Reflection Article/Essay

Action on the social determinants of health: Advancing occupational equity and occupational rights

Ações nos determinantes sociais de saúde: Avançando na equidade ocupacional e nos direitos ocupacionais[1]

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Abstract

Epidemiologists have sought to focus global attention on the "social determinants of health" - the conditions in which people are born, grow, live, work and age - and on the impact of the inequitable distribution of these determinants on people's opportunities to be healthy. Evidence demonstrates, unequivocally, that occupation is a determinant of human health and wellbeing. Because inequitable social determinants shape the availability of health-promoting occupational opportunities, occupational therapists have raised the importance of addressing occupational injustices. However, theoretical scholarship pertaining to occupational justice and occupational injustice has been disproportionately dominated by the culturally-specific perspectives of Anglophone theorists from the Global North. The purpose of this paper is to highlight some of the problems and confusions arising from Anglophone scholarship on occupational injustices; and to highlight the importance of action on the social determinants of health through occupation. Confused definitions of various occupational injustices are unhelpful to practitioners. The occupational therapy profession could actively address the social determinants of occupation through focusing on occupational equity and occupational rights, informed by existing scholarship on human capabilities. Issues of occupational rights, denial of occupational rights (occupational injustices), and of in/equities of occupational opportunities ought to be fundamental issues for the occupational therapy profession, whose most pressing concern should surely be: how can occupational therapists most

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effectively address the social determinants of occupation such that all people have the capabilities to engage in meaningful occupations that contribute positively to their own well-being and the well-being of their communities, as is their right.

Keywords: Human Rights, Wellbeing, Social Justice, Knowledge.

Resumo

Epidemiologistas vêm buscando focar a atenção global nos "determinantes sociais de saúde" – as condições nas quais as pessoas nascem, crescem, vivem, trabalham e envelhecem – e no impacto da distribuição desigual desses determinantes nas oportunidades de as pessoas serem saudáveis. As evidências demonstram, inequivocamente, que a ocupação é um determinante da saúde e bem-estar humano. Devido ao modelamento da disponibilidade de oportunidades ocupacionais de promoção à saúde feito pelos determinantes sociais desiguais, terapeutas ocupacionais vêm valorizando a importância de abordar as injustiças ocupacionais. No entanto, os estudos relativos à justiça ocupacional e à injustiça ocupacional têm sido desproporcionalmente dominados pelas perspectivas culturalmente específicas de teóricos anglófonos do Hemisfério Norte. Destacar alguns dos problemas e confusões feitos a partir de estudos anglófonos sobre as injustiças ocupacionais e destacar a importância de ações voltadas para os determinantes sociais da saúde por meio da ocupação. Definições confusas de várias injustiças ocupacionais são inúteis para os profissionais. A terapia ocupacional poderia ativamente abordar os determinantes sociais de ocupação por meio do foco na equidade ocupacional e nos direitos ocupacionais, informados por estudos teóricos existentes sobre as capacidades humanas. Problemas de direitos ocupacionais, negação dos direitos ocupacionais (injustiças ocupacionais) e de iniquidade/equidade de oportunidades ocupacionais devem ser questões fundamentais para a terapia ocupacional, cuja preocupação maior deveria ser: como terapeutas ocupacionais, efetivamente, abordam os determinantes sociais de ocupação de tal modo que todas as pessoas tenham capacidades para se envolverem em ocupações significativas que contribuam positivamente para o seu bem-estar e o bem-estar de sua comunidade, uma vez que é direito todos.

Palavras-chave: Direitos Humanos, Bem-Estar, Justiça Social, Conhecimento.

1 Introduction

Epidemiological researchers report that the chances of leading a flourishing life are unequally distributed, such that life expectancies are significantly reduced and ill health is markedly increased among those lower on the socioeconomic hierarchy and among those who experience chronic stresses arising from discrimination, and exploitative and oppressive societal conditions (Krieger, 2012; Marmot, 2004, 2015; Marmot et al., 2008; Thoits, 2010). Accordingly, they have sought to focus attention on the "social determinants of health" - the conditions in which people are born, grow, live, work and age (Marmot, 2004, 2015; Marmot et al., 2008, 2012) - and the World Health Organization (2018) has declared that "[…] the social determinants of

health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries".

Occupational therapists recognise that inequitable social circumstances shape the availability of the occupational opportunities that determine what people are able to do, can choose to do, believe they should do, or can envision doing (e.g. Bailliard, 2013; Gallagher et al., 2015; Galvaan, 2015; Hammell, 2019; Ingvarsson et al., 2016; Pitonyak et al., 2015; Restall et al., 2018; Rudman, 2015; World Federation of Occupational Therapists, 2014). Yet although dominant theoretical models, such as the Canadian Model of Occupational Performance and Engagement (CMOP-E, Townsend & Polatajko, 2007), acknowledge the influence of social and institutional environments on occupational engagement, surprisingly little professional attention in the Global North has focused on addressing the social determinants of occupation, or on engaging meaningfully in the struggle to achieve a society that respects everyone's occupational rights and that provides equity of occupational opportunity (Hammell, 2020; Levack & Thornton, 2017). Indeed, although a wealth of cross-cultural and cross-disciplinary research evidence demonstrates, unequivocally, that occupation is a determinant of human health and wellbeing (Hammell, 2020) the occupational therapy profession in the Global North has neither advanced occupation as a determinant of health, nor actively promoted the occupational rights of all people to engage in occupations that contribute positively to their health and wellbeing.

It is regrettable that dominance of the English language within the international publishing industry - coupled with active promotion, vigorous marketing and extensive exportation - has effectively reinforced the global supremacy and hegemony of occupational therapy assumptions, theories and modes of practice derived from Western knowledge, and informed by urban Western perspectives, priorities and concerns (Emery-Whittington & Te Maro, 2018; Hammell, 2009a, 2009b, 2011, 2015a, 2019; Magalhães et al., 2019; Yañez & Zúñiga, 2018; Yang et al., 2006). This constitutes a neo-colonial and neo-imperialistic dominance that excludes diverse worldviews and that neither enables nor permits equality of the opportunity to contribute knowledge derived from other perspectives (Grech, 2012; Martín et al., 2015; Santos, 2014). This inequity is epitomised by occupational therapy's theoretical scholarship pertaining to occupational justice and occupational injustice, which is disproportionately dominated by the perspectives of Anglophone theorists from the Global North. I employ the terms "Global North" or "West" to refer to North America, Northern Europe, Australia and New Zealand. Clearly, these are inadequate terms, not least because Australia and New Zealand are not, geographically, in the north! However, these are useful ways to refer to the small (white) minority of the global population that has traditionally wielded the majority of the world's power, wealth and cultural influence (Connell, 2007); and acknowledges that "[…] the economic and epistemological dominance of the global North has outlived colonialism" (Cleaver, 2016, p. ii).

The occupational therapy profession evolved in North America and the United Kingdom in the early part of the twentieth century and was subsequently exported to nations of the Global South and East by practitioners from Western countries, consistent with long-established colonial and imperial practices and with recent processes of globalisation (Hammell, 2011, 2015b, 2019). Many occupational therapy

students travelled from their home countries in the global South and East to be educated in the USA or UK and have developed occupational therapy education programs and services in their home countries encultured by theories and inspired by practices that arose within contexts very different from their own (Hammell, 2019; Lim & Duque, 2011; Murthi, 2019; Santos, 2016). This has inevitably contributed to the global dominance of ideas originating in North America, Australasia and Britain; ideas which may have limited relevance in the majority world contexts to which they have been exported (Gretschel & Galvaan, 2017; Hammell, 2019; Iwama, 2006; Yazdani, 2017).

However, since the 1970s, innovative socially-focused, ethical, politically-astute and rights-based approaches to occupational therapy have been developing in Brazil (Galheigo, 2018; Malfitano et al., 2014a, 2014b, 2019). Galheigo (2005, 2011a, 2011b, 2014) and colleagues (Barros et al., 2005; Barros et al., 2011) have provided English speakers with translated glimpses at Brazilian social occupational therapy practices that derive "from a critical standpoint" (Galheigo, 2005, p. 91); and exemplars of socially-engaged, critical occupational therapy practices in Chile (Alburquerque & Chana, 2011) and South Africa (Watson & Swartz, 2004) have provided further inspiration and guidance for the profession in the Global North. Despite these, and other Southern innovations, Galheigo (2011a, p. 65) has astutely observed that, within the occupational therapy profession,

> [...] contemporary history has witnessed the North and the West being positioned or positioning themselves both as the source of inspiration and provider of guidance or assistance for the South and the East.

This paper, which is offered as a contribution to ongoing Global South-North dialogue, has three aims. First, to sketch some of the problems and confusions that have arisen from the Anglophone definitions of occupational justice and injustice that currently dominate the occupational therapy literature; second, to highlight the work of critical epidemiologists who have advocated action on the social determinants of health; and third, to suggest a possible way forward for the occupational therapy profession through a clear focus on occupational equity and occupational rights, informed by existing scholarship on human capabilities.

It is important to preface this paper by declaring my social location as a white, class-privileged, married, heterosexual, adult Anglophone cis-gendered female, with neither physical impairments nor mental health challenges, and who holds citizenship status within two nations in the Global North. I recognise, acknowledge and strive to understand my ultra-privileged position as a member of a global minority, a settler and citizen of a colonized territory (Canada) and also a citizen of a nation that invaded, occupied and influences vast regions of the world as part of its colonial endeavour (the United Kingdom). Clearly, the perspectives that derive from my position and that shape my ideas are inevitably and unavoidably blinkered, slanted and incomplete; not least because I am unable to read anything that is not written in English. Furthermore, the *unearned* advantages and benefits that accrue to me because of my multiple privileged social locations are a manifestation of the unjust and inequitable occupational opportunities that this paper seeks to address.

2 Occupational Justice: a Brief History of a Concept

The idea of occupational justice was first articulated within the Anglophone occupational therapy literature by Wilcock (1998), redefined by Wilcock & Townsend (2000), redefined again by Nilsson & Townsend (2010), and then again by Wilcock & Hocking (2015). Despite repeated efforts to achieve an acceptable English definition of occupational justice, Durocher et al. (2014, p. 427) observed that definitions of occupational justice proposed by occupational therapy theorists, and repeatedly recited in the work of others, "[…] lack conceptual clarity, have not been developed with reference to other bodies of scholarly work, and are not supported by empirical evidence". Considerable confusion was also noted within theorists' work, such that it was unclear whether occupational justice constituted *action* to promote necessary change, or whether it constituted an outcome - the *accomplishment* of change - leading to the observation that "[…] a working definition of occupational justice remains elusive" (Hammell, 2017, p. 48).

A critical review has highlighted additional confusions among definitions of the five variants of occupational injustice that had been named and then recited frequently within the Anglophone occupational therapy literature – deprivation, alienation, imbalance, marginalization and apartheid (see below) – and has identified significant problems with the criteria by which occupational injustices are judged (Hammell & Beagan, 2017). This prompted the review's authors to recommend that in the absence of scholarly debate and theoretical refinement, the term "occupational injustice" should be used with extreme caution (Hammell & Beagan, 2017). Indeed, because Anglophone theorists tend to muddle the concepts of rights and of justice as if they (erroneously) believe these to be interchangeable terms, it was suggested that occupational injustices should be understood, clearly and succinctly, as violations of people's occupational rights (Hammell, 2017). "Occupational rights" have been defined as "[…] the right of all people to engage in meaningful occupations that contribute positively to their own well-being and the well-being of their communities" (Hammell, 2008, p. 62). It could thus be claimed that a violation of occupational rights, due to unfair and inequitable social conditions, constitutes an occupational injustice.

The World Federation of Occupational Therapists' *Revised Position Statement on Occupational Therapy and Human Rights* (World Federation of Occupational Therapists, 2019) has been amended in line with these critiques, declaring that "Occupational justice requires occupational rights for all" and articulating clearly that occupational justice "is the fulfilment of the right for all people to engage in the occupations they need to survive, define as meaningful, and that contribute positively to their own wellbeing and the wellbeing of their communities". This is a significant advance.

3 Occupational Injustices: Conceptualisations and Confusions

The occupational therapy profession in the Global North does not have a robust tradition of rigorous scholarly critiques of theoretical ideas (Duncan et al., 2007), so it should not be surprising that definitions of five occupational injustices, proposed by

theorists more than a decade ago, have been subjected to scant critical analysis, and recited repeatedly within the profession's literature as if they are believed to be correct or "true", or the product of expert consensus (Hammell & Beagan, 2017). This is regrettable, because the obvious definitional confusions and overlaps among these five forms of occupational injustice are profoundly bewildering for students, and inordinately unhelpful for practitioners who are tasked with translating theories into actions. For example, the concept of *occupational deprivation* was originally named and described by Whiteford (2000) but later redefined by Townsend and Wilcock (2004a, p.81), who asserted that occupational deprivation may arise "[…] when populations have limited choice in occupations because of their isolated location, their ability or other circumstances". This was problematic, due to the inherent implication that residence in a remote, rural location inevitably results in occupational deprivation, and the suggestion that limited occupational choices are an inevitable consequence of limited abilities rather than being produced by environments that are discriminatory and that unjustly limit the opportunities available to disabled people (Hammell & Beagan, 2017). When Stadnyk et al. (2010) subsequently redefined occupational deprivation, they omitted any mention of the important element of occupational choice and of inequitable constraints on people's abilities to make choices (Hammell & Beagan, 2017). Moreover Crawford et al. (2016) highlighted the problem in determining whether occupational deprivation pertains to an action by external forces, or to the experience of being occupationally deprived.

It is unclear why *occupational alienation* was defined by Townsend & Wilcock (2004b) without reference to the substantial and influential body of existent work on occupational alienation by Marx (1964). This effectively limited the ability of occupational therapists to communicate clearly with scholars from the social sciences and philosophy (Hammell & Beagan, 2017). Occupational alienation has since been redefined in the work of Stadnyk et al. (2010), and also of Nilsson & Townsend (2010) as being a form of social exclusion consequential to restricting a population from experiencing meaningful and enriching occupations. As a result, the concept of occupational alienation is now conceptually indistinguishable from either occupational deprivation or occupational marginalization (Hammell & Beagan, 2017). When *occupational marginalization* was originally named as a form of occupational injustice by Townsend & Wilcock (2004a), no definition was provided, although Stadnyk et al. (2010, p. 339) subsequently provided a description, and also claimed that "[…] occupational marginalization at its worst is a form of occupational apartheid". This indicates that some occupational injustices are conceptualised by theorists as being subsets of other occupational injustices (Hammell & Beagan, 2017). Moreover, the conceptual distinction between early depictions of occupational deprivation – in which people have limited choice in occupations – and occupational marginalization - in which people are prevented from participating in their choice of occupations - is unclear (Hammell & Beagan, 2017). The inevitable outcome of these confusing definitions is apparent in the occupational therapy literature, where, for example, occupational marginalization is bewilderingly associated with having "[…] too much…to do" (Du Toit et al., 2019, p. 578).

Occupational imbalance was identified as an occupational injustice by Townsend & Wilcock (2004a), based on the assumption that human health and wellbeing depend

upon a variation in people's occupational engagement. It is puzzling that occupational *imbalance* has not been discussed with reference to the significant body of scholarly work exploring occupational *balance* (e.g. Backman, 2004; Eklund et al., 2017; Wagman et al., 2012; Wagman et al., 2015), yet in the absence of an agreed definition of occupational balance it is impossible to determine whether an occupational imbalance exists (Hammell & Beagan, 2017). Does occupational balance - and thus occupational imbalance – pertain, for example, to *quantities* of time engaged in specific occupations or to *qualities* of experience while engaged in occupations; to a balance of engagement among "categories" of occupation prioritised by Western theorists (self-care, productivity, leisure) or to a balance of engagement among categories of occupation valued and prioritised by those engaged in occupation; to a balance among a range of occupations that are meaningful to the individual, or those that are meaningful to a collective; to a balance among occupations undertaken to fulfil individual or collective needs, aspirations or priorities; to a balance between obligatory and chosen occupations, between active or restful occupations, or between solitary, co-operative or collective occupations; or to a balance among the locations (e.g. within the home, in a building, on one's land or in nature) where occupational engagement occurs (Hammell & Beagan, 2017; Hammell, 2020)? Does an occupational injustice exist if the apparent "imbalance" among someone's occupations fits with their own priorities? And for how long does an occupational imbalance have to exist before it becomes an injustice? A year? A month? A week? Once again conceptual boundaries are unclear, with occupational therapy theorists' definition of occupational imbalance (Townsend & Wilcock, 2004a) substantially replicating Marx's definition of occupational alienation. Moreover, because Townsend & Wilcock (2004a, p. 82) described occupational imbalance "[…] as a form of occupational apartheid", it is apparent that occupational imbalance - like occupational marginalization - is a subset of occupational apartheid within a hierarchical system of injustices. It is regrettable and unhelpful that there has been no further work to explain the hierarchy of occupational injustices to which these theorists repeatedly allude (Hammell & Beagan, 2017).

First identified by Simó-Algado et al. (2002) and later defined in more depth by Kronenberg & Pollard (2005), *occupational apartheid* is unique among the five proposed forms of occupational injustice in having both an unambiguous definition and a clearly-identifiable causation (Hammell & Beagan, 2017). Occupational apartheid is defined as "[…] systematic segregation of occupation opportunity" (Kronenberg & Pollard, 2005, p. 59) that occurs

> […] through the restriction or denial of access to dignified and meaningful participation in occupations of daily life on the basis of race, colour, disability, national origin, age, gender, sexual preference, religion, political beliefs, status in society, or other characteristics (Kronenberg & Pollard, 2005, p. 67).

Moreover, a clear statement outlines both the causes and consequences of occupational apartheid:

> [...] occasioned by political forces, its systematic and pervasive social, cultural, and economic consequences jeopardize health and wellbeing as experienced by individuals, communities, and societies (Kronenberg & Pollard, 2005, p. 67).

Obviously, it is therefore inappropriate to misapply the term "occupational apartheid" to situations that do not match this precise definition and its specific, political, causality; and it is bewildering how occupational imbalance and occupational marginalization can be construed to be subsets, or instances, of occupational apartheid as Stadnyk et al. (2010) and Townsend & Wilcock (2004a) have insisted. Moreover, existing literature implies that the five forms of injustice that have been named, described and promoted by Western occupational therapy theorists are the only possible manifestations of occupational injustice, but no evidence supports this premise and it is surely naïve and unwise to place theoretical blinkers on the capability to perceive potential instances of occupational injustice[2]. Brazilian occupational therapists have drawn attention to the imperative for the profession to use unambiguous language that may be transmitted clearly to clients and others, and that embodies the clarity necessary for international transferability (Magalhães & Galheigo, 2010). It is apparent that clarity of English terminology concerning occupational injustices has not yet been achieved.

This very brief critique has attempted to highlight a few of the fundamental conceptual difficulties with existing variants of occupational injustice, and in so doing, to suggest that these perplexing categories are inadequate to inform research, advocacy or action. The following section provides a brief overview of the social determinants of health as a prologue to considering why and how occupational therapists might frame their endeavours to address inequities in terms of occupational rights.

4 The Social Determinants of Health

Anglophone occupational therapy theorists in privileged corners of the Global North have claimed that all humans participate in occupations as autonomous agents (Stadnyk et al., 2010; Townsend, 2012), and have a long tradition of asserting that people - all people - choose, shape and orchestrate their everyday occupations (e.g. Clark & Jackson, 1989; Kielhofner, 2008; Yerxa, 2000). Assumptions of unrestrained autonomy and free and unfettered choice fit comfortably with North America's dominant neoliberal ideology, which promotes individualism, independence, self-reliance and the notion of personal responsibility for one's circumstances, blames people's misfortunes on their own "poor choices" and underpins occupational therapy's fondness for individualistic interventions (Hammell, 2020). However, this toxic ideology has been vigorously challenged by critical epidemiologists and public health researchers, who insist that health behaviours and actions are *not* the products of free choice and autonomous action, but result, instead from inequitable social factors that determine people's abilities and opportunities to engage in health-enhancing

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[2] For a more thorough review of some of the confusions and problems inherent to existing Anglophone concepts of occupational injustice, see Hammell & Beagan (2017).

behaviours (Baum & Fisher, 2014; Frier et al., 2017; Frohlich & Abel, 2014; Marmot, 2015; Marmot & Bell, 2011). The *Lancet*-University of Oslo Commission on Global Governance for Health (Ottersen et al., 2014, p. 635) concluded that "[…] the context in which all human activity takes place presents preconditions that limit the range of choice and constrain action". Recognition of profound inequalities in people's opportunities to be healthy has prompted critical epidemiologists to focus on the "social determinants of health", and on human rights-based approaches to health improvement and promotion (Marmot, 2004, 2015; Marmot et al., 2008, 2012; Tajer, 2003).

According to the World Health Organization (WHO), the social determinants of health are

> […] the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries (World Health Organization, 2018, w/p).

Researchers assert that people's abilities to be healthy and to live lives they have reason to value

> […] are significantly socially produced (i.e. nurtured, protected, restored, neglected or thwarted) by a range of political, economic, legal, cultural and religious institutions and processes operating locally, nationally and globally (Venkatapuram, 2011, p. 3).

People who are economically and socially disadvantaged are born, grow, live, work and age in inequitable environments, in which they experience disempowerment, confront material and social hazards, and endure unfair and disproportionate exposure to violence, toxins, hazards and ecosystem degradation (Gamieldien & Van Niekerk, 2017; Marmot, 2015; Masuda et al., 2010; Oxfam, 2016); factors which lead to poor health and that significantly reduce life expectancies (Marmot, 2004, 2015). Marmot et al. (2008, p. 1661) are unequivocal in asserting that

> […] the unequal distribution of health-damaging experiences is not in any sense a natural phenomenon but is the result of a combination of poor social policies and programmes, unfair economic arrangements, and bad politics.

Thus, "[…] the right to health entails rights to equity in the social determinants of health" (Marmot et al., 2012, p. 1014).

Income inequality, which is increasing exponentially within and between countries (Braveman, 2012; Oxfam, 2016) exerts a negative impact on population health and wellbeing (Pickett & Wilkinson, 2015). In societies where income inequalities are

profound, physical health is worse, violence is higher, levels of illegal drug use are significantly higher (Pickett & Wilkinson, 2010) and rates of mental illness are five times higher than in more equal societies (Wilkinson & Pickett, 2010). Social oppression, resulting, for example, from class, caste and gender inequities, colonialism, racism, disablism, homophobia or transphobia, is a well-documented and measureable social determinant of health; and structural inequalities such as economic exploitation, inequitable transportation options and limited access to education and employment opportunities diminish the wellbeing of specific groups of people, thereby contributing to inequitable distributions of injury, illness and impairment over the life course and across generations (Balsam et al., 2011; Marmot, 2004, 2015; Marmot & Bell, 2011; Pachankis et al., 2014; Thoits, 2010). Importantly, racism, heterosexism, stigma and other forms of discrimination are found to be effective, not solely in reducing the opportunities, health, wellbeing and longevity of some, but in *expanding* the opportunities and enhancing the health, wellbeing and longevity of those within the dominant group (Lukachko et al., 2014). Inequitable (limited) opportunities and disadvantages for some people lead inevitably to inequitable (expanded) opportunities, privileges and advantages for others: as they are intended and designed to do *by* those in positions of privilege (Wildman & Davis, 1995).

Because inequitable social circumstances shape the available choices and determine what a person can or cannot choose to do, or envision doing (Smith & Seward, 2009), insights derived from research into the social determinants of health are of fundamental relevance to occupational therapists. Thus, in South Africa, occupational therapists have documented how structural inequities and chronic poverty violate people's "[…] right to be occupied in activities that enhance self-sustaining human development" (Watson & Duncan, 2010, p. 31); and in Australia, occupational therapists have identified structural disadvantages and socioeconomic injustices that inequitably impact the wellbeing and occupational rights of Indigenous people (Nelson, 2009).

Epidemiologists recognize that because inequalities in opportunities for full social engagement and participation produce a social gradient of health - in which the health and longevity of people closely match their economic and educational statuses - efforts at health promotion require a focus, not solely on biology and behaviour, but on the circumstances in which people live and work, on equality of opportunity, and on people's real abilities to choose among an equitable range of available opportunities: their *capabilities* (Marmot, 2004).

5 Action on the Social Determinants: Opportunities and Capabilities

Amartya Sen (1985, 1999, 2005) outlined the "capabilities" approach as a way to address human wellbeing, poverty and inequality from a human rights perspective. The capabilities approach demands consideration of whether a person is able to do the things they would value doing (their abilities), and also whether their circumstances actually allow them to use their abilities to do what they would like to do (their opportunities). The capabilities approach requires recognition

> […] that a person's capabilities are significantly shaped (and perhaps at least partly constituted) by their environmental and social circumstances – both past and present (Entwistle & Watt, 2013, p. 33).

This approach focuses attention, not solely on the things that people actually do, but on the range of choices that they can envision themselves doing and that are realistically available to them (Robeyns, 2005; Sen, 1999; Trani et al., 2009), and recognises that the ability to make and to enact choices is dependent upon both the *availability* of real choices and of "meaningful opportunity" (Ryff & Singer, 1998, p. 3; Connell et al., 2014).

Since Sen first articulated the capabilities approach, researchers and theorists have demonstrated its merit as a means to establish disability as a human rights issue and to focus attention on equality of opportunities, empowerment and participation (e.g. Dubois & Trani, 2009; Graham et al., 2013; Stewart, 2005; Trani et al., 2009, 2011a, 2011b). Congruent with the understanding of disability long held and advanced by critical disability theorists (e.g. Barnes, 1991; Neufeldt, 1999; Oliver, 1990), the capabilities perspective recognises that impairments do not inevitably lead to disability. Rather, society creates and sustains disability through processes of ableism, stigma, prejudice and discrimination that erect barriers to the full and equal participation of vulnerable people who have impairments (Trani et al., 2018). Thus, for example, an impairment and female gender (both personal traits) may interact with poverty (a lack of available resources) combined with a lack of support from the environment, to create disability (Mitra, 2014). A man in a position of racial, class and economic privilege with the same impairment (and thus the same degree of ability) may not experience disability. Disability derives, therefore, from reduced opportunities and from deprivation of basic capabilities.

People with mental distress experience disproportionate levels of poverty and are more likely than most people to be victims of violence, to be homeless or to live in disadvantaged areas, to be unemployed and under-employed and to experience stigma and discrimination: factors that both produce and perpetuate mental illness and that contribute to reduced life expectancies (Brunner, 2017). Accordingly, Sen's capabilities approach is being used by researchers concerned with mental health recovery as a tool to highlight the lack of community supports and financial resources that limit the substantive freedom for people with mental health problems to achieve recovery through making meaningful choices from a range of real opportunities (e.g. Onken et al., 2007).

Bailliard (2016, p. 4) has urged "[…] scholars and those advancing an occupational perspective of health to consider adopting the capabilities approach as a philosophical foundation for occupational justice", a recommendation supported by Hammell (2015a, 2017) and Pereira (2017). Moreover, occupational therapists have been encouraged to frame the right to engage in occupations that contribute to people's survival, health, and wellbeing as an issue of basic human rights (e.g. Bailliard, 2013; Galheigo, 2018; Hammell & Iwama, 2012; Hasselkus, 2004; Hocking, 2017; Watson & Duncan, 2010; World Federation of Occupational Therapists, 2014; Whiteford, 2014; Wilcock & Townsend, 2014). Taff et al. (2014, p. 324) contend that a human

rights perspective is required both to inform the practices of occupational therapy and to provide a basis for redefining the essence of the profession, and have advanced the capabilities human rights framework as "[…] a foundation for expansion of practice and research to meet global occupational needs and well-being of individuals, communities and populations".

6 Occupational Injustices and Occupational Inequities = Occupational Rights Denied

So far, this paper has outlined some of the problems inherent to existing Anglophone categories of occupational injustice. But it has also emphasised the fundamental importance of a human rights approach to advancing human health and wellbeing through attention to the social determinants of health, and has advanced the utility of a capabilities approach in so doing.

Because all people have equal human rights, and because health is a human right (Kallen, 2004), the right to engage in occupations that contribute positively to health and wellbeing ought to be enjoyed equally by all people, regardless of gender identity, sexual orientation, geographic location, race, ethnicity, age, religious/non-religious affiliation, citizenship status, class/caste, dis/ability or any other dimension of difference. Denial of occupational rights constitutes an occupational injustice. I contend, therefore, that all occupational injustices and inequities might be understood, clearly and succinctly, as violations of people's occupational rights (Hammell, 2017).

I see no useful purpose in delineating five specific occupational injustices (an endeavour that risks overlooking and obscuring all other instances of occupational injustice), or in striving to establish parameters that might demark one form of occupational injustice from all others (an endeavour that has proven futile over the course of two decades). I believe it is fundamentally more important to attend to the impacts of occupational injustices on people's lives than to determine which variety of occupational injustice they are experiencing. If displaced people in refugee camps, for example, are enduring profound disruptions to their habitual and valued occupations and, as a consequence, suffering severe and disabling effects that threaten their health and survival and that imperil the wellbeing of their families and communities, it is surely both more useful and more effective to be able to declare – unequivocally – that their occupational rights are being violated by their circumstances of occupational inequities and occupational injustices, than to expend energies arguing over whether occupational marginalisation is leading to occupational imbalance, or whether people are, instead, experiencing occupational deprivation or occupational alienation, or both. More importantly, if occupational therapists are to play any meaningful role in advancing action on the social determinants of health through a focus on occupation, we shall need to be able to use language that is unambiguous and devoid of discipline -specific jargon or "academic-speak". This is possible. It has been accomplished by the World Federation of Occupational Therapists (2014, p. 1), for example, when it was declared, unequivocally, that

> [...] all persons…by virtue of being human, have the right to occupational opportunities necessary to meet human needs, access human rights, and maintain health. This right is not conditional.

Numerous scholars have critiqued the occupational therapy profession's abiding preoccupation with individuals' problems and simultaneous heedlessness to the structural and systemic issues that impact the health and wellbeing, not just of individuals, but of collectives (e.g. Gerlach et al., 2018; Gupta, 2016; Hammell, 2019, 2020; Hocking, 2012; Rudman, 2013), and they have drawn attention to the fit between practices focused on modifying individuals and the neoliberal political and economic agenda that dominates the Global North (Hammell, 2020). Poverty, class, caste and gender inequities, sexism, colonialism, racism, disablism, homophobia and transphobia, that are well-documented determinants of health, are also determinants of occupational opportunity and engagement (e.g. Beagan & Etowa, 2009; Bergan-Gander & Von Kürthey, 2006; Björnsdóttir & Traustadóttir, 2010; Dowers et al., 2019; Gamieldien & Van Niekerk, 2017; Godoy-Vieira et al., 2018; Murthi & Hammell, 2018; Nelson, 2009; Trani et al., 2018); indeed, "[...] occupational injustices that are experienced at the individual level frequently point to larger structural issues of injustice" (Kinsella & Durocher, 2016, p. 163). I support the contention

> [...] that occupational therapists need to continue to advance the development and application of collective approaches to occupational justice to enable broader participation of people in their lives (Malfitano et al., 2016, p. 177)

and believe this would contribute to increasing the social relevance and impact of the occupational therapy profession.

I also believe that occupational therapists need to adopt a relational approach to the idea of choice and autonomy, recognising that capabilities are developed and exercised within deeply interconnected and interdependent relationships with others (Entwistle & Watt, 2013; MacDonald, 2002). Moreover, I contend that a broad focus on occupational injustice and its manifestations (e.g. social exclusion, discriminatory and inequitable access to resources and opportunities) would enable a focus on the larger structural issues of social injustices and their impact both on individuals and collectives, and that this would be more fruitful than seeking to identify which of five labels best encapsulates the nature of each injustice.

Poverty is one of the most important and consequential social determinants of health (Canadian Medical Association, 2013; Marmot et al., 2008). The problems inherent to poverty are not just about having inadequate financial resources, but about confronting multiple forms of social exclusion, such as limited access to education, employment, housing and transportation (Sakellariou & Pollard, 2009). Researchers have therefore characterised poverty as a restriction of opportunities that diminishes people's "capabilities": their abilities to act and to do (Frohlich & Abel, 2014). And this is why occupational therapists ought to be engaged in addressing inequities of

occupational opportunities for all those people whose abilities to act and to do are constrained by poverty (Hammell, 2015c).

Surely one of the most impressive innovations undertaken by occupational therapists to address the wellbeing, through occupation, of people living in poverty has been the Grandmothers Against Poverty and Aids (GAPA) project, which originated in South Africa. Initiated by an occupational therapist with a clear commitment to human rights, the project reflects a conscious effort to enable women living in poverty, and raising grandchildren orphaned by AIDS, to engage in new occupations within supportive social networks from which they gained financial benefits and which contributed significantly to their own well-being and the well-being of their grandchildren and their communities (Broderick, 2004). And in England, occupational therapists established community craft groups within an economically-deprived, inner city housing estate. These low cost, local interventions contributed positively to individuals' social, emotional and physical well-being through the development of social capital and community cohesion within safe spaces in which participants reportedly experienced a sense of belonging through the opportunity to participate in meaningful occupations (Diamond & Gordon, 2017).

Importantly, enlarging people's capabilities - their real opportunities to use their abilities - requires action to assure equity. In the English language, the word "equity" refers to fairness; it does not mean equality or sameness. It has been stated that "[…] there is nothing more unequal, than the equal treatment of unequal people" (cited in MacLachlan et al., 2016, p. 152); people differ both in their abilities to access resources, and in their need *for* resources, due to personal factors such as impairments or advanced age, social factors such as religious or cultural traditions, discrimination and stigma, and environmental, structural factors such as social policies or architectural barriers (Bailliard, 2016; Robeyns, 2005). A human rights perspective thus acknowledges that disparities (inequities) in the opportunities available, for example, to disabled people to live an ordinary life with the same rights as others lead to their entitlement to additional resources (Harnacke, 2013; Sen, 1999, 2010; Wilkinson-Meyers et al., 2015). Moreover, a capabilities and human rights perspective acknowledges that occupational therapists' efforts to enhance the capabilities of children who are racially-marginalized or refugees, or who live in impoverished communities, for example, are no less important than enhancing the capabilities of disabled children (Hammell, 2020).

Equality of occupational opportunity cannot be achieved by treating everyone the same; thus employing a capabilities approach "[…] elucidates the importance of discussing unequal chances in terms of inequity, rather than inequality, in order to underscore the moral nature of inequalities" (Frohlich & Abel, 2014, p. 199). This foregrounds the importance of striving towards *occupational equity*: conditions wherein the substantive freedom fully and fairly to access occupational opportunities necessary to fulfil occupational needs and rights for health and wellbeing is available to all people, fairly, regardless of their differences.

7 Concluding Comments

The work of epidemiologists and other social and health researchers demonstrates - unequivocally - the inseparability of human health, and social conditions. Action on the social determinants of health through attending to occupational injustices has been hampered by occupational therapy's dominant theoretical models – which portray social, economic and political forces as peripheral and divisible from individuals – and by Western modes of practice, which strive to enable individual clients to increase their abilities without addressing their unjust and unfair access to opportunities or the inequitable circumstances of their lives and of the collectives of which they are a part.

Issues of occupational rights, of the denial of occupational rights (i.e. occupational injustices), and of in/equities of occupational opportunities ought to be fundamental issues for the international occupational therapy profession, whose most pressing concern must surely be: how can occupational therapists most effectively address the social determinants of occupation such that all people have the capabilities to engage in meaningful occupations that contribute positively to their own well-being and the well-being of their communities, as is their right. Such a rights-based approach to practice requires the profession to consider how occupational therapists can better serve those most in need: those who have the least access to occupational opportunities, those whose wellbeing is imperilled as a consequence of occupational injustices, and those whose need for occupational therapy services, resources and supports is greatest, but whose access is often the least. Answering these challenges requires those in the Global North and South to draw from each other's knowledge and build on each other's experiences.

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