Decomposing intersectional inequalities in subjective physical and mental health by sex, gendered practices and immigration status in a representative panel study from Germany

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Background

- The mapping of immigration-related health inequalities remains challenging, since immigrant populations constitute a heterogenous socially constructed group whose health experiences differ by social determinants of health.
- In spite of the increasing awareness that population mobility and its effects on health are highly gendered, an explicit gender perspective in epidemiology is often lacking or limited.

→ In our analyses, we aimed to assess how intersections of sex, gender and migration status affect differences in subjective mental and physical health in a German representative population sample.

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Gender & immigration status as dimensions of social power

- Immigration status and nationality remain closely associated with racialisation processes in Germany as a receiving country
- Gendered power relations such as sexism, patriarchy or heteronormativity can be observed from the interpersonal up to the societal level and usually put women and persons of minoritised gender identities at a disadvantage
- We use gendered practices as a proxy for gender in our analysis

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Methods I

- We applied an intercategorical intersectional approach conducting multilevel linear regression models.
- Data: German Socioeconomic Panel (SOEP)

Hypotheses		Underlying intersectional quality
a)	Sex, gender and immigration status are associated with mental and physical health, adjusted for additional indicators of social position, i.e. age, socioeconomic status, region of residence and marital status.	Main effects needed to compare with effects for intersectional identities
b)	The intersection of sex, gender and immigration status shows an effect that goes beyond the explanatory power of the individual stratifying variable.	Multiplicativity quality in intersectionality theory
c)	Non-immigrant men with masculine gendered practices show the highest mental and physical health status.	Directionality quality in intersectionality theory
d)	Androgynous and feminine gendered practices are associated with poorer physical and mental health compared to masculine gendered practices.	
e)	Inconsistencies between social gendered practices and biological sex are associated with poorer health outcomes for both immigrant and non-immigrant populations.	

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Methods II

- **Outcome:** Subjective mental (MCS) and physical health (PCS) scores were surveyed with a SOEP version of the health-related quality of life (SF-12v2)
- **Social positions:**
  - Immigration status: country of birth
  - Sex assigned at birth differentiating between female and male
  - Gendered practices: gender diagnostic method building on gender-related variables based on Pelletier et al. (2016), resulting in a bipolar one-dimensional continuum ranging from feminine to androgynous and masculine gendered practices
- **Covariates:** age, martial status, SES, state of residency in Germany, chronic illness

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Sample characteristics

	n	valid %	mean	SD	missings (%)
Outcome					
Physical health			49.5	10.1	
Mental health			51.0	9.8	
Exposure					
Sex assigned at birth					
Female	11,795	56.4			
Male	9,102	43.6			
Gendered social practices					
Masculine gendered practices	6,966	33.3			
Androgynous gendered practices	6,965	33.3			
Feminine gendered practices	6,966	33.3			
Immigration status					
Born in Germany	17,124	81.9			
Not born in Germany	3,773	18.1			
Covariates					
Age					
18-30 years	3,634	17.4			
31-45 years	5,467	26.2			
46-60 years	6,421	30.7			
61-75+ years	5,375	25.7			
Socioeconomic status					
Low	2,288	12.3			2288 (11.0%)
Middle	12,258	65.9			
High	4,063	21.8			
Region of residence					
West Germany	16,047	76.8			
East Germany	4,850	23.2			
Marital status					
Living in a relationship	8,947	42.9			63 (0.3%)
Not living in a relationship	11,887	57.1			
Chronic illness					
Yes	8,495	40.7			47 (0.22%)
No	12,355	59.3			

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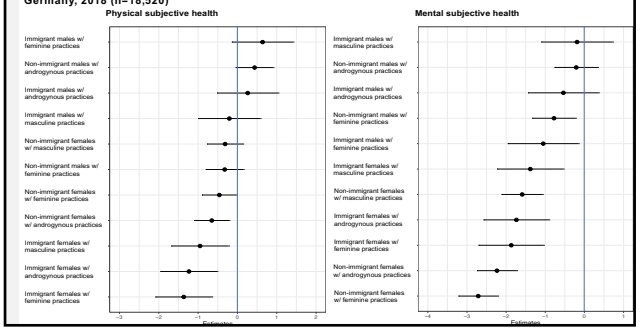
Linear regression coefficients of subjective physical and mental health by intersectional groups, SOEP, Germany, 2018 (n=18,520)



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Discussion – added value of an intersectional perspective?

- More in-depth analysis of immigration-related inequalities along the axes of sex and gendered practices → more integrative and accurate mapping of health inequalities
- By explicitly stating which core tenets were of relevance for this analysis (i.e. multiplicativity and directionality) and how these have been operationalised statistically (indicator variables for the intersecting social positions), we link methods and theoretical interpretation → aiming to overcome a lack of transparency when engaging with theories and their operationalisation

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Limitations

- Cross-sectional data
- Our study neglects axes of inequality/social division that are underrepresented in the dominant scientific discourse, e.g. sexual orientation and gender diverse identities
- Some of the items describing gendered practices – such as satisfaction and worries – are closely linked with (mental) health – circular effects?
- Categorisation of immigrant and non-immigrant populations oversimplified the heterogenous characteristics within both populations
- We limited our analysis to social determinants measured at the individual and household level and did not include upstream factors

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Conclusions

- Patterns of physical and mental health vary along the intersectional axes of sex, gendered practices and immigration status.
- These findings highlight the relevance of intersections in describing population health statuses and emphasise the need to take them into account when designing public health policies aiming at effectively reducing health inequalities.

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References

- Pelletier R, Ditto B and Pilote L. A composite measure of gender and its association with risk factors in patients with premature acute coronary syndrome. *Psychosom Med* 2015; 77: 517-526. DOI: 10.1097/PSY.0000000000000186.

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