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Socio-Economic Position

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What is Socio-Economic Position?

All societies are hierarchically structured, with key institutions (e.g., the labour market, education and legal systems) helping to determine an individual's position within a social hierarchy. Their position in this hierarchy shapes their (and their children's) access to and control over key resources (e.g., power, wealth, social connections, health, skills, access to educational, health, and welfare services), resources that play an important role in determining their life experiences, maintaining or improving their position in the social hierarchy and the position of their family (Graham H, 2007). The term socioeconomic position (SEP) refers to the position occupied in a social hierarchy by an individual or family (Socio-economic position should be considered broadly synonymous with the US term socio-economic status (SES) and is closely related to notions of social class.). As such, SEP lies on a continuum or gradient running from high to low. SEP is not, however, an inherent property of individuals or families. Rather it is the result of the interaction between the impact of powerful social institutions in stratifying the social order and people's active involvement in recreating and maintaining the social hierarchy through cultural and social practices (Graham H, 2007).

People occupying lower socioeconomic positions may have difficulty accessing resources that are necessary to enable them to live lives that are considered appropriate or decent within their society. That is, they may experience poverty (Lister R, 2004; Spicker P, 2007). Following the classic Townsend approach to defining relative poverty (Townsend P, 1979), the term poverty as used in this chapter refers to the situation of individuals or families who are unable "due to lack of resources, to participate in society and to enjoy a standard of living consistent with human dignity and social decency" (Fabian Commission on Life Chances and Child Poverty, 2006). Although poverty can be categorized as a simple construct of either poor or not poor, clearly there are degrees of poverty. At its most extreme, poverty may involve such a level of deprivation of resources that health or life itself is significantly threatened (a situation often referred to as "absolute" poverty).

Socioeconomic position and poverty both describe key aspects of the social positioning of people (or families) in a particular society at a particular point in time. They are culturally-specific and dynamic constructs. Societies vary considerably in the extent of inequality associated with social hierarchies, the nature and operation of institutions and cultural practices that maintain social hierarchies and the potential for upward and downward mobility in hierarchies (Wilkinson RG and Pickett KE, 2009; Organisation for Economic Co-operation and Development, 2008). Societies change over time, as do the key social institutions that help create and maintain social stratification.

What is the Association between Disability and Socio-Economic Position?

There are strong social gradients, across the lifecourse, in the prevalence of health conditions and impairments associated with disability. Generally, the higher one's position in the social hierarchy (or SEP), the less likely that person is to be or become disabled (Elwan A, 1999; Ingstad B and Eide A, in press).

- Among children and adolescents there are clear social gradients in the distribution of most (but not all) intellectual, mental, sensory and physical impairments and health conditions associated with disability (Parish SL et al., 2008; Emerson E and Hatton C, 2007; Emerson E et al, 2006; Leonard H et al., 2005; Leonard H and Wen X, 2002; Heikura U et al., 2008; Yang J et al., 2007; Newacheck PW and Halfon N, 1998; Emerson E et al., 2009; Dolk H, 2001; Varela M et al., 2009).

- Among working age adults there is strong evidence that the overall prevalence of disability is associated with lifetime socio-economic circumstances, and that these also predict the *onset* of functional impairments in adulthood (Breeze E and Lang IA, 2008; Melchior M et al., 2006; Brault MW, 2008; Harkonmaki K et al., 2007).

- Among older people, there are strong associations between wealth, the onset of physical impairments and the rate of decline in physical ability over time (Breeze E and Lang IA, 2008; Guralnik JM, 2006; McMunn AM et al., 2009; Ebrahim S, 2004; Lang IA, 2008; Minkler M et al., 2006). For example, a recent study in the UK reported that 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 (Breeze E and Lang IA, 2008).

These gradients (or social patterning of the prevalence of disability) are likely to result from a combination of factors that vary in their significance across the lifecourse.

- In young children, exposure to adversity and associated material and psychosocial hazards (e.g., inadequate nutrition, environmental toxins and teratogens, less than optimal parenting, accidental and non-accidental injury) prenatally and in the early years will increase the incidence of health conditions and impairments associated with disability (Elwan A, 1999; Hertzman C and Boyce T, 2010; Irwin LG et al., 2007; Keating DP and Hertzman C, 1999; Laplante DP et al., 2008; Bergman K et al., 2007; Shonkoff JP et al., 2009; Grantham-McGregor S et al., 2007; World Health Organization and UNICEF, 2008; Evans GW, 2006).

- In later childhood, these social gradients may also reflect the impact of the child's disability on family SEP as a result of the direct and indirect costs associated with care (Elwan A, 1999; Tibble M, 2005). However, it appears that in high-income countries it is likely that these effects are small as: (1) there is little, if any,

- In adulthood, downward social mobility resulting from the exclusion of disabled people from the labour market (see below) or the social and economic costs associated with associated health conditions is likely to play an important role in exacerbating existing social gradients (Elwan A, 1999; Ingstad B and Eide A, in press). It should be noted, however, that the *onset* of health conditions or impairments associated with disability in mid and later life continue to show strong social gradients (Breeze E and Lang IA, 2008; McMunn AM et al., 2009).

Indeed, there is considerable evidence to suggest that disabled people are disadvantaged with regard to key factors that promote upward social mobility (and defend against downward social mobility). These include early childhood experiences, education, employment and labour market experiences, social and cultural capital, health and well-being (Graham H, 2007; Ingstad B and Eide A, in press; Nunn A et al., 2007).

- Early childhood experiences are important determinants of later life chances (Graham H, 2007; Fabian Commission on Life Chances and Child Poverty, 2006; Hertzman C and Boyce T, 2010; Irwin LG et al., 2007; Shonkoff JP et al., 2009; Nunn A et al., 2007). 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 (Yang J et al., 2007; Emerson E et al., 2009).

- Education has been identified as one of the most important factors influencing social mobility (Graham H, 2007; Nunn A et al., 2007). Disabled children are less likely to attend school and, if they do, have more unauthorised school absences, are more likely to be bullied and to have poorer academic attainment than their peers (Elwan A, 1999; Ingstad B and Eide A, in press; Burchardt T, 2005; Williams B et al., 2008). Disabled children in some countries are also at risk of placement in segregated special schools, including residential special schools, settings that may significantly impede children's social inclusion (Audit Commission, 2007; UNESCO, 1994).

- Employment and labour market experiences. Disabled adults have significantly reduced employment opportunities (Elwan A, 1999; Ingstad B and Eide A, in press; Burchardt T, 2005; Williams B et al., 2008; Berthoud R, 2006; Maughan B et al., 1999; Rigg J, 2005; Emerson E et al., 2005; Grewal I et al., 2002; Office for National Statistics, 2002). In the UK, for example, rates of full-time employment

- 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 (Williams B et al., 2008; Emerson E et al., 2005; Grewal I et al., 2002; Shakepeare T, 2006).

- Health and wellbeing. Ill health can lead to a decline in socio-economic status (Graham H, 2007; Nunn A et al., 2007). 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 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 (Porterfield SL, 2002; Risdal D and Singer GH, 2004; Seltzer MM et al., 2001; Parish SL et al., 2004; Clarke H and McKay S, 2008; Loprest P and Davidoff A, 2004). Caring for a disabled adult has been linked to reduced employment opportunities and reduced income (Nunn A et al., 2007; Pickard L, 2004; Parker G and Lawton D, 1994; Young H et al., 2006).

Why is Socio-Economic Position Important in Understanding the Life Experiences of Disabled People?

The association between disability and poverty has been described as a 'vicious circle', with poverty leading to disability, and disability to poverty (Yeo R and Moore K, 2003). Poverty is central to understanding the life experiences of many disabled people.

First, it is clear that disabled children and adults are at increased risk of exposure to low SEP and poverty, social conditions that, in general, are associated with reduced social mobility, increased social exclusion and poorer health (Graham H, 2007; Fabian Commission on Life Chances and Child Poverty, 2006; Nunn A et al., 2007; Hills J et al., 2002; World Health Organisation, 2008). As such, they make up a disproportionate proportion of populations who may be generally considered to be 'at risk' or who have been made vulnerable to a range of adverse outcomes. This simple observation raises the rather obvious point that some of the adverse life experiences faced by disabled people

may simply reflect their status as poor people (rather than being the result of disability *per se*). Indeed, several recent 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 small literature suggest that increased risk of exposure to socio-economic disadvantage among disabled people may account for:

- 20-50% of the risk of poorer mental and physical health among children with intellectual disabilities (Emerson E and Einfeld S, under review; Emerson E and Hatton C, 2007b; Emerson E Hatton C. 2007a; Emerson E Hatton C. 2007c);
- Most or all of the risk for low psychological well-being among disabled adolescents and young adults (Emerson E et al., under review a).
- 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 (Emerson E et al., 2010; Emerson E et al., 2006).

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 (Emerson E et al., under review b; Honey A et al., in press). Similarly, in later life higher income appears to buffer the psychological impact of becoming disabled (Smith DM et al., 2005).

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 than it does on their non-disabled peers.

Second, it is possible that SEP may interact with disability-specific discrimination to further jeopardize the health and well-being of disabled people. Disabled children and adults are at risk of experiencing discrimination associated with their disability (disablism) (Williams B et al., 2008; Emerson E et al., 2005; Grewal I et al., 2002; Shakepeare T, 2006; Thomas C, 2007; Oliver M and Barnes C, 1998). The impact of disability discrimination on health and well-being is likely to be mediated by multiple processes.

- First, the existence of systemic disability discrimination in the operation of key social institutions may prevent disabled people gaining access to timely, appropriate and effective education, health and social care (Michael J, 2008; Disability Rights Commission, 2006).

- Second, discriminatory systems and practices contribute to the social exclusion of disabled people (see above). 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 (Graham H, 2007; Fabian Commission on Life Chances and Child

- Finally, the direct and indirect experience of disablism and disability discrimination may be expected to have a negative impact on the person's mental and physical health (Emerson E, under review). Equivalent processes (the experience of racism and racial discrimination) have been identified as central to understanding ethnic inequalities in health (Nazroo J, 2003).

Given the impact of inequality inter-group relations (Wilkinson RG and Pickett KE, 2009), it is possible, that both systemic discriminatory practices and overt disablist acts are more likely to be experienced by disabled people with lower SEP, especially in more unequal societies.

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