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Disability: A Brief Conceptual Overview

Chacko, Anooja

Zamorin's Guruvayurappan College

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Disability: A Brief Conceptual Overview

Disability is an umbrella term consisting of multiple deprivations. The impairment may either be temporary or permanent. Even though it occurs all over the world the complex nature of it interlinking the medical, social and environmental dimensions make it difficult to document and measure. According to the World Disability Report 2011, globally around 1 billion people experience some forms of disability and of which 200 million pass through chronic disabilities (WHO& World Bank, 2011).

Definition of Disability

Definition on disability is a highly controversial subject because of a couple of factors. The most important reason is that recognition of disabled as a separate group and the rights for them came into limelight only recently. Even though disability is a global phenomenon and prevails across societies, the measures to define and quantify it had not attained sufficient attention. The vast diversity of disabilities like physical, mental, acquired, disability by birth etc. creates problems in proper classification and definition. The doubts of categorising some status as disability made it more contentious. So offering a universally accepted definition for disability is a challenging task.

The term disability holds several definitions by various organisations and governments. From theoretical perspectives and practical purposes, disability definitions vary significantly. The theoretical perspective thrusts on the causes and drivers of disability. Of these there are two prominent models: medical model focusing on medical and individual factors and social model thrusting on social structures/ social discrimination. The former model is purely a medical science model while the social aspects and presence of social barriers are incorporated in the latter model.

Medical Model and Social Model

According to the medical model, disability is the outcome of physical or mental impairment and the consequences associated with it are purely emerged out of these problems. This model considers only the internal elements within the disabled for this situation and as remedy it advocates the careful scrutiny and prescription suggested by expert medical professionals. Here disability has only individual and medical dimensions. It is exclusively

correlated with the anatomic and psychological components. The social and institutional contribution has little space in this medical model.

As an extension to the medical model, there is a rehabilitation model. It also admits the authority of medical professionals in treating and modifying disability. It also adds that a person should try enough to come out of the disability and if still the disability continues it is due to the failure of the individual.

In contrast to these self centred models, a new school of thought emerged in 1980 with the publication of WHO framework. This marked the transition from medical model to more comprehensive social model. The crux of this model is that it treats disability as a social phenomenon-constructed and driven by the society- rather than an individualistic health issue. According to it, the disability is emerged out of the incapacity of the social system to afford the people with different abilities. The exclusion faced by them from social dimensions through the barriers and non accessibility creates the disability and thus it is more of a structural problem. Hence participation restriction is viewed as the prime element of disability.

The key supporters of medical model are health professionals, biologists and psychiatrists. Medical researchers also generally adopt this definition. But social scientists and policy organisations along with governments generally admit the social model of disability. The choice of impairment or access restriction as the contributor of disability serves the base of the specific model. But a demerit is that both these models often serve as dichotomous by exclusively sticking on their arguments and offering little space for co-operation and harmony.

It is obvious that disability is a complex interlinked phenomenon having several dimensions. Focusing on one and discarding the other aspects will reveal only certain elements of this phenomenon. Both impairment and social exclusion are part and parcel of the same phenomenon. So neither medicalization nor demedicalization will offer the desired output. What is required is a harmonious adoption of both aspects to serve the context better.

"Disability is a restriction or lack of ability to perform an activity in a manner or within a range considered normal for a human being."

(ICIDH Framework)

"Disability is an umbrella term for impairments, activity limitations, and participation restrictions. It denotes the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors)"

(ICF Framework, WHO 2001)

"Disability is the condition of difficulty in carrying out daily activities normally and in taking part in social life due to problems in parts of the body and the physical system as well as obstacles created by physical, social, cultural environment and by communication." (Government of Nepal)

Classification of Disability

ICIDH Framework

The complexities associated with the definitions of disability create challenges on the classification also. The pioneering attempt to categorise disability was done by WHO in 1980 when it developed the International Classification of Impairments, Disabilities and Handicaps (ICIDH), which was the first conceptual framework of its kind to incorporate the influences of personal, social and environmental factors on people with disabilities (Metts, 2004). This framework functions as a bridge between medical and social model and caters the need for personal assistance and rehabilitation along with change in socio economic policies and institutions for enhancing the access and participation in socio economic activities.

According to this definition, disability includes three aspects: impairments, disabilities and handicaps. The disability emerged from impairments is mainly associated with abnormalities of psychological or anatomical factors. The disabilities and impairments together constitute handicaps which deter the normal functioning of activities of an ordinary person. In this definition, the disability is byway connected with impairment and handicap.

This definition has expanded disability from the medical grounds and explains how the progression of it weakens the socio economic participation. For example, when a medical impairment like cerebral palsy or polio leads to some sort of disability for the affected person

and which may restrain her from normal functioning. The chronic disabilities and the resulted illness will also result in handicap and malfunctioning of activities.

ICF Framework

The WHO worked further to improve the ICIDH framework by incorporating more space to the social aspects and interventions. This framework encompassed personal factors like gender, race and ethnicity along with the environmental components like the structure, environment and institution within which the people make a living as key determinants of disability. Hence besides the physical and social aspects, it includes contextual factors also.

The highlight of ICIDH framework was that it viewed handicap as a cumulative effect of impairment and disability. But in the present framework, the interdependence of these elements have vigorously questioned. It establishes that even in the absence or less contribution of any of the problems, the disabilities may still exist. For this, it effectively highlighted the independence of capacity limitation and impairment. For example when someone is affected with a chronic disease even without visible impairment, it may slow down the performance of the patient by adding restrictions to their activity.

Similarly the disfigurement caused out of strokes, hearing impairment with hearing aids, visual problems rectified with specs etc. may not dampen the future activities and performance of the people. Moreover the environmental factors like level of receipt of medical assistance, access to better institutional support may help to reduce the disability and impairment. The case of Stephen Hawking is a classic example of it. The same disability may not sensitise equally in an affluent and poverty stricken family. The gender discrimination and the barriers faced by the women and marginalised society also stimulate disability.

Even now this is the most comprehensive framework with conceptual clarity. Still research on it is ongoing. The recognition of both interdependence and independence of the components improve the reliability of the framework.

Disability and Livelihood

Disability is a livelihood issue because disabled persons are facing a couple of challenges and multiple deprivations in making a living. The most striking challenge is the mutually feeding poverty and disability. A growing body of empirical research across the world indicates the increased prevalence of poverty and livelihood insecurity of the disabled. This marginalised

outlier section often experiences socio economic disparity. And the more pathetic fact is that this deprivation web extends to their family also. The deepening of poverty as a result of keeping away from economic and social activities limits the access to services and income support measures.

Poverty not only acts as a consequence but as a cause of disability also. Some disabilities could have been cured properly if it had diagnosed at right time. The negligence and lack of medical assistance have complicated several situations. The institutional and social negligence also add fire to the impairment.

The socio economic exclusion limits the options of livelihood for the family of the disabled as a whole. With the onset of chronic disability, they restrain themselves away from social functions, economic activities, participation in several institutional programmes. Some social and cultural norms also restrict the entry to public sphere. The socio cultural barriers emerging out of discriminatory barriers create emotional bottlenecks to the members of family also.

Need of Inclusive strategies

The illness and disability is a condition having multiple challenges. It not only affects the person but the family as a whole. The escalating and prolonged heath expenditure questions the financial robustness of the family as a whole. It creates serious barriers to financial services. Lack of gainful employment of the disabled person coupled with escalating costs for medication increases the financial vulnerability. It adds serious constraints in meeting livelihood needs. Besides it complicate the situation by failing to cover other livelihood expenditure on day to day living, education and other services, access to other amenities etc. The ability to develop assets and future savings of the family is also seriously constrained out of this disease. At this juncture various forms of services and supports are needed for the family to enhance their overall livelihood. Effective gainful employment opportunities are to be provided to the members of the family.

Since disability lowers the entire economic and emotional stability of the family, in several instances they are neither aware of the entitlements they are required nor what support mechanisms are entitled to. Similarly the support and assistance may vary across the patients according to their contexts and requirements. Hence proper communication is necessary with

the family to diagnose it and make them aware of it. Then only distribution of the resources and supports will suit their needs enhance the fruitfulness.

The policies and supports should be inclusive in nature. For that an effective co-ordination of the family of the disabled, palliative societies and palliative volunteers should be undertaken. Before framing policies, the requirements should be identified effectively. Both medical and other necessities should be incorporated in the policy kit. The improvement of social and basic infrastructure should rectify the problems of barriers to entry. The organisations of disabled and activists engaging in this arena should be provided enough space in formulation, implementation, monitoring and follow up of the apt policies tailored to the needs of the beneficiaries. All these activities should be based on evidence based baseline data through systematic action research.

The diverse instances of disabilities points out to the urgency for comprehensive policy action covering multiple aspects of livelihood vulnerability. In several cases disability serves as a feeding ground for poverty and other forms of discrimination. Hence it underscores the robust initiatives from the government to address the issue with due recognition.

Bibliography

- Albert, Bill (2004) *"Briefing Note: The Social Model of Disability, Human Rights and Development"*, Disability, Knowledge and research
- Altman, B., (2001), "Disability Definitions, Models, Classification Schemes, and Applications," in *Handbook of Disability Studies*, G. L. Albredht, K.D. Seelman, and M. Bury, Thousand Oaks, CA: Sage Publications, pp. 97–122
- Gronvik, Lars(2004), *"Definitions of Disability in Social Sciences: Methodological Perspectives"*, Digital Comprehensive Summaries of Uppsala Dissertations from the faculty of social sciences, 29-52pp
- Metts, Robert(2004), Background Paper Prepared For The Disability And Development Research Agenda Meeting, November 16, 2004, World Bank Headquarters, Washington, D.C.
- Mitra, Sophi et. Al(2011) *"Disability and Poverty from World Health Survey: A Snapshot from World Health Survey",*SP Discussion Paper No: 11109, World Bank
- UPIAS(1976), *Fundamental principles of disability*, Union of the Physically Impaired Against Segregation, London
- Smeltzer,S C(2007) *"Improving The Health And Wellness Of People With Disabilities: A Call To Action Too Important For Nursing Outlook*", Nursing Outlook, 55: 183-195
- United Nations Statistical Office (UNSO), (1990), *"Disability Statistics Compendium, Statistics on Special Population Groups"* New York.
- World Health Organization, 1980, *International Classification of Impairment, Disability and Handicap* (ICIDH), Geneva: World Health Organization.
- WHO(World Health Organization). (2001), "*International Classification of Functioning, Disability and Health*" Geneva: WHO.
- WHO(2011), *"World Report on Disability",* Geneva: WHO

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