CHAPTER 3
DISABILITY IN THE CONTEXT OF EMPLOYMENT

"From the beginning of time, humankind has wrestled with the paradox of what to do with persons with disabilities. In ancient times, they were simply put to death. They were a burden on the tribe. In ancient Greece there were two cities. Sparta removed the weak and the elderly for the good of the rest. In Athens, the warrior class protected the weak." (Thomas E. Stax M.D. as in Encyclopaedia of Special Education 2007:2061)

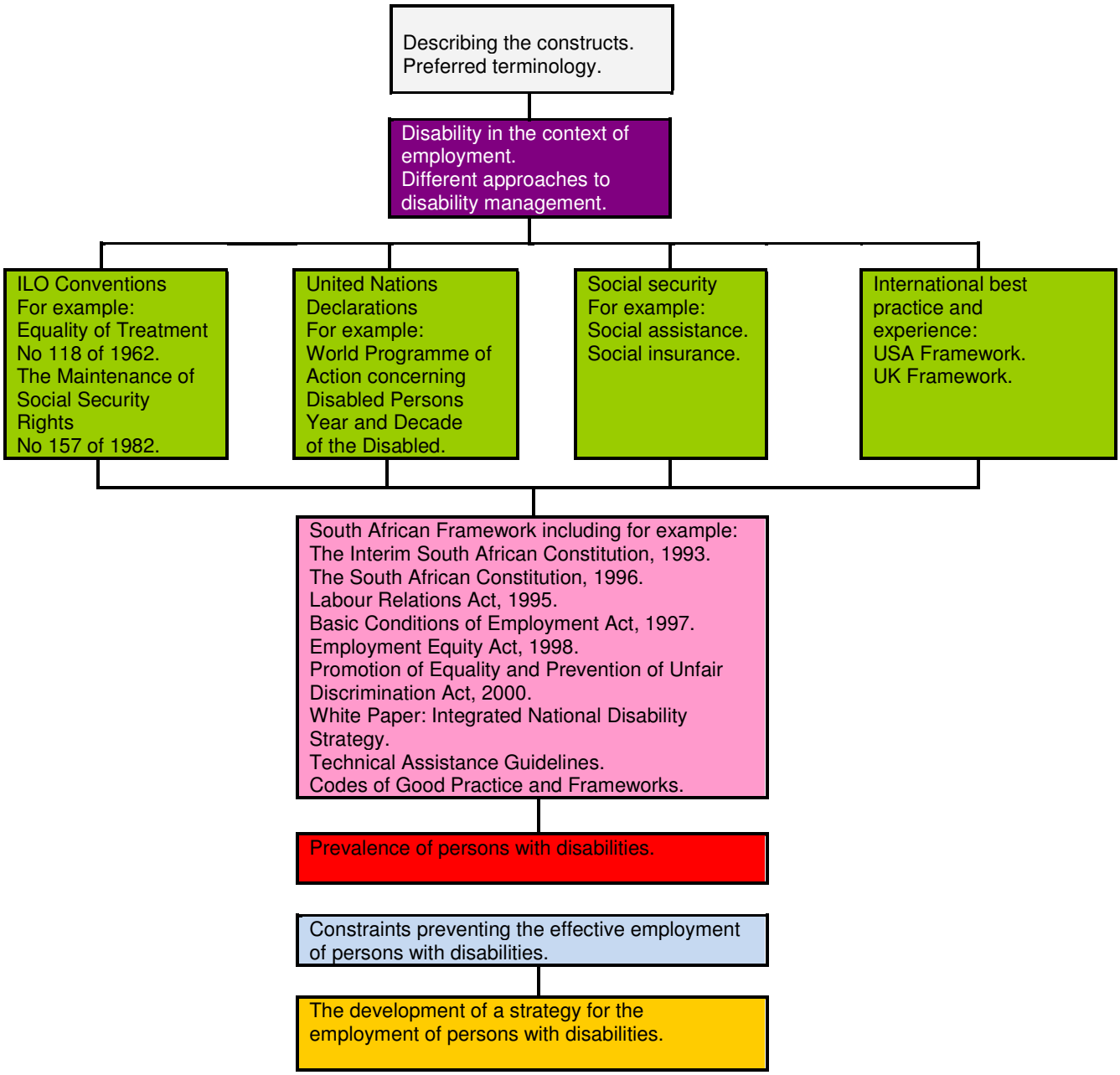
3.1 INTRODUCTION

This chapter endeavours to create an understanding of disability and the historical evolution of the various disability models. The chapter further reflects on disability management in the context of employment.

The discussion of the different models for disability management creates a platform from which the human resource management and labour relations field of research can implement strategies to increase the employment levels of persons with disabilities, which is the purpose of this research. The discussion in this chapter is therefore comprehensive to ensure that the models and the approaches to disability management which emanate from these approaches are properly contextualised.

Disability as a field of research has evolved over many years. Through the evolution process different schools of thought can be identified which are articulated in different models. Disability management has evolved from a moral approach to a medical approach, to a social approach. This evolution of the models is a result of the emergence of human rights, internationally and nationally, with a significant impact on the manner in which disability is managed. The contemporary model prevailing in South Africa, termed for purposes of this research as a social-political model, is discussed.

Table 7: Disability management literature review research framework



This chapter forms the basis from which a strategy can be developed to manage disability in the context of employment. The relevant contributions of this chapter to the research, whether contributing or contradicting to the purpose of the research, will be presented in the summary at the end of this chapter.

The relative position of the discussion in the overall literature review research framework is presented in purple in Table 7 above.

3.2 DIFFERENT APPROACHES TO DISABILITY MANAGEMENT

A number of disability models have been identified which captured the thinking about disability at a specific time period in history. The earlier models were not formal as they were merely a reflection of society's response to persons with disabilities. It is not possible to attach a specific date to the development of these models. In the developed countries the progress through these different models took place much earlier than in developing countries. In certain countries the development is still to take place.

The following key characteristics (as adopted from Kaplan date unknown) were used as a basis for examination of these models:

- Knowledge base – this indicates the origin of the model and creates an understanding of the principles underlying the relevant approach;
- roles – it refers to the context or source of the relevant model and the roles which exist within this context;
- rules and relationships – refers to the manner in which policies and practices are developed and how role-players interact; and
- shortcomings – it refers to shortcomings and criticisms of each model.

The key characteristics of the different models of disability, in the approximate order as they evolved over time, can be summarised as follows in accordance with the key characteristics identified above:

Table 8: Key characteristics of the most prominent disability models

MODEL	KNOWLEDGE BASE	ROLES	RULES AND RELATIONSHIPS	SHORTCOMINGS
Moral model.	➢ Oldest model but it is less prevalent today.	➢ Many cultures associated disability with sin and shame. ➢ Disability often associated with feelings of guilt.	➢ This model views disabilities as burdensome or an embarrassment. ➢ Families have hidden away the disabled family member, keeping them out of society.	➢ This model reflects society as it was in earlier years before the advent of human rights and social awareness.
Traditional model.	➢ Based on culturally and	➢ The roles persons with disabilities may	➢ A person with disabilities may be	➢ The model is culturally relative.

MODEL	KNOWLEDGE BASE	ROLES	RULES AND RELATIONSHIPS	SHORTCOMINGS
	religiously determined knowledge, views and practices. ➢ Depending on cosmology, social organisation and other factors, cultures show a broad range of perspectives which place persons with disabilities on a continuum from human to non-human. ➢ Some cultures practised infanticide.	assume within a given culture range from participant to pariah.	perceived as demonic or unfortunate. ➢ Person with disabilities may be an outcast.	➢ Objective, scientifically based knowledge is not associated with this model.
Tragedy/ charity model.	➢ Used by charities during fund raising.	➢ Graphically illustrated in the televised children-in-need appeals.	➢ Negative victim image. ➢ Oppressive to persons with disabilities. ➢ Persons with disabilities are seen as pitiful.	➢ Model is regarded as disabling. ➢ This approach segregates persons with disabilities. ➢ It tends to create pity.
Medical model.	➢ Based on scientific views and practices in medical professions. ➢ The problem is located within the body of the person with a disability.	➢ The context of the medical model is the clinic or the institution. ➢ Persons with disabilities assume the role of patient. ➢ This role may either be of short or long term nature depending on the individual's condition, policies related to the institutionalisation, community support and professional and	➢ Authority lies with professionals.	➢ The bio-medical perception of normalcy and the narrow band of legitimate knowledge which is usually medical and health related. ➢ The perspective of the person with a disability and social factors is not routinely within the knowledge base of the medical model. ➢ The person with a disability is

MODEL	KNOWLEDGE BASE	ROLES	RULES AND RELATIONSHIPS	SHORTCOMINGS
		social attitudes towards disability.		removed from the broader society and treated separately.
Rehabilitation model.	➢ An offspring of the medical model. ➢ It regards disability as a deficiency that can be fixed by rehabilitation professionals.	➢ The rehabilitation professional can provide therapy and other services to make up the deficiency caused by the disability.	➢ Historically it gained acceptance after World War II when many disabled war veterans needed to be re-introduced into society.	➢ Does not reflect modern society thinking.
Disability model.	➢ This model developed in opposition of the medical and rehabilitation models.	➢ Disability rights and independent living movements initiated this model.	➢ Social discrimination is recognised as the most significant problem experienced by persons with disabilities.	➢ The model never fully developed as it was overtaken by the development of the social model.
Economic model.	➢ Disability is defined by a person's inability to be economically active.	➢ It assesses the degree to which impairment affects an individual's productivity. ➢ Used primarily by policy makers to assess the distribution of benefits.	➢ The policy makers and economists see persons with disabilities as a problem to which they don't find an economically rational response.	➢ This model does not justify and support a socially desirable policy in economic terms. ➢ Which option is better - namely to pay persons with disabilities a social grant or to employ them in a sensible manner.
Social model.	➢ Based on knowledge, experience, views and practices of persons with disabilities. ➢ The problem is located within society rather than within the individual with a disability.	➢ Individuals with disabilities are the authorities. This is captured in the slogan "nothing about us, without us!" ➢ Persons with disabilities assume a range of roles, especially the advocate role, to pursue full expression of	➢ Rules are determined within a framework of choice and independent living with strong support from organised disability communities.	➢ Limiting the causes of disability either exclusively to social and environmental policies and practices or advancing perceptions of disability in mainly industrialised countries that emphasise individual rights

MODEL	KNOWLEDGE BASE	ROLES	RULES AND RELATIONSHIPS	SHORTCOMINGS
		educational and employment opportunities and citizenship.		rather than advancing broader economic rights that may reflect the needs of impoverished developing countries. ➢ This model is seen as the only acceptable model.
Socio-political model.	➢ This is the South African model. ➢ Located in the social environment.	➢ Provides for support and leadership at a political level but is driven by the community of persons with disabilities.	➢ Takes cognisance that disability is a social construct and that most effects are inflicted upon persons with disabilities by their social environment.	➢ This model is relatively new and needs to be researched further and more clearly defined.
Integrative model.	➢ Broad knowledge base ranging from medicine to literature which is informed by the experience of persons with disabilities. ➢ This model is still being construed.	➢ Persons with disabilities have many roles, including citizen and patient.	➢ There are a number of evolving policies and practices representing this model.	➢ This model is relatively new and also needs to be researched further and more clearly defined.

(Adopted from Kaplan date unknown, Kluth 2006, Albert 2004, AMHCW and Michigan Disability Rights Coalition, 2005 -2007).

The moral model is the oldest model and the least prevalent today. This model associates disability with sin and shame (Kaplan date unknown). It is also associated with feelings of guilt. This model is particularly burdensome for the disabled person as families sometimes even hide the disabled person away to avoid shame.

The traditional model is described as a belief that persons with physical, sensory or mental impairments were under the spell of witchcraft, possessed by demons, or as penitent sinners being punished by God for wrong-doing by themselves or their parents (Kaplan date unknown).

Kaplan (date unknown) and DPSA (2008) refers to the existence of more models (and definitions) namely, a rehabilitation model, disability model and a moral model. The rehabilitation model is an offshoot of the medical model, which regards disability as a deficiency that must be rehabilitated by rehabilitation professionals. The disability model, on the other hand, regards disability as a normal aspect of life and rejects the notion that persons with disabilities are defective.

The significant models namely the medical, social and South African models are discussed more comprehensively below.

3.2.1 MEDICAL MODEL

The medical model was the first “formal model” and it reflects the mindset of society (particularly the medical profession) at a particular stage. Attributing the word “model” to the approaches which existed before the medical model is actually a misnomer and an overstatement. The approaches are more a reflection of history and the manner in which earlier communities dealt with persons with disabilities. It is against this background that the medical model developed. The medical profession must have realised that they could make a difference to the lives of persons with disabilities, and hence the medical model developed.

The medical model views disability as a problem of the person, directly caused by disease, trauma or other health conditions, which requires medical care provided in the form of treatment by medical and related professionals. Management of disability by these professionals is aimed at cure and behaviour change. Medical care is viewed as the main solution to this medical problem, and at the political level the principal response is that of modifying or reforming health policy (Introduction to the World Health Organisation International Classification Framework: 2001:20, Kaplan date unknown).

The medical model came about as modern medicine began to develop in the 19th century, along with the enhanced role of the physician in society. Since many disabilities have medical origins, persons with disabilities were expected to benefit from coming under the direction of the medical profession (Kaplan: date unknown).

The approach of this model is that it is based on assessments of impairments from a deficit point of view, against normality. The question therefore is what a person with disabilities cannot do, instead of what such a person can do. This approach is therefore suggesting that some persons are normal and that persons with disabilities are deviating from this norm. This is having a very important negative psychological impact on persons with disabilities.

The medical model of disability sees illness or disability as the result of a physical condition which is intrinsic to the individual (it is part of the individual's own body), may reduce the individual's quality of life and causes clear disadvantage to the individual (http://en.wikipedia.org/wiki/Medical_model_of_disability, Albert 2004:3, AMHCW). As a result, curing or managing illness or disability revolves around identifying the illness or disability, understanding it and learning to control and alter its course. This approach leads directly to persons with disabilities not joining in activities of society because they have impairments.

Emanating from the medical model, society focuses on compensating persons with impairments for what is "wrong" with their bodies. This is done through special welfare benefits and providing special segregated services. The social assistance field of research will be discussed in more detail in Chapter 4 of this research. The removal of persons with disabilities from society shapes the way disabled persons think about themselves. This negative message was internalised over time and persons with disabilities believed that all disabled persons' problems stem from not having "normal bodies".

The medical model usually emphasises the impairment rather than the deeper needs and abilities of the person. The power to enable persons with disabilities seems to lie within the medical and associated professions. Disability has historically been

regarded from within the medical model as a health and welfare issue, and state intervention was channelled through welfare institutions. The focus was on the impairments of persons as a "problem" to be fixed or treated, with little or no consideration of the context in which that person functioned, and in isolation and exclusion from mainstream life (Draft National Disability Framework, 2008 – unpublished, Riesner http://inclusion.uwe.ac.uk, Brisenden 1986, Albert 2004:3).

The medical approach has been severely criticised nationally and internationally. It is not clear when this criticism started. The first criticism was noted during 1976 when the UK-based organisation Union of the Physically Impaired Against Segregation, claimed that disability was the disadvantage or restriction of activity caused by a contemporary social organisation which takes little or no account of persons who have physical impairments and thus excludes them from participation in the mainstream of social activities (http://en.wikipedia.org/wiki/Social _model_of_disability).

Criticism pointed out that the medical model is "…rooted in an undue emphasis on clinical diagnosis, the very nature of which is destined to lead to a partial and inhibiting view of the disabled individual" (Brisenden 1986:1). Further criticism is that the medical model does not address the challenges of a modern society. According to the White Paper on an Integrated National Disability Strategy (INDS 1997:9) disabled persons and their families have been isolated from their communities and mainstream activities. Dependency on state assistance has disempowered persons with disabilities and has seriously reduced their capacity and confidence to interact on an equal level with other persons in society.

The main implications of this criticism is that it leads to the "exclusion" of the disabled from society and that it sees the disabled person as having a "problem". The criticism developed when human rights and disability rights specifically came to the forefront. If it is kept in mind that the disability rights movement was formed mainly by persons with disabilities to make their suffering known, it basically became the first time that persons with disabilities made themselves heard.

The medical model should be seen as a point of evolution, and although medicine and the medical profession still plays a significant role in disability management, society has now learnt more and is following a more holistic approach.

3.2.2 SOCIAL MODEL

The social model views disability mainly as a socially created problem preventing the full integration of persons with disabilities into society and the workplace. Disability is not an attribute of an individual, but rather a complex collection of conditions, many of which are created by the social and work environments. The management of the "problem" therefore requires social action, and it is the collective responsibility of society at large to make the environmental modifications necessary for the full participation of persons with disabilities in all areas of social and work life. The issue is therefore an attitudinal or ideological one requiring social change, which at the political level becomes a question of human rights. This model emphasises the political context of disability management (Introduction to the ICF 2001:20).

The social model of disability proposes that constraints, prejudice and exclusion by society (purposefully or inadvertently) are the ultimate factors defining who is disabled and who not in a particular society. It recognises that while some persons have physical, intellectual or psychological differences from a statistical mean, which may sometimes be impairments, these differences do not have to lead to disability unless society fails to accommodate and include them in the way it would those who are "normal". The phrase "differently abled" is sometimes used to convey an aspect of the social model of disability. It further mentions that the origin of the approach can be traced to the 1960s and the Civil Rights Movement and that the term emerged from the United Kingdom during 1983. Olivier, 1983 held the view that the medical model is actually not a medical model but an "individual model" which is an idea he took from the distinction originally made between impairment and disability by the Union of Physically Impaired Against Segregation, 1976 (http://en.wikipedia.org/wiki/Social_model_of_disability).

One of the significant differences between the medical model and the social model is that "…The social model has been worked out by disabled persons themselves. Our

experiences have shown us that in reality most of the problems we face are caused by the way society is organised" (www.disabilitywales.org, Kluth 2006:2, www.circlesnetwork.org.uk/models_of_disability.htm). In Table 9 the social and medical models are compared with regard to the different disability management solutions they propose for enhancing participation of persons with disabilities in the workplace.

Table 9: Disability management solutions presented by the social and medical models

EMPLOYMENT RELATED DISABILITY ISSUE	SOCIAL MODEL SOLUTIONS	MEDICAL MODEL SOLUTIONS
Cannot perform work due to painful hands, unable to open jars or doors, unable to hold work tools.	Better designed lids, automatic doors, and work tools.	Medication or operations are required to take away the pain and increase the functionality.
Difficulty in standing for long periods.	More seats, or specially designed seats, differently designed production processes allowing the employee to be comfortable.	Medication or operations are required to take away the pain and increase the functionality.
"Housebound" or "confined to a wheelchair".	Design ramps and lifts in all buildings, also accessible transport/parking spaces, workplaces designed to be disability friendly.	Medication or operations are required to take away the pain and increase the functionality.
Cannot hear or see.	Recognition and use of sign language and Braille/raised letters in the workplace, enhanced technology as part of reasonable accommo-dation.	Medication or operations are required to take away the pain and increase the functionality.

(Adopted from www.disabilitywales.org, also based on Olivier, 1990 and http://www.jarmin.com/demos/course/awareness/print.html).

The social model of disability suggests that the collective disadvantage of disabled persons "is due to a complex form of institutional discrimination. This discrimination is fundamental to the way society thinks and operates. The social model is based on the belief that the circumstances of persons with disabilities and the discrimination they face are socially created phenomena and have little to do with the impairments of persons with disabilities. The disability rights movement points out that the "cure" to the "problem" of disability lies in restructuring society" (INDS 1997:11). Quinn and Degener (2002:10) indicate that in essence the human rights perspective of disability

means viewing persons with disabilities as subjects and not as objects. It entails moving away from viewing persons with disabilities as problems to viewing them as rights holders. Problems are located outside the person.

Waddington (1995:60) premises that the social model of disability is based thereon that the integration of persons with disabilities entails the removal of physical and attitudinal constraints and not on "normalisation" or cure.

The fundamental aspect of the social model concerns equality and accessibility, whereas the medical model emphasises the difference or the disability of persons with disabilities. The social model has drawn the distinction between the words "impairment" and "disability". "Impairment" is used to refer to the actual attributes (or loss of attributes) of a person, whereas "disability" refers to the restrictions caused by society when it does not give equal attention to the needs of individuals with impairments (http://en.wikipedia.org/wiki/Social_model_of_disability).

Olivier (1990) indicates that there is a danger in discussing issues related to disability and if we are not careful we will spend all our time considering what we mean by the different models. These semantic discussions will obscure the real issues in disability, which are about oppression, discrimination, inequality and poverty.

Albert (2004:8) concludes that the social model of disability represents a protean challenge to traditional thinking about disability. In the development context it has the potential to transform policies and practices as well as the lives of disabled persons, however, neither it nor a human rights approach are magic words.

3.2.3 THE SOUTH AFRICAN MODEL

The White Paper on an Integrated National Disability Strategy (INDS 1997:i) "….represents the government's thinking about what it can contribute to the development of disabled people and to the promotion and protection of their rights". It also emphasises that it was developed through a thorough process of consultation with all the relevant organisations of and for the disabled. The INDS (1997) is

therefore an important document in the research of disability management in South Africa.

The INDS (1997) follows a socio-political approach to disability. The socio-political approach originates from the perspective of the social model and it leads to fundamentally different policy priorities and choices mainly around disabling barriers and a strong emphasis on human and civil rights (Albert 2004:3). Disability is therefore located in the social environment, but in a supportive political environment. This takes cognisance of disabled persons' viewpoint that disability is a social construct and that most of its effects are inflicted upon persons with disabilities by their social environment. Persons with disabilities can therefore actively contribute to changing the social construct by advocating and lobbying in the political domain for improvements in their material and legal situation. By doing this the social model has promoted the idea that persons with disabilities should be actors in their own lives rather than passive recipients of care (Albert 2004:4).

The further distinct difference between the South African and the other models is the emphasis that it places on employing persons with disabilities. This characteristic is discussed further in Chapter 5.

Seelman (2004) indicates a number of international trends which illustrate the importance of re-examining disability models that are operative in countries and international organisations. The first trend involves conflict between health professionals who identify with the medical model and persons with disabilities who identify with the social model. The second trend involves technology. Increasingly, access to technology is associated with human rights as reflected in the ADA. The third trend involves rehabilitation research itself. The fourth trend involves the struggles of social welfare programmes and their administrators who try to keep benefit programmes solvent while serving growing numbers of persons with disabilities. The fifth trend is poverty, a barrier to the support of disability programmes in developing countries, where the majority of persons with disabilities live.

Upon analysis, these trends are addressed in the South African model as expressed in the INDS (1997) and related policies. These trends further reflect some of the challenges experienced by persons with disabilities on a daily basis. Especially the fifth trend (poverty) is a significant challenge. As mentioned in Chapter 1, persons with disabilities are amongst the poorest of the poor. Albert (2004:4) stresses that the social model is so powerful because it illuminates the facts that the roots of poverty and powerlessness do not reside in biology but in society.

Barnes (1997:3) points out those socio/political themes of disability that can be divided into two distinct but linked traditions, one American and the other British. The first draws heavily on American functionalism and deviance theory while the second is rooted in the materialist analysis of history associated with Max (1970 – as in Barnes 1997). The American theory explains the "social construction" of the problem of disability as an evolution of contemporary society while the British theory maintains that disability and dependence are the "social creation" of industrial capitalism.

The relevance of the various models and the five trends identified by Seelman (2004) is significant since employment of persons with disabilities is a fundamental policy guideline in the INDS (1997). The medical model approach does not encourage employment. It would however not be accurate to indicate that it restricts employment. The issue rather is that it does not aim to ensure that persons with disabilities are employed while the social model, and specifically the socio-political model, views employment of persons with disabilities as one of the critical policy guidelines.

3.3 SUMMARY

The contribution of this chapter to the research process and the development of a strategy to employ persons with disabilities can be summarised as follows:

- This chapter creates an understanding of disability as a field of research generally and the historical evolution thereof.
- Through the evolution many different schools of thought can be identified which are articulated in different models.

- Deep-rooted thinking exists in terms of the various disability models. The thinking reflected in each of the various models originates from the perspective of the field of research and the community from which the model originates.
- The models evolved from a moral approach to a medical approach to a social approach. This evolution is a result of the emergence of human rights, internationally and nationally, with a significant impact on the manner in which disability is managed.
- The medical model of disability sees illness or disability as the result of a physical condition which is intrinsic to the individual (it is part of the individual's own body).
- This approach leads directly to persons with disabilities not joining in activities of society because they have impairments.
- The fundamental aspect of the social model concerns equality and accessibility, whereas the medical model emphasises the difference or the disability of persons with disabilities.
- The social model of disability proposes that constraints and prejudice and exclusion by society (purposefully or inadvertently) are the ultimate factors defining who is disabled and who not in a particular society.
- The significant difference between the medical model and the social model is that the social model has been developed by persons with disabilities themselves.
- Prominent authors warn that there is a danger in getting caught up in semantic discussions about disability since such discussions could obscure the real issues in disability, which are about oppression, discrimination, inequality and poverty.
- Disability management is not a familiar topic in South Africa and an analysis in the context of employment creates a platform from which the human resource management field of research (including labour relations management) can implement strategies to increase the employment levels of persons with disabilities.
- The South African disability management model was developed through a thorough process of consultation with all the relevant organisations of and for the disabled. It follows a socio-political approach to disability. Disability is

therefore located in the social environment, supported by the political environment. This takes cognisance of disabled persons' viewpoint that disability is a social construct and that most of its effects are inflicted upon persons with disabilities by their social environment. Persons with disabilities can therefore actively contribute to changing the social construct by advocating and lobbying in the political domain for improvements in their material and legal situation.

- The comment made by Olivier (1990) is very relevant since it became clear that the various research fields prefer to operate in silos. Little effort is being made to incorporate the different models into a single all-encompassing model which can serve persons with disabilities better. The common denominator is better service to persons with disabilities. It is wrong of the different models to claim sole propriety of the rights of persons with disabilities.
- The further distinct difference between the South African and the other models is the emphasis that it places on employing persons with disabilities. This characteristic is discussed further in Chapter 5.
- The various models on thinking about disability, and the five trends identified by Seelman (2004) are significant for effective disability management in South Africa.

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