Intellectual and Physical Disability, Social Mobility, Social Inclusion & Health

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Summary of the Review

The Problem (pages 5-10)

- Disabled people experience significantly poorer health outcomes than their non-disabled peers, including in aspects of health that are unrelated to the specific health conditions associated with their disability. Poorer health outcomes are also experienced by the carers of disabled children and adults.
- There are strong social gradients, across the lifecourse, in the prevalence of disability.
- These gradients are likely to result from a combination of factors including:
  - The impact of adversity and disadvantage on the onset of health conditions associated with disability
  - Intergenerational transmission of socially patterned health conditions associated with disability
  - The impact of disability on social mobility
- As a result, disabled children and adults are more likely than their peers to be exposed to general socio-economic conditions that are detrimental to health. A significant proportion of the risk of poor health of the disabled person themselves and carers appears to be attributable to their increased risk of exposure to socio-economic disadvantage.
- Some health conditions associated with disability or impairments may specifically impede the attainment of positive health.
- In addition, disabled children and adults are at risk of experiencing social exclusion and discrimination associated with their disability (disabilism). The direct effects of such discrimination on health include reduced access to appropriate healthcare. Indirect effects of such discrimination on health operate through increased social exclusion, restricted social mobility and the psychological impact of direct personal experience of disablist actions.

Recommended Action (pages 11-14)

There already exist a plethora of health, educational and social care policies and guidance in England that seek to reduce health inequalities and social exclusion and improve social mobility. All too often, however, these policies pay scant regard to the specific situations faced by disabled people, the apparent assumption being that the benefits of interventions targeted at deprived areas or families will accrue equally across all social groups. There is considerable evidence, however, that behaviour change interventions (whether ‘upstream’ or ‘downstream’) aimed at reducing health inequalities are likely to be more effective if they are tailored to the specific social and cultural contexts experienced by ‘high risk’ groups. Without such attention to the specific contexts faced by disabled people there is a real risk that they may fail to benefit from existing ‘generic’ policies. It is also worth noting that the NHS and its constituent parts are under a legal duty to pay due regard to eliminating discrimination and promoting equality of opportunity for disabled people. Therefore the Commission will fail to provide them with practical information if it fails to have regard to disabled people in its work.
We therefore recommend that:

1) In coming to its recommendations, the Commission on Health Inequalities in England post-2010 should pay due regard to
   a) The likely impact of recommendations on disabled people
   b) What specific modifications or adjustments need to be made to ensure that disabled people experience equal benefits from the proposed initiatives.
2) Monitoring of progress toward reducing health inequalities at local (PCT), regional (SHA) and national (DH) levels should be undertaken in such a manner that data can be disaggregated by disability status and sub-categories of disability. PCTs should be required to include in their annual reports a summary of local progress in tackling the health inequalities faced by disabled people.
3) All changes to policy and practice should be developed and rolled out in ways that ensure evaluation and therefore maximise the potential for health gain and for policy learning. All evaluation studies should specifically address the impact of policy/practice initiatives on the health of disabled people.
4) A proportion of area based initiatives (e.g., Spearhead Trusts, Local Area Agreements, Sure Start, Improving Access to Psychological Therapies) should be encouraged to emphasise/prioritise issues specific to the situation of disabled people.
5) In order to promote disability relevant practice and information within public health and to contribute to the collection, aggregation and dissemination of information on the health of disabled people, a Public Health Observatory (PHO) on Disability should be established linked to one of the existing regional public health observatories.

There also already exists a plethora of English health, educational and social care policies and guidance that seek to improve the life chances of disabled children and reduce the disadvantage faced by disabled adults. We support the general thrust of these developments in health, education and social care, in particular their emphasis on:

- Prevention and early intervention
- The personalisation of support
- The co-ordination of support
- The devolution of resources and power to disabled people themselves (and, for children, their families)
- The move towards socially inclusive patterns of provision and support

We make a number of recommendations to strengthen these existing developments. Our recommendations - focusing on addressing disabilism and the disadvantages faced by disabled people from childhood and across their lives – outline a programme of policy review and development to inform and drive forward strategies to tackle the stark health inequalities between disabled and non-disabled people.

Recommendations for Future Research/Evaluation (page 14)

There exists a dearth of evidence on the effectiveness of strategies to reduce the health inequalities experienced by disabled people. As such we reiterate the importance of three key recommendations made in the previous section.
• All changes to policy and practice be developed and rolled out in ways that ensure
evaluation and therefore maximise the potential for health gain and for policy
learning. All evaluation studies should specifically address the impact of
policy/practice initiatives on the health of disabled people.
• In order to promote disability relevant practice and information within public health
and to contribute to the collection, aggregation and dissemination of information on
the health of disabled people, a Public Health Observatory (PHO) on Disability be
established linked to one of the existing regional public health observatories.
• The Department of Health to fund a programme of work examining the nature and
impact of disablism on health, well-being, social inclusion and social mobility.
What is the ‘Problem’

Preamble: Understanding Disability

Disability is a multi-dimensional concept and experience, arising from the interaction of health conditions and the environment. That disability is a multidimensional concept potentially affecting all areas of life is reflected in the 2007 UN Convention on the Rights of Persons with Disabilities and explicitly represented in the International Classification of Functioning, Disability and Health.\(^\text{1,2}\) It may be experienced as any or all of: an impairment of body function or structure, an activity limitation or a participation restriction (see Appendix 1). Just as environmental risk factors affect the onset and severity of health conditions, so there are environmental risk factors for disability. These environmental factors include the built environment, personal and community attitudes, products and technology, and systems, services and policies (see Appendix 1). For example, the absence of appropriate health and rehabilitation services may affect the severity of an impairment following injury or the maintenance of health by a person with a communication difficulty; employers’ attitudes may affect the likelihood of a person with intellectual disability obtaining and retaining employment; inadequate support services, uninformed community attitudes, inaccessible houses, public buildings and transport systems – all may restrict a person’s social and economic participation in wide-ranging ways.

A Significant Proportion of Children and Adults in England Live with Disability

Estimates of the prevalence of disability vary as a function of the methods used.\(^\text{3}\) However, it is clear that a significant proportion of children and adults in England live with disability.\(^\text{3-6}\)

- 8% of English children aged 7-15 have significant Special Educational Needs (SEN) associated with intellectual, developmental, communication, sensory or physical impairments.\(^\text{a}\)
- The prevalence of disability among working age adults ranges from 15% to 20%.\(^\text{3}\)
- Among older people, 20% of men and women aged 55-64 report difficulty in at least one of six activities of daily living (e.g., moving about the house, getting dressed). These rates rise to 58% of men and 65% of women aged 85+.\(^\text{6}\)

Intellectual and Physical Disabilities are Associated with Increased Mortality and Morbidity

There is extensive evidence that people with disabilities experience significantly poorer health outcomes than their non-disabled peers.\(^\text{7-27}\) It is important to note, however, that these negative outcomes extend to aspects of health (e.g., mental health) that are unrelated to the specific health conditions associated with the person’s disability.\(^\text{10-30}\) Poorer health outcomes, including health conditions associated with disability, are also experienced by family carers of disabled children and adults.\(^\text{31-47}\)

\(^\text{a}\) Data extracted from DCSF 2008 Spring School Census.
There Are Strong Social Gradients, Across the Lifecourse, In the Prevalence of Disability

- *Among children and adolescents* there are clear social gradients in the distribution of most (but not all) intellectual, sensory and physical impairments. For example, the prevalence of SEN associated with intellectual, developmental, communication, sensory or physical impairments among 7-15 year old children in England rises from 4.7% in the least deprived population decile to 11.1% in the most deprived decile (see Appendix 2 for further details).
- *Among working age adults* there is strong evidence of socio-economic gradients in the onset of functional impairments, and that the overall prevalence of disability is associated with lifetime socio-economic circumstances. 61-65
- *Among older people*, there are strong associations between wealth, the onset of physical impairments and the rate of decline in physical ability over time. 65-70 For example, 8% of non-disabled participants in the most wealthy quintile compared to 18% of non-disabled participants in the least wealthy quintile developed difficulties in activities of daily living over a four year period. 6

These gradients are likely to result from a combination of factors that vary in their significance across the lifecourse.

- **In young children**, social gradients are likely to reflect two processes. First, exposure to adversity (and associated material and psychosocial hazards) prenatally and in the early years will increase the incidence of health conditions and associated disability. 71-76 Second, intergenerational transmission of socially patterned health conditions or impairments are likely to play a significant role in certain contexts (e.g., mild intellectual impairments). 29 30 77 78
- **In later childhood**, it has been suggested that these social gradients may also reflect the impact of child disability on family social mobility as a result of the direct and indirect costs associated with care. 79 However, it appears likely that any such effects are small as: (1) there is little, if any, evidence that social gradients in child health increase with age; 50 54 56 80 81 and (2) gradients appear to be more pronounced for less severe impairments (see Appendix 2). 52
- **In adulthood**, downward social mobility resulting from the exclusion of disabled people from the labour market (see below) is likely to play an important role in exacerbating existing social gradients. It should be noted, however, that the onset of disability in mid and later life continues to show strong social gradients. 5 67

**Disability and Social Mobility**

While there is relatively little direct evidence on the association between disability and social mobility, there is abundant evidence that disabled people are disadvantaged with regard to key factors that promote social mobility. These include early childhood experiences, education, employment and labour market experiences, social and cultural capital, health and well-being. 40 82-84

- *Early childhood experiences* are important determinants of later life chances. 40 71 73 82-85 Young children with intellectual or physical impairments are more likely than their
peers to be exposed to aspects of socio-economic adversity that constrain life chances.\textsuperscript{55, 58, 86}

- \textit{Education} has been identified as one of the most important factors influencing social mobility.\textsuperscript{40, 82-84} Disabled children have more unauthorised school absences, are more likely to be bullied and to have poorer academic attainment than their peers.\textsuperscript{87-93} For example, while 69\% of English children without SEN achieved 5 or more GCSEs at grades A*-C in 2006/7, this rate fell to 23\% among children with SEN without a Statement of SEN and to 9\% among children with a Statement.\textsuperscript{93} Disabled children are also at risk of placement in segregated special schools, including residential special schools, settings that may significantly impede children’s social inclusion.\textsuperscript{94, 95}

- \textit{Employment and labour market experiences}. Disabled adults have significantly reduced employment opportunities.\textsuperscript{30, 65, 89-92, 96-102} Rates of full-time employment among working age adults in 2008 were 34\% for disabled adults compared to 61\% among their non-disabled peers.\textsuperscript{93} There has been little change in these rates over recent years.\textsuperscript{85} Among those in employment, disabled people are less likely to be employed in high status occupations and are employed at lower rates of pay.\textsuperscript{93} The onset of disability among people in employment is associated with increased risk of subsequent unemployment and reduced earnings.\textsuperscript{103-105}

- \textit{Social and cultural capital}. Socioeconomically more advantaged families tend to have access to a wider range of social networks and cultural capital that facilitate upward mobility and protect against downward mobility. Disabled people, as well as experiencing socio-economic disadvantage, also tend to have more restricted social capital, partly as a result of prejudicial and discriminatory practices.\textsuperscript{92, 99, 100, 106}

- \textit{Health and wellbeing}. Ill health can lead to a decline in socio-economic status.\textsuperscript{40, 82} As noted above, there is extensive evidence that people with disabilities experience significantly poorer health outcomes than their non-disabled peers, including in aspects of health that are unrelated to their \textit{specific} health conditions or impairments.

Disability is also associated with reduced social mobility of family carers. Childhood disability is associated with delayed entry of mothers into the workforce and increased rates of parental separation, factors that are likely to impede the social mobility of the families supporting disabled children.\textsuperscript{107-116} Caring for a disabled adult has been linked to reduced employment opportunities and reduced income.\textsuperscript{40, 41, 117, 118}

\textbf{Disabled Children and Adults Are More Likely Than Their Peers to Be Exposed to General Socio-Economic Conditions That Are Detrimental to Health}

Whatever the mechanisms underlying these associations it is clear that children and adults with disability are at increased risk of exposure to social conditions that, in general, are associated with reduced social mobility, increased social exclusion and poorer health outcomes.\textsuperscript{40, 71, 73, 82, 85, 119-124} As such, disabled people make up a disproportionate proportion of populations who may be generally considered to be ‘at risk’ of poor health, restricted social mobility and social exclusion.
To date, few studies have attempted to estimate the extent to which the poorer health outcomes experienced by disabled people may be attributable to their increased risk of exposure to socio-economic disadvantage (rather than any disability specific factors). The results of this nascent literature suggest that increased risk of exposure to socio-economic disadvantage may account for:

- 20-50% of the risk of poorer mental and physical health among children with intellectual disabilities;\textsuperscript{13-15 125}
- Most or all of the risk of poorer mental health and low rates of well-being among mothers of children with intellectual disabilities or developmental delay.\textsuperscript{126 127}

Other studies also point to the importance of social conditions for understanding the association between disability and health. For example, reduced psychological well-being among young disabled people may only be evident under conditions of either social exclusion or economic adversity.\textsuperscript{128} Similarly, in later life higher income appears to buffer the psychological impact of becoming disabled.\textsuperscript{129}

Thus, poorer socio-economic circumstances appear to both increase the risk of impairments and exacerbate their impact. Put another way, poorer circumstances may have a greater impact on the well-being of people with disability.

### Some Disabilities and Associated Health Conditions May Specifically Impede the Attainment of Positive Health

There exists evidence that, after controlling for socio-economic and other factors, (higher) intelligence is associated with (better) health.\textsuperscript{23 130-132} People with learning disabilities by definition constitute the tail end of the distribution of this particular aspect of human capital. What is unclear, however, are the mediating pathways which link intelligence and health. These are likely to include such individual factors as variations in health literacy, problem solving, negotiating and help-seeking behaviours. It should be kept in mind, however, that the impact of such individual factors may potentially be ameliorated by appropriate interventions and adjustments.

### The Poorer Health Outcomes Experienced by Disabled People Are Also Likely to Reflect Their Experience of Discrimination and Social Exclusion

Disabled children and adults are at risk of experiencing discrimination associated with their disability (disablism) and of having their human rights violated\textsuperscript{92 99 100 106 133-138} The significance of disability discrimination in the UK is exemplified through the passing of the Disability Discrimination Acts (1995/2005), the stated commitment of the UK government to ratify the 2007 UN Convention on the Rights of Persons with Disabilities and the existing policy commitment that ‘by 2025, disabled people in Britain should have full opportunities and choices to improve their quality of life and will be respected and included as equal members of society’.\textsuperscript{95} The impact of disability discrimination on health is likely to be both direct and indirect.

- Direct effects of discrimination on health result from the existence of systemic disability discrimination in the operation of health care systems, the direct
consequence of which is to impede disabled people’s access to appropriate health and social care.\textsuperscript{8,9,139-145}

- Indirect effects of discrimination on health arise through two interconnected pathways. First, discriminatory systems and practices contribute to the social exclusion of disabled people (see below). As a result, disabled people are more likely than their peers to be exposed to living conditions (poverty, unemployment, social adversity, low control, low status, poor housing) associated with poor health outcomes.\textsuperscript{71,73,76,82,85,86,119-124,146,147} Second, the direct and indirect experience of disabling and disability discrimination may be expected to have a negative impact on the person’s mental and physical health. While no direct evidence is available to support this contention, equivalent processes (the experience of racism and racial discrimination) have been identified as central to understanding ethnic inequalities in health.\textsuperscript{148}

All of these effects are likely to be exacerbated among disabled children and adults who are also at risk of discrimination and social exclusion as a result of their ethnic identity, gender, sexual orientation or age.

\textit{Disability and Social Exclusion}

Social exclusion has been conceptualised as encompassing participation restrictions in four key domains: consumption; production; political and civic engagement; and social interaction.\textsuperscript{149} There is extensive evidence to suggest that disabled people are at significantly higher risk of exclusion in each of these areas.

- \textit{Consumption:} As children and adults, disabled people are more likely to experience income poverty and material hardship than their non-disabled peers.\textsuperscript{145,48,58,86,92,93,99,100,150}

- \textit{Production:} As noted above, disabled adults have significantly reduced employment opportunities.\textsuperscript{30,65,89,92,96-101,103-105} In addition, they are at risk of exclusion from other socially valued modes of production, most notably parenting.\textsuperscript{29,151,152}

- \textit{Political and civic engagement:} Disabled people are less likely than their peers to vote or otherwise participate in the political and civic life of their communities.\textsuperscript{92,99,100}

- \textit{Social interaction.} As children and as adults disabled people are more likely to have restricted social networks, have looser ties to their local community, to experience bullying and to be victims of crime.\textsuperscript{87,88,92,99,100,106,153,154} The social disconnectedness of some disabled people is exacerbated by the use of segregated and, at times, geographically remote educational and residential services.\textsuperscript{94,155,156}

\textbf{Summary}

- Disabled people experience significantly poorer health outcomes than their non-disabled peers, including in aspects of health that are unrelated to the \textit{specific} health conditions associated with their disability. Poorer health outcomes are also experienced by the carers of disabled children and adults.

- There are strong social gradients, across the life course, in the prevalence of disability.
• These gradients are likely to result from a combination of factors including:
  o The impact of adversity and disadvantage on the onset of health conditions
    associated with disability, and on disabilities (impairments, activity limitations
    and participation restrictions)
  o Intergenerational transmission of socially patterned health conditions
    associated with disability or impairment
  o The impact of disability on social mobility
• As a result, disabled children and adults are more likely than their peers to be
  exposed to general socio-economic conditions that are detrimental to health. A
  significant proportion of the risk of poor health of the disabled person themselves
  and carers appears to be attributable to their increased risk of exposure to socio-
  economic disadvantage.
• Some disabilities and associated health conditions may specifically impede the
  attainment of positive health.
• In addition, disabled children and adults are at risk of experiencing social exclusion
  and discrimination associated with their disability (disablism). The direct effects of
  such discrimination on health include reduced access to appropriate healthcare.
  Indirect effects of such discrimination on health operate through increased social
  exclusion, restricted social mobility and the psychological impact of direct personal
  experience of disablist actions.
What Can Be Done About It?

There already exist a plethora of health, educational and social care policies and guidance in England that seek to reduce health inequalities and social exclusion and improve social mobility. All too often, however, these policies pay scant regard to the specific situations faced by disabled people, the apparent assumption being that the benefits of interventions targeted at deprived areas or families will accrue equally across all social groups. There is considerable evidence, however, that behaviour change interventions (whether ‘upstream’ or ‘downstream’) aimed at reducing health inequalities are likely to be more effective if they are tailored to the specific social and cultural contexts experienced by ‘high risk’ groups. Without such attention to the specific contexts faced by disabled people, there is a real risk that they may fail to benefit from existing ‘generic’ policies. As the Health Select Committee recently pointed out:

‘health inequalities are evident across a number of different measures—not only socio-economic status, but ethnicity, gender, age, disability and regional area. This suggests that health inequalities should perhaps be measured and targeted in a multidimensional way’.159

It is also worth noting that the NHS and its constituent parts are under a legal duty to pay due regard to eliminating discrimination and promoting equality of opportunity for disabled people. Therefore the Commission will fail to provide them with practical information if it fails to have regard to disabled people in its work.

We therefore recommend that:

1) In coming to its recommendations, the Commission on Health Inequalities in England post-2010 should pay due regard to
   a) The likely impact of the recommendation on disabled people
   b) What specific modifications or adjustments need to be made to ensure that disabled people experience equal benefits from the proposed initiatives.
2) Monitoring of progress toward reducing health inequalities at local (PCT), regional (SHA) and national (DH) levels should be undertaken in such a manner that data can be disaggregated by disability status and sub-categories of disability. PCTs should be required to include in their annual reports a summary of local progress in tackling the health inequalities faced by disabled people.
3) All changes to policy and practice should be developed and rolled out in ways that ensure evaluation and therefore maximise the potential for health gain and for policy learning. All evaluation studies should specifically address the impact of policy/practice initiatives on the health of disabled people.
4) A proportion of area based initiatives (e.g., Spearhead Trusts, Local Area Agreements, Sure Start, Improving Access to Psychological Therapies) should be encouraged to emphasise/prioritise issues specific to the situation of disabled people.
5) In order to promote disability relevant practice and information within public health and to contribute to the collection, aggregation and dissemination of information on the health of disabled people a Public Health Observatory (PHO) on Disability should be
established linked to one of the existing regional public health observatories (Note: the Department of Health have already committed to establishing a Learning Disabilities PHO\textsuperscript{167}.)

There also already exists a plethora of English health, educational and social care policies and guidance that seek to improve the life chances of disabled children and reduce the disadvantage faced by disabled adults\textsuperscript{90, 140, 143, 163, 167-176}. The evidence reviewed above supports the general thrust of these developments in health, education and social care, in particular their emphasis on:

- Prevention and early intervention
- The personalisation of support
- The co-ordination of support (e.g., the introduction of individual care plans by 2010 for all children with complex long term conditions)
- The devolution of resources and power to disabled people themselves (and, for children, their families)
- The move towards socially inclusive patterns of provision and support

We recommend that these existing developments be strengthened in the following ways.

\textit{Addressing Disabilism}

6) The Department of Health to fund a programme of work examining the nature and impact of disabilism on health, well-being, social inclusion and social mobility.
7) The Department of Health in conjunction with the Equalities and Human Rights Commission to implement a sustained campaign of social marketing aimed at reducing disabilist attitudes among the general public.

\textit{Improving the Lives, Services and Outcomes for Disabled Children and their Families}

8) Local Authorities and partners should adopt a robust attitude towards the new national indicator for disabled children’s services (NI 54) and ensure that strategic planning and commissioning takes account of the views of families.
9) The Department for Children, Schools and Families should fund the development and evaluation of a national demonstration programme that
   a) delivers intensive early intervention for pre-school children with or at risk of significant disabilities or early cognitive delay\textsuperscript{177-179}
   b) help families with young disabled children become more resilient
10) The Department of Work and Pensions significantly uprate DLA in order to cover the full additional costs associated with raising a disabled child.
11) The Department of Work and Pensions introduce new or modify existing benefits in order to provide appropriate financial support to cover the additional disability-related costs borne by disabled parents.
12) The Care Quality Commission undertake a review of the adequacy of access to appropriate health and social care support for disabled children with additional emotional or behavioural needs.
13) The Standing Commission on Carers urgently review the situation of children providing unpaid care for disabled relatives.
14) Local Authority performance is monitored against the proportion of children providing unpaid care for disabled relatives for more than a set number of hours per week.
15) The Department for Children, Schools and Families in conjunction with the Department of Work and Pensions take steps to ensure that sustainable high quality childcare is available for all disabled children and that benefit regulation ensure that the availability of childcare actively supports opportunities for the parents of disabled children to enter employment.\textsuperscript{180}
16) As proposed in the 2008 National Carers Strategy, health checks for family carers (including children providing unpaid care and parents caring for disabled children) should be introduced and incentivised in primary care.\textsuperscript{181}

**Addressing Barriers to Rewarding Employment for Disabled Young People and Adults**

17) The Department for Children, Schools and Families promote and monitor the entitlement to work experience for disabled children.
18) The Department of Work and Pensions review the current interface between employment related support programmes and the benefits systems that make it disadvantageous for many disabled people to work more than four hours but less than 16 hours.
19) The Department of Work and Pensions review the adequacy of employment support programmes for people with more severe or longer-term disabilities.\textsuperscript{182}

**Improving Access and Quality in Housing and Supported Accommodation for Disabled Children, Adults and their Families**

20) The Department of Communities and Local Government (DCLG) undertake a review of the housing needs of families with disabled children in order to develop specific policies to significantly improve the quality of such housing and develop systems for monitoring progress toward such a goal.\textsuperscript{76 86 146 147}
21) DCLG to conduct a review to determine whether local authority and registered social landlord housing allocations disproportionately channel disabled tenants to housing situated in concentrations of socio-economic disadvantage
22) The Care Quality Commission undertake a fundamental review of the rules and regulations that relate to residential care homes and their interface with charging policies and the benefits system with regard to: (1) housing security and tenure of residents; (2) benefit-related disincentives to employment; (3) adequacy of disposable income with which to progress aspirations around social mobility and community inclusion.

**Addressing Inequalities in Health & Social Care for All People with Disabilities**

23) A national framework of guaranteed outcomes, based upon human rights principles, should be developed for social care.\textsuperscript{144}
24) Establish a legal entitlement for self-directed assessment of needs for social care support, irrespective of income or funding available to local authorities.\textsuperscript{144}
25) The Quality and Outcomes Framework (QOF) is reviewed to ensure that it reflects and orients general practice to better meet the health needs of people with disabilities and their families.

26) The Health Select Committee recommendation that tackling health inequalities is made a specific objective of QOF should be implemented and monitoring of performance should include evidence that progress is made in reducing the health inequalities experienced by disabled people.

27) GPs should be brought directly within the scope of the DED. (At the moment, as independent practitioners, they are not and their work can only be influenced in DED terms through the commissioning activities of the PCT.)

28) The NHS be required to monitor key outcomes and the delivery of major health initiatives (e.g. screening) by disability and sub-groups of disability against population level indicators of need in order to be able to demonstrate compliance with the DDA.

## Recommendations for Future Research/Action Development

There exists a dearth of evidence on the effectiveness of strategies to reduce the health inequalities experienced by disabled people. As such we reiterate the importance of three key recommendations made in the previous section.

3) All changes to policy and practice be developed and rolled out in ways that ensure evaluation and therefore maximise the potential for health gain and for policy learning. All evaluation studies should specifically address the impact of policy/practice initiatives on the health of disabled people.

5) In order to promote disability relevant practice and information within public health and to contribute to the collection, aggregation and dissemination of information on the health of disabled people a Public Health Observatory (PHO) on Disability be established linked to one of the existing regional public health observatories.

6) The Department of Health to fund a programme of work examining the nature and impact of disabling on health, well-being, social inclusion and social mobility.

In addition we recommend that an over-arching information framework be developed, based on the ICF, to ensure that research and other sources of data build towards a coherent body of knowledge about disability and health.
Appendix 1: The ICF

The International Classification of Functioning, Disability and Health (ICF) was adopted by the World Health Assembly in 2001 after more than a decade of international collaboration on its development. The classification provides what is sometimes described as a bio-psycho-social model of functioning and disability; this model seeks to blend the key features of pre-existing models, notably the medical and social models of disability. According to the ICF, functioning and disability are experienced as body functions (and impairments of them), activities (and activity limitations) and participation (and participation restrictions). Environmental Factors are specifically recognised and classified, as having a crucial effect on a person’s functioning - either as facilitators or barriers. (See following diagram. More information can be viewed on the WHO web site - http://www.who.int/classifications/icf/en/ http://www.who.int/classifications/icfbrowser/)

![ICF: Interaction of Concepts](image)

Thus, disability is multidimensional and interactive. All dimensions are important and any one may affect the other. Impairment affects Activity, Activity and Participation affect Impairment; Environmental Factors affect everything, must be understood and may need to be changed. The approach to care and treatment is assumed to be person-centred, a partnership, holistic. Ethical guidelines for the use of ICF are provided in its Annex 6. The ICF is a multi-purpose classification intended for a wide range of uses in different sectors. It is one of WHO’s main reference classifications, the other being the ICD (International Classification of Diseases). The ICF ‘has been accepted as one of the UN social classifications and...provides an appropriate instrument for the implementation of stated international human rights mandates as well as national legislation’. The ICF provides a standard language and framework for describing and organising information on functioning and disability. A companion classification, published in 2007, is available for organising information about children and youth (ICF-CY).
The ICF comprises lists of codes, organised hierarchically, within chapters or domains, within the main components. Chapter headings for all the ICF components are listed in the following Table.

**ICF components and domains (chapters)**

<table>
<thead>
<tr>
<th>Body Function:</th>
<th>Activities and Participation:</th>
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<tbody>
<tr>
<td>Mental Functions</td>
<td>Learning and Applying Knowledge</td>
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<tr>
<td>Sensory Functions and Pain</td>
<td>General Tasks and Demands</td>
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<td>Voice and Speech Functions</td>
<td>Communication</td>
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<tr>
<td>Functions of the Cardiovascular, Haematological, Immunological</td>
<td>Mobility</td>
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<tr>
<td>and Respiratory Systems</td>
<td>Self Care</td>
</tr>
<tr>
<td>Functions of the Digestive, Metabolic, Endocrine Systems</td>
<td>Domestic Life</td>
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<tr>
<td>Genitourinary and Reproductive Functions</td>
<td>Interpersonal Interactions and Relationships</td>
</tr>
<tr>
<td>Neuromusculoskeletal and Movement-Related Functions</td>
<td>Major Life Areas (incl employment and education)</td>
</tr>
<tr>
<td>Functions of the Skin and Related Structures</td>
<td>Community, Social and Civic Life</td>
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<th>Body Structure:</th>
<th>Environmental Factors:</th>
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<td>Structure of the Nervous System</td>
<td>Products and Technology (incl building construction)</td>
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<tr>
<td>The Eye, Ear and Related Structures</td>
<td>Natural Environment and Human-Made Changes to Environment</td>
</tr>
<tr>
<td>Structures Involved in Voice and Speech</td>
<td>Support and Relationships</td>
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<tr>
<td>Structure of the Cardiovascular, Immunological and Respiratory</td>
<td>Attitudes</td>
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<tr>
<td>and Respiratory Systems</td>
<td>Services, Systems and Policies</td>
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<td>Structure Related to Movement</td>
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<td>Skin and Related Structures</td>
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<th>MLD</th>
<th>SLD</th>
<th>PMLD</th>
<th>ASD</th>
<th>PD</th>
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**Abbreviations:** IDACI = Income deprivation affecting children index of area deprivation; MLD = moderate learning difficulties; SLD = severe learning difficulties; PMLD = profound multiple learning difficulties; ASD = autistic spectrum disorders; PD = physical disabilities; SPLD = specific learning difficulties (e.g., dyslexia); SLCN = speech language or communication needs; VI = visual impairment; HI = hearing impairment; MSI = multiple sensory impairment

**Data:** Extracted from DCSF Spring 2008 School Census; child age range 4-15; n=6,795,720; SEN level of School Action Plus or Statement of SEN

**Analyses:** Simple multivariate logistic regression controlling for child age, gender and ethnicity and Local Authority
References


142. Social Care Institute for Excellence. Transition of young people with physical disabilities or chronic illness from children’s to adult’s services: Social Care Institute for Excellence, 2005.


