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Original Research

Intersectionality and public understandings of health inequity in England: learning from the views and experiences of young adults

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A B S T R A C T

Objectives: Attempts to reduce health inequities in England frequently prioritise some equity dimensions over others. Intersectionality highlights how different dimensions of inequity interconnect and are underpinned by historic and institutionalised power imbalances. We aimed to explore whether intersectionality could help us shed light on young adults' understanding of health inequities.
Study design: The study incorporatedqualitative thematic analysis of primary data.
Methods: Online focus groups with young adults (n = 25) aged 18–30 living in three English regions (Greater London; South Yorkshire/Midlands; North-East England) between July 2020 and March 2021. Online semistructured interviews (n = 2) and text-based communication was conducted for participants unable to attend online groups.
Results: Young adults described experiencing discrimination, privilege, and power imbalances driving health inequity and suggested ways to address this. Forms of inequity included cumulative, within group, interacting, and the experience of privilege alongside marginalisation. Young adults described discrimination occurring in settings relevant to social determinants of health and said it adversely affected health and well-being.
Conclusion: Intersectionality, with its focus on discrimination and identity, can help public health stakeholders engage with young adults on health equity. An upstream approach to improving health equity should consider multiple and intersecting forms of discrimination along with their cultural and institutional drivers.
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Introduction

Intersectionality is a concept used to understand inequity. Inequity refers to unjust inequalities. Inequities occur across many dimensions: for example, sex and gender identity, age, race, ethnicity, socioeconomic status (SES), place, sexuality, and disability. Intersectionality highlights how people experience multiple dimensions of inequity, how these dimensions interconnect, and how inequity is driven by historic and institutionalised power imbalances and discrimination.[1–5] The concept's origins are commonly attributed to Kimberlé Crenshaw: notably, her work on employment rights for African American women in the USA.[1,2]

Intersectionality has attracted growing interest amongst health equity advocates in England and other UK nations.[6–16] The COVID-19 pandemic may have encouraged recent interest in the ways different forms of inequity intersect to affect health outcomes.[17] Furthermore, social movements and civil rights activities have refreshed debates relating to different marginalised groups: for example, Black Lives Matter,[16,18,19] #metoo,[20] and widely publicised debates around gender identity.[21,22] These developments are part of a longer discourse, they are not uniquely English, and they are

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not primarily focused on health equity. Nonetheless, they place a renewed focus on issues such as racism, misogyny, gender identity, and class discrimination. They have prompted questioning of where public health policy, practice, and research in England is positioned in relation to these movements and debates and whether public health has itself been guilty of marginalising the interests of some social groups.[16,17,19]

Within English public health, a particular set of narratives around health inequity have dominated research, policy, and practice for decades. A comparison of landmark reports on health inequity commissioned by English and UK governments from 1980 to 2010 (the 1980 Black Report,[23] 1998 Acheson Enquiry,[24] and 2010 Marmot Review[25]) found "great similarities and very few differences" with respect to their policy recommendations and theoretical underpinnings.[26] These dominant discourses partly revolve around two models of health often framed as oppositional: one model emphasises socioeconomic determinants of health, and the other emphasises choices individuals make in relation to health behaviours such as diet, physical activity, tobacco, and alcohol.

These landmark reports and the more recent update to the Marmot Review,[27] emphasise social determinants approaches: often in relation to policy domains that would be familiar to nineteenth century reformers such as SES, unhealthy places, living and working conditions, and poverty, especially child poverty.[26–31] Doubtless, all these historic priorities are justifiable, but they leave other dimensions of inequity less represented.

A reconsideration of public health priorities would be timely and indeed has begun to occur. For example, compared to previous Marmot reviews, *Build Back Fairer: The COVID-19 Marmot Review* (2020) included more focus on equity issue related to ethnicity and LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer, and others).[17] With its foregrounding of multiple equity dimensions, the concept of intersectionality could potentially help us explore a wider set of intersecting public health priorities. The application of intersectionality theory to public health in the UK public health literature is under-developed, but some attempts have been made. There are examples of UK-based studies applying intersectionality to specific, marginalised groups.[8,9,11–15,22] Some studies explored practitioner views,[28,29] but public views and experiences of intersectionality in the UK have been less studied.

In this study, we have focused on young adults' views and experiences. We aimed to assess whether the concept of intersectionality can help us (i) discuss health (in)equity with young adults and (ii) identify dimensions and mechanisms of health (in) equity arising from young adults' accounts.

Methods

Study location and study design

Four groups of young adults (n = 25) aged 18–30 living in three English regions (Greater London, South Yorkshire/Midlands, and North-East England) took part in synchronous (n = 6) and asynchronous (n = 1) online focus group discussions (FGDs) between July 2020 and March 2021 (Table 1). We also conducted semi-structured interviews (n = 2) with two participants who could not make the FGDs.[1] COVID-19 restrictions led us to conduct online, instead of face-to-face, groups.[30,31]

Sampling and recruitment

Each group consisted of four to eight participants to achieve a balance between depth of discussion and group member familiarity. To explore potential differences in perceptions across groups and given the focus on intersectionality, we aimed for sampling variation in terms of age, gender identity, ethnicity, sexual orientation, class, education, and SES (Tables 1 and 2):

Participants were recruited via community organisations that were supporting young adults in various ways (e.g., support groups and activities for trans young adults; training, education, and skill development to help disadvantaged young adults securing employment). In each location, organisational representatives sent written information to potential participants, who had around 1–2 weeks to consider participating. FGD moderators arranged a preliminary call with potential participants to provide further information on the study, go through ethics, and answer questions. Interested participants sent written consent by email. London School of Hygiene & Tropical Medicine's Ethics Committee approved the study (Ref. 17783).

Procedures

For each FGD, we identified a gatekeeper—a young person who provided input on topic guides, language/terminology, recruitment, and FGD format. They were also present during the FGDs to assist us in creating a safe atmosphere for people to contribute (and in Group 2, cofacilitated the discussions). Each FGD lasted approximately 90 min and was digitally recorded. Chat sent during the discussions were also extracted. This research employed an adaptive qualitative research design whereby moderators and facilitators developed FGD topic guides, tailored in parts for each group,

Table 1
Sampling strategy.

Group	Study location	Description	Methods	Number of young adults, age, number of meetings	Platform used
1	Greater London	Minority ethnic backgrounds, men and women linked to a community group for young adults.	Synchronous online FGDs and SSIs	N = 7 participants Age: 18–24 (N = 4) Age: 25–30: (N = 3) Group met twice.	Zoom
2	Greater London	Ethnically diverse group of adults linked to a group for trans and gender-questioning young adults.	Synchronous online FGDs	N = 6 participants. Age: 18–24 (N = 6) Group met twice.	Zoom
3	South Yorkshire and the Midlands	Women from ethnic minority backgrounds.	Synchronous online FGDs	N = 8 participants. Age: 18–24 (N = 3) Age: 25–30: (N = 5) Group met twice.	Blackboard Collaborate
4	Northeast	Working-class White men.	Asynchronous online FGDs	N = 4 text/chat-based discussion. Age: 18–24 (N = 4)	WhatsApp

Note: FGD = focus group discussion; SSI = semistructured interview.

Table 2
Participant demographics.

Participant code	Gender identity*	Age	Ethnic identity	Migrant status	Occupation	Highest level of education	Religious affiliation	Long-term physical or mental illness or impairment
London Group 1								
P1	Cis female	19	Black African British	Born in the UK	Unemployed (waiting to start an apprenticeship)	Sport (Level 2–3)	Muslim	No
P2	Cis male	25	Asian British (Chinese)	Born in the UK	Unemployed (looking for work)	A Level	None	No
P3	Cis male	18	Black African British	Born in Nigeria (came to UK 15 years ago)	Studying (going to Year 13 in Sept 2020)	A Level (Year 12)	Christian	No
P4	Cis female	27	Any other White background (Romanian)	Born in Romania (came to UK 4 years ago)	Employed (refugees' project)	Master	Christian	No
P5	Cis female	30	Asian British (Indian)	Born in the UK	Unemployed/training (looking for work)	Bachelor	None	No
P6	Cis female	19	Arab	Born in Syria (came to UK 4 years ago)	Studying (College, level 2)	College (level 1)	Muslim	No
P7	Cis male	21	Any other Asian background (Sri Lankan)	Born in Sri Lanka (came to UK 6 years ago)	Unemployed (looking for work)	A Level	Hindu	No
London Group 2								
P8	Trans male	22	Mixed (White and Arab)	Born in the UK	Studying (Undergraduate course)	A Level	Muslim	No
P9	Trans female	18	Any other White background (American)	Born in the USA, international student	Studying (Undergraduate course)	High school	None	No
P10	Trans male	24	White British	Born in the UK	Not working (not looking for a job due to disability)	Diploma/College (did a year in University but dropped out)	None	Yes
P11	Trans female	18	Any other White background: British and German	Born in the UK	Unemployed (gap-year; will take an Undergraduate course in 2021)	A Level	None	Yes
P12	Trans male	19	Mixed (Indian and European)	Born in the UK	Studying (Undergraduate course)	A Level	None	Yes
P13	Trans female	24	White British	Born in the UK	Not working (not looking for a job due to disability)	A Level	None	Yes
South Yorkshire & Midlands Group 3								
P14	Cis female	24	White and Black African	Born in Mozambique. Came in the UK 5 years ago	Employed	Level 3	Christian	No
P15	Cis female	18	Black British	Born in the UK	Full time education	A Levels	None	Yes
P16	Cis female	31	Asian British (Pakistani)	Country of birth unclear (came to the UK 27 years ago).	Employed	Degree	Muslim	No
P17	Cis female	19	Asian British (Pakistani)	Born in Pakistan (came to the UK 16 years ago)	Unemployed	A Levels	Muslim	No
P18	Cis female	28	Black African	Born in Zimbabwe (came to the UK 14 years ago).	Employed	PG Diploma	Christian	No
P19	Cis female	24	Black African	Born in Nigeria (came to the UK 17 years ago).	Employed	Degree	Christian	No
P20	Cis female	29	Mixed (Indian and European)	Born in UK	Employed	NVQ 3 in Business and Admin	None	No
P21	Cis female	26	Black African	Born in Holland EU (came to the UK 15 years ago)	Employed	Degree	Muslim	Yes

(*continued on next page*)

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Table 2 (*continued*)

Participant code	Gender identity*	Age	Ethnic identity	Migrant status	Occupation	Highest level of education	Religious affiliation	Long-term physical or mental illness or impairment
Northeast Group 4								
P22	Cis male	23	White English	Born in the UK	Bricklayer	GCSE and NVQ level 2	None	No
P23	Cis male	23	White English	Born in the UK	British Army	GCSE	None	No
P24	Cis male	23	White English	Born in the UK	Groundworker	GCSE and NVQ level 2	None	No
P25	Cis male	22	White English	Born in the UK	Factory worker	NVQ level 3	None	No

*Gender identity refers to a person's innate, deeply felt internal and individual experience of gender, which may or may not correspond to the person's physiology or designated sex at birth (https://www.who.int/publications/i/item/WHO-FWC-GER-16.2). Cisgender (e.g. cis male, cis female) denotes a person whose gender identity corresponds with the sex registered for them at birth.
Abbreviations: PG: postgraduate; GCSE: General Certificate of Secondary Education; NVQ: National Vocational Qualification.

and (for the three FGDs that met a second time) building on experiences learned from previous sessions.[32]

Due to the different working patterns and personal circumstances, Group 4 preferred to take part in an asynchronous online FGD on WhatsApp, which enabled them to contribute at a preferred time, location, and pace.[31] The FGD lasted approximately 1 week with questions being posted daily by the moderator. The chat transcript was extracted and anonymised.

We encouraged participants to discuss social determinants of health, referring to intersectionality, COVID-19, and Black Lives Matter. FGD1 explored participants' experiences and understanding of (i) health inequity, disadvantage, and privilege, and (ii) between different dimensions of health inequity. FGD2 built on accounts from FGD1 to encourage discussion of (i) personal experiences and (ii) priorities for action on health inequity.

All participants received a shopping voucher as a ‘thank you’ (£25), which also included IT expenses.

Data analysis

The data presented in this paper include anonymised transcripts from synchronous online FGDs ($n = 6$) (and related chat extracts, $n = 6$) and the chat from the asynchronous FGD ($n = 1$). Transcripts and chats were coded in the NVivo 12 software, using a thematic framework analysis,[33,34] which focused on identifying experiences and meanings that young adults had of health inequity. After multiple readings of transcripts, KG created a list of “data driven” codes (working analytical framework), which were refined and validated by the rest of the team and were applied across all transcripts and chats. Codes were later grouped in natural clusters, and categories were labelled accordingly to create a finalised analytical framework. Data were then summarised using a framework matrix. Lastly, further interpretation of the data led to subthemes and themes, which were discussed and agreed upon by the team over the course of analysis sessions. A further theme of allyship was also identified, and we decided to make this the subject of a separate publication.[35]

Reflexivity

The authors are aware that their own hierarchies reflect and reproduce processes of privilege and marginalisation. The team includes authors who have personal experiences of discrimination linked to racism, low SES, nonbinary gender identity, or misogyny. Some authors fall within participants' age ranges. However, team members also had more privileged characteristics; the senior author is a White, male professor (albeit with a working-class background); and the research process itself arguably privileges researchers over participants. The concept of a ‘halfie’ is sometimes used to describe researchers with links to the communities they work with. The concept highlights how researchers can hold both insider and outsider positions at the same time. We think it is useful for describing the tensions and contradictions of our team's positionality.[36,37]

Results

We chose to focus on the following themes identified from the data:[1] Types of intersection;[2] impacts on health, wellbeing, and their social determinants;[3] and pathways to overcoming inequity. We will summarise each theme in turn. Appendix A presents these themes with further quotations from young adults. Discrimination was the main cross-cutting theme we identified.

Types of intersection (Appendix A, theme 1)

Although facilitators used the 'intersectionality' terminology, only a small number of participants did so from groups 2 and 3, both of which included young adults with higher education backgrounds. However, without explicitly using that terminology, young adults did discuss multiple intersecting equity dimensions. We identified recurring ways in which they did this: (i) cumulative impacts of different dimensions of inequity; (ii) experiencing discrimination within a marginalised group; (iii) interacting disadvantages; and (iv) privileges and discrimination.

Some young adults said multiple-equity dimensions had a cumulative impact. A Black, Muslim woman said, "me being a different race is one, me being a female is added extra, then me wearing a hijab and being a Muslim is […] more." (P3, Group 3) A young person from group 1 said someone who was Black and gay would "probably face more unequal treatment, than a White gay man." (P2, Group 1).

Conceptualising intersectionality as simply the cumulation of disadvantages has been critiqued for failing to unpick how dimensions of inequity combine.[3] Some young adults experienced the combination in terms of discrimination disrupting supportive networks within marginalised groups. For example, a trans young person said that racism could occur within that community: "… institutional racism that we're seeing in wider society mirrored in trans circles." (P10, Group 2).

Some recognised how disadvantages intersected in more complex ways. For example, a trans young person from an ethnic minority described how gaining acceptance from their family was impeded by religious and cultural issues, meaning they lacked the practical and emotional family support that some of the White trans peers benefited from: "… in the people of colour group, I didn't meet anyone who actually had a supportive family." *(P10, Group 2)*.

Although intersectionality tends to involve a focus on intersecting marginalised groups, it is also concerned with the production and reproduction of privilege. Furthermore, it recognises that individuals may be marginalised in some aspects of their lives and be privileged in others. For example, one young person seeking medical health as part of their gender confirmation felt fortunate about being able to afford private health care: "I wouldn't have been able to do that if it hadn't been for […] my parents being rich." (*P2, Group 2*).

Impacts on health, wellbeing and their social determinants (Appendix A, theme 2)

Participants also described how discrimination caused stress, unhappiness, and anger: one White working-class male told us, "sometimes, I feel angry and stressed just thinking about going to the shop 'cos of the way adults look at me." (*P25, Group 4*) Young adults' immediate strategies for coping with discrimination all tended to highlight the contrasting, and at times contradictory, roles an individual can adopt in different circumstances—another feature of intersectionality. In Appendix A, theme 3.1, these strategies are summarised as dual, disguised, and dissonant identities. One woman with Asian and White heritage was told by her managers to recruit fewer employees "from ethnic, from the BAME community … and employ adults who were British, English, White" (*P19, Group 3*). She felt compelled to comply and was saddened when business improved, seemingly confirming that customers preferred dealing with White British employees.

More typically, young adults discussed experiences of discrimination that could impact on their access to the kinds of services and opportunities that are considered social determinants of health. Most discrimination examples across the FGD could be described as 'vertical', in the sense that the perpetrators tended to be adults in some sort of position of direct power over the young adults. Young adults from different social groups identified some common themes of discrimination in the workplace, health service, and with police-targeting. We have discussed elsewhere how common experiences (albeit with historical and cultural distinctions) across different groups suggest a basis for solidarity, allyship, and collective action.[35]

However, barriers to services and opportunities also involved mechanisms that targeted specific characteristics of marginalised people. For example, an Asian woman born outside the UK said, "I am currently house-hunting. I called a company and suddenly the property was not available. I got my friend with a British accent to call the company, and she got a viewing."*(P17, Group 3)*. A trans young person said that employment depended on being able to hide their trans status: "In brutal honesty, employment comes down to how well you pass as cisgender" (*P11, Group 2*). White males we spoke to said that discrimination varied in response to their appearance. They gave examples of how wearing a military uniform (rather than their everyday tracksuits) or driving a more expensive car reduced stigmatisation.

Pathways to overcoming inequity (Appendix A, theme 3)

As well as discussing how they experienced and coped with discrimination, young adults also discussed pathways to overcoming inequity. They were sometimes pessimistic about their chances of success, but they made several suggestions. Many of these involved 'upstream' approaches that included improved employment equity laws (and enforcement); more funding to communities and services that promote equity, diversity, and inclusion; and a more accessible and understanding health service. Empowering pathways included having groups and organisations representing communities of interest and educational reform led by adults with diverse backgrounds.

Some of the suggestions related to more individual-level and behavioural pathways, but unlike typical discussions of health-promoting lifestyle behaviours (e.g., smoking cessation, physical exercise, etc), the young adults focused on behaviours that promoted mutual support, greater tolerance, and less discrimination.

Discussion

We aimed to explore whether intersectionality could help us understand young adults' views on health inequity and identify dimensions and mechanisms of inequity that may have been less prioritised within English public health. Few young adults used the term 'intersectionality'. However, many had relevant experiences and spoke about key concepts underpinning intersectionality, such as privilege and discrimination, uneven distributions of power, and different—often intersecting—dimensions of inequity. The young adults contextualised inequity in settings such as the workplace, housing system, health service, community, and family.

The young adults' views only partly fit with recent characterisations of public understandings of health inequity.[38–40] The Marmot Review[27] referred to the work,[39] claiming "low levels of understanding about social determinants of health among the public" characterised by an over-emphasis on individual choice; "us and them thinking" (focusing on perceived deficiencies of "other" adults and communities); and "fatalism" (27).

In contrast, the young adults we spoke to understood that discrimination was embedded in institutional practices and cultures as well as the behaviours of individuals. "Us and them" thinking was also evident, but frequently the young adults understood "them" to be adults in more powerful/privileged positions to themselves. Furthermore, participants complicated the "us and

them" dichotomy with understandings of multiple identities. As for fatalism, the young adults were sometimes pessimistic about the seeming intractability of inequity, but they also suggested pathways to overcoming inequity that included a mixture of upstream, empowering, and individual-level approaches.

The young adults we spoke to did not always link discrimination explicitly to health. However, they did link it to unequal access to services and opportunities. A life-course understanding of health helps public health stakeholders make the link between social conditions earlier in life and health outcomes that can occur later.[41,42] Better communication of such theories could help young adults see this link too. Young adults did discuss more proximal health outcomes: e.g., mental stress resulting from discrimination and the cognitive dissonance involved in 'passing' strategies for negotiating discriminatory environments.

We argue intersectionality can aid public health policy, practice, and research by adding to and improving upon dominant discourses of social inequalities in health. Firstly, by encouraging services delivered, commissioned, or partnered by public health practitioners to consider a wider range of marginalised communities and (intersecting) equity dimensions. Secondly, intersectionality emphasises the importance of discrimination as a socially embedded behaviour—one that is particularly useful for understanding the 'inequitable' part of health inequity. Environmental conditions, access to services, and health behaviours such as eating, drinking, physical activity, and smoking all help explain how health problems (or benefits) occur, but discrimination helps explain why such exposures, behaviours, and their health outcomes occur unevenly through society.

Strengths and limitations

Our study and the young adults' discussions occurred at a unique time: during the COVID-19 lockdowns and at a time when racism, sexism, and gender identity were prominent in public debates. It is realistic to assume that the young adults' accounts reflected these issues and contexts, and they certainly influenced our approach to recruitment, data collection, and thinking as researchers. We included young adults from a wide variety of backgrounds and, through repeated contact, we hope our approach gave participants space and confidence to air their views. Our research plans were disrupted by the COVID-19 pandemic and response. Online FGDs were a necessity rather than a choice, and we had particular difficulty engaging with one of our groups (which was conducted through WhatsApp messaging). There were limits to the range of adults we could talk to. We too have prioritised some voices over others and can only justify this pragmatically in terms of what could feasibly be achieved with our resources during the challenging conditions of the COVID-19 pandemic.

We and others from the public health community have a continuing obligation to expand our engagement with different marginalised and intersecting communities, avoiding 'one size fits all' solutions, and encouraging different people's needs, concerns, and goals to be heard.

Conclusion

The young adults we spoke to highlight the importance of discrimination in different everyday domains (e.g., workplace, health service, high street, housing system) and the power imbalances that underpin them. Such views are compatible with our current understandings of upstream social determinants of health. What intersectionality offers is an encouragement to be more inclusive in terms of the equity dimensions under consideration and a means of talking to people about health equity in a way that resonates with them.

Author statements

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Ethical approval

London School of Hygiene & Tropical Medicine's Ethics Committee approved the study (Ref. 17783).

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Competing interests

The authors declare no competing interests.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.puhe.2023.07.002.

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