Shadia Rask

Doctor of Philosophy (Public Health)
Project Manager
National Institute for Health and Welfare (THL)
shadia.rask@thl.fi

(Super)diversity and health in the population

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Migration is the driving force behind diversity in populations and society. At the same time, diversity exists without migration, since there is no such thing as a homogeneous society. The term superdiversity was coined by Steven Vertovec in 2007 to describe unprecedented complexity in Britain. But what do we know about (super)diversity and health in the context of Finland?

Immigration to Finland has been modest in size compared to its Nordic neighbors. Today around 350 000 persons considered to be of foreign origin are permanently living in Finland. This means around 7 percent of the overall population in the country. As a comparison, the foreign-born population in Sweden is almost 2 million persons, meaning nearly 19 percent of the whole population. Despite being modest compared to many other countries in the European Union, the size of the foreign-born population in Finland has tripled from 1998 to 2018. This has led to an increase in diversity-related research, which in turn, has opened discussion on how this line of research could and should evolve.

Increasing research – challenging categories

The Finnish Migrant Health and Wellbeing Study (Maamu, 2010—2012) was the first population health survey on foreign-born populations in Finland. It has been predominantly used as a data source in publications on migration and health in Finland. To date more than 25 peer-reviewed research articles have been published using these data, including my PhD research on diversity and health. It demonstrated that there are population groups in Finland with a higher prevalence of mobility limitations and mental health symptoms than the general population in Finland. Various factors, such as being unemployed, were shown to be associated with mobility limitations and mental health symptoms. An association was also found between mental health symptoms and mobility limitation. Finally, perceived discrimination was shown to increase the odds for poor health, also for those reporting subtle discrimination only.

Increasing research on diversity and health has increased the need to discuss the challenges in this line of research. One of these challenges is the categories that are created and used in research. Particularly in quantitative studies populations have been generally treated as technical statistical entities, bounded by the nationalist image of "us" and "them". Country of birth or nationality is most commonly used to define migrant background. Other common indicators include mother tongue, parental origin or country of birth, length of stay, legal status, residency, and reason for migration. These are often used as binaries, creating a bicultural situation of "self" and "other". The created categories leave little room for negotiation,

hybridity, fusion of cultures or diverse forms of belonging or identity.

The angle of superdiversity

Superdiversity, in turn, points towards fluidity and hybridisation of categories. It emphasizes the need to recognize multiple identifications and the coexistence of cohesion and separateness. Ten years after creating the concept, Vertovec concluded that the term has been used in diverse ways: as a modern synonym of diversity, as a study framework, to call for methodological reassessment, as a way to describe more ethnicity, as a multidimensional reconfiguration of social forms, as a call to move beyond ethnicity, and as a means to draw attention to new social complexities that arise from diversity that is driven by migration.

In a decade various disciplines and fields have embraced the term, with emerging work also in the field of migration and health. It is not yet clear how superdiversity can be integrated into quantitative research on health, such as epidemiology. What is clear is that capturing fluidity and hybridisation of categories is not easy for this kind of research. How can we rethink our approaches to population health and ultimately reduce health inequalities in diverse societies?

Looking to superdiversity and beyond

It is far easier to raise this question than to answer it. In an attempt to do so, it is helpful to look more broadly than merely in the direction of superdiversity. Also other frameworks and theories provide analytical tools that can be used to examine and improve research on diversity and health. For example, intersectionality draws attention to multiple intersecting identities and multiple interlocking forms of privilege and oppression. The public health critical race (PHCR) praxis was specifically developed to tailor critical race theory (CRT) to the field of public health and advance understanding of racism as a social determinant of health. Whereas European research on migration and health has fairly seldom drawn on CRT or PHCR praxis, superdiversity has been more widely used in Europe than in the United States.

Increasing attention within social epidemiology and political sociology has begun to investigate how political systems — and diversity and representation within these systems — shape population health and health inequities. Also some newer work around superdiversity has touched upon hierarchies and power relations. Health inequities between populations cannot be understood without an understanding of issues of power and discrimination. The starting and ending point of building this understanding should be voice. Voice refers to privileging and including the perspectives of marginalized persons and actively hearing members of marginalized groups. It has been questioned whether superdiversity in fact increases voice. Embracing the concept of superdiversity is not enough — improving health equity requires diverse representation and increased voice.

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