On Second Thought: Constructing Knowledge, Law, Disability, and Inequality

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I. Introduction

People with disabilities provide us with a means to understand the way in which social life can be organized to be fair, to be just, to be humanitarian, and to be equal. They provide us an opportunity to go beyond finding the roots of charity and to look instead for the roots of justice. Equality and nondiscrimination, which are the very basics of human rights law, can be brought into clear focus by reflecting on the place of people with disabilities in our societies.

A human rights and social justice approach enables the use of various categories of rights and recognizes how rights have to be a concern in thinking about approaches to disability and social policy that enhance, rather than diminish, the status of those with disabilities. These include political and civil rights, such as the right to life, freedom of opinion, a fair trial, and protection from torture and violence. These are the rights that are the most common concern of nations, particularly in the North and West. Human rights also include economic, social and cultural rights such as the right to work, social protection, an adequate standard of living, the highest possible standards of physical and mental health, education, and enjoyment of the benefits of cultural freedom and scientific progress. Finally, human rights include the right of nations to development, economic autonomy, and security of their citizens.

Civil, political, social, and economic rights are reflected in such international agreements on human rights and disability as the:

- UN Universal Declaration of Human Rights (1948)
- UN Declaration on Disabled Persons (1975)
- UN International Year of Disabled Persons (1981)
- UN World Program of Action concerning Disabled Persons (1983)
- UN Standard Rules on the Equalization of Opportunities for People with Disabilities (1993)
Social Development Accord (Copenhagen 1995)
Beijing World Conference on Women (1996)

Despite these international norms and standards there is persistent social and legal exclusion of people with disabilities throughout the world. It is important to take a closer look at why people with disabilities continue to be subject to infringements and contravention of their human rights. This is revealed in two ways. One can be found in the way in which the norms and standards are constructed—the content of the instruments themselves. The other is found in the manner in which nations meet their commitments to the standards that are set down.

Masked behind both the content of norms and standards and the treatment of people with disabilities are differing understandings of the concepts of disability and equality themselves. This article will unpack prevailing notions of disability and theoretical understandings of equality and examine how these differing notions have inherent, built-in biases towards particular standards of policy, program, and legal status. This has an effect on whether the human rights of people with disabilities are respected or abridged.

The scientific and social justifications for political action related to disability at both the national and international levels are traceable to identifiable and shifting ideological frameworks. The article will begin by exploring these social and scientific formulations of disability which underpin social policy and their reflections in the current dominant paradigms—one which is centralizing and homogenizing and one which is based on difference and diversity. These discrepant formulations of disability underlie the kinds of policy and programs that are found in most nations of the world, suggesting that knowledge in this field is created internationally, not nationally.

Shifting legal and philosophical standards of equality that further complicate the impact of the various formulations of disability will then be explored. Assumptions arising from the changing conceptual development of the notions of disability and equality that form the basis for many state policies, programs, and services, have made the many different and, at times, contradictory ways of treating people with disabilities arguably just and fair. They have provided a foundation for keeping people with disabilities in the status of second-class citizens both within nation states and as world citizens. These assumptions have also influenced the meaning and parameters of quality of life evaluations and have arguably limited the goals of rehabilitation and of human rights protections.
To study the case of disability is, therefore, to reflect upon the struggle for social justice and the political obligation to relieve inequality.¹ There is within the disability movements in many nations a resurfing discussion of some fundamental principles about how all people should be treated and the economic, social, and political rights to which they are entitled. Questions are being asked about the quality of the care being received by people with disabilities and whether it meets even minimal notions of what is fair and just. People with disabilities and their advocates are recognizing the need to put these questions within the broader context of principles of justice, fairness, and equality as they recognize that the way society treats people and the share of the national funding allocations they receive reflects other, more fundamental inequalities in society.² It is these more generalized inequalities that will have to be addressed if people with disabilities are to be full participants in their societies.

Disability provides insight into the interplay between national and international declarations of rights and rehabilitation systems and the way these have contributed to, and result in, differential treatment. The case of disability affords a way to tease out how the conceptualization and measurement of disability supports and reinforces limiting both the state and professional obligations to people with disabilities. Assumptions about equality raise some fundamentally different assumptions about disability itself, about whether disability is a private or a public responsibility and about the legal and social status of persons with disabilities. Understanding of disability and disability policy, therefore, finds its roots in particular theoretical and scientific constructs of both disability and of equality and of the interplay between the two.

II. SOCIAL AND SCIENTIFIC CHANGE IN HOW DISABILITY IS PERCEIVED, DIAGNOSED, AND TREATED³

How disability is perceived, diagnosed, and treated, scientifically and socially, is reflected in assumptions about the social responsibility towards people with disabilities as a group. The assumptions or postulates about disability are neither mutually exclusive nor temporally chronological. Some disciplines have clung tenaciously to the characterization of disability as either solely a medical condition or a personal deficit, while others have adopted either the framework of disability as a social and political condition or some hybrid of these two major schools of thought. Consequently, policy and programming, both within the professional sphere and coming from government, reflects attempts to accommodate these shifting understandings of disability as a status.
There are four identifiable social and scientific formulations of disability reflected in the treatment of persons with disability in law, policy, programs, and rights instruments. Two of them emanate from theories of disability coming from individual pathology and two from disability coming from a social pathology.
A. Formulations of Disability Based on Individual Pathology

There are two identifiable formulations of disability that arise from an assumption that disability is an individual pathology. One is grounded in a biomedical approach and the other is grounded in a functional approach. The two have a number of common characteristics. They:

1. **Approach disability as a field of professional expertise**;
2. **primarily use a positivist paradigm**;
3. **emphasize primary prevention including biological and environmental conditions**;
4. **characterize disability as incapacity in relation to nondisabled persons (a comparative incapacity)**;
5. **distinguish disability and its attached costs as an anomaly and social burden**;
6. **portray the inclusion of people with disabilities as a private responsibility**;
7. **use the individual as the unit of analysis for research and policy purposes**; and
8. **depict the individual condition as the primary point of intervention**.

1. **The Biomedical Approach**

Of formulations of disability that arise from individual pathology, the first emphasizes its biomedical origin. The biomedical approach has been a powerful influence in establishing disability policy and practice and the pre-eminence of biological science as the basis for diagnosing disability, influencing treatments, and guiding access to disability benefits. From the perspective of biology and the attendant biomedical approach, it is assumed that disability is caused by a mental or physical condition that can be prevented or ameliorated through medical, biological, or genetic intervention. Such a characterization of disability makes the condition itself the focus of attention. The aim of the professional or the researcher is to decrease the prevalence of the condition in the general population. Treatment and prevention occur through biological intervention and critical care, including surgery, drug therapy, prenatal screening, and genetic intervention. Commonly, the individual or fetus is viewed as sick, afflicted, or injured.

With the rise of institutional facilities and public benefits, medical science became established as the mechanism for gatekeeping for determining those who are to be legitimately considered disabled. Assessments extend to various aspects of an individual’s range of disability such as employability; capacity for learning and being educated; fine motor skills and hand–eye coordination; the need for financial benefits and mobility aids and devices; as well as the need for treatment services.
The biomedical model, with a focus on altering the biological condition, places secondary emphasis on the role society plays in limiting and enabling people. The public responsibility is restricted to the custodial and medical care that is characterized as beneficial within the parameters of a biomedical approach.

The social obligation attached to such characterizations of disability is limited to medical diagnosis and treatment, including medically directed therapeutic interventions. For those who cannot be cured or rehabilitated, institutions, other segregated housing, and all encompassing service provision centers have been the conventional models of care. Until quite recently (because people with disabilities were expected to make no contribution to society, were in many cases considered a danger to society, and were characterized as without potential), families were encouraged to place their children in institutions where they would receive the basic necessities of food, shelter, and clothing. The alternative was to keep them at home where they would have familial contact and care, but the State was under little obligation to provide services, supports, or the financial resources to acquire those. Quality of life within such a framework is measured within a set of parameters limited to the provision of basic needs.

Rights entitlements are restricted to their feasibility within the context of individual incapacity and to the extent of independence in exercising them. For example, individuals are entitled to an education in the neighborhood school if they can access the school and are able to learn in the classroom as it is structured. The onus is on individuals to fit within the institutions as they are structured and participation is a right only to the extent that that is possible.

2. The Functional Approach

The second of the two formulations of disability as an individual pathology is a functional approach. Like the biomedical approach, the underlying presumption is that the deficit stems from an individual condition or pathology. The feature that distinguishes this approach from the biomedical approach is that the way of understanding the condition is the impact it has on functional capacity. The ways of treating or addressing the functional incapacity are broader and include both ameliorating the condition and developing ways to enable people to develop their own potential.

Within the functional approach, the problems experienced by people with disabilities are interpreted as a result of a functional incapacity resulting from an individual impairment. To treat this functional incapacity, services are made available to enable the individual to become as socially functional as possible. For example, the goal of rehabilitation is to increase an individual’s range of skills and abilities to function more independently and to become a productive member of society. A program’s success
is measured by how closely people who use services can approximate the lives of ‘normal’ people and to what extent they can achieve the skills of able-bodied persons.

Services developed from a functional approach (e.g., physiotherapy, occupational therapy, nursing, and health visiting) have gone beyond therapeutic programs associated with the biomedical approach to include life skills training, prevocational training, functional assessments, counseling, and job training, as well as skills for independent living. They are usually publicly funded to the extent they are considered effective in normalizing, often through rehabilitation programs.

Society’s responsibility in dealing with disability is to ameliorate and reduce the negative effects and provide comfort of some kind. This approach develops systems of assessment, habilitation, and measures to improve self-care and social skills. This responsibility derives principally from a sense of charity and benevolence (and in some cases, a reduction of the social cost that attaches to being dependent in society). The definition of the hierarchy of needs to ameliorate the functional inability is left to professionals, who are attributed with the skills and knowledge to determine what is in the best interests of the individual and what will be most beneficial to the individual. Success in meeting the social and professional obligation (to ensure the individual’s quality of life) is measured by how closely people with disabilities who use services can approximate ‘normal’ people.

Placing the focus on the individual makes the interplay of environmental and situational factors with individual functional capacity a secondary, although not necessarily irrelevant, consideration in diagnosing and addressing the means to normalize a person’s life opportunities. Targeting the individual for change places professionals and public programs using a functional approach at risk of operating on assumptions about the person’s ‘best interests’ that may not always coincide with what a person wants for himself or herself.

In both formulations of disability originating in an individual pathology, labeling or diagnosing the physiological or psychological state is important to determine the individual pathology or functional disabilities and as a basis for undertaking curative or remedial treatment. Given the medicalization of disability, many instruments have been developed for the purpose of diagnosis such as the International Classification of Impairment, Disability and Handicap (ICIDH), now revised as the Diagnostic Statistical Manual (DSM), the International Classification of Disease (ICD), and various IQ tests. On the basis of such diagnostic tools, medical, or alternatively rehabilitation, therapy is initiated to address the diagnosed problem. The outcome for the treatment is to enable the individual to function as independently as possible within the
social and economic environments, as they are currently structured. Where environmental modifications are made, they have tended to be limited to the personal or immediate sphere, not the macro or systems level of social and economic organization.

B. Formulations Grounded in Social Pathology

In contrast to the two approaches to disability based on individual pathology, there are two identifiable approaches that recognize disability as a consequence of social pathology. They both start from a perspective that assumes that disability is not inherent to the individual. Rather, they assume that the disability is inherent to the social structure. It is a structural model rather than an individual model. The pathology is that there is something wrong with the society that has to be fixed rather than something wrong with the individual that needs fixing.\footnote{7}

These approaches have a number of identifiable characteristics. They:

1. assume that disability is not inherent to the individual independent of the social structure;
2. give priority to political, social, and built environment;
3. emphasize secondary prevention rather than primary treatment;
4. recognize disability as difference rather than as an anomaly;
5. portray the inclusion of people with disabilities as a public responsibility;
6. use the social structure as the unit of analysis for research and policy purposes; and
7. depict the social, environmental, and economic structures as the primary point of intervention.

1. The Environmental Approach

Advances in knowledge based on an understanding of disability as a social pathology show that personal abilities and limitations are the result not only of factors residing in the individual, but also of the interaction between individuals and their environments. Increasingly, researchers demonstrate that the impacts of disability are exacerbated by the failure of ordinary environments to accommodate people's differences.

An environmental perspective on disability places the policy and program focus on the way the environments are arranged. For example, the absence of ramps into an office building creates an employment handicap for someone who relies on a wheelchair for mobility. The lack of an ergonomically adapted workspace makes it impossible for a person with limited upper body movement to perform job tasks. Similarly, many policy studies have shown that the lack of proactive hiring and employment
retention policies creates disadvantages for individuals who require time away from work because of fatigue and other conditions caused by disability. An educational service disadvantages persons with a speech impairment where it fails to provide the opportunity to learn an alternative method of communication, for example, through bliss symbolics or sign language instruction.

Increasingly, there is evidence in policy research that the impact of disability can be lessened, as environments are adapted to enable participation. Policy research demonstrates that building codes, principles of barrier free design, adapted curricula, targeted policy and funding commitments are useful mechanisms to reduce discrimination and increase equal participation. These mechanisms enable modifications and supports to be made in home, school, work, and leisure environments, and increase the participation of people with disabilities in society while limiting the disadvantages they would otherwise face.

Disability is handled from this approach by identifying the barriers in society that restrict the participation in economic and social life of people with impairments or disabilities including criteria or program parameters that restrict individual determination of needs and individual control of services and supports. Structural barriers to independent living or community living become the site of ‘therapy’ or modification. Prevention, then, is through the elimination of social, economic, and political barriers. Elimination of physical barriers, for example, building ramps or adoption of employment equity or affirmative action policies, is a method of prevention from the perspective of this approach to disability.

2. The Rights Outcome Approach

Another approach to disability is the notion that disability has social causes. It is a consequence of how society is organized and the relationship of the individual to society at large. Research, policy, and law from a rights outcome approach looks beyond particular environments to focus on broad systemic factors that keep some groups of people from participating as equals in society.

This approach identifies wide variations in cognitive, sensory, and motor ability as inherent to the human condition, and consequently, the variations should not limit the potential to contribute to society. It draws from a variety of disciplines (eg, anthropology, sociology, economics, and law), but it frames disability issues through the lens of human rights principles. It assumes that public policy and programs should aim to reduce civic inequalities and address social and economic disadvantage. It presumes that some people will need supports (eg, personal services, aids, and devices) in order to gain access to, participate in and exercise self-determination as equals in society.
This is a much more expansive theoretical framework than the other approaches. Policy from a rights outcome approach constructs an analysis of how society marginalizes people and how society can be adjusted to respond more effectively to the presence and needs of those who have been systemically marginalized. Treating the disadvantage is postulated as being the reformulation of social and political policy. Prevention is effected through recognizing the condition of disability as inherent to society. It is presumed that people with disabilities are an inherent part of society, not some kind of anomaly to normalcy.

From this perspective disability is regarded as a predetermined and a 'normal', inevitable part of the population, not a deviant condition. The quality of life indicator theorized from this perspective is the degree to which civic inequalities have been reduced, that is, the degree to which social and economic disadvantages have been addressed. Recognition of social and political entitlements is based on humanity rather than economic contribution and rights are equated with those of all others in society. Society is obliged to provide supports and aids and devices to enable social and economic integration, self-determination, legal and social rights, focusing on the disabling aspects of society, supporting human diversity and empowering disadvantaged individuals.

These social and scientific formulations of disability provide a means to recognize how scientific ideology has justified the kinds of political policies and programs and the kinds of treatment and treatment modalities that are in place. They are significantly important in the lives of people with disabilities—in the allocation of national and international research funds in the field, in medical and social decision making, in treatment and care, in legal decisions about entitlements and capacities, in housing and welfare arrangements, and in the protections of human rights of people with disabilities.

IV. CHANGES IN UNDERSTANDING THE CONCEPT OF EQUALITY\textsuperscript{11}

While there have been changes in how disability is perceived, a concurrent shift in the theoretical constructs of equality is occurring. These constructs fit generally into three categories. One is the formal theory of equality, that is, the equal-treatment model.\textsuperscript{12} The second is the liberal theory of equality,\textsuperscript{13} incorporating both the ideals of equality of opportunity and special treatment. The third is the equality of well-being, or equality of resources model.\textsuperscript{14}

Each of these models makes different claims to the meaning of equality. The choice of model has importance for people with disabilities, particularly in light of the ways in which disability is perceived. For example, take
the case where the social, economic, and political organization in place is assumed to be necessary for society to function, and differences are defined as intrinsic to the individual. Those defined as different, who might make a claim for greater equality with others in society, will, in those circumstances, have no grounds on which to challenge their unequal status and benefits. They will be denied on the basis of their inherent differences and the need to maintain the status quo for the good of society.

Assumptions about the meaning and content of equality can be identified in the mechanisms for distributive justice applied to disability. The premises on which distributive justice is argued may vary significantly depending on which meaning of equality is adopted. This is not a new dilemma. Political and professional tensions about distributive criteria have shaped and are shaped by the understandings and approaches to disability, including criteria concerning appropriate recipients of social assistance or support.

What will constitute equality generally and which model of equality is most likely to ensure a just distribution of goods, services, and support to individuals in achieving equality is yet to be resolved. The resolution of this debate is particularly significant for persons with disabilities because of the nature of their differences. Their differences tend to stem from those characteristics on which participation in the social structure and determination of equal status have been determined. Implicit in the notion of participation is the notion of who will not participate, and that makes up the content of difference on which entitlement to participation is limited. The traditional assumption is that, having limited abilities considered intrinsic to citizenship or exercising legal rights in the conventional social, legal, and economic environment, people with disabilities have had no basis for a claim to equality. It is often the case that they establish such a claim only to the extent they can approximate other citizens.

The implications of a priori assumptions about the genesis and relative value of human characteristics are decisive in ensuring equality. The elements understood to comprise equality are as important.

A. Equal Treatment

If equality depends on sameness (the equal treatment model) and being similarly situated (in the same circumstances), the concept of equality requires that likes be treated alike and presumes the impartial enforcement of legal and social rights. Because difference warrants unequal treatment, there is no utility in clarifying what makes people equal in particular circumstances or for particular purposes. The principle simply establishes the generally accepted rule of law that procedural fairness must be applied for law to be legitimate. Neutrality in the application of the law
and the absence of different treatment are presumed to result in equality. The differential impact of the law or the treatment has no consequence on whether equality has been achieved. Individual difference justifies limiting claims to entitlement, while still meeting the standard of equality.

The equal treatment standard of equality can be relatively easily met. If the social and scientific perception of disability rests in an individual deficit (as when it is characterized as a biomedical or functional problem), the equal treatment standard can be met even in the face of significantly different social and economic entitlements and outcomes. Failure to provide education or the same standard of education for people with disabilities has been justified on this basis. The restriction on immigration of people with intellectual disabilities to Canada has not yet been stricken down as an infringement of equality rights under an equal treatment standard of equality. Therapeutic interventions, for example, prevocational training and sheltered workshops, have met this standard of equality based on the reasoning that segregating people or failing to provide access to usually provided public programs is legitimate in the case that a person has a capacity that can be differentiated from the norm.

For example, people who cannot fill out forms may be denied the right to vote, while others who can read and write are afforded that right. The law is equally applied to all those who cannot supply the information in the administratively specified method. Therefore, the fact that it may have a differential impact on those with some disabilities is deemed insignificant, as are the extraneous causes for such lack of ability. Neither the legal exclusion of some groups of people with disabilities from the regular school system nor the means of eliciting the information, which is in a mode of communication less accessible to them than to others, are taken into account in determining which distinctions are justified and unjustified.

This standard of equality justifies many predominantly used measures of quality of life that are based upon notions of diminished capacity, competence, and exercise of social life, as determined by some objective standard. For example, legal decisions deny babies with serious physical and mental disabilities medical interventions because their predicted ‘quality-of-life’ will be limited. The standard of ‘quality of life’ in those instances is based on a particular set of definitions normally attributed by those without disabilities. It fails to recognize that the benchmarks for ‘quality’ may vary from the subjective perspective of those living with disabilities. Thus, they assume a standard that cannot be shown to be empirically objective and universal.

B. Equality of Opportunity

Much recent discourse on equality has addressed the inherent problems of such a limited notion of equality. The literature draws attention to the
substantive inequality between disadvantaged groups and advantaged
groups in society.\textsuperscript{17} Equality of opportunity addresses some of the limita-
tions of formal equality by taking into account and redressing historical
conditions of inequality. It removes the necessity for the disadvantaged
group to prove they are the same with the same skills and abilities as
others. Equality of opportunity recognizes that there may be prejudices
and barriers to participation (eg, in education or the labor market) that
have disadvantaged some groups of people unfairly. They, therefore, have
a legitimate claim to compensation—in such forms as affirmative action
and employment equity—to enable them to start in a relatively similar
position as others.

The dilemma for enabling equality for people with disabilities using
this model is that their differences are not solely the result of historic cir-
cumstances, and there is no obligation to address disadvantage inherent
to the structure of social standards. Lynn Smith, a University of British
Columbia legal scholar, argues that the equal opportunity model fits well
in cases such as race, where physical differences can be legitimately
argued to be legally irrelevant. However, she observes that:

[T]here are physical differences between the sexes in relation to child-bearing and
breast feeding which make identical treatment of the sexes unequal in some con-
texts. Running the race from the same starting line does not solve the problem of
maternity along the way. Classifications based on sex may be legally relevant.
Similarly there are differences between the able-bodied and the disabled and
between young, middle-aged, and old people which can make identical treatment
unequal. Simple equality of opportunity cannot conceivably produce equality of
results in many of these situations. Such issues do not arise as squarely with
respect to racial discrimination.\textsuperscript{18}

In most cases, people with disabilities cannot overcome natural charac-
teristics and become like the ‘norm’, even if given equality of opportunity.
This is because equality of opportunity is based on the assumption that
the objective is to provide access to the competitive, individualistic market,
not to such non-comparable goods as minimal nutrition and medical sup-
port. The basis for the claim to equality of people with disabilities can be
made only on their citizenship, their humanness or on a general egalitar-
ian value assumption—for example, that all people should be accorded
equal respect by their government because they are persons,\textsuperscript{19} not because
of their ability to compete. Their claim on resources is to enable participa-
tion, even though in some cases they will unlikely be competitive (within
the existing social and economic climate) without some degree of ongoing
support. The claim is not for support to redress past discrimination or to
overcome particular barriers to participation (equality of opportunity).
Instead, the claim of people with disabilities is for redistribution of state
resources and ongoing systemic support to allow them to exercise the
same rights as others. This claim is not premised on the measurable social
benefits, such as economic efficiency and effectiveness, foreseen as
achievable in exchange for additional state costs or support.

The unarticulated premises of the equality of opportunity model,
homogeneity and interchangeability, combined with a perception of
disability as an individual deficit rather than a structural or systemic
problem, limit equal outcomes. The individual is expected to integrate
within social and economic structures that are based on substantially
male nondisabled standards, making no long-term allowances for the
individual’s inherent differences.

C. Equality of Well-Being

A model of equality based on well-being as an outcome incorporates the
premise that all humans—in spite of their differences—are entitled to con-
sideration and respect as equals, and have the right to participate in the
social and economic life of society. Unlike the other models of equality, it
would take into account the conditions and means of participation that
may vary for each individual, entailing special accommodation to make
this possible. Although the outcome—equality of well-being—should
be universal, the programs or means to ensure equality should justifiably
be targeted to enable support on a temporary or long-term basis for those
least able to achieve well-being. Difference would be both acknowledged
and accommodated in ensuring the outcome. Political and legal decisions
would have to take differences in the achievement of well-being into
account in the distributive paradigm of social justice.

Well-being has a number of components including equal achievement
of self-determination, participation and inclusion in social life through
democratization, and the exercise of fundamental citizenship rights. Equality itself would be an end, not a means, to meeting other social
goals. Alternatively, equal treatment and equal opportunity in most
formulations treat equality as a means to ensure fairness in achieving
some other end. Thus, in the latter case, people of equal need and ability
should have equal opportunity to obtain desired scarce resources.
Equality of well-being recognizes that while people are not equal in
talent, social usefulness, or willingness to serve the community, they are
entitled to make choices about how to live and what constitutes the good
life for them as long as they operate within the framework of mutual
recognition of others’ self-determination. Quality of life is measured
by neither an exclusively objective nor an exclusively subjective standard.
It becomes the interpretation and the personal and collective realization
of generally accepted social values and goals.
Equality, defined as the inclusion and participation of all groups in social positions, makes clear the onus to include even those people who cannot meet the standards of economic self-sufficiency. Equality as inclusion and participation shifts the basis for distributive justice away from economic contribution as the primary factor of entitlement to other forms of participation. The reproduction of material and ideological conditions that benefit only one segment of the population is no longer the primary rationale of social institutions, law, and policy. Rather, their rationale is to support the outcome of equality of well-being for all citizens.

V. THE INTERSECTION OF THESE TWO TRENDS

The intersection of these two major trends—the shifting formulations of the meaning of disability and the philosophical and practical formulations of the concept of equality—provide a schemata for deriving new structures and policies, programs and treatment modalities. The interaction of these two trends also provides a means for explaining the incongruous decisions in case law and policy involving disability as well as the discrepancies in international instruments affecting the rights of persons with disabilities. As with any schemata, this one has a certain degree of subjectivity. It is presented as a way of making some order out of the various claims formulated about disability and uncovers the arbitrary nature of the subject matter itself.

In practice, the diverse ways of perceiving, diagnosing, and treating disability combined with the differing models of equality lead to identifiable legal, clinical, and service treatment modalities and differing standards and measures of quality of life and entitlements to human rights. There is evidence of each of these models in existing national policies and programs and in international standards. They reflect the adoption of one or another of the approaches to disability and a preference for one model of equality over another. Some distinguishable typologies of disability emerge from the concepts explored. They include policy and legal entitlements based on the status of civil disability, the status of compensatory privilege; and entitlement based on well-being. Although these models provide a general guideline to begin exploring services, laws, and ethical standards in place, the mosaic is more complicated because of combinations and variations. There are no hard and fast lines between the typologies, and their overlap can be seen in Figure 11.2.

This schema suggests a progression from a view of disability as a biological condition or a functional anomaly that would justify a standard of equality that differentiates people on the basis of their objective deviation from the norm (the civil disability model), leading to a dissimilar social
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Figure 11.2. Impact of these two major trends

Responsibility, legal treatment, and ethical standards. The schema moves to a characterization of disability as a functional differentiation from the norm that may emanate from a biological condition, or the interaction of biological with existing environmental conditions. This is coupled with a model of equality that poses recognition of difference as a basis for entitlement to the extent that the difference is shown to be based on unjustifiable discrimination. This approach still maintains the essence of the existing meritocracy. The third typology consolidates a characterization of disability as a result of social and political conditions with a substantive notion of equality that presumes the participation and inclusion of all groups in the social and economic standard of living to which States entitle their citizens and a consequent redistribution of resources. Difference, in this typology, becomes the source of entitlement rather than disentitlement.

Each of the three identified typologies has a distinguishable standard of social responsibility, an inherent ethical foundation, and a justification of individual rights and opportunities.

A. Civil Disability

A social responsibility to protect individuals with disabilities, both legally and socially, flows from the presumption that disability is the consequence of an individual's largely unchanging pathology coupled with equality premised on equal treatment. Similar to the status of children and people who are sick, people with disabilities are given a distinct status: a status traditionally entitling them to protections by the State (both negative and
positive) to which others, who do not have that status, are not entitled. The State is responsible to protect such individuals from the ill-effects and limitations of disability and to provide at least minimal assistance. The protection may include both entitlements to minimal material goods such as welfare and to the limitations of rights normally accorded citizens.

State protection is based on a positivist social premise, premised on some clearly identifiable and distinguishable characteristics inherent to the individual on whom a distinction can be made and legitimated as a basis for differentiation. For instance, the World Health Organization has defined this as an impairment. The objectivity of the classification, grounded in scientific identification of disability as inherent to the individual, enables law and policy to be designed to exclude or treat differently those designated and still meets the test of equality (based on the equal treatment model). The implicit assumption is that there is something both abnormal and negative (ie, deviant) about those identified characteristics, warranting both the protection of the individual from society and the protection of society from the individual with such characteristics.

The negative value placed on such characteristics has led to a widespread, arguably universal, presumption that preventing such characteristics is a social good. As a result, significant scientific and social activity is directed to the elimination, cure, or amelioration of the characteristics, including such diverse practices as social segregation, genetic research,
genetic screening, facial surgery for Down syndrome, and involuntary sterilization of those identified with intellectual disabilities.

The ideal of impartiality on which the normative difference is premised justifies a legal and social status that both entitles and disentitles individuals, giving over to the State, or the provider of entitlements, decision-making authority in a complicated interaction. Authority is given over to those who claim the scientific knowledge to determine capacity and competence. This differentiation includes the power to suspend citizenship rights and to formalize the dependent relationship of the individual to the State through legislation that provides unequal social and economic entitlements. It legitimizes the imposition of care, treatment, service, and legal status that is not imposed on others without the disability. The individual deficit provides the basis for the differential and unequal treatment. This translates in practice to paternalistic decision making, policies, programs, and services including, for example, institutional living, segregated education, sheltered workshops, services based on professional classification schemes, and rehabilitative protocols. Basic social rights are, then, traded for the charity that is provided by the State and others. The person with a disability is forced to surrender private judgment in return for such concrete benefits as medical care, housing, welfare, and therapeutic services. This has been the basis for statuses, such as unemployability and ineducability, that limit usual responsibilities both of the State and of the individual. For example, if an individual is determined to be uneducable, he or she has no responsibility to attend school. On the other hand, there is no requirement on the State to ensure that schools can accommodate such a student or to put in place alternative learning models.

The state of disability has also been used to limit access to medical procedures including such procedures as organ transplants and life-saving surgeries for newborns. It has also led to widespread counseling for selective abortion and euthanasia. These procedures tie into predictive notions of quality of life that use indicators held to be objective and which do not incorporate the subjective knowledge of the disabiling condition. The cultural authority of the medical decision maker or genetic counselor is premised on a notion of disability as an individual’s undesirable pathology, thereby legitimating a different standard of medical and ethical care. The treatment may have two elements: (1) to suspend the usual rights and responsibilities of the individual and (2) to give the authority to the professional to deviate from the usual norms, both legal and social, and substitute his or her authority.

There are also legal consequences. Legal distinctions are drawn based on determinations made within a framework of so-called objective, value-neutral, positivist scientific criteria. Disability has provided a social, legal,
and ethical justification for curtailing legal status through legislation establishing, for example, legal incompetence and prohibitions on marriage, immigration, and democratic rights such as voting. Legal declarations of incompetence relieve the requirement for individual consent and justify substituted legal consents, either by the State or by a guardian.

Restrictions on the exercise of human rights, lifestyle choices and self-determination are legitimated both because of the portrayal of disability as a characteristic particular to the individual and because the individual is then differentiated from others in ways that are portrayed as material to access to rights and social goods.

B. Compensatory Privilege

There is a long history of providing care and treatment to people with disabilities as a charitable act. The compensatory privilege that can be claimed, using this standard, is based on benevolence and compassion and on forms of paternalism. The social responsibility arises from the acknowledgement that while there is a functional incapacity inherent to the individual, the physical and social environment may exacerbate it. Therefore, equal opportunity should be provided to the extent that the disability is a consequence of external factors. It is recognized that if it can be shown that the way in which services have been delivered and the environment structured has resulted in discrimination, independent of the disability, the individual, and even the class of individuals, may be entitled to redress of those historical injustices. The argument, in such a circumstance, is that the historical injustices are socially caused. It is not binding on the State to provide the same outcome as other citizens, however, because difference can be attributed to the individual.

To the extent that an individual is able and can show abilities to exercise rights in the manner of other citizens and function in society as others, he or she is entitled to equitable treatment and rights. Where the cause of the individual functional incapacity can be attributed to social, economic, and physical barriers, there is a social responsibility to provide the additional resources to enable individuals to exercise their rights.

Using this standard, people with disabilities may trade rights for charity. Generally, third parties and professional gatekeepers make decisions with respect to the extent of disability attributable to individual incapacity and the extent attributable to environmental barriers. In other words, reflected in clinical, social service, and legal practice is control exercised through medical decision making and expert judgment. Statutory human rights commissions are commonly charged with the authority to make decisions about what is ‘reasonable accommodation’ and what is ‘undue hardship’ and thus, what discrimination is justified.
The means of dealing with identified dependency is to provide an opportunity for the individual to overcome the dependency through affirmative action and to demonstrate the capacity for equal participation in school, labor markets, and other social arrangements. Otherwise, society provides compassionate care under the direction of the experts in the field. Social responsibility and political obligation towards people with disabilities derives from the notion of ‘desert’ based on a presumption of intrinsic dependency and an assumption that others will have the knowledge to determine what constitutes the person’s ‘best interests’. This has resulted in policies based on professional paternalism, that is, the quid pro quo for benefits (or enhanced benefits) in exchange for possible future reduction of social costs. Social segregation and limiting entitlements to social benefits and rights is justified where social dependency has little or no probability of being ameliorated.

Rights and benefits providing income and employment for people with disabilities are meted out according to individual potential for self-reliance. A marked preference and concern for those seen to have the greatest potential for independent functioning is inherent to goals of prevention and amelioration. However, for the residue, the ‘worthy poor’ who need some form of permanent care and financial support, benefits are provided as a humanitarian gesture rather than as an entitlement based on enabling them to achieve the benefits of society available to
those without disabilities. Quality of life in this context involves situational-specific conditions measured by external and professionally designed criteria.

Two of the key international human rights instruments designed to provide rights to people with disabilities reflect a compensatory privilege standard of entitlement. In the UN Declaration on the Rights of Mentally Retarded Persons of 1971, the rights delineated are programmatic benefits such as, for example, habilitation, medical care, physical therapy, rather than the types of universal outcome rights, which are recognized in the UN Universal Declaration on Human Rights of 1948. In the 1948 Declaration, rights such as the following are recognized: ‘recognition everywhere as a person’, ‘freedom of movement’, and ‘a standard of living adequate for health and well-being’. Similarly, programmatic rights are delineated in the UN Declaration on the Rights of Disabled Persons 1975. In both disability declarations a clause limits the state responsibility to integration within the ability of the State (in terms of capacity and resources) to meet the obligations under the declarations. Further, there are clauses which qualify and limit the responsibility of the State to integrate the individual to the capacity of the individual to exercise the delineated rights (ie, ‘The mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings’; and ‘Whenever mentally retarded persons are unable, because of the severity of their handicap, to exercise all these rights...’). The implications of these clauses which qualify the extent to which the State is obliged to guarantee rights (for reasons of the State’s incapacity or of the individual’s incapacity) are enormous, because they limit the claims that can justifiably be made relating to the allocation of resources. It is therefore possible to justify the protection of the rights of some people but not of those with disabilities and meet the standard set in the very instruments designed to protect their specific rights.

The legitimate limiting of the rights of people with disabilities within the context of compensatory privilege is reflected in these and other international instruments and in national policies. Programmatic benefits, rather than rights, are laid out, but even those are restricted, dependent on the extent to which the individual deficit can substantiate the abridgement of those entitlements. Equality of opportunity is thus circumscribed by the extent to which an individual will be able to exercise the opportunity.

C. Well-Being

An emerging standard is treatment, care, and the allocation of resources based on entitlement to citizenship rights and equal outcome for people with disabilities (equality of well-being). Society’s responsibility is to provide political and social entitlements that are equal in outcome to those of
other citizens and is built on the acknowledgement that disability is a consequence of social, economic, and political organization, not individual pathology. It takes into account the historical disadvantages that people with disabilities have faced, the current structure of society, which maintains systemic discrimination, and the reformulation of non-disability specific policy, programs, and services. The disability itself is less the focus of attention, rather it is evidence of lack of entitlement or the limitation of the exercise of fundamental human rights and freedoms. The quality of the act rather than the quality of the actor is the core of the standard and it is the nature of the activity itself, including policies, social programs, and services, that comes under scrutiny.

This standard—ensuring human rights, citizenship, and equality of well-being—does not assume that everyone starts in the same position or that the removal of formal barriers, both systemic and individual, will leave everyone in the same position. Rather, it argues that formal barriers have placed groups in substantively different social positions, i.e., that differences are sources of social disadvantage. Consequently, removing the barriers without also redressing associated disadvantages does not result in significant change.

This standard recognizes the limitations of the traditional legal justifications for excluding people legally, socially, and economically. It also addresses the limitations of the law in ensuring equality by taking into account the fallacy of the assumption that existing distributions of power and wealth are a product of individual initiative rather than state action. Entitlement is based on a comprehensive notion of human rights and citizenship not on an individual's status as a member of a class of deserving poor or on inequality in talent or social usefulness. Resource redistribution necessary to ensure equality of well-being requires both the redistribution necessary to enable equal opportunity as well as the redistribution necessary to take into account unequal needs because of physical and mental differences. In other words, differences must be accommodated in order to neutralize them as barriers to entitlement and participation.

This could mean, as it did in a 1997 decision of the Supreme Court in Canada, that adverse effects of policies or programs, faced by an individual, are not simply the result of an imposition of a burden not faced by nondisabled people in the population. Adverse effects result from the failure to ensure that people with disabilities benefit equally from a service offered to everyone. In that particular case, 26 three individuals, born deaf and preferring sign language as their form of communication, contended that the absence of interpreters impaired their ability to communicate with their doctors and other health care providers and thereby increased the risk of misdiagnosis and ineffective treatment. Medical care, in their province of British Columbia, is delivered primarily through two mechanisms, neither
of which pays for sign language interpretation. Sign language interpretation has traditionally been paid for as a personal service through welfare or a service delivery mechanism. Hospital services are funded by the government under the Hospital Insurance Act, which reimburses hospitals for the medically required services provided to the public. The province's Medical Services Plan provides funding for medically related services delivered by doctors and other health care practitioners. Arguing that a government is required to take special measures to ensure that members of disadvantaged groups are able to benefit equally from government services, and that discrimination can accrue from a failure to take positive steps, the court held that government must provide interpreters for deaf persons as a medically required service, to meet the constitutional equality rights set out in the Charter of Rights and Freedoms.

A question that arises with the standard of equality of well-being is how to acknowledge difference (pluralism) without resulting in inequitable or unfair practices, while at the same time ensuring the benefits of integration (assimilation) into the economic and social structure. Assimilation has to be achieved without overlooking the unique needs and differences faced by disadvantaged individuals and groups that must be addressed to realize those benefits, including the expression of self-determination, inclusion in social life through democratization and the exercise of fundamental citizenship rights. At issue is the conventional framing of equality and difference as mutually exclusive terms, a framing that misrepresents their relationship. Placing equality and difference in an antithetical relationship denies the way difference has figured in political notions of equality, presuming in the case of disability that the pathology is traceable to the individual.

Equality, within a political theory of rights, depends on the recognition of a group of people as different. The issue, therefore, is to find a notion of equality predicated not on sameness but on difference. Albie Sachs, the South African jurist, argued against the usual presumption that the right to be the same and the right to be different are competing rights: On the contrary, the right to be the same in terms of fundamental civil, political, legal, and social rights, provided the foundation for the expression of difference through choice in the sphere of culture, lifestyle, and personal priorities. In other words, provided that difference was not used to maintain inequality, subordination, injustice, and marginalization, it represents a positive value in human society.

Internationally, the importance of different treatment as a means to achieving equality is being recognized. The UN Human Rights Committee issued a General Comment in 1989, stating that 'The enjoyment of rights and freedoms on an equal footing, however, does not mean identical treatment in every instance.'
GOAL: Equal outcome in expression of self-determination, inclusion in social life (through democratization), and exercise of fundamental citizenship rights

MEASURES: Extent to which equality of access to social, economic, and legal opportunities/variables is achieved

RIGHTS GUARANTEE: Guarantee of social, economic, democratic, political, and legal rights accorded to others in nation state (and in international agreements)

EXAMPLES IN CLINICAL AND SERVICE TREATMENT AND GOVERNMENT POLICY:
- Equitable access to social and economic opportunities
- Opportunity for inclusion in non-segregated activities
- Human rights legislation with anti-discrimination prohibition based on mental and physical disability
- Physical and program adaptations to generic facilities, institutions, services
- Individual control of service program, financing, and staff
- Income programs based on need and individualized funding

Figure 11.5. Equality of well-being standard (standard which protects equality of outcome and rights based on difference; defines disability as a political condition)

Some examples, specific to disability, should prove helpful. In Canada, under the Canadian Charter of Rights and Freedoms, individuals are protected both before and under the law and are entitled to the equal protection and equal benefit of the law. A 1989 decision by the Supreme Court of Canada has suggested how extensively this is to be interpreted. Although the legal decision did not concern an individual with a disability, it has a significant impact because of the interpretation provided of what equality means under the Charter. The Supreme Court extended the concept of equality to recognize that 'every difference in treatment between individuals under the law will not necessarily result in inequality and, further, that identical treatment may frequently reproduce serious inequality'. As the Court held, 'In fact, the interests of true equality may well require differentiation in treatment.' If equality implies an even distribution of and access to justice, then the accommodation of differences is a substantial part of the essence of equality. The Court also held in that case that 'distinctions based on personal characteristics attributed to an individual solely on the basis of association with a group will rarely escape the charge of discrimination, while those based on an individual's merits and capacities will rarely be so classed'.

A Canadian education decision applied this legal standard of equality to a case involving education in the local school for a student with an
intellectual disability. The court held that education in a special school or class is not a question of pedagogical theories but is ‘one of determining the legal framework within which that choice is made’. Acknowledging the obvious difference in ability of Emily Eaton and other children of her age, and the obvious application of the best interest principle for Emily, the judge maintained that the issue in question was not the right to education but the right to equality. She held that the Charter ‘requires that, regardless of its perceived pedagogical merit, a non-consensual exclusionary placement be recognized as discriminatory and not be resorted to unless alternatives are proven inadequate’. She went further to place education in its social context: ‘When a measure is offered to a disabled person, allegedly in order to provide that person with her true equality entitlement, and that measure is one of exclusion, segregation, and isolation from the mainstream, that measure, in its broad social and historical context, is properly labeled a burden or a disadvantage.’ She concluded: ‘There may be ongoing pedagogical debate as to what is best for Emily’s education. There can be no doubt, however, that as a person with disabilities, it is not against her best interest to assert her equality right.’

This case was subsequently overturned by the Supreme Court of Canada in a decision that turned on whether Emily Eaton experienced a burden or disadvantage from the denial of access to inclusive education. Arguing that since she was not denied equality under Section 15 of the Charter, there was no need to get to a discrimination inquiry. The Court, by arguing that: ‘Integration can be either a benefit or a burden depending on whether the individual can profit from the advantages that integration provides’, changed the equality issue into one of pedagogy and then argued that since it was in the best interests of Emily to attend a segregated school, it could not be discriminatory. Using the best interests argument had been explicitly rejected by Madame Justice Arbour at the Appeals Court level where she argued that to apply such a test obscures the right to equal benefit and protection of the law.

This case shows how amorphous the line is between the various legal notions of equality and disability as a category. While the decision at the Ontario Appeal Court was clearly argued from the perspective of equality as equal outcome and a formulation of disability as constructed from systemic conditions that lead to the disentitlement to rights, the Supreme Court went back to a standard of ‘best interests’, one that even precluded the family as an authority on deciding best interests and reflected a civil disability standard. Further it privatized the notion of disability and medicalized the educational needs of children with disabilities. There remain, however, in the decision some important conclusions about disability equality. The Court recognized that Section 15’s equality guarantee has
two aims: first, to eliminate discrimination that attributes untrue characteristics to a person based on stereotyping attitudes about a person’s immutable characteristics and second, to establish that equality requires structural and societal changes. The Court ruled that ‘exclusion from the mainstream of society results from the construction of a society based solely on ‘mainstream’ attributes to which the disabled person will never be able to gain access’. Equality requires changes be made so that society’s ‘structures and assumptions do not result in the relegation and banishment of disabled persons from participation’. Analysts have predicted that the Court’s holding that integration is a starting point for the placement of children with a disability, requiring school boards to justify exclusion and that there is a prerequisite for a child and his or her parents to have a meaningful role in decisions about the child’s placement suggest that the equality provisions will likely be upheld in future cases, even in the face of this case. And the emphasis of the Court on the importance of removing barriers facing people with disabilities to ensure full participation in society suggests that the direction of future courts, and particularly in circumstances that do not include the complication of involving a child, will likely tend towards an equality of well-being standard of law.

VI. CONCLUSION

Monitoring the exercise of human rights of people with disabilities according to a standard of well-being involves the unmasking of the structural and systemic context of people with disabilities. This is because it is a standard that recognizes disability as a consequence of social organization and the relationship of the individual to society, coupled with an understanding of equality as equality of outcome. To monitor human rights by this standard, the following would be open to analysis: the equitable access to social and economic opportunities that are available to citizens in general and the structural conditions that facilitate or inhibit access to those opportunities (including legal, financial, and service opportunities). Well-being is measured according to the equality of access and the exercise of human rights and citizenship. Such a standard questions the legally and socially constructed barriers individuals face in access to those outcomes.

In recognizing the social and scientific formulations on which treatment and care of people with disabilities has been constructed and the way in which this interacts with theories of equality to determine entitlement to citizenship rights, the basis for fair, non-discriminatory social policy becomes clearer and more transparent. Understanding the rationale for a social policy of exclusion raises questions of the most appropriate
method of addressing rights. Does society continue to confine the rights analysis to individualistic needs of those with disabilities? Or does society begin to recognize the inequalities inherent in the institutional structures and put the onus on the State and on international bodies to begin to develop provisions based on principles that include the rights of all people to participate freely and adjust achievement measures?

The human rights of people with disabilities leads to examining the various categories of human rights, recognizing the interdependence of civil and political rights and economic, social, and cultural rights. One of the major innovations of the Convention on the Rights of the Child is that its provisions are the first in a treaty to integrate fully the two broad classifications of rights: civil and political, and economic, social, and cultural. As Toope concluded: The world community spent almost twenty years attempting to codify in the form of one binding treaty the provisions of the Universal Declaration of Human Rights. It never succeeded, largely because of the failure to agree on the interrelationship between civil and political rights and economic, social and cultural rights. It became necessary to conclude two separate treaties. The drafters of the Children’s Convention were able to agree upon a text that treats the broad classifications of rights as interdependent and morally equivalent. This equivalency will open up arguments that both categories of rights are equally binding. Before the Children’s Convention, it was possible to argue that whereas civil and political rights were binding here and now, economic, social, and political rights were mere statements of aspiration, requiring only the efforts of States to promote ‘progressive implementation’ of the rights where circumstances permitted. States could divorce the two types of rights because they were physically divorced in the key international conventions. Significantly, the Children’s treaty contains specific provisions for children with disabilities.

The equivalency of the two sets of rights is important in the field of disability. The assumption, made by many governments, particularly Western governments, that the achievement of civil and political rights will ultimately lead to a democratic polity ensuring that people will be treated equitably in relation to their economic, social, and cultural rights, has not proved to be true for people with disabilities. Political and civil rights of people with disabilities have not guaranteed that their needs are met. This is a result of the construction of legal and social inequality and exclusion using standards of civil disability and of compensatory privilege. Social and economic rights are, not infrequently, seen as optional and dependent on the economy of the state government. That the roots of discrimination against people with disabilities are grounded in expenditures that excluded them from social participation, and consequently from the exercise of their rights, is not considered. The argument is made
that if disability is an individual pathology and equality implies equal treatment or equality of opportunity, then denial of rights can be justified.

These arguments and others suggest the importance of reviewing international agreements, particularly those related to disability, to ensure that they do not have inherent biases that legitimize segregation and the denial of rights of people with disabilities. If we wish to work towards societies that are distinguished by a culture of justice, recognition of difference and the public ownership of private disadvantage, scholars and citizens have to find a framework that takes into account and struggles to include all people, including those who do not fit conventional norms. This deconstruction of inequality will have to be addressed by concerted, coherent action.

The recognition of rights as greater than simply the individualistic indicators inherent in the deficit model of disability and in equal treatment frameworks of equality, places accountability on social, political, and economic structures. They have to be organized in a manner that enables individuals to participate in decision making. They have to permit the development of a human rights model and indicators of compliance that incorporate both structural and individual properties.

Patterns of injustice throughout the world have prevented people with disabilities from participating in the same way as those without disabilities. Science, medicine, economics, and government policy—in both the national and international sphere—have rationalized and justified selective participation, entitlement, and rights. In every nation of the world a system of social discrimination disenfranchises and restricts the opportunities of people with disabilities to participate equally in society. Despite the facts we now know about the many abilities of people with disabilities, people with disabilities continue to experience the general injustice of disregard, disrespect, isolation, and discrimination. The injustice of having a double standard—one standard for those without disabilities and one for those with disabilities—in allocating resources and in developing criteria for participation in society—has to be addressed. By redressing the denial of human rights, fundamental freedoms and the restriction of participation in society, governments must deliver on their promise to their citizens, both those with and without disabilities.

NOTES


3. This section has been adapted from an earlier published article, MH Rioux, ‘Disability: The Place of Judgement in a World of Fact’ (April 1997) 41 Journal of Intellectual Disability Research 102–111.


11. Parts of this section have been adapted from an earlier published article, MH Rioux, ‘Towards a Concept of Equality of Well-Being: Overcoming the


16. Re S.D. 3 WWR 597 (BC Provincial Court, 1983); 3 WWR 618 (BC Supreme Court, 1983).


20. Roeher Institute, Social Well-being: A Paradigm for Reform (Toronto: Roeher Institute, 1993).


On Second Thought

27. Hospital Insurance Act of British Columbia.
34. ibid.
35. ibid.
37. ibid.
38. ibid 59.
40. ibid 274.
42. ibid 406.
44. UN Convention 1991.
47. UN, UN Convention on the Rights of the Child, art 23.