INCAPACITY FOR WORK: RIGHTS AND WRONGS

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Since the Poverty Inquiry (1974 to 1976) and with the rising level of unemployment, the extent and nature of poverty in Australia has become central to the public debate about social welfare policies and priorities. Concern for the needs of handicapped persons has moved up the political agenda, and at the same time medicine is developing concepts to better understand the nature and effects of disability. The medical concept of handicap — as social disadvantage — shares parameters with sociological and economic definitions of poverty: such overlap is central to the determination of invalidity for an invalid pension. During the past three years doctors appear to have complied with an administrative direction to redefine invalidity as an intrinsic characteristic to the exclusion of the person's relationship with his/her social world. These events have implications for the professional orientation of doctors and social policies for disablement.

To reduce handicap is a principal goal of health care and social welfare. The doctor treats disease and injury and aims to prevent these conditions whilst social welfare attempts to ameliorate their impact. Disability causes impoverishment of families and

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its highest incidence is amongst the poor.[1] Doctors assess individual health needs whereas social welfare is administered to meet publicly defined, and therefore legitimated, needs. In providing invalid pensions, or compensation for that matter, there is potential conflict between personal and public perception of disability (both subject to irrationality) and between medically perceived need and social need.

The essence of this conflict over invalidity is the nature of poverty and handicap. In the polemics of the poverty debate, there is one belief that the basic needs of survival can be defined and measured by an economic poverty line or there is the appreciation that poverty is a relative phenomenon.[2]

As Townsend puts it — poverty is relative deprivation and may be assessed by attributes of a person's style of living. Poverty may be expressed in relative terms as a lack of access to, and participation in, the global patterns and requirements of modern life: nutrition, education, housing, health, legal rights, recreation and social/cultural activities.[3] This was the stance taken in the second and third main reports of the Poverty Inquiry 1974; significantly these two reports were on the law and poverty[4] and on social/medical aspects of poverty[5]. These differing perceptions of the nature of poverty are especially relevant to invalidity and income maintenance and mirror divisions in medicine as to whether disabilty can be measured in quanta of deficits or whether it is fundamentally a relationship between an impaired person and his/her social world.

Whatever the criteria or perspective (social, economic, medical or legal) might be, the purpose of these definitions is to define an individual's disadvantage so that a remedy is offered. From each perspective the same person may be categorised: as handicapped by health, as disadvantaged by welfare, as poor by economists and as a claimant by the law. These are dynamic social constructs and constantly changing — poverty in 1880 is different from poverty in 1980: welfare has shifted from selectivity and charity

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1 Many chronic diseases and injuries are distributed according to occupational socio-economic class; this has been extensively documented by the Black Report on *Inequalities in Health in the United Kingdom* in April 1980, see P. Townsend and N. Davidson, *Inequalities in Health: The Black Report* (1982). The survey by the Australian Bureau of Statistics, *Handicapped Persons in Australia* 1981, shows that handicapped persons and families with handicapped members are poor relative to the rest of the population and this is greater with severe handicaps and older family units.
The Australian Government Commission of Inquiry into Poverty, *Poverty in Australia,* First Main Report, Chairman Professor R. F. Henderson (April 1975) 22, found that 25.5% of adult income units in which there was sickness and invalidity were very poor.

2 The Henderson Poverty Inquiry note 1 *supra,* attempted to define a poverty line which has been subsequently widely accepted by welfare groups but criticised by some economists and social administrators, see for example, D. I. Stanton, "The Henderson poverty line — A critique" *Social Security* (December 1980) 14-24.
The issues in measuring poverty are discussed comprehensively in: "The Poverty Line: Methodology and Measurement", *Social Welfare Research Centre Reports and Proceedings,* No. 2, October 1980, S.W.R.C., University of New South Wales.

3 P. Townsend, *Poverty in the United Kingdom: A Survey of Household Resources and Standards of Living* (1979).

4 The Australian Government Commission of Inquiry into Poverty, *The Law and Poverty in Australia,* Second Main Report, Chairman Professor R. Sackville (1975).

5 The Australian Government Commission of Inquiry into Poverty, *Social/Medical Aspects of Poverty in Australia,* Third Main Report, Chairman Rev. G. S. Martin (1976).

towards universalism and equal rights and the law now concerns itself more with issues of discrimination against disadvantaged people.[6]

In a technical sense, medicine now defines diseases more precisely (and has lost some of its mystique in doing so) and in the past two decades has begun to appreciate the social dimension of disease expressed through disability and handicap.[7]

In this paper, recent medical and legal concepts of handicap shall be commented upon, together with the failure of social welfare administrators to comprehend these changes and the significance of this for the role of doctors. The events I refer to were described as a "crackdown on invalid pensioners"[8] and either merit Hugh Stretton's description as "Australia's war on the poor"[9] or were an example of careless and mindless public administration.

I. DEFINING INVALIDITY

1. Proposed National Compensation and Rehabilitation Scheme

Central to the proposals of Woodhouse and Meares (1974)[10] for a national compensation and rehabilitation scheme was the intention to remove decisions about incapacity from the courtroom, and for compensation benefits to be paid periodically. They sought to have incapacity determined objectively and by standardised methods to achieve "broad and reasonably uniform justice".[11]

Medical impairments, they considered, could be decided by clinical assessments and incapacity itself would be assessed in relation to the effect of these impairments on a person's working capacity and quality of life. The eligibility for benefits would be decided administratively on a doctor's advice of percentage of incapacity. Thus, decisions normally taken together were nominally separated.

Doctors were to determine permanency of impairment and to calculate the extent of impairment of the whole person. Standardisation was to be achieved by using Guides to Impairment published by the American Medical Association.[12] The introduction of these guides makes a critical point distinguishing between impairment and incapacity, which was reiterated by Woodhouse and Meares in their report:

> much confusion has resulted from inadequate understanding by physicians and others of (a) the scope of medical responsibility in the evaluation of permanent

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6 See the Reports of the South Australian Committee on the Law and Persons with Handicaps, Chairman Mr. Justice C. H. Bright, Volume 1, *Physical Handicaps* (1978); Volume 2, *Intellectual Handicaps* (1981); the Reports of the New South Wales Anti-Discrimination Board, Chairman Mr. P. Stein, *Discrimination and Physical Handicap* Volumes 1 and 2, (1979) and *Discrimination and Intellectual Handicap* (1981). See also S. C. Hayes and R. Hayes, *Mental Retardation: Law, Policy and Administration* (1982).

7 World Health Organisation, *International Classification of Impairments, Disabilities, and Handicaps* (1980). For explanations by Dr. P. H. N. Wood who contributed largely to the W.H.O. classification see P. H. N. Wood and E. M. Bodley, "An epidemiological appraisal of disablement" in A. E. Bennett (ed.), *Recent advances in Community Medicine* (1978).

8 *Sydney Morning Herald,* 3 July 1980.

9 H. Stretton, "The Australian war on the poor" *New Society* (15 November 1979) 368-370.

10 Report of the National Committee of Inquiry, *Compensation and Rehabilitation Medicine in Australia* (July 1974).

11 *Id.*, para. 400 a.

12 *Id.*, para. 400 i.

disability and (b) the difference between "permanent disability" and "permanent impairment"...

(a) Permanent impairment. This is purely a medical condition. Permanent impairment is any anatomic or functional abnormality or loss after *maximal rehabilitation* has been achieved (my italics), which abnormality or loss the physician considers stable or non-progressive at the time evaluation is made. It is always a basic consideration in the evaluation of permanent disability.

(b) Permanent disability. This is not a purely medical condition. A patient is "permanently disabled" or "under a permanent disability" when his actual or presumed ability to engage in gainful activity is reduced or absent because of "impairment" which, in turn, may or may not be combined with other factors. A permanent condition is found to exist if no fundamental or marked change can be expected in the future.[13]

The Woodhouse-Meares proposals relied heavily on the assessment of impairment by doctors, as it depended on their translation of medical findings into a percentage of the severity of incapacity. Impairment would be converted to incapacity without a further social assessment. Indeed, the American Medical Association Guides enable a calculation to be made, converting a structural or functional impairment into an impairment of the whole man. In the Woodhouse-Meares scheme, benefits were to be available above 15% incapacity (calculated in terms of the whole man) and 85% was defined as total incapacity. The Bill incorporated a formula to calculate benefits for permanent partial incapacity.

Clause 33. In the case of incapacity that the Director-General determines to be partial incapacity that appears likely to be permanent, the rate of benefit in respect of each week during which the incapacity continues is subject to this section, the rate calculated in accord with the formula:

$$\frac{ap}{100}$$, where —

a is 85 per centum of average weekly earnings last published before the benefit begins to be payable; and

p is the percentage of the person's incapacity.[14]

Clause 35. (1) For the purposes of section 33 or 34, the percentage of a person's incapacity is that percentage (being a multiple of 5 per centum) that a medical practitioner determined in writing to be the percentage of a person's incapacity.

Clause 35. (4) For the purpose of making a determination as to the percentage of a person's incapacity, a medical practitioner —

(a) shall take into account not only the person's physical or mental disability but also the extent to which his personal efficiency and ability to lead a normal life have been impaired; and

(b) shall have regard to the tables of relative impairment in the work entitled "Guides to the Evaluation of Permanent Impairment" prepared by the Committee of the

13 American Medical Association, Committee on Rating of Mental and Physical Impairment, *Guides to the Evaluation of Permanent Impairment* (1971) iii.

14 *Id.*, 276.

American Medical Association on Rating Mental and Physical Impairment and published during the year 1971 by the Association.[15]

Were these generous, ungenerous, or fair provisions? The fact that social assessment was not included, and medical impairment was the principal yardstick, could have disadvantaged those with lower skills and those with mental and functional disorders. On the other hand, the threshold for benefits was set lower than for invalid pensions and benefits would be paid in proportion to assessed severity of impairment; that is, a sliding threshold.

It is not difficult to imagine that certain doctors with special interests might tightly equate incapacity with assessed impairment, and others of eclectic vein might appreciate the wider social significance of a person's condition. The way was open under this scheme for a Director-General to benevolently select or rigidly reject an alternative doctor's certificate.

2. Repatriation

Justice Toose in his review of the Repatriation system noted that the intention of the War Pensions Act was that "incapacity" related to "inability to earn", and followed principles in the Workers' Compensation Act.[16] The Administrative Appeals Tribunal in *Foulger's* case interpreted incapacity arising out of war service as the effect on the person and not the injury or disease itself.[17] Thus, incapacity is equal to disability in the Repatriation system.

Instructions to Repatriation Medical Officers state that the following elements of incapacity have to be considered: impairment, restriction of ability to engage in employment, pain, discomfort, disfigurement, loss of enjoyment of life and restricted normal recreations. The availability of employment, the member's economic position, trade or professional skills are not to be taken into account.[18] Doctors making assessments for the Repatriation Commission use guides containing tables of impairments and have made limited use of American Medical Association Guides already referred to.[19]

The point to be made is that the Repatriation Commission has made extensive use of standardised criteria of impairments to determine war-caused incapacity. Social factors are excluded from this assessment but the medical findings have only the status of opinion before the Repatriation Commission and its Review Tribunals. It would seem that a balance is being struck between a purely medical assessment and the socially extended perspective of lay representatives on determining tribunals.

3. International Developments

Medicine's concept of disease has served well in attacking the causes of ill health especially in the case of single aetiological agents. However, even here social factors have to be accounted for; tuberculosis is most prevalent amongst the poor, measles has

15 *Id.*, 277.
16 Cited by K. J. A. Fleming in "Assessment in Repatriation", Report of the *First Annual Conference of the Repatriation Review Tribunal* (1982) 31.
17 *Ibid.*
18 *Id.*, 33.
19 *Id.*, 34.

its most devastating impact amongst the undernourished. The disease concept is the basis of the International Classification of Diseases which has taken half a century to develop and is still developing. Diseases are classified on three levels: (1) aeticology — for example, tuberculosis is classified by the presence of Myobacterium tuberculosis; (2) pathology — coronary heart disease on the structure of the coronary arteries and (3) manifestations — angina pectoris is the chest pain due to coronary artery insufficiency. But these categories are limited in their explanatory power for many phenomena of significance to health care.[20] Their orientation is aetiological and structural rather than functional, and the consequences of disease for the sufferer are not included.

Thus, for a person with a chronic or residual condition, his/her health needs are not classifiable and for the health care system (except for public health) little data can be obtained about its effectiveness. A person admitted to hospital with chest pain due to a coronary occlusion, or breathless due to heart failure caused by a coronary occlusion may be discharged without symptoms but the health status before and after admission would be listed as coronary occlusion. Therefore, a new system to characterise the consequences of disease is needed, especially as the burgeoning work of the health system in developed (and developing) countries is the management of chronic conditions.

The World Health Organisation (W.H.O.) started work on a classification to measure the consequences of disease in 1972.[21] W.H.O. identified the need for a system to structure clinical and rehabilitation activities, to ascertain the prevalence of disabled individuals (for example, to determine those eligible for pensions and benefits) and for a range of applications to health statistics, planning health resources, social security, social administration and social policy.[22]

To date, preliminary classifications have been circulated widely throughout the world for comment. In October, 1975, an international conference recommended the publication of the Ninth Revision of the International Classification of Disease following a meeting between W.H.O. and international social security bodies. The International Classification of Impairments, Disabilities and Handicaps was published for worldwide trial purposes in 1980.[23]

The manual includes the following definitions (all in the context of health experience):

Impairment — any loss or abnormality of psychological, physiological or anatomical structure or function.

Disability — any restriction or lack of ability (resulting from an impairment) in performing an activity in the manner or within a range considered normal for a human being.

Handicap — a disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex, and social cultural factors) for that individual.[24] These definitions describe

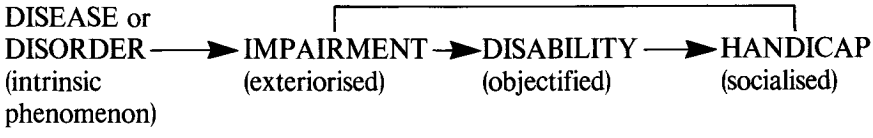
20 Note 7 *supra.*
21 *Ibid.*
22 *Ibid.*
23 *Ibid.*
24 *Ibid.*

the multiple effects of chronic disability on a person and set a framework for clinical and rehabilitation services and social provisions.

Social policies for disabled people would especially address the W.H.O. survival levels for handicap:

(i) Orientation — the individual's ability to orientate himself in relation to his surroundings.
(ii) Physical independence — ability to sustain a customarily effective independent existence.
(iii) Mobility — to move about effectively in his surroundings.
(iv) Occupation — ability to occupy his time in a manner customary to his sex, age and culture.
(v) Social integration — to participate in and maintain customary social relationships.
(vi) Economic self-sufficiency — to sustain customary socio-economic activity and independence.
(vii) Other circumstances which may give rise to disadvantage.[25]

While the distinction between the categories in the classification are not precise, they describe a transition in the human impact of chronic conditions.



The person suffers a disease or disorder recognisable by the components of the medical model of disease (aetiology, pathology, manifestation). Then the pathology becomes appreciated by the person or an observer. However, the connection is variable as many pathological states remain asymptomatic and many symptoms cannot be explained. Next, the awareness of something amiss causes the person's behaviour to change and/or the impairment directly alters performance so that activities are restricted. This is the experience of disability and affects the person's overall function.

As a result of any of these states of perception or function, the individual may be disadvantaged relative to others; this is the state of handicap. Thus, between the underlying disorder and the resulting handicap, a sequence exists of exteriorisation (impairment), objectification (disability) and socialisation (handicap). Not all cases of handicap follow this linear path. Facial disfigurement is handicapping without impairment, and, in many instances, this is also true of epilepsy. In other cases, psychological reactions will cause disability and handicap.[26] Classifying disabilities and handicaps is a major concern of W.H.O. and international social welfare bodies, and I presume has the support and interest of social and health legislators and administrators in this country.

25 *Ibid.*
26 *Ibid.*

II. NEEDS OF HANDICAPPED PERSONS

These definitions are important to handicapped persons since legislation to provide services and benefits involves the categorisation of their needs. If handicapped persons are discriminated against by public attitudes, then parliamentarians and legislation should not reinforce these attitudes. Justice Bright, Chairman of the South Australian Committee on the Rights of Persons with Handicaps, found a complete lack of uniformity of terms in South Australia legislation used to describe handicapped persons and, even within the same Act, different phrases were used to describe handicapped persons. Twenty-four different phrases were discovered which described physical handicaps and more for mental handicaps. Many of the phrases were pejorative and discriminatory as, for example, "incurables" and "weak". Even "the handicapped" is pejorative and depersonalising. He also found that legislation was "littered" with examples of discrimination against handicapped persons.[27] He recommended that the definitions used should be accurate, consistent and not negative; and that the definition of handicapped person be:

> one who as a result of a physical impairment, together with community attitudes and the physical environment, is substantially limited in his opportunities to enjoy a full and active life.[28]

The report of his committee accepted the W.H.O. definitions and recommended that legislation should recognise the distinction between impairment, disability and handicap.

In view of the recent controversy over invalid pension legislation, Justice Bright's committee's opinion about the provision of benefits to handicapped persons is relevant:

> It is inappropriate for the law to give *benefits* on the basis of impairments . . . many of the inequities . . . [in the] Social Security System arise when benefits are awarded on the basis of impairment.[29]

His committee believed that social benefits should be allocated on the basis of "handicaps".[30]

The Tasmanian Inquiry into the Needs of the Handicapped also noted the legislative confusion about disability and handicap, and recommended that in Tasmanian legislation the definitions of handicap should be "reviewed and redefined so that the terms used are consistent, relevant and non-discriminatory".[31] The W.H.O. definitions, the Inquiry considered, would provide a relevant basis for legislators, social and health planners to examine the needs of handicapped persons on the community.

Two States, South Australia and New South Wales, have introduced anti-discrimination legislation which in New South Wales applies to those with a physical disability and/or intellectual handicap. The New South Wales Anti-Discrimination Board noted that many terms used to describe handicapped persons are pejorative and

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27 Note 6 *supra.*
28 *Id.*, 33.
29 *Id.*, 11.
30 *Ibid.*
31 *Report of the Tasmanian Board of Inquiry into the Needs of the Handicapped,* Chairman Professor I. W. Webster (March 1980) 115.

preferred the expression "person with a physical handicap".[32] Their definition of physical handicap was adopted from the Bright committee[33] and is consistent with the W.H.O. concepts.

To achieve consensus on the nature of disadvantage will be difficult since our concepts of humanity are so diverse. Disabled people "have nothing in common but their disability: they can be young, old, rich, poor, suffer a static or progressive condition, possess every available appliance and support or be isolated or unaware of the help available"[34]; yet it is by their disabilities that we categorise them and isolate them.

In their book on *Mental Retardation, Law, Policy and Administration,* Hayes and Hayes are careful in choosing "mental retardation" in preference to terms such as "intellectual handicap" and "mental handicap", but they equate disability with impairment, and define handicap in such a way as to include characteristics coded as disabilities by the W.H.O. definition.[35]

III. ELIGIBILITY FOR INCOME MAINTENANCE

Income support is a fundamental need of disabled persons but the invalid pension is hardly an extravagant handout of taxpayers' money as it is set at a subsistence level, arguably lower than that required to prevent poverty. The Poverty Inquiry demonstrated the connection between disability and poverty as did the recent survey by the Australian Bureau of Statistics[36] and the connection is implicit in the W.H.O. codes for handicap.[37] Thus, medical decisions of invalidity are critical to the economic survival of thousands of Australian citizens (one in twelve are handicapped by a disabling condition[38]). While the distinction between levels of disability is difficult, there are other medical decisions which affect income maintenance. There are borderlands between temporary incapacity for work and sickness benefits and temporary unemployment and unemployment benefits; as well as between chronic disability and long-term unemployment. Each distinction requires a medical decision about disability.

In the past, doctors assessing claimants for an invalid pension and deciding whether they were permanently incapacitated for work to the extent of 85%, were advised to use additional data as well as diagnosis and clinical decisions: "employment background, educational standards, work skills, social and environmental aspects (family, domicile, etc.) and psychological aspects (attitudes, motivation, personality, etc.)".[39] But a legal opinion to the Department of Social Security described these

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32 *Discrimination and Physical Handicap* vol. 1, note 6 *supra,* 3-4.
33 Note 6 *supra.*
34 M. Maclean, "Review of 'Provision for the Disabled' " (1976) 10 *Social Science and Medicine* 343.
35 Note 6 *supra.*
36 Note 1 *supra.*
37 Note 7 *supra.*
38 Note 1 *supra.*
39 P. Hanks, "Invalid Pensions: Rights at Risk" (1980) 5 *Legal Services Bulletin* 145, 172; see also section 35 of the Commonwealth Medical Officer's Handbook prior to June 1980.

guidelines as "an unauthorised gloss" on the law.[40] Doctors were directed to exclude social and environmental factors from their consideration and to observe new criteria.[41]

In view of the developing understanding of disability, evidenced by the W.H.O. codes, it is remarkable that doctors so willingly complied with this directive. In 1982 A.C.O.S.S. estimated that 45,000 persons (pensioners and dependants) did not receive an invalid pension that they could reasonably have expected to receive on past trends.[42] I have estimated from trends over the previous ten years that in 1982 there were 38,000 fewer invalid pensioners than expected. This is well outside any variation that could be explained by statistical factors.

The threshold of invalidity had been reset towards biological and tangible criteria and the social (and psychological) world largely excluded. Incapacity had been equated with impairment, rather than with disability, which runs counter to the Bright Committee's recommendations for the implementation of social policy. It also runs counter to that which social welfare legislation is directed; namely the prevention of poverty, a handicap which results from impairment and disability. As a layman in legal matters, I found it difficult to appreciate how a legal opinion could advise such a narrow interpretation, and as a doctor I have been disappointed that my colleagues (except for a few) have been oblivious to the significance of these events.

As I judge it, the legal definition of incapacity for work comes mainly from law related to compensation cases. The Griffith & Hulme opinion pointed out that there is a difference between being compensated for losses arising from physical incapacity for work and welfare benefits for incapacitated persons. Nevertheless, they argued for a definition of incapacity for work from compensation cases. But their advice was confused precisely on the point at issue when they stated ". . . the qualification [for an invalid pension] relates to the degree of permanent *impairment* (my italics) compared with the capacity for work which the claimant would have had but for his disability, rather than the state of the labour market or the absence of the opportunities for work in that labour market".[43]

The compensation background could explain the direction towards impairment as the criterion of invalidity, as compensation cases seem to be a contest between provable and unprovable losses of function and income. However, invalid pensions are social welfare provisions for basic sustenance and prevention of poverty in which social and environmental factors may predominate. Thus, in my opinion, these factors should be taken into account together with impairment, when assessing incapacity for an invalid pension. To a degree, this is explicit in the income tests for eligibiity, but this copes inadequately with the notion that poverty is expressed through relative deprivation and socially structured "styles of living".

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40 Opinion given by Gaven Griffith and S. E. K. Hulme, 1979; see Memorandum 23 May 1980 *Control of Invalid Pensions* signed by the Director General of Social Security.

41 Department of Social Security, *Circular Instruction,* No. 60/15, 25 February 1980. Department of Health, Circular Instruction, June 1980.

42 P. Smith and P. Bedwell, "Unfit for the Pension" *Report on the Eligibility Criteria and Administration of Invalid Pensions* Australian Council of Social Service (1982).

43 Note 39 *supra,* 173. See also note 40 *supra.*

IV. IMPLICATIONS FOR SOCIAL POLICY

Following the publicity and concern expressed about the "crackdown" on invalid pensions, the Federal Government moved to redress the policy on the assessment and legal rights of invalid pensioners. Their claim was that the policy was unchanged but the administration of medical decisions was the problem:

> The guidelines were clarified in May 1981 and released for use by Commonwealth Medical Officers and for the information of the public generally. The revised guidelines make clear that permanent incapacity for work may result from a combination of medical impairment and any other factors, such as the claimant's *education, age, sex, personal disabilities and lack of skills.*[44] (my italics)

The social dimension is central to a person's incapacity to work — although the social welfare bureaucracy and politicians fail to appreciate that work itself is a social function, and that occupations represent social divisions of labour which are drastically affected by economic policies and hence limit the opportunities of disabled persons.

The legal rights of invalid pensioners prior to September, 1980, were less than for other pensioners and beneficiaries. Their appeals against medical decisions were handled by medical referral and consultation (just as the original claims were), and not by independent tribunals. In September, 1980, the Social Security Appeals Tribunals (S.S.A.T.'s) were given authority to review and *advise* upon medical decisions taken by the Director-General and his delegates. Their jurisdiction was widened and medical practitioners were appointed. Further, the Administrative Appeals Tribunal, the President of which is a Judge of the Federal Court, was empowered to review any decision of the Director consequent upon a review by the S.S.A.T. This meant that medical decisions could reach the A.A.T. where the disabled person could be represented in his/her claim for an invalid pension.[45]

Commendable as these policies are, they do not alter the fact that the events of 1979 have meant that many thousands of persons were denied an invalid pension. The Department of Social Security recognised the decline in invalid pensions in 1981-1982 as 2.4%[46], which runs counter to the rising trend of other social welfare indicators. There were 4,356 outstanding appeals against medical decisions as at 30 June 1982.[47]

V. MEDICAL IMPLICATIONS

At the heart of the administration of social policy for disabled persons are medical judgments and advocacy of health and social needs. The personal doctor recommends and advises the disabled person to apply for an invalid pension, or agrees to support an application on the advice of a social worker or other party. Depending on his/her assessment of the person's needs and, unfortunately, his/her beliefs about welfare, the medical report and opinion may or may not be supportive of the claim.

In the bureaucracy, publicly employed and privately practising doctors assess the

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44 Department of Social Security, *Annual Report* (1981-1982) 21.
45 *Id.*, 42-44.
46 *Id.*, 21.
47 *Id.*, 45.

legitimacy of the claims. Whether or not a disabled person receives an invalid pension depends on a fair medical assessment of incapacity. The doctor's decision will officially open or shut the gate to social welfare benefits for a disabled pension. Doctors act as agents of social control by legitimising the impairments of some and rejecting the claims of others.

The prevailing ethos of medicine towards acute medicine and the training of doctors has not equipped them well to be assessors of disability and that may explain how they, so readily it seems, complied with the direction to exclude social and environmental factors from their assessments of incapacity. The W.H.O. and other bodies are attempting to enhance the medical understanding of disability and related concepts. It is remarkable that these concepts had not permeated the Departments of Social Security and Health or reached practising doctors, or the legal counsel who advised the Government. More seriously, medical decisions reflect the medical perception of welfare needs and legitimacy of State-provided income maintenance.

Apart from the Doctors' Reform Society, no medical body identified publicly with the welfare of invalid pensioners whereas welfare organisations such as the Australian Council of Social Service, the Catholic Commission on Peace and Justice and advocate groups for handicapped persons did. The Australian Medical Association privately sought clarification from the Minister for Social Security, as doctors in country areas complained that invalid patients had their pensions withdrawn.[48] One doctor said:

> Previously we operated under a humane interpretation. Now we have been forcibly instructed — those are the words used — that we are to exclude all socio-economic factors and availability of work from our assessment. That means abandoning all the considerations that make for proper, decent and humanitarian medicine.[49]

The controversy which surrounds the eligibility of disabled persons for income maintenance demonstrates in medicine the conflict between a tightly conceived professional ethos of individual practice and a publicly defined social role as a certifier of disability. Herein lies the potential for the alignment of medicine's professional values so as to be used in the social control of dependent population groups. Further, it demonstrates, from a different perspective, the causal connection between health status and poverty, and the role of health services in social policy.

VI. CONCLUSIONS

Social policies for disabled people have objectives to lessen the incidence of disability, reduce its severity and lessen the prevalence of handicaps in the community. Invalid pensions are provided to reduce the handicap of poverty and involve the application of eligibility criteria based on the severity of disability and a person's economic resources.

Since (i) the level of income maintenance is set at an arguable low subsistence level so that recipients are by definition still (or nearly) poor, and remain so; (ii) the threshold of invalidity is incapacity to work (to the extent of 85%); and (iii) work is fundamentally a social activity, although dependent on physical and intellectual capacity: then it would

48 N.S.W. Branch of the Australian Medical Association, *Monthly Bulletin* (March 1981) 8-9.

49 Part-time Commonwealth Medical Officer reported in *The Sydney Morning Herald,* 18 July 1980, 10.

seem entirely reasonable that social and environmental circumstances should be essential criteria in the determination of invalid pension eligibility.

For these reasons, the 85% incapacity for work threshold should be interpreted generously, as the concept of total incapacity is more appropriate to compensation payments than to the needs of a borderline functioning person who is to be sustained at a living standard on the margins of poverty. The fine distinction between disability-caused poverty, *handicap,* and poverty *per se* suggests that universal provisions for income maintenance, with supplementation for the special needs of disabled persons, be they old, poor, impaired or otherwise disadvantaged may be more appropriate social policies than the selective approach to groups of disabled persons.

In current circumstances, with existing social welfare provisions, disabled persons do have special and unmet needs which necessitate special consideration. A more appropriate definition of invalidity for an invalid pension would be a lower threshold of incapacity; for example, a permanent incapacity which substantially contributes to an inability to work. Since no one is able to predict what the labour market will be in the future (possibly worse in the short to medium term) then the current state of the distribution and availability of work should be part of this assessment.