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

Social Science and Medicine 2018, 200, 92-98.

DOI link to article:

https://doi.org/10.1016/j.socscimed.2018.01.025

Date deposited:

12/01/2018

Embargo release date:

28 January 2019

Word count: 7838

Understanding the Micro and Macro Politics of Health: Inequalities, Intersectionality & Institutions - a Research Agenda

Highlights

- Bridges intersectionality and institutional approaches to health inequalities.
- Considers health inequalities beyond socioeconomic status.
- Considers the intersections between institutions and individuals.
- Emphasises the macro and the micro facets of the politics of health.
- Suggests an intersectionality and institutionally informed research agenda

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.

Keywords: Health inequalities; intersectionality; institutions; health politics; social positioning

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 & 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 & 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.

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 & 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.

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, 1998; Link & 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 & 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 & 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 a fundamental meaning-making category for the conceptualisation of Europe as the land of whiteness (Goldberg, 2006). The European expansion and global dominance is a history of colonisation and enslavement associated with violence, exploitation and forced movement of racialised populations. The spheres of global dominance shaped during European imperialism are still in effect to a significant extent across many regions in Asia and Africa. Combined with modern forms of economic and military interventions, colonial legacies are responsible for the underdevelopment that limits their capabilities to achieve their health potential and forces them to immigrate often to Europe (De Maio, 2014; Sen, 2001). Simultaneously, the forms of racism that emerged during European colonisation (Goldberg, 2006) still inform institutional and everyday discrimination in modern European societies affecting both new-comers and ex-colonial citizens. Hence, race emerges as a crucial category for the study of health inequalities. Racialised subjects in Europe bear a legacy of oppression that is still responsible for increased economic marginalisation, physical violence, discrimination, and cultural and institutional barriers in accessing healthcare (Préteceille, 2011). All those factors are by definition determinants of poor health and health inequalities between white and non-white populations within Europe but also between regions at a global scale (De Maio, 2014).

Beyond race, immigrant status emerges as a distinct category that should be integrated in intersectional health inequalities research (Castañeda et al., 2015; Krieger, 1999). Immigration is often the outcome of particularly health damaging conditions (e.g. poverty or prosecution) while the actual movement itself may cause physical and psychological trauma (Krieger, 1999). As a status, immigration has particular implications for individuals' access to a series of civil, political and human rights in the receiving societies and is associated with experiences of discrimination and everyday microaggressions especially today within the current climate of rising xenophobia.

In terms of gendered health inequalities, the literature suggests that in developed countries women report generally worse health than men - particularly in terms of mental health- while experiencing lower overall mortality rates (Bambra et al., 2009). While most researchers have attributed these patterns to biological, behavioural, and psychological differences between men and women, radical feminist approaches have problematised patriarchy. Patriarchy has been seen either as a force imposing gender social roles reducing women's access to material resources (Annandale & Hunt, 2000; Doyal; 1995, 1979) or as a complex system of power organised across institutions and social relations that privileges men over women in terms of rights and responsibilities beyond material resources (Kapilashrami et al., 2015; Stanistreet et al., 2005). Today, we face a paradoxical reality where although some women -predominantly white middle class in high income countries- have made it to the top of the ladder in politics, financial institutions or the academia, women continue to be overrepresented among the world's poorest populations, and segregated in lower paid and less regulated sectors where gender roles are still strict (Abercrombie & Hastings, 2016). Although women claim their body autonomy dynamically, intimate partner violence is still a serious public health threat especially in less affluent contexts (Devries et al., 2013). Simultaneously, trans* people suffer multiple and particularly violent forms of social exclusion with health consequences that are rarely discussed (Dean et al., 2000).

Gender is therefore still a crucial stratification force although mediated by additional factors. An intersectional approach allows us to capture those mediations. Marxist feminists and critical race scholars emphasize the role of social class and race respectively (review in Salem, 2016). However, if we follow the current discourse on trans* rights, it appears that the extent that individuals conform to the gender binary creates additional hierarchies within men and women with significant health effects. If we further consider immigrant status, then it has been demonstrated that the social determinants of health for immigrant women (e.g. employment, healthcare access, social security) have often been subject to their dependence on a male family member (Soysal, 1994). Further, if we add sexuality to the analysis, then we see that it drives unique experiences and implies further internal exclusions.

Sexuality has only recently attracted researchers' interest as a meaningful category for the study of health inequalities (Reczek et al., 2017; Agénor et al., 2014; Doyal, 2009; McNair, 2003; Meyer, 2001; 1995). Again though, it has been studied as autonomous from other dimensions of difference present among lesbians, gays, queer and bisexual people (Fish, 2008; Meyer, 2001), either referring to demographic characteristics or to the extent that individuals perceive their sexual orientation as an identity. Terms like *gay, lesbian,* or *queer* are perceived as western constructs fitting to the experience of the white, middle class people and creating a paradigm that excludes or downgrades the experience of everyone else (Fish, 2008). Hence, when the health needs of lesbian, gay and bisexual communities are considered, research usually focuses on the experience of dominant subjects within those communities (i.e. middle class white gay men). From an intersectional viewpoint, this selective attention is understood in the frame of intersecting axes of oppression (heterosexism, sexism and racism) that render certain social groups more visible than others (Meyer, 2001). We can see this interplay manifesting in researchers' increased interest in HIV risk among gay men compared to lesbians' risk of breast cancer (Faulkner & Lannutti, 2016); in the scarcity of studies on the psychological impact of being lesbian, gay or bisexual and member of an ethnic or racial minority (Kertzner et al., 2009); or on the health of working class lesbians and gays (McDermott, 2006). An intersectional viewpoint enables us to deal with this kind of scientific bias that renders dominant subjects as the main point of reference (Weber & Parra-Medina, 2003) and to study those excluded both from dominant and subversive discourses or falling outside the boundaries of essentialised categories (e.g. Black lesbians or trans* people).

Intersectionality & Institutional Approaches on Health Inequalities

Using an intersectional lens to focus on the individual social positioning is necessary but not enough for an integrative understanding of health inequalities. Privilege and disadvantage are not individual attributes but products of the power structures operating at the contexts we are embedded. Although the importance of the context in intersectional frameworks on health inequalities has been acknowledged (Hill, 2016; Kapilashrami et al., 2015), the role of institutions remains neglected. Institutions play a significant role in the politics of health (Bambra, 2016; Beckfield et al., 2015) and in targeting the fundamental causes of health inequality (Raphael & Bryant, 2015), still, their integration in health inequalities research has been limited. Studies have focused mainly on welfare states classified across certain typologies (eg. Esping-Andersen, 1990) as mechanisms that rank people into social hierarchies and (re)distribute social determinants of health. Hence, it has been demonstrated that socioeconomic inequalities in health vary across welfare states (Bambra et al., 2010; Eikemo et al., 2008). However, the heterogeneity of welfare policies as well as the impact of simultaneous institutional arrangements in fields beyond welfare (e.g. education, immigration, incarceration) still need to be considered in health inequalities research (Beckfield & Bambra, 2016). The same applies for institutions' stratification effects across multiple axes of power beyond the socioeconomic (e.g. gender) and their interplay with individual social positioning. These gaps encourage us to shift our attention to the development of an institutional theory of health inequalities that also considers insights from intersectionality.

From its very definition intersectionality emphasizes that intersections between social categories are nothing less than reflections of intersecting systems of power (Collins, 2015). This idea of fluid and permeable boundaries between the structural context and individuals offers a crucial theoretical tool for the development of new institutional theories that do not seek to merely explain how institutions shape individual experience but rather the interaction between the two (Lowndes, 2010). To develop this argument further, we need to acknowledge that the interplay between institutions and individuals does not happen in a vacuum. Institutions are embedded within contexts where specific power dynamics are in effect and negotiated (Lowndes, 2010), they open or close options for connections (Hall & Lamont, 2009) and reforms (Immergut, 1992) and therefore shape the pathways available for social-claims (re)-rendering certain groups more powerful than others. From another view, intersectionality scholars suggest that power is exercised through institutional arrangements controlled by dominant social groups (Weber & Parra-Medina, 2003). However, at the same time they acknowledge oppressed groups' agency and capacity for resistance and social claims (Collins, 2000).

If we bridge those views in relation to health inequalities, institutions are not seen as simple facilitators of the distribution of health promoting resources anymore. Rather, they reframe health inequality in terms of power relations that explain how certain groups enjoy a health privilege at the expense of others (Weber & Parra-Medina, 2003). For example in Europe, immigrants are often excluded from access to social benefits on the basis of certain eligibility criteria (e.g. working permission) that systematically benefit non-immigrants. Moreover, it emerges that beyond looking at the stratification effects of institutions, we need also to explore the way they open possibilities for social connections and collective action and its impact on public health. This will allow us to understand the mechanisms through which privilege sustains itself and is associated with health benefits for dominant groups but also the way that oppressed groups exercise their agency through the available institutional pathways and its effects on their health.

An additional benefit of applying intersectionality to institutional approaches lies in that we are offered a theoretical framework that accounts for the heterogeneity and non-linear, simultaneous operation of institutions across time and analytical levels. Immergut (1992) suggests that institutional contexts have developed along a process through which elements that are not always inter-connected have been patched together through time. Moreover, Bambra et al. (2005) have stressed that the majority of social determinants of health are shaped by policies beyond the healthcare sector (e.g. housing or employment) and recently, Beckfield et al. (2015) have approached this issue in terms of "institutional imbrication." Institutional imbrication captures the fact that individuals are simultaneously affected by multiple policies that may work in different domains and levels, in convergence but also in divergence while their impact is always subject to the individuals' intersectional social positioning. The beneficial link between these macro-level arguments and intersectionality's emphasis on interlocking systems of inequality at the individual and contextual level emerges easily (Collins, 1991; Crenshaw, 1989). However, what is more important is that by theorising institutional imbrication in the light of intersectionality, we not only make our analysis on health inequalities more robust -by accounting for the interaction of different institutional elements with individual social positions- but we also explicitly interrogate the role that institutional imbrication has in the entrenchment of health privilege for certain social groups (e.g. how citizenship regimes and labour market regulations intersections result in consistently benefitting the health of native born populations). This synthesis leads to an understanding of the interaction of both the *macro* and the *micro* elements of the politics of health.

Finally, the interconnectedness between institutions and power is crucial for the elaboration of a situated intersectional analysis focused on categories and intersections that matter and not on an endless list of interactions. As we stressed earlier, the question *which categories should be integrated in an intersectional analysis of health inequalities in a particular context?* is answered through the context itself. Here, institutions as vectors of power struggles have a significant role. They bear crucial information (for example within institutional or policy documents) about the way health and health promoting goods are defined (e.g. citizenship right or as a market commodity), which groups have control over that definition (like doctors, patients, unemployed, capital owners, women) and how their needs are met, which groups have been excluded in that process (like mentally ill patients, prisoners), what is the impact of this exclusion on their health and what are the available pathways for reforms (for example, if immigrants suffer poorer health than the rest of the population, what are the formal and informal channels available to them to pursue an improvement of their situation?). By looking at the institutions involved in shaping the social determinants of health or healthcare access, we can trace which categories matter and how their intersection may result in particular benefits for certain groups or in the marginalisation of others (Bambra et al., 2005; Hankivsky et al., 2012). Characteristic examples are how welfare reforms in the 1990s have had a disproportionately negative impact on immigrants' and non-citizens' social rights (Sainsbury, 2006) or more recently, how austerity has had a particularly devastating effect on women's health (Greer Murphy, 2017).

Setting an Intersectionality and Institutionally Informed Health Inequalities Research Agenda

Intersectionality informed research on health inequalities has already started to attract scholars' interest and has been examined from a broad series of methodological approaches. Examples include ethnographic studies (Collins et al., 2008), comparative quantitative designs (Reczek et al, 2017; Abichahine & Veenstra, 2016) and policy analyses (Hankivsky et al., 2012; 2011; 2009). In line with the theoretical roots of intersectionality, the dimensions of race, gender and sexuality and their intersections have been considered in most cases in relation to multiply marginalised groups and their experience of health and ill-health (Doyal, 2009) and their access to and utilisation of healthcare services (Agénor et al., 2014). Still, the integration of intersectionality and institutions in health inequalities research allows for the emergence of a broader research agenda not just concerned with individuals but also with how the institutions shape individuals' positioning and experience of health. This leads to a series of urgent questions, and challenges us to stretch our limits across all the phases of the research process as described below.

Intersectionality effects everyone and it is a context informed analytical tool. This has particular implications for the emergence of research questions and the particular axes of social division that should be interrogated in relation to health. We live in times of austerity, conflict and increased forced migration. In these circumstances, old and new social struggles coincide (e.g. socioeconomic justice and anti-discrimination claims) and the role of the state is again a focus for public health researchers (Bambra, 2016). An intersectional lens allows us to formulate research questions about the situation of specific social groups and interrogate the institutional factors responsible for their increased vulnerability. Examples include questions on the health of women, trans* and LGB refugees and the particular hazards or health damaging experiences they face during their migration trajectories e.g. rape or exchange sex (Freedman, 2016). Does their socioeconomic status contribute to the avoidance of such hazards? Does the situation they left in their country of origin (e.g. war, poverty) have a long-term impact on their health? To what extent are their reproductive or sexual health needs integrated in the healthcare schemes developed in refugee camps and across different host societies? How do international asylum policies favour or harm their health? For example, the EU-Turkey agreement has been already found to have a severe negative impact on women and girls and especially for those who do not manage to prove their Syrian background (Women's Refugee Commission, 2016). In such examples we clearly see how gender, ethnicity, and immigration status intersect and how an intersectional analysis that considers individuals together with national and even transnational institutional elements is deemed necessary.

We may further study relationships of inequality between newly arrived immigrants and refugees and groups who have been historically marginalised in the hosting countries and especially Black men and women. Those communities have accumulated the effects of structural and individual discrimination across time (Krieger, 2012). Now, they are found in a position where they have to deal with an additional retrenchment of social policy, less regulated labour markets and a reemerging xenophobic atmosphere primarily targeted against immigrants but unavoidably hurting communities who may have been present in predominantly white societies for long but they are still considered as non-belonging (Goldberg, 2006). We may compare marginalised groups with those assumed to enjoy a series of privileges like native employed men. We can also make more nuanced distinctions by comparing them with native (wo)men of working age who have suffered recent downward social mobility due to the crisis and who therefore combine elements of both privilege and disadvantage in terms of the multiplicity of their social position. Further, we may question the impact of newly introduced anti-discrimination and family protection policies for lesbian, gay, bisexual and trans* people on the health of each subgroup stratified by socio-economic inequalities and within the context of welfare retrenchment and austerity. With such comparisons and with the interrogation of migration and welfare policies, labour market regulations, equal opportunity frameworks, citizenship regimes, and family regulations, not only may we unravel the range of emerging or previously ignored relationships of inequality, but also we may grasp what multiple disadvantage means for one's health in certain contexts and what kind of privileges are deemed protective.

Taking this agenda forward will also require a series of methodological considerations. The development of an intersectional methodology has been intensively debated (Bauer, 2014; Nash, 2008; McCall, 2005). Most of the times the discussion has focused on whether intersectionality is applicable beyond qualitative methods. In our view, intersectionality is an analytical tool that transforms the way we do our research either qualitative or quantitative (Collins & Bilge, 2016). Especially in relation to health inequalities research that often focuses on populations, there are certain methodological considerations deemed necessary. Bauer (2014) has given a comprehensive account which we extend with some additional points below.

How do we use social categories? McCall (2005) in her systematic categorisation of intersectional methodologies (i.e. anti-categorical, intra-categorical, inter-categorical) emphasises the importance of this question. Regardless of whether our research focuses on the margins of certain categories (i.e. intra-categorical) or on the relationships of inequality that categories produce across contexts (i.e. inter-categorical), we should interrogate their content and the conflations and exclusions they imply. This should be traced easily in our research questions and theoretical arguments but also in the operationalisation of our measures. For example, studies on ethnic health inequalities should be explicit about the content of ethnicity. Does it refer to a self-identification or to an institutional label? Does it conflate race or other categories? Are there subjects whose experience is suppressed from this operationalisation? How do we account for those experiences? Considering these questions is a step against the normalisation of the invisibility of certain individuals, communities, and populations within research.

What is our unit of analysis? This question should be first answered conceptually. With an individual focus that is often used in health inequalities research, we should be explicit about whether we are interested in individuals as members of a certain group who share a similar positioning within a power structure or treat individuals as cases with unique experiences of identity (Yuval-Davis, 2005; Collins, 2003). Using individuals as proxies for groups and the opposite is likely to be problematic especially because it may conceal the effect of power relations. For example, generalising the case of a highly educated white middle class lesbian woman as a representative of lesbians as a group may conceal the group's socioeconomic marginalisation. On the other hand, studying a group of white lesbians without allowing for socio-economic differences to emerge might conceal internal hierarchies within the group or the ways that socioeconomic advantage may compensate for experiences of social exclusion due to sexual orientation. Being concrete about our unit of analysis will serve for the correct choice of methods and data. For example, in a qualitative design, the content of interview questions should be consistent with the chosen unit of analysis and allow for dimensions of difference to emerge. Similarly, in comparative quantitative studies, the sample should be equally representative for the minority and majority groups included in a population.

Should quantitative methods be avoided? Despite the intense debate on the applicability of intersectionality to quantitative methods, we suggest that health inequalities researchers should insist on bridging the two traditions (Spierings, 2012). Comparative designs which inevitably fall into the inter-categorical approach (McCall, 2005) promise the examination of a large range of intersections and do this across different institutional contexts (Bauer, 2014). Quantitative studies can focus on the actual position of individuals as members of groups within specific power structures and examine how the political, social and institutional implications of this positioning affects health and its social determinants. It also allows the large N population wide analyses. Developing intersectionality informed quantitative designs asks for a change in perspective rather than extremely sophisticated statistical methods. The consideration of location and dispersion statistical measures, the use of dummy variables for the construction of the dimensions of categories (e.g. *migrant =1, woman=1*), interaction terms for the operationalisation of intersections (e.g. i*mmigrant X woman*), multi-group models with two way interaction terms for the analysis of the intersections between three categories, and multi-level models for the analysis of cross-level interactions are all available statistical tools that enable us to follow an intersectional direction (Spierings, 2012).

How to deal with institutions? In line with the idea of *connectedness* as a tool that enables people to deal with life challenges (Hall & Lamont, 2009), we suggest that we need to study the role of institutions in shaping social connections. Given that social connections are shaped across areas beyond the economic sphere, we need to also look upon arrangements involved beyond just social or labour market policies - which has been the main focus of analysis to date (e.g. Bambra, 2011; 2008). Policies relative to education, immigration, incarceration but also institutional frameworks relative to collective action, political representation, anti-discrimination, and information exchange should be studied in terms of their health impact. Indexes (e.g. Migrant Integration Policy Index) and aggregated quantitative data could be used for cross-national comparisons, while policy documents, grey literature and other discursive material (e.g. parliamentary speeches, online information pages) could be also used for intersectionality based policy analysis (Hankivsky, 2012; 2011) e.g. How do institutional actors frame questions of social position and health?

Conclusion as a Call for Action

In times of massive socio-economic changes and political upheaval, a synthesis of intersectional and institutional insights on health inequalities research highlights how certain groups are excluded from health-inequalities discourses and enables the simultaneous analysis of the health effects of both vertical (e.g institutional factors) and horizontal (e.g. individual/ community factors) social stratifications. It has the potential to bridge the different streams of scholarship (i.e. socioeconomic, gender, racial inequalities etc.) and brings to the fore the politics of health while it urges researchers to:

- Reframe health inequalities in the light of power relations and interrogate the processes that produce them instead of individual 'labels'.
- Consider intersections at the institutional level beyond healthcare policy and explore the way they interact with individual positions.
- Avoid conflating categories with distinct socio-historical backgrounds (e.g. race and ethnicity).
- Integrate intersectionality beyond qualitative research to population studies and policy analysis.

- Develop appropriate multifaceted indicators of dimensions of privilege and disadvantage in future data and push for representative data across majorities and minorities and across countries.
- Read existing findings on health inequality with an intersectional lens, reflect upon potential exclusions they may involve (e.g. institutional effects, social categories, marginalised social groups) and develop new research questions accordingly.
- Do research as an inclusive process that involves subjects with differential social positioning and viewpoints during all the research stages.

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