An Intersectionality Approach to Health Care.

Paper presented at the ADAPT Conference Bologna, Jan 22nd, 2015

by ***Prof. dr. J. van Mens-Verhulst*** *(www.vanmens.info/verhulst/en)*

To begin with, I want to express my gratitude to David Ingleby, who invited me for this talk. It is wonderful to get in touch with European colleagues who want to explore how the intersectional approach can contribute to health services, maybe the epidemiological aspects, maybe the service delivery. I sincerely hope that we will have a fruitful discussion on the promises and limitations of the intersectionality paradigm.

In my view, the intersectional perspective offers a promising approach to respecting socio-cultural diversity in the sense of *including* important categories of social difference, such as gender, ethnicity, age, class, sexual diversity, and differences in ability. However, we will also see that that are already important amendments available.

As you may know, the term "intersectionality" originated in the work of Kimberlé Crenshaw, as a means of describing the interaction between gender- and ethnic discrimination. Today, it is used as a *metaphor* for multiple forms of subordination and exclusion.

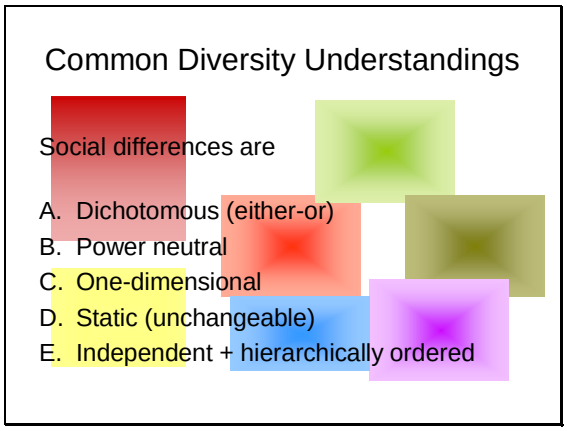
She and Patricia Collins support and elaborate on a USA-version of intersectionality, which constructs it as a political project and hence attention is focused on power relations. In Europe, the focus has been on intersectionality as a *methodological project*. Within psychology, this has involved elaborating on intersectionality at the individual level as a way of understanding the implications of multiple identities. Political scientists, on the other hand, have been more interested in the implications for policy. [1]

Personally, I have been involved in intersectionality explorations for almost 14 years, initially focused on individual clients, but later, also on management and policy issues. Prior to this, I spent more than 20 years studying the implications of *gender differences* for the quality of health care. The continuity in these projects was, of course, my interest in countering on-going, unjustified social inequalities in the diagnosis, treatment and management of health care, as well as in health research.

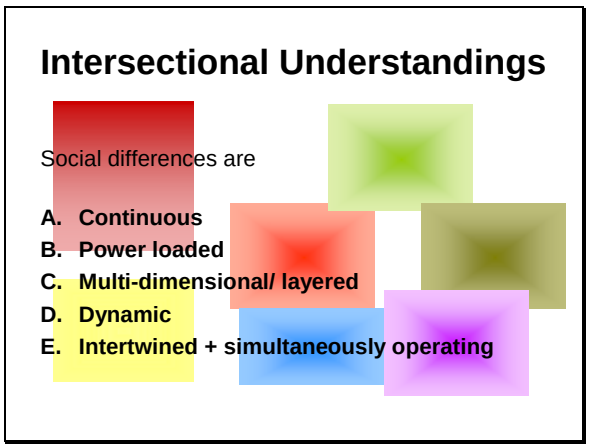
In addition, I aimed to contribute to better health for all citizens – not independent from the disparities among them, but on the contrary, acknowledging these differences. So, my reasons for these projects are both ethical and practical.

[1] Kathy Davis (2009)

In my talk, that I have prepared in cooperation with professor Lorraine Radtke from Calgary University, I will first briefly introduce the intersectionality approach by contrasting it with the conventional way of thinking about diversity. Next, I will relate the intersectionality approach to health and health care, and the possible mechanisms involved (especially stress). Thirdly, I will go into the implications for policy, touch upon promises and some critical points and finally I will suggest Complexity Theory as a possible solution.

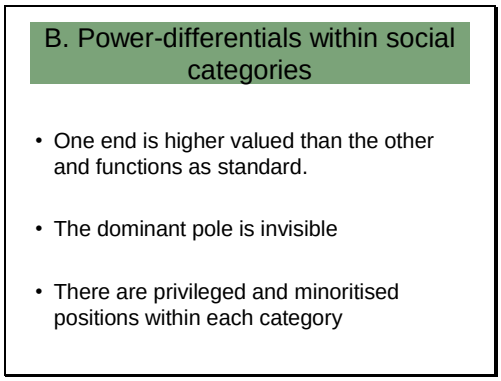


On this slide you see an overview of five common, but problematic views of *social* categories. In contrast, the intersectionality approach offers a much more complex track to be tamed. The categories of social difference are conceptualized as continuous, entailing power relations, multi-dimensional (multi-faceted) and dynamic. Finally, and importantly, they are viewed as intertwined and inseparable, simultaneously exerting influence:



Besides, these categories of social difference can be understood as constructions; as principles of social organization that simplify the social word and give it meaning. Constructions however at the expense of ignoring similarities and other differences.
Thus, as you will recognize, I am adopting a constructionist version of the intersectionality approach. This is important to keep this in mind, for the discussion, because there also exists an approach that treats these categories as natural.

In this ADAPT-community, I will provide a more detailed discussion of the second and fifth characteristic, i.e. the power load of categories of differences and their intertwinement.



Thinking about categories - or axes – of difference, it is unmistakable that one end is valued more highly than the other, and thus sets the societal standard for the other positions on the continuum, pathologising those who depart from that norm. The privileged positions in western societies include: Men (over women), heterosexuality over gay/lesbian/bisexual/ transgender, and adult age (between 25 and 45, so to say) over either young or old age. Being privileged means: having social, cultural, economic or ethical capital, or some combination of advantages, in a *knapsack* as it were.[2]

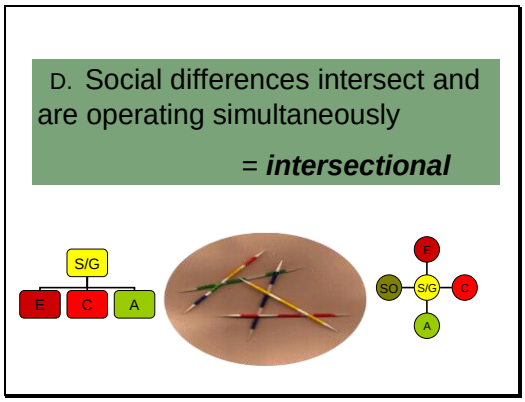
Importantly, the advantages for privileged people are mostly taken for granted, and not consciously noticed. They are almost invisible, so to speak. As a rule, insight into one's own privileges is not readily evident. For that, one may listen to *"outsiders within":* people who participate in the privileged group but are - or have been - also part of the minoritised group (upstairs-downstairs, is an example). As a result of this invisible privilege, the term "diversity" frequently is used to refer only to the group with the minority status, instead of enc**o**mpassing *every* power position. In the intersectionality approach, however, diversity means more than women; people of colour; gay/lesbian/bisexual/transgender people; disabled people, the elderly and so on. This approach claims that people are minoritised or privileged – not by inherent properties that they possess – but by all kinds of socio-historical and political processes pushing them towards a disadvantaged or advantaged position.

Additionally, the intersectionality approach recognizes the possibility of combinations of privilege and minoritisation[3]. For example, some members of so-called disadvantaged groups also hold privileged identities: e.g. middle- or higher class Blacks, White women, and able-bodied elderly. Such contradictory mixing also exists for privileged groups, as in the case of men who are Black, gay or unemployed; White people with disabilities, women professors, and so on. Such combinations may cause unease, because they disturb easy stereotyping. On the other hand, by focusing on power relations, we notice unexpected

[2] Peggy McIntosh (1988)
[3] Erica Burman (2004. p. 60, footnote 2).

similarities that may be relevant for health care. We may come to understand health issues in a new light and see equivalencies that previously were not apparent. For example, the psychological sense of "being under siege"(p. 212) on multiple fronts associated with the lives of Black middle-class men[4] may - in terms of mental health outcomes - bear some similarity to the psychological consequences for working- class White men - of feeling that economic restructuring, changes in gender roles, and increased immigration have eroded privileges they previously held with respect to their status as earners, their gender, and their race.

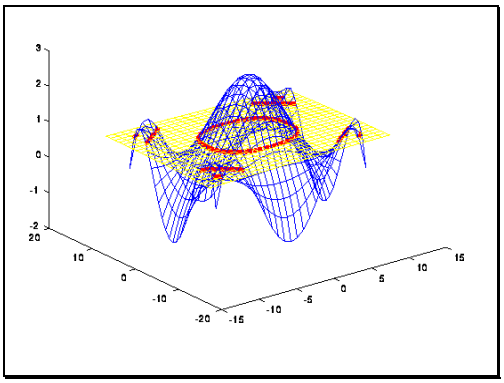
However, I would like to emphasize that power is not strictly negative. In my view - and in this respect I follow Foucault - power can be positive in that, for example, it is also associated with having the strength to demand access (to services, for instance), to normalize certain practices, to enable, to inspire and to create order. So, researchers who adopt an intersectional perspective must decide how they want to conceptualize and operationalize power, on which levels and so on. In my view, Bourdieu's theory (about different types of capital: economic, cultural, social, moral – but also intimate and physical) and Foucault's theorizing of power, with its focus on continuity, (multidimensionality) layeredness and dynamics fit very well with the intersectional approach.



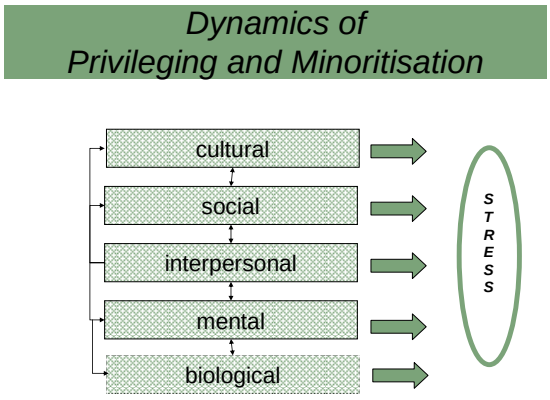
Now, we will focus on the combination of the "axes" of social difference. These two images depict conventional theorizing, with a central role allotted to sex/gender. In the left image, sex/gender has a one-sided impact downwards on the meaning and operation of ethnicity, class and age. In the right image, the influence between sex/gender and the other categories of difference is *reciprocal,* but without any connections between the other categories of difference. The intersectional conceptualisation of diversity assumes that the intersections of social axes operate simultaneously. To put it differently: The meaning of gender varies with ethnicity, and the meaning of ethnicity varies with gender. More concretely: The sexual interest imputed to men varies with the colour of their skin. (Black men are stereotyped as more sexually active). Also, the emancipatory behaviour and assertiveness expected from women varies with skin colour. White women are stereotyped as less assertive.

[4] Weis, Proweller, & Centrie (1997) in Cole (2009)

But these constellations also vary with class, age and sexual preference. All of these images and expectations operate simultaneously: in daily interactions, during professional interventions, and in policy development. And, what is taken for granted, and what is considered to be problematic, can shift within a society. Remember what happened after the war on terrorism was proclaimed; and how the commotion about sexual abuse in religious institutions has worked out, for instance.
The image of simultaneity is sometimes expressed as a Mikado-game: even if the axes of difference are the same, their combinations can be different. Another metaphor is the Kaleidoscope.



To stimulate your imagination I show you a third intersectional image, between two two-dimensional figures. You could see it as symbolizing four axes (2 blue ones, two yellow ones) with the red lines representing the simultaneous crossing. You can imagine the dynamics yourself, I hope. If the categories change, the red lines will change too, of course.

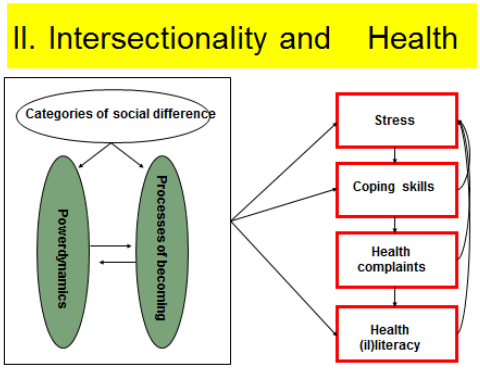


Now, I want to go back to power relations, to be more precise about power mechanisms and especially about some unique social stressors that may affect health. Namely, stress associated with being in a minority position, and stress associated with being in a privileged position.

Minority stress[5] stems from one's ascribed inferior status. In fact, it is a chronic condition in which socialisation and internalisation processes mean that the individual frequently confronts unfavourable self-images. No wonder, then, that a sense of powerlessness may be internalized, and may result in a lack of confidence – even shame; in anxiety that one may not be fully accepted; in feelings of helplessness and hopelessness and in the inclination to withdraw, with a permanent fear of being labeled and stigmatized[6].
In addition, a minority position may result in survival strategies, such as keeping silent, concealing, telling lies, avoidance behaviour, indirect responding, and appeasing, strategies that contribute to continuation or worsening of the situation.
A chronic stress condition may be exacerbated by discriminatory events (sometimes legal injustice, other times physical or psychical violence). Such events are stressful in three ways: because of the experience itself; because of the fear that this could happen, and because of the possible self-devaluation that is the result.
Other types of stress that are relevant in relation to social divisions are gender role stress and acculturation stress. Both refer to situations in which one does not fit into the available social categories in terms of drives, feelings, and behaviour.

Contrary to what you might expect**,** privileged positions also imply some specific sources of stress. Here, we find the fear of loss (because most privileges are not guaranteed forever). And the desire to be liberated from feelings of guilt about the privileges (that perhaps one sees as undeserved ?). Remember the imposter's syndrome - originally ascribed to women but nowadays also observed among men. Another stressor is the alienation from what seems to be one's "other part". Hence, the "knapsack" is filled with stressors and coping skills too - and this content is partly historically defined.

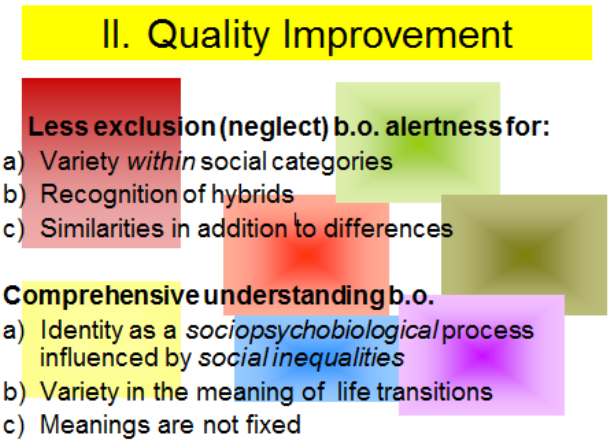
However, remember that the intersectional lens also showed us that people don't necessarily live in a completely minoritised position; and that not all women, immigrants and elderly belong to a vulnerable group. They may be privileged in other respects: education or money, for example.



[5] Katarzyna Banas, B.A. & John B.F. de Wit (2006) Minority stress, Self-Esteem and Health of Homosexuals (2006).
[6] Meyer (1995). Gail Pheterson (1986)

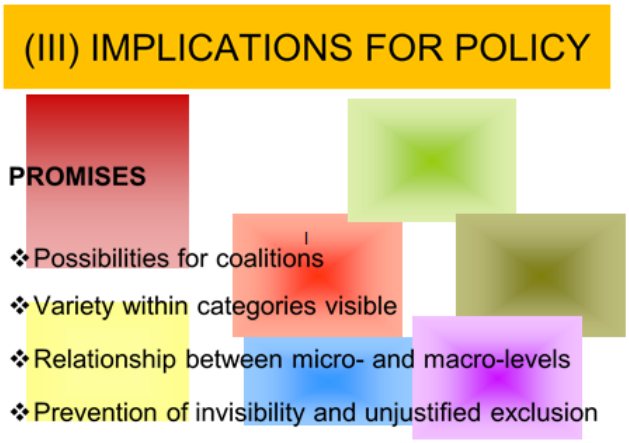
Now we arrive at a key question: How may clients, professionals and policymakers in health care profit from the intersectionality approach?
Here you see a scheme in which I have tried to capture the main points. On the left, the intersectionality view is summarized as multiple categories of social difference that entail power relations and identity formation, in mutual interaction. On the right, I have depicted (very briefly) the most relevant health aspects from the clients' perspective, namely health threats and health behaviour. Health threats in the sense of stress (we just talked about). Coping skills and health literacy are also influenced by one's social positioning – now and in the past.

My scheme shows rather roughly some important mechanisms: how social disparities may affect individual clients, or groups of clients – possibly resulting in various physical and psychological symptoms, or contributing to them. Just have a look on the possible contribution of an intersectionality approach to quality improvement:



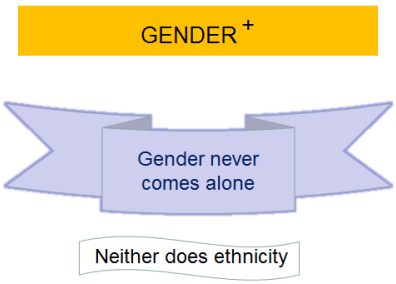
In contrast to that "one size fits all" approach of conventional health care, the intersectionality approach claims that such universality does not exist. Taking social differences as a point of departure, the intersectionality lens makes visible groups and people who were hitherto hidden within or between categories, or were misunderstood because they were too easily stereotyped (as privileged perhaps). Summarized, the quality of health care, and especially preventive care, may increase by less exclusion, by policy-makers as well as direct providers. In addition, the intersectionality lens may simply improve health care through its more comprehensive understanding of clients. Further translation of the theory into convenient procedures of practice and research is necessary, however.

So far, my talk has been more about insights into the micro level of patients and professionals rather than about implications for health care policy. Now, we arrive at a different story.



Initially, the promises of the intersectionality approach looked clear and simple; and very valuable for the health care domain; also for equality in migrant health care. Thanks to the attention paid to similarities, possibilities for coalitions/ alliances/ networks between categories of inequality emerge. Thanks to the attention paid to differences, the variety within categories of inequality become manifest. Also, an intersectionality approach would clarify the relationship between the micro level of the human being and the macro levels of society. And an intersectionality approach would prevent invisibility of groups and unjustified exclusion.

However, the intersectional approach is not so easily translated into policy-making and management solutions. For this part of the story, I switch from the identity branch to the political branch of intersectionality studies. Therefore, I draw on the discussions among political scientists in gender studies, especially the QUING-group. They investigated the quality of diversity mainstreaming in what they call the "equality architecture" in Europe. This has resulted in a very "rich" website that still exists. For this, they adopted a "gender +" point of view – to express their attitude that `gender never comes alone'. So, you may notice that they have chosen an approach in which gender is always present but the relevance of other axes of inequality needs to be established empirically for each policy context.



They make the same claim for ethnicity: "ethnicity never comes alone". It's a pity that the group did not study the realm of health care, but their insights and discussions can be easily extended to this domain.

Before I will present the critical notes and amendments to the original intersectionality paradigm that have been produced by gender studies' specialists, I will explore firstly the implications of the intersectional approach for diversity-sensitive health care, in the sense of the accessibility of services, professional guidelines, legislation, and mainstreaming.

Firstly we will regard accessibility. From an intersectionality point of view, the current organization of health care institutions may enlarge health inequalities: By ignoring relevant differences, by pre-structuring streams of patients through forcing them into a category they perhaps don't want to be identified with. Simultaneously, questions of proportionality pop up: should an organization provide proportional care for each group of the population; or provide the care as needed by a specific group of the population (f.e. refugees or working class men)? If health inequalities between groups and/ or organizations are identified, however, further comparisons are necessary. Not only input, but also throughput and output must be taken into account so that drop-out can be noticed too. [7] And, in addition to factual accessibility, perceived accessibility may be relevant, i.e. all the factors that make clients "feel at home" in the organization. Frankly, I would not welcome a health care system based on an endless proliferation of differences. Instead, the requisite variety, i.e., the relevant intersecting axes of difference are something to be worked out *within* the relationships between (individual) patients and professionals (individually or as – temporary - groups). This is possible if professionals are equipped with an intersectional approach to diversity and with associated tools and sensitivity. [8] Here, I see a mission for the institutions and teachers in health care education.

In addition, guidelines could be an important support system for such "diversity sensitive" health care. However, the system must become much more nuanced and dynamic. Today, guidelines are still mainly tailored to a – non-existing - standard human

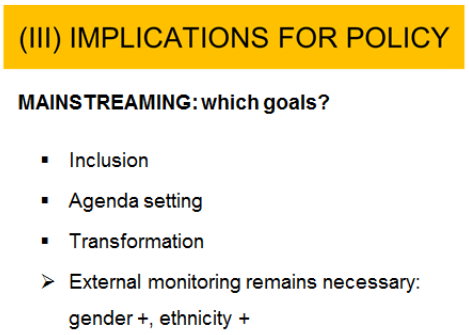
[7] P.m. Davide Malmusi (2014)
[8] Van Mens-Verhulst (2010)

citizen, and a revision may take years. Therefore, the production of guidelines should be organized differently. The inclusion of knowledge about women or migrants may be guaranteed by rules that require firstly the contributions of experts and perhaps representatives of specific axes of difference, and secondly the inclusion of separate sections dealing with sex/gender-, ethnic-, age- and class differences, thus resulting in guidelines that are very critical about the generalizability of the underlying knowledge.

Furthermore, It is clear that government legislation on health care, in combination with financial conditions, may enable or hinder intersectionality inspired health care. This point is up to legal experts. As a researcher, I only know that a government needs facts about specific health inequalities but also about their inequity and avoidability, and if so, possibilities for change.

Fourthly, diversity policy will undermine the policies focused on specific categories independent of their effectiveness. No wonder, that health care informed by an intersectionality approach may be seen as a threat to already existing services organized to meet the needs of specific groups identified as belonging to a category of inequality. Consequently, a competition may arise between the organizations (e.g., deliverers of services, policy makers, NGOs, researchers) that are specialized in one form of inequality (the so-called silos of David[9]). May be that the "plus-strategy" of the QUING-group, by Hankivsky qualified as Gender Based Analysis+ (GBA+) in contrast to the Intersectionality Based Policy Analysis (IBPA) she advocates, is more realistic, therefore.

What to say about diversity mainstreaming? It may vary in the goals that are set, just like gender mainstreaming. One may aim for inclusion of disadvantaged groups in policies (as a matter of statistics; frequently intra-categorical), or/and agenda setting by which inequalities are officially recognized (and all types of transversal dialogues must be organized), or/and transformation of relationships of inequality in the system. (when also the standards of the system – masculine and white f.i. – must be revised).

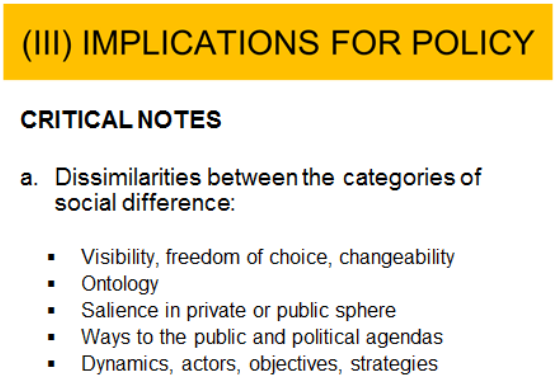


In practice, most (established) policymakers try to limit mainstreaming to the "relatively simple" inclusion. And in all cases, the question arises, how far mainstreaming should extend

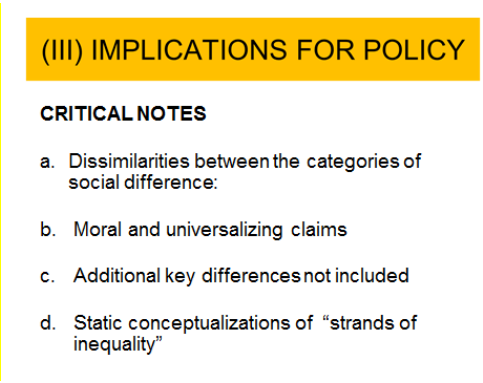
[9] Ingleby (2015)

– in space and time. Can it ever be said to be accomplished?

Experience with gender mainstreaming indicates that external monitoring remains necessary to support the continuation of mainstreaming. Negatively formulated: to avoid evaporation. Probably, this will be the same for mainstreaming of all the diversity categories: gender +, migrant +, et cetera.



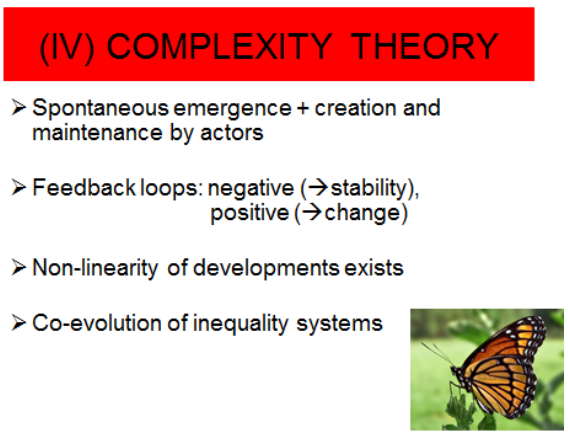
Well, now it's time for the amendments, I think.
To begin with, the assumption within the intersectionality approach that all categories of social difference are similar should be more nuanced. There are at least five important dissimilarities. First, the categories differ in their visibility, freedom of choice and changeability. F.e. age and sexuality are easier to conceal than sex/gender or colour of skin. Secondly, they are onto**lo**gically different in that their constructions draw from different layers of meaning, at least initially: class from a socio-economic layer; sex/ gender from biological and cultural layers, and ethnicity from a cultural layer, for instance. Thirdly, their importance varies according to the spheres of life. In private life, differences in sex/gender and age are almost inherent – and although relevant to the labor-division in society, are not overtly significant distinctions in a merit-based system. Differences in class and ethnicity are more explicitly salient in public life – although the overt politics of class and race may also be present in multicolor adoptive families or in labor relationships within the home where there is a white employer and a visible minority employee, f.i.. Fourthly, the categories of inequality differ in how, or if, they are taken up in public and political agendas. And, fifthly, they differ in their dynamics, actors (stake-holders), objectives and strategies. Everyone who is familiar with European diversity policies will recognize the variations between inequality strands: in the speed of developments, the range of committees, authorities and NGO's involved, and their priorities.



Additionally, some moral and universalizing claims made by early adopters of intersectionality theory require revision – and replacement with a more empirical orientation. The a priori assumption of the simultaneous impact of all categories of inequality on an individual's or group's life is both questionable and unworkable. Instead, the potential interaction (interference) between social categories is assumed without there necessarily being a "full" intersection of all possible categories. So, a willingness to always orient to the specificities of the immediate context is required: for professionals, policymakers, and researchers in particular. Intersectionality, in the sense of simultaneous intersection and mutual shaping of inequalities must be empirically demonstrated.

Also, there are further key differences that are important in policy discussions but are not included within the recognized inequality strands. For example, consider the effects parental and partner status (e.g., being a lone mother) on health outcomes.[10]

Finally, a constructionist view of inequality categories ("strands or axes", as you want) requires another – less static - language, that acknowledges the contextuality, dynamics and actors (constructors) involved. Thus, the focus of intersectionality policy analyses should be sites, interacting processes and subject positions – and their resulting "configurations".[11]



[10] P.m. Malmusi. Hankivsky
[11] Urbanek (2009), following M.M.Ferree and Lez.

To realize such process-oriented intersectional analyses, we have to abandon the usually static conceptualization of social systems (political systems, health care systems, knowledge systems) and adopt more dynamic and less linear ideas about their functioning. Such a view is provided by complexity theory – that helps us to acknowledge that configurations of inequalities may spontaneously emerge out of lower system levels, but are not reducible to those lower systems (any more). This is in addition to systems consciously created and maintained by actors. Take, for example, health movements "popping up" alongside long-standing, accepted institutions. In the Netherlands, there is a client's movement, a feminist health movement (undergoing a recent revival), and a migrant health movement. (Remarkably, the last one was not started by patients but by professionals.)

Crucial are the boundaries a system chooses. Actually, they show which identity the system has adopted and will adopt. Also, we are helped to acknowledge that we should look for feedback loops in the configurations to understand how the negative ones are maintaining the status quo, and the positive ones are "pushing toward" change (toward a new equilibrium). In other words, configurations may be more or less open to external influences, at a certain point in time.

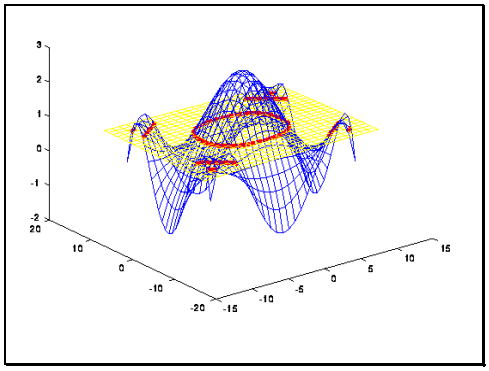
Promoting a gender-sensitive or migrant health care, we are inclined to qualify the negative feedback loops as "resistance", but laws or guidelines are useful, because, like professional organizations and educational institutions, they help to stabilize the health care system. Problems arise when a configuration that has arrived at some sort of equilibrium begins to show self-closure (i.e., to become rigid) and tries to maintain the current state-of-equilibrium through any means. Thus, in order to facilitate change, such negative feedback loops must be interrupted by demanding, for example, that expertise on the health of migrants, gender-sensitivity or other inequalities should be a criterion in the appointment decisions for professorships and director positions. Simultaneously, positive feedback loops need to be installed: to destabilize the equilibrium – and in some cases cause chaos (far-from-equilibrium) – all meant to arrive at another, more inclusive state of equilibrium. F.e. creating positive loops by expert-training programs, and `communities of practice', and introducing monitoring agents. But also by looking for ways to include members of subordinated groups in the policymaking and research process, e.g., participant-action research. And the most poetic possibility: release butterflies in the hope that they will cause storms at some point and place. Descriptions of good practices may have that function, sometimes.

Complexity theory also helps to acknowledge that there exists non-linearity of developments. So, there is no reason for disappointment if our direct actions for change don't meet our expectations because configurations do not always develop in a linear fashion, and mainstreaming should not be conceptualized as a linear process either. In this case, it may be effective to look for the people who are already receptive to change, and encourage them to join your project.

Additionally can be acknowledged that configurations of inequality exist in co-evolution:

they constitute each other's environment, and changes in one configuration may interfere with, facilitate or attenuate developments in other ones. So, if a constellation reorganizes itself in order to meet the health care needs of migrants, the needs of women may become invisible and neglected (this could also occur in the research context). And, as money can be spent only once, grants for one configuration of inequality may slow down the activities in another configuration.

But (!) if health professionals are trained to explore the axes of social difference and to reflect on the privileges and disadvantages they are confronted with (regarding their clients and regarding themselves), all clients may profit form this "diversity competence", and the total quality of health care may be raised. (A reason to introduce diversity competence, and the diversity paradigm as soon as possible into the health education landscape, in my opinion)[12]. Similarly, all configurations may profit from one monitoring European authority. And this ADAPT-group may profit from the QUINGproject.

- 

Do you remember this intersectionality metaphor? This is the landscape we are operating in in order to reduce inequalities in health care. Our influence – in my view - may increase if we can reduce some of this complexity. I expect that incorporating the insights derived from intersectionality analyses associated with advocating for gender-sensitive health care will strengthen the promotion of migrant health care, but making an intersectional approach practical and feasible will be a necessary step.

Now, it's almost time for discussion.

[12] Van Mens-Verhulst (2006)

(IV) COMPLEXITY THEORY

- ✓Actors, and how is their power?
- ✓Negative feedback loops to be interrupted?
- ✓Positive feedback loops to be installed?
- ✓Interaction of inequality configurations: where, when, reinforcing?

This was only a short overview. But even then, you may understand that the combination of intersectionality and complexity opens up new views, also strategically. Because it draws our attention to:

- Who are the actors involved in the emergence of configurations? And how is their power?
- Which feedback loops maintain the current equilibrium of the configuration? Must they be interrupted?
- How can positive feedback loops be utilized or created to trigger change?
- Where and when is the interaction of inequality configurations reinforcing, or just weakening?