

Disability in Latin America Operationalized as a Social Problem Points to Social Solutions

Erika Sanborne, University of Minnesota



UNIVERSITY OF MINNESOTA

Disability Primer

Panel 1: I have a LOT of difficulty seeing! This affects SO many things—work, family, school, friendships...

Panel 2: That sounds like a YOU problem.

Panel 3: If only I had glasses.

Panel 4: Hmm. If you had glasses, could you drive, work, and do what you value?

Panel 5: If I had glasses, I would have no difficulty seeing. Then I could drive, do my job, and so much more. **WOW**

Panel 6: In the MEDICAL MODEL, difficulty seeing is the disability, a personal problem.

Panel 7: In the SOCIAL MODEL, lack of access to glasses is the disability, a social issue.

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Disability Indicators

Medical Model

Disability is functional impairment. The indicator of **disabled** is constructed from six IPUMS MICS items that ask whether respondents have difficulty seeing, hearing, walking, remembering or concentrating, communicating, and caring for self. If women reported at least “a lot” of difficulty in 1+ domain, they are **disabled**. This aligns with WG recommendations for comparability.

Social Model

Disability is lack of access. The indicator of **lackAccess** is constructed from two IPUMS MICS items. For women who reported “a lot of difficulty” seeing and who also reported that they did not have eyeglasses, they **lackAccess**.

Questions and Objective

1. How does using a social model of disability affect comparative analyses of national survey data?
2. Are well-being gaps apparent through this approach?

The objective is sustainable development, to begin bridging the gap between the conceptual framework that locates disability as the interaction between person and environment and the empirical demographic research that still treats disability as a personal, medical condition.

Social Model

Where j indexes the cutpoints of the 11-level ordered outcome variable Y (the Cantril ladder, life satisfaction measure)

$$\text{logit}(P(Y \leq j)) = \beta_{j0} + \beta_1 \text{lackAccess} + \beta_2 \text{ethnicity} + \beta_3 \text{wealth} + \beta_4 \text{edlevelwm} + \beta_5 \text{married} + \beta_6 \text{discriminated} + \beta_7 \log(\text{age}) + \beta_{\text{interaction}} (\text{lackAccess} \times \text{ethnicity})$$

Medical Model

Where j indexes the cutpoints of the 11-level ordered outcome variable Y (the Cantril ladder, life satisfaction measure)

$$\text{logit}(P(Y \leq j)) = \beta_{j0} + \beta_1 \text{disabled} + \beta_2 \text{ethnicity} + \beta_3 \text{wealth} + \beta_4 \text{edlevelwm} + \beta_5 \text{married} + \beta_6 \log(\text{age}) + \beta_{\text{interaction}} (\text{disabled} \times \text{ethnicity})$$

Substantive Findings

Non-disabled women in regions with *fewer* economic resources have a **remarkably high** predicted probability of attaining the highest levels of life satisfaction.

Significant interactions emerged between ethnicity and lack of access. And **the well-being penalty** associated with disability is greater for Black and Indigenous women in regions with *more* economic prosperity.

This suggests a **development-disability gap**.

Implications

- Reducing within-country inequalities requires addressing the access needs of Black and Indigenous disabled women.
- Including measures of access when disaggregating data by disability can highlight crucial development-disability gaps.
- Disabled people need *a more accessible social world*.

Background & Methods

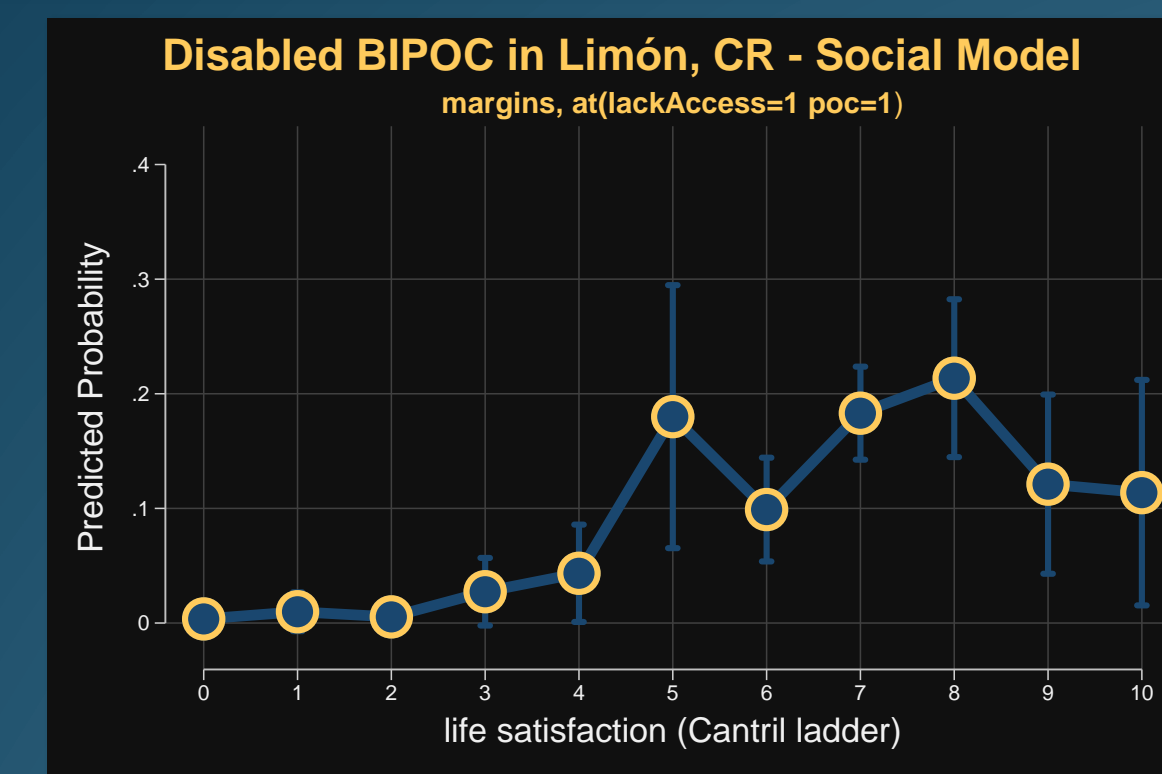
Background

There is an increasing volume of research disaggregating demographic data by disability, as recommended by many*. Standardizing measurement is important for comparability. The Washington Group Short Set (WG-SS) is foundational for this. The 2030 Agenda for Sustainable Development prioritizes leaving no one behind. Identifying and reducing within-country inequalities is key. Operationalizing disability as a personal problem suggests medical solutions. If disability is a social issue, accessibility is needed. This is worth investigating, as disability is an axis of inequality, and these deprivations are potentially so costly.

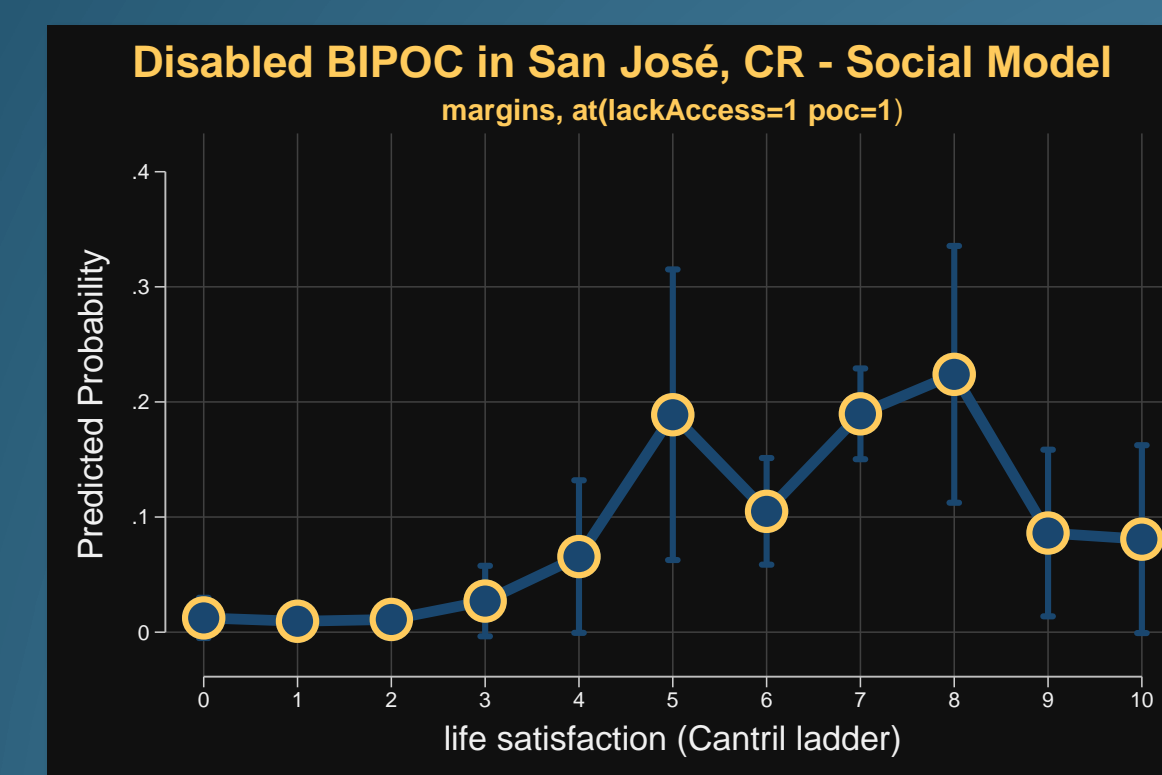
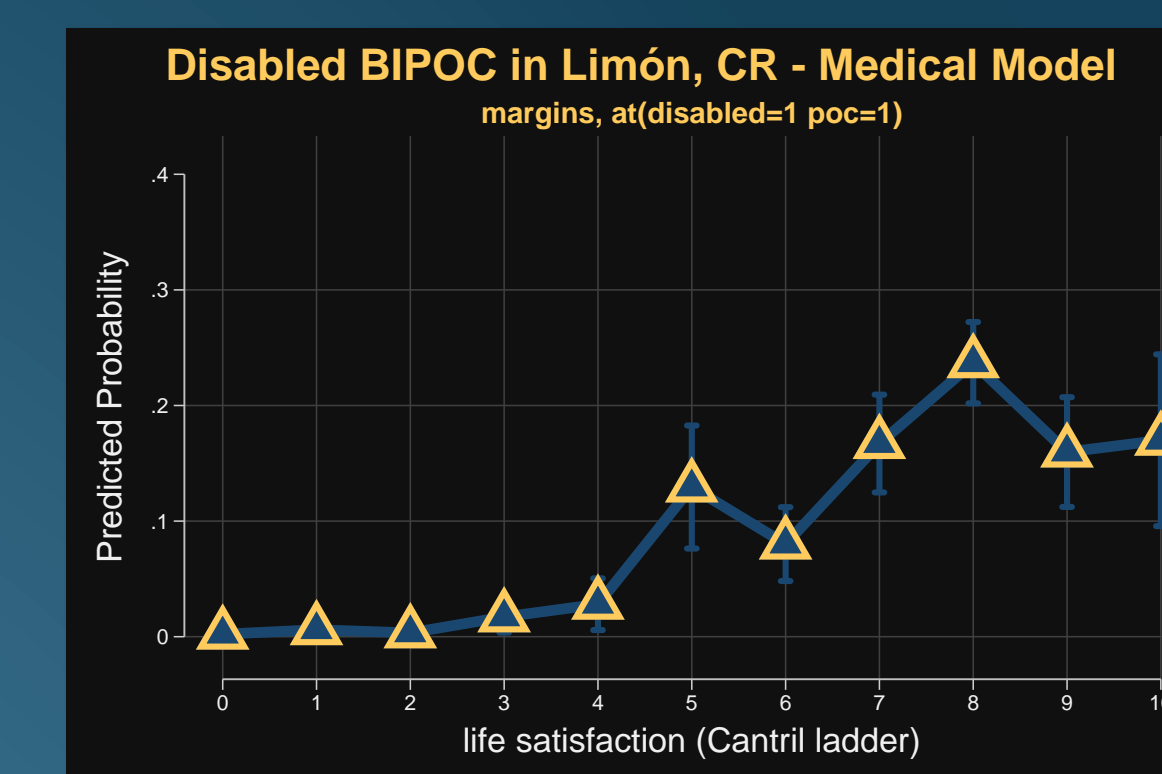
*United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD); World Health Organization (WHO); World Bank; Organisation for Economic Co-operation and Development (OECD)

Methods

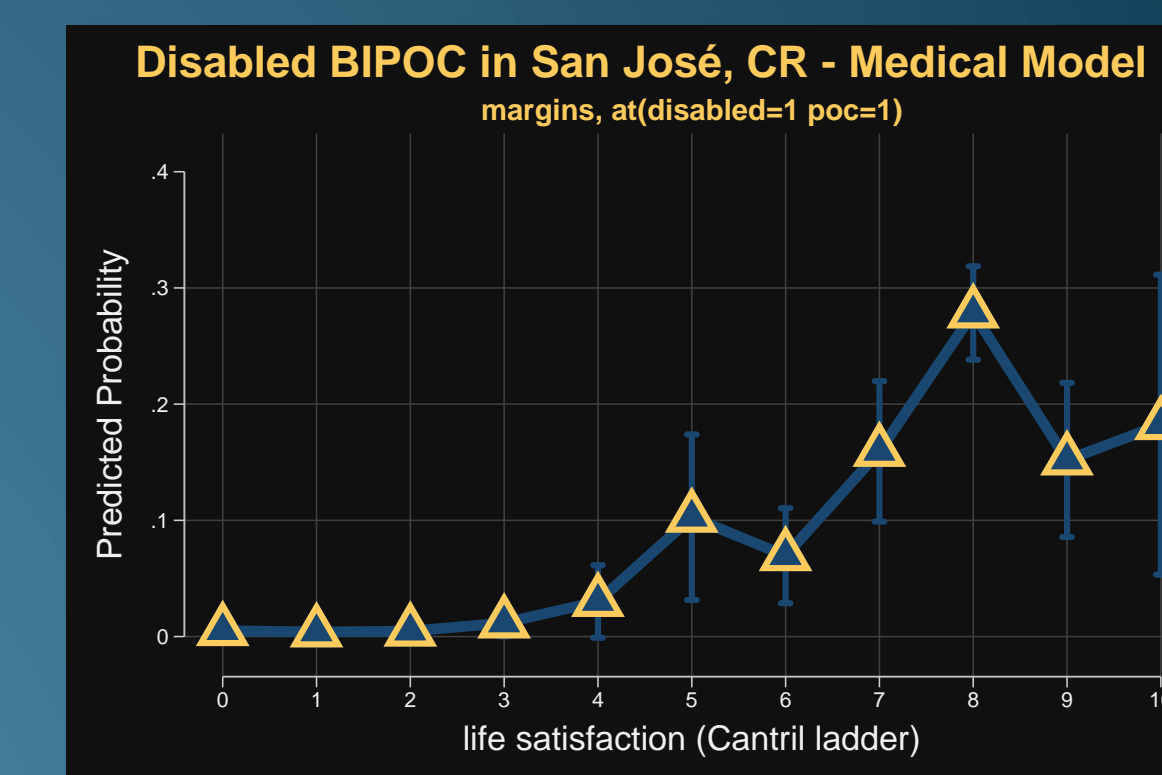
The regression models in this study (medical model and social model) examine the associations between *life satisfaction* (Cantril ladder) and *disability* within the theoretical framework established by the WG. Life satisfaction serves as a comprehensive proxy for assessing individuals’ well-being, reflecting overall quality of life. Nationally-representative samples from Costa Rica, Dominican Republic, Honduras, Cuba and Suriname were studied. Suriname and Costa Rica models were fitted due to data limitations. Data: IPUMS MICS



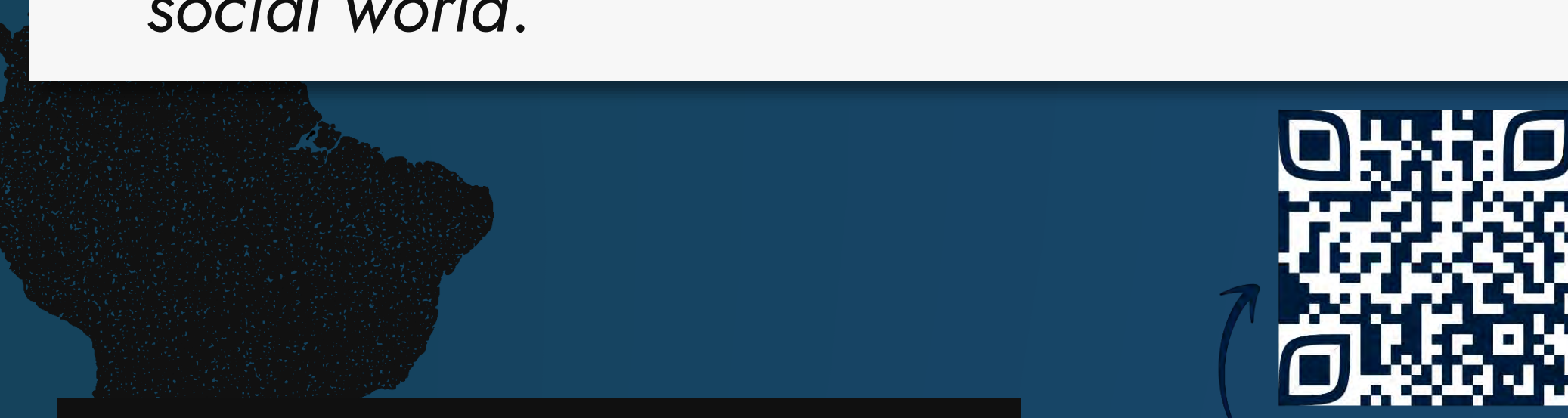
Limón Province is distinct for having high overall life satisfaction, being home to much of the Afro-Costa Rican population, and for having the lowest score (0.767) on the Subnational Human Development Index (HDI).



San José Province is known for including the largest urban agglomeration in Costa Rica and the capital city. It also has the second highest score (0.836) on the Subnational HDI.



The social model here reveals important inequalities that can get lost in other measures. Lack of access is associated with a substantial life satisfaction penalty for disabled women of color in this otherwise thriving province. These women need accessibility.



Acknowledgements

Contact/More info

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