Conceptualising the linkages between the Social Determinants of Health and Disability

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Presentation Outline

- Rationale for this lecture
- Overview of the key concepts of the Social Determinants of Health framework
- Brief overview of the key concepts and ideas with regard to disability research, policy and practice
  - Why they are important
- An analysis of the synergies and complementarities between the Social Determinants of Health framework and disability policy and practice
- Concluding comments

_Caveat – many issues will be dealt with at a very elementary level, due to time constraints_
Introduction I

- The Social Determinants of Health (SDH) framework has become a major international paradigm:
  - Embraces an holistic conception of health, including political, economic, demographic, and cultural factors.
  - It needs to become more influential in the future.
  - Yet the Commission for SDH Global Report does not make any reference to disability issues whatsoever.

- Disability studies (as an academic discipline), and the disability movement, has an ambivalent conception of “health”.
  - In the past, the international disability movement has been very wary of engaging with medical and para-medical professionals, in the belief that they have too much power over the lives of disabled people.
  - Yet disabled people need access to affordable and effective health care and rehabilitation, particularly in developing countries.
Introduction II

• Yet, the SDH framework and disability studies, policy and practice have a great deal in common.
  – These synergies and linkages have yet to be analysed and exploited.

• The purpose of this presentation is to examine some of these synergies
  – This is still very much a “work in progress”
  – There needs to be a concerted effort to undertake further research in this important field.
  – A copy of a working paper can be found on the Leonard Cheshire Disability and Inclusive Development Centre’s website:
    [http://www.ucl.ac.uk/lc-ccr/centrepredictions/workingpapers](http://www.ucl.ac.uk/lc-ccr/centrepredictions/workingpapers)
Introduction to the Social Determinants of Health Framework
The SDH Framework

- The Social Determinants of Health (SDH) has had a significant influence on the international public health agenda - the framework is increasingly used by UN, bilateral agencies, governments and civil society organisations.

- It is likely to become of increasing importance.

- The fundamental premise upon which the SDH is based is that health inequalities - both mortality and morbidity - are the result of structural factors existing in all countries (global North and South).

- These produce an inequitable distribution of health outcomes and inequitable access to health services, (Commission for the Social Determinants of Health, 2008).

- It is further argued that there is a "social gradient" with regard to health inequalities both within and between countries - a result of "the unequal distribution of power, income, goods and services"

- Hence, health inequalities are the result of existing social and economic inequalities, including factors such as income, occupational category, socio-economic status, geographical location, level of education, and social capital
The SDH Framework II

• Generally, SDH research clearly shows those who are poor, or who are most socially excluded and marginalised, find it harder to access appropriate and affordable healthcare services compared to those who are more affluent and socially integrated and, on average, live shorter lives and have higher levels of morbidity and mortality.

• Consequently, "This toxic combination of bad policies, economics, and politics is, in large measure, responsible for the fact that a majority of people in the world do not enjoy the good health that is biologically possible" Commission for the Social Determinants of Health, 2008: 26).

• In determining its theoretical framework to investigate the SDH, the Commission intended to address the following three questions:
  1. Where do health differences among social groups originate, if we trace them back to their deepest roots?
  2. What pathways lead from root causes to the stark differences in health status observed at the population level?
  3. In light of the answers to the first two questions, where and how should we intervene to reduce health inequities?” (Solar and Irwin, 2007: 4)
The SDH Framework IV

• Both the Global Report and *The Marmot Review - Fair society, Healthy Lives: Strategic Review in Health Inequalities England post-2010* identify six common policy objectives for tackling health inequalities that include:

1. Give every child the best start in life;
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives;
3. Create fair employment and good work for all;
4. Ensure a healthy standard of living for all;
5. Create and develop healthy and sustainable places and communities; and

• Each of these policy objectives will be examined in relation to disability later in this presentation
Fundamental Concepts within Disability Studies, Policy and Practice
Disability Statistics

• Since the late 1990s, it has been assumed that there are approximately 650 million disabled people in the world, 80% of whom live in developing countries.

• Recently revised to 1 billion (= 15% of the world’s population – World Report on Disability (WHO, 2011))
  – Many disabilities could be prevented with timely and appropriate health interventions (public health and basic rehabilitation services)
  – DFID estimates that 50% of disabilities are preventable

• Disability and poverty are both a cause and consequence of each other
  – 20% of the world’s poorest are disabled people

• Disabled people constitute one of the most marginalised and socially excluded groups within any society
  – Lack of access to mainstream public services, including health, education and employment
  – 98% of children with disabilities do not complete primary education
  – These are at best guestimates - “evidence by citation” (Murray Strauss, 2007)
Definitions of Impairment and Disability
The Union of physically Impaired Against Segregation 1976

• “Impairment (is) lacking part of or all of a limb, or having a defective limb, organism or mechanism of the body;

• Disability (is) the disadvantage or restriction of activity caused by contemporary organisation which takes no or little account of people who have physical impairments and thus excludes them from the mainstream of social activities.”
Why definitions of disability are important

- Definitions of disability are not solely of semantic or academic interest
- The manner in which disability is defined is fundamentally linked to issues of power, legitimacy and agency
- Power has been understood as “who gets what, when and how?”
- Therefore, contrasting understandings of “disability” determine who sets the agenda for the provision of public services (including health), and decisions regarding what and how priorities are set
- Historically, disabled people have been characterised as passive recipients of charity and welfare, who are unable to make informed choices for themselves – the medical model of disability
- In ideological juxtaposition to this approach, the social model of disability maintains that those with impairments have been systemically marginalised and excluded from society
- This is linked to contemporary debates regarding participation within international development
The International disability policy environment III

International Instruments

- UN Convention of the Rights of Persons with Disabilities, 2008
  - First human rights treaty of the 21st century
  - Culmination of 30 year involvement of UN in disability issues
    - 1981 UN International Year of the Disabled
    - 1983-1992 UN Decade of Disabled Persons
    - 1993 UN Standard Rules on the Equalisation of Opportunities of Persons with Disabilities
  - Negotiated with the full involvement of civil society institutions
  - Does not establish any new human rights
  - For the first time, disabled people have an international legally-binding instrument to hold their respective governments to account
  - To date, 103 sovereign states have ratified the Convention
Medical Model
Focus: The Disabled Individual

- Care/cure
- Segregated Institutions
- Medical Rehabilitation
- Sheltered Employment
- Social workers

Individual
Charity Model
Focus: The Disabled Individual

- Can’t walk/see
- Need to be looked after
- “Brave”
- Pitied
- “Bitter and Twisted”
- Sad, tragic
- Patient
Social Model
Focus: The Disabling Society

- Inadequate services
- Inaccessible buildings & transport
- Discrimination
- Poverty
- Inclusion
- Rights

Disabling Society
The international disability movement

- Originally arose during the 1970s after the Vietnam War
- Disabled people’s organisations (DPOs) are run and managed by disabled people themselves, and are primarily concerned with promoting disability rights
- The ideological foundations of the disability movement is the social model of disability
  - Hence, disability is the result of physical, attitudinal and institutional barriers that result in systemic oppression, discrimination and social exclusion of disabled people.
  - Therefore, disability is a socio-political construct rather than the result of physical and/or intellectual abnormalities of the disabled person
  - The clarion call of the disability movement is “nothing about us without us”
- The disability movement played an instrumental role in the negotiation of the 2008 UN Convention
- However at country level, their democratic credentials are sometimes questionable
Synergies between the SDH and Disability
Preliminary Statements

- Having an impairment does not necessarily imply that you are ill.
- Disabled people need access to medical and para-medical services.
- Disabled people develop the same health problems and conditions as their non-disabled counterparts.
- It is contended that both “impairment” and “disability” are socio-political constructions.
- The *World Report on Disability* states that disabled people have less access to health services than non-disabled people.
  - The WHO 2002-2004 *World Health Survey* which gathered data from 51 countries, reported that disabled people were more likely to seek inpatient and outpatient care.
  - However, the same survey also reported that disabled people were not in fact receiving such provision.
- Both the SDH framework and disability policy and practice are underpinned by the principles and axioms of human rights.
“States Parties recognise that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation” (United Nations, 2008).
1. **Give every child the best start in life**

- Throughout the global North and South, but more critically in developing countries, poverty is linked to the appearance of a number of potentially preventable disabling conditions.
  - Lack of access to health care and early intervention programmes
    - Un-stimulated children do less well in later life
  - Sexual abuse of disabled children
  - Unsafe housing and lack of basic sanitation
  - Increased risk of polio and measles
  - Lack of financial resources means that the initial disabling conditions can worsen over time or that disabled children face additional and potentially preventable further illnesses or conditions
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives

- Disabled children, young people and adults ‘maximise their capabilities’ to enable them to have control and autonomy over their lives (Read et al, 2006);
  - Disabled children and adults have a right to achieve the same ‘developmental milestones” as their non-disabled counterparts.
  - Need family support to encourage and nurture their disabled children
  - The vast majority of disabled children do not complete primary education
    - 89% globally according to UNESCO
    - Stigma, negative attitudes held by school teachers, school fees
    - In 1994 the Salamanca Statement and Framework for Action on Special Needs Education strongly endorsed disabled children’s right to education
  - Disabled adolescents often not encouraged to make their own decisions.
    - Relationships, employment, where to live etc.
  - Also, they often do not participate in social and community events
    - Depleted levels of social capital, relational bonds, social exclusion etc.
3. Create fair employment and good work for all

- In all societies, disabled people have higher rates of unemployment than their non-disabled counterparts
  - Stigma, inaccessible workplaces, negative attitudes of employers etc.
- Disabled people have higher living costs in order to survive
  - The direct costs of medical treatment and rehabilitation
  - The indirect costs (for example, costs of transportation)
  - The opportunity costs of not being able to make a sustainable living in open labour market.
- In 2000, the World Bank estimated that the annual loss to global GDP of people with disabilities not working who were in a position to do so, was between $1.37 trillion and $1.94 trillion (Zadek and Scott-Parker, 2001).
4. Ensure healthy standard of living for all

- Strongly linked to the disability-poverty nexus
  - A disabled person is more likely to be economically poor, due to lack of access to education and employment opportunities.
  - Similarly, those who are the most poor are more likely to become disabled, due to living in unhealthy and insanitary environments, lack of access to affordable health care, greater susceptibility to non-communicable diseases etc.

- In the vast majority of developing countries, with few notable exceptions, there are no social protection programmes for disabled people
  - Those that do exist are based on the medical model of disability
  - Vast majority of disabled people in developing countries do not have long-term sustainable employment
    - Lack of income often results in not having enough to eat, which exasperates poor health
5. Create and develop healthy and sustainable places and communities

- This policy objective covers a multiplicity of factors related to the physical environment directly relevant to disabled people
- Linked to the healthy cities debate (Rydin, et al, 2012),
  - Disabled people often live in urban slums, which has a detrimental health impact
- Climate change
  - The Lancet Commission on Climate Change clearly demonstrates that climate change impacts will result in higher rates of mortality and morbidity in the future (Costello et al, 2009).
  - The greatest impact will be on the poor living in developing countries
  - Will result in higher rates of impairments and disability developing countries
- Inaccessible environments
  - Transportation systems, public buildings etc.
  - Results in significant isolation and exclusion from participating in society
  - Negative impact on the physical and psychological impact of disabled people
6. **Strengthen the role and impact of ill-health prevention**

- “Prevention” is a highly politicised and controversial subject in disability studies
  - Some disability scholars maintain that all prevention initiatives are unethical, as this leads to wanting to create a “perfect society”
  - I disagree
  - For example, some disability activists maintain that prenatal testing for impairment is inherently wrong, for it diminishes the positive and productive role that disabled people can and do play in society
  - Counterarguments that emphasise the wishes and rights of parents have been equally important
- This is by far the hardest policy objective to synchronise within the SDH framework and policy agenda with regard to disability policy and practice.
Equity for all
Human rights
Discrimination
Social exclusion
Effective public policy
Conclusion
Some Concluding Remarks

- The agendas of both the SDH approach and disability policy and practice have a great deal in common
  - Equity to health services, human rights etc
- The potential synergies exist, but have yet to be subjected to rigorous analysis and research
- The potential for collaboration between the two fields are huge and will only increase over time
  - Demographic projections
  - Aging population
  - Detrimental health effects of climate change
- Has the potential to make a significant impact on health policy and practice, both at national and international levels