



The Royal Australasian
College of Physicians

Royal Australasian College of Physicians

Policy Statement on Disability

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Australasian Faculty of Public Health Medicine

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About the RACP

The Royal Australasian College of Physicians (the RACP) trains educates and advocates on behalf of more than 13,500 physicians – often referred to as medical specialists – and 5,000 trainees, across Australia and New Zealand. The RACP represents more than 25 medical specialties including paediatrics & child health, cardiology, respiratory medicine, neurology, oncology and public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

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PART ONE: EXECUTIVE SUMMARY

Introduction and background

In August 2008, Australia ratified the *United Nations (UN) Convention on the Rights of People with Disabilities*. The Council of Australian Governments (COAG) endorsed the *National Disability Strategy 2010 – 2020* in 2011. Following these initiatives the Productivity Commission released a draft document, *Disability Care and Support*, which recommended a National Disability Insurance Scheme, and a National Injury Insurance Scheme. The Royal Australasian College of Physicians (RACP) considers it is time to outline its response to these government documents and produce its own policy on disability.

The RACP supports a National Disability Insurance Scheme, and National Injury Insurance Scheme, which would ensure more equitable funding for people with disability.

Purpose of document

The purpose of this policy is to increase knowledge about disability within the College and, more broadly, to help people with disabilities achieve their full potential. The policy draws attention to the many disadvantages suffered by people with disability and identifies ways in which these disadvantages can be mitigated especially by organisation and delivery of health care.

Definition of disability

For the purpose of this document the World Health Organization (WHO) definition of disability is accepted:(1)

Disabilities is an umbrella term covering impairments, activity limitations and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations.

Thus disability is a complex phenomenon, reflecting an interaction between features of a person's body and features of the society in which he or she lives.

United Nations Convention on the Rights of Persons with Disabilities

The United Nations Convention on the Rights of Persons with Disabilities, to which Australia is a signatory, emphasises that people with disabilities should be included fully within society. Some sections of this United Nations Convention are of particular importance to health care professionals such as:

Article 9 – Accessibility

Article 10 – Right to life

Article 19 – Living independently and being included in the community

Article 20 – Personal mobility

Article 25 – Health

Article 26 – Habilitation and rehabilitation.¹

The RACP endorses the principles contained within the Articles of the UN Declaration and agrees with the WHO's definition of disability.

Impact of disability

There is overwhelming evidence that people with disability have poor health compared to others in the community; they have more risk factors for disease, increased morbidity and increased mortality.

Some sections of the population with disability, especially those with intellectual and psychiatric disabilities, are more vulnerable to ill health than others. The indigenous population carries a large disability burden. In spite of this increased risk for disease, people with disability typically have diminished access to health services.

The RACP will aim to include a disability medicine component at the review of each curriculum. The RACP will also consult an expert on disability medicine at the time of the curriculum review.

Recommendations

The RACP will advocate for:

- comprehensive prevention, early intervention and continuing health services for people with disabilities
- equitable access to health promotion and preventive health programs for people with disabilities
- the Commonwealth Government, in partnership with the Australian Institute of Health and Welfare (AIHW), to establish a National dataset about the health of people with disabilities.

Childhood disability

Disability in childhood imposes a life-long burden on carers, especially on families of the growing child. Early diagnosis is essential and early intervention has proven benefits. Children need multidisciplinary services and they need assistive devices to be provided in a timely fashion. Carers should be acknowledged and provided with support. When children pass from paediatric to adult services formal transition services are necessary to ensure that appropriate specialist care is available.

Recommendations

The RACP will advocate for:

- increased funds and other resources for research into causes and treatment of childhood disability
- adequate early childhood intervention services and parental support when childhood disability is first identified
- specialist multidisciplinary assessment and treatment throughout childhood

¹ These Articles are included as Appendix 2.

- the availability of assistive devices without delay when required
- the design and funding of transition clinics in appropriate locations to facilitate the transfer of children from paediatric to adult specialist care
- health services for people with disabilities from childhood to old age with a lifespan approach and facilitate smooth transition from one service to another

Rehabilitation services

Rehabilitation medicine plays a large part in caring for people with disabilities and aims to improve their chance for employment and position in society. Rehabilitation physicians work in multidisciplinary teams and take responsibility for maximising the functional potential of individuals.

Recommendations

The RACP will advocate for:

- the provision of equitable access to allied health and other disability and rehabilitation services, particularly for those individuals with a disability belonging to a minority group
- family caregivers to carry out their important social and community role by supporting them socially, economically and medically
- culturally appropriate services for carers to enable them to continue their caring role for the person with a disability at home, or in other settings
- the integration of medical and allied health services for people with disabilities

Education aspects

Students with a disability have the same rights to education as other students. Their optimal participation in the workforce is critically dependent on adequate education. *Disability Standards on Education 2005* sets out the obligations of schools and post school educational services to provide education without discrimination on the basis of disability.

The RACP supports the aim of the *Disability Standards on Education*.

Employment aspects

The Australasian Faculty of Occupational and Environmental Medicine has released a position paper emphasising the value of work in the rehabilitation of persons with disabilities. The paper urges that employers and physicians recognise the benefits to society and individuals of returning persons with disabilities to work as early as possible. A practice of fitness for work rather than certification as unfit for work is essential to re-define the attitudes of employers and physicians.

Recommendations

The RACP will advocate for:

- the removal of barriers to the employment of people with disabilities
- assistance for people with disabilities to participate in the workplace by the education of medical providers and employers

Medical disorders and screening

Medical disorders are more common in people with disabilities than those without. The disorders are often unrecognised and if recognised, poorly managed. There are many barriers to treatment, including lack of physical access, attitudinal problems and the attribution of presenting symptoms to the person's disability (diagnostic overshadowing). Research is inadequate and medical students receive little training in the area of disability. Psychiatrists and general practitioners have acknowledged that they need more post graduate training in this area.

The RACP should advocate health screening using purpose specific instruments such as the Comprehensive Health Assessment Programme (CHAP) for people with intellectual disability (28) to enable health checks and identify undiagnosed health conditions.

Recommendations

The RACP will advocate for:

- the provision of dedicated funding for research into the causes and treatment of disability especially for intervention trials
- increasing the time in the medical curriculum for adequate education of medical undergraduates about disability.

Medical services for people with disabilities

Medical services for people with disabilities require the involvement of all health service providers to be coordinated and continuous. Research has shown that screening programs, such as CHAP, are effective in the disability population. Provision of a Medicare Item for yearly assessment of people with intellectual disability by general practitioners remains underutilised.

The large burden of medical disorders requires that more adequate medical care should be provided in an organised manner throughout the lifespan of people with disabilities. The role of the physician is to diagnose, treat and coordinate, recognising that disability is associated with economic disadvantage and communication difficulties. Specialised medical care is just as central to adults with disabilities as it is to children with disabilities.

Recommendations

The RACP will advocate for:

- targeted funding to be made available for research into the causes and health outcomes of people with disabilities in an effort to improve their health and well-being
- the establishment of multi-disciplinary clinics nationwide to deliver specialised medical care to people with disabilities, or establish other mechanisms to facilitate this care
- the establishment of a Medicare Item to enable specialists to do annual assessments for people with disabilities.

PART TWO: DETAILED FINDINGS

Introduction and background

On 17 July 2008, Australia became a signatory to the *United Nations (UN) Convention on the Rights of Persons with Disabilities*. Article Four of this convention requires that “States Parties undertake to ensure and promote the full realisation of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability.” As a result the Council of Australian Governments (COAG) has issued the National Disability Strategy 2010 – 2020.(3) This Strategy sets out a ten year plan to improve the lives of Australians with disabilities, and their friends and carers. One of the six policy areas in the Strategy is Health and Wellbeing.

The Strategy acknowledges the health disadvantage experienced by people with disabilities and outlines policy directions basically aimed at the need:

- for health services to be much more responsive to the needs of people with disabilities
- for universal health reforms to address the needs of all people with disabilities, ensuring those from minority groups are included
- to strengthen health care planning, training and the capacity of universal health care providers to diagnose and treat the health and co-morbid conditions of people with disabilities
- to strengthen the continuity, coordination and range of primary, multidisciplinary and sub-acute care available to meet the health needs of people with disabilities.

COAG endorsed this ten year plan at its meeting in February 2011. In addition, the Commonwealth Government instructed the Productivity Commission to investigate funding of Disability Care and Support. The recently released *Productivity Commission Draft Report into Disability Care and Support* examines the feasibility, costs and benefits of replacing the current system of disability services with a new arrangement which provides essential care and support for all Australians in the event of significant disability. The Royal Australasian College of Physicians (RACP) has already produced a mainly favourable response to the draft report of the Productivity Commission.(4)

The present interest in disability by all levels of Australian governments requires response from major health organisations. Leading medical associations must be careful to clearly state their support for the rights of people with disabilities who are over-represented in patient populations.

In May 2010, the Policy and Advocacy Committee of the Australasian Faculty of Public Health Medicine decided to develop a position statement on disability to be presented to the RACP for adoption. A public health physician, with personal experience of disability, was appointed convenor and volunteers were sought from the Division of Paediatrics and the Faculties of Public Health, Rehabilitation, and Occupational and Environmental Medicine. Two additional academics in the field of disability were also invited to join the working party: Professor Nick Lennox (Director of the Queensland Centre for Intellectual and Developmental Disability, School of

Medicine, University of Queensland); and Professor Patricia O'Brien (Chair in Disability Studies and Director, Centre for Disability Studies, University of Sydney). The final group consisted of ten members.

The RACP supports a National Disability Insurance Scheme, and National Injury Insurance Scheme, which would ensure more equitable funding for people with disability.

Purpose of document

This document aims to provide a framework by which Fellows of the RACP and its faculties and chapters will better understand people with disabilities and help them achieve their potential. The policy will increase the awareness of disability among Fellows and ensure that the health and wellbeing of people with disabilities have a high priority.

This document outlines the principles which underpin the practice of disability medicine by adapting the principles of the UN Convention. It describes the current practice of health care delivery to people with disabilities and draws attention to any gaps in these practices. A broad definition of disability is accepted which includes all types, ages and degrees of disability.

People with disabilities are vulnerable to other disadvantages besides poor health. Their education levels are low compared to those without disability. They suffer income loss as a result of low participation in the workforce. They may need assistive devices and transport to access the environment. Some with sensory disorders and communication problems need special access to information. This statement will show how education, training and employment are essential for people with disabilities to achieve a place within society. To prevent them from falling into the health system by default, adequate income, accommodation, transport, equipment and information are necessary. Thus, the scope of this document includes environmental factors that affect the functioning of people with disabilities in society.

Definition of disability

The definition, models and measurement of disability have important policy implications in Australia and elsewhere in the world.⁽⁵⁾ The RACP supports the International Classification of Functioning, Disability and Health (ICF) where disability is recognised as a universal experience that takes into consideration social as well as medical and biological features. In keeping with the ICF, disability is conceptualised as multidimensional arising from interaction between body structure and function; levels of activity and participation; and environmental and personal factors.

The ICF was officially endorsed by the World Health Organization (WHO) in 2001 as a Framework for Classifying Health and Disability at both individual and population levels. The ICF provides a lens through which disabilities can be viewed and impact described through detailing the relationship between the impairment; its restrictions on activity and participation; as well as recording the environmental and personal context within which the disability is experienced.⁽¹⁾

For the purpose of this document the World Health Organization (WHO) definition of disability is accepted:(1)

Disabilities is an umbrella term covering impairments, activity limitations and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations.

Thus disability is a complex phenomenon, reflecting an interaction between features of a person's body and features of the society in which he or she lives.

Types of disability

The policy statement has taken a broad approach to types of disability to ensure that it covers a wide range of persons with disabilities, and the approach is consistent with the conception of people with disabilities as those “who have long-term physical, mental, intellectual or sensory impairments which in interaction with various physical, social and environmental factors may hinder their full and effective participation in society on an equal basis with others.”(6) This definition is in keeping with the *UN Convention on the Rights of Persons with Disabilities* that Australia ratified in 2008, thereby agreeing to be held accountable to its Principles of Equality, Respect and Full Participation with Article 25 specifically ensuring attainable standard of health without discrimination on the basis of disability. The *Disability Discrimination Act 1992* (Appendix 1), and the various state based jurisdictional legislative equivalents, provide the legal basis for this agreement.

United Nations Convention on the Rights of Persons with Disabilities

On 18 July 2008, Australia ratified the *UN Convention on the Rights of Persons with Disabilities* and under the Convention “is obliged to ensure, promote and recognise that people with disabilities are entitled to all human rights and fundamental freedoms, without discrimination of any kind on the basis of disability.” Fellows of the College should understand their responsibilities under this convention.

The eight general principles are as follows:(6)

- a. *Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;*
- b. *Non-discrimination;*
- c. *Full and effective participation and inclusion in society;*
- d. *Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;*
- e. *Equality of opportunity;*
- f. *Accessibility;*
- g. *Equality between men and women;*
- h. *Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.*

The Convention identified people with disabilities as including:

those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

Of particular relevance to the college are the following articles: 9; 10; 19; 20; 25 and 26.²

The RACP endorses the principles contained within the Articles of the UN Declaration and agrees with the WHO's definition of disability.

Impact of disability

There are 3.9 million (17 percent) Australians with disability (7) and 1.2 million of them have severe or profound core activity limitations.(7) Disability (in this case severe or profound core activity limitation) is strongly associated with age: the prevalences are two percent among young adults, 12 percent among people 65-74, and 58 percent among people over 85 years.(7)

According to the Australian Institute of Health and Welfare (AIHW):

People aged under 65 years with severe or profound disability had a higher prevalence rate of all types of selected long-term health conditions than people without disability. Almost half (48%) of people with severe or profound disability had mental health problems, compared to 6% of people without disability. The prevalence of physical long-term health conditions was higher for people with both mental health problems and severe or profound disability than for those with mental health problems but no disability.(8)

Among Australians with severe or profound disabilities aged 15-64 years, 29 percent report excellent or very good health; the corresponding figure for people without disabilities is 70 percent.(8) The most commonly reported health conditions for Australians under 65 with severe or profound disabilities are mental health and back problems, arthritis, cardiovascular disease and asthma. For the first of these, 48 percent of people with disabilities report these problems, compared to 6 percent among people without disabilities.(8) The prevalence of all other health conditions (including epilepsy, diabetes and cancer, among others) is higher among people with disabilities than those without.(8)

Behavioural or emotional problems with usual onset in childhood or adolescence are more common among people with severe or profound disabilities, high blood sugar level, arthritis and injury are all more common before age 25, and osteoporosis is more common among those aged less than 45.(8) In 2007-08, 58 percent of people aged 18-65 without disability were overweight or obese; among those with severe or profound disability the prevalence was 69 percent.(8) The prevalence of inadequate exercise, smoking, and attempted suicide is higher among Australians with disability than those without disabilities (Table 1).

² These articles can be found at <http://www.un.org/disabilities/default.asp?id=259> (and are included as Appendix 2).

Table 1: Prevalence (%) of risk factors and behaviours, Australians with and without severe or profound disabilities (data from 8)

Risk factor or behaviour	Without disability	With severe or profound disabilities
Very low or no exercise	31	43
Current daily smoking	18	31
Medium or high risk alcohol consumption	35	25
Attempted suicide	1	18

People with disabilities are more likely to use health services than those without. From the 2007-08 National Health Survey 56 percent of those with severe or profound core activity limitation reported visiting a specialist in the 12 months before interview, compared to 16 percent among those without a disability.(8) Higher levels of disability may result in a greater likelihood that health services do not meet needs. Among people with intellectual disability inadequate training of health professionals and greater likelihood of misdiagnosis and inappropriate treatment may contribute to this.(8)

While estimates are available for years lived with disability in the Australian population there are not good Australian data on the association, broadly, between disability and mortality.(9) Various studies do, however, indicate higher mortality among the population with disabilities than others, particularly for cerebral palsy and moderate to severe intellectual disability.(10-13)

An increased risk for disability and the health effects of disability exists among certain sections of the population. Indigenous Australians have nearly three times the disability adjusted life year (DALY) burden from intellectual disability compared with other Australians.(14) They also have 1.6 times the DALY burden from mental disorders.(14) In spite of the increased burden of disease borne by people with disabilities they typically do not have increased access to health services and may be prevented from equal access by many barriers.

No universal collection of health related data for people with disabilities is available to researchers and policy makers in Australia. Although mortality data are available in some states for people with intellectual disability, there is no agreement on overall mortality of people with disabilities. Within the available data it is difficult to calculate the proportion of people with disabilities who consult doctors or are admitted to hospital partly because of a lack of agreed definition of disability.

People with psychiatric disability also carry an increased burden of disease. The reasons for this increase are multiple but certainly include smoking, which may result in emphysema and cardiovascular disease.

The RACP will aim to include a disability medicine component at the review of each curriculum. The RACP will also consult an expert on disability medicine at the time of the curriculum review.

Recommendations

The RACP will advocate for:

- comprehensive prevention, early intervention and continuing health services for people with disabilities
- equitable access to health promotion and preventive health programs for people with disabilities
- the Commonwealth Government in partnership with AIHW to establish a National dataset for the health of people with disabilities

Childhood disability

Disability poses a significant problem for children, their parents and extended families, and for society. It is a lifelong problem with a continuing need for support and special assistance. There are almost 300,000 children (or about 7.6 percent of all children) in the age group 0–14 years in Australia with a significant disability.⁽¹⁵⁾ Despite these large numbers and significant impact, there are large gaps in services for these children. In addition, the causes of many disabilities remain unknown and the best treatment methods uncertain, pointing to the urgent need for more research.

Diagnosis and early childhood intervention

Children with disabilities require early diagnosis and provision of timely early childhood intervention. There is ample evidence that intervention is most effective if provided early and in a family-centred multidisciplinary manner. Parents require support in coming to terms with the diagnosis, information about services and guidance to help their child achieve optimal outcomes.

Ongoing care throughout childhood

Children with disabilities have multiple needs that require input from a number of health, educational and other professionals. All children grow and develop, but the presence of a disability has an impact on all areas of life. As children progress through the preschool and school years, they require:

- access to a family doctor who has an understanding of disability
- regular contact with a paediatrician to address health needs, to ensure that appropriate services are in place and to support families to access educational, therapy and support programs
- access to a variety of other specialists including audiologists, ophthalmologists, orthopaedic surgeons, dentists and neurologists
- provision of psychology, social work and allied health services with access to multidisciplinary assessment, when required
- access to an appropriate well-supported preschool and school program ensuring full participation but with a modified curriculum, if needed

- provision of specialised equipment including wheelchairs, bath aids and communication devices
- access to the same community and recreational activities as other children including holiday programs and sports activities
- provision of respite for families in home or in out of home facilities, where required. For a small number of children, care outside the family may be required
- access to parental counselling and, at times, psychiatric help.

It is important to note that there has been an increase in the complexity of health care needs of children with disabilities. Many children now have interventions including gastrostomies, need for regular medication, suction, continuous positive airway pressure (CPAP) or Bi-Level Positive Airway Pressure (BiPAP) at night, which have a significant impact for families and also service providers.

Transition

At the time of transition from childhood to adult life, young people with disabilities and their families face a number of issues. For example, they become over-age for paediatric services, they leave school whereupon post-school options must be explored and secured, and the respite facilities available to them as children often cease to be available.

In some locations around Australia, transition clinics have been established but these clinics are inadequate to cater for the large number of young people exiting from paediatric facilities and, in addition, are often geographically distant. There has been difficulty in encouraging adult physicians to take up the challenge of caring for these young people. The Faculty of Rehabilitation Medicine has shown a lead in this area with some clinicians beginning to work in this branch of medicine. But more needs to be done to ensure that young adults in all areas of Australia have access to services, possibly using technologies such as videoconferencing for remote individuals.

Recommendations

The RACP will advocate for:

- increased funds and other resources for research into causes and treatment of childhood disability
- adequate early childhood intervention services and parental support when childhood disability is first identified
- specialist multidisciplinary assessment and treatment throughout childhood
- the availability of assistive devices without delay when required
- the design and funding of transition clinics in appropriate locations to facilitate the transfer of children from paediatric to adult specialist care
- health services for people with disabilities from childhood to old age with a lifespan approach and facilitate smooth transition from one service to another.

Rehabilitation services

The prevalence of disability increases gradually throughout the adult lifespan and does so precipitously in extreme old age.(16) In 2009 the overall prevalence of disability reported by Australians was 19 percent and there were 2.6 million carers supporting people with disabilities. Acquired diseases of the musculoskeletal system and connective tissues are the most common conditions reported as causing the disabilities. In addition, trauma is an important cause of severe disability that is acknowledged, with injury prevention and control recognised as a National Health Priority Area.

Rehabilitation physicians make important contributions to the management of people with complex disabilities. Training programs of the Faculty of Rehabilitation Medicine operate in adult and paediatric rehabilitation medicine. Rehabilitation physicians have a central role in preparing their patients for participation in society and employment. Their programs cover acquired and developmental disability. The Faculty's training curriculum defines rehabilitation medicine as "that part of the science of medicine involved with the prevention and reduction of functional loss, activity limitation and participation restriction arising from impairments; management of disability in physical, psychosocial and vocational dimensions; and improvement of function".(17)

Specific learning objectives in the curriculum with reference to developmental and intellectual disability in adults are to "recall basic knowledge of developmental and lifelong intellectual disability which has arisen in childhood; to complete a comprehensive assessment of an adult with developmental/intellectual disability; and to form a rehabilitation plan in consultation with Persons Responsible and carers who are able to facilitate the patient's participation in the plan".(17)

Areas of clinical practice for rehabilitation physicians include paediatric, adult and geriatric rehabilitation for neurological disorders, musculoskeletal and orthopaedic conditions, acute and chronic pain, amputations, occupational injuries, cardiorespiratory disorders, other complex or chronic conditions including cancer and burns.(18)

While concurrently increasing the capacity of rehabilitation services through training of rehabilitation physicians, rehabilitation nurses and allied health professionals service developments at a state level remain essential. Victoria has a well developed Subacute Service Plan that includes rehabilitation services and New South Wales has recently published a Rehabilitation Model of Care that could form the basis of restructuring rehabilitation service provision. Considerable rehabilitation activity also exists in the private hospital sector.

However, many people with disabilities are socially, educationally and economically disadvantaged. This is unlikely to change unless the National Disability Insurance Scheme and the National Injury Insurance Scheme, as recently recommended by the Productivity Commission and supported by the RACP, are established.

Recommendations

The RACP will advocate for:

- the provision of equitable access to allied health and other disability and rehabilitation services, particularly for those individuals with a disability belonging to a minority group
- family caregivers to carry out their important social and community role by supporting them socially, economically and medically
- culturally appropriate services for carers to enable them to continue their caring role for the person with a disability at home, or in other settings
- the integration of medical and allied health services for people with disabilities

Education aspects

Australia's future depends on a high quality and dynamic school education system to provide students with foundation skills, values, knowledge and understanding necessary for lifelong learning, employment and full participation in society.(19) If we accept that work benefits health and that education increases employment then education is essential to any individual with a disability, regardless of age.

The Survey of Education and Training (SET), a 4-yearly household survey by the National Centre for Education and Training Statistics, Australian Bureau of Statistics, provides a comprehensive picture of participation, outcomes and access to education and training. Results for 2009 showed that persons aged 15-64 years with a disability had similar levels of participation to those without a disability in non-formal (26 percent versus 28 percent) and informal³ (82 percent versus 85 percent) learning but they were less likely to have undertaken formal learning (18 percent versus 30 percent).(20)

Formal learning is structured, taught in educational institutions and organisations, as well as through the workplace, and leads to a recognised qualification. In August 2005, the Federal Government made Disability Standards in the area of education, known as the *Disability Standards on Education 2005* (the Education Standards).(21) The Education Standards set out the rights of students with disabilities under the *Disability Discrimination Act* (DDA) in the area of education. The Education Standards also set out the obligations of education providers, such as schools and universities, under the DDA to assist students with disabilities in the area of education.

The main aim of the Education Standards is to give students with disabilities the right to participate in educational courses and programs on the same basis as students without disabilities. This means a person with disability should have access to the same opportunities and choices in their education that are available to a person without disability.

The RACP supports the aim of the *Disability Standards on Education 2005*.

³ Formal learning is always organised and structured, has learning objectives and is always intentional from the learner's standpoint. Informal learning is never organised, has no set objectives in terms of learning outcomes and is never intentional from the learner's standpoint. Non-formal learning falls between the two; it is rather organised and can have learning objectives. [include reference].

Employment aspects

Realising the Health Benefits of Work (22) is a position statement of the RACP facilitated by the Australasian Faculty of Occupational and Environmental Medicine (AFOEM). The position statement has two underpinning principles which have a strong international evidence base:

1. Work, in general, is good for health and wellbeing; and
2. Long term work absence, work disability and unemployment have, in general, a negative impact on health and wellbeing.

Until now, these principles have largely been unrecognised, especially in the case of people with disabilities. People with disabilities need access to work in order to realise health and other benefits. Ultimately, this is to the benefit of society as a whole.

Long term worklessness is one of the greatest known risks to public health. It is imperative that these principles of access to work are applied equitably to individuals with or without a disability within the working age population.

People with disabilities have higher unemployment and are less likely to work in management. Women with disabilities experience disadvantage as a result of both their gender and disability.(23)

A review of critical factors related to employment after spinal cord injury (24) showed that employment rates varied widely depending on several factors. When considering a strict definition of paid employment, the average rate of any employment after spinal cord injury in the USA was 35 percent, compared to an employment rate of 79 percent reported for persons without disabilities.

Barriers to returning to meaningful work included inadequate transportation, concerns about benefits or finances, employer perceptions of liability and capability, and access to healthcare. Rehabilitation programs that address these problems are essential and there is potential for further research into the role of supported employment approaches compared to the conventional vocational rehabilitation model.

Consideration needs to be given to the cost of provision of equipment, workplace modifications, and what are “reasonable accommodations” to support individuals with a disability within a workplace.

Building from the *Realising the Health Benefits of Work* position statement, the relevant issues for attention include:

- educating treating practitioners to incorporate training in workplace occupational health and vocational rehabilitation
- providing “fitness” not “sickness” certification practices
- health professionals responsibly promoting the health benefits of work to their patients
- addressing the barriers that prevent employers moving beyond legislative requirements to embrace the spirit of inclusive employment practices, workplace safety, health and wellbeing, and best practice injury management

Recommendations

The RACP will advocate for:

- the removal of barriers to the employment of people with disabilities
- assistance for people with disabilities to participate in the workplace by the education of medical providers and employers

Medical disorders and screening

People with disabilities experience higher levels of medical and psychiatric disorders when compared to those without a disability. They also experience higher mortality rates especially if they have cerebral palsy, or moderate to severe intellectual disability.(10-13, 25, 26) Medical and psychiatric disorders are frequently unidentified, or if identified, then poorly managed. Co-existing disorders are common especially for people with intellectual disability with on average 5.4 co-morbid conditions experienced per person.(27)

People with disabilities are less likely to receive health screening and health promotion messages may be inaccessible.(28, 29) Many barriers exist to people with disabilities receiving health care services; these include physical access, communication problems, difficulties with recall of health information, healthcare providers' attitudes, fragmentation of support services and diagnostic overshadowing.(30)

Primary care providers struggle to provide as high quality care to people with disabilities as they do to their patients without disabilities.(31) Regular guided health assessments have been demonstrated to provide some benefit to people with intellectual disability; however, this approach has not been examined in people with other forms of disability.(28)

People with disabilities are often excluded from generic research and there are few disability-specific randomised control trials, systematic review or meta-analyses evaluating healthcare interventions in people with disabilities.(32-34) Chronic conditions receive considerable research to examine the effects of interventions; however, these studies largely focus on the underlying condition rather than the consequent disability.

Medical curricula in Australia include from three to 36 hours of training on disability.(35) The Royal Australian College of General Practitioners and The Royal Australian and New Zealand College of Psychiatrists include disability in their training curricula.

The College, Faculty and Chapters should advocate for health screening using purpose specific instruments such as the Comprehensive Health Assessment Programme (CHAP) for people with intellectual disability (28) to enable health checks and identify undiagnosed health conditions.

Recommendations

The RACP will advocate for:

- the provision of dedicated funding for research into the causes and treatment of disability especially for intervention trials

- increasing the time in the medical curriculum for adequate education of medical undergraduates about disability

Medical services for people with disabilities

People with disabilities require ongoing medical and allied health input for the coordination of management strategies. Therefore it is essential that medical practitioners, general practitioners in particular, nurses and allied health practitioners be involved.

Screening programs for people with intellectual disability are effective.(28) The Australian Government, under Medicare, funds health assessments for people with intellectual disability by general practitioners. In Australia In 2007-08, 5,600 assessments were conducted in Australia and 7,100 in 2008-09. There are an estimated 640,000 people with an intellectual disability or restrictive long-term health condition, which suggests these Medicare items may be under-utilised.(7) If this under-utilisation is real, it may reflect inadequate provision of care for people with intellectual disability. Therefore it is important to investigate ways in which adequate provision of medical services can be provided.

Perceived inadequate knowledge or skills among some professional groups may contribute to poor health service access among people with disabilities. Among people with intellectual disability, guidelines for management are available but there are considerable barriers to finding evidence on specific clinical issues. Therefore it is likely that practitioners will continue in needing to apply general management principles and humane judgement in managing patients with disabilities.

Services for children with disabilities, although imperfect, are more satisfactory than those for adults. Adults also need access to multidisciplinary teams of specialists who are funded to give them the time and expertise needed for diagnosis and treatment of complex problems. Some rehabilitation physicians are providing services but the involvement of other specialists is minimal and could be increased by a specific Medicare assessment item for specialist care.

In general, medical services for people with disabilities are fragmentary, unevenly distributed and uncoordinated. Patients experience barriers to accessing medical services which range from the physical inability of a person in a wheelchair to negotiate stairs to the geographical location of health facilities. The lack of inclusiveness in Australian society broadly is mirrored in medical services and facilities, which tend to be disease rather than person centred.

Role of Physicians

Physicians should be familiar with the rights of people with disabilities as expressed by the UN Convention and in legislation. They work in a complex system with other health care professionals. Physicians need to understand and appreciate the contribution by others in the multidisciplinary healthcare team looking after people with disabilities. Some physicians work almost exclusively in disability medicine, others are involved as consultants, however, all physicians should recognise that disability is associated with economic disadvantage and communication difficulties.

They should act as advocates for the individual rights of their patients with disabilities who face discrimination and inequitable access to services.

Apart from the above general responsibilities, the particular role of the physician can be summarised as follows:

- diagnose the cause of disability, if possible
- maintain general health of patients with disabilities
- identify and treat co-morbid conditions
- prevent further disabilities
- refer to appropriate health professionals for needed therapy
- ensure that relevant community services are in place
- help to obtain assistive devices
- maximise functional activity as part of multidisciplinary team
- conduct research relevant to disability
- include people with disability in general medical research
- educate colleagues and students about the nature and impact of disability
- help patients with disabilities to achieve access to education, training, employment and retirement activities as fully as possible.

Recommendations

The RACP will advocate for:

- targeted funding to be made available for research into the causes and health outcomes of people with disabilities in an effort to improve their health and well-being
- the establishment of multidisciplinary clinics nationwide to deliver specialised medical care to people with disabilities, or establish other mechanisms to facilitate this care
- the establishment of a Medicare Item to enable specialists to do annual assessments for people with disabilities

Conclusion

People with disability suffer multiple disadvantages in relation to education, societal participation, income and health. If these disadvantages were addressed, people with disabilities would be able to function better and contribute to Australian society to their full potential. As the UN Declaration has shown, disability does not diminish the rights of any individual to live as a fully participating member of society. Justice requires that there should be equal access to health care and rehabilitation as part of the obligation of a civil society to each citizen.

For people with disabilities many barriers exist to health care. Some of these barriers are surmountable such as the ignorance and attitudes of providers, the lack of

coordination and continuity of health care, inadequate research and lack of a national data set. Health care is only part of the solution to full participation of each individual. For instance, children with disabilities require the same access to education, as all children and adults with disabilities require access to training and employment.

Medical practitioners play important roles in the care of people with disabilities. Individually, and via the specialist colleges, medical practitioners have the capacity to influence perceptions and attitudes to people with disabilities at many levels of society. The RACP acknowledges the *UN Convention on the Rights of Persons with Disabilities* especially in relation to access, inclusion, and equity in health care. The College also welcomes the recent initiatives by all levels of Australian Government to establish guidelines for the provision of health and welfare services to people with disabilities.

PART THREE: REFERENCES AND APPENDICES

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Appendix 1

Similar to the UN Convention, the Commonwealth of Australia under the *Disability Discrimination Act 1992* also embraces a broad definition of types of disability that is adopted within this policy. Specifically **disability**, in relation to a person, means:

- a. total or partial loss of the person's bodily or mental functions; or
- b. total or partial loss of a part of the body; or
- c. the presence in the body of organisms causing disease or illness; or
- d. the presence in the body of organisms capable of causing disease or illness; or
- e. the malfunction, malformation or disfigurement of a part of the person's body;
or
- f. a disorder or malfunction that results in the person learning differently from a person without the disorder or malfunction; or
- g. a disorder, illness or disease that affects a person's thought processes, perception of reality, emotions or judgment or that results in disturbed behaviour;

and includes a disability that:

- h. presently exists; or
- i. previously existed but no longer exists; or
- j. may exist in the future; or
- k. is imputed to the person.

Appendix 2

United Nations Convention on the Rights of Persons with Disabilities

Article 9 – Accessibility

1. To enable persons with disabilities to live independently and participate fully in all aspects of life, States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas. These measures, which shall include the identification and elimination of obstacles and barriers to accessibility, shall apply to, inter alia:

- a) Buildings, roads, transportation and other indoor and outdoor facilities, including schools, housing, medical facilities and workplaces;
- b) Information, communications and other services, including electronic services and emergency services.

2. States Parties shall also take appropriate measures to:

- a) Develop, promulgate and monitor the implementation of minimum standards and guidelines for the accessibility of facilities and services open or provided to the public;
- b) Ensure that private entities that offer facilities and services which are open or provided to the public take into account all aspects of accessibility for persons with disabilities;
- c) Provide training for stakeholders on accessibility issues facing persons with disabilities;
- d) Provide in buildings and other facilities open to the public signage in Braille and in easy to read and understand forms;
- e) Provide forms of live assistance and intermediaries, including guides, readers and professional sign language interpreters, to facilitate accessibility to buildings and other facilities open to the public;
- f) Promote other appropriate forms of assistance and support to persons with disabilities to ensure their access to information;
- g) Promote access for persons with disabilities to new information and communications technologies and systems, including the Internet;
- h) Promote the design, development, production and distribution of accessible information and communications technologies and systems at an early stage, so that these technologies and systems become accessible at minimum cost.

Article 10 - Right to life

States Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others.

Article 19 - Living independently and being included in the community

States Parties to the present Convention recognise the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

- a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;
- b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;
- c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

Article 20 - Personal mobility

States Parties shall take effective measures to ensure personal mobility with the greatest possible independence for persons with disabilities, including by:

- a) Facilitating the personal mobility of persons with disabilities in the manner and at the time of their choice, and at affordable cost;
- b) Facilitating access by persons with disabilities to quality mobility aids, devices, assistive technologies and forms of live assistance and intermediaries, including by making them available at affordable cost;
- c) Providing training in mobility skills to persons with disabilities and to specialist staff working with persons with disabilities;
- d) Encouraging entities that produce mobility aids, devices and assistive technologies to take into account all aspects of mobility for persons with disabilities.

Article 25 - Health

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

- a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;
- b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;
- c) Provide these health services as close as possible to people's own communities, including in rural areas;
- d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;
- e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;
- f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

Article 26 - Habilitation and rehabilitation

1. States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:

- a) Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths;
- b) Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.

2. States Parties shall promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services.

3. States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation.”