

Early-life impairments, chronic health conditions, and income mobility

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Abstract

Individuals who have congenital conditions or become disabled early in life tend to have poorer educational and occupational outcomes than non-disabled individuals. Disability is known to be a complex entity with multiple causations, involving, inter alia, physiological, social, economic, and cultural factors. It is established that social factors can influence educational and occupational attainment for disabled people, and current disability policy in many countries, particularly in the Global North, stress the importance of equality of opportunity. However, there is a scarcity of research that explores the specific degrees to which advanced welfare states contribute to the equalization of life chances for individuals with early-life impairments and chronic health conditions. In this study, we use a Norwegian sample of high-quality register data on individuals with vision loss, hearing loss, physical impairment, type 1 diabetes, asthma, and Down syndrome diagnosed early in life and compare their intergenerational income mobility trajectories with a random sample drawn from the country's entire population. We find that individuals' early-life diagnoses are linked to significantly worse income outcomes in adulthood than what is observed among the general population. We conclude that even in one of the most advanced egalitarian welfare states, such as Norway, much remains to be done to

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equalize life chances for individuals with early-life impairments and chronic health conditions.

KEYWORDS

chronic health conditions, disability, impairments, income mobility, Norway

1 | BACKGROUND

The link between disability and intergenerational mobility is an underexplored area of research. Yet there has been a call for greater scholarly attention to this topic of social inquiry (Bengali et al., 2021; Chatzitheochari & Platt, 2019). According to one of the most fundamental principles of a just society, everyone, regardless of their health in the first years of life, should be given equal opportunities to succeed in life (Nussbaum, 2006). The theory of social causation in intergenerational mobility research implies that adverse parental socioeconomic position increases the likelihood of children having various impairments and chronic health conditions, while the theory of health selection implies that individuals' initial health adversities have significant negative consequences for educational and occupational attainment (Bartley, 2017; Bulczak & Gugushvili, 2022; Kröger et al., 2015). However, there is only limited research that investigates large samples of individuals with various impairments and chronic health conditions and follows them across long periods of their life course (Priestley, 2001).

After decades of theorization, disability is generally acknowledged to involve individual (impairment-specific) and structural (disabling) causes, whether framed in terms of oppression (Oliver, 1990), ableism (Goodley, 2014; Wolbring, 2008), functioning (World Health Organization, 2001), discrimination and barriers (United Nations, 2006), a predicament (Shakespeare, 2013), or a gap between social role expectations and individual capabilities (Tøssebro, 2004). But there is no universally acknowledged conceptual model of disability (Thomas, 2004), and untangling the physiological, socio-political, economic, and cultural aspects of causation, and identifying the mechanisms of marginalization as well as inclusion is problematic. Confounding the issue further, the conceptual distinction between impairment as a permanent or long-term attribute of individuals and disability as a structural and relational attribute of individuals' situated encounters with society is not always sustainable, since some conditions only *become* impairments in specific societal contexts (e.g., dyslexia in literate societies). Although we try to sustain a distinction between "impairment" (as encoded in our dataset) and "disability" (as constructed in society), we acknowledge that they should not be viewed as a binary pair, but as partly overlapping.

Despite the international turn towards an anti-discrimination and equality of opportunity policy in the disability field (Lawson, 2006; United Nations, 2006), there is a scarcity of research showing whether and how an advanced welfare state, through its institutional settings, legislative framework, affirmative actions, social services, and welfare benefits, can raise the levels of income of individuals with disabilities and impairments at the level of the general population (Gugushvili et al., 2023; Mladenov, 2015). One of the main reasons why there are virtually no studies on this important topic is the unavailability of high-quality data on individuals and their parents' income in most cross-sectional, cohort, and panel surveys (Brewer et al., 2017).

In a recent study, Chatzitheochari et al. (2022) explored the links between childhood disabilities and social mobility using a nationally representative cohort study for England. We complement this research by employing a Norwegian sample of high-quality register-based data on individuals with various impairments and chronic health conditions diagnosed early in life, and compare their intergenerational income mobility trajectories with a random population sample. Although the occupation-based social class is a central sociological measure of socioeconomic position (Barone et al., 2022), we think that exploring early-life impairments and chronic health conditions in relation to individuals' income mobility is an equally, if not more, important avenue for sociological research. Individuals with impairments and chronic health conditions often have higher expenses than others in terms of sustaining their daily

lives (Morris et al., 2022), which further underscores the significance of income as an important measure of the quality of life of individuals with life-altering conditions diagnosed at a young age.

2 | REGISTER-BASED DATA ON IMPAIRMENTS AND CHRONIC HEALTH CONDITIONS

To explore the life chances of individuals with early-life impairments and chronic health conditions in Norway, we use a data set that includes all individuals who were alive at the time of accessing the data in 2021, were born in cohorts 1977–1995, and had been diagnosed with the following conditions by the age of 15: (1) three types of impairment—(a) vision loss (3% of all conditions), (b) hearing loss (10%), or (c) physical impairment (25%); (2) two somatic conditions—(a) type 1 diabetes (13%) or (b) asthma (41%); or (3) Down syndrome (8%). This population was identified through the register of cash benefits recipient families who had a child (or children) with an impairment or a chronic health condition. In Norway, families may apply for benefits to compensate for the extra care needed and/or expenses related to a chronic medical condition. The term medical condition refers to a permanent injury, illness, or functional impairment. The level of benefits depends on the amount of extra care or assistance the child needs or the additional expenses the families incur because of the condition. The diagnosis and the severity of the condition constitute the only valid criteria for receiving the benefits; neither income nor any other aspects of the family situation are considered. The register data do not cover all childhood conditions relevant for income mobility. Conditions that qualify for cash benefit have also changed over time. Therefore, we have chosen to focus on conditions that have remained stable over time, and represent the diversity of conditions found in the register.

The total sample size of individuals having the listed conditions and for whom parental and own income data are available is 7020 in the main analyses. We compare the outcomes for these individuals with a randomly drawn sample of the general population of Norway born in cohorts 1977–1995 ($N = 18,892$). The register data were assembled by Statistics Norway.

To explore intergenerational income mobility, we operationalize individual's origin position by parental level of personal income at the birth year of that individual. Our measure stems from the year when individuals are born because some of the diagnosed conditions are already likely to affect parents' position in income distribution in the first years of life, particularly for mothers through various mechanisms such as reduced working hours, and greater health-related expenses (Wondemu et al., 2022). For explicitly considering mothers in our research (Beller, 2009; Hout, 2018) and based on the insights from social learning theory on gendered intergenerational transmission of behaviours (Wainwright & Watts, 2021), in the main analyses, we describe income mobility separately between fathers and sons, and mothers and daughters.

We use a relative measure of income. For each individual in our sample, both in the diagnosed and general population groups, for presentational reasons we divide the fathers' and mothers' incomes into three groups (income tertiles) and observe the relative paternal and maternal standing in comparison to other males and females at the year of the individual's birth. We use the same procedure for individuals when they reach age 30, so that for each male and female in the diagnosed and general population groups, we know the income tertile to which their parents belonged at the time of the individual's birth, and the income tertile to which each individual belonged by the third decade of their lives. After exploring individuals' distribution in terms of parental and own income tertiles and the income mobility trajectories, we disaggregate the main results by specifically looking at the outcomes for individuals with: (1) sensory and physical impairments, (2) somatic conditions, and (3) Down syndrome.

3 | RESULTS

We start by describing the distribution of fathers and sons, and mothers and daughters, for diagnosed impairments and health conditions, and for a sample of the general population across income tertiles. Figure 1 shows that fathers

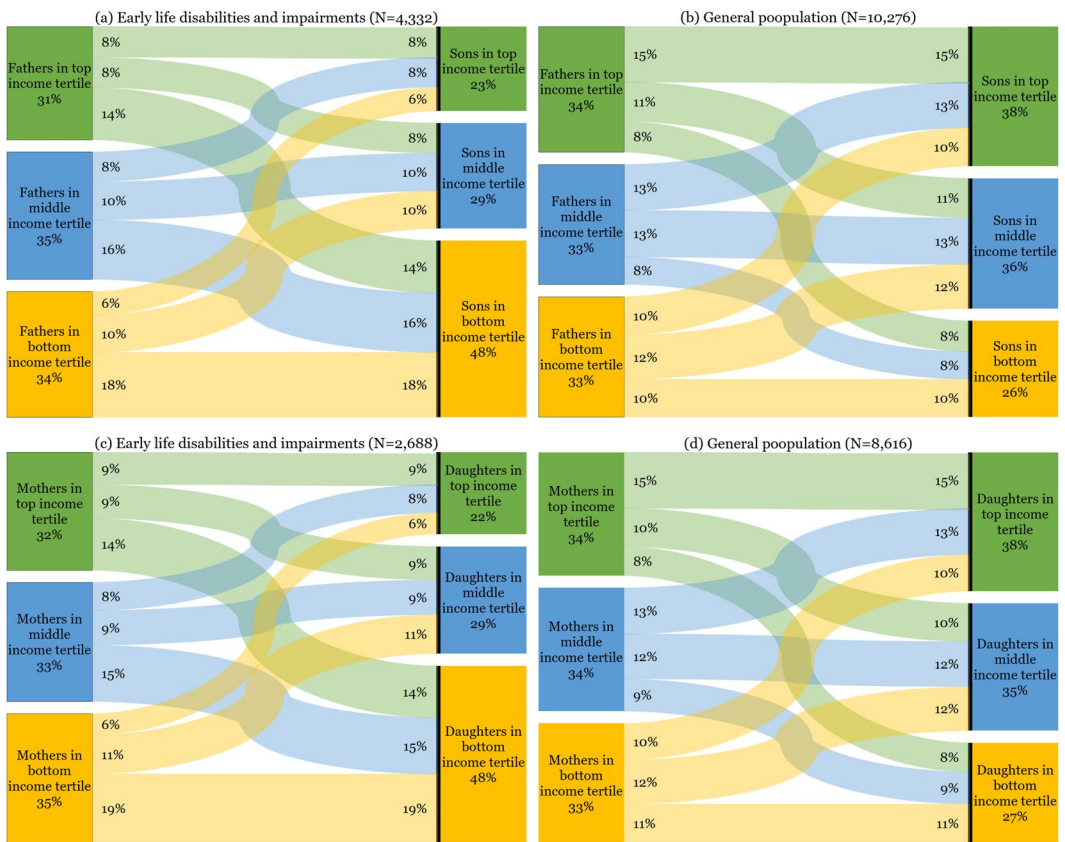


FIGURE 1 Parental income tertiles at the year of individuals' birth and individuals' income tertiles at the age of 30 with specific mobility trajectories. [Colour figure can be viewed at wileyonlinelibrary.com]

of individuals with diagnosed conditions in early life are slightly over-represented in the bottom income tertile and under-represented in the top tertile. Fathers of sons from the general population, on the other hand, are almost equally distributed across all tertiles.

When we observe their sons' distribution in the income tertiles at the age of 30, we see that almost half of the sons with early-life impairments and chronic health conditions are in the bottom tertile. This is a significant increase of 14% points, compared to their fathers' positions in the income tertiles. The share of sons in the middle and the top tertiles decreases by 6 and 8% points respectively. On the other hand, the group of sons without early-life diagnosed conditions experience a decline in their share within the bottom tertile (from 33% to 26%), while their share within the top tertile reaches almost two-fifths of the sample.

We observe broadly similar patterns of inequality in intergenerational income distribution among mothers and daughters. The mothers of individuals with diagnosed conditions in early life are slightly over-represented in the bottom tertile and under-represented in the top income tertile, while the mothers of individuals in the general population are equally distributed across the income tertiles. For the general population, the share of daughters decreases in the bottom tertile and increases in the top tertile, while the opposite is observed among daughters with early-life impairments and chronic health conditions. Their share in the bottom income tertile increases by 13% points to make up almost half of the sample, while in the top income tertile, it shrinks to 22% of the sample.

Figure 1 also shows the destinations of sons and daughters starting from their same-gender parental income tertiles. For sons, we can see that more than half of the individuals who started in the bottom tertile remain in the bottom tertile at the age of 30 and only 6% of them move to the top income tertile. Only a quarter of the sons

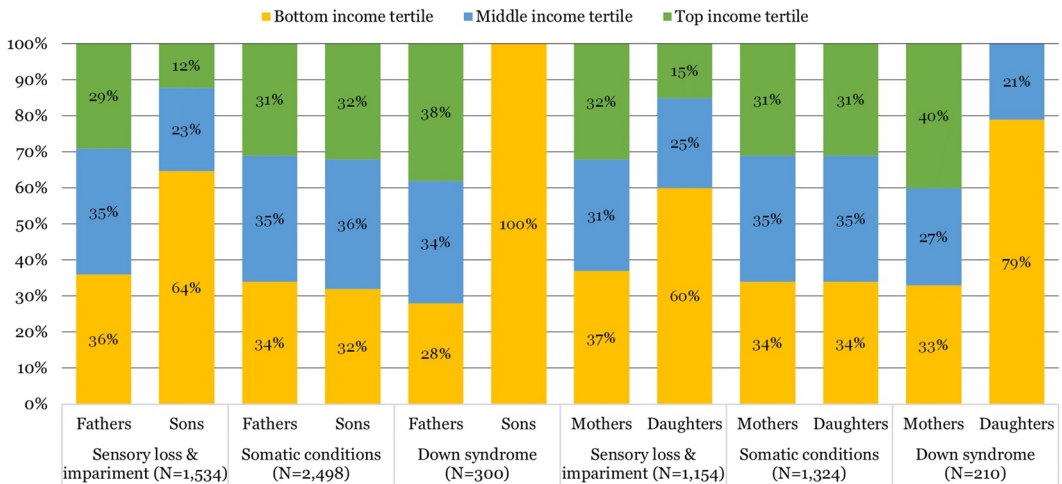


FIGURE 2 Parental income tertiles at the year of individuals' birth and individuals' income tertiles at the age of 30 for individuals with disabilities and impairments, somatic conditions, and Down syndrome. [Colour figure can be viewed at wileyonlinelibrary.com]

whose fathers were in the top income tertile can maintain their position, while the majority move to the bottom or the middle income tertiles. As for the group originating from the middle income tertile, twice as many sons experience downward income mobility than upward mobility. The mobility is very different for sons in the general population sample. More than a third of the individuals from the bottom tertile experience upward mobility, either to the middle or to the top income tertile.

Similar patterns of intergenerational income inequality are observed for females with early-life diagnosed conditions, as around half of them either remain in the bottom tertile or experience downward mobility from the top and the middle tertiles. Only 9% of females with impairments and chronic health conditions manage to maintain their position in the top tertile, while only a small minority of daughters move from the bottom and the middle tertiles to the top tertile. For the groups of daughters from the general population, a larger share moves to the top tertile from the bottom or the middle tertile. In addition, much fewer daughters from the general population experience downward mobility to the bottom income tertile (17% as compared to 29% in the group with early-life impairments and chronic health conditions).

After identifying significant inequalities between individuals with early-life impairments and health conditions and the general population, we split individuals with the diagnosed conditions into three groups—(1) sensory loss and physical impairment, (2) somatic conditions, and (3) Down syndrome—to identify whether there is an interplay between these conditions and income mobility at the age of 30. In Figure 2, we see that the relative position of sons with a somatic condition—asthma or type 1 diabetes—slightly improves in comparison to their fathers, as there are fewer individuals in the bottom tertile and more individuals in the middle and the top tertiles. For females, however, having the same conditions is not associated with a significant change in their shares across income tertiles.

A major shift in income distribution takes place for sons and daughters with sensory loss and physical impairment, with their shares in the bottom tertile significantly increasing and their shares in the top tertile significantly decreasing in comparison to their fathers and mothers. The parents of individuals with sensory loss and physical impairment are also over-represented in the bottom income tertile. This intergenerational shift is more pronounced for sons than for daughters. The most drastic downward income mobility takes place for individuals with Down syndrome. While their parents' income is relatively equally distributed across income tertiles, all males and almost 80% of females with Down syndrome end up in the bottom income tertile.

In the supplementary materials, we demonstrate intergenerational income mobility with pooled parental income, Figure S1, and between fathers and daughters, on the one hand, and between mothers and sons, on the other hand,

Figure S2. In Figures S3 and S4, we further investigate if our findings are affected by constructing the initial income tertiles when individuals were, respectively, 5 and 10 years old, instead at the year of their birth. This is important because parental leave in Norway in 1977 was 18 weeks. Some of the considered impairments and chronic health conditions are present at birth and could have affected decisions regarding return to or participation in the labour market. For the individuals' destinations, at the other end of the life course, in Figures S5 and S6, we also check the results when individuals' income tertiles are measured at the age of, respectively, 35 and 40. In Figure S7, we present results using income quartiles instead of tertiles. With all these new estimates, we observe similar patterns as in the main analyses, which confirms our central finding on the large inequalities in intergenerational income mobility between individuals with early-life impairments and chronic health conditions and the general population of Norway.

4 | DISCUSSION

In this study, we explored the association between parental and individual relative income among those who were diagnosed early in life with different impairments and chronic health conditions, and compared these findings with the results observed among the general population of Norway. Researching the outcomes of individuals with impairments and health conditions concerning income is particularly important as, for many of these individuals, it is harder than for the general population to attain high levels of education and consequently compete for demanding and well-paid jobs. Yet, it is still possible that the highly developed welfare states, like the ones we observe in Scandinavian countries, could secure the levels of income for individuals with early-life disadvantages through various social arrangements and welfare benefits. To answer this question, we used a unique register-based data set which resolves many of the concerns related to the reliability of the survey data, particularly in relation to the quality of information related to parental income.

Using data on individuals born in 1977–1995, we show that those with an early-life diagnosed condition are significantly more likely to experience downward income mobility and significantly less likely to experience upward income mobility compared to the general population. There are only small differences in the relative income of parents at birth year across the groups, with the possible exception of individuals with sensory loss and physical impairment. This suggests that children's impairments and chronic health conditions are not significantly associated with their parents' incomes at the time of birth and that a large share of the described impairments and chronic health conditions are not necessarily congenital or inherited from their parents. When looking at specific diagnosed conditions, in addition to Down syndrome, downward income mobility is particularly salient for females with vision of hearing loss and physical impairment. On the other hand, males and females with type 1 diabetes and asthma manage to maintain or in some instances even improve their relative standing in the income tertiles.

After summarizing the major intergenerational income inequalities between the general population and individuals who were diagnosed with impairments and chronic health conditions in early life, an obvious question is how these inequalities can be explained. On a general level, our results speak directly to a debate on the relative importance of individuals' initial health and well-being for their later life socioeconomic outcomes (Gugushvili et al., 2021; Hoffmann et al., 2019). We demonstrate that diagnosed conditions in the first years of life are significantly and negatively related to the likelihood of being in the higher income tertiles in adulthood. This supports the predictions of health selection theory that individuals with impairments and chronic health conditions would attain worse socioeconomic position than those without such conditions.

With the presented study we cannot provide answers on specific mechanisms of why and how the diagnosed conditions are linked to lower income attainment as young adults. There can be several potentially important mechanisms at work that require further investigation. For instance, in recent decades, Norway has implemented various reforms for improving its system of inclusive education and the outcomes for pupils and students with special education needs, yet evidence suggests that children and adolescents in special education have to face a lower-quality learning environment than others without the special needs (Haug, 2020; Nilsen, 2020). The latter context is

associated with significantly worse educational outcomes for children with various impairments and chronic health conditions (Finnvold, 2021). In turn, education attainment is one of the strongest predictors of occupational and income outcomes in Norway (Lorentzen et al., 2019). Individuals with diagnosed conditions early in life might also be restricted by the nature of their impairment, or by discrimination to take up jobs in certain occupations and sectors of the economy.

Our study has its limitations. The data set consists of individuals who were alive at the time of accessing the data. This makes the sample positively selected by individuals' survival probabilities. If so, our results underestimate the disadvantages associated with early-life impairments and health conditions (Zhu et al., 2013). Our empirical analysis does not account for the severity of the diagnosed conditions such as vision loss or Down syndrome that could affect individuals' life chances, in general, and their incomes, in particular. Although we compare the results for the early-life diagnosed individuals with a sample of the general population and we also estimate income outcomes in the late 30s in the supplementary materials, this period in the individuals' life courses might still be too early for assessing their ultimate income levels (Veenstra & Aartsen, 2022). It is also a possibility that other variables of socioeconomic position such as social class or status are more appropriate indicators to account for social gradient in disability at birth.

Regardless of the described limitations, the main findings of this study are clear. Early-life impairments and chronic health conditions are associated with significantly worse income outcomes in adulthood than what we observe among the general population, and these inequalities are particularly large among those with sensory loss, physical impairment, and Down syndrome. Even in one of the most advanced egalitarian welfare states, such as Norway, much remains to be done to equalize life chances for those with early-life impairments and chronic health conditions.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from Statistics Norway. Restrictions apply to the availability of these data, which were used under license for this study. Data are available from the author(s) with the permission of Statistics Norway.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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