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Disabled people, inclusion and policy: better outcomes through a public health approach?

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The social model of disability has implications for evaluation of disability policy. Public health analyses suggest that a population and environmental approach to enablement is more likely to impact positively on disabled people than person-centred action. The capacity of people living with disabilities to participate in a range of social activities and the attitudes of others to such participation are, along with environments, important factors contributing to disability situations and therefore the restriction of our promotion of personhood. These are areas where metrics could be used to evaluate the impact of disability policy.

Keywords: disability policy; public health; inclusion; evaluation

Points of interest

- Disability is a spectrum of both limitation of activity and impact on social participation.
- Lessons from public health highlight the importance of population/environment approaches and metrics to argue for change.
- Public health and disability studies have much to offer each other.
- Personhood, recognition and the right environment are central to inclusion, which is itself part of personhood.
- Many inequalities suffered by disabled people include and result from restricted opportunity for development.
- Evaluation of disability policy should encompass change to socio-cultural and physical environments and impact on participation.

Introduction

Disability policy is traditionally underpinned by biomedical needs analysis of the disabled population. Policy is evaluated through matching the characteristics of the disabled population and social and health service provision available. Today it is

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generally accepted that disability policy should take into account a diversity of situations, framed by non-discriminatory and participatory human rights principles. There is a policy trend away from treating disability as an individual problem towards recognition that socio-cultural and physical environments can enable or disable people (Swain et al. 2004).

This has been recognized in the United Nations Convention on the Rights of Persons with Disability. In the preamble to the convention, disability is conceptualized as ‘the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others’ (United Nations 2006). This is coherent with both the International Classification of Functioning, Disability and Health (WHO 2001) and the Quebec Classification Disability Creation Process (Fougeyrollas et al. 1998).

We now face the challenge of evaluating disability policy on the basis of non-discriminatory principles. Taking up this challenge should be informed by evidence that can be used to argue for action. We propose a structural analysis of disability informed by population health principles within an interdisciplinary social science framework. This has the capacity to consider disability not as a tragic affair of a few unlucky members of society to be taken care of by specific professionals and institutions, but of concern to us all in terms of risk and social justice. This involves a radical rethink of both policy and its evaluation. It is no longer adequate or acceptable to consider that there is a specific domain given over to ‘the disabled and their treatment’. As Pierre Bourdieu (1987), in considering other social phenomena insists:

Rather than being satisfied with an intimate knowledge of a small area of the reality for which, for lack of self-interrogation, one does not really know how it fits in the space from which it was taken or how the way it works is related to this position, one should [...], strive to build a short description of the whole space considered. (1987, 207; our translation)

Inequality as an environmental disabling factor

Many examples show the impact of social environment and deprivation on disabled people. French evidence shows that children with learning disabilities of families of lower socio-economic status are seven times more likely to be cared for in residential centres than children whose parents are from the professional classes (Mormiche 1999). Such choices of provision can scarcely be characterized as ‘free’. Similar graded inequalities not only impact on the type of care provision but explain a range of phenomena such as going to the cinema by disabled people (Jourdain and Brzustowski 2003). Early life experience before and after birth may have considerable importance on future health outcomes (Barker et al. 1993). From a learning disabilities perspective, research in developing children shows that although cognitive performance may differ between individuals, social class will largely determine whether such performance is maintained or falls back once children reach the age of 10 (Feinstein 2003). The dice are loaded in favour of those born into families of higher socio-economic status. Drawing on the Handicap–Incapacité–Dépendance survey, Jourdain and Lucas (2009) examined the degree of socio-professional integration with respect to gender and the type of social insurance cover. Their findings suggest that the profession of parents is highly correlated with outcomes in terms of integration.

The spectrum of disability

Using data from the same Handicap–Incapacité–Dépendance survey the ‘whole space’ of disability situations may be described by factor analysis (Jourdain, Lucas, and Sherlaw 2013). This has been used to carry out a preliminary structural analysis of disability informed by the International Classification of Functioning, Disability and Health variables, notably incorporating indicators of limitation of activity¹ and restriction of social participation,² thus allowing a description of the population of disabled people (Mont and Loeb 2010). The two main factors from the factor analysis performed on a representative sample from a French population show the following:

- How each point (person) is affected by disability defined through the above dimensions.
- The characterization of a spectrum from complete autonomy to total dependency (see Figure 1), encompassing a range of intermediary situations in the overall population for all ages and social status (Jourdain and Brzustowski 2003).
- Key features include (see Figure 1): the gradient from the central section where two indicators of disability, limitation of activity and restriction of participation have low values and the number of people in the population is high, and the bottom right quadrant where these indicators are highly negative and the population is sparse.
- There is a continuum of disability situations in a population. This is ample justification for the implementation of a non-discriminatory disability policy



Figure 1. The space of situations of limitation of activity and social participation in the French population.

enshrined in law because there is no sharp divide between the disabled and the non-disabled population.

- The gradient may be further broken down into five classes by cluster analysis:
 - (1) the majority of the population in good health;
 - (2) a population of seniors aged 50–70 years presenting certain signs of degrading health; a population working in the sheltered workshop sector;
 - (3) and two severely disabled middle-aged population groups:
 - (4) one confined to their homes, and
 - (5) the other not.

This analysis highlights the need for policy-makers to provide a diversity of graduated social policy solutions covering a spectrum of situations and life-course experience. Crucially, the analysis shows that individuals with similar levels of limitation of activity may present very different levels of participation. We hypothesize that such differences may be explained by reference to the environment, resources made available by the State, social participation and the recognition offered by members of society with respect to such participation. We present a model incorporating these criteria for evaluating disability policy later in this article.

Having suggested that interactions between individuals and the environment (including people) determine resulting experiences, we now consider how this structural analysis relates to inclusion with insights from public health (with its emphasis on populations), philosophical anthropology, developmental and socio-cultural theory. This highlights how different factors impact on people's lives contributing to disability.

Public health and its relevance to disability policy

Disability policy is often viewed as being in tension or contradiction with public health. Reflection shows that disability policy has much to gain from a population health perspective and its exploration of environmental and social factors since disability concerns the whole of society. Public health is principally concerned with population health; currently, disability policy is often seen to apply to individuals. Public health is also seen to be in close alliance with biomedicine, anathema for many disability social model theorists. Public health seeks to improve population health and tackle health inequalities. Given the focus on inequality and inclusion among public health practitioners, it is surprising that disability does not figure more prominently on the public health agenda. In public health circles, disability appears to be the inequality that dare not speak its name. This is a missed opportunity. Through measuring the scale and impact of an issue through epidemiology, public health brings evidence into policy and intervention design, and uses evaluation and critical thinking to assess the effectiveness of policy and service provision.

Along with health economics this involves the prioritizing of health and social care resources and actions. Thus it is driven by information including measurement of disease and health at population level.

In public health terms, if you want to change something, measuring it is a good starting point. Traditionally, disability theorists have shied away from the idea of measurement since it has been very much associated with the reduction of people to their impairment. Nevertheless measurement, not of people but of their

interaction with different environments, is vital to evidence-based disability paradigms and policy evaluation. Both disability and public health practice are characterized by tension between the needs and goals from a population perspective and the needs and goals of the individual members of the population or target group. Disability practitioners find themselves, often in contradiction with their non-discriminatory training and credo, singling out particular target groups; that is, people labelled as being disabled. Similarly public health practitioners, taught to treat health as a social phenomenon rather than an individual one, find themselves targeting at-risk groups and high-risk individuals for specific treatment – in many ways, the antithesis of population health. There is also tension between treating disease as a continuum and splitting this continuum into disease and non-disease, the basis of case definition (Rose 1992/2008). Public health goes beyond treating disease to explore the wider environmental and social factors that contribute to poor health, and seeks action on these factors. Disability practitioners and public health professionals have much to share and this process may be informed by the social determinants of health paradigm (Marmot 2000, 2010; Rose 1992/2008).

Rose's legacy and its relevance to disability policy

Rose (1992/2008) theorizes two statistically informed approaches for improving health and societal problems in a population: an *individually focused approach*, which targets members of a population at high risk; and a *population approach*, which attempts to impact on what is underlying or driving the production of disease or other social phenomena. While we believe that both targeted and population approaches are important for disability, the second approach has been relatively neglected in the past yet has potential to strengthen social model thinking and long-term effective policy.

Rose (1992/2008) presents us with a graph from Keys (1970) of overlapping bell-shaped curves contrasting cholesterol levels in south Japan and eastern Finland. It is immediately obvious that:

- the distributions and the average level of cholesterol are different in eastern Finland (high) and in south Japan (low),
- What counts as high cholesterol in south Japan corresponds to what counts as low cholesterol in eastern Finland,
- To explain this difference it is necessary to search for 'community wide factors'.

Comparing individuals within the population offers no solution to why disease incidence varies between populations. This implies that population health and well-being depend on the conditions within a society and may be modified. This insight has great relevance for tackling disability at the population level, with implications for both policy and evaluation.

One may draw parallels between treatment and measures to prevent disability and the prevention of morbidity and mortality in disease conditions. These observations are relevant to preventing impairment, living with impairment, and minimizing the impact of impairment. If it is at times straightforward to make distinctions between disabled people and non-disabled people, disability as an experience is a continuum.

Traditional biomedical individually oriented disability policy should be revisited in the light of new definitions concerning disability. The latter may be viewed as being an interaction between functioning (the impact of impairment) and contextual environmental factors. Targeted individual approaches make partial sense since impairment concerns the body and thus can be anatomically and physiologically limited and treated as a case. The environment, however, may vary according to location and is open to modification. What is more, it demonstrably impinges on both psyche and body (National Research Council 2006).

Parallels between individually oriented disability policy with high-risk targeted approaches in public health may be drawn. As Rose (1992/2008, 82) noted: ‘the achievements of the high risk strategy, as of any individual-based approach, are limited to the individuals concerned: they are palliative, local and temporary’. We should be sceptical of individually oriented approaches in disability since many answers are not to be found at individual level but depend on the environment in which people live. Hence individual targeted approaches must necessarily be less than totally effective. Individual approaches have their place, but the long-term and effective strategy for disability must be population based.

As Marmot (2000) points out, policies aimed at high-risk individuals will never remove what is driving the phenomenon and the problem will remain since every year a new cohort will join the population replacing those targeted. Lessons may be usefully drawn for disability policy, both in preventing disability and in its management. We wish to highlight four.

Firstly, although it is crucial to treat all individuals by appropriate medical, psychological, or social-work interventions, in the case of disabled people such individual treatment should take into account the different contexts and environments (situations) in which the person moves and lives. This should be guided by the choices of the person they have reason to value (Sen 1999).

Secondly, individual treatment fundamentally may do little to:

- change the present conditions that form barriers liable to create disability; and
- impact on the social and physical environmental conditions that fuel the production of avoidable disease and impairment and disability.

Individual piecemeal arrangements may offer solutions for that person but have no real significant impact for others and those that will undoubtedly follow. Viewed more optimistically, individual experience over the years will filter down into the collective psyche and social and health institutions, and consequently lead progressively to social change.

Thirdly, disability theorists may strengthen the social model (Union of the Physically Impaired Against Segregation 1976) through pointing out (as in other conditions, such as high blood cholesterol) that different social conditions in different countries produce more or less disability and different treatment of disabled people. This may be linked to the values underlying the societies and may be shown through both historical and geographical comparisons (Gardou 2010). We would encourage such comparisons as opportunities to highlight conditions that could be changed.

Fourthly, disability forms part of a health-disease continuum and the definition or self-definition of being ‘disabled’ or not being disabled is a reflection of processes at work throughout society. Labelling a person as disabled is often linked to bodily

experience in the particular environment. The seeds of much future disability are experienced throughout the individual life-course but, most importantly, the evolution of the society is both a source of and a potential solution for disability. To echo Rose (1992/2008, 161), ‘the primary determinants of disease are mainly economic and social, therefore its remedies must also be economic and social’. The solution for disability similarly must be economic, social and hence political.

Inclusion and disability: an anthropological approach

If we are to enable people to pursue their valued life-choices (Sen 1999; Touraine 1992) we must remove barriers that inhibit their participation. People with disabilities in all their diversity have the same human needs as every other human being and must be treated as equals. As the French philosopher Simone Weil emphasizes:

Equality is a vital [human need]. It consists in recognition, at once public, general, effective and genuinely expressed in institutions and customs, that the same amount of respect and consideration is due to every human being because this respect is due to the human being as such and is not a matter of degree. (Weil 1949, 26)

Non-discrimination does not exclude different provision for people with different needs. An integral part of this approach is its theoretical foundation. Rather than treat disability and issues important for the lives of disabled people as a special case, with specific theories and practices, the time has come to consider disability and the evaluation of disability policy as part of the wider political, social and public health agenda – namely, social exclusion/inclusion with its emphasis on ‘participation in key activities of the society’ (Burchardt, Le Grand, and Piachaud 2002); and social relationships within society (Guildford 2000). This may be informed by theories used to explain all human lives and choices.

Personhood

Ikäheimo (2009) has argued that personhood, in particular interpersonal personhood, is a vital component of whether true inclusion of disabled people is present. The key component involved is interpersonal recognition. This may take different names and has been discussed in the philosophical work of Ricoeur (2004). Regarding inclusion of disabled sheltered workshop workers, Lucas (2008) – referring to Honneth (2000) and Elias (1991) – put forward a preliminary framework involving recognition for the evaluation of disability policy. We will develop later this idea and suggest how it could be operationalized. In line with Ikäheimo’s work we take the position that, like all public policy, disability policy should be formulated and evaluated by reference to its capacity to create enabling conditions for the protection, maintenance and development of interpersonal personhood.

If we are to explore the necessary conditions for a person to thrive we should first expand on what is meant by personhood. Rescher (1990) proposed seven essential conditions, namely: mutual recognition, self-esteem, self-understanding, rationality, agency, affectivity, and intelligence. We have inverted Rescher’s original order since in any social theory of disability recognition is at the heart of being an active member of society. Whilst it is true that some or all of these seven different characteristics may be called into question in the case of, for example, someone

with profound and multiple learning difficulties, it is in these very cases where personhood is vulnerable that it is vital to safeguard and uphold it. Rescher maintains that it is part of being a person to accept such highly vulnerable people as persons. The United Nations Convention on Rights of Persons with Disabilities sets out conditions for the thriving of disabled persons and recognizes the right of disabled children:

to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realize that right. (United Nations 2006)

This is an example of upholding personhood. Health and social service care professionals and disability practitioners have an important role in upholding, protecting, maintaining, nurturing and developing personhood.

Good healthcare incorporating free and informed consent is vital for the health and well-being of disabled people. Disabled people have the right to generic care like other people, and specific care relating to their impairment (United Nations 2006). But if one's body and care, as all disabled people and their families know, is an inevitable part of the equation of disability, it is far from being the sole determinant. Individuals and their bodies have great powers of adaptation. They gain new and unexpected ways of functioning and being flourishing in friendly environments. Two key features of personhood are especially relevant to the inclusion of disabled people, yet are often denied – namely, agency and recognition. Recognition within face-to-face interaction has been extensively theorized by Goffman (1983). Here we will focus on how society's institutions grant or do not grant recognition to disabled people's choices. Recognition may, but does not necessarily, demand special treatment. Indeed at times it will demand that we treat the person with disability as any other person, thus favouring 'functioning in an ordinary way without receiving special attention' (Van de Ven et al. 2005).

With respect to agency, we will also argue that choice is always made in a context and takes into account not just personality, socio-economic resources and bodily possibilities, but also their articulation with or without human and technical aid.

Disability: an interaction between modified developmental trajectories and the environment

Physical and socio-cultural environments impact on all people's life trajectories. We go further and suggest that considering disability policy and individual disability as a life-course and developmental phenomenon (Priestley 2003) may offer new insights and policy vistas. This approach may be supported by theories in human ecology. Tudge, Gray, and Hogan (1997) recall that Bronfenbrenner advanced the thesis that development is a function of an interaction between person and environment. Introducing development into the disability equation in no way removes the importance of the physical and socio-economic and cultural environment or indeed valued life-choices, which remain crucial. Rather it highlights, as social models of disability and population models of health suggest, the necessity to think of human development of all people, not as isolated biological entities but as social beings

that may also, as Krieger and Davey Smith (2004) maintain, embody environmental influences. It opens the possibility of alternative development that leads to new capacities. Impairment is generally viewed as being a deficit in functioning confined to the person's anatomical structures or physiological functioning. An implicit measure of the difference between past 'normal' functioning (based on personal subjective appreciation, normative views or statistical distributions) and current functioning is made. However, such a measure is based on loss and deficit. A developmental trajectory perspective, without neglecting past possibilities, would highlight different scenarios for the future depending on interplay between the person and their environment. Thus insights may be offered by considering impairment as being a modification of bodily possibilities and of expected development from the viewpoint of the person, their family, community and society. Enhancement in this view would be an increase of bodily possibilities and expected development. The case of congenital impairments underlines the fact that human beings are autopoietic like other biological organisms, being formed from their environment whilst at the same time influencing and creating their environment (Varela 1989). This perspective highlights the role of the family and the developmental process by which a human being can unconsciously or consciously incorporate the idea of future time and development, and underlines that early life experience and loving care for such children is vital. Disability could be considered as a reduction of opportunity for development being related to what normative society offers or denies the individual and family concerned and how the individual and family respond in given situations and how the person is recognized or disavowed.

This, for the individual, may lead to emergence of new possibilities and may be revelatory. The idea of restricted opportunity for development being avoidable may be linked to social justice and inequality. Lack or denial of opportunities would lead to a loss of potential and such loss is avoidable and thus unjust (Whitehead 1991; Wolff 2010).

A developmental approach highlights the importance of socio-cultural context and time. Different developmental stages, involving both key biological and culturally significant events, may be pinpointed in a life-course approach. We suggest it is useful to identify three different time frames that are nested in each other.

Long-term context: culture acting on policy and practice the socio-cultural history of disability

First we may speak of cultures and how they bequeath representations and practice from past generations but nevertheless are renewable. Cultures have power to frame situations at a distance; yesterday's choices and decisions impinge on today's behaviours and representations (Sherlaw 2006). Cultures can support and enable or undermine and disable. They can foster or negate the personhood of disabled people. They can honour personal choice or impose institutionalized solutions. Nevertheless, disabled people and their families and friends can reaffirm, challenge or reinterpret the conditions imagined and bequeathed to them.

Socio-cultural environments with their associated policies and practices provide a context for disabled peoples' lives and institutions and disability professionals (Cook 2000). These contexts may vary according to traditions and policy but include such features as disability rights, anti-discrimination legislation, theories, classifications (Bowker and Star 2000) and measuring devices, founded on the

contemporary knowledge base. Theories and policy orientations may favour universal design, inclusive or segregative institutions and practice. Are specialized or generic facilities provided? Are people with epilepsy honoured or stigmatized? (Kleinman 2002; Fadiman 1998). Is enablement of people at the heart of the agenda or are special care and education services favoured? (Lucas 2008). Should deaf infants be instructed in how to use sign language or implanted with cochlear devices? (Kermit 2009). Policies that address the physical and social environment and expectations for this and future generations offer the greatest gains for reducing disability.

Life trajectory context: policies impacting on life trajectories

A slightly shorter time frame encompasses lives and life-projects envisaged by disabled people, or on their behalf. Such life-plans are framed by what the State offers disabled people. Thus policy and accompanying governmental measures may be considered as a backcloth context framing individual personal life-projects and either promoting or denying opportunities. These include ensuring access to work, health, education, leisure activities, justice and the political system. Such measures may be viewed in terms of human rights and the duty the State has in protecting and furthering the rights of people with disabilities and doing its utmost to ensure that the voices of disabled people are heard and that their views are taken into consideration.

Immediate context: what possibilities are open to me?

Lastly, and importantly, we may identify situations on shorter time-frames, life-events or sequences in which people with disabilities may undertake day-to-day participation in society, allowing the emergence of life-projects and histories. They incorporate the risk of being ignored, or rejected, but also of the opportunity to be recognized and affirmed. On an everyday level, provision of resources for the people with sensorial, intellectual and physical disability, such as Braille documents, sign-language interpreters, and accessible transport and buildings for people with wheelchairs and those who have difficulty using steps, will all impact on participation.

The State in our view has the duty not just to reflect current mores, but to enable and construct a more inclusive culture.

Disability: an interplay between persons, environment, culture and time

There is a difficult balance in relation to impairment to seek between:

- people's expectations based on their current experience and experience prior to the occurrence of impairment,
- assisting people to incorporate some kind of acceptable compromise, and
- favouring different development and the revelation of latent potentialities.

Any compromise should be in the purview of the disabled person. Others may have useful opinions to consider, but if you start with the assumption that disabled people are best placed to decide what is acceptable, then you acknowledge the importance of their autonomy.

As in other health/disease trajectories (for example, tuberculosis; Bowker and Star 2000) there may also be a conflict between systems that have evolved to deal with disability in the past, usually categorized by impairment, potentially leading to the reifying of people and individuals with unique histories and aspirations. Once systems are put in place, they may intrinsically have or develop inertia that may then set up barriers limiting the choices open to the people they were created to help.

Having examined the complexity of disability, and how it impacts on people's lives, we are faced with the challenge of reducing this complexity to manageable dimensions for purposes of policy formulation and its evaluation. This involves choosing a model that:

- can incorporate the participation of disabled people;
- makes sense to disabled people, social and health professionals and policy makers; and
- recognizes the importance of environmental and socio-cultural contexts but is not prisoner to the latter (see Figure 2).

Evaluating disability policy and measuring inclusion

Here we propose a simple model relating disability policy, and its evaluation to inclusion and exclusion, and primarily focus on factors involved in successful inclusion of people living with disabilities in society. We postulate that measurement of inclusion may be made by reference to three main variables – namely, 'what the State offers' (resources and environment made available to people), 'social participative acts', and 'recognition' (how society responds). It may be refined methodologically and implemented through the participation of disabled people

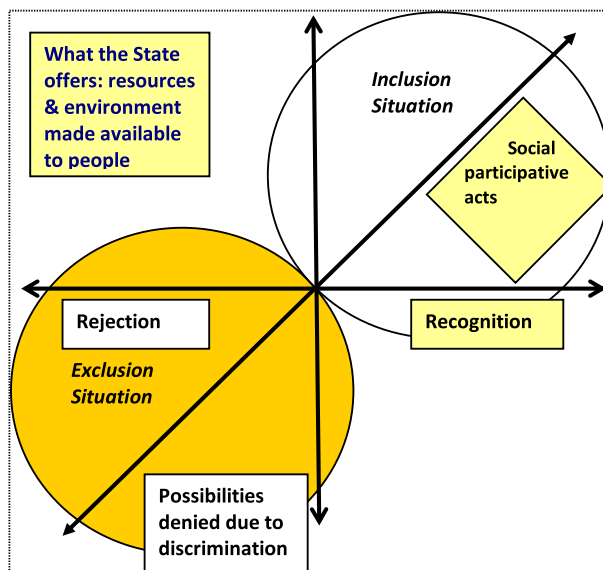


Figure 2. The three key dimensions of inclusion of disabled people.

(Abma, Nierse, and Widdershoven 2009). The model should be considered dynamic, immersed in a socio-cultural political and economic context that impacts on disability policy and disabled people's lives. It may be used to take a 'snap-shot' but also longitudinally across more than one generation of people with disability, their carers, and institutional services and providers.

We suggest the model offers policy-makers a framework for designing policy, and evaluators a basis for policy assessment at local, national or transnational levels. The model highlights the importance of 'structure' and 'agency' with a balance between the 'socially defined and personally defined' (Layder 2006). In disability situations there is interplay of the physical environment, the social setting with its facilitating or disabling features and how the person responds within the situation in which he or she is placed or chooses. The model primarily provides a framework for measuring and comparing the impact of policy at a collective level through reference to population level indicators.

The three key dimensions

What the State offers (resources and environment)

This concerns the real possibilities of choice – the opportunities open to the person in terms of training, employment, housing, social protection, social life, participation in society, and so forth. This should offer data on accessibility (or lack of accessibility) to transport, to sources of information, to schooling and university education, and to cultural facilities such as cinemas theatres, and museums. This does not just concern whether legally such choices are theoretically possible, but whether they are really available. A distinction between policy discourse and its application must be made. An evaluation of such resources will give an indication of how people with disabilities needs and views have been taken into consideration.

Social participative acts

These are acts that have meaning for the person. Through these he or she attempts to transform intangible choices into tangible actions that may lead to the building of relationships and participation in projects. In setting out to accomplish such acts there will always be, as in any human interaction, an element of risk. Here we are concerned with meaningful social acts within the social and political arenas. Virtually all individual acts ultimately could be defined as being social, but we believe that it is possible to distinguish between, say, eating a pizza alone at home, eating a pizza in a pizzeria alone, and eating with friends in a pizzeria. The first is not essentially a social act, whereas the other two situations are because they offer the possibility of interactions with others. For example, what percentage of disabled people are candidates or appointed to posts of responsibility in the professional, social, educational or political world? The converse of this would be examples of discrimination against disabled people.

Recognition: how society responds

Having transformed intangible choices into acts with the explicit or implicit aim of investing oneself in a social interaction, the success of such acts will depend on their reception by others (Honneth 2000). The attitudes of others may provide

Table 1. Illustration of the model applied to a master's programme and sheltered employment.

	What the state offers	Social participative acts	Recognition
Master's programme	Right to study open to all (Equality of opportunity; Renaut 2007). Accessibility arrangements: adapting learning and teaching resources and examinations (extra time and secretarial assistance provided if appropriate).	Quantitative data on: – number of disabled students enrolled, – number of students completing course. Qualitative data on being a disabled student: – facilitating factors and difficulties.	Data on employment following master's course: equality of results (Renaut 2007).
Sheltered employment	Extensive at arm's length agencies (associations) run subsidized provision for disabled workers funded through State and local authorities. Different legal status from ordinary workers – remuneration + adult disability allowance. Total job security with potential job satisfaction (perhaps not available in other systems). Possibility to move into the ordinary workforce is supported (but low, 1–2%) (Velche 2009). Is the sheltered workshop system segregative or protective? Does its very existence offer disabled people real choice?	Quantitative data collected on number of adult workers who are offered trial placements in the ordinary workplace. Qualitative data on work satisfaction and choice.	Quantitative data on the number of workers having taken up employment in the ordinary workplace following trial placement and their retention. Qualitative data on feeling of recognition by their fellow workers and management and society.

positive recognition of the person, complete indifference or outright rejection. From an institutional-level perspective we are dealing with the medium-term to long-term outcome of the disabled person's 'investment' or the taking up of the challenge. Challenges and the 'pain' of challenges are a part and parcel of all meaningful life, as *Brave New World* reminds us (Huxley 1932). Within an equality of opportunity agenda it is important to recognize this while ensuring that unfair obstacles to participation are removed. If we get it right, people living with impairments will have choice about the challenges in life which they choose to take on, rather than having challenge imposed upon them by the environment and by the expectations of others.

Thus the challenge for both disabled people and theorists is to take on board the switch from positive action based on an individual model of disability to a different mode of recognition expressed through non-discrimination.

A brief illustration of the working of our model is given in Table 1 for the following:

- disabled students undertaking a master's programme; and
- disabled adults working in French sheltered workshops (ESAT) situated liminally between inclusion and exclusion (Lucas 2008).

Conclusion

Disability policy and its evaluation have much to gain from population health approaches complemented by an interdisciplinary social science framework. Disability policy and its evaluation may be based on International Classification of Functioning, Disability and Health population health evidence. As our example highlights, this allows the existence of a gradient, of strong differences between individual situations and the existence of life-course trajectories to be taken into account. However, in itself this is insufficient since disability cannot be adequately addressed through only considering problems of functioning and participation, but must also incorporate the choices of people with disability and their families as well as the recognition of people with disability by society. Consequently, we suggest a preliminary model incorporating three elements:

- the resources and environments made available through State action,
- participative social acts, and
- recognition.

Such a model may inform disability policy and provide a participative basis for its evaluation.

We offer four complementary closing remarks. Firstly, our model depends on mechanisms and systems being in place to allow individuals and families to voice their views and have their rights implemented. Secondly, public health and disability professionals should accept that their primary role is not to shape policy through expert knowledge and power, but rather through new practice based on facilitation and advocacy to enable disabled people themselves participate in the shaping of policy (Harris and Roulstone 2011). Thirdly, to combat inertia, policy designers should incorporate a degree of flexibility of provision. Fourthly, policy should be evaluated at fixed regular intervals to allow suitable and timely adjustments to be made to the services and environment provided.

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Notes

1. Activities pertain to a wide range of deliberate actions performed by an individual. They are deliberate actions undertaken in order to accomplish a task, such as walking or climbing stairs.

2. Participation refers to activities that are integral to economic and social life and the social roles that accomplish that life, such as being able to attend school or hold a job.

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