

Disability and public health research in Australia

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One in five Australians is disabled. The prevalence of disability increases with age from three per cent among children under four years of age to 85% in people aged 90 years and older.¹

The past decade has seen an increased focus on disability service and policy development in Australia, notably the National Disability Insurance Scheme (NDIS)^{2,3} and the National Disability Strategy.⁴ Despite this, public health researchers have not focused on the health of people with disability. Instead, disability has featured as an outcome to be prevented (e.g. through seatbelt legislation) and in burden of disease studies where disability is conceived as a health deficit and 'health states' (e.g. living without a limb) are weighted less than 'full health' in the computation of Disability Adjusted Life Years (DALYs). In both of these conceptions, disability is an outcome and, to some extent, a 'failure' of public health. It is also conflated with poor health.

In this Commentary, I argue that improving the health of people with disability should be core business for public health researchers and that this requires the application of social determinants of health and health equity approaches. First, I outline how disability is conceptualised and measured in public health research on disability according to the World Health Organization's International Classification of Functioning, Disability and Health (ICF) and show how the ICF aligns with the social determinants of health and health equity frameworks. Second, I focus on mental health to illustrate how the social determinants of health drive disability-related mental health inequities. Finally, I look at two areas of social policy relevant to people with disability: the NDIS and the income support and reflect on how public health research could elucidate the health effects of these policies.

Health equity and disability

Health equity – a guiding framework for public health – refers to the elimination of avoidable causes of health inequalities. The social and economic determinants of health – the conditions under which people are born, live, work and grow – drive these inequities. Determinants include poverty, education, employment, economic security and housing as well as structural drivers of disadvantage, from local and national policies through to commercial determinants driven by multi- and trans-national interests.⁵ Krahn et al. have previously argued that people with disabilities should be considered a 'health disparity population' alongside other marginalised groups.⁶

Disability is a contested concept. In the 1980s, British scholars put forward the social model of disability, arguing that disability arose because of the societal barriers that prevented people with disability participating in society in the same way as others. They contrasted this to the 'medical model', which they argued positioned disability as an individual condition for which the most appropriate treatment is medical.⁷ The social model has been criticised as not taking adequate account of individual experiences of impairment that may limit participation.⁸ Scholars also draw on critical disability studies, which posits that dis/ability is discursively produced; however, this approach has not found its way into empirical research.⁹

The biopsychosocial model of disability is the most relevant model for public health as it explicitly recognises the complex interactions between individual-level biological and psychological factors and social factors. The WHO International Classification for Functioning, Disability and Health (ICF), which underpins the conceptualisation of disability

worldwide, is a biopsychosocial model. The ICF distinguishes between functional limitations related to an impairment affecting body functions and structures (e.g. loss of arm), activity (e.g. dressing) and participation in life (e.g. employment). These domains are classified as bodily, individual and societal perspectives in the ICF, respectively. In the ICF, 'functioning' refers to all body functions, activities and participation, while disability is an umbrella term for impairments, activity limitations and participation restrictions. The ICF also lists environmental (e.g. discrimination, policies) and personal (e.g. age) factors that interact with all these components.¹⁰ The conceptualisation of disability embodied in the ICF aligns well with social determinants of health approaches because it foregrounds how physical, social, economic, political and cultural barriers prevent people with disabilities having access to the same opportunities as non-disabled people. These barriers flow through to social and economic disadvantage, which then produces poorer health, at least some of which is *avoidable*, i.e. unfair. More widespread application of the ICF in public health research may enable a shift in public health thinking from disability simply being an outcome to be avoided to a population group who may experience ill-health as a result of socioeconomic disadvantage.

Australian evidence on disability-related mental health inequities

People with disability are more likely to experience poor health, including poorer mental health.¹¹ Australians with disability experience higher levels of poverty, housing insecurity and unemployment and lower levels of education, income, labour force participation and social support.¹²⁻¹⁴ They are more likely to experience violence, abuse and discrimination.¹⁵⁻¹⁷ Australian children with disability are more likely to experience child abuse and neglect¹⁶ as well as bullying from their peers.¹⁸

A challenge for public health research on disability, socioeconomic disadvantage and health are disentangling the extent to which disability is a *cause* or *consequence* of disadvantage. Most public health research has concentrated on socioeconomic disadvantage as a cause of disability, but

econometric studies have established that disability is associated with downward social mobility. For example, compared to non-disabled Australians, Australians with disability are more likely to be over-educated for their jobs¹⁹ and to transition out of full-time employment into part-time employment or unemployment,^{20–22} and are less likely to transition back into full-time employment.²²

More recently, epidemiological studies have demonstrated that disadvantage explains much of the poorer mental health of disabled Australians. Two Australian studies that used causal mediation analysis found that peer-based bullying accounted for nearly 40% of the poorer mental health of adolescents with disability²³ and material factors, such as employment and income, explained nearly one-third of the mental health decline experienced by adults who acquire a disability.²⁴ Other Australian studies have shown that while acquiring a disability leads, on average, to a decline in mental health and wellbeing, this decline is worse for people who are already disadvantaged.^{25–34}

A health equity approach to policy and disability

Researchers need to consider the impacts of disability-specific policies and programs such as the NDIS as well as universal programs such as Medicare on inequities between people with and without disabilities, as well as within the disabled population, where particular groups may be more disadvantaged than others based on characteristics such as type of disability and socioeconomic status.

There is a burgeoning literature regarding how to obtain strong evidence on the impact of policies using methods that minimise bias by taking advantage of the fact that even though policies and programs are not randomised they are not 'chosen' by individuals (i.e. exogenous). These are referred to as natural experiments or quasi-experimental study designs.³⁵ I discuss below how this approach can be applied to the evaluation of the NDIS and changes to eligibility to the disability support pension. In fact, this design has already been used to evaluate the impact of the introduction of stricter eligibility criteria for the disability pension in Sweden and Denmark between 2005 and 2013 on employment and income support. In these countries, the introduction of stricter eligibility criteria for the disability

pension resulted in people with moderate and severe health problems moving from the disability pension to either temporary means-tested benefits or no benefits. They did not examine the health effects of these policy changes.³⁶

It is important to note that the NDIS and income support schemes have different policy logics. The NDIS is a social insurance scheme designed to provide services and supports to people with disability to facilitate their participation in society and, unlike the JobSeeker Payment and the Disability Support Pension (DSP), is not means-tested. JobSeeker and the DSP involve cash transfers and other benefits to alleviate financial hardship and material disadvantage.

The National Disability Insurance Scheme

The NDIS provides individuals who have severe, permanent disabilities with individual funding packages to purchase services and supports. When fully implemented across Australia in 2020, approximately 475,000 Australians under 65 years (at entry to the Scheme) will receive packages. Researchers can take advantage of the fact that Scheme was rolled out at different times and across different areas and compare changes in health among people who live in areas where the NDIS had been implemented with those who did not and who were still exposed to state-funded disability services and supports. It is possible that the NDIS creates new gaps because some participants and families are better able to advocate for well-funded plans and exercise 'choice and control' in a marketized system. These differences in capabilities are likely to be socioeconomically patterned. Similar inequities may arise between people with different types of disabilities with people with intellectual and psychosocial disabilities or disabled people in rural and remote regions who may fare worse because of the lack of availability of services. Such an evaluation would provide policy-makers with evidence about whether or not the Scheme is delivering health benefits and not creating new inequities among people with disabilities.

Income support policy changes

It is well recognised that the JobSeeker Payment – Australia's unemployment allowance (previously called Newstart) – is insufficient to meet basic costs of living.³⁷ JobSeeker increases in line with the Consumer Price Index while other income support payments, including the DSP, are

indexed using a more complex procedure that takes into account cost of living and wage rises.³⁸ While other payments have risen over the past two decades, there has been no real increase in unemployment benefits until the COVID-19 pandemic, when the Commonwealth Government effectively doubled Newstart and renamed it the JobSeeker Payment. There are additional costs related to having a disability (e.g. health care, equipment), which mean that it is hard for people with disability to meet daily living expenses.³⁹ With the NDIS, many of these costs will be reduced, however many people on JobSeeker will not be eligible for the NDIS.

Over the past decade, eligibility requirements for the DSP have tightened with the proportion of people who apply for DSP being deemed eligible dropping dramatically from 63% in 2001–02 to 2010–11 to 43% from 2011–12 to 2014–15³⁸ and 30% in 2016–17.⁴⁰ The number of new DSP recipients dropped from 89,000 in 2009–10 to 32,000 in 2016–17. This drop coincides with the introduction in 2011–2012 of new assessment tables for work-related impairments and additional job capacity assessments for new DSP applicants.³⁸ More people with disability are now receiving the JobSeeker Payment with 30% of JobSeeker recipients having only a partial capacity to work (200,000 Australians) compared to 21% in 2014. Using longitudinal, linked data, researchers could examine these policy changes on social and economic outcomes such as housing stress as well as health outcomes such as health service use and mental health problems. This information is important for government in designing policy so that policy changes do not inadvertently cause health disadvantage, which will likely result in increased demand for health and human services.

At the time of writing the situation has changed dramatically; while unemployment benefits have increased, there has not been an increase in the DSP with many DSP recipients now receiving less than they would if they were on the new JobSeeker Payment. People with disabilities have argued that they are now experiencing greater economic precarity in the light of increased costs of living associated with the pandemic and associated shutdowns. These changes also provide an opportunity to assess the differential impact of social policy changes made at a time when society experienced unprecedented health and economic shocks.

Conclusion

The health of disabled Australians has received little attention in public health research, yet disabled people experience significant disadvantage that may contribute to their poorer health. The application of social determinants and health equity frameworks present questions and potential policy solutions that could advance the health of people with disabilities. It is time public health stepped up to the challenge of providing evidence that will improve the health of disabled citizens.

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