Original Article

What can health inequalities researchers learn from an intersectionality perspective? Understanding social dynamics with an inter-categorical approach?

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Abstract The concept of intersectionality was developed by social scientists seeking to analyse the multiple interacting influences of social location, identity and historical oppression. Despite broad take-up elsewhere, its application in public health remains underdeveloped. We consider how health inequalities research in the United Kingdom has predominantly taken class and later socioeconomic position as its key axis in a manner that tends to overlook other crucial dimensions. We especially focus on international research on ethnicity, gender and caste to argue that an intersectional perspective is relevant for health inequalities research because it compels researchers to move beyond (but not ignore) class and socioeconomic position in analysing the structural determinants of health. Drawing on these theoretical developments, we argue for an inter-categorical conceptualisation of social location that recognises differentiation without reifying social groupings – thus encouraging researchers to focus on social dynamics rather than social categories, recognising that experiences of advantage and disadvantage reflect the exercise of power across social institutions. Such an understanding may help address the historic tendency of health inequalities research to privilege methodological issues and consider different axes of inequality in isolation from one another, encouraging researchers to move beyond micro-level behaviours to consider the structural drivers of inequalities.
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Introduction

Health inequalities refer to systematic differences in the health of people occupying unequal positions in society (Graham, 2009). In the United Kingdom, health inequalities are often interpreted with reference to health differences between population groups occupying different socioeconomic or social class positions. In this article, we critique this interpretation of health inequalities via a conceptual examination of the relationship between health and other important aspects of social location. We challenge the assumption that socioeconomic gradients should be understood as the primary drivers of health inequalities, drawing on the concept of intersectionality to argue for a more complex understanding of identity, social position and inequality in the social determinants of health. We hope that such an understanding may help inform the development of future health inequalities research.

The paper starts by briefly introducing the UK's historical focus on health inequalities in relation to social class and – more recently – socioeconomic position. The concept of intersectionality is then offered as a means for moving beyond this often unidimensional understanding of social inequity in order to consider multiple axes of social position and their relevance for health inequalities. Our core argument is that an intersectionality perspective offers scope for novel enquiry in health inequalities research in ways that highlight both the complexity of social location and its influence on health, and the shared mechanisms of causality comprising the unequal power relations that underpin different axes of health inequity.

To elaborate the relevance of an intersectional perspective in health inequalities, we explore the importance of other social locations affecting health, but importantly insisting that these social locations need to be understood as more than the sum of their parts. Specifically, we argue for an inter-categorical account of social location that enables researchers to recognise differentiation without reifying social groupings – thus encouraging a focus on social dynamics rather than social categories, recognising that experiences of relative advantage and disadvantage also reflect the exercise of power across social institutions. We note how some health inequalities researchers, particularly those outside the United Kingdom, have paid much greater attention to these aspects of social position, and explore the theoretical contributions of this work in relation to three axes of inequity – ethnicity, gender and caste – to our understanding of the relationship between social position and health.

Finally, we touch on the potential implications of an intersectionality perspective for our understanding of health inequalities, noting how this perspective encourages researchers to recognise commonalities in the structural drivers and fundamental causes of health inequalities via an analysis of power relations.

While it is beyond the scope of this paper to set out a framework to guide empirical health inequalities research, we hope that this discussion will help stimulate further debate and development in this area.

Social Class and Socioeconomic Inequalities in Health

The United Kingdom has a long history of research focusing on the relationship between social class and health. The routine collection of data on mortality and occupation since the mid-nineteenthth century has allowed generations of researchers to examine the association between occupational class and health (Macintyre, 1997), while residential location has provided health researchers with a proxy for social class in both the United Kingdom and continental Europe (Susser *et al*, 1985).

The Black Report of 1980 provided a landmark analysis of social class differences in the health of the population in England and Wales (DHSS, 1980) and remains a seminal document in health inequalities research. A key contribution of the Report was its analysis of potential explanations for class-based differences in health, which continues to inform contemporary health inequalities research. Importantly, the Report's authors ultimately rejected explanations reliant on biological, behavioural and cultural factors, and instead focused their attention on 'class structure' and the extent to which this shapes people's access to health-promoting resources (Macintyre, 1997).

Social class – the concept of 'general standing in the community based on occupational skill' (Bartley, 2004, p. 1) – was widely familiar to the British public at the time the Black Report was published. More recently, health inequalities research in the United Kingdom has moved towards a focus on socioeconomic position as the principal marker of social inequality. This partly reflects methodological challenges associated with social class and its less widespread use in countries outside of Europe (Lynch and Kaplan, 2000; Bartley, 2004), but may also be seen as a move away from an explicit focus on the unequal distribution of power within society and links with theories of exploitation *and* social stratification, most notably informed by Marxian and Weberian theses respectively. These intellectual and research frames vary enormously, but we might summarise them by saying that Marxian accounts divide societies into distinct social classes based on people's relationship with the means of production (Lynch and Kaplan, 2000, p. 15); while Weberian accounts work also with issues of party and status, focusing less on people's relationship with the means of production and more on their ability to compete in a market economy – including the resources or 'life chances' available to groups of people sharing similar characteristics and circumstances. A contemporary account informed by

the Weberian tradition is Grusky's (2001) analysis of systems of social stratification, taking in the roles of types of assets (not just financial but also human capital), the nature and function of different classes, *relative* degrees of inequality, and social rigidity in terms of economic inflexibility and social immobility.

In contrast, 'socioeconomic position' (SEP) is typically a less politicised term which tends to focus attention on individual circumstances rather than the social structures that shape them. Krieger and colleagues define socioeconomic position as '[a]n aggregate concept that includes both resource-based and prestige-based measures' (Krieger *et al*, 1997). Social class is often regarded as one aspect of SEP, – although, Krieger *et al* (1997) argue that social class is more appropriately regarded as 'logically and materially prior to' socioeconomic position, which can be seen as the 'expression' of social class in terms of the distribution of material and prestige-based resources across society (p. 346).

Socioeconomic position is more widely used than social class – particularly outside the United Kingdom and Northern Europe – and has the advantage of being more easily assessed using individual-level indicators such as education and income (Galobardes *et al*, 2006). This reliance on individual-level attributes is also a potential limitation of SEP for its potential to mask the role of social structures in shaping social position (Lynch and Kaplan, 2000). More recently, the 'Bourdieusian turn' has tried to reconfigure the touchstones of contemporary class analysis, taking in consumption and symbolic practices (Skeggs, 2004; Savage *et al*, 2001). A popular illustration is the BBC 'Great British Class Calculator' – a survey which seeks to rethink traditional ways of categorising class for the twenty-first century by focusing on how individuals feel about, and respond to, their class location (Savage *et al*, 2013). The striking tendency in this tradition has been the omission of race and ethnicity. In a recent reading of this work, Rollock (2014) has argued that it retains a tendency to proceed 'without taking account of the intersecting role of race':

> Specifically, exposing how white identity and white racial knowledge work to inform and protect the boundaries of middle class and elite class positions (to the disadvantage of minoritised groups) remains central to advancing race equity and genuine social mobility. (Rollock, 2014, p. 449)

Despite this dominance of social class and (more recently) SEP in UK health inequalities research, some UK researchers (such as Nazroo, Karlsen and Bhopal) have focused on other aspects of health inequalities, while Graham (2007) offers an explicitly pluralistic understanding of social position in relation to health. Health inequalities researchers outside the United Kingdom have more often focused on aspects of social position other than social class / SEP. Researchers in the United States have focused largely on ethnicity or race, while those in Canada, Australia and New Zealand are also concerned with indigenous

status. Research on the role of gender in determining health inequalities is often conducted by those concerned with the status of women in society, but – as we discuss below – this has gained greater prominence in recent decades (Annandale and Hunt, 2000). The significance of sexual orientation is only now emerging as a priority (Institute of Medicine, 2011), while other aspects of social position that serve as the basis of marginalisation, such as caste and disability, remain largely uncharted in mainstream discussions on health inequalities.

Already then we can observe how a number of social locations present a challenge to the prevailing dominance of social class and SEP in analyses of health inequalities. In the next section we set out how a theoretically informed account of intersectionality can provide a framework for incorporating multiple axes. In the subsequent sections we show how research examining the relationship between health and inequalities defined by ethnicity, gender and caste has contributed to the development of an intersectional approach, making it a valid means of enquiry into health inequalities and its fundamental drivers.

Intersectionality and Health Inequalities

'Intersectionality' describes a cluster of theoretical positions which seek to revise the view that our social relations are experienced as 'separate roads' (Roth, 2004). While this necessarily takes in more than ethnicity or gender, the provenance of the concept may be traced to a particular black feminist critique of the ways in which mainstream (white) feminism had historically ignored the intersections of race and patriarchy (Crenshaw, 1988, 1991). In one reading, intersectionality has compelled feminist researchers to explore how their 'moral positions as survivors of one expression of systemic violence become eroded in the absence of accepting responsibility of other expressions of systemic violence' (Collins, 2000, p. 247).

For those interested in the social determinants of health, it appears self-evident that an intersectional approach should yield fruitful insight. Indeed, recent years have seen an increasingly enthusiastic engagement with this concept in the study of health inequalities (for example, Hinze *et al*, 2012; Seng *et al*, 2012) and population health more broadly (Bauer, 2014). Yet as Dhamoon and Hankivsky (2011, p. 17) describe, 'health researchers, practitioners, and advocates have paid little attention to the breadth of theoretical developments and current debates and discussions in the field.' What is specially overlooked, they maintain, are the ways in which, 'intersectionality as a research paradigm has a longer and more substantive history in the theoretical literature'. Some researchers, and especially Hankivsky, have tried to correct this but it is worth registering their underlying observation: namely, that there is a risk that intersectionality in

health inequalities remains operable at surface level, perhaps as a semantic device in policy discussion, but without a substantive reconfiguration at the analytical level. Another way of characterising this problematic is to follow Yuval-Davis's (2006, p. 195) concern over a 'conflation or separation of the different analytic levels in which intersectionality is located, rather than just a debate on the relationship of the divisions themselves'. It is to these delineations that we now turn.

In one delineation of intersectionality, Hancock (2007, p. 64, p. 67) distinguishes this from other 'unitary' and 'multiple' forms of social categories. In the first approach, 'only one category is examined, and it is presumed to be primary and stable'. In contrast, in the 'multiple' approach 'the categories are presumed to be stable and to have stable relationships with each other' (Walby *et al*, 2012, p. 228). In the 'intersectional' approach, meanwhile, 'more than one category is addressed; the categories matter equally; the relationship between the categories is open; the categories are fluid not stable; and mutually constitute each other' (ibid.). To some extent then, this last usage returns to the origins of intersectionality in the argument that 'systems of race, social class, gender, sexuality, ethnicity, nation and age form mutually constructing features of social organization' (Collins, 2000, p. 299). To avoid the additive tendency, however, we need to remind ourselves that different identity categories have a different ontological basis (Yuval-Davis, 2006). For example, in Werbner's (2013, p. 410) reading, 'identities of gender and race imply an essentialising definitional move on the part of wider, dominant society that subordinates and excludes'. In contrast, ethnicity is deemed to be 'an expression of multiple identities' which are 'positive, creative and dialogical'.

Another cluster of theoretical readings of intersectionality seeks to distinguish between three related strands. McCall (2005, pp. 1773–1774) describes the first as 'intra-categorical' because it centres 'on particular social groups at neglected points of intersection … in order to reveal the complexity of lived experience within such groups'. The objective here is to make *visible* group dynamics that were previously made invisible in thinking of a group category as homogeneous. The second strand, 'anti-categorical', is 'based on a methodology that deconstructs analytical categories' (ibid.). This critiques the idea of unchanging internal coherence within groups, in a manner that seeks to challenge notions of identity as fixed. McCall's final, 'inter-categorical' reading of intersectionality 'provisionally adopt[s] existing analytical categories to document relationships of inequality among social groups and changing configurations of inequality among multiple and conflicting dimensions' (ibid.). This last formulation is her preferred means of reconciling identity and social structures, and – for Choo and Ferree (2010, p. 134) – allows McCall to stress

> dynamic forces more than categories – racialisation rather than races, economic exploitation rather than classes, gendering and gender performance rather than genders – and recognize the distinctiveness of how power operates across particular institutional fields. Because of its interest in mutually transformative processes, this approach emphasizes change over time as well as between sites and institutions.

The *inter*-categorical approach is thus a means of accepting categories almost 'under erasure', in a manner that can harnesses their utility in knowledge of their limitations. This echoes Young's (2000, p. 89) view that such an approach allows us to 'retain a description of social group differentiation, but without fixing or reifying groups'. In subsequent sections, we also explore the extent to which explorations of the links between ethnicity, gender, caste and health incorporate and *inter*-categorical account of intersectionality.

While intersectionality offers a useful framework for understanding the multiple layers of advantage and disadvantage relevant for health inequalities, the prevailing literatures have overlooked its potential in this respect. One means of addressing this is to walk through three areas of health inequities that make the *intra*-categorical visible. The first centres on ethnicity, the second on gender and the third on caste. By focusing on the constituting parts of an intersectional approach to health inequalities research, we hope to show that taken together such enquiry also contributes more than the sum of its parts.

Ethnic inequalities in health

Ethnicity is a form of collective social identity that typically includes elements of language, culture, shared history and common ancestry (Williams, 1997; Karlsen and Nazroo, 2007). Socially constructed by both internal and external group membership, ethnic identity involves a complex and dynamic negotiation between those included in a particular ethnic grouping and the society in which that grouping has social significance. This identity is not static: on a broad level, the boundaries and terminology used to define ethnicity change with time and place; and on an individual level, the same person may identify with different ethnic identities in different social contexts and at different points in their life course. It is therefore, a looser definition than 'race' and the key distinction with other ways of conceiving groups is that ethnic identity makes self-definition central.

In many countries, disparities in the health status of different ethnic groups are comparable in magnitude to socioeconomic health inequalities. For example, the gap in life expectancy between Indigenous and non-Indigenous populations is 7 years in New Zealand (SNZ, 2013) and 10–12 years in Australia (AIHW, 2011), while in the United States, African Americans have a life expectancy 5 years

lower than that of White Americans (Arias *et al*, 2010). Diverse explanations are presented or assumed to account for such differences. As with socioeconomic inequalities, these tend to fall along a spectrum from an individual to a structural focus. The persistence of biological (including genetic) explanations for ethnic differences in health emphasises the extent to which these explanations are theoretically driven, or how '[obsolete] ideas can endure and be made to seem real if they have social and political-economic utility' (Goodman, 2013, p. 50).

Many researchers have focused on the common correlation of minority ethnic status and lower socioeconomic position (Davey Smith *et al*, 2000). Some regard socioeconomic differences as the primary explanation for ethnic inequalities in health, with race even being used as a proxy for socioeconomic status in the United States (Davey Smith *et al*, 2000; Kawachi *et al*, 2005). While an association between socioeconomic status and ethnicity is clearly a contributing factor, it is simplistic to assume that differences in socioeconomic position 'explain' ethnic health inequalities. Such a framing cannot account for why ethnic minority groups are more likely to be disadvantaged in terms of occupation and income, nor explain the significant ethnic disparities that persist among those with comparable income, education or occupational status (Nazroo, 2003).

Racism is increasingly recognised as an important – perhaps fundamental – cause of ethnic inequalities in health (Williams, 1997; Davey Smith *et al*, 2000; Gravlee, 2009). Members of ethnic minority groups are more likely to experience racially motivated discrimination, with the experience of such discrimination linked to poorer health (Williams and Mohammed, 2009). Alongside this personally mediated racism, 'institutional racism' connotes ways in which social structures and institutions systematically privilege some ethnic groups while disadvantaging others (Jones, 2000). Ethnic inequality in this respect is normalised through conventions that are not codified in a statute but nonetheless sanctioned in prevailing practices. This includes the tendency for ethnic minorities to gain less benefit from mainstream education, labour market and health systems, impacting profoundly on their access to the social determinants of health.

Importantly, this work suggests a complex interplay between ethnic identity, experiences of racial discrimination, and other aspects of social location with significant implications for health. Within a given socioeconomic stratum, minority ethnic status is often associated with additional health disadvantage (Nazroo, 2003; Williams and Mohammed, 2009); but it's also worth noting that the socioeconomic profile of a particular ethnic minority group may itself impact the extent to which membership in that group is associated with racial discrimination and additional health disadvantage (Ren *et al*, 1998). Research from the United States suggests that, for members of the same ethnic minority group, the relationship between discrimination and poor health is stronger for those born in or living longer in the United States (Viruell-Fuentes *et al*, 2012)

and may also be more pronounced for those of higher socioeconomic status (Hudson *et al*, 2013). These complex patterns points to intersecting relationships between ethnicity and other aspects of social location.

Gender inequalities and health

Ostlin *et al* (2001) describe gender health inequalities as reflecting the unequal position of men and women in society, thus encompassing two (linked) conceptions: (i) that men and women occupy different social, economic, and political positions within society; and (ii) that these disparities in social position give rise to health differences which are socially based, avoidable, and (therefore) unjust. In other words, despite the obvious similarities in the lives of women and men from the same social group, marked differences can be found in their health and well-being. These are shown to result from differences in living and working conditions and in access to a wide range of resources and privileges (Doyal, 1999).

Much of the earlier work on gender inequalities in health dates back to the early 1970s and sought to challenge the effects of patriarchy on women's lives and well-being and explain differences in patterns of male and female morbidity and mortality (Annandale and Hunt, 2000). This work gained prominence under the twin influences of liberal feminism (emphasising the occupancy of social roles) and radical feminism (emphasising gender and patriarchy over other structures in the production of inequality) (ibid.). These advanced analyses on differential experiences of women and men in the spheres of paid and domestic work and consequent access to health enhancing resources; in the process defining the relationship between gender, women's triple roles as defined by patriarchal structures (described by Caroline Moser as productive, reproductive and community), and their physical and mental health. Feminists highlighted the 'invisibility' of women in the sociology of work and employment, diminished attention to women's occupational health despite their increasing participation in the labour market, and the *male bias* in health research (Doyal, 1994; Crompton, 1997). Links between gender and socioeconomic position were examined; and differences in income were shown to have a greater impact on the health of women compared with men (Denton and Walters, 1999). The health impacts of gender differentiation in labour markets has ongoing significance in the contemporary context of economic globalisation. Studies contend that women tend to be employed and segregated in lower paid, less secure and informal work with precarious employment conditions and minimal regulation and social protection (Avirgan *et al*, 2005; Sen *et al,* 2007; Loewenson *et al,* 2010).

The relational perspective (Kabeer, 1994) on gender suggested the inadequacy of 'social and occupational roles' in explaining gender inequalities. Gender came to be viewed as a complex 'system' whereby gender differences are created,

maintained, and reproduced by core institutions (such as the family, market, religion and state), and social relations organised on the basis of that difference (Ridgeway, 1997; Ferree *et al,* 1999). This system governed how power is embedded in social hierarchy, and shaped the roles, status, material resources, rights and responsibilities that people access and claim. These power relations constitute the root causes of gender inequality, determining who falls ill (differential exposure and vulnerability to ill health), whose health needs are acknowledged (beliefs, norms and system-wide biases), who gets treated (access) and with what costs and consequences (Sen *et al*, 2002).

Contemporary scholarship on gender inequalities in health challenges the 'orthodoxy' set in the sociological research of the seventies and eighties on gender differences (Annandale and Hunt, 2000), making a strong case for an intersectionality perspective. Alluding to the transformations of gender relations in globalised societies, several authors highlight the conceptual and methodological limitations in these understandings (Walby, 1997). First, social roles within (and outside) the household were changing as a result of women's increased participation in the workforce, access to education and the changing nature of the labour market; Second, there was growing recognition of the links between masculinity, gender, and the relative neglect of men's health (Schofield *et al,* 2000; Doyal, 2001). This replaced the simplistic view of maleness as health promoting with improved understanding of the complex and systemic operations of gender, and revealed how the heterosexual male identity and hegemonic constructions of masculinity (Cornwall, 2000) shape risk-taking and health-seeking behaviour among men that is detrimental to their health. For example, in many societies men are more likely than women to smoke or drink in excess, engage in high risk sports and practice unsafe sex – putting them at higher risk of accidents and increasing their biological predisposition to chronic diseases and sexually transmitted infections (Mac an Ghaill and Canaan, 1996). The third and most significant shift was the attempt to overcome gender binaries to develop a nuanced understanding of the operation of power at the intersections of multiple structural positions alongside confronting male hegemonic power and its implications for health equity (Tolhurst *et al*, 2012). In grounding this analysis in social and political determinants such as colonial history, migration and developmental violence and constructions of socio-cultural identities, it offered a 'transversal politics' (ibid.) crystallising the shift towards anti- and inter-categorical understandings of gendered intersections, advancing the analytical frame of intersectionality.

Critiquing epidemiological studies describing the 'feminization' of HIV epidemic among young South Africans, Doyal (2009) highlights the ontological status of reified categories (of 'male' and 'female') that research participants are often assigned. Conflating sex and gender prevents us from unpacking the inter-related domains of biological and social causality and from making sense of the

different influences that shape such trends (for example, the material and cultural worlds young South Africans inhabit offer useful insights into the gendered nature of the pandemic) (ibid.). To overcome this challenge, Doyal adopted an intersectionality framework to explore lived realities and subjectivities of a group of HIV positive, black women and men who immigrated to London from Africa, thus exploring the constitutive relationships between being a migrant, black, heterosexual man/woman/gay and the identity of being HIV positive. The study highlights the distinctive experiences of stigma and discrimination associated with HIV among women (linked to the moral and social dimensions of motherhood), heterosexual men (linked to access to work, money and power), and gay men (linked to sexual deviance).

Gendered research has sought to acknowledge multiple dimensions of social position to explore how gender power relations are intersected by other axes of social position and systems of oppression. More recent work deploying an intersections framework has generated new understandings of health-on patient-clinician interactions and the nature of care provision by integrating analyses of gender, class and race with location and religious orientation (Reimer-Kirkham and Sharma, 2011; Veenstra, 2011). Notwithstanding these advancements, mainstream public health research continues to be dominated by biomedical perspectives and, as Shiffman and del Valle (2006) note, research on inequalities in maternal mortality tends to focus on clinical factors associated with pregnancy and childbirth (that is, the 'biological') while ignoring social and political factors at the individual or societal (social norms and institutions) level.

Caste-Based Oppression and Inequalities

Caste is a longstanding and important determinant of socioeconomic inequalities affecting health and well-being in South Asia (Baru *et al*, 2010), most notably India, which is home to over 160 million Dalits,[1] constituting 16 per cent of the country's population. Caste-based discrimination and oppression, however, is pervasive in the South Asian subcontinent as well as the South Asian diaspora in East Africa, Europe and North America (Bob, 2007). Yet, caste remains marginal to most accounts of health inequalities and discussions on intersectionality.

In his seminal text, *Annihilation of Caste*, Ambedkar (1990) refers to caste as a hierarchical system of graded inequality, symbolically reproduced through discourses of purity/pollution in relation to *Dalits*. It is simultaneously a system that structures *production relations* through the division of labour and labourers, thus enabling control over material resources and knowledge to maintain exploitation, as well as a system of controlling *reproduction* through the structuring of sexual relations. The latter is enabled through prohibition of

intermarriage or endogamy, a defining characteristic of this system of social organisation.

The lowest position in the caste hierarchy around which the traditional Hindu society is structured is occupied by Dalits, a group that is socially segregated and economically disadvantaged by the lower status accorded to them. Occupationally, most are landless agricultural labourers or engaged in what were regarded as ritually polluting occupations (Subramanian *et al,* 2008). However, more recent work emphasises the heterogeneity of this social group, with additional occupationally based hierarchies of sub-castes, geographic and regional variations, and considerable ethnic and linguistic differences (Bob, 2007). While dalit are predominantly Hindu and rural, many have circumvented the rigidities of caste-based oppression through conversion to Christianity and Buddhism; and migrated to cities in search of economic opportunities (Mendelsohn and Vicziany, 1998).

In his analysis of how the caste system is maintained, Ambedkar argues that practices such as child marriage, enforced widowhood and *sati*[2] are prescribed by *brahminism* in order to regulate against transgression of boundaries. In purporting so, he brings to fore the interdependency of caste, class and gender (whereby controlling women's sexuality becomes quintessential to maintaining the caste system) and how these construct each other to shape social relations of power. These intersections are further exposed by Sharmila Rege's account of the contestations to the hegemonic control of the upper castes, whereby any attempts to seek higher status in the caste hierarchy implied 'stricter *brahminical* regulatory codes for women of caste' (2013, p. 29). Here violations of rites and ritual purity became subordinate to questions of purity and chastity of women (for example, violation of endogamy), resulting in strict codes of seclusion followed by womenfolk (ibid., p. 26). Chakravarti (1993) contends that, in the Indian context, an understanding of the patriarchal gender system is incomplete without an understanding of class and caste. While class and caste cannot be collapsed into one category, class relationships are intrinsically tied with caste.

Earlier work examining caste inequalities focused on historic struggles to secure or protect livelihood entitlements such as land or work and freedoms from oppression and atrocities. Health inequities resulting from caste oppression is a more recent area of investigation; although, the earliest documented examples of such investigation date back to the mid-nineteenth century and underlined the birthing experiences and deplorable conditions for lower caste women (Chakravarti, 1998). More recent research on caste and health focuses on denial of access to wider social determinants and the relationship between social exclusion, utilisation of health care, and poor health outcomes (Nayar, 2007). Barooah (2010) attributes caste-based differences in health outcomes (for example, average age at death) to

the social structures that impair their capabilities to function effectively in society and predicate poor health, lack of treatment and care, and premature death. Gupta and Dasgupta (2007) also reveal systemic weaknesses of the health systems that perpetuate socioeconomic disparities in health; with a majority of those who are socially marginalised having the least access to preventive and curative health services.

The international significance of locating caste-based inequalities in discussions of health inequalities is highlighted by the findings of the recent UK report on caste prejudice among the South Asian diaspora in the United Kingdom (Metcalf and Rolfe, 2010). The report evidenced caste-ism at workplace, schools, and in relation to provision of services including health and social care. For example, harassment and discrimination were reported as limiting access to day centres and denying access to care across a range of specialities including social care, physiotherapy and diagnostics. The report also points to the interlinkages and overlaps between caste, religion and kinship groups that play out in the performance of caste-ism in the United Kingdom.

Scholarly work on gender and caste intersections in India gained momentum with the rise and assertion of *dalit* women's autonomous organisations in response to their exclusion from the two important social movements of the 1970s – the dalit movement (with its patriarchal rendering) and the women's movement (with its *brahminical*, middle class bias) (Guru, 1995; Rege, 1998). Women's issues and the caste question have had a complex and tenuous relationship; Citing Patnakar, Rege (1998) highlights the overlapping and specific ways in which *Brahmin* patriarchy exploits women of different castes. Establishing the imperative for feminist politics to historically locate 'difference' in struggles of marginalised women, Sharmila Rege (ibid.) argued such assertion of dalit women's voices as suggestive of a new *dalit* feminist standpoint. This coincided with an upsurge of interest in the realities of *dalit women;* several studies revealed that in addition to their gender disadvantage, *dalit* women are disenfranchised by their caste and poverty, the latter concomitant of their caste and gender. Literature reports disproportionately higher rates of illiteracy and undernutrition than national averages; poor access to resources such as water, fuel and sanitation, severe threats of violence and humiliation from both men and women of higher castes, and relatively poor access to health services with higher rates of untreated morbidities compared with men and women from other castes (Nayar, 2007; Acharya, 2010; Irudayam *et al,* 2011).

More recent studies acknowledge transitions in the caste system brought about by changes in state formation, economic and social relations in the post-colonial period, greater assertion of caste identity in politics post-1980, and a series of legislative and constitutional changes to strengthen protection for dalit communities. With greater fluidity of the categories, declining public legitimacy of caste,

and shifts in caste status 'from being a marker of vertical relative rank to representing horizontal cultural distinctiveness' (Beteille, 1996) mean the contemporary practice of caste-based segregation is less uniform and rigid (Bob, 2007). These developments, along with patterns of international migration, necessitate a more nuanced approach to analysing caste-based inequalities at multiple levels, addressing the institutional, experiential and inter-subjective dimensions in a changing context. Mangubhai's (2014) examination of the interrelated ways in which caste, class and gender shape the experience of different women and men and their construction of privilege (and struggle for access to resources) adds useful insights to this body of work. Her analysis takes into account the history of these processes and the politics of recognition, with two distinctive dimensions: equalisation of rights (that is, redistribution of resources) and recognition of difference (assertion of a distinct identity). Such engagement with caste identity and the oppression of caste system offers useful insights into operationalising an intersectionality framework for an improved understanding of multiple axes of domination (in this case manifested in terms of deprivation of livelihoods and health related resources) and their material consequences.

Conclusion

The concept of intersectionality has emerged as a way of understanding multiple intersecting aspects of social location. In this article, we have examined the theoretical explanations of health inequalities relating to the standard categories of ethnicity and gender as well as caste, hitherto peripheral to discussions of intersectionality, and highlighted the complexity of such groupings and the extent to which an appreciation of both their heterogeneity and inter-categorical complexity is necessary to fully understand the multiple axes of power inequity that underpin such health inequalities. In doing so, we have also traced the theoretical developments (genealogy) within these systems that contribute to our understanding of, and warrant the use of, an intersectionality perspective in health research. Recognising this multiplicity is essential in moving beyond a crude categorisation that treats any one social group as homogeneous. A *dalit* immigrant woman living with her daughter in Tower Hamlets may have a very different life experience, and access to health-related resources, to a second generation Punjabi lawyer living with her partner in Notting Hill – yet surveys (and health researchers) often place these individuals in the same category, making it difficult to explore how different aspects of social location affect these women's lives. As Barbeau *et al* note (2004, p. 273) 'none of these social constructs is a stand-in for any other, and all are necessary for generating adequate depictions of social inequalities in health'.

There are two key considerations in embracing intersectionality for examining the complex relationship between social identity, social position and health. First, social identity is multifaceted, with each person simultaneously occupying multiple identities relevant to their relationship with others and their position within society. These social identities are not fixed but vary historically and by context, as the fluidity in caste and gender binaries have illustrated. Hence, depending on the context, further stratification of the 'category' for livelihood, age, place, religious and sexual orientation, and migration status may be necessary within the larger sociopolitical and economic context of globalisation. Second, just as categories are fluid, it is important not to assume *a priori* that extreme ends of disadvantage and advantages are static or given. As described in the case of caste, certain privileges accorded in the form of constitutional rights may enable the negotiation of an entitlement but exacerbate disadvantages in other spheres. A nascent but emerging body of research is adopting nuanced analyses of intersections to deconstruct the notions of the marginalised 'other' and bring to fore the lived experiences of those who 'occupy multiple locations to advance their own freedoms' through the life course (see Iyer *et al*, 2008; Khanlou and Hankivsky, 2011).

As its application to health research is gaining strength (as evidenced by the two edited volumes that advance the conceptual and methodological debates on intersectionality, particularly in the areas of violence, HIV, utilisation and provision of care), we argue that an intersectionality perspective offers particular benefits for health inequalities research in the United Kingdom. First, it offers a lens via which we can move beyond a unidimensional focus on social class or socioeconomic position to recognise the multiple systems of privilege and oppression with relevance for health. This analytic framework combines a focus on understanding (i) health disparities for populations from multiple historically marginalised groups (that is, the micro); and (ii) how systems of privilege and oppression (such as racism, hetero-/sexism, classism) intersect at the macro social-structural level to reinforce and maintain health inequalities. In doing so, it is well-aligned with the equity and social justice goals of public health within which contemporary work on inequalities must be located. Second, its focus on the social-structural factors allows an in-depth examination of how social systems and resources maintain or even reproduce inequalities. Such understandings may usefully inform the development of structural level interventions (directing attention away from reductionist explanations of health and health behaviour focused on individual factors) that are more likely to address the fundamental causes of health inequalities. Third, it enables us to move beyond the differences in distribution of resources and entitlements to unpack the processes and structures through which those entitlements are negotiated or social inequalities that underlie health inequalities reinforced.

Researchers therefore need to move beyond merely describing health inequalities to examining the social processes and structures that reinforce inequalities in power, 'so that bringing the agency of the disadvantaged into focus does not leave the actions of the powerful out of sight' (Walby, 2012, p. 228). In doing so it is important not to focus only on the experience of the less powerful, but to also examine the basis of privilege and power within society.

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Notes

1 Dalit is a term in Marathi, a language spoken in Western India, to denote the 'untouchables' or the most oppressed in the caste system. The term was popularised by the Dalit leader and the author of the Indian constitution, Dr B R Ambedkar, and is used both in Indian politics as well as by those seeking to bring issues of caste oppression to the international context.

2 *Sati* refers to a traditional ritual practiced in some South Asian communities in which a widowed woman lights herself on the husband's funeral pyre, as a mark of devotion and chastity to her husband.

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