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Race, gender, class, sexuality (RGCS) and hypertension

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ABSTRACT

Informed by intersectionality theory, a tradition that theorizes intersecting power relations of racism, patriarchy, classism and heterosexism, this paper investigates the degree to which race, gender, class and sexuality manifest distinct and interconnected associations with self-reported hypertension in nationally-representative survey data from Canada. Binary logistic regression is used to model the main effects of, and interactions between, race, gender, education, household income and sexual orientation on hypertension, controlling for age, using data from the 2003 Canadian Community Health Survey ($n = 90{,}310$). From a main effects ('additive') perspective, Black respondents, respondents with less than high school and poorer respondents were significantly more likely than White respondents, university-educated Canadians and wealthier Canadians, respectively, to report hypertension. However, the interactive models indicate that the additive models were poor predictors of hypertension for wealthy Black men, wealthy South Asian women, women with less than a high school diploma and wealthy bisexual respondents, who were more likely than expected to report hypertension, and for poor Black men, poor South Asian women, poor South Asian men and women with a university degree, who were less likely than expected to report hypertension. It appears that, with regard to blood pressure at least, Canadians experience the health effects of education differently by their genders and the health effects of income differently by their identities defined at the intersection of race and gender. This study provides empirical support for the intersectional approach to cardiovascular health inequalities by demonstrating that race, gender, class and sexuality cannot be disentangled from one another as predictors of hypertension.

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Introduction

High blood pressure, or hypertension, is one of the most important risk factors for heart disease and stroke. Hypertension is, however, unequally distributed along social lines. In Canada, for instance, researchers have determined that Aboriginal, Black and Filipino people are at higher risk of hypertension than White people (Veenstra, 2009) and poorly-educated people are at higher risks of hypertension than highly-educated people (Milar & Wigle, 1986). These findings, among many others from Canada and elsewhere (e.g., Brondolo, Rieppi, Kelly, & Gerin, 2003; Chiu, Austin, Manuel, & Tu, 2010; McKetney & Ragland, 1996; Mensah, Mokdad, Ford, Greenlund, & Croft, 2005; Williams & Neighbors, 2001), illustrate the detrimental effects on blood pressure of being situated at the disadvantaged ends of axes of social inequality.

Notwithstanding the importance of these insights regarding the social distribution of hypertension, the theoretical infrastructure underpinning empirical research of this kind has not stayed current with developments in social theory and, therefore, runs the risk of presenting simplified or incomplete depictions of the complex social phenomena that influence cardiovascular health. In particular, intersectionality theory, a tradition which has achieved significant traction in legal, feminist and critical race scholarly circles in recent decades, has yet to meaningfully permeate the quantitative health determinants literature (but see Black & Veenstra, 2011; Hinze, Lin, & Andersson, 2012; Kobayashi & Prus, 2011; Rosenfield, 2012; Seng, Lopez, Sperlich, Hamama, & Reed Meldrum, 2012; Veenstra, 2011; Warner & Brown, 2011). Intersectionality theory presents a sophisticated framework for conceptualizing the nature of relations of power pertaining to racism, sexism, classism and heterosexism in modern societies and possesses enormous potential for providing insight into the nature of inequalities in cardiovascular disease by race, gender, class and sexuality in particular.

Systemic relations of power between dominant and subordinate groups in society exist simultaneously at the macro levels of structures and institutions and the micro levels of interpersonal relationships and personal experiences. Most sociological traditions attentive to the analysis of systemic relations of power in society, including incarnations of feminism and Marxism, have theoretically privileged one dimension of inequality over others

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(King, 1988). Intersectionality theorists, by contrast, argue that the fundamental axes of inequality in contemporary societies, namely, racism, patriarchy, classism and heterosexism, are intrinsically entwined; they mutually constitute and reinforce one another and cannot be conceptually and empirically disentangled from one another. That is to say, power relationships along the lines of race, gender, class and sexuality are mutually defining rather than analytically distinct systems of oppression, together forming what Patricia Hill Collins (2000) labels a 'matrix of domination.'

In light of the intersecting nature of relations of power at multiple levels of society, intersectionality scholars argue that individual-level subordinate-group identities, e.g., non-White, female, lower class or non-heterosexual, interact with one another in a synergistic way leading to unique experiences as a 'multiply-organized other' (Purdie-Vaughns & Eibach, 2008). This idea is encapsulated in the intersectional principle of 'multiplicativity.' Multiplicativity posits that intersections between axes of inequality create complex social locations—such as upper-class White heterosexual male or middle-class Asian lesbian—which are more central to the manifestation of social experiences and outcomes than are any of the identities that comprise them considered individually (Baca Zinn & Dill, 1996; Brewer, 1993; Collins, 1993, 2000; Espiritu, 2000; Glenn, 2002; King, 1988). Multiplicativity stands in direct contrast to the notion of 'additivity' which assumes that people with multiple subordinate-group identities experience the oppressions associated with those identities as distinct phenomena and that the total amount of discrimination directed at them is simply equal to the sum of the distinct discriminatory experiences.

Multiplicativity implies that the additive strategy of examining the empirical relationship between an inequality-based variable and a health variable before or after 'controlling for' one or more other inequality-based identity variables is intrinsically nonsensical. If, for example, people experience their racial identities differently by gender, class and/or sexual orientation then straightforward relationships between racial identity and health are not meaningful; there is no singular Black experience per se that differs from Asian, South Asian or White experiences. Accordingly, health researchers who have investigated the degree to which structural, behavioural and/or psychosocial factors explain gender differences in health are mistaken when they assume that these factors operate similarly in the lives of women and men with different racial, classed and sexual identities and as a result misrepresent the nature of gendered health disparities. Similarly, researchers who have examined whether socioeconomic status and perceived discrimination explain Black–White disparities in hypertension misrepresent racial health inequalities when they assume that processes of racism and discrimination operate identically in the lives of Black and White people (and Aboriginal people, and Asian people, etc.) possessing different gendered, classed and sexual identities. Even researchers who have investigated the degree to which the health of men and women are differentially sensitive to socioeconomic factors or the degree to which racial health inequalities and explanatory factors for them differ by gender have not risen to the challenge of intersectionality theory by failing to account for the possibility of intersections between three or more axes of inequality.

Put in statistical terms, regression modelling of the main effects of race, gender, class and sexual orientation on health is not useful or even appropriate from an intersectional perspective. Rather, multi-way statistical interactions between race, gender, class and sexuality must be foregrounded in modelling of health outcomes which is informed by and reflects the tenets of intersectionality theory. Examination of statistical interactions between inequality variables enables investigation of whether and how people experience the health effects of education or income differently by their gender, their race and/or their sexuality, whether and how people experience the health effects of their racial identity differently by their gender, their social class and/or their sexuality, and so forth. Main effect models are consistent with additivity and interaction models are consistent with multiplicativity.

A small corpus of studies has explicitly applied intersectionality theory to health inequalities in quantitative analyses. In the United States, Seng et al. (2012) attempted to model intersectionality by examining structural (education, poverty), contextual (high crime neighbourhood, racial minority status, trauma exposures) and interpersonal (perceived discriminatory experiences) factors as predictors of post-traumatic stress disorder symptoms and a quality of life index score. The regression analyses were additive rather than multiplicative in nature, however, calling into question the degree to which the study truly reflects an intersectional worldview. Applying sophisticated growth curve analyses, Warner and Brown (2011) examined age-trajectories of functional impairment for White, Black and Mexican American men and women. They found that White men reported the best levels of functional health and that, over time, Black women experienced a trajectory of accelerated disablement. However, they failed to forefront interactions between race, gender and class and thus, like Seng et al. (2012), presented an additive rather than intersectional depiction of societal axes of inequality and their health effects.

Explicitly addressing multiplicativity, Hinze et al. (2012) examined intersections between race (Black versus White), gender and education to predict self-rated physical health among US older adults. They found that race and gender interacted to predict self-rated physical health among study participants with less than high school education but not among Americans with a high school diploma or some higher educational credential. Rosenfield (2012) used two US datasets to examine three-way intersections between race, gender and class as predictors of mental health outcomes. She found that the effects of race (Black versus White) and gender on mental health problems differed by education, albeit not quite significantly so. However, she failed to find any evidence for three-way interactions between race, gender and income.

In Canada, Veenstra (2011) examined interactions between race, gender, class and sexuality as predictors of self-rated health. Although four-way interactions between these axes were not statistically viable and none of the three-way interactions that comprised them was statistically significant, Veenstra did find that the effects of education, income and race on self-rated health all varied by gender and that the effect of income on self-rated health varied by race and by sexual orientation. Kobayashi and Prus (2011) stratified a national sample by gender and visible minority status to examine relationships between immigrant status and multiple health measures. They found that the healthy immigrant effect applied more for some complex social identities, such as mid-life visible minority males, than for others and that mid-life long-term immigrant women, both White and visible minority, had especially poor health. Kobayashi and Prus neatly accommodated multiplicativity by virtue of their consideration of ways in which gender and visible minority status texture the experiences of immigrants to Canada. However, they treated class in an additive rather than multiplicative manner, homogenized the experiences of non-White Canadians and did not conduct tests of significance for the statistical interactions.

Lastly, in a cross-national comparative analysis, Black and Veenstra (2011) found that race significantly interacted with gender and with income to predict self-rated health in Toronto but not in New York City while gender interacted significantly with education to predict self-rated health in New York City but not in Toronto. Although the authors did not examine three-way

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