

Disability and social security: compatible or not?

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Everyone, as a member of society, has the right to social security and is entitled to realization ... of the economic, social and cultural rights indispensable for ... dignity and the free development of ... personality.

Article 22, *Universal Declaration of Human Rights*, 10 December 1948.

Introduction

Social security in international law

Article 22 of the Universal Declaration of Human Rights recognises that social security is a core element of social and political rights under international law.

This right is amplified in later treaties, such as art 9 of the 1966 International Covenant on Economic, Social and Cultural Rights (operative 3 January 1976). In common with other social and economic rights, it necessarily suffers from a lack of specificity and standards for enforcement: it is more educative than normative in its impact.¹ This is because social security is a 'positive' right of access to state largesse or state insurance, rather than a more easily policed (and less resource intensive)

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1 The work of the UN Committee on Economic, Social and Cultural Rights, established to receive and comment on State reports under the International Covenant on Economic, Social and Cultural Rights does canvass social security from time to time, as in the adverse remarks about Hong Kong in its 1996 *Concluding Observations of the Committee on Economic, Social and Cultural Rights (Hong Kong) : United Kingdom of Great Britain and Northern Ireland*. 06/12/96. E/C.12/1/Add.10 <<http://www.unhchr.ch/tbs/doc.nsf/385c2add>>. Australia lodged a report in 1998, with extensive (but descriptive) detail of social security provision, including those for people with disabilities: *Third periodic report: Australia* 23/07/98. E/1994/104/Add.22 (State Party Report) <<http://www.unhchr.ch/tbs/doc.nsf/23a89bf90>>.

'negative' or individual protective right, such as freedom from torture.

However the formulation of the right to social security also conceals a difficult policy tension so far as disability² is concerned. That tension has been evident for the last quarter century or more, as illustrated by the language of arts 3 and 7 of the UN Declaration on the Rights of the Disabled (9 December 1975), which read:

Article 3. Disabled persons have the inherent right to respect for their human dignity. Disabled persons, whatever the origin, nature and seriousness of their handicaps and disabilities, have the same fundamental rights as their fellow-citizens of the same age, which implies first and foremost the right to enjoy a decent life, as normal and full as possible.

Article 7. Disabled persons have the right to economic and social security and to a decent level of living. They have the right, according to their capabilities, to secure and retain employment or to engage in a useful, productive and remunerative occupation and to join trade unions.

The conceptual tension in this language is between a literal application of principles of normalisation and equal treatment, and provision of social security in ways which recognise the specific needs of people with a disability. It is a tension also embedded in academic analysis of equal opportunity laws as they affect disabled people (Jones and Bassar Marks 1999b).

It is trite law that international treaties do not become part of Australian law unless domestic legislation is passed to give effect to their provisions.³ Although several key disability treaties appear as schedules to the legislation constituting the federal Human Rights and Equal Opportunity Commission, they simply inform it in its work; no specific legislation has been enacted to give direct effect to those treaties.

In the absence of concrete expressions of international standards, the policy rift between the 'equality' and the 'special needs' goals has widened in recent years in Australia, as detailed below.

2 The term 'disability' is adopted because it remains in common usage, despite the negative connotations and stigma it continues to gather over time (Jones and Bassar Marks, 1999a).

3 Account may be taken of the values and principles enshrined in international treaties when exercising discretionary powers in certain (fairly rare) cases: *Minister for Ethnic Affairs & Immigration v Teoh* (1995) 183 CLR 273. For a review and discussion of Federal Government proposals to restrict this power see Allars 1995; Lacey 2001.

Social security rights for disabled people in Australia

This article will demonstrate a parting of the ways between social security policy on the one hand and contemporary debate about welfare on the other. It will be shown that disability and social security were once virtually synonymous, sharing common conceptual headwaters. Now social security comprises a separate — and somewhat degraded — stream. That divergence in the pathways of disability and social security has several origins; some commendable, some less so.

For its part, disability thinking has been transformed by conceptual debates about how to promote equality of social participation. As argued elsewhere (Carney 2000b) this translates as a claim for *citizenship*, and for recognition of the disabled as rights bearers. It necessarily involves a reconceptualisation of disability. This is briefly rehearsed in the next section of the article.

Social security on the other hand, has struggled to find principled bases to ground its entitlements. Australia conceived social security as a buttress to reliance on labourforce participation as the prime guarantee against want (Castles 1985; Castles 1994; Jamrozik 1994). Income testing of payments and tight definition of categories of entitlement were two expressions of this. Payments for sickness or 'invalidity' at first took a pragmatic approach to qualification: eligibility mimicked the functional tests of an ability to obtain a real job in a real labour market, as first laid down as the touchstone in the field of workers compensation. 'Permanence' was integral to qualification for the invalid pension, and the other substantive elements promised a fair measure of the formal 'security' expected of social security, even though practical security was undermined for nearly three-quarters of a century by the lack of any external merits review prior to 1975 (Carney 1982).

A decade or so ago, fiscal pressures led policy-makers to substitute easy to administer tables of medical conditions in order to cap the growth in numbers of invalid pensioners. The pension was also reconceptualised in the early 1990s to exclude consideration of local labour market conditions when judging qualification. In 1996 Australia abolished its government run 'labour exchange' (the Commonwealth Employment Service) and contracted out all job matching to a network of private providers (Carney and Ramia 2002a), creating a new 'enterprising state' (Considine 2001). Under new policies of 'mutual obligation', social security recipients of workforce age were also expected to enter into reciprocal obligations to engage in an 'activity' as a condition of payment, transforming income security from an 'entitlement' (or ingredient of 'citizenship') into a more 'contractual' form (Weatherley 1994; Carney and Ramia 1999; Macintyre 1999).

Under the thrall of the McClure report on welfare reform (McClure 2000), the Federal Government sought to widen the coverage of 'mutuality' principles (O'Donnell and Tham 2000; Carney and Ramia 2002b), enacting legislation extending it to sole parents (Carney 2002b) but failing to obtain approval either for its application to disability pensioners or for the proposal to break the nexus between pension and access to specialist disability services programs. Even so, a greater share of the burden of managing the 'risk' of insecurity is now borne by individuals rather than by the system of income transfer payments (Wearing 2001).

It is argued that serious fault lines have opened in the relationship between disability and social security, both at a conceptual and a practical level. At its core this divergence reflects the clash of some fundamental forces, not least the contemporary embrace of low taxation and small government, allied with a preference for privatisation of services. This trend is often labelled 'neoliberalism' (Beeson and Firth 1998) or 'new public management' (Considine 1999; Considine 2001; Ramia and Carney 2001), and it is a trend which poses new dilemmas for welfare worldwide (Ascoli and Ranci 2002; Handler 2002) — dilemmas such as whether rights and 'security' can be protected in the new 'contractual' or 'mutual obligation' environments (Considine 2000; Drover 2000; Carney and Ramia 2002a). One illustration of this, to which we will return in the conclusion, is the enactment of an overly restrictive eligibility requirement, the strict application of which would have eviscerated Australia's disability pension scheme had the Federal Court not rejected its literal meaning in *Pusnjak*.⁴

Another global trend which it will be demonstrated is also played out in Australia is that public disability policies are poorly constructed and mean-spirited. Too much weight is carried by residential services, or inadequately supported family carers, especially in the case of children with a disability (Doyle 1999); and there is a neglect of contextual or 'structural' dimensions of disability, unduly 'personalising' it (Drake 2000). One purported defence of this position is that it is not the job of social security to correct for social inequities of 'socially constructed' disability. Attention should instead turn to equal opportunity laws as the basis for equalising the 'participation' rights of people with disabilities, thus remedying environmental, social or other external contributions to disability. This is the position encapsulated in the stalled government disability reforms discussed below; a position opposed in this article on the ground that disability policies should reflect prevailing realities and should be tailored to personal experiences of applicants. Moreover, individual rights

⁴ *Secretary, Department of Social Security v Pusnjak* (1999) 164 ALR 572; 29 AAR 561; 56 ALD 444; [1999] FCA 994 para 28 (Fed Ct), Drummond J.

enforcement strategies cannot deliver structural change (Bickenbach, Chatterji, Badley and Ustun 1999a; Carney 2000b).

Accepting that there is legitimate debate about how best to evaluate public policies (Gleeson 1998), it is argued that failure by a prosperous country such as Australia to redress poverty and inequality through its social security system, or to fail to deal with discrimination and stigma associated with disability, can legitimately attract the attention of the UN Committee on Economic, Social and Cultural Rights under the International Covenant on Economic, Social and Cultural Rights.⁵ This is a prospect which might lead to some reunification of the divergent paths, drawing on the common ground which exists between the 'social participation' goal embraced by Australian welfare reform programs (McClure 2000) and similar sentiments in international treaties on disability.⁶

Conceptions of disability: towards participatory citizenship?

Conceptions of disability have long been in a state of flux (Carney 2000a). Three main approaches can now be discerned (Shakespeare 1999). Disability can be conceptualised as:

- a medical issue — this frames disability in the language of medical diagnoses, impairments or deficits;
- a rights issue — this portrays disability as a question of advancing minority civil rights; or
- a social issue — this steps off from a view of disability as a social construct: a result of structural, attitudinal and other features of society.

In explaining the last of these, Shakespeare writes of disability as a social category, one constituted by *processes* of 'social policy, language and cultural representation' (id, 32). The most positive spin which can be placed on recent trends in Australian welfare reform is that their aim is to shift those paradigms in this latter direction.

5 The 1996 report on Hong Kong's record is a clear case in point (see n 2 above).

6 For example the preamble to the Declaration of Rights of the Disabled, which speaks of 'assisting disabled persons to develop their abilities in the most varied fields of activities and of promoting their integration as far as possible in normal life', and in art 3 emphasises the 'inherent right to respect for human dignity' which 'implies first and foremost the right to enjoy a decent life, as normal and full as possible'.

However the varying paradigms can also be presented another way, within the more prosaic framework originally developed by the World Health Organisation (WHO).

The original WHO paradigms

The original classification published by WHO in 1980 distinguished between three terms:

- ‘impairments’, defined as loss of psychological, physiological or anatomical structure;
- ‘disabilities’, defined as the restrictions flowing from any impairment; and
- ‘handicaps’, defined as the impact which a disability has on social roles of the person (such as the ability to work).

Despite its limitations (of under-weighting the ‘socio-biological’ components of a social model of disability), this classification is useful for certain limited purposes.

As we shall see below, for instance, the ‘invalid pension’ legislation in force between 1908 and 1991 provided income support for disabled people based on a measure of the severity of their ‘work related *handicap*’. The current disability support pension shifts the conceptual base towards a measure of medical *impairment* (in tables incorporating, to some degree, the restrictions — or what WHO originally termed the ‘disabilities’ — which flow from an impairment).

Criticism of the WHO taxonomy has produced a more inclusive and more sophisticated conceptualisation, however.

The social, or ‘bio-psycho-social’ model of disability — ICDH-2

One deficiency of the original WHO model was its linear assumption that social consequences (called ‘handicaps’ by WHO) *stem from* individual characteristics (‘impairments’), and indeed may be an inevitable consequence of such conditions (Gleeson 1998). Related to this criticism was the lack of attention paid to external events: what we may call the social components of disability. Undue weight was given to factors *intrinsic* to physical (or psychological) attributes of the person (Mulvany 1998: 261; Bickenbach, Chatterji, Badley and Ustun 1999b: 1175; Nordenfelt 2000: Ch 11). Another possible difficulty was the lack of individuation of the model; for instance, starting with a notion of an impairment leaves little room for Nordenfelt’s plea for incorporation of reference to an individual’s ‘*own vital goals*’ (2000: 127, my emphasis).

Gleeson summed up the problems when he wrote:

Many disability advocacy groups and social theorists have criticised the WHO definition of disability for its implication that functional limitation is a necessary consequence of physical impairment. Many such critics support an alternative 'social constructionist' view of disability that emphasises the social origin of the everyday limitations and exclusions experienced by disabled people (Gleeson 1998: 315).

These objections can be overstated of course. It goes too far to define disability solely as a social construct without *any* regard to those factors intrinsic to the individual (Germon 1999: 688). Strictly speaking, reliance on mechanical steering of motor vehicles is a social construct which denies access to a driving licence to those people for whom mechanical aids cannot be devised to enable them to steer a car, but it is a social construct which cannot *meaningfully* be changed or overcome at this time (Bickenbach, Chatterji, Badley and Ustun 1999b: 1178).

In recognition of such lines of criticism, a 'bio-psycho-social' model was developed by the WHO which conceives of 'disablement' as a product of dynamic interplay between (1) the functions and structure of the body, (2) 'activities' and (3) 'participation', all three of which are impacted by environmental factors. So disability goes well beyond the impairment, involving other dimensions located in social, cultural and environmental factors, intrinsic or extrinsic to the person (Hartley and Wirz 2002). The new model recognises that it is not realistic to completely ignore medical or other features intrinsic to the person (Bickenbach, Chatterji, Badley and Ustun 1999b: 1171), but it emphasises new measures of 'participation' and the relationship to the human environment (Stineman 2001).

This new model, the *International Classification of Impairments, Activities and Participation* (ICIDH-2), retains the concept of 'impairment' but replaces 'disability' with 'activity limitation' and adopts 'participation' as the overarching concept which captures the social impact dimension formerly called 'handicap'. Most significantly however, it reflects an 'ecological' model which combines medical and social approaches where:

Each dimension of disablement is conceptualised as an interaction between intrinsic features of the individual and that of the person's social and physical environment [together with] a fourth component, a listing of environmental factors that can be used, in conjunction with the classifications or separately, to identify the determinants of disablement at the body, person or person-in-context levels of human functioning (Bickenbach, Chatterji, Badley and Ustun 1999b: 1183).

This framework is more nuanced than a simple choice between medical and social conceptualisations of disability, or an enquiry about where policy lies on a medical/social spectrum. Instead it blends features from individual, local contextual and wider environmental settings (Chopra, Couper and Herrman 2002; Hartley and Wirz 2002).

In short, disability literature now adopts a framework which promotes the goal of equality of social 'participation', otherwise translated as pursuit of TH Marshall's claim of 'social rights of citizenship' (Marshall 1963; Carney and Hanks 1994; Carney 2002a).⁷

Issues in Australian social security: towards parsimony and insecurity?

The framework for Australian income transfer payments for people with disabilities is contained in the *Social Security Act 1991* (Cth). Originally concerned to meet real social needs consequent on the inability of disabled adults to obtain work or for families to cope with additional burdens of care of disabled children, it will be demonstrated below that income transfers are now more parsimonious, offering less security, and paying less attention to the 'social' dimension of disability.

Policy tensions

The new WHO ICIDH-2 framework is one useful yardstick for assessing Australian social security provisions.

As we shall see, the revised 'impairment tables' governing the disability support pension (DSP) can be criticised because they load too little by way of the interaction a person has with their social and physical environment, while other parts of the legislation go on to shut out the ICIDH-2's environmental factors. Indeed, the legislative tables themselves are expressed to:

represent an empirically agreed set of criteria for assessing the severity of functional limitations for work related tasks and do not take into account the broader impact of a functional impairment in a societal sense.⁸

Wider considerations, then, are expressly factored out of the calculus.

7 In terms of domestic policy, the contours of the Australian policy debate about participation were first flagged in 1988 by the Social Security Review (Cass, Gibson and Tito 1988).

8 *Social Security Act 1991* (Cth) Sch 1B, Introduction, note 1.

Another tension point is the vexed one of how fully to express 'normalisation' principles, such as those captured in anti-discrimination ('equal opportunity') legislation. This does not arise as a direct issue of law, because s 51(1)(d) of the *Disability Discrimination Act 1992* (DDA) specifically exempts the *Social Security Act* from its operation.⁹ However this is the policy issue at the heart of those DSP cases (such as hearing impairment cases) which hinge on the relevance of reactions to disability as evidenced, say, by prospective employers or by the disabled person themselves.

Echoing a strong form of Shakespeare's 'social' model, one popular argument is that such barriers must be ignored in DSP calculations, leaving the DDA (or other measures) to do the work of ensuring equality of access to work by disabled people. We will return to this debate below.

Disability support pension for adults

From invalid pension to disability support

Income security payments for the adult disabled originated with the 1908 'invalid pension' which came into force a year or two later (Carney and Hanks 1994: 189-95). As already mentioned, eligibility for this payment hinged on establishment of a permanent disability and satisfaction of workers compensation style tests of showing that a worker could no longer attract a real job in a real labour market (the criterion of 85 per cent incapacity for work). The test, then, was ultimately a *functional* one: the ability (or otherwise) of the person to compete in real labour markets.

The clarity of the original functional test of eligibility for the disability pension is captured in a few key sentences from the relevant passages from the definitive Administrative Appeals Tribunal (AAT) decision in *Re Panke* (Davies J, Hall and Glick).¹⁰ Ruling that invalid pension legislation adopted the workers compensation concepts of ability to work *and* to exploit that capacity, Hall and Glick went on to say:

The assessment of the degree of incapacity for work in fact involves two quite distinct steps — firstly an evaluation in purely medical terms of the person's physical or mental impairment; and, secondly, the ascertainment of the extent to which that physical or mental impairment affects the person's ability to engage in paid work. ... In our view, it is

9 *Re Connell* [1998] AATA 13007 unreported AAT decision, 23 June 1998, Ettinger SM, para 8.

10 *Re Panke* (1981) 4 ALD 179 (Davies J, Hall and Glick).

not enough ... to have regard in any abstract sense, simply to 'jobs that exist as jobs' in the community. ... The assessment of what work is suitable to be undertaken [involves] consideration of matters such as the nature and extent of his disabilities, his capacity to sustain his work effort throughout a normal working day or week, his age, his previous work experience and the types of paid work available in the community which a person with those characteristics may reasonably be expected to be able to perform.

Plainly, then, this was a test of 'work related handicap' within the original WHO model. The DSP, introduced in 1991, radically altered this scheme (Carney 1991).¹¹ The object was to make two changes: a conceptual change and a practical change.

The conceptual change involved shifting from the former focus on the 'social impact of disability' to a new test which gave greatest weight to the 'impairment'. Eligibility now hinges, among other things, on obtaining a 20 point rating under medical 'tables of impairment' written into the legislation to form part of the law about eligibility. Non-legislative tables of 'ability to work', introduced in 1998, help to structure the answer to the next eligibility question of whether a person has a 'continuing inability to work'; but failure to obtain a 20 point rating is fatal to success. Any narrowing of the gateway wrought by the adoption of impairment tables cannot be overcome by subsequent steps of the process.

The practical difference is that impairment tables, rather than more subjective assessments adopted in the former invalid pension law, now serve as the measure of disability for pension purposes.

DSP qualification

The key parts of the legislation now provides:

94(1) A person is qualified for disability support pension if:

- (a) the person has a physical, intellectual or psychiatric impairment; and
- (b) the person's impairment is of 20 points or more under the Impairment Tables; and

11 Australia is not alone in this; very similar reforms were introduced at around the same time in the Netherlands (Hendricks 1999: 158). US law puts more emphasis on showing 'objective medical evidence' in support of the diagnosis of impairment, something which may be extremely difficult to satisfy in the case of a condition such as chronic fatigue syndrome (Foley, 1999). The Australian tables of impairment are adapted from the concepts enshrined in the US AMA's 'Guides to the Evaluation of Permanent Impairment'. For a discussion of some of the limitations of these measures see Spaulding 1990; O'Keefe 1994.

- (c) one of the following applies:
 - (i) the person has a continuing inability to work;
 - (ii) [or the person is participating in a specially approved supported wage program] and
- (d) the person has turned 16; and
- (e) the person [meets residential conditions]

Meaning of continuing inability

94.(2) A person has a *continuing inability to work* because of an impairment if the Secretary is satisfied that:

- (a) the impairment is of itself sufficient to prevent the person from doing any work within the next 2 years; and
- (b) either:
 - (i) the impairment is of itself sufficient to prevent the person from undertaking educational or vocational training or on-the-job training during the next 2 years; or
 - (ii) if the impairment does not prevent the person from undertaking educational or vocational training or on-the-job training — such training is unlikely (because of the impairment) to enable the person to do any work within the next 2 years.

94.(3) In deciding whether or not a person has a continuing inability to work because of an impairment, the Secretary is not to have regard to:

- (a) the availability to the person of educational or vocational training or on-the-job training; or
- (b) if subsection (4) does not apply to the person — the availability to the person of work in the person's locally accessible labour market.

The requirement to isolate one or more 'impairments' did not significantly alter the previous law, but the new insistence on clarity of diagnosis and treatment, together with much tighter definitions of what constitutes a consequent 'continuing inability to work', did markedly tighten and transform the concepts of disability enshrined in the DSP law, as shown below.

An 'impairment'

The first prerequisite of DSP qualification is that the person has a physical, intellectual or psychiatric impairment and that this impairment is rated at 20 points or more under the impairment tables.¹²

12 *Social Security Act 1991* (Cth), s 94(1)(a), (b). Under the former impairment tables, the required rating was expressed as a 20 per cent impairment.

It is not the restrictiveness of the term impairment which is the major constraint on qualification. Under the tables, an 'impairment' refers to any loss or abnormality of psychological, physiological or anatomical structure or function remaining after appropriate medical treatment and rehabilitation have been completed.¹³ The width of this concept is reinforced by the decided cases. As Drummond observed in *Pusnjak*,¹⁴ it can include psychiatric conditions due to a physical impairment. Or as the AAT said of the issue of poor motivation in *Re Chami*:

The Tribunal finds that it arises from his abnormal illness behaviour and results from his ankle injury and its sequelae, and therefore, using the words of the Act, it is part of his 'physical, intellectual or psychiatric impairment'. We make a distinction between poor motivation of the work-shy (a social phenomenon), and the motivational problems exhibited by this Applicant arising out of his injury. We rely on the decision *Re Malcolm and anor v Broadhurst* (1970) 3 All ER 508 in concluding that we must take the Applicant as we find him, and this Applicant has developed abnormal illness behaviour arising out of his injury for reasons intrinsic to him.¹⁵

Moreover, when deciding if the impairment takes away a person's capacity for work, regard may be paid to impairments which do not attract a rating, should this prove necessary to obtain a 'whole person' assessment (such as in one case involving Meniere's disease).¹⁶

The need for a stabilised, diagnosed and treated condition

The larger issue is satisfaction of the requirement that the impairment be diagnosed, treated and stabilised before it can attract a rating. Impairments cannot attract ratings until a detailed medical history has been taken and a comprehensive examination conducted. Conditions must be fully documented and diagnosed, and they must first have been investigated, treated¹⁷ and stabilised.¹⁸ Moreover, the condition must be

13 *Social Security Act 1991* (Cth), Sch 1B Impairment Tables, note 1; see also *Re Kadir* (1989) 10 AAR 149 [17 ALD 220], Balmford SM at 228 (paras 25-26).

14 *Secretary, Department of Social Security v Pusnjak* [1999]164 FLR 572; 29 AAR 561 FCA 994 para 27 (Fed Ct), Drummond J.

15 *Re Chami* (1993) 31 ALD 387 (FT) para 31.

16 *Re Busstra* (1997) 3 (2) SSR 14 para 20.

17 Treatment and stabilisation requires only that reasonable interventions be considered: *Re Tlonan* (1997) 24 AAR 467.

18 *Social Security Act 1991* (Cth), Sch 1B, Introduction, note 4; *Re Dyer* (1998) 51 ALD 190; *Re Tlonan* (1997) 24 AAR 467; *Re Dahman* (1993) 30 ALD 414 (FT).

'permanent', defined as a condition which is likely to persist for the foreseeable future (that is, for more than two years).¹⁹

A condition cannot be regarded as diagnosed, treated and stabilised until there is sufficient evidence to ground that opinion.²⁰ This does not necessarily require a *precise* diagnosis, rather that the condition be well established. *Re Hudson* is one illustration.²¹ Here the AAT accepted that an abdominal condition of three years standing should be rated, even though extensive tests and treatment had failed to pin down a precise diagnosis or markedly alleviate the reported symptoms. On the other hand, a condition of hypertension was given a zero rating due to insufficient documentation, while a mitral valve condition could not be accepted at hearing on the then available evidence. Likewise in *Re Condon*,²² where chronic fatigue syndrome qualified as an impairment once the AAT reinterpreted available medical documentation applying draft diagnostic guidelines recently issued by the Royal Australasian College of Physicians.

Moreover, regard must also be had to whether further 'reasonable' medical treatment 'is likely to lead to a significant functional improvement within the next two years'.²³ Reasonableness of treatment is now expressed as being taken to include a treatment that is feasible and accessible 'where a substantial improvement can reliably be expected and where the treatment or procedure is of a type regularly undertaken or performed, with a high success rate and low risk to the patient'.²⁴ This codifies the ruling in *Re Tlonan*,²⁵ which decided that the question of what reasonable treatments had been undertaken was relevant to the issue of the investigation, treatment and

19 *Social Security Act 1991* (Cth), Sch 1B, Introduction, note 5.

20 This rests on the *Briginshaw* adjusted civil 'balance of probabilities' test: *Re Dyer* (1998) 51 ALD 190 at 171. The evidence must also be sufficiently definitive of the impact on the applicant, rather than speak in generalities about conditions such as, for example, psychological harm should a highly profoundly deaf person undertake menial work: *Department of Social Security v Chin* [1999] FCA 44, at para 38 (Fed Ct), reversing *Re Chin* (1998) 27 AAR 1; 52 ALD 337.

21 *Re Hudson* (2000) 4(4) SSR 51 [2000] AATA 502 unreported AAT decision 22 June 2000.

22 *Re Condon* (1999) 30 AAR 41; 3(11) SSR 162 unreported AAT decision 10 August 1999, Christie M.

23 It is an error for a decision-maker to simply conclude that a chronic condition like alcoholism will not respond to treatment: *Secretary, Department of Social Security v Murphy* (1998) 52 ALD 268, at 271 (Fed Ct).

24 *Social Security Act 1991* (Cth), Sch 1B, Introduction, note 6. Weight may be given to associated risks or side effects which are 'unacceptable to the person'.

25 *Re Tlonan* (1997) 24 AAR 467, paras 57-59.

stabilisation of the condition, just as it had been when assessing the 'permanence' of the condition under the former legislation. The difference is that under the Federal Court ruling in *Dragojlovic*²⁶ the old test was subjective, going to the 'genuineness' of the reasons for rejecting treatment.

Whether the fact of permanent incapacity for work is established is to be decided by reference, inter alia, to the availability of remedial treatment. A disability which can be relieved by treatment which is reasonably available is not permanent. But where the claimant is a person who actually cannot — because of fear or religious beliefs, for example, or for some other reason of a genuinely compulsive nature — accept that treatment, the question is whether his disability is one which can, in fact, be relieved.

Arguably the new test is an objective one. In practical terms this shift may lead to fairly similar results: only a few fairly basic procedures will satisfy the new language, and cases where applicants failed to take 'simple procedures' to alleviate conditions (such as wearing a cervical collar) have been found to constitute acting unreasonably.²⁷

Continuing inability to work

To qualify for DSP it must also be established that any qualifying level of impairment results in a 'continuing inability to work'.²⁸

A continuing inability to work is specially defined as meaning that the impairment, taken in isolation from 'other matters that may influence [their] attitude to working', stops²⁹ the person for the next two years from doing work³⁰ (anywhere in Australia)

26 *Dragojlovic v Director-General of Social Security* (1984) 52 ALR 157; 1 FCR 301; 5 ALN N416 (Smithers J).

27 *Re Hughes* (1991) 62 SSR 869 unreported AAT decision, 30 May 1991; Compare *Re Bloom* (1992) 28 ALD 250.

28 *Social Security Act* 1991 (Cth), s 94(1)(c).

29 Mere personal distaste for certain work is not relevant, but a condition (such as immature personality disorder) may foreclose otherwise suitable prospects: *Re Kemp* (1994) 82 SSR 1199 (FT AAT); *Re Warner* (1994) 36 ALD 313 (FT). It is a question of fact as to whether self-employment demonstrates a capacity for such work: *Re Churley* (1993) 31 ALD 405.

30 Work currently means at least 30 hours a week at award wages or above: s 94(5). The 2002 Federal Budget announced plans to reduce this to 15 hours, a measure which Opposition numbers in the Senate defeated on several occasions as Government reintroduced the measure in amended form in the hope of striking a compromise. Although the legislation no longer refers to a person's 'usual work', the principle of looking to a person's potential capacity remains appropriate even if there are temporary

which otherwise would be within their existing skills and experience,³¹ or that the impairment alone is sufficient to prevent the person from undertaking educational, vocational or on the job training during the next two years, or if such training is possible, it would be unlikely to enable the person³² to do any work within the next two years.³³ The education and training envisaged covers everything *except* specialist disability programs.³⁴ Only assistance from standard programs of formal training need be considered here,³⁵ on the rationale that the specialised programs are designed to help truly disabled groups of people back into work. On the other hand, the retraining program need not be a formal one. 'On the job training' takes its wide non-technical meaning on the theory that any workplace program which can return a person to work renders it premature to pay DSP.

Exclusion of reference to locally accessible labourmarkets

In determining whether a person has a continuing inability to work, a person's capacity is assessed when wearing aids, such as spectacles or hearing aids,³⁶ consistent with the old policy of making a realistic assessment of work capacity. However the assessment now must *not* have regard to the *actual* availability to the person of educational, vocational or on the job training,³⁷ or to the *actual* availability to the person of work in the person's locally accessible labour market.³⁸ The enquiry

reasons why a capacity is not being exploited (such as a person who is studying): *Re D'Ambrosio* (1995) 37 ALD 299 301; *Re Smith* (1995) 86 SSR 1251 (FT AAT). Account must be taken of the realities of the workforce, and it is not sufficient to count on finding a 'benign' employer: *Re Oates* (1993) 36 ALD 183; *Re Warner* (1994) 36 ALD 313 (FT). Drummond J (obiter) doubted if this remained open, but this is plainly wrong: *Department of Social Security v Chin* [1999] FCA 44 (Fed Ct) at para 50. However there must be evidence to show that *only* a benign employer would be able to offer suitable work: para 54.

31 *Secretary, Department of Social Security v Pusnjak* [1999]164 FLR 572; 29 AAR 561 FCA 994 (Fed Ct), Drummond J, para 32.

32 Literacy or numeracy skills are not relevant unless the program is realistically designed to equip a person for a place in the workforce: *Re Oates* (1993) 36 ALD 183.

33 *Social Security Act* 1991 (Cth), s 94(2)(b).

34 *Social Security Act* 1991 (Cth), s 94(5); *Re Chami* (1993) 31 ALD 387 (FT); *Re Warner* (1994) 36 ALD 313 (FT). A person engaged in a special program may nevertheless retain an aptitude for mainstream training programs: *Re Button* (1993) 32 ALD 343 (FT).

35 *Re Hamal* (1993) 18 AAR 137 [30 ALD 517] (FT); *Re Chami* (1993) 31 ALD 387 (FT).

36 *Re Bell* (1998) 52 ALD 472 (AAT), at 473.

37 *Social Security Act* 1991 (Cth), s 94(3)(a).

38 *Social Security Act* 1991 (Cth), s 94(3)(b).

becomes a more artificial and more individually focused one of asking what abstract *capacity* the person exhibits. External contributions from the characteristics of local labour markets are generally excluded. In a concession to older workers, it is only when a person has turned 55 that account may be had to the likely availability of locally accessible work when deciding whether educational or vocational training is likely to equip the person to do work.³⁹

This does not mean that there is no scope to take individual experience or skills into account, as would seem to be the case if a literal reading is given to the requirement that attention be confined to the impairment alone. The Federal Court in *Pusnjak* held that s 94(2)(b)(i) remains focused on the 'necessarily limited range of work activities for which the particular claimant is fitted by [their] actual skills and experience'.⁴⁰ In making this assessment, the 'of itself' phrase does not preclude taking into account the actual work skills, experience and capacity of the person to be retrained.⁴¹ Nor does it mean that age cannot be considered *at all* when judging work capacity of a person under the age of 55.⁴²

Through these nuances and complexities one thing shines very clearly: in relation to the DSP the characteristics and consequences of the medical impairment are now quite central, whereas under its predecessor everything hinged on whether or not a real job was open. Another way of looking at the former invalid pension, of course, is that it offered 'protection' to disabled people, doing so by providing *security* of pension entitlement for anyone unable to work and thus earn their own livelihood. Disabled adults unable to satisfy the new DSP rules are confined to the temporary payments provided for the unemployed (Newstart allowance) or temporary sickness and incapacity (sickness allowance), paid at rates which are lower than that for DSP, with less favourable rules about the treatment of external income from part-time earnings (lower 'free of income test' amounts and higher rates of taper reducing payments for each dollar of external income (Carney 2001)).

39 *Social Security Act 1991* (Cth), s 94(4).

40 *Secretary, Department of Social Security v Pusnjak* (1999) 164 ALR 572; 29 AAR 561; [1999] FCA 994 para 28 (Fed Ct), Drummond J.

41 *Secretary, Department of Social Security v Pusnjak* (1999) 164 ALR 572; 29 AAR 561; [1999] FCA 994 (Fed Ct), Drummond J. A literal construction of this phrase was rejected because it led to an absurd or unreasonable result, and departed from the discernable intent of the provision: para 39; *Re Bell* (1998) 52 ALD 472 (AAT), at 475.

42 *Secretary, Department of Social Security v Pusnjak* (1999) 164 ALR 572; 29 AAR 561; [1999] FCA 994 (Fed Ct), Drummond J, para 38.

In short the DSP is more parsimonious and offers less security than did the former invalid pension.

Rights or protection: the hearing impairment cases

Critics, though, argue that the protection offered by the former invalid pension went hand in hand with cultivation (or tolerance) of dependence, contravening the rights of disabled people to have equal access to work (or perhaps also to other forms of social participation). The two competing perspectives of social security identified as implicit within international human rights instruments have been very prominent markers of shifts in Australian policy. The 'protective' and the 'equal rights' perspectives have competed for acceptance in this context. So is it acceptable to adopt an 'equality' paradigm in the expectation that other policies will bring about desired changes in the external labour market? Or is Drake closer to the money in his critique of British reforms for their failure to place enough emphasis on structural reform to external environments (Drake 2000)?

The Australian cases dealing with hearing impairments provide a good test of the relevance of employer prejudice, and of a disabled person's reaction to the stress of dealing with workplace disadvantage, when judging 'employability'. Centrelink often argues that such prejudice should be ignored, because the DDA and improving employer practices already protect disadvantaged workers. The contrary argument is that a person who will only find work with a 'benign' employer should not be disentitled from pension; that a real, rather than a theoretical, workplace should be the reference point.

In *Chin*,⁴³ a profoundly deaf 17 year old able to communicate using Auslan or in writing (but unable to lip read) and possessing good academic skills argued that DSP qualification was established because the 'light work' occupations accepted to be technically within her capacity would be so demeaning as to pose psychological risk to her emotional stability and sense of self-worth. The AAT accepted the argument that classes of work must be suitable, and concluded, based on medical testimony, that menial work would not be suitable for a person of such intellectual capacity,⁴⁴ and in any event, would still require communication skills which the applicant lacked and which could only be offset by grace of a 'benevolent employer'.⁴⁵ On

43 *Re Chin* (1998) 27 AAR 1; 52 ALD 337 (Barnett DP, Billings and Weerasooriya).

44 Para 12.

45 Para 13.

appeal to the Federal Court however, Nicholson J found that there was insufficient evidence to support those findings (leaving open the question of whether the 'benevolent employer' protection remained good law given that s 94(2)(b)(ii) now speaks of 'any' work).⁴⁶

Re Bell,⁴⁷ by contrast, involved an unskilled person without good clerical or language skills who depended on her lip-reading capacity and fuzzy hearing aid to provide communication. Having previously held down only part time, casual unskilled work, often assisted by a benign employer (such as family members or employers eligible for wage subsidies), the AAT decided that eligibility was established. As the AAT said in *Re Rowbottom*⁴⁸ of an applicant part-way through a University course:

It is not my understanding of the operation of s 94 that the work to be considered in the context of that section means work of the applicant's choosing but rather refers to work in general and looks to work which the applicant may or may not be able to perform. If there are fields of employment in which the applicant can perform to a standard which satisfies the definition of 'work' in s 94(5) then, on my understanding of the operation of s 94, the Tribunal cannot be satisfied that there is a continuing inability to work.

It seems, then, that the calculus is a multi-factorial one. Employer prejudice is relevant, but 'pickiness' on the part of an applicant is subject to a test of reasonableness.

From a human rights perspective, the case law appears to have softened the impact of the shift away from the protective, real employment markets paradigm of the old invalid pension regime. The policy 'shandy' is now a mix of rights and protection, where protection is the stronger of the two. But it is not beyond disputation, or settled for all time, given the more purist message which can be read from the DSP legislation.

Carer allowance (CA) mimics some of these trends, but also raises some new policy tensions.

46 *Department of Social Security v Chin* [1999] FCA 44; 56 ALD 682; 3(11) SSR 174; Federal Court, Nicholson J, 3 February 1999.

47 *Re Bell* (1998) 52 ALD 472, Handley, SM, Paras 56, 58.

48 *Re Rowbottom* [1999] AATA 553 unreported AAT decision 29 July 1999, para 12 (Senior Member Beddoe).

Carer allowance for adults and children

CA came into operation in July 1999. It is one of two payments (a more restrictive but more generous 'carer payment' (CP) is its companion measure).⁴⁹

CA combines two former payments: the former child disability allowance (CDA) and the former adult domiciliary nursing care benefit payable for care of disabled adults. The new payment retains and extends reliance on objective test instruments as the basis of qualification for the payment. A year earlier, in July 1998, the former CDA payment came to be governed by an instrument called the 'child disability assessment tool' (CDAT) (Myee 1997). The CDAT tables⁵⁰ replaced a 'social test' which formerly asked only about whether a disabled child needed 'substantially more' care and attention than did a non-disabled child of the same age.⁵¹ An 'adult disability assessment tool' (ADAT) now matches the CDAT in the case of adults.

The first condition of qualification for CP remains unchanged from the old law, calling for a finding that the person affected has a disability. However this is

49 Eligibility for carer payment hinges on obtaining a higher (80 points) rating score or meeting a test of 'profound disability': s 198(2)(a), (b). Section 198(8) states that if there are two children the test is whether their combined level of care is 'at least equivalent to the level of care required by a profoundly disabled child (see next para below)'. Centrelink policy interpreted this to mean that between them, the children must have at least three of the seven conditions. However in *Re Borg* (2002) SSR 5(1) 2; [2001] AATA 1047 unreported AAT decision, 10 December 2001, the AAT ruled that it was sufficient if the total 'care burden' was equivalent: reasons, para 12 (Senior Member Purcell).

Profound disability is established only if at least three of seven narrowly defined conditions are present. That list includes tube feeding of all food and fluids, having a tracheotomy, using a ventilator at least eight hrs a day, faecal incontinence day and night, is unable to stand without support, having a terminal condition for which only palliative care is appropriate, and needing personal care at least twice each night: s 197(2)(c)(i)-(vi). In *Re Harrison* (2002) SSR 5(1) 2; [2001] AATA 1001, unreported AAT decision, 10 December 2001, a child who could rise unaided from a seated position to then (usually) wobble and fall, but who was unable to stand unaided where most people would do so, failed to show that he was unable to 'stand without support': reasons, para 23 (Bell, Member).

50 The CDAT is contained in an instrument (disallowable determination) which provides a list of 'recognised' disabilities (which are not required to be rated: ss 38D(3), 953), together with a 'test for assessing a young person's functional ability, emotional state, behaviour and special care needs' and a basis for scoring those qualities: s 38D(1), (2). The rating scale must award a negative score to qualities which 'indicates an absence of a physical, intellectual or psychiatric disability at a significant level' and a positive score where it is found to be significant: s 38D.

51 *Social Security Act* 1991 (Cth), saved s 952(c). (The 'old' law is retained for a period of five years for anyone already on CDA when the change was made.)

generously defined in s 952, where a disabled child is expressed as a person over the age of 16 who:

- (a) has a physical, intellectual or psychiatric disability; and
- (b) is likely to suffer from that disability permanently or for an extended period.

A disability is broadly (and simply) construed as a lack of some physiological capacity recognised in medical diagnostic manuals. So PKU qualified in *Re Bryer*⁵² even though the condition (an inability to breakdown excess amino acid) had not manifested itself in symptoms such as mental retardation into which it often progresses if untreated. Asthma has been qualified as a disability without the applicant showing that it was chronic or especially severe: *Re Bodney*.⁵³ Attention deficit disorder (ADD) also qualifies since it is recognised by DSM IV,⁵⁴ and age-atypical bed-wetting/soiling has also been accepted, along with conditions such as deafness, diabetes, and learning disabilities (an intellectual disability).⁵⁵

Nor does the duration of the condition pose a major barrier. As *Re Bodney* put it, this means no more than that the condition must be one likely to last for an extended or prolonged period, while the word 'likely' involves making an estimate about the future (though conditions lasting less than 12 months are unlikely to qualify).⁵⁶

The limitation of the scope of carer allowance is brought about by the inclusion of s 953(1)(c)(ii):

- 953(1) A person is qualified for carer allowance for a disabled child (the *care receiver*) if:
- (a) ... [child is a 'dependent' child]
 - (b) ... [child is an Australian resident]; and
 - (c) *either of the following applies*:
 - (i) the disability from which the care receiver is suffering is *declared*, under subsection 38D(3), to be a recognised disability for the purposes of this section;

52 *Re Bryer* (1987) 13 ALD 334; 41 SSR 516.

53 *Re Bodney* (1986) 35 SSR 443 unreported AAT decision, 19 August 1986.

54 *Re Hart* (1997) 2(12) SSR 170.

55 *Re MacLean* (1993) 177 AAR 104, 30 ALD 92; *Re Wallis* (1999) unreported AAT decision, 15 April 1999.

56 *Re Pascoe* [1999] AATA 873 unreported AAT decision (Senior Member Kiosoglous), 19 November 1999 (oxygen dependence of a premature baby).

- (ii) the care receiver has been assessed and rated, and been given a positive score of not less than 1, under the Child Disability Assessment Tool; and
- (d) because of the disability from which the care receiver is suffering, the care receiver receives care and attention on a daily basis from:
 - (i) if the person is a member of a couple — the person, the person's partner or the person together with another person (whether or not the person's partner); or
 - (ii) if the person is not a member of a couple — the person or the person together with another person;
- in a private home that is the residence of the person and the care receiver; and
- (e) [carer is in Australia]; and
- (f) [carer an Australian resident].

Because of the way 'recognised disabilities' are currently expressed, some of the old concepts do survive in exceptional cases. This is because one of the conditions 'declared' (within s 38D(3)) as a 'recognised disability' in the case of a child under six months of age was one described as a 'severe multiple or physical disability (including uncontrolled seizures) requiring constant care and attention'. In *Re Roe*⁵⁷ it was held that a child suffering from cystic fibrosis qualified under this option, even though the child did not achieve a positive score of 1 under CDAT. But this is very rare.

The shift in conceptual foundation

In the case of children, the change wrought in July 1998 was quite significant.

The CDAT rating scale has a different foundation to the previous test, omitting the 'social impact' component of that former test. It will be recollected that the pre-1998 test involved making an assessment of the degree (or burden) of additional care required to be provided by the parental carer of the disabled child. It was a measure of the 'social burden of care' (Carney 2001).

Instead, the new table effectively measures degrees of divergence from developmental milestones normally achieved by a child of a given age (Carney 2000b). Consequently some medical conditions qualifying for CDA under the pre-1998 test, such as the extra burden of care involved in providing watchfulness and care for epileptics or diabetics, often do not now qualify for CA. This is because some conditions do not affect achievement of developmental milestones, even though the

57 *Re Roe* (2000) (4)(2) SSR 14 [2000] AATA 17 unreported AAT decision 19 January 2000 (Senior Member Kiosoglous).

condition does generate an additional burden of care (14 hours a week in *Re O'Brien*).⁵⁸

This is made plain in *Re Gibbons* where a carer of a child with ADD (ADHD in this case) was rejected because a positive rating of 1 was not achieved (rating -4.18 based on the treating doctor, and -3.25 after taking account of the parent's answers). As Senior Member Hallows noted:

[C]hildren, assessed under the CDA Tool, may, because of their above average functional abilities, not qualify for [CA] even though they require continuing care which may only be available from their carer because of their anti-social behaviour or because of their special care needs (reasons, para 14).

Or as she said about diabetes in *Re Gilbert*:

In the Tribunal's opinion the Tool reflects little understanding of the demands care and attention place on parents, particularly those who are remote from medical services and who are placed under considerable stress for, if they are not careful, a life threatening or a permanently disabling situation may arise. The provision of a health care card does not compensate a parent, particularly ones in remote areas, for the considerable additional expense involved in maintaining their child in optimum health despite their disease (reasons, para 11).

The former burden of care test was not without its critics of course. It was difficult to operationalise because of its heavily subjective character. Consistency and fairness were difficult to achieve. Moreover, no account was paid to what was arguably the central issue in the mind of most parents and carers: namely the financial outlays entailed. Many lobbyists had therefore argued for a 'costs of care' payment along British lines.

But as we have seen, instead of moving towards social and financial indicators of

58 Diabetes appeals failed under the new instrument in a string of cases, including *Re Brammer* [2000] AATA 310 unreported AAT decision, 20 April 2000 (Senior Member Hallows); *Re Bell* [2000] AATA 573 unreported AAT decision, 12 July 2000 (Fayle SM; Haslam M; McKnight M); *Re Gilbert* [2000] AATA 859, unreported AAT decision, 26 September 2000 (Senior Member Hallows); and *Re O'Brien* [2001] AATA 230 unreported AAT decision, 23 March 2001 (Campbell M). By contrast, a favourable outcome was achieved under the old law in *Re Kolta* [1999] AATA 100 unreported AAT decision, 24 February 1999 (Shanahan M).

qualification, the Government again opted for measures which place most weight on bio-medical indicators of 'normal' development.

A loss of transparency

One of the other byproducts of the new CDAT scale was a loss of transparency about the basis of assessments. The CDAT⁵⁹ determination covers 30 pages. Calculation of a rating involves applying 12 separate rating steps.

Centrelink therefore relies on automated data processing programs to transform the raw scores into a final score. Unsurprisingly, clients are none the wiser about how or why a determination is reached. As the AAT said in *Re Gibbons*:

Certainly the level of understanding of the program by parents and carers will not be increased unless the application of the ... CDA tool for assessing a young person's functional ability, emotional state, behaviour and special care needs is spelt out so that a parent or carer may understand how a treating health professional's response and their responses to the questionnaires in the CDA Tool are translated into a score. It appears that this is done with the aid of a computer program (para 2).

Complexity can be unavoidable in some instances of course; some diagnoses and professional judgments are more a matter of faith than a matter open to lay dialogue. However it must be doubted that this will often be the case. Clients too have been unimpressed. As a recent research report on reactions by parents of diabetic children bluntly reported:

It would appear therefore that with the new assessment guidelines, the legislative changes have failed in their attempt to recognise the impact of such a significant disability as diabetes on families. The new method of assessment has failed in its 'measurement' of this disability (Stratton and Delaney 2000).

By excluding certain categories of disability previously catered for by predecessor payments, and by switching the focus from the 'burden of care' to rates of progress towards developmental milestones, the width of coverage has become more parsimonious (though rates of payment are now generally superior).

59 The assessment tool was first issued as a determination of the Minister under the then ss 23(1), 952A(4), made on 25 March 1998, to take effect from 1 July 1998.

Conclusion

The short point from this review is that the literature about how to conceptualise disability has moved in one (progressive) direction, while Australian social security has moved in another direction.

Disability literature started its journey with a paradigm highlighting disability characteristics inherent in the individual, as captured in a model incorporating both functional limitations and social impacts, and did so by way of a linear extension of some foundation in medically oriented 'impairments'. The disability literature ended the journey by discussing the merits of, and by embracing, inclusive models such as the ICIDH-2 which fully respect contextual and environmental dimensions of disability; models stressing the social over the medical.

Social security began its journey at a time when the law applied two 'social impact' tests: a disability pension offering protection and security for a sufficiently disabled person who had lost the capacity to attract a real job from a real employer, and a child disability payment turning on assessment of the level of additional burden of care imposed on their family. It ended its journey with a disability pension principally built around medical assessments of levels of medico-functional 'impairments', and a child carer payment pivoting on degrees of variance from 'normal development' (and an adult measure combining measures of level of need for, and capacity to provide care).⁶⁰

At the beginning of the trip disability and social security, while certainly not in full harmony, shared significant common ground. The invalid pension test of work related consequences of adult disability, and the CDA test of the burden of parental care consequent on care of a disabled child, offered a close reading of the third stage of the original WHO model (it hinged on measuring the social impact or what the WHO defined as a 'handicap'). However, now there is very little common ground at all.

The rise of neoliberalism

The divergence between the two different conceptions of disability has been no accident. Since the 1970s the number of disability pensioners rose more quickly than the growth in the workforce. For males, the number on disability pensions more than doubled as a proportion of male workers over the period 1970 to 1990, a growth rate

60 US reforms have also impacted on people under 18 (Roberts-DeGennaro, 2001).

of 7 per cent a year against a population growth of 2 per cent a year (Carney and Hanks 1994), though female pensions rose more modestly. Under the press of Treasury concerns to reduce fiscal outlays, government policy enshrined in the 1991 *Social Security Act* endeavoured to strip out the 'social' and to substitute objective measures of impairment. In adult disability this led to enactment of overly restrictive language in s 94(2)(a). Designed to eliminate consideration of 'social factors' (such as a person's limited education, skills or language), it expressed itself as insisting that the person's impairment must *of itself be sufficient* to stop the person working, being retrained, or from being employable after a period of two years. Un-noticed and un-enforced, it was not until July 1999 that the 'sleeping giant' of the 'of itself' phrase was slain by the Federal Court in *Pusnjak*. Parliament had used in s 94(2)(a) language which, if read literally, would have barred qualification for DSP to all except the virtually comatose (for only such conditions 'of themselves' prevent a person from working), thus rendering other criteria in the section largely superfluous. This result was avoided only because the provision was poorly enough drafted for Drummond J to set aside its literal meaning as leading to 'absurd or unreasonable results'.⁶¹

Despite these measures, disability pension numbers have continued their disproportionate rate of growth (the highest in the OECD), averaging over 4 per cent a year in the last four years to reach more than 650,000, with half of all new grants being made to people over the age of 50 (Explanatory Memorandum 2003). In response to this situation the Government's Welfare Reform Taskforce proposed in 2000 that greater efforts be made to encourage or preserve workforce and community participation by people with a disability. It suggested breaking the nexus between pension security and access to specialised labour market support or rehabilitation services, fresh measures to avoid consigning disability pensioners to permanent exclusion from the workforce, and avoidance of the 'silo' effect of overly sharp distinctions between payments for unemployment (Newstart allowance), sickness (sickness allowance) and the disability pension (McClure 2000). The Government's official response, however steered clear of adopting the report's more radical suggestions of a basic 'income guarantee' topped up by 'participation payments' (Howard and Newman December 2000).

The 2002 Budget instead unsuccessfully proposed a legislative reform package trenchantly criticised by peak welfare and disability groups (ACOSS 2002) and

61 *Secretary, Department of Social Security v Pusnjak* (1999) 164 ALR 572; 29 AAR 561; 56 ALD 444; [1999] FCA 994 para 28 (Fed Ct), Drummond J. para 39. In making this assessment, the 'of itself' phrase does not preclude taking into account the actual work skills, experience and capacity of the person to be retrained: para 28. Also *Re Bell* (1998) 52 ALD 472 at 475 (AAT).

consistently blocked by opposition parties in the Senate, which voted to split it away from an attractive set of new programs to support vulnerable and long term unemployed. Passage of that spending package (worth approximately \$900 million) was guaranteed in March 2003 in return for government agreement to reduce the severity of 'non-payment' penalties imposed on unemployed people who breach their 'activity test' obligations — reducing the effective loss of income for a first offence from \$890 to a penalty of around \$270 (ACOSS 2003).

The current version of the stalled disability reform Bill — the Family and Community Services Legislation Amendment (Disability Reform) Bill [No 2] 2003 — was most recently reintroduced in the Senate on 23 March 2003, only to be defeated at second reading on 24 June 2003. It proposed that for claims made or determined after July 2003, the s 94(5)(a) definition of what constitutes 'work' for disability pension purposes be halved from its current figure of an ability to undertake 30 hours of work under award conditions to a figure of 15 hours a week. If enacted this would preclude from pension anyone able to engage in the workforce for that period of time. The Bill also proposed to break the nexus between pensions and specialist disability services by precluding from eligibility for pension anyone able to be assisted back into work by such *specialist* services within the next two years (currently only responsiveness to being helped by general labour market services bars qualification). And, in addition to responsiveness to formal and informal (on the job) training as a route back into work over the next two years, the Bill proposed to include 'prevocational' assistance which merely enhances 'prospects of work' or which might 'assist in seeking' work — thus excluding another group of people who currently qualify for pension. People aged over 55 would also lose the current dispensation in s 94(4) which allows consideration to be paid to whether jobs would be available in the person's locally accessible labour market. Sickness allowance recipients (or Newstart allowees paid on sickness allowance conditions) would also become liable to requirements to 'participate' in such activities at the discretion of Centrelink delegates of the Secretary.

The net effect of measures such as these would be to further narrow eligibility for the more secure DSP, and to expose more adults with disability to obligations to undertake 'mutual obligation' activities. Individuals would be expected to share a greater proportion of responsibility for realising participation in the workforce or wider society. Income security payments would offer less security, and would be more parsimonious (especially for those switched from pensions to unemployment or sickness 'allowances'). In policy terms this is entirely consistent with the neoliberal agenda of smaller government, lower taxation and greater individual responsibility (Clarke and Newman 1993; Jayasuriya 2001; Ramia and Carney 2001; Kinnear 2002) which now renders social citizenship heavily 'conditional' (Dwyer 1998).

A normative role for international agencies?

Australia is not alone in attracting criticism for inadequately constructed disability services policies. Doyle (1999) for instance criticises Britain for its undue reliance on residential services, for its paternalism, and for its highly fragmented income supports. Drake is likewise critical of the Blair Government's 'New Deal' reforms for the disabled, because they concentrate unduly on the individual at the expense of the need to give attention to structural reform of the nature of work if disabled people are to be enabled to participate more fully in employment (Drake 2000).

What is less evident, perhaps, is agreement about the evaluative lens through which policies might be assessed. Alleviation of poverty and need provides one widely accepted goal of policy, but this only sets base level standards (Gleeson 1998); beyond that, evaluative perspectives are heavily contested. Certainly failures of a wealthy country to address poverty and inequality through its social security system, and any failures to deal with discrimination and stigma associated with disability, do attract the attention of the UN Committee on Economic, Social and Cultural Rights in discharging its monitoring role under the International Covenant on Economic, Social and Cultural Rights. The 1996 report on Hong Kong's record is a clear case in point.⁶²

Understandably, perhaps, the international treaties and their monitoring agencies have as yet not engaged more closely with domestic disability policy. But this might change in the future so far as the alignment between the 'social participation' goal of welfare reform programs and similar sentiments in international treaties on disability is concerned. Participation is somewhat muted in international treaties and declarations. But, as mentioned, it does sound in passages such as the preamble to the Declaration of Rights of the Disabled, which speaks of 'assisting disabled persons to develop their abilities in the most varied fields of activities and of promoting their integration as far as possible in normal life', and in art 3 emphasises the 'inherent right to respect for human dignity' which 'implies first and foremost the right to enjoy a decent life, as normal and full as possible'.

In terms of domestic policy, the contours of the Australian policy debate about participation were first flagged in 1988 by the Social Security Review (Cass, Gibson and Tito 1988). The more radical position laid out from that time on contended for minimalist definitions of disability which exclude social components, use objective measures and are of universal application. The argument is that richer, more complex

62 See n 2 above.

definitions of disability would harm the disabled, perpetuating their plight by tolerating continuance of environmental, social or other external contributions to their disability. The counterargument was that definitions of disability should reflect prevailing realities and be tailored to personal experiences of applicants.

This tension can be illustrated by considering two applicants with severely arthritic knee and ankle joints, one living in a paved city environment, the other in a remote sandy desert location. The first position would rate both claimants equally, while the second would view the need to navigate unpaved, uneven ground as a factor increasing that person's level of disability and therefore strengthening their claim for a pension. The first position essentially argues for elimination of environmental inequalities through *other* initiatives, rather than accepting that welfare policy should treat people differently by virtue of their differing *needs* which are a product of, say, their locational, attitudinal or labour market disadvantages. Apart from its instrumental/dehumanising implication (that disentanglement from welfare is leverage for structural change), the weakest aspect of this argument is its counterfactual — that equal opportunity laws *will* ultimately remedy such structural biases. As argued elsewhere, this is a false hope: 'individual rights enforcement' strategies will not deliver the required further structural change (Bickenbach, Chatterji, Badley and Ustun 1999a: 109ff; Carney 2000b).

Nor is it clear how avenues of participation are to be realised without resort to coercion, thus undermining the very *security* supposedly at the heart of social security payments. At present, the activation proposals for disability support pension echo Britain's 'New Deal' for the disabled. One of five 'voluntary' strands of the new deal package (the unemployed face greater compulsion), the UK program currently involves writing a 'letter of invitation' encouraging voluntary attendance by disability pensioners at an interview (Millar, 2000: 5). Certainly some countries, such as Denmark, have made strenuous efforts to ensure that such so-called 'activation' strategies remain cast in supportive terms (Torfing 1999: 17). But there are inexorable pressures for coercion to expand (Philpott 1997: 74; Dwyer 1998: 449-500; Walker 1998: 540). This risk is accentuated by British evidence reporting that disabled people number among the strongest supporters of inclusion of elements of conditional welfare (or 'mutual obligation'), endorsing its possible role as a 'circuit breaker' role (Dwyer 1998: 506). This is another reason to continue to explore ways in which international human rights law may find purchase in these policy debates.

As argued in this article, by adapting the latent 'social participation' and 'social security' standards of international treaties, Australia's disability payments may yet come under scrutiny by bodies such as the UN Economic, Social and Cultural Rights committee which monitors compliance with instruments such as the International

Covenant on Economic, Social and Cultural Rights. Then the 'social citizenship' standard of genuine security and social participation may at last be more fully realised in domestic policy.

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