



DISCRIMINATION

–A THREAT TO PUBLIC HEALTH

Final report – Health and Discrimination Project

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Participants in the project

The National Institute of Public Health (FHI)

FHI was formed in 1992. FHI is a government authority whose main assignment is the improvement of public health, with a special emphasis on measures to help groups exposed to the major health risks. FHI is a national centre for information about public health which monitors national public health policy and exercises supervisory control in the alcohol, narcotics and tobacco areas.

The Office of the Ombudsman against Ethnic Discrimination (DO)

DO was formed in 1986. This public authority is assigned to counter discrimination in Swedish society based on ethnic background and religious or other beliefs. DO helps people who suffer from discrimination, exercises supervision of employers and the higher education sector, provides training and information, and seeks to influence public opinion in order to counter discrimination.

The Office of the Disability Ombudsman (HO)

HO was founded in 1994 with the goal of ensuring full participation of people with disabilities in society, and equality in everyday life. HO monitors discrimination legislation, investigates complaints, conducts investigations and provides training and information.

The Office of the Ombudsman against Discrimination on grounds of Sexual Orientation (HomO)

HomO was founded in 1999, and is assigned to counter homophobia and discrimination based on sexual orientation in all areas in Swedish society. HomO monitors compliance with discrimination legislation, takes initiatives to counter discrimination, provides training and information and investigates complaints of discrimination.

Preface

When issues involving human rights are discussed in Sweden, the focus tends to be on the position in other countries. The emphasis in the *Discrimination – a threat to public health* report is on the situation in Sweden, in particular on ways in which people feel they are discriminated, the extent to which this applies, and how these experiences are related to the human health.

Discrimination in society means that people do not have equal prerequisites for achieving good health on equal terms. The prerequisites differ, due to gender, ethnic background, religion, other beliefs, disability and sexual orientation. Discrimination has negative consequences in the form of greater ill-health and higher costs for society as a result of absence from work due to ill-health, increased demands on health-care services, and an unutilised labour-force reserve.

This report is a key source of expertise in systematic efforts to counter discrimination and improve public health, and constitutes a warning-bell for decision-makers at the national, regional and local levels because it sheds light on strong correlations between discrimination and ill-health, and indicates that people experience a considerable degree of discrimination.

The report also points to future possibilities of investigating the incidence of discrimination in a more systematic manner than today. Further studies can provide crucial information and help to ensure that more effective measures are taken to counter all forms of discrimination, thus improving public health.

Discrimination – a threat to public health is the final report of the joint “Health and Discrimination” project, which is the result of cooperation from 2004-2006 between the National Institute of Public Health (FHI), the Office of the Ombudsman against Ethnic Discrimination (DO), the Office of the Disability Ombudsman (HO) and the Office of the Ombudsman against Discrimination on grounds of Sexual Orientation (HomO). Jonas Frykman, the project manager, has compiled this report in close cooperation with Weini Kahsai Nobel (DO) (researcher), Johanna Ahnquist (FHI) (researcher), Anna Schölin (HO) (lawyer) and Marie Lindberg (HomO) (development director).

Gunnar Ågren
Director General, National Institute of Public Health (FHI)

Katri Linna
Ombudsman against Ethnic Discrimination (DO)

Lars Lööw
Disability Ombudsman (HO)

Hans Ytterberg
Ombudsman against Discrimination on grounds of Sexual Orientation (HomO)

Summary

Discrimination – a threat to public health is the final report of the “Health and Discrimination” (HD) project conducted jointly from 2004 to 2006 by the National Institute of Public Health (FHI), the Office of the Ombudsman against Ethnic Discrimination (DO), the Office of the Disability Ombudsman (HO) and the Office of the Ombudsman against Discrimination on grounds of Sexual Orientation (HomO). The principal aims of the HD project have been to develop methods for measuring health and discrimination, to shed light on the correlations between health and discrimination, to develop indicators for discrimination, and subsequently to disseminate the results at the national, regional and local levels.

HD has employed reports of self-reported discrimination at the individual level to quantify the incidence of discrimination and clarify the correlation with health issues. Posing questions on experiences of discrimination in population surveys makes it possible to relate such experiences with other measures of health based on person experience. HD considers that self-reported discrimination is a good indicator for monitoring the development and prevalence of discrimination since the sum total of such experiences reveals structures in society related to gender, age, ethnic background, religion, disabilities and sexual orientation.

According to a demographic survey (the national public health questionnaire) analysed by HD, discrimination is common, takes different forms and is correlated with gender, age, country of origin, disabilities and sexual orientation. Discrimination also occurs in public institutions which are crucial for human health: social insurance offices, employment offices, and medical and health care services. The survey indicates that there are close links between discrimination and ill-health and, particularly in the case of mental ill-health, even a very strong correlation. Although HD clearly indicates strong links between discrimination and ill-health, there are still many question marks. As a result, further research is required in the future in order to investigate the underlying mechanisms at work in greater detail.

In order to determine which questions should be posed in demographic survey to measure self-reported discrimination, HD has assigned Statistics Sweden to implement three focus groups and 14 in-depth interviews with 27 people, evenly distributed in terms of gender, age, country of origin, disabilities and sexual orientation.

Statistics Sweden’s conclusions are presented in the context of publication of this report. In the view of HD’s expert group, the preliminary results indicate that discrimination is a many-sided concept, that harassment cannot always be equated with discrimination, and that a sense of offensive treatment is primarily one of many possible reactions to discrimination. As a result, HD shares the expert group’s view that further analysis of these studies is required.

In conclusion, HD considers that measures to counter discrimination should be taken in all possible areas of society. A method handbook focusing on the measurement of discrimination should be prepared, in order to facilitate investigation of the incidence of discrimination at the central government, county council and municipal levels. A list of recommendations regarding the prevention of discrimination is also required to assist and supplement the tasks performed by municipalities. It is also important to develop monitoring systems for discrimination at the national, regional and local levels, and that operations which are crucial for human health undertake investigations designed to chart the incidence of discrimination from a user perspective. Finally, HD considers that investigation of children’s experiences of discrimination should be initiated.

Introduction

The Swedish government's Action Plan for Human Rights for the period 2006-2009 was approved in 2006. The Action Plan's long-term objective is to safeguard full respect for human rights in Sweden. To achieve this goal, the government intends to increase knowledge and awareness of human rights, improve coordination of the human rights process and promote human rights in other ways. (1)

The "Health and Discrimination" project (HD) was initiated before the Action Plan was approved, but it nonetheless complies well with the Action Plan's long-term objectives. The project has developed new expertise in two areas which are fundamental for human rights: the right to equal treatment and the right to the best possible standard of health. This project is an example of a cross-sectoral endeavour, in the form of cooperation between various public authorities to achieve improved coordination of human rights efforts. The Action Plan indicates that the government is considering measures in the health area, for example in the light of the information collected in the HD project. (1)

Discrimination may take many forms, and there are many blank areas. Discrimination may occur in many different locations – in the workplace, in the interface with public authorities, in shops, in bars and restaurants, and in clubs and voluntary associations. There are various interpretations of the discrimination concept, and opinions differ among people who have been exposed to discriminatory treatment. It is difficult, in the current situation, to monitor the incidence of discrimination for various groups, and there is no reliable data. Complaints to JämO, DO, HO and HomO, for example, do not give the full picture since by no means all discrimination is reported to the ombudsmen. Developing ways of measuring the incidence of discrimination is not merely an important aspect of making discrimination visible in society - it also clarifies links with health.

Publication of this final report signifies the conclusion of the HD project. The aim of the report is to present information of both a qualitative and a quantitative nature, based on the results of various initiatives taken under the project's auspices. The report also looks to the future, and proposes measures for subsequent implementation. The report, per se, is a strategic tool in achievement of the project's goal, namely dissemination of information at the local, regional, national and international levels.

During 2006, HD has been primarily financed by funds provided by the European Commission, thus giving HD new opportunities to disseminate information about the results of the project to a wider group of interested parties, for example the Commission itself, various networks in Europe which are active in questions concerning discrimination and public health and also, as a result of this report, a greater number of EU member states.

Health and Discrimination – a joint project

Background

During 2004, National Institute of Public Health (FHI) took an initiative which evolved to become the joint “Health and Discrimination” project (HD). In addition to FHI, the Office of the Ombudsman against Ethnic Discrimination (DO), the Office of the Disability Ombudsman (HO) and the Office of the Ombudsman against Discrimination on grounds of Sexual Orientation (HomO) have also participated in all phases of the project. The Office of the Equal Opportunities Ombudsman (JämO) participated in phases 1-2.

The background for this initiative was the need to identify appropriate questions for the national public health survey which could pinpoint the existence of discrimination. It became clear at an early stage that there were no documented and validated questions designed to reflect human perceptions of discrimination. It was also clear that there was a lack of information about the correlation between discrimination and health. In view of this, in the spring of 2004 the four ombudsmen decided to draw up a project to elucidate this issue.

The aim of the HD project was to gather information and develop a joint approach to the discrimination concept in order to develop one or more appropriate methods for measuring discrimination, clarify links between discrimination and health, develop indicators, and subsequently disseminate the results to interested parties at the national, regional and local levels.

The public authorities participating in this project considered that the prevalence of discrimination and its correlation with health should be clarified and monitored on a continuous basis in order to ensure that the right measures are applied in the future operations of the authorities concerned.

HD’s aim has been to elucidate the correlation between discrimination and health, with a special focus on discrimination with links with gender, ethnic background, religion and other beliefs, disability and sexual orientation. Age is another key factor in discrimination, although in contrast with the other factors, it is not currently covered by any specific legislation.

There are no reliable indicators which measure discrimination of various population groups on a continuous basis. As a result, the project has endeavoured to develop indicators which can provide a monitoring tool and a reliable picture of changes in and the prevalence of discrimination and which can also explain differences in public health.

Four phases

The project has involved four different phases, although the focus in this report is on phases 3-4.

Phases 1-2, which were implemented in 2004-2005, were concerned with the development of a knowledge base in the form of scientific articles on discrimination and health, and analysis of this information with the help of experts. These aspects of the report are summarised in the report entitled “Discriminatory and Offensive Treatment - a report on correlations between discrimination and health” (2).

Phases 3-4 were completed during 2005-2006, and involved qualitative investigations carried out by Statistics Sweden (SCB) and analysis of the national public health survey carried out in 2004-2006. These two phases also involved dissemination of information, including a workshop and a conference on discrimination and health.

Funding

The first two phases of the project were funded by FHI. The final phases in 2006 were primarily supported in financial terms by the European Commission, under the auspices of the “European Community Action Programme to combat discrimination (2001-2006)” and, in other respects, were financed by all the authorities involved in the project.

Expert support

In order to augment discussion of discrimination and health, the project appointed an expert group which submitted individual written opinions published in full in the form of “Discriminatory and offensive treatment – a report on correlations between discrimination and health” (2). These documented statements of opinion provided guidance for the project in its ongoing assignment.

The expert group comprised:

Gunilla Krantz, Senior Lecturer in behavioural medicine at the Centre for Health Equity Studies at Stockholm University/Karolinska Institutet and the Department of Community Medicine and Public Health, Sahlgrenska Academy, at Göteborg University, a doctor of medicine specialising in general medicine and social medicine and with a doctorate in social medicine at Lund University.

Anders Lange, Professor in international migration and ethnic relations at the Centre for Immigration Research (CEIFO) at Stockholm University and Assistant Professor in Education and Educational Psychology with a doctorate in psychology.

Bera Moseng, research student in sociology at the Norwegian National Institute for the Study of Ageing and Later Life (NISAL), and involved in research into the habits, mental health and suicide rate of homosexual and bisexual persons.

Anders Printz, who is a lawyer and was, at the time in question, an expert for the executive group at the National Board of Health and Welfare where he coordinated the Board’s implementation of the national action plan for disablement policy. Anders Printz is currently working with Anders Milton, the Swedish national psychiatry coordinator.

The project has received external expert assistance in phase 3 for the design and analysis of the project’s qualitative studies assigned to Statistics Sweden.

This expert group comprised:

Martin Börjeson, Ph.D. in social work and special expert at the National Board of Health and Welfare. He is project manager for the development of a system to chart living conditions for the disabled in a functional and uniform manner.

Fredrik Lindencrona, research student in transcultural psychology at the Department of Clinical Neuroscience at Karolinska Institutet. He is a qualified psychologist specialising in organisation psychology and clinical psychology. His doctoral thesis involved conditions relating to stress on the part of recently-arrived refugees and the measures that can be implemented to deal with such risk factors.

Karin Nyquist, a behavioural scientist and methodological statistician with the Swedish Association of Local Authorities and Regions organisation where she has primarily been involved with information submission questions, consultation aspects and method support. She was previously employed by the National Institute of Public Health, where she drew up the national public health survey and was involved in surveys targeted at HBT persons.

Non-governmental organisations

Three non-governmental organisations have participated in project activities: ¹

- The Swedish Disability Federation (HSO), an umbrella organisation for 43 associations for the disabled,
- The Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights (RFSL), an association working for the rights of HBT persons,
- The Cooperation Group for Ethnic Associations in Sweden (SIOS), a non-profit association with no party-political or religious ties comprising voluntary associations of recognised and unrecognised ethnic minority organisations.

During the period December-February, these non-governmental organisations were invited to participate in separate meetings for presentation of the project and discussion of the design of the qualitative studies. These organisations subsequently had access to the results of the project and discussed appropriate steps for the future on three occasions: at the international workshop on 19 June, at a joint meeting of all organisations on 21 August, and in participation in the project's final conference on 25 September.

Reference group at the national level

A reference group was set up at the national level in order to utilise the know-how and experience of other government authorities, to establish support for the project at a national level and to disseminate the results of the project. Eleven public authorities were invited to participate, of whom three declined. The reference group met on two occasions. At the first meeting on 20 February 2006, the project was presented and the reference group expressed opinions on the design of the qualitative studies. The second meeting on 6 September 2006 discussed the results of the project and key measures for the future.

Reference group at the local/regional level

A reference group was set up at the local and regional level in order to utilise the know-how and experience of municipalities and county councils, and to disseminate the results of the HD project. Seventeen municipalities, three county councils and the Swedish Association of Local Authorities and Regions non-governmental organisation were invited to participate. Actual participation was confined to representatives of nine municipalities, one county council and the Swedish Association of Local Authorities and Regions. The reference group met on two occasions. At the first meeting on 22 February 2006, the project was presented and the reference group expressed opinions on the design of the qualitative studies. The second meeting on 7 September 2006 discussed the results of the project and key measures for the future.

Workshop on discrimination and health

A workshop session took place on 19 June 2006 in Stockholm, with a total of 30 participants who analysed the first preliminary results of the project. This meeting is documented under a separate heading and is presented as a basis for this report.² The working language for this workshop was Swedish, due to difficulties for participants from other countries to attend. Experts and representatives of central government ministries, public authorities and non-governmental organisations participated.

¹ This information is based on the websites of the organisations concerned (www.hso.se, www.rfsl.se and www.sios.org), as of 2 October 2006.

² See Appendix 1: A workshop on discrimination and health, 19 June 2006. Appendix 1 is available on the following websites: www.fhi.se, www.do.se, www.ho.se, www.homo.se.

National conference

A national conference was held in Stockholm on 25 September 2006. The results of the project were presented to the various interested parties at the local, regional and national levels in order to reinforce efforts to counter discrimination and improve public health. There were 100 participants, representing central government, county councils, municipalities, the research community and a high proportion of non-governmental organisations.

Reports and fact sheets

The “Discriminatory and offensive treatment – correlations between discrimination and health” report was published in February 2006. This report, which presented HD’s two initial phases, was only issued in Swedish and 500 copies were printed. It did not cover project phases financed by the European Commission. Two facts sheets on the project appeared in April 2006, one of which was in English. The object of these fact sheets was to participate in dissemination of results of the project at both the national and international levels. The Swedish fact sheet was published in 500 copies and the English version in 100 copies. These fact sheets were distributed to the project’s target groups and were made available on the DOI, FHI, HO and HomO websites, and at www.stop-discrimination.info, and were also disseminated at various arrangements organised under the project’s and other auspices. The fact sheets were also distributed to various EU networks.

Disposition of the report

This report is the final HD report, and hence it covers all phases of the project, even if the focus is on the final phases (phases 3-4).

Chapter 1 contains discussion of the discrimination concept, and presents HD’s approach to discrimination. Chapter 2 describes various methods of measuring discrimination and health. One such method – self-reported discrimination – is presented in more detail in this chapter. Chapter 3 discusses previous research, and possible explanations of correlations between discrimination and health.

Chapter 4 presents the results of the national public health survey which, for example, shed light on the incidence of discrimination in society and links with health. Chapter 5 presents the preliminary results of the study carried out by Statistics Sweden and commissioned by HD, which focuses on validation of questions about discrimination.

The results are summarised in the final chapter (Chapter 6), and HD presents some proposals for further assignments.

Chapter 1.

Approach to discrimination

Right to equal treatment

The right to receive equal treatment – i.e. non-discrimination – is a fundamental aspect of human rights, under which no one is to be treated differently on the grounds of gender, ethnic background, religion or other beliefs, sexual orientation or disability. There is legislation prohibiting discrimination related to these factors, and this legislation is designed to safeguard the principle of non-discrimination, which is also expressed in the Swedish constitution and in international conventions to which Sweden is a party under international law. Protection against discrimination has been progressively strengthened in Swedish law, and there are currently seven statutes which prohibit discrimination on the grounds of gender, ethnic background, religion or other beliefs, disability and sexual orientation. (2)³.

In Sweden, there are special ombudsmen for human rights, appointed by the government. Four of them are ombudsmen to counter discrimination (JämO, DO, HO and HomO). The fifth ombudsman, the Children's Ombudsman (BO), is assigned to follow up questions involving the interests of children and young people. All these ombudsmen have a key role to play in the protection of human rights. (2)

Discrimination – a concept with many meanings

Potentially, there may be a considerable difference between what is commonly referred to as discrimination in an everyday context and what is classified as discrimination in a legal sense.

The legal definition of discrimination refers to situations in which one individual is unfairly penalised by being treated worse than another individual in a comparable situation, and this treatment is related to one of the grounds for protection against discrimination. Harassment related to one of the grounds for protection against discrimination is also regarded as a form of discrimination in a legal context since, like discrimination; it fundamentally involves behaviour or actions which offend individual dignity. The legislation also covers indirect discrimination, under which someone is penalised in a manner related to one of the grounds for discrimination as a result of rules or provisions which are apparently neutral but which, in practice, involve penalisation of the individual. (3)

In the Swedish National Encyclopedia, discrimination is defined as “offensive treatment (of individuals or groups) (from the Latin *discriminatio*: to distinguish), involving deviation from the principle of equal treatment in similar cases”. Another distinction made in the National Encyclopedia is between individual discrimination and institutional discrimination. (4)

The latter form means that rules, regulations or practice in a social system have discriminatory consequences, intentionally or unintentionally; discriminatory acts are part of the formal and informal routines that apply in institutions. The objects of discrimination may be, broadly speaking, any categories, groups or collectives whatsoever. International law and national legislation define the groups that are to be regarded as protected against discrimination. (4)

³ These statutes are the Act concerning Equality between Men and Women (1991:433), the Measures to Counteract Ethnic Discrimination in Working Life Act (1999:130), the Prohibition of Discrimination in Working Life of People with Disability Act (1999:132), the Prohibition of Discrimination in Working Life because of Sexual Orientation Act (1999:133), the Equal Treatment of Students at Universities Act (2001:1286), the Prohibition of Discrimination Act (2003:307), the Discrimination and Degrading Treatment of Children and Pupils Act (2006:67). The Discrimination and Degrading Treatment of Children and Pupils Act (2006:67) was approved by the Swedish Parliament in 2006.

Structural discrimination is another concept used to explain the occurrence and incidence of discrimination. In the terms of reference for the *Det blågula glashuset – strukturell diskriminering i Sverige* official report, there is a definition of structural discrimination on the grounds of ethnic or religious background. (5)

Structural discrimination refers to rules, norms, routines, generally accepted approaches and behaviours in institutions and other social structures that constitute obstacles for ethnic and religious minorities to achieve equal rights and opportunities enjoyed by the majority of the population. Such discrimination may be visible or invisible, and it may be intentional or unintentional. (5)

According to Paulina de los Reyes and Mats Wingborg, as researchers, discrimination is an expression of a structural order which gives certain individuals priority over others. In this instance, the fact that discrimination is structural is a fundamental principle for the way in which relationships between human beings are formed in contemporary society, and also for the way in which resources, influence and power are distributed between individuals and groups of individuals. According to De los Reyes and Wingborg, it is important to distinguish between individual, institutional and structural discrimination since this indicates the difference between the need for long-term measures (e.g. changing attitudes) and concrete measures designed to modify the regulatory structure and practices in workplaces and public authorities. (6)

HD's approach to discrimination

One of HD's aims has been to develop a common approach to discrimination which is not confined to a formal, legal definition of the concept.

HD considers that discrimination at the individual and structural level should not be regarded as isolated incidents. All forms of discrimination, irrespective of whether they are acts committed by individuals or institutions, are structural to the extent that they are based on the prevailing structures in society. These structures include the relationship between subordinate and dominant groups which, for example, may be seen in terms of gender, age, ethnicity skin colour, religion, other beliefs, disability and sexual orientation.

HD's approach is as follows:

Structural discrimination refers to rules, norms, generally accepted approaches and behaviours in institutions and other social structures that constitute obstacles for subordinate groups to achieve equal rights and opportunities possessed by dominant groups. Such discrimination may be visible or hidden, and it may be conscious or unconscious.

This approach is closely related to the definition proposed in the *Det blågula glashuset – strukturell diskriminering i Sverige* report. (5)

Since HD aims to include an “intersectionality perspective”, this approach also involves different power structures, and this can provide the prerequisites for more in-depth analyses which take into account the way in which power structures and the grounds for discrimination interact and are correlated with each other.

Paulina de los Reyes, one of the most prominent intersectionality researchers, considers that the intersectionality approach is useful and constitutes a key theoretical tool for analysis of structural discrimination. In her view, “in contrast with previous approaches which draw attention to the forms of dominance generated by a power structure and a set of relationships (class, gender, ethnic hierarchies, the hetero norm, etc.) intersectionality puts the spotlight on the complexity which characterises the exercise of power and the construction of inequality in different institutional and historical contexts.” (7)

HD considers that there is currently a need for a comprehensive approach to issues involving discrimination. One prerequisite is a greater understanding of the way in which different structural norms interact and lead to different forms of inequality based on normative perceptions of gender, ethnic background, religion, functional ability and sexual orientation. HD considers, in this context, that a common approach of this nature constitutes an appropriate platform for tracking and monitoring the development and incidence of discrimination. As a result, this approach should be adopted by more active participants in society in the future, and should point the way to a more systematic process of attaining a society which is free from all forms of discrimination.

Chapter 2.

Measuring health and discrimination

Different ways of measuring health and discrimination

Nancy Krieger, Professor at the Harvard Public Health School and one of the more prominent researchers in the discrimination and health field, has described different methods of measuring correlations between discrimination and health.(8)

One method is to investigate, for example, the extent to which discrimination practised by a doctor in the medical and health care sector can explain differences in the treatment of different groups in society. Differentiated treatment may subsequently result in differences in health status. Applying this method, known risk factors such as differences in socioeconomic status are investigated to see if they explain differences in the health outcome between individuals from dominant and subordinate groups, respectively. In cases in which known risk factors have been taken into account and differences between groups still apply, further analysis should be carried out to look for other possible explanations of such differences. If there continue to be differences in health status between different groups after other possible explanatory factors have been taken into account and checked, there is a greater probability that discrimination is contributing to such differences. (8)

Nancy Krieger also describes two other methods for measuring correlations between discrimination and health, based on the population-level. This may involve investigating the way in which discrimination, for example in the form of a segregated housing market, can explain health differences in the form of higher sickness or mortality figures at the population-level. Another method discussed by Krieger, but which has not yet been tested in epidemiological research, might be to investigate health of the population in relation to various countries' ratification and implementation of legislation and functions in society to safeguard human rights and prohibit discrimination. (8)

In Krieger's view, the above methods, involving indirect measurement of the correlation between discrimination and health, can only produce indirect evidence. Indirect methods cannot measure direct experiences of discrimination in a clear manner, nor can they measure effects related to the intensity or persistence of discrimination, or the period in which discrimination has occurred. As a result, indirect methods of measuring discrimination must be supplemented by other strategies, for example by measuring discrimination directly by means of self-reported experiences of discrimination. (8)

Apart from the fact that these methods only measure the correlation of discrimination and health indirectly, HD considers that they also have other limitations. A method which measures whether the discrimination applied by doctors in the medical and health care sector can explain differences in the treatment of different groups in society, for example, is good because it can indicate discrimination and result in concrete measures in the operation concerned. On the other hand, due to its operational focus, this method is too limited to be generally applied to indicate a correlation between discrimination and health in society as a whole.

HD considers that methods which measure the correlation between discrimination and health at the population-level are good because they provide a more general picture of societal trends. On the other hand, such methods fail to provide the necessary statistical information for certain grounds for discrimination (for example ethnicity, sexual orientation and disability) to enable them to be fully applicable for closer analysis of correlations between discrimination and health.

Nancy Krieger advocates self-reported discrimination as the most appropriate method for measuring the correlation with health. This method measures the way in which discrimination is related to specific health outcomes as a result of people's personal experiences. (8)

Krieger considers that many factors need to be taken into account in studies of discrimination and

health. Discrimination may take various forms: it may be lawful or unlawful, institutional, structural or interpersonal, direct or indirect, open or hidden. Discrimination may be applied by the state, or by non-governmental entities or private individuals. The cumulative exposure to discrimination is the key to understanding correlations between discrimination and health. This exposure may be a question of the point in the individual's life at which discrimination occurred, but also the intensity, frequency and persistence of discrimination. (8)

In Krieger's view, human reactions to discrimination should be taken into account in studies, since reactions either protect or injure health. An example of a protective reaction might be if individuals or societies actively resist discrimination (which involves organising, lawsuits, social networks and social support). Other protective reactions might be the creation of "safe" areas in which the individual is strengthened and accepted in social, cultural and sexual terms, etc. There are also harmful reactions to discrimination, for example introverted suppression, when the individual blames himself or herself, and as a result of denial. Another negative reaction is a resort to drugs (whether illegal or illegal). (8)

Krieger considers that it is difficult to use responses to a limited number of questions phrased in general terms to pinpoint discrimination, since discrimination may occur at many different levels. This means that questions of a more specific nature should be included in a survey. Such questions may, for example, cover the type of discrimination involved, the context in which it occurred, at what stage in the individual's life, at what intensity and how the individual reacted. Other questions which should be included are concerned with a sense of anxiety regarding possible exposure to discrimination and possible awareness on the individual's part about the existence of discrimination targeted at his or her own group. (8)

In Krieger's opinion, a survey based on self-reported discrimination can be supplemented by other research techniques. In this context, qualitative interviews may provide deeper understanding of the individual's experiences of discrimination, and what the responses in a questionnaire may actually mean. Another way of supplementing a study based on self-reported discrimination is to include questionnaire items that reflect the individual's political awareness, identity building, prejudices and introverted suppression. The object of questions of this nature is to indicate whether the responses express self-awareness or awareness of society that may affect the correlation between discrimination and health. (8)

Other methods of measuring the incidence of discrimination (not correlations with health)

There are several other methods which can be used to measure the incidence of discrimination, but which have so far not been developed for further elucidation of the correlation with health.

One common method is to measure the population's attitudes to various phenomena in society, for example attitudes to various groups, such as homosexuals, Muslims or the disabled. HD considers that surveys that are properly designed and implemented may provide a standard measure of the prevailing social climate or the atmosphere at a place of work, but that such surveys must be handled with considerable caution – this view was also put forward in the workshop arranged by HD.⁴

In HD's view, the risk involved in surveys of population attitudes is that, it is assumed in many cases that the respondents are part of the normative majority in the population. Hence, there is a risk that questions about attitudes posed to minority groups will produce misleading results from a statistical point of view. Such surveys may also be very inappropriate from an ethical viewpoint since respondents who do not comply with the "norm" – for example people who are not heterosexual - are expected to answer questions about their attitudes to their own group – for example homosexuals or bisexuals.

⁴ See Appendix 1: A Workshop on discrimination and health, 19 June 2006. Appendix 1 is available on the following websites: www.fhi.se, www.do.se, www.ho.se, www.homo.se.

There is also a risk that questions posed in attitude surveys are formulated in a manner that leads to a situation in which different groups may be placed in opposition to each other, and this, per se, contributes to greater polarisation and stigmatisation between these groups.

HD's experience of surveys of population attitudes is that the respondents tend to underestimate the negative attitudes in their immediate proximity (for example at their place of work) and overestimate such attitudes in society as a whole. People who are members of a minority group may also perceive certain attitudes as negative, while the majority group considers the situation to be satisfactory.⁵ Surveys of this nature can also be misleading because they are sensitive to current reports and campaigns in the media.

The discrimination ombudsmen's case statistics provide another option which is sometimes used to chart the incidence of discrimination. In HD's opinion, this is not a reliable method, and there are very considerable information gaps. These statistics are linked to current legislation and do not cover all areas of society or all grounds for discrimination (e.g. age).

Situation testing⁶ is an experimental method employed in the collection of quantitative information regarding the incidence of direct discrimination. This method can be used in areas of society where it is suspected that discrimination exists. Situation testing can be used for various purposes, for example to obtain a quantitative assessment of the extent of discrimination in order to influence public opinion, develop policy measures, or for use in the application of legislation against discrimination. (10) HD considers that this method may be an effective way of revealing discrimination in certain special areas (e.g. working life), but that it is hard to use it to measure the prevalence of discrimination in society as a whole. HD also believes that further development of this method is called for in order to reveal the correlation with all the grounds for discrimination.

Discrimination indicators

In April 2003, the Swedish Parliament approved a national public health policy, with the overall goal of "establishing the prerequisites in society for satisfactory health on equal terms for the entire population". As a result, it is particularly important to improve health standards for the groups that are specially exposed to ill-health. The national health policy is broken down into 11 objectives which cover the key factors determining health – "the factors in society, living conditions and living habits that contribute to health and ill-health". (11)

The determining factors covered by the various objectives are monitored by indicators. An indicator is defined as "a circumstance employed as an indicator for some other circumstance, for example education as an indicator of socioeconomic status or litmus paper to determine the acidity of a chemical solution". (12) Anders Lange describes the verb "to indicate" as constituting or indicating signs of or symptoms of something", "pointing to or demonstrating", or "providing information about (something)". According to Lange, the noun form, "indicator" denotes "a device for attracting attention", for example a dial or a warning light. (2)

One of HD's aims has been to develop indicators for discrimination. The discrimination concept is very broad and complex, and it is difficult to measure. On the other hand, the point of indicators is to show that a given circumstance, that is to say the incidence of discrimination, is developing in a given direction. HD considers that the great advantage of indicators is that they provide a relatively simple way of monitoring changes in discrimination and thus revealing, for example, when the steps taken are having some effect.

⁵ An example of a survey exhibiting this phenomenon is the National Institute for Working Life's survey of working conditions for homosexuals and bisexuals. (9)

⁶ Also referred to as "discrimination tests".

Self-reported discrimination – a discussion

Measuring self-reported discrimination and health may be accomplished in various ways. HD's analysis, for example, is based on asking a limited number of questions about individual experiences of discrimination within the framework of a population survey (the national public health survey) which are then related to various experience-based measures of health. The results of this survey are presented in Chapter 4.

As part of the process of designing the national public health survey, HD concluded that the questions that had the best prerequisites for pinpointing the incidence of experiences of discrimination (including harassment) would involve experience of being treated in an offensive manner, whether such offensive treatment was caused by one or more grounds for discrimination, and in what context this treatment had occurred⁷.

In the Swedish discrimination legislation, discrimination (including harassment) is defined as behaviour that is offensive to the individual's dignity. Thus, the question about offensive treatment referred to possible experience by the respondent of one or more specific occurrences. (2) This proposal was recommended by Sarah Wamala, a researcher working at FHI, who referred to similar questions in an international research context. (13)

There are no tried and tested questions about self-reported discrimination, and validation of the questions is a key issue. As a result, HD has assigned Statistics Sweden (SCB) to carry out qualitative studies concerning questions involving discrimination, which are presented more fully in Chapter 5. The aim was to ensure that the questions posed complied with what was to be measured (i.e. self-reported discrimination).

At the workshop arranged by HD in June 2006, with participants from the research community, public authorities and non-governmental organisations, there was discussion of self-reported discrimination as a method for measuring discrimination and health, and as a method for measuring the incidence of discrimination in society.⁸

The wordings were discussed in some detail, in the light of the questions in the national public health survey:

- Experiences of offensive treatment and of discrimination are not completely synonymous concepts. Offensive treatment is a wider concept than discrimination. People may consider that they have been treated offensively, but without being discriminated. It is also possible to experience discrimination without offensive treatment.
- Offensive treatment occurs in an interpersonal relationship, but discrimination may occur without any personal contact.
- It may be difficult for the person concerned to know whether offensive treatment is an expression of discrimination and, if so, on what grounds.
- Offensive treatment is a useful concept since it includes the individual's personal experience, which may be assumed to be a crucial factor from a health perspective.
- Self-reported offensive treatment may be used to measure discrimination (in the absence of a better alternative), providing that we are aware of the deficiencies and the fact that there is no exact compliance between the two concepts.

During the workshop discussion, it emerged that self-reported discrimination can also be measured by:

- Asking if people have felt that they have been discriminated (this calls for consensus on the meaning of the concept),

⁷ The exact wording of these questions is described in Chapter 4, "Results of the national public health survey".

⁸ See Appendix 1: Workshop on discrimination and health, 19 June 2006. Appendix 1 is available on the following websites: www.fhi.se, www.do.se, www.ho.se, www.homo.se.

- Questions about offensive treatment and what the respondent feels about the reasons for such treatment – self-reported offensive treatment,
- Questions about offensive treatment without asking for the reasons, and then subsequent comparison between groups based on the grounds for discrimination (assuming that the differences reflect the degree of discrimination),
- Concretisation by providing examples of discriminatory situations without making any reference to either offensive treatment or discrimination

More experience of self-reported discrimination is required as regards what the questions mean for different individuals and population groups. Asking rather general questions in population surveys about experiences of discrimination may entail risks, for example both underestimation and overestimation of the respondent's experiences. This risk is increased if the discrimination concept is also included in a question⁹.

The question of underestimation and overestimation has already been pointed out by Anders Lange, who considers that individuals may feel that they have been discriminated although, in objective terms, there has been no discrimination. Individuals can also feel the reverse, that is to say they do not consider that they have been discriminated, even though in a purely objective sense, they have suffered discrimination. (14) The individual's level of education may be an important factor in this context. One study indicates that women with higher education report higher levels of self-experienced discrimination. (15)

In the case of discrimination involving ethnicity, Lange considers that people with a poor grasp of the Swedish language tend to report more experiences of ethnic discrimination than those who have a good command of the language. Lange has also noted that all ethnic groups regard their status as somewhat higher than assessments made by others. This may result in a situation in which people underestimate their group's exposure to discrimination. People who report a higher degree of discrimination tend to regard the status of their own group as being markedly lower than people who report a lower degree of discrimination. (14)

When considering the "Pollyanna syndrome"¹⁰, there is a risk, according to Anders Printz, who has studied discrimination against people with disabilities, that people experience their situation as better than it really is. According to Printz, this may be due to associating satisfactory living conditions with success, which entails greater respect. As a result, Printz considers that people may refrain from reporting experiences of discrimination. (2)

In the course of the discrimination and health workshop, it was stated that people may also overestimate or underestimate experiences of offensive treatment as a result of:

- over-reactions,
- high sensitivity, low thresholds,
- misinterpretation of acts as offensive, and
- offensive treatment for reasons other than discrimination.

In the case of underestimation, it was proposed, for example that

- people avoid certain situations in order to avoid offensive treatment,
- people are excluded from certain situations,
- normalisation – people can become so accustomed to offensive treatment that they do not regard it as such,
- rationalisation – people do not want to define themselves as discriminated since this is downgrading,

⁹ One example of a question of this nature might be "Have you experienced discrimination personally in the past three months?"

¹⁰ Pollyanna is a character in a children's book who retained her cheerful spirits despite numerous setbacks.

- unawareness – offensive treatment that people are not aware of (not being summoned for an interview, for example) or offensive treatment which is not regarded as such, and
- Insensitivity/stoicism, high threshold.

One of the conclusions drawn at the workshop was that a question should be formulated concerning the extent to which people avoid situations in which they risk discrimination. Another conclusion was that underestimation is probably more common than overestimation, if people with long-term illnesses who tend to give more negative answers are taken into account.

In the course of the workshop, it was noted that questions involving self-reported discrimination first require validation before determining what conclusions can be drawn about a possible impact on health. Our knowledge is still inadequate as regards the complex correlations between discrimination and ill-health, the way in which social experiences affect our biology, and the way in which these correlations are affected by factors at the group, societal, individual and situational level. This is an area for further study.

Self-reported discrimination – a summary

HD has employed self-reported discrimination as a method for pinpointing the incidence of discrimination and demonstrating correlations with health. As a result, HD's starting point has been questions posed in the national public health survey. This approach is not entirely problem-free, but at the same time it offers many advantages.

HD is aware that it is not easy to pinpoint the incidence of self-reported discrimination with just a few questions. There are differences in attitudes to the concept of discrimination among respondents and in society as a whole, and this makes it difficult to pose a direct question as to whether a respondent considers that he or she has experienced discrimination.

HD is also aware that self-reported discrimination does not measure the incidence of all forms of discrimination in society. There are probably cases of discrimination which are not experienced by the respondent, but which nonetheless occur in objective terms and which probably affect people's lives and health. Examples might include a respondent who is not called in for an employment interview, who does not receive the right medical treatment, or who is refused assistance by the local social welfare unit.

There are probably respondents who avoid certain situations in order to avoid being exposed to discrimination, and this has an impact on their lives and health. Avoiding certain social situations and networks may mean, for example, that people do not get opportunities to apply for jobs, or to become involved in in-house training programmes at a workplace.

Finally, it is also possible that respondents have experienced discrimination at certain periods in their lives which has affected their lives and their health, but which does not show up in a population survey with specific time limits. This may, for example, involve people who have suffered discrimination in their childhood - at school for instance.

HD has taken these constraints into account as follows:

1. HD has not formulated a direct question as to whether the respondent has felt discriminated, but has instead formulated a question as to whether an experience of offensive treatment was due to one or more types of discrimination. The object here is to measure a human experience and to avoid a formulation that increases the risk of overestimation and underestimation of the response.
2. HD considers that there are practical advantages in using only a limited number of questions, since these questions may be included in the framework of other, larger demographic surveys

undertaken at the national, regional or local level which are primarily intended to chart public health, for example, and are not primarily concerned with discrimination. This makes it possible for a greater number of participants to measure the incidence of discrimination in society.

3. Since the population survey includes background factors such as gender, age, country of origin, disability and sexual orientation, and there is other data in the survey covering socioeconomic factors, social relationships and health, indirect supplementation of the discrimination analysis is feasible. This permits inclusion of people who have suffered discrimination without being aware of it themselves, people who avoid situations in which they risk discrimination and people who have experienced discrimination at an earlier stage, for example in childhood.

HD considers that self-reported discrimination offers many advantages. Apart from measuring things that people experience, this method also means that it is possible to directly relate such experiences to experience-based measures of health. This makes it possible to pinpoint correlations with health.

In HD's view, self-reported discrimination is also a good indicator for monitoring changes in and the prevalence of discrimination since the surveys should always reflect people's own experiences, in the first instance. The sum total of these experiences reveals, in a reliable manner, structures that exist, and which may for example have links with gender, age, ethnic background, religion, skin colour, disability and sexual orientation.

The approach to the discrimination concept previously described in this report may be reflected by using self-reported discrimination as an indicator. The sum total of self-reported discrimination, that is to say people's own experiences, reveals *rules, norms, generally accepted approaches and behaviours in institutions and other social structures that constitute obstacles for subordinate groups to achieve equal rights and opportunities possessed by dominant groups*. Self-reported discrimination gives a picture of discrimination, irrespective of whether it is *visible or invisible and/or conscious or unconscious*.

HD is aware that, as an indicator, self-reported discrimination does not cover the entire discrimination concept, and therefore considers that the "self-reported discrimination" indicator should be supplemented by other indicators. As a result, data from areas such as the labour market, the housing sector and the medical and health care field should be included, in order to supplement analysis of discrimination.

Chapter 3.

Correlations with health

Good health is not equally distributed

Health is not easy to define. HD applies the generally accepted WHO (World Health Organization) definition which is sufficiently broad to include many different health aspects. Under this definition, good health is “a state of complete physical, mental and social well-being and not merely the absence of sickness and disability”. Obviously, there is a clear correlation between ill-health and sickness, but it is important to note that an individual may experience good health or poor health, irrespective of whether or not he or she has received a medical diagnosis. Most people regard health as a desirable objective, and maintaining good health is a prerequisite for so many other aspects of life. (16)

Obtaining a picture of the population’s health status and examining the population from various viewpoints – for example gender, age, country of origin, disabilities and sexual orientation – provide a good basis for charting correlations between discrimination and health.

According to FHI¹¹, good health is not equally allocated within and between various groups in society. This ties up with the fact that some groups say that they have experienced offensive treatment to a greater extent than others, and that such treatment is due to one or more grounds for discrimination. The unequal distribution of health may be summarised as follows:

- Older people regard their health status as poor to a greater extent than younger people, while younger people tend to experience poorer mental health.
- On the whole, women experience poorer health than men.
- People born outside the Nordic region (especially people from other continents) tend to have poorer health than people born in Sweden or the other Nordic countries.
- Homosexual and bisexual people tend to have poorer health than the rest of the population.
- Transgender persons tend to have poorer health than the rest of the population.
- People with disabilities tend to have poorer health than the rest of the population, although there are considerable variations in this group.

Previous research on correlations between health and discrimination

In order to obtain an overall picture of know-how in the discrimination and health field, the HD project has taken two compilations of scientific articles as its starting point. On the one hand, there are 20 articles by Nancy Krieger in the period 1984-1998 (8), and on the other, compilations prepared by Karin Liljeberg on HD’s behalf, based on 39 articles published from 1998-2004. (18)

On the whole, these articles demonstrated many similarities.

Most of the studies concerned are cross-sectoral, utilising questions about self-reported experiences of discrimination, but there are also batteries of questions for various studies. In most cases, specific cases have been listed in which the respondent has had an opportunity to pinpoint various situations in which he or she has experienced discrimination.

The majority of these studies are concerned with ethnic discrimination/racism, and a high proportion involved gender discrimination. On the whole, very few of the studies published involved discrimination on the grounds of sexual orientation, religion, disability or age. Most of these studies have analysed discrimination in a broader perspective, and have been concerned with other reasons for the discrimination experienced (e.g. gender and ethnic background).

¹¹ Based on the results of (12) and (17).

Most of these studies have an American survey population. Three Swedish research reports are based on the same data, which includes people from Poland, Chile, Turkey and Iran, but also including people with Swedish origins for purposes of comparison. Another study focuses on young people from Turkey in Norway and Sweden, also with a reference group of people born in Sweden or Norway.

All these studies indicate links between discrimination and ill-health. In most case, there is also a correlation between discrimination and mental health. Some of the studies indicate a correlation between physical ill-health (e.g. cardiac and vascular diseases) or unhealthy habits (excessive consumption of tobacco, alcohol or narcotics). The majority of these studies also investigates the effects of multiple discrimination, and indicates that this increases the risk of ill-health.

A relatively high proportion of these studies have indicated the way in which different reactions in countering or dealing with discrimination affect health, and whether factors such as social support or membership of a group (e.g. an ethnic group) offer protection against negative health effects. They indicate that social support can both exacerbate and reduce the impact of discrimination on health. Basically, it is the actual content of such support that counts. Alcohol abuse and cigarettes can function as “escape mechanisms” to reduce the strains cause by discrimination. Suppression of aggressive feelings in connection with discrimination increases the risk of high blood pressure – a study by Karlsen and Nazroo in 2002 shows, for example, that individuals who stated that they were going to report and challenge/question racism had a higher blood pressure than people who said that they would be going to exercise tolerance and would not submit a report. (19) A negative health effect of this nature may also be the result of suppressed anger. Similar correlations between experiences of racism and suppressed anger have also been revealed in another study. (20) More passive reactions to discrimination appear to have potential long-term effects on health, for example in the form of high blood pressure and cardiovascular diseases. (21)

Can the correlations be explained?

In the HD “Discriminatory and Offensive Treatment” interim report, four experts presented their views on the correlations between discrimination and health. On the whole, the experts supported the view that there is a correlation between discrimination and health, even if they noted that there were several information gaps in this area. (2)

Gunilla Krantz has drawn together previous research in the discrimination and health field by pointing to correlations in a number of different forms, such as physical and mental symptoms, self-reported health, subjective assessment of the quality of life, mental ill-health, violent behaviour, experiences of discrimination and unfair treatment, suicidal thoughts and alcohol habits, and also physiological factors such as higher blood pressure, a higher pulse rate, higher levels of cortisol in urine, and also the consumption of health-service facilities. (2)

Krantz considers that the various health outcomes indicated above as the result of discrimination have a common basis in that offensive treatment, or an experience of this nature, leads to stress, irrespective of the reason for discrimination. Stress occurs in situations in which the demands made by the immediate environment exceed the individual’s ability to cope with such demands. (22) If the individual’s resources are inadequate in relation to a specific situation, the individual loses his or her sense of control, and this results in stress which may become manifest in the form of ill-health or illness. The ill-health which occurs as an answer to chronic stress may take various forms, and may lead to a number of symptoms as a result of the effect of stress hormones on the cardiovascular system, the metabolic system, the immune system and mental health. (2)

Anders Lang’s previous research has included study of correlations between discrimination and health (from an ethnic perspective). (23) Based on his previous study and his cautious assessment of previous

research in this area, Lange concludes that it is highly probable that “experiences of unfair, negative discriminatory treatment as a result of membership of specific groups or categories have a negative impact, primarily on mental health, but also on physical health”. On the other hand, Lange considers that it is hard to make statements about more specific links between certain types of negative experiences and the risk of specific health problems. (2)

According to Lange, unfair negative discriminatory treatment often involves more or less deep-seated offensive treatment, mainly because human dignity is in question and diminished. If such instances of offensive treatment accumulate over an extended period, this results in a higher level of “malign” stress, with all the consequences to health which such a state of affairs may lead to. The variation in the degree of severity of such consequences is presumably affected by the individual’s ability to handle the situation and the factors that influence the development of an ability of this nature. Lange considers, however, that there is probably some sort of “threshold level”, which means that when the volume of such offensive experiences exceeds this threshold, the individual is unable to handle the situation. (2)

Bera Moseng’s expert statement of opinion primarily focused on discrimination of homosexual and bisexual persons in a health context. Moseng stressed that most homosexuals and bisexuals lead satisfactory lives, but that, at the same time, a significant minority are struggling with a difficult situation and poor health. She considers that these factors may be explained in one way or another by scepticism about, and a negative attitude to, non-heterosexual forms of cohabitation. (2)

In Moseng’s view, there are few studies today that focus on links between discrimination and health among homosexual and bisexual groups, but that several broadly-based studies indicate that homosexuals and bisexuals are over-represented in the statistics for violence and the threat of violence, and that a substantial minority feel, in social terms, that they are excluded from social arenas such as the home, a circle of friends and the workplace. According to Moseng, the reasons for these differences may be traced to the attitudes of the majority of the population and negative discrimination of homosexuals. It is also likely that something in the conditions experienced by homosexuals and bisexuals makes them more vulnerable than heterosexuals, in the sense that their capacity to deal with experiences of discrimination is less developed¹². (2)

Anders Printz analyses correlations between discrimination and health by examining the position for people with disabilities. According to Printz, there is little experience of this area, at least in Scandinavian research. In recent years, however, there has been research into the stigmatisation of people with mental illnesses and functional impairments which has demonstrated links between experiences of stigmatisation and the level of psychiatric symptoms and care requirements. (2)

Printz points to the limited number of studies that have demonstrated a correlation between treatment received, self-awareness/self-esteem, studies of discrimination of disabled persons in the labour market and poor access, and studies indicating that people with disabilities have poorer health than the rest of the population. All in all, he considers that this provides a basis for an assumption that there are correlations between clear instances of discrimination and the widespread ill-health experienced by people with disabilities. (2)

What are the possible mechanisms involved?

Two researchers, Sarah Wamala and Carina Bildt, have described various mechanisms which may possibly explain the correlation between discrimination and health. (13)

- Discrimination leads to differences in opportunities in life and in living conditions which result in unequal socioeconomic circumstances (e.g. in education).

¹² This analysis is based on this study (24).

- Discrimination results in different kinds of treatment, leading to differences in access to health-promoting resources (e.g. health care).
- Discrimination reduces participation in society and influence, and this has a negative impact on health.
- Experiences of discrimination lead to stress – both acute and chronic – which may give rise to mental well-being and physiological changes, but which may also have a negative effect on health.
- Discrimination can affect health as a result of its impact on living conditions, and a hostile environment may affect patterns of behaviour and life-style factors as a result of internalisation of discriminatory experiences (e.g. smoking and the use of drugs and alcohol). (13)

Wamala and Bildt consider that it is essential to adopt a broad approach in studies of discrimination and health. Discrimination is a structural factor that affects socioeconomic circumstances that, in their turn, affect the degree of influence and access to health-promoting resources. Unfavourable socioeconomic circumstances can also create stress, per se, which in its turn influences the behaviour of individuals. (13)

At the workshop session arranged by HD, Sarah Wamala considered that socioeconomic factors and living habits play their part in the unequal distribution of health in the population, but that they cannot account for the entire difference. She stressed that there are still strong correlations, even after adjustment to allow for age and long-term illness. She also indicated that experiences of offensive treatment on the part of a public authority have stronger correlations with health than, for example, offensive treatment in a restaurant, where there appears to be no correlation at all.¹³

¹³ See Appendix 1: A workshop on discrimination and health, 19 June 2006. Appendix 1 is available on the following websites: www.fhi.se, www.do.se, www.ho.se, www.homo.se.

Chapter 4.

Results of the national public health survey

The national public health survey

FHI conducts a national public health survey, “Health on equal terms”, which is designed to chart public health in Sweden. Various questions are posed in this survey to ascertain people’s health, living habits, social and economic circumstances, and also their sense of security and their social relationships.

This survey was conducted over a three-year period, from 2004-2006, and involved a random sample of the population.

2004 (18-84 years of age): 53,600 people (response rate 63%)
2005 (16-84 years of age): 63,500 people (response rate 63%)
2006 (16-84 years of age): 93,000 people (response rate 61.2%)

Disability was one of the variables covered in 2005, but this was not the case in 2004 and 2006.

“Disability” was defined in the survey in terms of people who report poor sight, poor hearing, considerably reduced mobility and people who have had a long-term illness which has reduced their work capacity to a considerable extent or prevented some other form of employment. This applied to a high proportion of the respondents – 23 per cent.

In 2005, sexual orientation was included as a variable, which was not the case in 2004 and 2006.

“Sexual orientation” was reported in terms of heterosexual, and homosexual and bisexual. Unfortunately, due to an inadequate response rate, it is not possible to present separate results for homosexual and bisexual groups, respectively, in the national public health survey. Only slightly more than 2% indicated a non-heterosexual orientation.

Indicators for individually reported discrimination

The national public health survey includes three questions designed to pinpoint the incidence of discrimination. These questions were presented and discussed in Chapter 2, “Measuring health and discrimination”.

1. Have you been treated in a way that you felt was offensive during the past three months?
(Response alternatives: No, Yes, occasionally, Yes, on several occasions)
2. Who treated you in a way that you felt was offensive?
(Response alternatives: Health care services, School/work, Employment office, Police/judicial system, Social services, Social insurance office, Shops/restaurants, Bank/insurance company, Landlord/local housing office, Close relative, Unknown person in a public place, Other – open question)
3. Why were you treated in a way that you felt was offensive?
(Response alternatives: Ethnic background, Gender, Sexual orientation, Age, Disability, Religion, Other – open question, Don’t know)

The wording of HD's indicator for self-reported discrimination was as follows:

“Experiences of offensive treatment during the past three months due to one or more grounds for discrimination”.

Results of the public health survey

The results of the national public health survey in 2004, 2005 and 2006 are presented in this report under the following headings:

- Incidence of discrimination
- Reasons for offensive treatment/attitudes
- Some arenas for discrimination
- Correlation between discrimination and health

The results of three parallel surveys are reported, in order to permit monitoring over time and because certain questions and variables were not included in all three surveys. Sexual orientation, for example, was only included as a variable in 2005.

The results of the question concerning exposure to discrimination in various types of arenas are only partially presented in this report, since these results are misleading to some extent. The overall results of offensive treatment in various types of arenas indicate that the outcome depends on exposure to the arena concerned. If, for example, the respondent has had no dealings with the police, he or she cannot have been exposed to any discrimination on the part of the police.

There are arenas that can be presented, however, since other questions in the survey indicate in various ways that the respondent was in contact with a specific arena, and this can be subsequently checked with a statement that the person concerned has experienced discrimination in this arena during the past three months. The arenas investigated by HD are medical and health care, social insurance offices and employment offices, all of which are operations of the utmost importance for people's health.

Incidence of discrimination

The proportion of people in the population who stated that they had experienced discrimination during the previous three-month period was 6.7 per cent in 2006. This proportion represented a decline in comparison with 2004, when the figure was 7 per cent, but this reduction is not statistically significant. The proportion of women who stated that they had experienced discrimination amounted to 8.4 per cent in 2006. The corresponding proportion of men was 4.5 per cent in 2006, which is a statistically significant reduction in comparison with 2004.

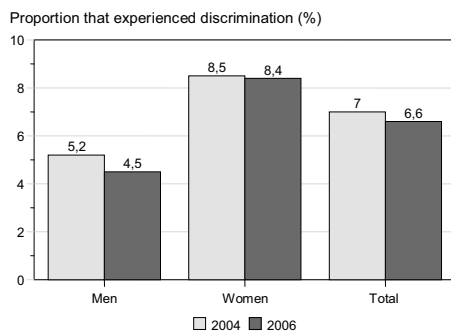


Figure 1. Proportion (percentage) of people in the population in the age range 18-84 who reported that they had experienced discrimination in the survey in 2004 and 2006. Age standardised values.

Source: Health on Equal Terms, National Public Health Survey, 2004 and 2006, National Institute of Public Health.

Another way of indirectly determining the incidence of discrimination in society is to show which groups stated, to a greater extent than other groups, that they had experienced offensive treatment. According to the survey, 20 per cent of the population said that they had experienced offensive treatment in 2006. This applied, in particular, to young women (34%), people born outside Europe (27%), people with disabilities (26%) and people with a homosexual or bisexual orientation (43%). The figure for sexual orientation applies from 2005, when slightly less than a quarter of the respondents said that they had experienced offensive treatment.

Reasons for offensive treatment

In 2006, 35 per cent stated that the offensive treatment they experienced was due to discrimination. This is an increase compared with 2004, when 26 per cent said that such treatment was due to discrimination (Figure 2). The overall incidence of experiences of discrimination reported in Figure 1 is not affected, since the total number of people who reported offensive treatment declined from 29 per cent in 2004 to 20 per cent in 2006. It was more common for women, particularly younger women, to report discrimination as a reason (Figure 3). In the case of women, the most common reasons for discrimination cited in 2006 were gender and age and, in the case of men, ethnic background and age.

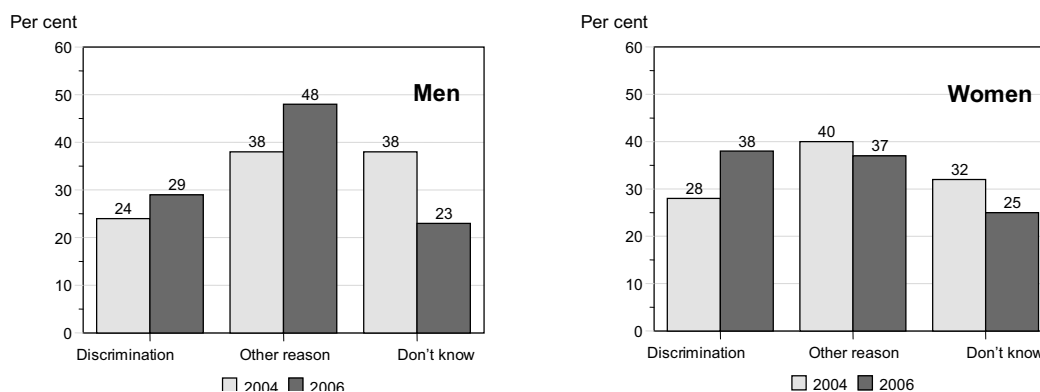


Figure 2. Proportion (percentage) of men and women, respectively, in the age range 18-84 who reported that they had experienced offensive treatment due to discrimination or for some other reason during 2004 and 2006. Age standardised values.
Source: National Public Health Survey, 2004 and 2006, National Institute of Public Health

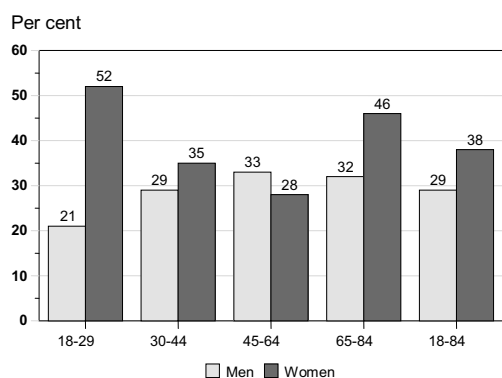


Figure 3. Proportion (percentage) of people in various age groups who reported that they had experienced offensive treatment due to some form of discrimination.
Source: National Public Health Survey, 2006, National Institute of Public Health

Some Arenas for discrimination

Since the results describing the incidence of discrimination experienced in the medical and health care sector, social insurance offices and employment offices are based on the 2004 survey, it is important to focus on the results in 2004. In 2004, 29 per cent reported that they had experienced offensive treatment, of whom 26 per cent said this was due to discrimination.

Of the 25 per cent in 2004 who reported that they had experienced offensive treatment in the medical care sector, 33 per cent said this was due to discrimination (Figure 4). Of the 18 per cent who reported in 2004 they had experienced offensive treatment by social insurance offices, 25 per cent said this was due to discrimination (Figure 5). Of the 26 per cent who reported in 2004 they had experienced offensive treatment by employment offices, 32 per cent said this was due to discrimination (Figure 6).

The results indicate that offensive treatment by social insurance and employment offices was less than the average for society as a whole. On the other hand, respondents stated to a greater extent than the average that offensive treatment was due to discrimination in two of the operations concerned, namely medical and health care services and employment offices.

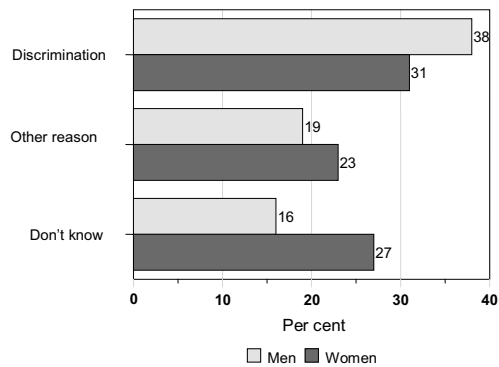


Figure 4. Proportion (percentage) in the age range 18-84 who reported that they had experienced offensive treatment in the medical care sector of those who cited discrimination, some other reason or who did not know the reason (n= 4,496). Age standardised values.
Source: National Public Health Survey, 2004, National Institute of Public Health.

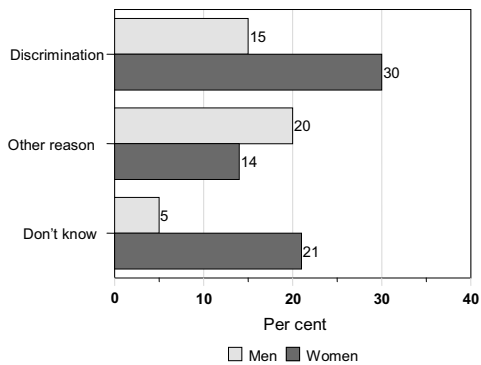


Figure 5. Proportion (percentage) in the age range 18-84 who reported that they had experienced offensive treatment at the social insurance offices and those who cited discrimination, some other reason or who did not know the reason (n= 798). Age standardised values.
Source: National Public Health Survey, 2004, National Institute of Public Health.

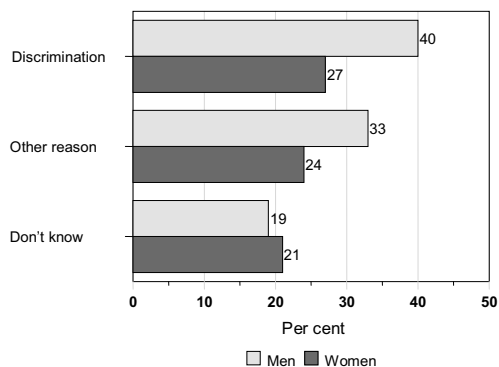


Figure 6. Proportion (percentage) in the age range 18-84 who reported that they had experienced offensive treatment at employment offices of those who cited discrimination, some other reason or who did not know the reason (n= 620). Age standardised values.
Source: National Public Health Survey, 2004, National Institute of Public Health.

Correlation between health and discrimination

Table 1 indicates the extent to which people who experience, or do not experience, discrimination, respectively, consider that they suffer from mental or physical ill-health, expressed in terms of eight measures. It is more common, or much more common, for people who have experienced discrimination to report both mental and physical ill-health. The correlation was stronger in the case of mental ill-health, and men who had experienced discrimination were more likely to report poor mental and physical health than women.

Ill-health indicators	Discriminated			
	Women		Men	
	Yes	No	Yes	No
Reduced mental well-being	39	17	44	12
Severe anxiety, apprehension, angst	16	4	19	2
Very stressed	9	2	8	1
Severe sleep problems	17	6	17	4
Suicidal thoughts	30	11	33	8
Suicide attempt	10	4	12	2
Low estimate of own health	17	6	17	5
Physical ill-health*	34	20	28	15

Source: National Public Health Survey, 2006, National Institute of Public Health.

* Those who stated that they had not been in good physical health for at least 15 days during the last 30 days.

Table 1. Proportion (percentage) of men and women in the age range 18-84 with poor health of those who had experienced or had not experienced discrimination. Age standardised values.

Figures 7-10 indicate that people who have reported discrimination are more likely, or much more likely, to report reduced mental well-being (2-3 times more likely in the case of women, and 3-4 times more likely in the case of men), that they are suffering from considerable stress (4 times more likely in the case of women, and 8 times more likely in the case of men), that they have had suicidal thoughts (2-3 times more likely in the case of women, and 4 times more likely in the case of men), and that they say that they are in poor health (2-3 times more likely in the case of women, and 3-4 times more likely in the case of men), compared with people who have not reported discrimination.

The survey also indicates that people who have reported discrimination are more likely, or much more likely, to have no practical or emotional support, to have a lack of confidence in institutions (e.g. social insurance and offices and health and medical care services), and little confidence in their surroundings.

According to the survey, in the case of people who reported more than one basis for discrimination as a reason for offensive treatment it was common (women), or much more common (men), to state that their general health status was poor, as compared with people who reported a single reason for discrimination (Figure 11).

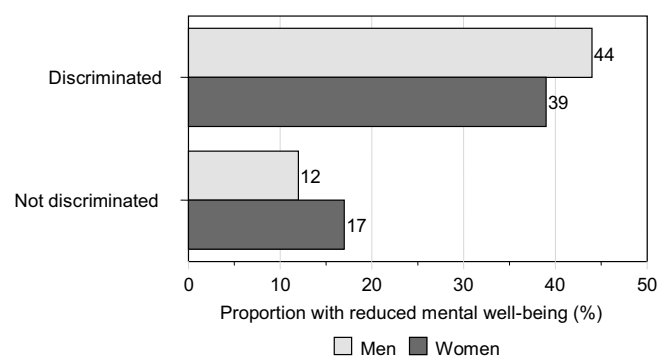


Figure 7. People in the age range 18-84 with reduced mental well-being, as a proportion (percentage) of people who have or have not experienced discrimination. Age standardised values.

Source: National Public Health Survey, 2006, National Institute of Public Health.

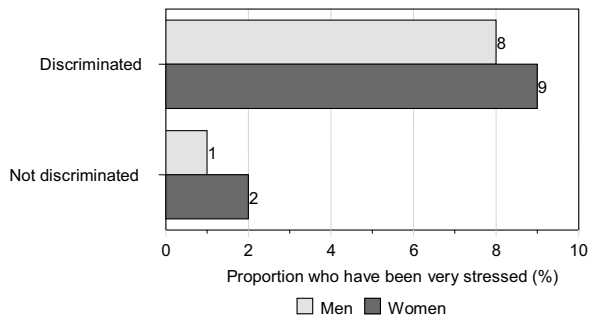


Figure 8. People in the age range 18-84 with reduced mental well-being, as a proportion (percentage) of people who have, or have not, experienced discrimination. Age standardised values.
Source: National Public Health Survey, 2006, National Institute of Public Health.

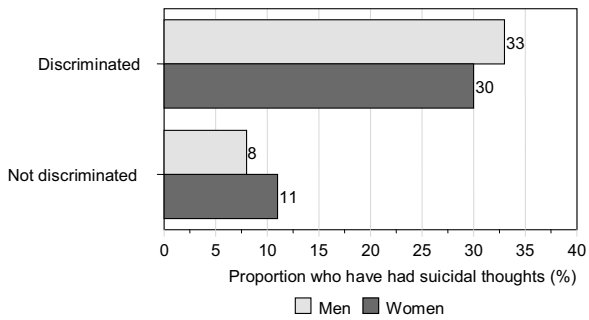


Figure 9. People in the age range 18-84 who have had suicidal thoughts, as a proportion (percentage) of people who have, or have not, experienced discrimination. Age standardised values.
Source: National Public Health Survey, 2006, National Institute of Public Health.

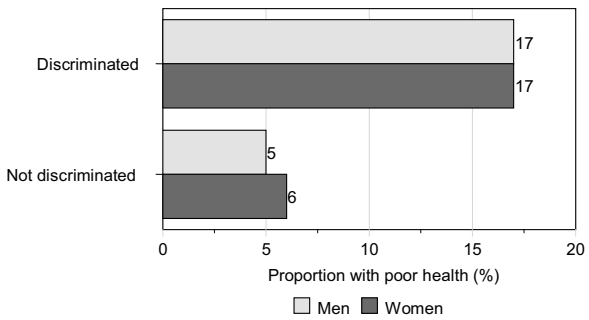


Figure 10. People in the age range 18-84 who reported poor general health status, as a proportion (percentage) of people who have, or have not, experienced discrimination. Age standardised values.
Source: National Public Health Survey, 2006, National Institute of Public Health.

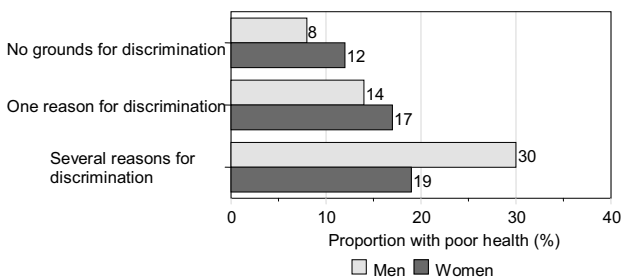


Figure 11. People in the age range 18-84 who reported poor general health status, as a proportion (percentage) of people who have, or have not, experienced discrimination (n=9,077). Age standardised values.
Source: National Public Health Survey, 2006, National Institute of Public Health.

Chapter 5.

Results of the qualitative survey

Validation of responses for self-reported discrimination¹⁴

HD has assigned the Statistics Sweden to carry out qualitative studies in order to validate questions involving self-reported discrimination, based for example on questions in the national public health survey, but also on other wordings and concepts in this field. The aim was that validation was to provide a basis for both “batteries of questions” and future indicators for self-reported discrimination. Obtaining more information about the correlation with discrimination and ill-health or other factors was another objective.

These studies were intended to examine in more detail correlations between discrimination and ethnicity, sexual orientation and disabilities. One key question was to study what links and distinguishes different grounds for discrimination, and how they are related to each other – the way in which various forms of discrimination reinforce or weaken other forms. These studies involved three focus groups and a number of in-depth interviews at the individual level.

A number of sample criteria were determined, in cooperation with HD. It was important to achieve diversity and the best possible prerequisites for communication – full coverage in terms of age, gender and employment. It was desirable to have a varied period of residence in Stockholm, and a high proportion of people who were not active members of voluntary associations or who had not filled in so many questionnaires. Since the focus groups included homosexuals and bisexuals, people born in another country and people with various disabilities, there were also several other specific sampling criteria.

In all, 27 people were recruited for focus groups and interviews, based on the above criteria. Recruitment was accomplished via the project’s own contacts and networks, for example from voluntary associations and organisations – in other words via “gate-keepers” and “snowball” samples. During the spring of 2006, three focus groups and 14 in-depth interviews with 27 people were conducted, involving 14 women and 13 men, ranging from 19 years of age to slightly more than 60.

These people were born in a total of seven countries, had different kinds of disability (hearing, sight, mental problems, stroke, impaired mobility and dyslexia). Nine people were openly homosexual and bisexual, and three people were born in Sweden, openly heterosexual and also free from disability. Most of them were working in various fields (18), some were students (6), some were both working and studying (2), one was applying for a job, and one was in the process of retiring. A question guide was developed for the focus groups and the interviews which was concerned with the way in which the participants understood and experienced the discrimination concept and the terminology used in this context, for example harassment and offensive treatment.

Negative special treatment based on actual or assumed group affiliations¹⁵

Prior to publication of the final Statistics Sweden report¹⁶ containing the full results, the HD expert

¹⁴ This section is based on Appendix 2, “What does discrimination mean – comparisons between the opinions of various groups and associated concepts”, Statistics Sweden, 2006. Appendix 2 is available on the following websites: www.fhi.se, www.do.se, www.ho.se, www.homo.se.

¹⁵ This section is based on an internal memorandum submitted to HD by the expert group on 18 August 2006 and the expert group’s presentation at the National Conference on Discrimination and Health on 25 September 2006. The expert group comprises Martin Börjesson, Fredrik Lindencrona and Karin Nyqvist.

¹⁶ This report will be published in connection with the HD Final Report; Appendix 2: “What does discrimination mean – comparisons between the opinions of various groups and associated concepts”, Statistics Sweden, 2006. Appendix 2 is available on the following websites: www.fhi.se, www.do.se, www.ho.se, www.homo.se

group has examined written documentation for the focus groups and the interviews. The expert group presented various aspects of the work on the qualitative studies and made an overall assessment of the results in an internal memorandum, and at the National Conference on Discrimination and Health.

The HD expert group stressed the importance of validation of issues related to self-reported discrimination, and the fact that self-experienced discrimination and, in particular, its links with health constitute a new area and a complex and abstract concept. As a result, it is desirable to be aware of this concept's limitations and sub-aspects of the concept, in accordance with what various interviewees say.

The expert group made some general observations, based on the studies, as demonstrated by a selection of quotations from the focus groups and the interviews.

1. Discrimination is a many-sided concept.

“Discrimination seems to assume that there has been a generalisation of some people who can be placed in a familiar pigeon-hole”

“...some sort of splitting into groups, based on features or characteristics ... a hierarchy between groups ... normative ...linked to value added ... Discrimination is presumably the actual consequence of that sort of thinking.”

“Discrimination is being excluded from something ...”

“Discrimination means being treated in a special way ...”

“...not being looked at on the basis of your potential ...”

“... not having access to the same opportunities ...”

“Discrimination is taking someone's rights away from them due to their ethnic background, appearance or political views ...”

“It means being unfairly treated, unfairly treated for no reason”

2. Harassment is not the same thing as discrimination

For the most part, harassment is regarded as more drastic than discrimination, since it affects the individual more deeply than discrimination, which is more related to groups. The reason for harassment may be based on one of the grounds for discrimination.

Harassment is more deliberate:

“...one distinction, at any rate, must be “awareness” ...”

“Harassment is never unconscious – it is a deliberate choice, in order to get at someone in one way or another ...”

“...it feels as if there are deliberate, bad intentions if someone embarks on harassment”

Harassment is more symptomatic:

“...it is more systematic, in some way”

“People attack someone on a continuous basis”

“I think harassment involves persecution.”

Harassment is also regarded as more individual and physical:

“It is aimed at an individual. Discrimination is treating a certain type of people in one way ...”

“I think harassment is more violent... more physical ...”

3. Offensive treatment primarily leads to a feeling which is one of many possible reactions to discrimination:

“It’s a feeling”

“... the term fits because it has to do with feelings. I feel offended. That’s really the worst thing about discrimination, mobbing or harassment”

“Discrimination describes an action that excludes someone from something – and this can result in this person feeling offended.”

“... in my case... if I was to be “offended”, then it would be very much a question of a personal wrong”

“...extremely personal... Someone has stamped on my way of being, on my life and the way I live it, and what I am.”

“Offensive treatment makes you feel degraded... And as far as I’m concerned it’s something that happens in a public place ...”

“...to degrade ... to be out to harm someone...”

Finally, the expert group has proposed a tentative empirical definition of discrimination. This definition, which merits further study, takes the focus groups and the interviews as its starting point:

“Negative treatment based on actual or assumed group belonging”

Chapter 6.

Countering discrimination to improve public health

Discussion/summary

HD has presented its results in this final report. They include a common approach to discrimination and self-reported discrimination as a way of measuring discrimination and health, and as an indicator for monitoring changes in and prevalence of discrimination. In this context, in Chapters 4-5, HD presents the results of the national public health survey and the preliminary results of the qualitative studies carried out under the auspices of Statistics Sweden.

The results indicate that discrimination is common, takes various forms in society and has links with gender, age, country of birth, disabilities and sexual orientation. Discrimination occurs in the three institutions analysed: social insurance offices, employment offices and medical and health care services.

The incidence of self-reported discrimination has been virtually static in the period 2004-2006. The only clear difference is that people have definite opinions to a greater extent in 2006 and are more likely to indicate discrimination as a reason for offensive treatment than in 2004. One possible explanation may be that people have become more aware of discrimination. This, in its turn, may be explained by the fact that anti-discrimination legislation has started to take effect, and that discrimination issues have been widely discussed in the media in recent years.

The results show that correlations between discrimination and ill-health are strong, on the whole, and even very strong. Correlations with mental ill-health were stronger than for physical ill-health. The correlations were also stronger for men than for women, and people who gave more than one reason for discrimination reported that their health was worse than people who only reported a single reason for discrimination.

HD has demonstrated and made it clear that the correlations between discrimination and ill-health are strong, although there are still many question marks. The national public health survey is a “cross-section” study, which makes it impossible to investigate causal relationships between discrimination and health. HD has suggested possible explanations for correlations between discrimination and health. It has proved that discrimination can affect health in many different ways and, as a result, further research in this area is important.

Statistics Sweden’s qualitative surveys are designed to pinpoint the questions that should be posed to get a grasp of the incidence of discrimination. Statistics Sweden is presenting its own conclusions in connection with publication of this final report. The preliminary results indicate that discrimination is a many-sided concept, that harassment cannot be equated with discrimination, and that the experience of being subjected to offensive treatment primarily involves feelings, as one of several possible reactions to discrimination. As a result, there is a considerable need for further validation of the questions.

To summarise, HD considers that efforts to counter discrimination are also efforts to improve public health, and that measures to counter discrimination should be taken in all possible spheres in society.

Action proposals

The national Action Plan for Human Rights states that, in the light of the information and knowledge gathered, for example in the Health and Discrimination project, the government is considering what steps can be taken to improve the prerequisites for a satisfactory health status among people who expe-

rience discrimination. (1) The knowledge and information gathered in this project are based on our own investigations, statements of expert opinion and the implementation of workshops, reference-group meetings, meetings with non-governmental organisations, and a national conference.

1. The validation process should continue

HD considers that the Statistics Sweden studies have established good foundations for continued validation, and that the next, more sophisticated stage, in this process should be taken.

In its internal memorandum, the expert group has proposed implementation of an explorative process model as the next stage in the validation process. According to the expert group, this model involves gaining an understanding in greater depth of experiences of discrimination which provide the prerequisites for improved studies of the relationship with health, and the relationship between objective and subjective experiences of discrimination. The starting point for this task is the raw data that has been collected, but which needs to be supplemented by some additional interviews.¹⁷ A quantitative validation should then conclude the validation process.

2. A handbook on the measurement of discrimination

It is particularly important that active participants in the discrimination and health field at the national, regional and local levels and non-governmental organisations chart the extent to which discrimination occurs and how it is linked to health, both jointly and independently. Several of these parties conduct their own research or undertake population surveys or projects with links with the discrimination/health area.

Following on from the project and, in particular, the proposal for continued validation (see Proposal 1), a methodological handbook for the measurement of discrimination should be prepared. This would facilitate the use of questions for charting the incidence of discrimination and the utilisation of other indicators to supplement the picture.

3. An in-depth population survey of discrimination and health

Only a limited number of questions about experiences of discrimination are posed in the national public health survey, and hence there is a lack of information about key aspects of such perceptions. As a result, an in-depth survey of discrimination and health is called for.

An in-depth survey can point to other factors related to the discrimination experienced, for example the time point involved, the extent, the manner in which it occurred, the reason, and also how people who have experienced discrimination have reacted and what effects this may have, for example on health.

A validated questionnaire for a survey of this nature is already in existence, prepared by Nancy Krieger and entitled Experiences of Discrimination (EOD). (25) Gunilla Krantz, one of HD's experts, notes that various studies have indicated that EOD has a high degree of reliability and validity in comparison with other alternatives. Krantz considers that an instrument of this nature could be translated into Swedish and tested on a larger population, including groups with a high risk of experiences of discrimination. (2)

¹⁷ The explorative process model is described in full in an internal memorandum submitted to HD by the expert group on 18 August 2006 and at the expert group's presentation at the National Conference on Discrimination and Health on 25 September 2006. The expert group comprises Martin Börjeson, Fredrik Lindencrona and Karin Nyqvist.

One limitation of this questionnaire in the current situation is that it primarily focuses on ethnic discrimination, but it might possibly be used to provide a basis for a questionnaire aimed at other types of discrimination. When validation (see Proposal 1) has been completed, a quantitative validation of EOD should be carried out, thus translating the battery of questions into a Swedish context and making it valid for all types of discrimination.

4. A comparative population survey in the European Union on discrimination and health

On the assumption that Proposal 3. (An in-depth population survey of discrimination and health) is implemented, other countries within and outside the European Union should also draw up and carry out a corresponding survey of discrimination and health. Since the framework for the survey consists of the questionnaire developed by Nancy Krieger, which has already been employed in English and Spanish, there are excellent prerequisites for corresponding batteries of questions in other countries, languages and societies. (25) As in the case of the Swedish survey, comparative surveys should also cover all grounds for discrimination.

5. Allocation of research funding for discrimination and health

In HD's view, more research is required in the discrimination and health field, and special funds should be allocated for this purpose¹⁸. HD considers that such research should focus on:

- The societal consequences of discrimination, in terms of both health and the economy,
- The mechanisms underlying the impact of discrimination on health,
- The way in which various power structures and reasons for discrimination are inter-related, in order to achieve a better understanding of the way in which discrimination in society is related to health,
- The way in which reactions/strategies as regards experiences of discrimination affect health, and
- Ways in which measures to counter discrimination have an impact on the incidence of discrimination and the health of those affected.

Some of the above factors may be elucidated by designing and implementing an in-depth survey of discrimination and health which complies with the validated investigation carried out under Nancy Krieger's auspices (see Proposals 3-4).

6. The national public health questionnaire should include a question about sexual orientation

It is now possible to delineate to most of the reasons for discrimination in the national public health survey. As a result, it is highly important, in the future, to include a question in the national public health survey which reflects the respondent's sexual orientation.

The National Institute of Public Health's report on the health status of HBT groups indicated that there were substantial differences in health, and that discrimination was a major reason for such discrepancies. (17) As a result, continued charting of sexual orientation should be of major interest in clarifying health inequalities and discrimination. In addition, it has proved that posing a question about sexual orientation has had no significant impact on the rate of response in previous public health surveys. The challenge is more a question of designing a question that includes sexual orientation in a satisfactory manner.

¹⁸ Several of HD's proposals comply with the proposals in (13).

7. The national public health survey should be supplemented by qualitative studies, on a regular basis

Questions regarding self-reported discrimination should be supplemented on a continuous basis (every fourth year) by qualitative studies designed to ascertain whether the questions posed are still relevant for measuring experiences of discrimination or whether changes in society mean that the question has acquired a different meaning and should be modified, or even replaced.

8. Questions in the national public health survey about discrimination should be reformulated

When validation (see Proposal 1) of the questions involving self-reported discrimination has been implemented, HD proposes that a review should be carried out regarding possible reformulation of the questions – for example the question concerning offensive treatment, the links with discrimination and the arena in which discrimination occurs.

In order to ensure that respondents do not experience any sense of culpability in the discrimination to which they are exposed, HD would like to reformulate the question, as soon as possible, to read:

- Why were you treated in a manner which you felt was offensive?
(Response alternatives: Ethnic background, Gender, Sexual orientation, Age, disability, Religion, Other – open question, don't know)

Instead, this question should read:¹⁹

- Was the offensive treatment you experienced related to any of the following alternatives?
(Response alternatives: Ethnic background, Gender, Sexual orientation, Age, disability, Religion, Other reason, don't know)

9. Cooperation with a focus on children and young people

HD has not taken the children's perspective into account sufficiently. One reason is that the quantitative data on which the project has been based (the national public health survey) has extended from 16 years of age upwards, and the qualitative surveys have been primarily targeted at the adult population, with the aim of validating questions involving self-reported discrimination.

Obviously, the experiences of children and young people as regards offensive treatment and discrimination are a very important part of the picture, particularly in view of the results reported by the project indicating that the younger generation is subject to offensive treatment and discrimination to a greater extent than older people. In the light of the new Discrimination and Degrading Treatment of Children and Pupils Act (2006:67) and the fact that one of the national public health policy objectives focuses on children, cooperation regarding measurements (quantitative and qualitative) of children's experiences of offensive treatment and discrimination should be implemented. Potentially, cooperation could be established with the National Agency for Education, which has recently been assigned by the government to survey the incidence of offensive treatment and discrimination in schools.

10. Implement user studies of discrimination

HD proposes that user studies of the incidence of discrimination should be implemented in operations with direct contacts with users and which are relevant for human health. Such contacts may, for

¹⁹ This proposal for formulation of this question may be subsequently modified.

example, involve medical and health care services, national insurance offices, employment offices and municipal services such as individual and family care, care of the disabled and care of the elderly.

In the case of the central government sector, such studies may be covered by the framework for implementation of anti-discrimination strategies targeted in the Action Plan for Human Rights in the period 2006-2009. In addition to the drawing up of anti-discrimination strategies, the 2006 Action Plan for Human Rights also emphasises the importance of equal treatment in medical services. (1) FHI's feedback report on the HBT assignment also stresses that active efforts to counter discrimination of HBT people are an important feature of its external activities directed to customers/users. (17)

The *Blågula glashuset – strukturell diskriminering i Sverige* report proposes the establishment of a health-care know-how bank in a multi-technical society, under which knowledge and information is to be built up under the auspices of HDH. (5) In this connection, DH considers that the know-how bank should cover all grounds for discrimination, and that in this case the initial task should be to chart users' experiences of offensive treatment and discrimination in the medical and health care sector.

11. Establish a national monitoring system for discrimination

DH considers that a national discrimination follow-up should be established. The current system of looking at discrimination on the basis of several policy areas and with a focus on different grounds for discrimination and different types of operations, is an obstacle to obtaining a satisfactory overview of the way discrimination in society changes, in point of fact, as time passes.

There is no cohesive analysis which includes all protected (and unprotected) grounds for discrimination and various aspects of discrimination which may be relevant in various types of operations – for example in the housing market, medical and health care services and the labour market. A more systematic approach might help to provide an ongoing picture of the way discrimination is changing, and possibly expanding. A follow-up system could cover various aspects of discrimination under the same umbrella, and the resultant analysis could provide a sound basis for decisions regarding appropriate measures and optimum allocation of financial resources.

The existing structure for implementation of national public health policy provides a suitable platform for monitoring changes in discrimination in society on a continuous basis. Apart from providing an existing and functional structure, the goal of “establishing the prerequisites in society for satisfactory health on equal terms for the entire population” is closely associated with human rights which involve, per se, an endeavour to counter discrimination. Furthermore, DH considers that extensive efforts which have already been implemented by FHI to present evidence in this context for correlations between determining factors/indicators and health/ill-health should be utilised.

One of the weaknesses in the existing monitoring of national public health policy is that discrimination, as one of the determining factors for health, is only mentioned under one of the target headings (Objective 1), where the focus is on ethnic discrimination. As a result, it is important to monitor discrimination on the basis of the overall goal of “establishing the prerequisites in society for satisfactory health on equal terms for the entire population”.

Objectives 1-6 may be regarded as highly relevant for elucidation of discrimination in society. Participation and influence, a sense of economic and social security, secure and satisfactory conditions for growing up, health in working life, healthy and secure living environments and products, and the medical and health care sector are all crucial areas, in which analyses of inequalities in health should always take into account from the discrimination perspective. The other objectives should also be taken into account, as required, and supplemented in an analysis of this nature.

²⁰ In their official response to the Public Health Policy report, DO (26) and HomO (27) present some suggestions for indicators to supplement a national monitoring system.

One weakness in many of the existing indicators is that they are cannot currently be broken down at the local or regional level, they cannot be used to report all the grounds for discrimination called for (apart from gender and age), and they cannot always indicate and/or affect factors in society that involve the living conditions of various groups subject to discrimination²⁰. DH considers that the self-reported discrimination can be supplemented by other more valid indicators, thus reinforcing/modifying patterns which may be reported in this kind of analysis.

Analysing national public health policy from a discrimination perspective offers considerable opportunities for arriving at a more cohesive picture of the situation as regards the development and prevalence of discrimination and, at the same time it is a natural and systematic way of approaching the correlation of discrimination with health. A proposal of this nature goes hand in glove with the 2006 Action Plan for Human Rights, which states that indicators are to be developed for the evaluation and monitoring of the promotion of human rights at the national level, (1) and is line with the discussion of national public health policy by the Official Committee on Power, Integration and Structural Discrimination, which has recently presented its report. (28)

12. Establish a local and regional monitoring system for discrimination

The Action Plan for Human Rights in the period 2006-2009 proposes that municipalities should draw up targets and action plans for human rights. (1) In its specification of measures, the public health policy report stresses the importance of reinforcing efforts to counter discrimination at the local and regional level. (12) In harmony with these measures and in cooperation with a reference group at the local and regional level, DH notes that one prerequisite for steps of this nature is that the incidence of discrimination is monitored at the local and regional level.

DH considers that a local and regional monitoring system for discrimination should be established. The structure of this system should be on the same lines as the national monitoring system, and should be drawn up in close cooperation with representatives of municipalities and county councils.

In HD's view, municipalities and county councils are a very important factor in achieving a change which can make a difference to people's lives. There is a considerable interest on the part of municipal and county council elected representatives and officials in a change process to counter discrimination. On the other hand, there are a few reliable instruments for measuring discrimination at the local and regional level. Reliable figures and measurement tools could enable local councillors to get a picture of the situation and follow-up whether any measures taken are having an impact on employees and/or local inhabitants. This would permit elected representatives to introduce discrimination as a variable in their annual reports/balance sheets and would give them an opportunity to include measures to counter discrimination in a systematic manner in their regular target and budget process.

National public health policy can provide inspiration and support for work at the local and regional level in various ways. One model applied by some 40 municipalities in Sweden is termed the "Local welfare balance sheet", which is a method for control and follow-up of municipal operations, drawn up by the National Institute of Public Health, the Swedish Association of Local Authorities and Regions and a high proportion of local authorities all over Sweden. The aim of local welfare balance sheets is "to establish societal prerequisites for good health on equal terms for inhabitants of the municipality". The health and welfare of local inhabitants is described in terms of 30 determining factors and 39 indicators which are of crucial importance for public health, but which are also relevant from a local and regional perspective. (29) This model has already been tested, and is being progressively developed in close cooperation with a majority of municipalities and county councils.

²⁰ In their official response to the Public Health Policy report, DO (26) and HomO (27) present some suggestions for indicators to supplement a national monitoring system.

In the light of the discussion in the previous section of the special suitability of national public health policy as a platform for a national monitoring system for discrimination in society, DH considers that local welfare balance-sheet processes could fill a similar function at the local and regional level.

13. Prepare materials to help municipalities to counter discrimination

It is not enough to measure the incidence of discrimination and relate it to health. During the course of the project, it has been asserted in municipal and regional quarters that there is no support, in practical terms, for effective measures to counter discrimination²¹ which apply on a general basis for various forms of discrimination or which are focused on a single type of discrimination. As a result, DH considers that such materials should be produced, in close cooperation with municipal and county council representatives.

²¹ This proposal was raised, for example, at the National Conference on Discrimination and Health held on 25 September 2006 in Stockholm, but was also discussed at the meeting with the DH reference group at the local and regional level on 7 September 2006.

Final comments

When the HD project started in 2004, information and knowledge about discrimination and health were limited, from a Swedish perspective. With assistance from the national public health survey and the research conducted in recent years, it is now possible to say a great deal more about the correlation between discrimination and health and about appropriate ways of monitoring changes in and the prevalence of discrimination than was the case in 2004.

The authorities that have cooperated in this project have experienced mutual benefits.

In the case of DO, HO and HomO, this joint project has provided know-how and information about how discrimination affects people's health and, as a result, has reinforced the outgoing task of counteracting discrimination in society as a whole. In addition, when it comes to measuring the incidence of discrimination, this project has helped to provide a more reliable picture of the extent to which discrimination occurs in society and this, in its turn, can help make it clearer whether the right measures are being taken to counter discrimination.

For FHI's part, the joint project has helped to ensure that the annual surveys of public health contain questions that throw light on discrimination as far as possible. Analyses of the data have been carried out in a way that also permits a focus on the discrimination of various groups in society. As a result, there has been a broader approach to discrimination issues, and they cover additional target groups and objectives which, per se, help to strengthen and clarify public health assignments at the national, regional and local levels.

The HD project will be terminated on 31 October 2006. The project's executive group consists of Jonas Frykman (project manager), Weini Kahsai Nobel (DO), Johanna Ahnquist (FHI), Anna Schölin (HO) and Marie Lindberg (HomO). In the course of the project, HD has had occasion to be grateful to many people and organisations for the satisfactory progress made.

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Discrimination – a threat to public health

Final report – Health and Discrimination Project

The *Discrimination – a threat to public health* report presents the results of a major population survey which indicates that the incidence of discrimination is prevalent, takes various forms in society, and is correlated with gender, age, country of origin, disabilities and sexual orientation. According to this survey, there are very strong links between discrimination and mental ill-health.

According to a qualitative study presented in the report, people have a wide range of views on the discrimination concept. There is a great need for the formulation of reliable questions to measure the incidence of discrimination, but this is also a complex matter. According to the report, efforts to counter discrimination also entail efforts to improve public health. As a result, it is essential to arrive at satisfactory methods for investigating and monitoring discrimination in society if effective measures are to be taken to counter discrimination.

Discrimination – a threat to public health is the final report of the joint Health and Discrimination project. This project was conducted from 2004–2006 by the National Institute of Public Health (FHI), the Office of the Ombudsman against Ethnic Discrimination (DO), the Office of the Disability Ombudsman (HO) and the Office of the Ombudsman against Discrimination on grounds of Sexual Orientation (HomO). During 2006, the project was largely funded by the European Commission.

This report is supported by the European Community Action Programme to combat discrimination (2001–2006). This programme was established to support the effective implementation of new EU anti-discrimination legislation. The six-year Programme targets all stakeholders who can help shape the development of appropriate and effective anti-discrimination legislation and policies, across the EU-25, EFTA and EU candidate countries.

The Action Programme has three main objectives. These are:

- To improve the understanding of issues related to discrimination
- To develop the capacity to tackle discrimination effectively
- To promote the values underlying the fight against discrimination

For more information see: http://europa.eu.int/comm/employment_social/fundamental_rights/index_en.htm

The information contained in this report does not necessarily reflect the position or opinion of the European Commission.



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