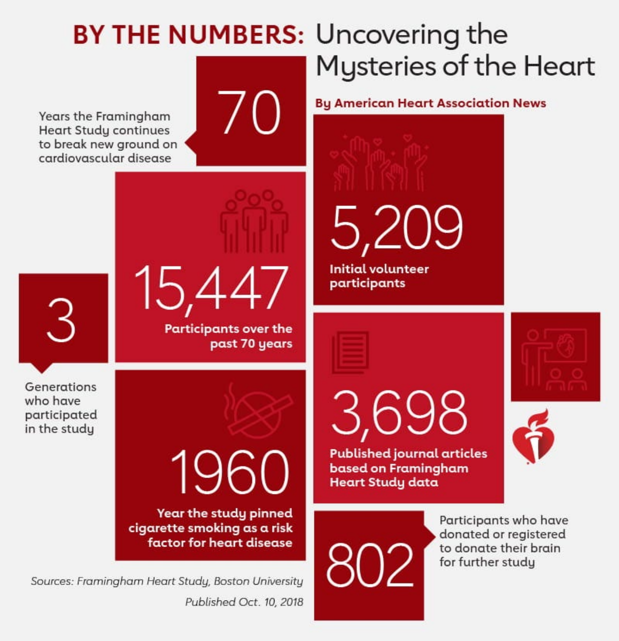
Thomas McKeown

THE NUFFIELD
PROVINCIAL HOSPITALS TRUST
1976

The birth of behavioral epidemiology

Framingham Heart Study (1948): famous long-term cohort study including 5’209 adult subjects from Framingham (Massachusetts).

Epidemiology of hypertensive or arteriosclerotic cardiovascular disease, revealing the effect of lifestyle: diet, smoking, physical exercise, etc.



BY THE NUMBERS: Uncovering the Mysteries of the Heart

By American Heart Association News

70 Years the Framingham Heart Study continues to break new ground on cardiovascular disease

5,209 Initial volunteer participants

15,447 Participants over the past 70 years

3 Generations who have participated in the study

3,698 Published journal articles based on Framingham Heart Study data

1960 Year the study pinned cigarette smoking as a risk factor for heart disease

802 Participants who have donated or registered to donate their brain for further study

Sources: Framingham Heart Study, Boston University

Published Oct. 10, 2018

Journal of
PHYSIOTHERAPY
journal homepage: www.elsevier.com/locate/jphys

Research

People who identify as LGBTIQ+ can experience assumptions, discomfort, some discrimination, and a lack of knowledge while attending physiotherapy: a survey

Megan H Ross, Jenny Setchell

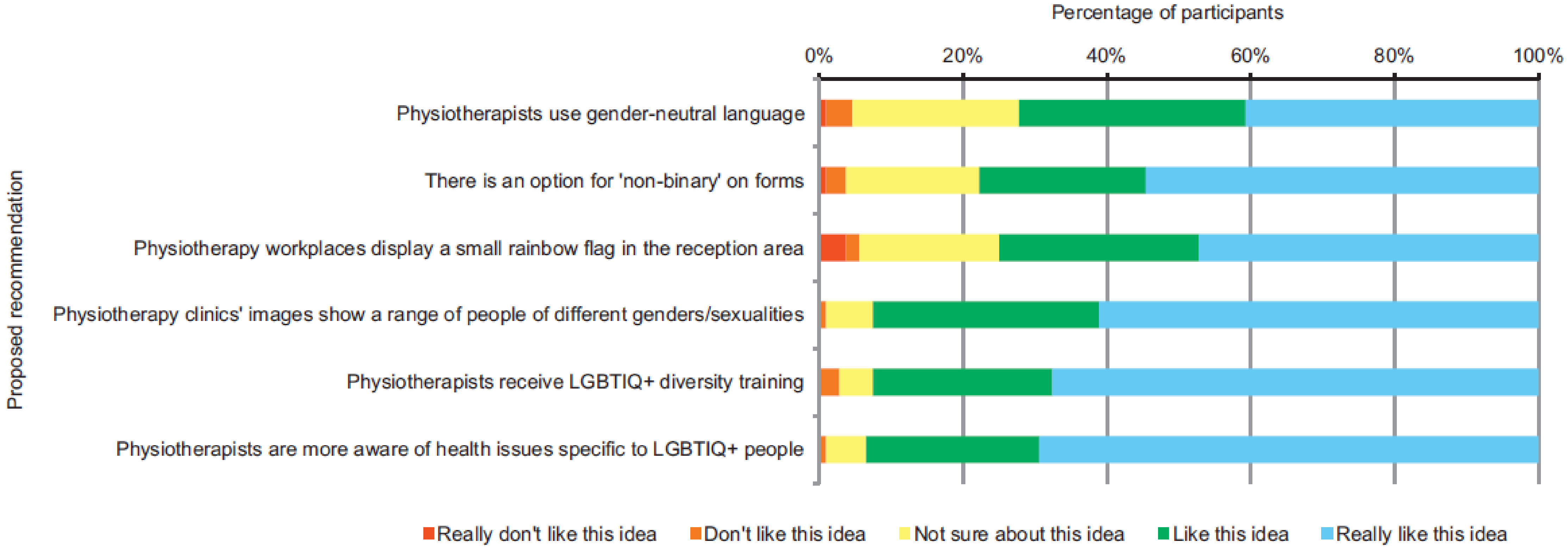
School of Health and Rehabilitation Sciences, University of Queensland, Brisbane, Australia

KEY WORDS

Sexual and gender minorities
Health
Communication
Gender identity

ABSTRACT

Questions: What are the experiences of people who identify as lesbian, gay, bisexual, transgender, intersex, queer or related identities (LGBTIQ+) and attend physiotherapy? How could these experiences of physiotherapy be improved? **Design:** Primarily qualitative design using a purpose-built online survey. **Participants:**



Biomedical Vs sociomedical : polarization during the cold war

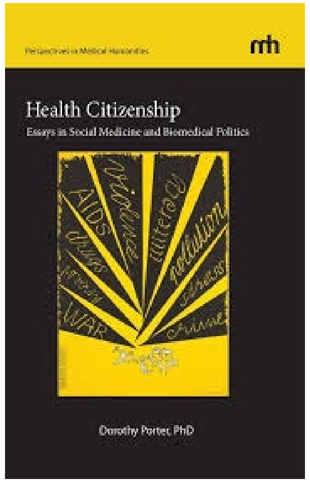
« This considerable success in the control of venereal diseases in the USSR is explained, in the first place, by social reasons. Amongst these are the abolition of unemployment, the recognition of the right to work for men and women, equal pay for men and women and the suppression of prostitution and alcoholism alcoholism. ». (OMS, 1948, p. 41).

USSR withdraws from the WHO in 1949 :

“WHO, like many other international organizations, has become a battle ground for two points of view: two camps. One is the peace camp, representing the interests of humanity, which demands, that the attainments of medical science should serve the whole human race. This camp is represented by the Soviet Union and by the popular democracies. The other, the capitalist camp, represents the interests of a small number of people, who treat science as a source of gain, and as a weapon of war.”

The biomedical ideal is associated with the capitalist West, while the sociomedical ideal is associated with Eastern Bloc countries.

A new «social contract of health»



Economic development, welfare state, behavioral epidemiology, East/West polarization, etc.

The state provides free access to healthcare: it’s now your responsibility to take care of your health!

Prevention is aimed at individual behaviors. Social and structural causes of health become secondary.

Questioning individual responsibility regarding health in the UK:

Since 1836, in the United Kingdom the Births and Deaths Registration Act required the General Registrar General Office to keeping registers (births, deaths, marriages, civil partnerships, stillbirths and adoptions) in England and Wales.

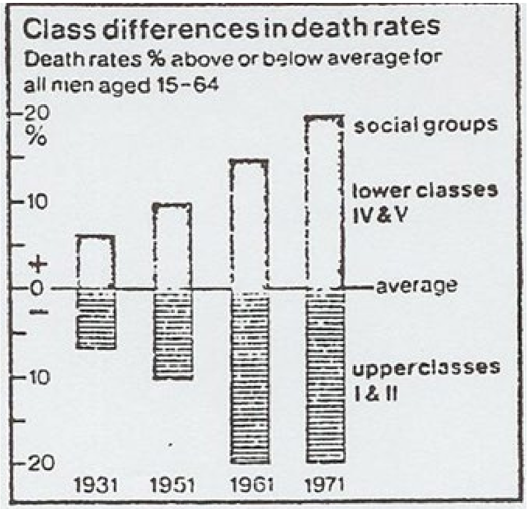
It is responsible for publishing the Decennial Supplement for England and Wales, which reports mortality rates by age, sex and cause of illness.

Since 1911, the same socio-professional categories are used: (I) Professional and Managerial, (II) Intermediate, (III.1) Non-manual, (III.2) Manual, (IV) Semi-skilled Manual, (V) Unskilled Manual.

Before the Black Report :

Richard Wilkinson (33 at the time), still a student, uses General Registrar General Office data. On December 1, 1976, he published an open letter in *New Society* to David Ennals, Labour's Secretary of State for Social Services, citing the results of research showing social inequalities in health.

“No matter whether one looks at the relative or absolute size of the gap between the death rates of upper and lower social classes. It is two or three times as large now as it was in the early 1930s. It widened slightly during the 1930s and 1940s; it widened dramatically during the 1950s (in spite of the NHS): and it has continued to widen since then”. (Wilkinson, 1976)



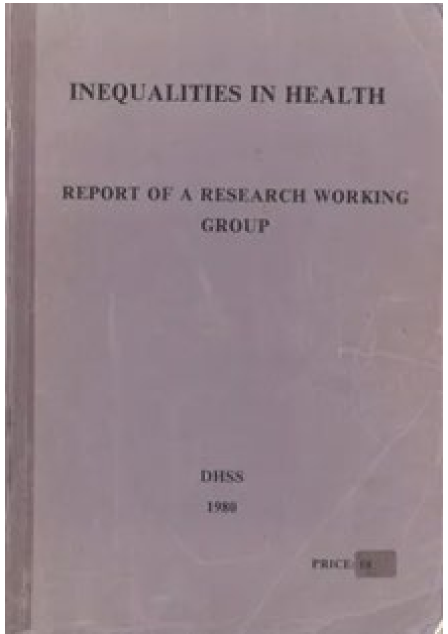
The Black Report

Wilkinson’s open letter ends up in the hands of David Ennals the Labor’s

Secretary of State for Social Insurance. Ennals commissioned Douglas Black to form a group to verify the data. The Report confirms Wilkinson results.

The Black Report is published in 1980. Only 260 copies of the document are published in the middle of August, the week of the August Bank Holiday weekend.

Margaret Thatcher became Prime Minister: Neoliberal turn, Thatcher tries to cut public spending, the government is accused of censoring the public data.



INEQUALITIES IN HEALTH

REPORT OF A RESEARCH WORKING
GROUP

DHSS
1980

PRICE [illegible]

The rise and fall of social medicine.

In the second half of the 20th century, the medicosocial ideal declined in favor of an individualistic/curative representation of health.

The Black Report represents an emblematic turning point:

Since World war, 2 neither **economic development**, nor **universal access to healthcare**, nor **prevention** strategies aimed at individual behaviours, have reduced social inequalities in health.

Note: the authors of the report give a purely materialistic explanation, *i.e.* the fact of being poor (bad housing, bad foods etc.) explains the inequalities between the most privileged and most deprived classes.

Plan :

1 - History of public health and social inequalities in health : An old story.

2 - The rise and fall of social medicine.

3 - Social inequalities in health: the birth of social epidemiology.

The birth of (psycho-)social epidemiology in the US

Social epidemiology:

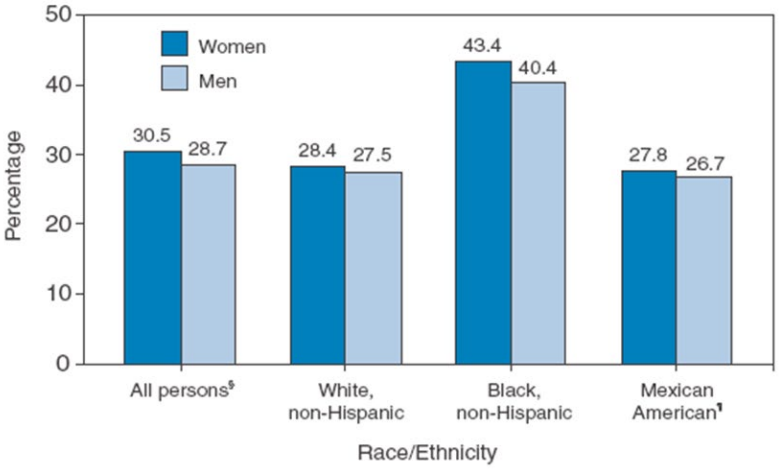
“the branch of epidemiology that studies the social distribution and social determinants of health states” (Berckman and Kawachi, 2000).

The term “social epidemiology” appears for the first time in a paper published in the *American Sociological Review* by Alfred Yankauer (1950) : “Correlation between infant mortality and residential segregation in New York's black population”.

Older occurrence: research project on excess mortality in the African-American population (Bishop, 1929).

The term is closely associated with the American public health context context : racial discrimination and the prevalence of cardiovascular disease in pathologies in the USA.

Percentage* of Persons Aged ≥20 Years with Hypertension,† by Race/Ethnicity — United States, 1999–2002



What is the cause of African-American high hypertension : An old issue

Lennard HL and Glock CY (1957) “Studies in Hypertension: VI. Differences in the Distribution of Hypertension in Negroes and Whites : An Appraisal ”, *Journal of Chronic Diseases* 5(2): 186–196.

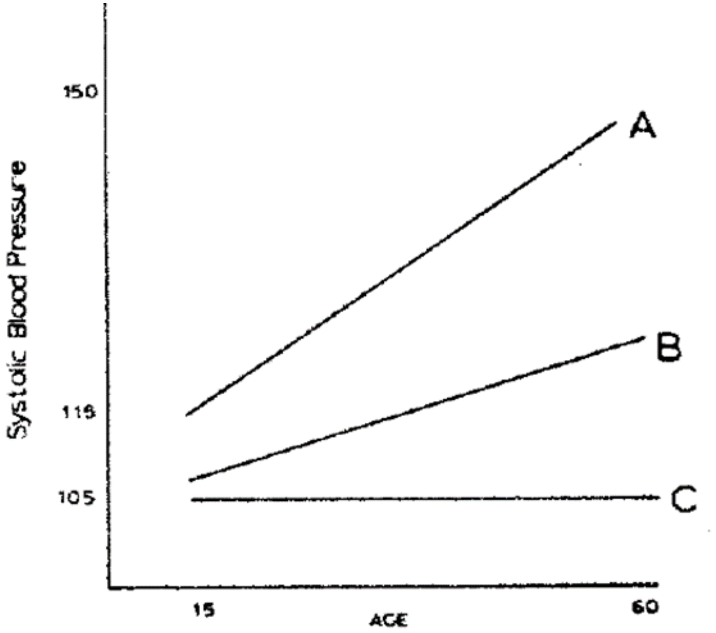
(1) **The “physical exhaustion” hypothesis:** African-Americans occupy the lowest-paid professions, requiring the greatest physical effort. No data available. In addition, physical exercise reduces the risk of heart disease.

(2) **The “repression” hypothesis**: hypertension is linked to “psychic conflicts” resulting from the repression of aggressive feelings and emotional stress linked to racial segregation. No data, or only qualitative data.

(3) **The “associated disorders” hypothesis**: hypertension is thought to be associated with other diseases such as syphilis. Data are contradictory.

(4) **The “genetic” hypothesis**: genetic particularities predispose African-Americans to hypertension. Data are lacking.
To validate this hypothesis, a racial predisposition to hypertension would have to be established in African populations or populations of African origin worldwide.

1967: the social epidemiology of hypertension



Stamler J, Stamler R and Pullman TN (1967)

A - Highly developed countries.
B - Rural and agricultural areas with little urbanization.
C - Hunter-gatherers (no contact with the outside world)

Absence of hypertension in hunter-gatherer populations. (has since been widely confirmed worldwide with South American Kuna, West African Kung).

Numerous studies (physiology, epidemiology, etc.) converge to validate the thesis that hypertension in African-Americans is induced by the effect of psychosocial stress induced by segregation (minority stress).

Psycho Vs materialist epidemiology

Leonard Syme: First sociologist appointed Professor of Epidemiology at the Berkeley School of Public Health.

Shows that while the prevalence of hypertension is higher among African-Americans than among whites, a social gradient can be identified within the white community, as well as within the African-American community.

In other word the poorer you are, the more hypertension you have, but socio-economic status, and therefore material conditions, don't explain everything.

There are social statuses (race, gender... and any other trait that can lead to discrimination) that also induce, by the means of psychosocial stress, health disparities.

Marmot: the implementation of (psycho)social epidemiology in the UK.

Ph.D. under Syme until 1976.

Joins the London School of Hygiene and Tropical Medicine where Geoffrey Rose (New Public Health), led the Whitehall Studies.

Cohort study conducted since 1967 involving 1,800 civil servants, aimed at analyzing the prevalence of cardiovascular disease between the ages of 40 and 64.

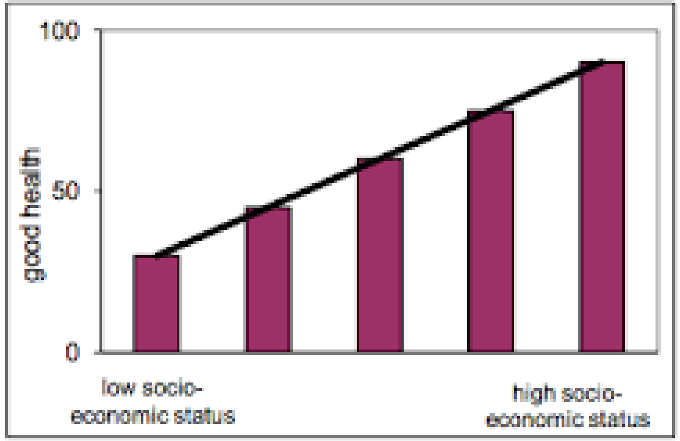
It included civil servants of all hierarchical statuses considered to be representative of the hierarchical distribution found in the United Kingdom in the general population.

Social gradient in health :

Marmot has shown that there is a social gradient in health, that is to say

«The higher the position, the higher the health».

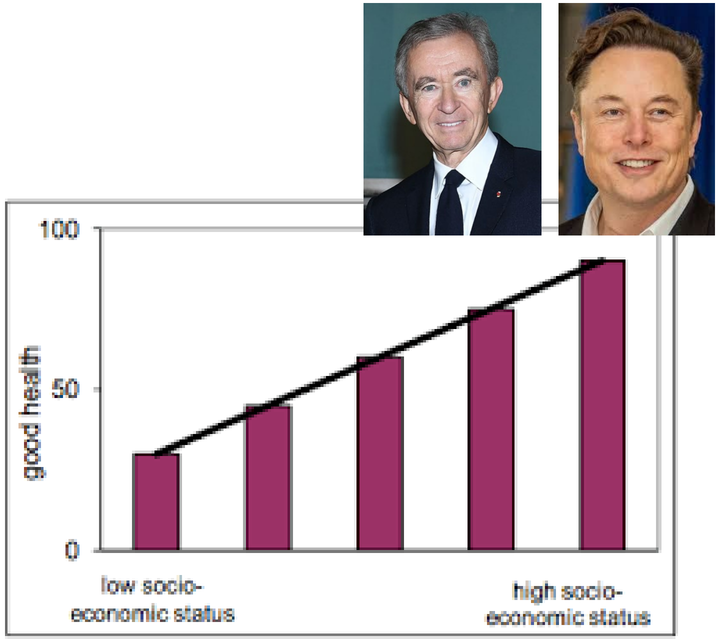
The Black Report's materialist approach apprehended social inequalities in health in terms of an opposition between advantaged and disadvantaged social classes as if social inequalities in health would disappear beyond a certain level of income and material comfort.



Social gradient in health

There is always someone above us in the hierarchy who is potentially healthier than we are.

Psychosocial explanation : Marmot has shown empirically that the higher you are in the hierarchy, the more friends you have (social support), the more hobbies you have, the more vacations you go on, the more autonomy you have in your work and the more social rewards you receive. And all this reduces stress.



Social gradient in health

One concluding remarks on Switzerland.

There is no real tradition of research into social inequalities in health in Switzerland (as in the UK, for example).

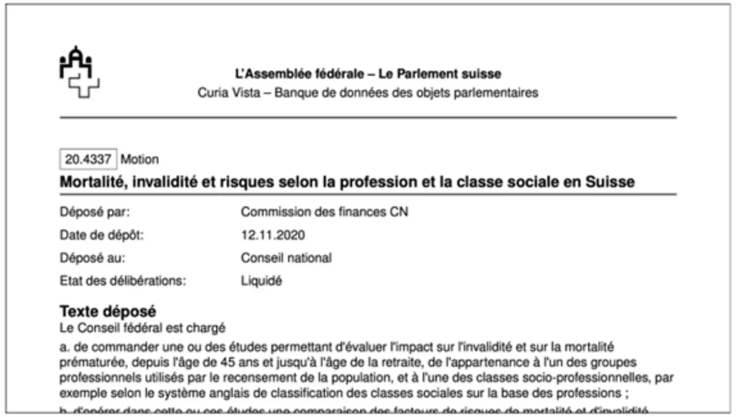
In a rich country like Switzerland, we tend to think that poverty doesn't exist and is “imported”.

There is also a tradition to focus on differences between cantons instead of class.

Some cohort research, contemporary with the Black Report, exist. For instance, the SOMIPOPS study showed in the 80’s that, like everywhere else, Social inequalities in health exist in Switzerland.

Like all developped societies, Switzerland has monitoring tools (OFS & OFSP) which should make it possible to produce (as in the UK) morbidity and mortality statistics by social class.
No precise data available on their sites. At best, you find data correlated with level of education.

Why ?



L'Assemblée fédérale – Le Parlement suisse
Curia Vista – Banque de données des objets parlementaires

20.4337 Motion

Mortalité, invalidité et risques selon la profession et la classe sociale en Suisse

Déposé par: Commission des finances CN
Date de dépôt: 12.11.2020
Déposé au: Conseil national
Etat des délibérations: Liquidé

Texte déposé

Le Conseil fédéral est chargé

a. de commander une ou des études permettant d'évaluer l'impact sur l'invalidité et sur la mortalité prématurée, depuis l'âge de 45 ans et jusqu'à l'âge de la retraite, de l'appartenance à l'un des groupes professionnels utilisés par le recensement de la population, et à l'une des classes socio-professionnelles, par exemple selon le système anglais de classification des classes sociales sur la base des professions ;

We are not immunized against censorship (Thatcher Vs Black Report).

November 12, 2020,

the Swiss government was questioned by the National Council's Finance Committee about the inadequacy of statistics on life expectancy in Switzerland, which distinguish only between age and gender. The Commission therefore tabled a motion calling for studies to be carried out to assess life expectancy in relation to income.

The motion was rejected on the grounds that it would be “problematic to take state decisions on the basis of statistics”.

But on what basis should we ?

Social inequalities in health : a topic with high political stakes.

We still have work to do, both scientifically **and politically**!

Conclusion

The question of social inequalities in health is an old one, inseparable from the emergence of Western societies.

It becomes visible in times of crisis, which means that it is periodically made invisible. The current period of visibilisation (post-covid, war, health system crisis, etc.) may not last (so it's up to us to make it visible).

Since the Second World War, the sociomedical ideal has gradually been replaced. Our societies are now dominated by an individualistic, biomedical curative representation of health that needs to be deconstructed.

We need to be aware that some political and economic forces do not necessarily welcome the evidence about social inequalities in health (Thatcher Vs Black Report).

We need to be aware of our blind spots. The comparison I have made between American and British epidemiology should make us question our own ways of conceptualizing health inequalities, in order to understand them in an ever more inclusive way.

Thanks for your attention !

For any further information do not hesitate to get in touch with me :

mathieu.arminjon@hesav.ch

Bibliography

- Arminjon, Mathieu, and Sandrine Maulini, ed. 2023. *Inégalités de santé. Fondements historiques et enjeux contemporains de l'épidémiologie sociale*. Médecine Société. Genève: Georg.
- CSDH. 2008. *Closing the Gap in a Generation : Health Equity Through Action on the Social Determinants of Health: Final Report of the Commission on Social Determinants of Health*. WA 525. Geneva: World Health Organization.
- Cueto, Marcos, Theodore M. Brown, and Elizabeth Fee. 2019. *The World Health Organization: A History*. Global Health Histories. Cambridge: Cambridge University Press.
- Foucault, Michel. 2002[1974]. The birth of Social Medicine. In *Power, Essential Works of Foucault*, 3:134–156. London: Penguin Books.
- Marmot, Michael G. 2006. Status syndrome: A challenge to medicine. *Jama* 295: 1304–1307.
- McKeown, Thomas. 2014[1979]. *The Role of Medicine: Dream, Mirage, or Nemesis?* Princeton, N.J.: Princeton University Press.
- Porter, Dorothy. 2011. *Health Citizenship: Essays in Social Medicine and Biomedical Politics*. Perspectives in Medical Humanities. Berkeley, CA: University of California, Medical Humanities Consortium.
- H, Bucher, and Gutzwiller F. 1987. Health behavior and social inequality in the Swiss population. Results from the SOMIPOPS study (Sociomedical Model Indicators of the Population of Switzerland). *Schweizerische Medizinische Wochenschrift* 117: 1583–1590.

Discrimination dans les soins des personnes LGBTIQ+

Taux de suicide beaucoup plus élevés que dans la population générale.

Taux maladies cardiovasculaires, cancers, diabètes et de handicaps plus élevés que la Population générale.

Problématique d'accès au soin en raison des discriminations ou de la peur des discriminations (par ex. continuer à nommer selon le sexe).

Problèmes relatifs à l'intimité ou au toucher.

Journal of
PHYSIOTHERAPY
journal homepage: www.elsevier.com/locate/jphys

Research

People who identify as LGBTIQ+ can experience assumptions, discomfort, some discrimination, and a lack of knowledge while attending physiotherapy: a survey

Megan H Ross, Jenny Setchell
School of Health and Rehabilitation Sciences, University of Queensland, Brisbane, Australia

KEY WORDS
Sexual and gender minorities
Health
Communication
Gender identity
Physical therapy

ABSTRACT

Questions: What are the experiences of people who identify as lesbian, gay, bisexual, transgender, intersex, queer or related identities (LGBTIQ+) and attend physiotherapy? How could those experiences of physiotherapy be improved? **Design**: Primarily qualitative design using a purpose-built online survey. **Participants**: People aged 18 years or older, who self-identified as LGBTIQ+, and had attended physiotherapy in Australia. **Methods**: Open responses were analysed with thematic analysis and quantitative responses with descriptive statistics. **Results**: One hundred and fourteen participants responded to the survey, with 108 meeting all eligibility criteria. Four main themes were identified in the analysis, with almost all participants reporting experiences during physiotherapy interactions relating to at least one of the following themes: 'assumptions' about participants' sexuality or gender identity; 'proximity/exposure of bodies', including discomfort about various aspects of physical proximity and/or touch and undressing and/or observing the body; 'discrimination', including reports of overt and implicit discrimination as well as a fear of discrimination; and 'lack of knowledge about transgender-specific health issues'. Positive experiences were also evident across the first, third and fourth themes. Participants suggested or supported a number of ways to improve LGBTIQ+ experiences with physiotherapy, including: LGBTIQ+ diversity training for physiotherapists, education specific to the LGBTIQ+ population (particularly transgender health), and open options for gender provided on forms. **Conclusion**: People who identify as LGBTIQ+ can experience challenges when attending physiotherapy, including: erroneous assumptions by physiotherapists, discomfort, explicit and implicit discrimination, and a lack of knowledge specific to their health needs. Positive findings and participant-suggested changes offer ways to improve physiotherapy for LGBTIQ+ people across educational and clinical settings. **[Ross MH, Setchell J (2019) People who identify as LGBTIQ+ can experience assumptions, discomfort, some discrimination, and a lack of knowledge while attending physiotherapy: a survey. *Journal of Physiotherapy* 65:99–105]**

Introduction

A significant, and increasing, number of Australians identify as not being heterosexual (3 to 11%)[1] and/or gender diverse. Lesbian, gay, bisexual, transgender, intersex, queer and related identities (LGBTIQ+) civil rights have become a topic of increased social and political debate in Australia and other countries over recent years. Although this debate has resulted in reduced discrimination, including policy changes such as legalisation of same-sex marriage in some countries, stigma and inequity still exist.[2]

Health and access to healthcare remain an important area of inequity for LGBTIQ+ people.[3] Globally, LGBTIQ+ people experience significantly poorer health and greater barriers to healthcare. Research consistently highlights poorer mental health,[4–6] including much higher suicide rates than in the general population.[7,8] Physical health is also poorer,[9] with those identifying as LGBTIQ+ more likely to be diagnosed with cardiovascular disease,[10,11] cancer,[12] diabetes,[13] and disability.[11,14]

One third of Australians who identify as LGBTIQ+ do not disclose their sexuality or gender identity when accessing healthcare,[15] with reasons largely unresearched but proposed to be due to fear of discrimination, including receiving poorer care.[16] Research has highlighted that LGBTIQ+ patients feel judged and receive suboptimal care from a variety of health professions, including medicine and nursing,[17] mental health,[16,18] and peri-natal care.[19] However, there has been no research investigating how people who identify as LGBTIQ+ experience physiotherapy.

While similarities between physiotherapy and other health professions exist, and previously identified barriers may apply to all forms of healthcare, it is likely that there are barriers unique to physiotherapy.[20] Physiotherapy can be innately intimate, with undressing, critical observation and touch common during treatment.[21,22] These aspects can be difficult to negotiate, with some physiotherapy patients feeling uncomfortable or judged.[23] There may be similar effects for LGBTIQ+ people.

LGBTIQ+

REVUE DE LA LITTÉRATURE

Pratique physiothérapeutique et chirurgie d’affirmation de genre homme à femme : un examen de portée (*scoping review*)

Loïse Yersin , Christel Michon , Mathieu Arminjon

DOI: 10.55498/MAINSLIBRES.2022.10.2.85

Résumé

Selon quelques sources les dysfonctions du plancher pelvien sont moins fréquentes chez les personnes avec un suivi physiothérapeutique en préopératoire de dilatation de la néocavité vaginale (28 % vs. 86%) que celles sans intervention.

Pratique de chirurgie affirmation de genre à Lausanne et Zurich et pourtant il n’y a aucune indication de soins claires relatives à la physiothérapie.