

Disability Policy in Canada

An Overview

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Over the last century there has been a shift from conceptualizing disability as a challenge to law and order, to viewing disability as a medical and/or economic deficit and then as a sociopolitical issue. In Canada, these changing conceptualizations of disability have been reflected in the development of disability policies, which form part of general Canadian social policies. Each model of disability captures a particular aspect of disability and focuses on particular goals, and each depicts a different account of what society owes people with disabilities. However, the lack of linkages between the models and their conceptual bases means that no one model can be used to guide disability policy development. Decision making about the goals of disability policy and the rights of people with disabilities requires the development of a normative foundation.

Ideas about health and disability have changed a great deal over the last century. In the early part of the 20th century, the behavior of people with mental illnesses and intellectual impairments primarily was seen as a threat to law and order, and such individuals were institutionalized to protect themselves and society. Between the 1920s and 1970s, individual medical and vocational limitations were viewed as the main obstacles to full participation in society by individuals with disabilities. The focus was on providing treatment and support services to these individuals, and on improving their ability to perform job roles. Those unable to work received some financial compensation.

In the 1970s a sociopolitical definition challenged the individualistic conceptualization of disability by stating that disability stems not from individual limitations but from the failure of the social environment to adjust to the needs of people with different abilities (Hahn, 1985). Emphasis was placed on enhancing the participation of people with disabilities in their communities, by, for example, increasing access to buildings, transportation, and employment.

According to Townsend (1979), “The way in which an issue is viewed contains an implicit prescription for policy” (p. 25). The present article examines how changing views of disability have been reflected in the development of disability policies in Canada. Disability policies form part of general social policies in this country and so need to be considered in relation to the broader paradigms of national social policy development. The various models of disability emphasize different goals and use different normative bases to identify what society owes those

with disabilities. This article examines the implications of these differences for current and future disability policy development.

Social Policy Context

Two nations emerged from the American Revolution: The United States is the country of the revolution, and Canada is the country of the counterrevolution. The leaders of the Canadian confederation were monarchists who supported the development of a strong state. Canada’s colonial links to Britain and Europe helped foster beliefs about the importance of collectivism, respect for authority, and acceptance of the need for state intervention. These values are reflected in the country’s policies and social structures (Lipset, 1989). Disability policy development was part of the evolution of collectivist social policies.

During the 19th and early 20th centuries, the general responsibility of the government regarding health services for the population had not been established—it fell to physicians to advise people regarding health matters. After the Depression and the Second World War, it began to be acknowledged that economic hardship and personal crises could defeat people. Efforts were made to introduce a welfare state. Between 1950 and 1970 there was much support for the development of collectivist, financial redistributive welfare legislation. In the 1960s the Canadian government enacted a number of welfare-state policies based on three principles: equality of condition

(a social minimum), equality of opportunity (education), and equality of consideration (human rights). By 1970 all provinces were receiving grant aid from the federal government to develop health-care, education, and social welfare programs. There was general support for universal, equitable, publicly administered programs in health and postsecondary education.

The Hospital Insurance and Diagnostic Services Act of 1957 and the Medical Care Act of 1967 provided universal access to hospital services and physician care, respectively. The Unemployment Insurance Act of 1940 was the first federal welfare-state program introduced in Canada. Under this act, unemployment insurance was to be funded by premiums paid by employers and employees, backed by the Consolidated Revenue Fund.

In 1965 the federal government introduced the Canada/Quebec Pension Plan (RSC, 1965a, C-8), a contributory pension scheme that provided a national system of social insurance to the paid labor force—specifically, for people in retirement, widows and widowers, orphans, persons with disabilities, and children of disabled contributors. The objectives of the federal Canada Assistance Plan of 1966 were the creation of a consistent national welfare apparatus and the extension of assistance to anyone who might need it, with need being the only criterion (Hum & Simpson, 1993). The aforementioned programs related to income and health services were helpful to people with disabilities because those individuals were liable to make more use of these programs than was the general public.

In 1977, the federal government introduced the Federal-Provincial Fiscal Arrangements and Established Programs Financing Regulations, to control costs associated with open-ended, federal-provincial matching grants. By this time, there was ambivalence about general income support for those in need (Guest, 1980). While the federal government continued to develop universal health and postsecondary education programs over the next 7 years, no further developments occurred in income security programs (Crichton & Jongbloed, 1998).

Canada's welfare state was a bourgeois welfare state: an outcome of the middle classes' accepting the importance of distributing the country's wealth more evenly. Programs were established not only to meet the needs of poor people but also to ensure that all Canadians had access to education and health-care services through redistribution of resources. Welfare states can be classified according to their emphasis on capitalist development versus provision of social entitlements to their citizens. Graycar and Jamrozik (1989) identified three divisions in welfare states' programming: expenditures in favor of low-income groups (e.g., unemployment benefits, old age pensions); universal provisions (e.g., public education, public health care, public transportation); and expenditures in favor of high-income groups (e.g., assistance to industry, concessions to business, tax-free dividends). As a market-oriented welfare state, Canada is not very sympathetic to people with income security problems (National Council on Welfare, 1989). However, between 1945 and 1975 there was greater concern with providing income support services, which favor low-income

groups, than there is now. Since 1975, concern with income support has been diminishing, and this affects people with disabilities because a high percentage of these individuals depend on expenditures that favor low-income groups (e.g., income support, public housing; Torjman, 1988). There has been ongoing emphasis on funding universal services used by the majority of the population (e.g., health care, education) and an increased interest in assisting producers of goods and services that favor high-income groups. While redistribution to high-income groups is seldom questioned, there is a belief that budget deficits result from spending on welfare programs for low-cost sectors. In reality, these deficits stem primarily from large expenditures on entitlement programs (Crichton & Jongbloed, 1998).

By 1980, Canada, along with other countries, had begun questioning whether the welfare state was the best form of social organization (Pleiger, 1990). Goals began to shift from those of a welfare state to those of a welfare society. The welfare-society paradigm proposed that financial redistribution alone would not create a true collectivist society and that all citizens had the right to be accepted for what they could contribute. Furthermore, it did not stigmatize those who were unable to work. The concern about financial redistribution thus broadened to include the social needs of the disadvantaged. It was recognized that changes in attitude toward people facing discrimination were as important as financial redistribution. The aims of the welfare society were reflected in the Charter of Rights and Freedoms (1982), which identified four groups as particularly disadvantaged: women, native people, visible minorities (i.e., groups who are visibly non-Caucasian), and people with disabilities.

An Historical Review of Disability Policy Development

The questions of what it means to have a disability and what society owes people with disabilities have been answered in different ways at different times. Accordingly, policies developed at particular points in time emphasize different dimensions of disability as well as different goals. Disability policy is the outcome of complex social negotiations that pertain to changing definitions of *impairment*, *disability*, and *handicap* and notions about the rights and responsibilities of individuals and groups (Fox & Willis, 1989). An early paradigm held that people with disabilities were dangerous and disruptive and that society should be protected from them; the resultant policies focused on confinement and control (Rioux, 1993). Disability policies in Canada began with a law-and-order approach.

Law-and-Order Approach

In the early to middle 1800s, people with mental illness typically were either put in jail or cared for at home. At first, the criminal population was not separated from those with mental ill-

ness (Allodi & Kedward, 1977), but gradually this was sorted out. Simmons (1982) and Bates (1977) documented the history of policies related to people with intellectual impairments, in Ontario and the four western provinces, respectively. The idea that a person with an intellectual impairment needed protection was the main justification of the asylum model of care from 1860 to 1890. By the end of the 19th century there was pressure to build more institutions because these provided places in which to confine people with mental illnesses and intellectual impairments.

Large provincial institutions served the function of asylums, housing senile older persons, those with intellectual impairments, mental illness, or syphilis. The institutions also provided a social support system by keeping children, adolescents, and adults (such as unemployed young women and unmarried pregnant women) in their care. As well, the institutions served a social control function; some residents had run into trouble with the law, others were unmarried mothers who had violated the moral standards of the time. They were cared for at public expense but had to sacrifice individual freedom. In general, people with physical disabilities were not institutionalized. They were not viewed as disruptive and hence did not require social control. Also, the majority of children with physical disabilities did not survive into adulthood. It was not until the mid-20th century that institutional care was provided for people with tuberculosis, survivors of polio epidemics, victims of road accidents, and old people who needed support.

Medical and Economic Models

Hospitals and disability pensions for war veterans were established during World War I. Rehabilitation programs were aimed at those who, with treatment and training, could return to the labor market (Pensions Commission, 1990). At about the same time, training assistance was developed to meet the needs of injured workers. Provincial workers' compensation schemes, introduced between 1914 and 1950, were social insurance systems wherein coverage was usually compulsory (Ison, 1989). A personal deficit was presumed to be the reason for the individual's unemployment, and rehabilitation aimed to return the individual to work as soon as possible. Adoption of veterans' benefits and workers' compensation programs reflected an assumption that those whose disabilities resulted from serving the economic or military interests of the nation deserved government assistance more than those whose disabilities had arisen in other ways (Hahn, 1985).

Welfare-state policies introduced in the 1960s included the Vocational Rehabilitation of Disabled Persons Act (1961), which was aimed at returning people with disabilities without other resources to the workplace. It enabled the provinces to recover 50% of vocational training costs related to individuals with disabilities. The Canada Pension Plan (1965) resulted from a federal-provincial agreement to provide a national system of social insurance, which took the form of either a retirement pension, for those in paid employment, or a disability pension.

The Canada Assistance Plan expanded the scope of federal involvement in social policy. It encouraged integration of assistance programs across provinces and extended cost sharing to a wide range of social services, including programs for people with disabilities. It also resulted in the standardization of social assistance plans across the provinces. The medical and economic models of disability co-existed between 1910 and 1970 and shaped the formation of disability policies during those years. The medical model is rooted in an emphasis on clinical diagnoses. It conceptualizes disability as the attribute of a person who is functionally limited and biologically inferior (Hahn, 1985) and represents the individual as a patient with special medical needs who deserves a charitable response in the form of provision of health services. Diagnostic categories are linked to programs aimed at improving functional capacity, and medical professionals become the gatekeepers to benefits. However, the medical model underestimates the social aspect of disability (Bickenbach, 1993).

Helping people become economically independent is consistent with the North American ideology of individualism. The economic model of disability is predicated on an individual's inability to participate in the paid labor force (Bickenbach, 1993). It assumes that an individual's ability to work is determined primarily by his or her functional capacities, and there is little focus on altering job expectations to accommodate the individual (Hahn, 1993). People with disabilities are seen either as past contributors to the economic system and thus deserving of assistance or as outside the economic system and so meriting only charity. There is, however, ambivalence about the extent to which people who never worked should receive public benefits (Stone, 1984). The main concern of the economic model is to distribute and reduce the costs associated with limited productivity. In this model, disability is not located solely in the individual; it is a function of the individual within a social context (Bickenbach, 1993).

The objectives of responding to legitimate medical needs and increasing employability among people with disabilities have influenced the development of social assistance and workers' compensation schemes. Social assistance legislation reflects a response to medical and economic needs by providing minimal financial support to those unable to work. Although the primary rationale of workers' compensation is economic efficiency, the medical model also influences workers' compensation policies in that earning capacity is usually estimated in terms of the nature and degree of the injury, and employability is therefore assessed as a medical, not an economic, phenomenon (Stone, 1984).

Sociopolitical Model

In the 1970s organizations concerned with human rights began forming across the country. The first patients' rights groups, formed by ex-psychiatric patients in New York and Vancouver in 1970, focused on challenging existing laws. Parents began to pressure governments to deinstitutionalize individuals with

intellectual disabilities (Simmons, 1982). The Coalition of Provincial Organizations of the Handicapped (COPOH), which was formed in 1977, was the first politically active national coalition of organizations that represented consumers with disabilities. It monitored federal and provincial legislation and emphasized that persons with disabilities should direct and supervise services provided to them. This cross-disability coalition, now known as the Council of Canadians with Disabilities (CCD), carries much clout at all levels of government. Groups representing people with disabilities argued that improvement in the status of persons with disabilities required alteration in the external environment rather than changes in individual functioning (Dreidger, 1990). These demands were made in the context of other societal changes, namely (a) a shift in goals from those of a welfare state to those of a welfare society, (b) the International Year of Disabled Persons in 1981, and (c) the introduction of the Charter of Rights and Freedoms in 1982. The Charter designated individuals with disabilities as one of four disadvantaged groups. This timing enhanced the responsiveness of the federal government to the demands of disability rights advocates.

The politicization of disability during the 1970s and 1980s resulted in the creation of the sociopolitical model of disability, which held that disability resulted from a failure in the social environment, rather than from individual functional limitations. It challenged the individual focus of the medical and economic definitions and emphasized modification of the social environment (Hahn, 1993). Activists emphasized the goals of respect and equality and aimed to destigmatize particular groups through empowerment rather than legal remedies. Such counter-hegemonic politics attack a dominant social framework and as such are more revolutionary than political protests about laws or policies (Bickenbach, 1993)

Obstacles, a report by the Special Parliamentary Committee on the Disabled, identified three interlocking goals of people with disabilities: They wished to be treated with respect, to have the right to control their fate, and to have opportunities to participate in all aspects of Canadian social life (Ministry of Supply and Services, 1981). This report called for amendments in legislation related to human rights, transportation, housing, employment, and income. Following this, a parliamentary standing committee was given the responsibility of monitoring the application of human rights and disability policies and of pressuring the federal government to implement policy changes (Ministry of Supply and Services, 1981).

General federal and provincial housing and transportation policies affect the lives of persons with disabilities, and considerable progress was made in these areas between 1983 and 1991 (Young, 1992). The federal government (Canada Mortgage and Housing Corporation, 1986) supported the construction of cooperative housing, the goal of which was to provide shelter for low- to moderate-income people. Subsidies were given to 30% to 50% of units, and 5% of those were to be made available to persons with disabilities. The Canada Mortgage and Housing Corporation's (1986) Residential Rehabilitation Assistance Pro-

gram provides grants and low-interest loans to persons with disabilities and to their families or landlords, to cover the costs of improving accessibility.

Soon after the publication of *Obstacles*, attention turned to transportation issues, not only because they were viewed as an essential part of access but also because the federal government had broad authority in this area. Gradual refinements to transportation policies under federal jurisdiction were made in 1983, 1984, 1988, and 1991 (Young, 1992). Transport Canada is committed to providing a fully accessible national transportation system, including air, rail, and ferries; it also provides financial assistance to small communities for the purchase of vans (Ministry of Transport, 1992). Provincial and municipal governments developed their transportation policies along the same lines as the federal government. They issue bus passes, fuel tax rebates, and parking placard programs. Provinces and municipalities consider design features, such as low floors, when buying new buses.

Though income and employment are important determinants of health, there has been little progress in income and employment policies for people with disabilities over the last 2 decades. Many people with disabilities live in poverty. For example, a single person with a disability in British Columbia receives \$787 per month (Poverty Fact Sheet, 2000)—\$457 below the low-income cutoff. The major causes of poverty are unemployment and underemployment. Approximately 70% of nondisabled persons ages 15 to 64 were in the workforce in 1991, compared with 40% of persons with disabilities in this age group (Fawcett, 1998). The representation of people with disabilities in the labor force can be increased by such measures as affirmative action and contract compliance. However, the response of the federal government in these areas has been weak. Affirmative action must be mandatory to be effective. The Employment Equity Act (1986) was designed to promote the implementation of programs that would help ensure that women, native people, persons with disabilities, and visible minorities could achieve equitable representation and participation in the Canadian workforce. However, it contains no mandatory enforcement procedures. Another strategy for correcting workforce imbalances is contract compliance, whereby firms with contracts with the federal government agree to implement affirmative action for people with disabilities. The federal government initiated a contract compliance program in 1986, whereby contractors with 100 or more employees and with contracts worth \$200,000 or more are required to commit themselves to specific initiatives with regard to reducing employment barriers for persons with disabilities. COPOH had asked that organizations with contracts over \$20,000 be required to comply with the program, claiming that the program in its present form has little effect on persons with disabilities (COPOH, 1986).

Currently, the income of a person with a disability who is not working depends on whether he or she became disabled at work or in a car accident, contributed to the Canada Pension Plan before the disability, or is a war veteran. Workers' Com-

pensation Boards base compensation levels on a proportion of the worker's insurable earning before the accident and the extent and duration of the injury (Rioux, Muszynski, & Crawford, 1992). An individual seriously injured in a motor vehicle accident in British Columbia would be given generous income support, physical rehabilitation, physical maintenance, home renovations, an adapted transport van, and vocational rehabilitation. However, many people with disabilities are not eligible for such benefits and consequently receive provincial social assistance, which is a last-resort program characterized by low-income payments and needs-testing. Benefits are lower than can be earned in the workforce, to provide an incentive for people to seek and retain employment; however, benefits are so low that many recipients live in poverty. The current disability system does not acknowledge that all people with disabilities need adequate income support regardless of the cause of their disability. There are several barriers to the development of equitable income policies for people with disabilities. First, it is not a priority of the federal government. Second, reform in this area requires agreement among the federal, provincial, and territorial governments, and such consensus is not easily achieved. Third, the legal profession and the private insurance industry benefit financially from the current system and oppose the move to a comprehensive scheme. Both groups have strong input into the political process, and the federal government is reluctant to antagonize them (Muszynski, 1989). Groups representing people with disabilities are less powerful and less well organized.

Implications of Lack of Change in Some Policies

Societal values (and society's ways of conceptualizing issues) shape policies; and the structures put into place at one time, which reflect the values of that time, frequently persist into a later period when ideas have changed. Thus, layers of social programs developed to suit ideas current in 1910 or 1940 coexist with those developed in the 1990s (Crichton & Jongbloed, 1998). For example, the economic paradigm emphasizes reducing costs associated with unemployment and assumes that if the individual develops skills, he or she will be able to enter the workforce. When Canada's main national social programs were introduced in the 1960s, people with major disabilities were viewed as unable to engage in competitive work. Thus, disability programs introduced at that time, such as the Canada Pension Plan, defined disability in terms of permanent unemployment. This definition persists today. To be eligible for disability income from the Canada Pension Plan—or any other long-term disability plan—the individual has to be declared unemployable by a physician. By not allowing individuals with disabilities to work part-time and receive some employment benefits, these programs deny people the satisfaction of paid employment and prevent them from becoming taxpayers and fully participating in society (Jongbloed, 1998).

The structure of some provincial social assistance programs deters recipients from returning to work because reentry into the workforce is accompanied by loss of the benefits they receive while on social assistance, such as dental care and prescription medicines. These policies reflect the view that an inability to work is an individual issue, and that people are either completely disabled or completely able-bodied. Although now we acknowledge the interaction between the individual and the environment, and that disability is relative, many disability income programs have not altered to incorporate these views (Rioux et al., 1992).

Principles Underlying Disability Policies

Canadian disability policies are fragmented, for several reasons. First, programs developed incrementally to deal with separate demands; second, disability policies are part of general welfare-state policies, which are also fragmented; and third, we have not satisfactorily addressed what it means to have a disability and what society owes people with disabilities. Disability is multidimensional; it is associated with medical and economic challenges, and with issues related to discrimination. The law-and-order, medical, economic, and sociopolitical definitions of disability focus on particular dimensions of disability and emphasize certain goals and societal responsibilities that have been reflected in medical, economic, and sociopolitical policies. However, we lack a unified, comprehensive policy toward people with disabilities. In addition, each model uses a different normative base to answer the question of what society owes persons with disabilities. Because the models and their normative bases are not conceptually linked, no one model can be used as the basis for disability policy development (Bickenbach, 1993). The medical model focuses on medical needs and suggests the normative principles of charity and accommodation. It does not raise questions of justice, nor does it emphasize the rights of people with disabilities. The economic model stresses participation in the form of economic integration and the principle of welfare maximization. The thrust of the sociopolitical model is the attainment of rights and equality, and here disability becomes part of the moral and political sphere, where issues of justice and entitlement have to be addressed.

Disability policy needs to provide an interpretation of the general goals of respect, participation, and accommodation. According to Bickenbach (1993), questions that need to be answered include the following:

- Should the goal be to foster participation in education, employment, and community life?
- Should benefits for people with disabilities be viewed as rights that can be legally enforced, or as privileges?
- Are benefits intended to produce particular results, such as increasing the employment level

among persons with disabilities, or are they a means to an unspecified end, such as a skills-upgrading program?

- Should government initiatives be measured in terms of outcomes, or should they offer flexibility? Should programs be evaluated in terms of results achieved?
- Should policies benefit everyone in society or just those with disabilities? For example, should a program improve the employment situations of people with disabilities, or improve the economic conditions of people with disabilities and of society?

Decisions regarding one of these issues may produce policies that conflict with other policies. The answers to these questions could result in various possible normative approaches—for example, a strong emphasis on individual rights, or much emphasis on social benefits. Will the main emphasis be rights or benefits?

Conclusions

Changes in disability policy over the last century have reflected shifts in views of disability and a questioning of processes and structures as new ways of conceptualizing issues have arisen. However, one policy paradigm never completely replaces another; rather, policies based on different views of disability co-exist. Persons with disabilities have achieved much over the last 80 years but continue to press for increased rights and benefits. However, these demands come at a time when federal and provincial governments are under pressure to reduce fiscal deficits and commitments to welfare-state social policies are decreasing. There is general acceptance of the idea of providing benefits but much less agreement regarding how much should be shared. What is needed is an acknowledgement of the multidimensional nature of disability and an attempt to address the normative question regarding what society owes people with disabilities. This requires the development of a normative foundation for analyzing the goals of respect, participation, and accommodation that will result in consistent policy objectives.

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