Social Science & Medicine 200 (2018) 92–98

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Review article

Understanding the micro and macro politics of health: Inequalities, intersectionality & institutions - A research agenda

Anna Gkiouleka[a,*], Tim Huijts[a], Jason Beckfield[b], Clare Bambra[c]

[a] Department of Sociology, University of York, York, UK
[b] Department of Sociology, Harvard University, Cambridge, USA
[c] Institute of Health & Society, Newcastle University, Newcastle, UK

ARTICLE INFO

Keywords:
Health inequalities
Intersectionality
Institutions
Health politics
Social positioning

ABSTRACT

This essay brings together intersectionality and institutional approaches to health inequalities, suggesting an integrative analytical framework that accounts for the complexity of the intertwined influence of both individual social positioning and institutional stratification on health. This essay therefore advances the emerging scholarship on the relevance of intersectionality to health inequalities research. We argue that intersectionality provides a strong analytical tool for an integrated understanding of health inequalities beyond the purely socioeconomic by addressing the multiple layers of privilege and disadvantage, including race, migration and ethnicity, gender and sexuality. We further demonstrate how integrating intersectionality with institutional approaches allows for the study of institutions as heterogeneous entities that impact on the production of social privilege and disadvantage beyond just socioeconomic (re)distribution. This leads to an understanding of the interaction of the macro and the micro facets of the politics of health. Finally, we set out a research agenda considering the interplay/intersections between individuals and institutions and involving a series of methodological implications for research - arguing that quantitative designs can incorporate an intersectional institutional approach.

1. Introduction

Almost a decade after WHO Commission on Social Determinants of Health published its influential report (2008), health inequalities within and across countries remain high on the research agenda. Acknowledging the complexity of the issue, scholars increasingly stress the need for the development of a theoretical framework that will integrate the multiple factors involved in shaping health inequalities, from individual social positions and experiences to institutions (Beckfield et al., 2015; Krieger, 2012, 2011). In this direction, intersectionality offers a fertile ground upon which such an integrative approach can grow (Hill, 2016; Kapilashrami et al., 2015; Bowleg, 2012; Hankivsky, 2012; Weber and Parra-Medina, 2003). In this essay, building on the theoretical and methodological tenets of intersectionality, first we outline the relevance of intersectionality for health inequalities research and we elaborate on how it can bring together health inequalities research focusing on the impact of a range of established social determinants of health beyond socioeconomic position. Further, we demonstrate how integrating intersectionality and institutional insights on health inequalities allows for the study of institutions as heterogeneous entities that weave social privilege and disadvantage beyond socioeconomic stratification (Beckfield et al., 2015) as well as for the use of intersectionality as a context informed analytical tool considered with social categories that matter for individuals' positioning, experience and health (Yuval-Davis, 2005). We argue that such an innovative synthesis allows us to interrogate the fundamental causes of health inequality in light of power relations and to shift our focus from individual attributes to processes of health inequality (re)production. Taking a step forward, we demonstrate how this synthesis can infuse an intersectionality and institutionally informed health inequalities research agenda involving a series of urgent research questions and methodological considerations for qualitative, quantitative and mixed methods designs. We argue that in the present climate of increased forced migration and neoliberal disruption, the demographic shifts taking place in various contexts are accompanied by interlocking processes of social exclusion based for example on gender, racial, ethnic, socioeconomic and sexual differences. Hence, intersectionality becomes all the more relevant as it enables us to reveal a range of minority political struggles that are often obscured and diluted within a liberal discourse of 'diversity' (Bilge, 2013; Hankivsky and

* Corresponding author. Department of Sociology, University of York, Wentworth College, Heslington, YO10 5DD, UK.
E-mail address: a.gkiouleka@york.ac.uk (A. Gkiouleka).

https://doi.org/10.1016/j.socscimed.2018.01.025
Received 8 March 2017; Received in revised form 15 January 2018; Accepted 18 January 2018

Christoffersen, 2008). In the following paragraphs, first we elaborate on intersectionality as an analytical tool of stratification and then, we demonstrate its implications for health inequalities research in regard to individual social positioning and to institutional effects.

2. Intersectionality: theoretical & methodological underpinnings

Intersectionality was initially developed by Black critical thinkers and activists as a way to conceptualise the multiple disadvantage experienced by Black women as an oppressive experience that could not be captured by approaches that treated race and gender as distinct entities (Crenshaw, 1991, 1989; The Combahee River Collective, 1986; Davis, 1983; Hooks, 1981). Since then, intersectionality has influenced scholarship in various fields (see Collins and Bilge, 2016 for an overview) and has travelled across different contexts where in many cases it has developed in new directions, detached from its radical origins (Salem, 2016; Bilge, 2013). Collins (2015) gives the basic tenets of intersectionality as an analytical strategy stating that social categories like gender, race, class, or sexuality are mutually constructed and underlie intersecting systems of power that foster social formations of complex social inequalities. Inequalities are historically contingent and cross-culturally specific and they are organised via unequal material realities and social experiences that vary across time and space. Individuals and groups are differentially located within the intersecting systems of power and their location shapes their point of view of their own and others' experience.

Intersectionality as an analytical tool of social stratification (Yuval-Davis, 2015) challenges the idea of a single, fixed social hierarchy. It perceives social positioning as a spot within a matrix of intersecting power axes (Crenshaw, 1992). Hence, there are no sociological categories (e.g. race, gender) that have an *a priori* greater significance in shaping individual experience. Rather, social positioning is shaped through an interplay that involves multiple categories within specific socio-historical contexts. And although the consideration of multiple categories has been a significant point of critique on intersectionality (i.e. how we can integrate everything in our analyses without prioritising certain categories over others), it is the simultaneous concern with the context and the individual that intersectionality provides that is important. Yuval-Davis (2015) elaborates on that and describes intersectionality as a context informed analytical tool (*situated intersectionality*) that focuses on the categories that reflect the social divisions shaping most people's lives (e.g. race and gender) in certain contexts and simultaneously it is sensitive enough to render visible other divisions shaping the experience of individuals and groups at marginal positions (e.g. sexuality).

Such a view stresses that intersectionality concerns everybody (Yuval-Davis, 2015). Individuals bear varying amounts of disadvantage and privilege associated with varying experiences of oppression and domination specific to their context (Nash, 2008). There are multiple ways in which marginalised subjects may be traumatised by complex systems of power (e.g. patriarchy, white supremacy, heterosexism) like Black homosexual women living in predominantly white heterosexual contexts, but there are as many others in which subjects may enjoy the benefits of their privilege in one system of power, while suffering symbolic violence in another (Iyer et al., 2008; Nash, 2008). For example, white women experience race privilege combined with gender disadvantage. This suggests that we cannot develop a deeper understanding of disadvantage without the consideration of the various mechanisms that produce and establish privilege (Nash, 2008) and that the intersections between disadvantages may turn out in non-anticipated ways (i.e. when being a Black woman has a different effect on one's well-being than the sum of the effects of gender and race). Also, we need to account for differences within categories that may operate for the production of additional internal exclusions (e.g. the exclusion of Black women from anti-racism movements in places such as the US) (Bowleg, 2013; Crenshaw, 1991).

In terms of methodological underpinnings, McCall in her often cited work distinguishes three approaches according to which researchers focus on the constructed character of social categories, on the permeability of their boundaries or on the relationships of inequality they imply (i.e. anti-categorical, intra-categorical, and inter-categorical, see McCall, 2005). However, we consider that two additional distinctions should be made for the development of an intersectional methodology applied to health. First, we need to distinguish between the different facets of social reality as described by Yuval-Davis (2015), namely the actual individuals' position within the power structure, their own experience of identity and belonging, and their normative values. Second, between the individual and the group as units of analysis described by Collins (2003). Both scholars suggest that individuals as members of groups may share common positions with specific material, political, and institutional implications within a power structure while their individual experiences of this membership may vary significantly. These underpinnings infuse the theoretical arguments and the research agenda discussed in the next sections.

3. Intersectionality & health inequalities beyond socioeconomic status

The sizeable health inequalities literature has developed across quite independent streams but with a dominant (and arguably excluding) emphasis on socioeconomic position as the key social determinant of health. In some contexts like the UK for example, 'health inequalities' refer almost exclusively to socioeconomic position with little reflection on how that is stratified by other factors such as gender (Bambra et al., 2009). Despite the multiplicity of channels through which socioeconomic position impacts health (Bartley et al., 1998; Link and Phelan, 1995), most studies focus on single linking mechanisms at a time. Socioeconomic position is usually defined by income, occupation or educational level alone, often with other variables like gender serving as a control (Huijts et al., 2010). Respective findings show that people with better socioeconomic position are healthier across different societies regardless of their level of economic development (Beckfield et al., 2015; Eikemo et al., 2008). However, this approach obscures the multiple stratification systems that people embody *simultaneously* (Krieger, 1997). And although there has been significant work on the impact of those additional stratification systems beyond the pure socioeconomic (e.g. ethnic, gendered and sexuality based health inequalities), this has usually evolved as an alternative rather than an integrative focus on health inequalities.

Research on racial or ethnic health inequalities usually conflates the categories of race and ethnicity as equivalent and homogenises the experience of distinct populations (e.g. immigrants, aboriginal, ethnic or racial minorities) with different demographic characteristics, migration trajectories and institutional statuses. Despite empirical findings revealing differential patterns of health inequality between those who are perceived to belong to a nation/state and those who do not (La Parra-Casado et al., 2017; Huijts and Kraaykamp, 2012), the discussion is often focused on the health disadvantage that members of ethnic/racial minorities face due to their lower socioeconomic status (Navarro, 1990) or their experience of discrimination (Nazroo and Williams, 2005). More importantly, those two elements are approached as if they are necessary corollaries of minority status with an autonomous and undifferentiated impact on everybody.

In contrast, an intersectional approach considers the distinct socio-historical processes associated with racial and ethnic categories across contexts (Graham et al., 2011) interrogating the categories' salience and impact on individual experience. For example, in Europe, the interchangeable use of race and ethnicity as well as the preference for the term 'ethnic minorities' results in the dismissal of race as an ostensibly irrelevant category and consequently in the mutation of racialised subjects (Bilge, 2013). However, a consideration of the socio-historical context through an intersectional lens reveals that race has always been