ADDRESSING INEQUALITIES
The Heart of the Post-2015 Development Agenda and the Future We Want for All

Global Thematic Consultation

INEQUALITIES RELATING TO HEALTH AND THE LIFE COURSE: DISABILITY, MENTAL ILLNESS AND OLDER AGE

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Abstract

Issues related to early childhood feature prominently in the MDG framework (as do malnutrition, HIV status and malaria), and data collection in these areas is fairly advanced. Other sources of inequality are notable by their virtual absence – among these, older age, disability and mental illness, although these issues each appear to affect sizeable numbers of particularly vulnerable people throughout the world. A clear obstacle to ‘mainstreaming’ these sources of inequality in a new post-2015 agreement is the widespread lack of nationally representative internationally comparable data. This could arise from definitional or technical issues (what to measure and/or how), operational issues (e.g., resource or capacity constraints), attitudinal issues (relating to stigma) and/or lack of demand from data users. Greater attention is needed to explore these constraints and how they might be overcome. To this end, this paper discusses currently available data and its limitations, constraints to better data collection and efforts needed to adjust key international survey instruments – the World Bank’s Core Welfare Indicator Questionnaire (CWIQ) and Living Standards and Measurement Survey (LSMS), Macro International’s Demographic and Health Survey (DHS) and the UNICEF Multiple Indicator Cluster Survey (MICS) – to collect reliable data on these sources of inequality, alongside other household indicators.
Introduction

Inequality takes many forms. Often considered are those relating to gender, race and ethnicity, class, and place of residence. Early childhood features prominently in the current MDG framework (as do malnutrition, HIV status and malaria). But inequalities associated with later stages of the life course and other health conditions are notable by their absence – among these, older age, disability and mental illness. This paper concentrates on the need to include these three sources of inequality in a post-2015 framework agreement. Not only are they global in scale with salient effects on large numbers of people but they are also closely associated with vulnerability and a lack of fulfilment of human rights. These sources of inequality are important in themselves while their neglect is also likely to have constrained MDG achievement. For example:

- Older people may be more susceptible to fatal forms of malaria owing to age-associated loss of immune function;
- Over one-third of school aged children remaining out of school have a disability;
- Poor mental health can engender poor physical health, and vice versa.

A post-2015 development agreement that is truly concerned with inequality in its multiple manifestations ought to take these issues into account. A clear obstacle is the widespread lack of nationally representative internationally comparable data. This could arise from definitional or technical issues (what to measure and/or how), operational issues (e.g., resource or capacity constraints), attitudinal issues (relating to stigma) and/or lack of demand from data users. Greater attention is needed to explore these constraints and how they might be overcome. To this end, the paper discusses currently available data and its limitations, constraints to better

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2 A wealth of evidence points to their importance to a post-2015 framework.
3 Although mental health conditions are a common cause of disability, in this paper they are considered separately because they are not necessarily disabling and because the discourse on disabilities often neglects people in mental illhealth.
data collection and efforts needed to adjust key international survey instruments – the World Bank’s Core Welfare Indicator Questionnaire (CWIQ) and Living Standards and Measurement Survey (LSMS), Macro International’s Demographic and Health Survey (DHS) and the UNICEF Multiple Indicator Cluster Survey (MICS) – to collect reliable data on these issues. It closes with some thoughts regarding how these sources of inequality might be incorporated into a new global agreement.

Size and potential vulnerability of affected groups

The number of people experiencing older age, disability and/or mental illness is substantial. Moreover, in many contexts, particularly those in which relevant policies and safety nets are absent, they tend to be disadvantaged. These forms of disadvantage tend to overlap with one another in distinct ways, as well as with more often-studied sources of inequality such as gender and place of residence. For each group in turn, we review the most recent evidence concerning size and vulnerability, before outlining some ways in which these sources of inequality appear to overlap.

Older age

The population as a whole is ageing. People aged 60 years and older currently make up 11 percent of the global population, a share that is expected to double to 22 percent, or 2 billion people, by 2050. At a global level, the number of older persons already exceeds that of children under 5 and it is expected to exceed the number of youth 15 years and under in 2050. The fastest growth is happening in developing countries with profound implications not only for older people themselves, but for their households, the social and community infrastructure, and for social policy.

Ageing is associated with different types of disadvantage. Recent studies in developing countries found that households with older residents tended to be poorer than other

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households.\textsuperscript{v,vi} Ageing may mean that people become less able to work and receive fewer employment opportunities, while policies and programmes designed to enhance livelihoods often exclude older people in promoting activities that require high levels of labour capacity and mobility. However, only one in five older persons has a pension and coverage is even lower in developing countries.\textsuperscript{vii} Presently some 340 million older people are living without a secure income; on current trends, this number will rise to 1.2 billion by 2050.\textsuperscript{viii} Between 15 and 30 percent of older people live alone or with no adult of working age.\textsuperscript{ix} Moreover, in many countries where children have been orphaned by HIV/AIDS, older people are assuming a considerable caretaking burden,\textsuperscript{x} which, like other forms of the ‘care economy’, is not systematically monitored.

\textit{Disability}

Disability is not a rare event. Leading estimates from the World Health Organization’s World Health Survey\textsuperscript{xi} and Global Burden of Disease report,\textsuperscript{xii} both using 2002-2004 data, suggest that between 15 and 20 percent of the population worldwide have some form of disability,\textsuperscript{5} and that 2 to 4 percent of people have a severe disability. On balance, disability is linked to a higher probability of being poor.\textsuperscript{xiii,6} In many settings, persons with a disability are less likely to obtain an education – owing to constraints on access, stigma and a lack of support – and face reduced employment opportunities and earnings. Additionally, other household members may have to relinquish paid employment in order to care for disabled members. Typically, disabled persons have higher health care costs, and they may also face social and political marginalization.\textsuperscript{xiii} The poor, in turn, are more likely to be malnourished, in low quality employment, subject to difficult living conditions and to be exposed to environmental hazards, all of which increase the likelihood of disability. Several meta-studies and individual country studies support this relationship. For example:

\begin{itemize}
  \item \textsuperscript{5} Including those resulting from mental health impairments.
  \item \textsuperscript{6} A recent meta review identified seven studies that found a positive link between disability and economic poverty and five that did not.\textsuperscript{xiii}
\end{itemize}
• Analysis of 15 developing countries found that in the majority, ‘persons with disabilities, on average, experience multiple deprivations at higher rates and in higher breadth, depth and severity than persons without disabilities’; \textsuperscript{xiv}

• In 13 developing countries, school-age children with disabilities were less likely to start school or to be enrolled; \textsuperscript{xv}

• Households with a disabled member were 20 percent more likely to be poor in Tanzania; \textsuperscript{x} they were 38 percent more likely to be poor in Uganda, \textsuperscript{xvi}

• In India, disabled children were over five times more likely not to be in school, while employment rates for disabled persons were some 60 percent lower on average. \textsuperscript{xvii}

At a national level, the relationship between disability and poverty varies greatly according to the availability of health care, nutrition programmes, disability benefits and accessible schooling, highlighting the importance of policy. \textsuperscript{xiv}

\textit{Mental ill-health}

Mental health disorders account for 13 percent of the world’s Global Burden of Disease, \textsuperscript{xviii} affecting some 450 million people, or more than 6 in every 100 people worldwide. Severe Depression affects 99 million people; the share of affected people has risen since 1990 and World Health Organisation predicts that by 2030, depression will affect more people than any other health problem. \textsuperscript{xviii}

Although there is a less consistent evidence on the relationship between mental illness and poverty, \textsuperscript{iii} it is strongly associated with certain factors that heighten the probability of being socially excluded: a recent meta-review found that education, food insecurity, housing, social class, socio-economic status and financial stress are consistently related to common mental disorders. \textsuperscript{xix} Changes in life circumstances brought on, for example by illness, ageing, being widowed or in poor health and other adverse events such as war may also contribute. \textsuperscript{iii, xx}

The extent to which these and other sources of inequality overlap and reinforce one another mayheighten exclusion and disadvantage. For example, older people are much more likely to be disabled – indeed, 38 percent of older people worldwide have disabilities, \textsuperscript{xii, xi} and older,
disabled people are more likely to be multidimensionally poor than those who are not
disabled.\textsuperscript{xiv} Dementia is projected to rise in relation to the demographic transition to affect
115.4 million people by 2050.\textsuperscript{xxi,xxii} Women are more likely to experience disability and some
mental health conditions than men.\textsuperscript{xii, iii} Disability is more evident in rural than in urban areas.\textsuperscript{xii}
Physical and mental ill health often are linked. For example, depressive disorders have been
associated with a higher prevalence of cardiovascular disease and of diabetes, while
schizophrenia has been linked to high mortality rates due to suicide but also infectious
disease.\textsuperscript{xxiii}

Their size and vulnerability notwithstanding, people belonging to these groups are relatively
neglected in international level conventions and instruments that seek to combat inequality, as
well as in domestic policymaking in many countries. Greater efforts to uphold their rights and
to ensure policies that combat the exclusion they often experience are needed.

\textbf{International attention to older age, disability and mental illness}

No international convention exists as yet on the rights of older persons although calls are
growing given the extent and prevalence of age discrimination and a recognised gap in
protection. The 2002 Madrid International Plan on Ageing was the first to make explicit
connections between ageing, development aims and human rights. It remains the only global
agreement that commits governments to integrate issues related to ageing into economic and
social development policies and the MDGs. Yet the MDGs ‘completely ignore the ageing of
societies and poverty in old age’,\textsuperscript{viii} a finding echoed by the UNDP.\textsuperscript{vii} The right to an adequate
standard of living is routinely denied to older people through the absence of a pension,
although several studies point to their feasibility even in low-income settings. Policies are
needed in other areas that affect older people in particular ways such as caretaking
responsibilities, and tackling domestic and institutional abuse and violence.

The 2006 \textit{Convention on the Rights of Persons with Disabilities} marked an advance for the rights
of disabled persons but member states now need to work towards further implementation of
its commitments. The UN General Assembly Resolutions (2008, 2010) reinforced the need for
greater attention to disability and highlighted the statistical invisibility of disabled people. Even
though people with disabilities are not explicitly included in any of the MDG targets and indicators, the 2010 and 2011 MDG Reports acknowledged the needs of disabled people but the 2012 Report did not. Greater attention – both in monitoring and programming – is needed. Mental health ‘remains a largely ignored issue in global health, and its complete absence from the MDGs reinforces the position that mental health has little role to play in major development-related health agendas’. There is unmet need for mental health treatment, particularly in developing countries. In Colombia, Lebanon and Mexico, an estimated 76 to 85 percent of people with severe mental health conditions do not receive treatment, and even in high income countries, unmet need is estimated at between 35 and 50 percent of people with severe conditions. Resources are part of the problem: one third of the world’s countries do not have any health budget allocation for mental health while in a fifth of those that do, the allocation is less than one percent of the total health budget. Stigma about mental health also impedes treatment, a theme we revisit below.

**Major international survey instruments – existing data and gaps**

A lack of data and monitoring mechanisms means that the situation of older people, disabled people and those with mental health issues is often invisible, rendering it more difficult to document and dismantle entrenched patterns of discrimination. Particularly lacking are data from nationally representative household surveys used to monitor MDG targets, which would permit a multidimensional perspective on how older people, people with disabilities and those with mental health conditions are faring, the circumstances of their households and their access to services. It would also allow better monitoring of the distributional impact of policies and budget allocations on different populations. The most efficient means of eliciting relevant information on these topics in a global context is through internationally comparable household surveys, such as those administered by World Bank (namely the Living Standards and Measurement Survey and Core Welfare Indicator Questionnaire), Macro International (Demographic Health Survey) and UNICEF (Multiple Indicator Cluster Survey).
The World Bank regularly conducts several types of surveys, among them the Core Welfare Indicator Questionnaire (CWIQ) and Living Standards and Measurement Surveys (LSMS). The CWIQ, a concise questionnaire that fits on eight pages alone, is designed to monitor social indicators in Africa annually. It aims to obtain a quick snapshot of the communities it covers in terms of access, usage and satisfaction with public services.

The LSMS by contrast is an in-depth household survey that undertakes a rich multidimensional profile of countries (Tanzania’s 2010/2011 LSMS, for instance, is 48 pages long). Accordingly, it is a more suitable vehicle for collecting the information needed to ascertain whether individuals in households are disabled and are likely to be experiencing mental illness, and for linking information on age, disability status and mental health to other dimensions of wellbeing.

The Demographic and Health Survey (DHS), conducted by Macro International, is conducted in a range of developing countries every five years on average, and targets women of reproductive age (15 to 49 years old) and children under 5 years old. The survey consists of a household questionnaire and separate interviews for ‘eligible’ women within the household, and in most countries, men aged 15-59 years. UNICEF’s Multiple Indicator Cluster Survey (MICS) have been conducted in more than 100 countries since 1995 – the survey is focused on providing MDG tracking data. The representativeness and structure of the survey are similar to the DHS surveys and the two data sources are comparable.

We identify technical adjustments that would enable these surveys to improve their coverage, collect richer information and to identify better these three groups. Each aspect is discussed in turn.

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7 Two other key surveys are Integrated Surveys and Priority Surveys but as these are intended to monitor a key set of household reactions to macroeconomic environment, we do not focus upon them here. See: http://www.surveynetwork.org/home/index.php?q=tools/questionnaire/standard
10 The age range varies in some countries, see http://www.measuredhs.com/pubs/pdf/DHSM4/DHS6_Sampling_Manual_Sept2012%5BDHSM4%5D.pdf.
Coverage

The first gap concerns **coverage** – here two adjustments to sampling would increase the ability to obtain a representative picture of society as a whole. The first is to extend survey coverage to individuals that are not resident in traditional household units. Typical household surveys are restricted to people living within households, which exclude those members of society living outside household units – e.g., on the streets and in institutions such as residential care facilities, long-stay hospitals or orphanages. Extending coverage would provide a more accurate picture of how societies as a whole are faring, and is particularly important for these three groups which are likely to be disproportionately living in institutions, and in the case of the mentally ill, on the streets.

The second adjustment – which pertains to DHS and MICS only – would involve sampling households regardless of the age composition of their members. The CWIQ questionnaire asks all questions, except those that are only relevant at the household level, for each member of the household aged up to 99 years, and the LSMS elicits a full roster of all household members and their ages up front. The DHS and MICS are not designed to capture issues relating to older age, not least because they only include in their sample households that include a woman of reproductive age.

Richer information

The second gap we identify concerns the need to collect **richer information** about these groups’ experiences. Here, two types of adjustments are recommended: first, asking already-included questions of all household members; and second, asking questions on issues that may affect these groups in particular.

Asking questions of all household members is important to account for the intrahousehold distribution of resources and to obtain information that is as accurate as possible. Because the unitary model of the household prevails, above all when it comes to assessing income and consumption, each member of the household is typically assigned a per capita value equivalent to the total value divided by the number of household members, sometimes adjusted for age.
and household size. But this method does not give any insights into the actual allocation of resources within the household. Equally, for other indicators too, it is better to ask the data directly of the household member concerned rather than to ask a household head or other nominated person to answer on behalf of other household members. A recent World Bank experiment signalled the difference this could make, comparing answers derived from household survey questions on employment obtained on the basis of proxy reporting and self-reporting. Findings indicated that response by proxy yielded lower male labor force participation, female working hours and employment in agriculture from men – and pointed to information imperfections within the household especially relating to a distance in age between respondent and subject.

Finally, household surveys ought to address issues that may apply to particular groups – for example, they would become more age sensitive if greater attention were paid to issues that affect older people (and women) in particular, such as the care economy and domestic violence. Collecting data on caretaking requires time use surveys that are time consuming and require painstaking effort to collect. Turning to domestic violence, questions are not always addressed to women under 50 years old, despite evidence the problem may be sizeable among other groups in the population. For example, in Europe, an estimated four million older people experience physical abuse, and in Mozambique, Zambia and Tanzania, witchcraft accusations, robbery, land and housing seizures and emotional abuse affecting older people are common.

In DHS and MICS, domestic violence questions are an optional module asked to a selected woman in each household (of reproductive age). CWIQ does not address domestic violence and just three LSMS surveys ask pertinent questions: India (Bihar/Utter Pradesh), 1997/98, Malawi 2004 and Tanzania 2008/09. The India and Tanzania surveys ask their questions on “violence against women” only of women of reproductive age – the former, of one woman in the household aged 15-49, and the Tanzanian survey, of all women in the household aged 15-

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50. The Malawi questionnaire in contrast, asks its questions of all family members in the context of a general module on safety and insecurity. It asks each household member if they have experienced physical violence and then lists ‘household member’ among the potential perpetrators – though household power relations can condition responses. It is no doubt better to inquire about the possibility of domestic violence in the context of questions designed to elicit this type of violence, though these are sensitive to ask and require special enumerator training. But there is little justification for asking only of women in a certain age range.

Identification

The final gap we address concerns the identification of people in older age, with disabilities and with mental health conditions. Here there is also a sampling issue. To highlight the circumstances of smaller numbers of people – for example, among older people, those in advanced old age – it may be necessary to oversample particular groups in order to obtain representative data. But a key issue is to ask questions that accurately identify people, particularly those who have a disability or are experiencing mental illness. Earlier work on disability and mental illness (as well as older age) highlighted physical aspects, while more recently, models have come to the fore which emphasize how physical conditions interact with societal structures to enable activities and participation. With this conceptual model in mind, we examine how surveys have sought to identify these two groups of people, highlighting examples of best practice.

Disability

Household surveys rely on three main ways of identifying disability. The first is to rely on self-report or past clinical diagnosis. For instance, the 2006 Iraq LSMS survey asks respondents “Do you suffer from any disability?” then the nature of that disability, its cause and when it started. CWIQ asks one self-reporting question of disability: “Is [NAME] physically or mentally handicapped or disabled?”\(^\text{13}\) Such questions are problematic because they rely on perceptions of what constitutes ‘disabling’, which may differ across individuals, and are rooted in a physical

\(^{13}\) This question contains the qualification “Include person only if handicap prevents him or her from maintaining a significant activity or schooling”.
model of disability that does not acknowledge social constraints on functioning. Such questions yield underestimates of prevalence, particularly where access to health services is low, or stigma toward disability conditions responses.

The second approach, which is usually applied in conjunction with the first, is to try and ascertain the degree of disability by asking questions that relate to particular functionings – for example, the 2004 Bosnia Herzegovina survey asks the respondent whether they consider themself to be disabled, and then the following follow up questions:

*Has your health activity limited your ability to perform vigorous activities such as lifting heavy objects, running, or participation in strenuous sports?*

*Has your health limited your walking uphill?*

*Has your health limited you from bending, lifting, or stooping?*

This is useful though not comprehensive in the range of activities it includes.

The third approach undertakes a more systematic inquiry of the person’s functionings across an agreed set of domains. The United Nation’s Washington Group on Statistics takes this approach. It has marked a major step forward in recommending a simple set of internationally comparable questions to establish the prevalence and severity of disability (Box 1), adopting a functional approach that is concerned with the constraints that a person’s physical condition has upon his or her ability to undertake a range of basic activities needed in order to function in society – namely seeing, hearing, mobility, cognition, self-care, and communication, respectively. The WG questions have been posed in the World Health Survey and 2006 Ugandan DHS.
Box 1 – Washington Group recommended questions on disability

Because of a physical, mental, or emotional health condition...

1. Do you have difficulty seeing even if wearing glasses?
2. Do you have difficulty hearing even if using hearing aid/s or are you deaf?
3. Do you have difficulty walking or climbing stairs?
4. Do you have difficulty remembering or concentrating?
5. Do you have difficulty (with self-care such as) washing all over or dressing?
6. Do you have difficulty communicating (for example, understanding or being understood by others)?

Question response categories: No, Some, A lot, and Unable.

Source: http://www.cdc.gov/nchs/citygroup.htm

The measurement of disability in Uganda provides an example of how prevalence can vary even within the same country over roughly similar periods using these different approaches. Using the Washington Group questionnaire, the 2006 DHS survey established a 20 percent disability rate for the population aged five years and above. This stands in contrast to the 3.5 percent rate captured in the country’s 2002 Population and Housing Census and the 7 percent rate that emerged from the 2005-2006 Uganda National Household Survey.xxi,14

Disability does not form part of the DHS core survey but questions are included in some surveys. MICS have passed through four phases; the 2nd phase introduced an optional Ten Question Module that seeks to identify children with congenital and developmental disabilities by asking about impairments, actual health conditions (such as epilepsy) and activity limitations (e.g., difficulties in walking, speaking) – though analysis of the resulting data suggests implementation issues.xxxii

14 Note the populations differed slightly in that the latter two surveys considered all people, not just those aged 5 years and above.
The 2010 Tanzania NPS gives an example of best practice in which all respondents aged 12 years and older are encouraged to reply for themselves and the enumerator is instructed to record whether or not the response is obtained directly or by proxy. The questions follow the WG model, asking additionally when each specified difficulty began, whether it reduced the amount of work the respondent could do (at home, work or school) and whether any measures had been taken in the last 12 months to improve the disabled person’s performance of activities.

**Mental health**

Mental health has received short shrift in international survey instruments to date.\(^{15}\) As with disability, three approaches can be used to elicit mental illness. Again, the first is to ask the respondent to self-report a condition or to report a clinical diagnosis (CWIQ, most LSMS). Most of these questionnaires present mental disorders either as a possible answer to the question of whether the respondent has a chronic illness or injury/disease during a particular period (e.g., *Have you had any illness/ injury during the past 4 weeks?* – Jamaica 1999) or as a response category for the question on self-reported disability (e.g. *Do you suffer from a handicap? What type of Handicap?* Romania 1994; *What type of disability or chronic disease did “_” suffer?* Albania 1996). The second approach uses questions on overall mood and on perceived psychological status. These feature in some LSMS surveys and are useful as a general assessment of mental health, but they do not permit identifying specific disorders. Finally, screening questionnaires ask a short number of questions that aim to identify particular mental health conditions. The 2001, 2003 and 2004 Bosnia Herzegovina LSMS typify this approach.

WHO efforts to develop cross-country psychiatric surveys from the 1990s resulted in the Composite International Diagnostic Interview (CIDI), which from 1998 was expanded under the World Mental Health (WMH) Survey Consortium to cover severity, impairment and treatment. These questionnaires have a stem-branch structure: the respondent is asked a small number of

\(^{15}\) The DHS core questionnaire does not include any questions relating to mental health and only the 2002 Uzbekistan survey included a module on mental health using screening questions. No MICS surveys include mental health issues. LSMS surveys have paid the most attention to mental health. Customized for each country, of a total of 96 surveys conducted to date, 17 surveys in 7 countries – Albania, Bosnia Herzegovina, India, Jamaica, Kyrgyzstan, Nicaragua and Romania – contain relevant questions.
screening questions, and if they respond positively, they are further asked about associated symptoms leading to a full diagnosis. It has been shown that short screening instruments can elicit reliably the prevalence of common mental disorders and can be successfully incorporated into large and nationally representative standard household surveys. iii A CIDI short form (CIDI-SF) was found to diagnose and classify common mental health conditions accurately, and while this particular instrument has fallen into disuse, several related and complementary screening questionnaires have been developed based on the same structure (Box 2).

Box 2 – Screening instruments used to evaluate mental health

| PRIME-MD, which focuses on depression; |
| Mini-International Neuropsychiatric Interview, which focuses on 15 disorders; |
| General Health Questionnaire (GHQ), which has 12 and 28 question versions; and |
| K6 and K10, used in WMH surveys to identify serious mental illness (anxiety, mood, behavioural and substance disorders) |


Information on mental health is not only important in itself, but also would add insights to the material already being collected in key household surveys. Though the CWIQ is likely too short to permit questions that would identify mental illness, obtaining such information would give useful insights into the inequalities in access to treatment and other public services people with mental health conditions face. In the DHS, questions on conditions relating to reproductive health such as sexual dysfunction and postpartum depression could be particularly apt. And the early onset of many mental health disorders xxxiii suggests that MICS could potentially be a valuable instrument to collect information on risk factors at early stages.
Other constraints: Resources, politics and attitudes

The previous section has outlined definitional and technical considerations relating to the incorporation of questions designed to elicit information about older age, disability and mental health in standard internationally-comparable household surveys. However more inclusive data collection may also require greater resources and/or capacity, political will and the lifting of attitudinal or cultural constraints that could preclude households and communities from revealing the existence of and circumstances facing disabled or mentally ill members.

Adding questions to surveys renders them more costly and time consuming – both for enumerators and respondents. Survey fatigue can set in, and this can affect data quality. The insufficient coverage of several current MDG indicators in poorer countries may suggest a focus on existing data gaps rather than expanding into new areas. At the same time, the size and vulnerability of these three groups – coupled with a lack of detailed information about their circumstances and the demonstrated ability to collect needed data efficiently – makes a strong case for making the recommended adjustments.

Evidence has shown that older people, and those who are disabled and mentally ill are often politically marginalized. Not only some of them are denied the right to vote, as the case for those with mental conditions in Thailand or those under guardianship in Hungary, but they may be relegated from family decisions too. It follows that elected representatives may not adequately heed their needs and preferences, particularly in the light of a lack of data on use of public services. The scant attention paid to these issues is evident in the relatively small budget allocations directed to addressing them in many countries.

Stigma and negative social perceptions stemming directly from physical or mental impairments impede the advancement of basic rights. Fear of stigmatization has been found to be a barrier to revealing and seeking treatment for mental health problems. For instance, in a survey of Nigerian high school children, over 65 percent of respondents expressed feeling afraid to talk to someone with these conditions or embarrassment if friends knew that someone in their family
had mental health problems.\textsuperscript{16,xxxvi} These widely held opinions can contribute to social distancing and feelings of isolation, and reduce the effectiveness of treatment.\textsuperscript{xxxvii} Similarly, the recent World Alzheimer Report shows that two-thirds of people with dementia and their carers feel excluded from society.\textsuperscript{xxi} Efforts to generate greater awareness are needed.

**Implications for a post-2015 framework agreement**

A post-2015 framework presents an invaluable opportunity to tackle inequalities at a global level and to advance commitment to the rights instruments that pertain to these three particular sources of inequality. Equally it provides the opportunity to make these groups visible in national and international monitoring frameworks. A two track approach to policy is proposed. The first track would seek to ‘mainstream’ disability and older age by including these categories as ‘cross-cutting’ issues associated with disadvantage, in much the same way as gender is included in the MDGs. Any targets established that apply to individuals or households would therefore need to be monitored by disability status and age group. A second, complementary, approach would seek to establish particular targets related to these issues. Here numerous possibilities have been proposed: Disability could be explicitly included across targets related to employment, education and health. A goal devoted to mental health treatment and awareness raising could potential benefit several hundred million people. Age inclusive goals could include an increase in healthy life expectancy at birth. Goals aiming at health and income security by extending social protection floors would benefit all people affected by economic inequalities.

**Conclusion**

The MDGs do not address inequalities associated with age, disability and mental health; this has constrained their attainment and reinforced them. A new post-2015 framework should be sensitive to these three issues, advancing the commitments specified in international human rights frameworks, and ensuring that they are adequately measured and monitored.

\textsuperscript{16} Similar results obtained in a survey of UK adults.\textsuperscript{xxxvii}
This paper has shown that it is feasible to collect data on these three types of inequality in standard international household surveys and has identified examples of best practice. To obtain a richer view of the circumstances facing older people, modifications to the coverage, sampling and content of traditional household surveys are proposed. To identify disability, the recommendation of the short Washington Group questionnaire is recommended. And for mental health conditions, screening instruments have been identified as feasible to incorporate into standard household surveys.

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