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Conceptualising the linkages between the Social Determinants of Health and Disability

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ABSTRACT

The objective of this paper is to examine the potential relationships and synergies that exist between the ideological premises, methodology, principal findings and policy recommendations of the Social Determinants of Health (SDH) framework and disability research. What follows is primarily based on the seminal work on the SDH, *Closing the Gap in a generation: Health equality through action on the social determinants of Health,* published by the Commission on the Social Determinants of Health (hereafter referred to as the Commission) in 2008 (Commission for the Social Determinants of Health, 2008) and *Fair society, Healthy Lives: Strategic Review in Health Inequalities England post-2010 (The Marmot Review)* (Marmot et al, 2010). It also draws heavily on a paper written by Solar and Irwin in April, 2007 entitled *A Conceptual Framework for Action on the Social Determinants of Health* that sets out the intellectual antecedence, theories and overall theoretical framework on which the approach is premised. What follows is a position paper primarily written to assist in exploring potential areas for future collaborative avenues of research between researchers and advocates in SDH and disability studies. The paper will begin by outlining the foundational thesis and theoretical framework of the SDH, and then will examine this in relation to contemporary debates in disability studies and international development.

THEORETICAL FRAMEWORK OF THE SOCIAL DETERMINANTS OF HEALTH

Introduction

The Social Determinants of Health (SDH) has had a significant influence on the international public health agenda, and with the framework being increasingly used by the 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 in terms of mortality and morbidity, are the result of structural factors that exist in all countries (both in the global North and South) which produce an inequitable distribution of health outcomes and inequitable access to health services, (Commission for the Social Determinants of Health, 2008). 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 (Friel and Marmot, 2011).

In general terms, SDH research clearly shows that those who are poor and those who are the most socially excluded and marginalised, will find it harder to access appropriate and affordable healthcare services than those who are more affluent and socially integrated and, on average, live shorter lives and have higher levels of morbidity and mortality. Such health inequalities arise from or are compounded by the implementation of poor and inadequate social policies, unfair economic arrangements and "bad politics". 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 adopts an holistic concept of health, with the reduction of health inequalities being considered as an ethical imperative – a matter of fairness, equity and social justice. Consequently, the reduction of health inequalities involves two strands: improving average health status and abolishing, where possible, avoidable inequalities.

The WHO Department of Equity, Poverty and Social Determinants of Health has defined "health equity" as

> "*the absence of unfair and unavoidable or remediable in health among population groups defined socially, economically, demographically or geographically". (Solar and Unwin, 2007: 7)*

Therefore, the strategic policy goal of the SDH is the achievement of health equity and equality for all people, irrespective of all other social, political, demographic or economic factors. Furthermore, in common with mainstream debates within international development, there is recognition that while economic growth is vitally important in any society, the inclusion of non-economic criteria are also crucial in the development of social and economic policy. This is in line with the findings and recommendations of the Commission on the Measurement of Economic Performance and Social Progress, published in 2009 (Stigltz, Sen and Fitoussi, 2009).

Social inequalities as they relate to health are defined as being caused by manmade phenomena, and therefore it follows logically that such inequities can be overcome by manmade initiatives undertaken by organisations such as UN agencies, governments and civil society institutions. The WHO SDH Global Report advocates that governments and civil society must make strategic interventions, targeted at every stage of the life-cycle, in order to make substantial progress in reducing health inequalities. Unsurprisingly, both the Global Report and *The Marmot Review - Fair society, Healthy Lives: Strategic Review in Health Inequalities England post-2010* identify common policy objectives for tackling health inequalities that include:

- Give every child the best start in life;
- Enable all children, young people and adults to maximise their capabilities and have control over their lives;

- Create fair employment and good work for all;
- Ensure a healthy standard of living for all;
- Create and develop healthy and sustainable places and communities; and
- Strengthen the role and impact of ill-health prevention (Commission for the Social Determinants of Health, 2008; Marmot).

In order to achieve health equity, the Commission has advocated a three-tiered approach:

- Improve the conditions of daily life - the circumstances in which people are born, grow, live, work, and age;
- Tackle the inequitable distribution of power, money, and resources - those structural drivers of conditions of daily lives - globally, nationally and locally; and
- Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health (Commission for the Social Determinants of Health, 2008: 26).

THE INTERNAL STRUCTURE AND RATIONALE OF THE SDH MODEL

The model developed by the Commission assumes that an interactive temporal and hierarchical relationship exists between (1) the socio-economic and political context, (2) the social structure and hierarchy existing between different groups, and (3) the socio-economic position of an individual within any society. This in turn determines and calibrates the SDH in any society, which then, ultimately, determines the extent of health equity and well-being in any given country. It is important to systematically describe each of these components.

First, the socio-economic and political context in any given country determines how public policy (including the health sector) is formulated and implemented. This is underpinned by underlying philosophical values – such as, for example, the importance attributed to the relative size and funding of the welfare state, and the extent to which there is a commitment to the redistribution of public resources. Solar and Irwin (2007) argue that there are six fundamental areas of policy that should be addressed when analysing the SDH. These are:

- Governance: understood in its broadest sense that includes the structure and processes of government; the rule of law; accountability; transparency; and the role and participation of civil society in policy formulation;
- Macroeconomic policy: including monetary and fiscal policy; the balance of payments and trade policy as these influence the underlying labour market structures;
- Social policies: including labour policy; social protection systems; land and housing;
- Public policy: including education, medical care and water and sanitation;

- Culture and social values: including religious beliefs; and the extent to which a nation regards addressing health inequalities as a priority in the broader context of competing claims on public expenditure; and
- Epidemiological conditions: such as major epidemics, which may have a significant impact on the current and future demographic structure of a country.

Second, it has been widely acknowledged that social stratification (income, social class and occupational status) has a direct impact on and correlation to how different social groups understand their own health needs and how effective they are in accessing health services. Hence, within any society, individuals have, differing access to monetary and non-monetary resources (for example, level of education and social capital). This means that individuals will attain different positions in the social hierarchy within their own countries, which in turn, results in inequitable access to public services, including health. Solar and Irwin (2007) argue that occupational status and social class are important predictors of average mortality and morbidity rates, with those in the lowest social classes and income levels invariably having the poorest health.

THE RELATIONSHIP BETWEEN THE SDH, HUMAN RIGHTS AND POWER

The SDH framework is fundamentally linked to the concept of human rights, as framed by the 1948 Universal Declaration of Human Rights (United Nations, 1948). The Universal Declaration maintains that "Everyone has the right to a standard of living adequate for health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services" (Article 25). This was reinforced by the Alma-Ata Declaration on Primary Health Care in 1978. The Alma Ata declaration provides many of the intellectual antecedents of the SDH framework, being one of the earliest high-profile statements that linked health status with social and economic factors, especially for those living in developing countries. The Declaration states:

> "Economic and social development, based on the New International Economic Order, is of importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace" (Alma Ata Declaration, 1978: Clause III).

The Declaration was also important for several other reasons. First, it stated that people have a right to participate, both individually and collectively, in the planning and implementation of their healthcare. Second, it also stated that national governments should develop primary health policies that ensure that primary healthcare is fully integrated into the respective country's national healthcare policy.

The SDH embraces this human rights framework, using it to provide a robust conceptual and legal infrastructure for the achievement of health equity. Linked to this is the notion of "power", which is a highly contested concept within the social

sciences. Broadly, political theorists make a critical distinction between "power to" and "power over" (for example, Hume, 1995). The former refers to an individual's ability to take any action on their own (agency), whereas the latter refers to an individual's or group's ability to make others act in certain ways, which may or may not be in accordance with their own preferences.

The SDH argues that socially excluded and marginalised groups, particularly those in developing countries, do not have the ability to exercise sufficient power in order to claim their own human rights, including those associated with health. Consequently, the realisation of human rights within the context of health also implies the necessity for the empowerment of poor and marginalised groups (Yamin, 1996). In their discussion addressing issues of power, in relation to the SDH, Solar and Irwin state:

> *"First and most fundamentally, [issues of power] remind us that any serious effort to reduce health inequities will involve changing the distribution of power within society to the benefit of disadvantaged groups. Changes in power relationships can take place at various levels, from the 'micro' level of individual households or workplaces to the 'macro' sphere of structural relations among social constituencies, mediated through economic, social and political institutions. ... By definition, then, action on the social determinants of health inequities is a political process that engages both the agency of disadvantaged communities and the responsibility of the state"* (Solar and Irwin, 2007: 17).

It is further argued that there is a "social gradient" with regard to health inequalities both between and within countries, which are a result of "the unequal distribution of power, income, goods and services" (Commission for the Social Determinants of Health,, 2008: 1). Again, those who are poorest are also at significantly increased risk of being in the worst health. This is a matter of "life and death" for the 40% of the world's population living in developing countries on less than $2 per day, but it equally applies many members of vulnerable and marginalised populations living in developed countries, including people with disabilities. There is therefore a continuum upon which health inequalities are encountered by different groups within all societies. Hence:

> *"Depending on the nature of these environments, different groups will have different experiences of material conditions, psychosocial support, and behavioural options, which make them more or less vulnerable to poor health. Social stratification likewise determines differential access to and utilisation of health care, with consequences for the inequitable promotion of health and well-being, disease prevention, and illness recovery and survival"* (Commission for the Social Determinants of Health, 2008:7).

For example, Scandinavian countries enjoy some of the most progressive health policies and these policies seem to have helped build and maintain populations with some of the most equitable health statuses in the world. The Commission attributes this to a long tradition of civil and political rights that encompass a commitment to full employment, gender equity and low levels of social exclusion. Yet at the same time, some low income countries, such as Costa Rica, China, the State of Kerala in India and Sri Lanka have achieved high levels of health status that are out of proportion to

their per capita income. Irwin and Scali (2005) attribute this to five political factors: an historical commitment to health as a social goal; a social welfare system orientated to development; community participation in health-related decision-making; universal coverage of health services for all social groups; and inter-sectorial linkages for health.

The Role of Economic Growth and Incomes

The Commission argues that economic growth and income distribution represents a significant contribution to health inequalities and the distribution of the social determinants of health. However, some important caveats need to be highlighted at this point. First, economic growth inevitably provides vitally important resources for investment and improvement in a nation's health. This is particularly the case for those countries with a per capita income of less than $5,000. However, for middle-income countries (for example, Argentina and Korea), the correlation between per capita income and health inequalities become less critical, and this is equally true for high income countries. (Commission for the Social Determinants of Health 2008). Second, a further critical factor is income distribution *within* countries. Where there is a high degree of income inequalities, there is likely to be a correspondingly high degree of health inequalities. Third, the international development aid paradigm also has a significant impact on health status, with some developing countries paying back more through high interest rates on outstanding loans to donor countries, than they receive in international aid. This results in a net outflow from developing countries, which can only have further negative impact on health inequalities (Deaton, 2003).

LINKS BETWEEN THE SDH APPROACH AND DISABILITY

First and foremost, it must emphatically stated that, within the context of this paper, disability is primarily perceived as being a socio-political construction. Consequently, those with impairments are principally excluded from participating in society from the environmental, institutional and attitudinal barriers that exist that preclude them from participating in contemporary society. Notwithstanding this, within the international context, disabled people are often among those who are the most poor, and are subjected to high levels of social exclusion and marginalisation. Moreover, many are often in need of "healthcare", in order to mitigate the negative impact of their impairments as much as possible. In addition, given that the vast majority of disabled people live in developing countries, the basic an overarching thesis that is presented by the SDH framework is directly applicable to those with impairments who live in the global South (Stein et al, 2009; Hwang et al, 2009).

The objective of this section is, therefore, to outline the linkages that exist between the SDH framework and disability issues, particularly in terms with regard to disability policy and practice. In some instances, these are linkages are easy to make, while in others links are more complex. Therefore, within this and the next section, reference will be made, where possible, to the existing published disability studies literature to elaborate on these synergies that exist between the two fields of study. However,

here are some conceptual areas, as will become clear, where the synergies between the two approaches have yet to be developed, and that warrant further research.

At the outset, it is important to state that both the SDH framework and disability studies (in terms of research, policy and practice), are explicitly based on a human rights approach. (Commission on the Social Determinants of Health, 2010; United Nations, 2006). For people with disabilities, in both the global North and South, the UN Convention on the Rights of Persons with Disabilities (CRPD) which came into force in May, 2008 and has now been ratified by more than 125 countries, has become of increasing importance of provoking and securing their inalienable and intrinsic rights (Lang et al, 2011) The Convention has been instrumental in helping to create a fundamental shift in the manner and environment in which disability policy and practice is being designed and implemented.

Interestingly, "disability", as it is defined in the Preamble of the CRPD, shares much common ground with the SDH. There is no universally agreed definition of what defines "disability", with different disability scholars and activists taking divergent positions (Shakespeare, 2006; Oliver, 1990). However, the CRPD explicitly recognises that disability as an "evolving concept" arising "from the interaction between persons will impairments in and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others".

The CRPD also explicitly acknowledges that that disabled people have a right to health and rehabilitation services. Hence, article 25 states that:

> *"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, 2006).

Furthermore, Paragraph D of Article 25 states that States parties shall:-

> *"Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter-alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care".*

Thus, both the SDH framework and the disability rights framework are primarily concerned with addressing systemic inequalities that exist within any given society. They also both specifically focus on marginalisation, social exclusion and discrimination of poor and marginalised populations. Furthermore, the analysis of the SDH suggests that those who are poor (both in terms of monetary income and non-monetary variables such as social capital and formal educational qualifications) are those who are most likely to have the highest mortality and morbidity rates, as well as the least likely to access health services.

Moreover, there is a growing body of evidence that clearly demonstrates disabled people do not have equitable access to or the ability to utilise general health services, compared to their non-disabled counterparts (European Disability Forum, 2009). Nor are disability-specific services available for the vast majority of disabled people who need such healthcare. For example, 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. Indeed, the *World Report on Disability,* published jointly by the World Health Organisation and the World Bank, states that *"[N]eed and unmet needs exist across the spectrum of services – prevention, promotion and treatment"* (World Health Organisation, 2011: 60).

It is important to highlight that this is not a small problem that does require significant attention. The *World Report on Disability,* estimates that are were approximately 1 billion people in the world, thereby constituting 15% of the world's population. This is an even higher figure for the global disabled population than was first estimated in the 1970s of 10% (World Health Organisation, 2011). The vast majority of disabled people moreover, live in developing countries.

INTEGRATING THE SDH FRAMEWORK WITH DISABILITY

At this point, it will be instructive to highlight each of the policy objectives identified at the outset of this paper as 'key components' of the SDH framework (delineated in both the global and England reports: Commission for the Social Determinants of Health, 2008; Marmot et al 2010) of and link these with disability policy and practice. Where possible, reference will be made to the existing published disability studies literature to illustrate the point. Furthermore, for each of these policy objectives, it is imperative to recognise that each is linked to poverty as it has been conceived within a multidisciplinary perspective.

- Give every child the best start in life;

Giving every child the 'best start in life' can include an array of issues that speak to preventing unnecessary impairment where possible, while at the same time, addresses the need to ensure the best start in life for children who are born with or become disabled.

Throughout the global North and South, but critically in developing countries, poverty is linked to the appearance of a number of potentially preventable disabling conditions. Lack of access to basic healthcare, nutrition and safe delivery for pregnant women, access to basic child health (i.e. immunisations, treatment of simple ear or eye infections, access to good basic nutrition) can prevent some impairments in infants and children. Infants and children born in economically poor households, however, are at significantly higher risk of becoming disabled due to lack of healthcare, as well as through other key SDH linked to poverty. These include malnutrition, unsafe housing, water and lack of basic sanitation, unsafe modes of

transportation and living in areas that have high rates of violence, which can all potentially lead to increased rates of disability.

The SDH framework also affects children who are born with a disability or who become disabled during the course of their childhood. Prejudice, stigma and lack of adequate resources means that children with pre-existing disabilities are less likely than their non-disabled peers to have access to adequate healthcare, both rehabilitative care and basic healthcare available to all other children (Ingstad and Reynolds Whyte, 1995; MacLachan et al 2010). They are often denied equal access to the resources of the households they live in, for example, receiving less food and clothing. Other resources – for example, access to mosquito nets or vitamin A supplements – are often considered lower priority for children with disabilities. This lack of resources means that the initial disabling conditions can worsen over time or that disabled children face additional and potentially preventable impairments (for example, a child born with an intellectual disability is at the same risk as all other children from polio or measles, if he or she is not vaccinated). Moreover, in those communities where children with disabilities are shunned or hidden away, many children with disabilities are less likely to receive the nurturing and appropriate level of stimulation that will ensure their healthy physical, psychological and emotional development.

- Enable all children, young people and adults to maximise their capabilities and have control over their lives;

To ensure that disabled children, young people and adults 'maximise their capabilities' to enable them to have control and autonomy over their lives, a series of skills and abilities must be developed during childhood and there provision made within the society for such individuals to exercise this control (Read et al, 2006).

Building such capabilities is a process that occurs throughout the lifespan and relies on an interlocking progression of experiences and opportunities from infancy. Unfortunately, for children with disabilities, there are significant barriers at each step in this process. Therefore, the cumulative result is often that the capabilities of individuals with disability are increasingly limited rather than being allowed to grow and flourish.

Infants and young children with disabilities are often kept socially isolated, are not allowed or unable without assistance to explore the world around them. Well-meaning families often shelter them rather than challenge them or provide the input and stimulation to encourage young children to reach developmental milestones – (or in the case of children with specific limitations – developmental milestones that represent the best of their abilities). Support for families of children with disabilities, appropriate training on children with disabilities for health personnel, early education experts and inclusion of young children with disabilities in general outreach efforts for pre-school children have all been strongly recommended and encouraged in recent publications and reports by WHO and UNICEF.

Inclusion of children with disabilities in education has also been the focus of major initiatives over the past two decades. In 1994 the Salamanca Statement and Framework for Action on Special Needs Education strongly endorsed disabled

children's right to education, and that this should be provided in mainstream public schools, so that disabled children are educated alongside their non-disabled peers (UNESCO, 1994). The principles and axioms of inclusive education had been endorsed in Article 24 (Education) of the CRPD (United Nations, 2006).

The strategic goal is to enable all children with disabilities to attend mainstream schools in their local communities. Again, this is an urgent priority and there are numerous challenges that militate against disabled children attending local schools. Many disabled children are born into families who cannot afford to pay school fees. Moreover, the public transport infrastructure and the physical inaccessibility in many schools preclude many disabled children from attending, even if they have the financial resources to do so (Singal, 2007).

More damaging is the common assumption by parents and community members, that educating children with a disability is unnecessary or that such children will never need an education. This view is often shared by teachers and educators who also assume that a disabled child would be a problem in the classroom or would slow the learning of other children.

The result is that while major pushes for universal education in many countries now sees primary school enrolment over 90% for all children, primary school enrolment levels for children with disabilities often remains below 10%. UNESCO estimates that a third of all primary school age children currently not in school are children with disabilities. And secondary and tertiary school attendance rates for children with disabilities in many developing countries, remains at less than 2%. This stands in marked contrast to developed countries where mandatory school attendance up to the age of 16 or 18 means that children and adolescents with disabilities are in school or vocational training programmes at rates comparable to their non-disabled peers up to later adolescence. While the quality of such education may vary, even in developed countries, the fact that these children with disabilities are part of the educational process in itself is an important component to building capabilities.

Maximising capabilities extends beyond early inclusion and formal education however. To become participating members of the community and wider society, disabled people must be part of a host of family, community and cultural experiences that build their abilities, hone their skills and enmesh them within a series of supportive networks and peer groups. Both formal and informal participation in social and cultural events, religious ceremonies, sports teams and peer groups, all build capabilities. Unfortunately, disabled people are often marginalised, or excluded from such events. Nor are their opinions or ideas often sought or listened to either within their own households, in schools or in the boarder society. Young adults and adults with disabilities often have little or no say about where or with whom they will live, whether they will have relationships, be able to marry or have families of their own, or decide whether they can find a job or what type of work they will do. All these issues impact on their ability to have control over their lives – a key component of SDH approach.

- Create fair employment and good work for all;

The rate of unemployment and marginal employment is of critical concern to millions of disabled people, keeping them and their households in poverty. High levels of stigma in many cultures attached to people with disabilities, which makes people reluctant to hire someone with a disability and makes many families reluctant to allow their family member to appear in public as they fear this family member will be ridiculed or abused. (Coleridge, 1993: Coleridge 2000: Instad and Reynolds Whyte, 1995). In some cultures, having a disabled member of the family in the work force is thought to negatively reflect on the rest of the family.

Erb and Harriss-White, in their social anthropological study of disability in three villages in Tamil Nadu, South India, identified that there were three categories of additional economic costs associated with the onset of disability: the direct costs of medical treatment and rehabilitation; the indirect costs (for example, costs of transportation); and the opportunity costs of not being able to make a sustainable living in open labour market. Consequently, some families are not able to provide the necessary care or are not willing to provide for a disabled family member, primarily due to the additional time that is required, compounded by financial constraints (Erb and Harriss-White, 2002). Additionally, the lack of educational and vocational training opportunities means that an estimated 80-90% of all disabled adults are unable to secure sustainable, long-term employment.

Many people with disability who are employed often are under-employed - working part-time or working only when there is a good deal of work available (Mitra et al, 2013). This means that they are usually the last hired/ first fired. Those who do find work often can find only entry level jobs with no possibility of advancement over time. Furthermore, while employment or self-employment is difficult for all people with disabilities, women with disabilities are at increased disadvantage. Even in the best of times, they are less likely to bring in a living wage than are men with disabilities - and both are underemployed compared to non-disabled peers. Adolescents with disability are also at increased risk of unemployment and under-employment, even when they are able to secure an education or vocational training. (Singal and Jain, 2012) 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).

Additionally and importantly, in many cases, when disabled people are able to bring income into their households, they are permitted to decide where these wages go. Often someone else in the household is given their wages directly or the person with a disability is expected to hand over their wages. This practice can only be anticipated to increase during times when household and family budgets are constrained. In cases where there is disagreement about how and where the money earned will be spent, the legitimate right of people with disabilities to decision making may be pushed aside.

- Ensure healthy standard of living for all;

This policy objective is strongly related to the previous one: the need for an adequate standard of living and a sustainable source of income which can pay for the basics of a good standard of living – a decent place to live, access to enough food, clean

water, basic sanitation, access to healthcare where needed and enough income to allow meaningful participation in the community and society in which one lives.

Again, persons with disabilities and households with disabled members, often find themselves among the poorest members of society, with not only lower incomes because of a disabled individual's inability to find employment, but also because disability itself often brings additional expenses to the individual and the household (i.e. medical care – both Western and traditional, transportation, the need for others to carry water or prepare food); and in cases where an individual with disability needs help throughout the day, the need of one or more other household members to either stay out of the workforce or not attend school, to stay home to assist.

Social protection programmes, including cash transfers are increasingly perceived as an effective and efficient mechanism by which to address chronic poverty in developing countries, and have become central within contemporary development studies discourse (Gentiilini, 2009: Scott, 2008: Devereux, and Sabates-Wheeler, 2007). Where such policies and programmes have addressed these issues – either through employment schemes, social service support systems, collectives of persons with disabilities themselves or various social protection initiatives that have enabled disabled people to experience a healthy standard of living – the individual, members of that individual's household and society as a whole, benefit (Gooding and Marriot, 2009). There are few better examples of how, by addressing key components of the SDH framework as these pertain to disabled people, the results work for the benefit of all.

- Create and develop healthy and sustainable places and communities;

This SDH policy component covers a wide range of issues and concerns that are of immediate relevance to disabled people – from accessible buildings, streets and transportation systems, environmentally sustainable systems of waste disposal, access to clean water and air, and safe and secure neighbourhoods free of violence and crime that allow all individuals and groups to work in accessible places to live and work.

While a wealth of attention and research has been undertaken through efforts such as the Healthy Cities movement (Rydin, et al, 2012), the recent global meetings around sustainable environments and the attention regarding the detrimental impact of health status resulting from climate change (Costello et al, 2009). Hence, there is a great deal of scope for a much greater degree of collaboration between scholars in the academic disciplines of the SDH framework and disability studies. This current gulf between the two areas of policy and research is unfortunate, because there is a great deal of overlap that can be exploited. Indeed, one of the cornerstones of the current Disability Rights Movement began with groups of people with disabilities protesting against inaccessible transportation systems, schools, and public and private spaces that kept millions virtually imprisoned in a world in which they could not manoeuvre without help or could not use at all (Driedger, 1989: Imire, 2004). While there are some experts and organisations who specialise in developing healthy, sustainable places and communities that are disability accessible (Barnes,

2011), all too frequently, planners and architects continue to plan without close consultation from persons with disabilities.

It is worth noting that many international instruments, including the UN Convention on the Rights of Persons with Disabilities, specifically address the need to create accessible environments, as do many national laws and policies that are currently being developed and implemented in several countries where the UN Convention has now been ratified. Where such laws are taken seriously and backed up by oversight and enforcement, disability accessible environments are helping to create healthy, sustainable and safe places to live and work. Unfortunately, in many countries, such legislation that should directly address the specifics outlined in this component of SDH are being largely or completely overlooked (Harphan, 2009). This seems to be particularly true in rapidly growing cities in Africa and Asia, where all too often, many new building feature impressive staircases and multiple levels but no ramps, or new bus and train systems are inaccessible by wheelchair users or where pavements are uneven and a lack of street lighting, these all serve to decrease rather than increase the accessibility and liveability of the surrounding environment (Cervero, 2005; Gleeson, 2001). This is certainly an area in which SDH and disability researchers need to establish a growing collaborative partnership.

- Strengthen the role and impact of ill-health prevention.

This issue of ensuring all children with a healthy start in life was addressed above. However, equally important is the need to, where possible and appropriate, prevent the occurrence of impairment, while also ensuring that disabled people have access to adequate healthcare that will ensure that they are able to stay as healthy as possible for as long as possible.

The prevention of disability is a very highly controversial issue within the international disability arena, and there are protagonists for both for and against prevention (Parens and Asch, 2000; Garcia et al, 2011). At the heart of the issue is a popularly held view that ill-health and disability invariably are linked, or indeed, considered to be the same phenomenon. It is important to underscore the fact that a person with an impairment can be both disabled *and* healthy.

It is not within the scope of this paper to adequately discuss all of the issues in sufficient depth to do justice to them here (see Shakespeare 2006 for a detailed discussion). 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. However, it is important to recognise that if the ethical issues surrounding the prevention of impairments through genetic engineering and other means were sufficiently agreed, this would only affect 2% of the disabled population, whose impairments can be directly attributed to congenital causes (Solberg, 2009).

Other types of disability prevention interventions – polio immunisations, nutritional supplements to prevent blindness or other malnutrition related diseases, traffic safety efforts to prevent avoidable accidents – are far less controversial. Moreover, many

of these measures are equally applicable to disabled people. For example, a blind man is at no less risk for being permanently disabled in a car accident than anyone else. In these realms, the SDH framework strongly overlaps with contemporary scholarship in the field of disability studies. Hence, those at risk of these types of preventable impairments will be more likely to be poor and/or members of marginalised groups – including people with disabilities.

Another synergy between SDH and disability studies is found in the issue of prevention of ill-health. Both the SDH and the emerging Disabilities Studies literature place a great deal of emphasis upon health equity and equality (European Disability Forum, 2009). In the absence of disabled people having sufficient income, many are unable to pay for adequate and sustainable healthcare – either healthcare specifically related to their disability, rehabilitative care or general healthcare that is not disability-related. Unfortunately, this issue has not been addressed in any depth within disability studies (Shakespeare, 2006). What is known is that disabled people, especially in developing countries have inequitable access to health services in comparison to their non-disabled counterparts.

This latter point is emphasised in the *World Report on Disability* (WHO, 2011), quoting the *World Disability Survey (*2002-2004), which sampled healthcare needs in 51 countries and found that both male and female respondents with disabilities "reported not receiving [health] care at rates higher than people without disability" (WHO, 2011:60). Moreover, the *World Report on Disability* identified several significant barriers that hinder disabled people from accessing mainstream healthcare services. These include lack of transportation; inaccessible healthcare facilities and health equipment (e.g. mammogram machines or examining tables that that wheelchair users cannot access); healthcare providers unable to understand the complex nature of the needs of disabled people; the lack of knowledge to know where to access services; and in extreme cases, actually being denied care by healthcare providers who feel that the health and well-being of persons with disability are a low priority or an unwarranted expense. (WHO, 2011:63). Of all barriers however, the inability to pay for healthcare services was the primary barrier for disabled people. Again, this seminal Report states that "for the 51 countries 32-33% of non-disabled men and women cannot afford healthcare, compared with 51-53% of people with disabilities."

It should also be recognised, that historically, disabled people (particularly those in Western countries) have had a somewhat problematic relationship with the medical and paramedical professions, with many individuals having experienced situations where medical professionals had undue influence or legally defined to make decisions on behalf of disabled people, often in areas unrelated to healthcare needs (Brown, 2009: Lang, 2011). In many countries, the right to obtain an education, to marry or have children, to drive a car or participate in social events, was left to medical or social service professionals rather than to persons with disabilities themselves (Oliver, 1990). The global Disability Rights Movement and the recent UN Convention on the Rights of Persons with Disabilities are direct outgrowth of and reaction to these earlier barriers. But for many people with disabilities, years of interaction with medical – as well as social service and educational – professionals has made them wary of such 'experts.' The situation is analogous to the rights

women have placed on being able to make decisions on their own behalf in all walks of life.

CONCLUSION

The objective of this paper has been to examine the potential relationships and synergies existing between the ideological premises, methodology, principal findings and policy recommendations of the Social Determinants of Health (SDH) framework and disability studies. The analysis has been premised primarily upon the *Closing the Gap in a generation: Health equality through action on the social determinants of Health,* published by the Commission on the Social Determinants of Health in 2008 and *The Marmot Review - Fair society, Healthy Lives: Strategic Review in Health Inequalities England post-2010* (Marmot et al, 2010). This analysis has categorically demonstrated that there are strong similarities and synergies that exist between the SDH framework and disability studies that have yet to be exploited. These are particularly in the area of promoting a human rights agenda and the ability to address the substantial inequalities and in inequities that exist in relation to access to healthcare and rehabilitation services. Moreover, this paper has shown that such inequalities must be placed in the context of much broader social, political and economic contexts within and between countries. This paper has also outlined some of the key intellectual antecedence, theories and overall theoretical framework on which the approach is premised. It is beyond the scope of this paper to explore in great depth the synergies between SDH and disability concerns, but it is our hope that the issues raised here will provide an outline of the relationship between SDH and contemporary debates in disability studies, particularly as these relate to issues of vulnerable and marginalised populations in global health and international development circles. Finally, it is important to recognise that this is a very embryonic stage in exploiting the synergies that exist between the two academic fields, and that a great deal of further research needs to be commissioned in this area.

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