Disability, Poverty and Welfare Policy:
A Critical Disability Theory Analysis of Alberta’s Assured Income for the Severely
Handicapped and Implications for Saskatchewan

A Thesis Submitted to the Faculty of Graduate Studies and Research

In Partial Fulfillment of the Requirements

For the Degree of

Master of Social Work

University of Regina

By

Dionne Christine Miazdyck-Shield

Regina, Saskatchewan

September, 2012

Copyright 2012: D. Miazdyck-Shield
Dionne Christine Miazdyck-Shield, candidate for the degree of Master of Social Work, has presented a thesis titled, *Disability, poverty and Welfare Policy: A Critical Disability Theory Analysis of Alberta's Assured Income for the Severely Handicapped and Implications for Saskatchewan*, in an oral examination held on August 31, 2012. The following committee members have found the thesis acceptable in form and content, and that the candidate demonstrated satisfactory knowledge of the subject material.

External Examiner: Dr. James Daschuk, Faculty of Kinesiology and Health Studies

Supervisor: Dr. Miguel Sanchez, Faculty of Social Work

Committee Member: Dr. Garson Hunter, Faculty of Social Work

Committee Member: *Dr. Darlene Chalmers, Faculty of Social Work

Chair of Defense: Dr. Brenda Anderson, Luther College

*via Video-Conference*
ABSTRACT

Throughout modern history, people with disabilities have been socially and economically excluded and subject to intrusive, segregated services. The systemic exclusion of people with disabilities from mainstream society is a product of entrenched discrimination and the devaluing of their lives. The majority of people with disabilities are left with limited options, forcing them to rely on family members, charity and/or state programs to meet their financial and daily living needs.

Disability activists have challenged the hegemonic belief that disability is an individual problem, labeling this the ‘individual pathology’ model of disability. They propose an alternative framework, ‘the social model’ which views disability as entirely subjective and societal, rather than a problem within individuals. This thesis examines how the underlying belief that people with disabilities are tragic and flawed, deserving of charity but not equality, may still be a critical factor that influences the construction of social policy, despite the rising popularity of social model thinking.

Utilizing choice analysis, this thesis studies the Assured Income for the Severely Handicapped (AISH) in Alberta. The questions are asked: which model of disability influenced how and why AISH was developed; and has the AISH program evolved with the growing recognition of the social model of disability? The analysis is then used to reflect on the emerging Saskatchewan Assured Income for Disability (SAID) program.

The systemic exclusion of disabled people has been de-politicized. Alternatives to the individual pathology model, although known to policy-makers, have been ignored in mainstream policy discourse. (Oliver, 1996; Titchkosky, 2006). If positive change is to happen, the situation of people with disabilities must be re-politicized and their collective experience of exclusion acknowledged and as they define their own needs (Oliver, 1990).
ACKNOWLEDGEMENTS

I am grateful to the disability theorists who, through their critical analysis, challenged me to rethink disability. People with disabilities have enriched my life as friends, teachers and colleagues. I hope I can contribute to challenging the oppression and exclusion they face. Thank you to members of People First of Saskatchewan for grounding me in the reasons why disability rights are important.

The Faculty of Graduate Studies granted me scholarships which helped make this journey possible. I received the Graduate Centennial Merit Scholarship in 2009 for $5500. In 2008, I received the Graduate Students’ Association (GSA) Scholarship (part-time status) which was $750.

Thank you to my thesis supervisor, Dr. Miguel Sanchez, who taught me a great deal about oppression and was part of my inspiration for this work. Dr. Sanchez was encouraging, supportive and patient, as this thesis was a drawn-out, labour of love.

Thank you to Dr. Garson Hunter for teaching me how to be critical of social policy. Your thorough analysis and clear commitment to quality made this thesis better. Your diligent work as a committee member is appreciated.

Thank you to Darlene Chalmers for stepping in at the last minute as a committee member and for providing valuable feedback and a fresh set of eyes.

Thank you to Kathleen Handford for taking the time out of a very busy life to read my work critically and give me a careful analysis and practical suggestions for improvements. You are a true academic.

Thank you to my husband David for “getting it” and being there to listen. I couldn’t have done this without you. I dedicate this work to you and our beautiful son, Luther.
# TABLE OF CONTENTS

ABSTRACT........................................................................................................... i

ACKNOWLEDGEMENTS.................................................................................... ii

TABLE OF CONTENTS....................................................................................... iii

LIST OF ABBREVIATIONS................................................................................... v

LIST OF FIGURES............................................................................................... vi

1 INTRODUCTION............................................................................................... 1

2 REVIEW OF LITERATURE AND CONCEPTUAL FRAMEWORK....................... 5

  2.1 Disability Theories..................................................................................... 5

    2.1.1 The individual pathology model of disability.......................... 6

    2.1.2 Critical social model theories: challenging conceptions of disability................................. 10

      (a) History of the social model.................................................. 11

      (b) Historical materialist theory.............................................. 14

      (c) Social constructionist theory.......................................... 16

      (d) Oppressed minority theory............................................... 19

  2.2 Disability, Society and the State............................................................ 23

    2.2.1 The historical relationship with society and state....... 23

    2.2.2 Disability income policy................................................. 24

    2.2.3 Disability, poverty and unemployment.......................... 32

    2.2.4 Medical and genetic policies......................................... 34

    2.2.5 Disability and the social contract.................................. 38

  2.3 The Use of Language in Disability Studies.......................................... 41

  2.4 Summary: The Relevance of the Literature in the Review of AISH 44
3 METHODOLOGY.............................................................................. 46
3.1 Analyzing Social Policy with a Critical Lens......................... 46
3.2 Analysis of Underlying Ideology Using Comparative Criteria..... 52
3.3 Critical Discourse Analysis.................................................... 55
3.4 Data Collection........................................................................ 57
4 ANALYSIS OF THE ASSURED INCOME FOR THE SEVERELY HANDICAPPED (AISH).......................................................... 59
4.1 The Historical Development of AISH................................. 59
4.2 AISH in an Era of Welfare Reform....................................... 71
4.3 A Missed Opportunity: Ignoring the Social Model Roadmap..... 85
4.4 AISH Today............................................................................ 89
  4.4.1 Application procedure and eligibility............................. 90
  4.4.2 Description of clientele....................................................... 95
  4.4.3 Stated goals of the AISH program................................. 96
  4.4.4 Type of benefit and analysis of adequacy..................... 97
  4.4.5 Rights, responsibilities and restrictions on clientele....... 104
5 DISCUSSION.................................................................................. 111
5.1 Learning from AISH—Reflections for Saskatchewan............ 119
  5.2 The Social Model of Disability in Practice—
      Implications for Social Work.............................................. 124
6 CONCLUSION................................................................................ 131
REFERENCES.................................................................................. 133
**LIST OF ABBREVIATIONS**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AACL:</td>
<td>Alberta Association for Community Living</td>
</tr>
<tr>
<td>ACCD:</td>
<td>Alberta Coalition of Citizens with Disabilities</td>
</tr>
<tr>
<td>AISH:</td>
<td>Assured Income for the Severely Handicapped</td>
</tr>
<tr>
<td>ADF:</td>
<td>Alberta Disabilities Forum</td>
</tr>
<tr>
<td>ADS:</td>
<td>Alberta Disability Strategy</td>
</tr>
<tr>
<td>CACL:</td>
<td>Canadian Association for Community Living</td>
</tr>
<tr>
<td>CCD:</td>
<td>Council of Canadians with Disabilities</td>
</tr>
<tr>
<td>CCSD:</td>
<td>Canadian Council on Social Development</td>
</tr>
<tr>
<td>CDA:</td>
<td>Critical Discourse Analysis</td>
</tr>
<tr>
<td>CPP-DP:</td>
<td>Canada Pension Plan Disability Program</td>
</tr>
<tr>
<td>CTDs:</td>
<td>Circling the Drain</td>
</tr>
<tr>
<td>CURA:</td>
<td>Community University Research Alliance: Disabling Poverty/Enabling Citizenship</td>
</tr>
<tr>
<td>DISC:</td>
<td>Disability Income Support Coalition</td>
</tr>
<tr>
<td>DNR:</td>
<td>Do Not Resuscitate</td>
</tr>
<tr>
<td>LICO:</td>
<td>Low Income Cut-Off</td>
</tr>
<tr>
<td>MLA:</td>
<td>Members of the Alberta Legislature</td>
</tr>
<tr>
<td>ND:</td>
<td>No date</td>
</tr>
<tr>
<td>ODI:</td>
<td>Office of Disability Issues</td>
</tr>
<tr>
<td>ODSP:</td>
<td>Ontario Disability Support Program</td>
</tr>
<tr>
<td>PC:</td>
<td>Progressive Conservative</td>
</tr>
<tr>
<td>RRSP:</td>
<td>Registered Retirement Savings Plan</td>
</tr>
<tr>
<td>SAID:</td>
<td>Saskatchewan Assured Income for Disability</td>
</tr>
<tr>
<td>SAP:</td>
<td>Saskatchewan Assistance Program</td>
</tr>
<tr>
<td>SFI:</td>
<td>Supports for Independence</td>
</tr>
<tr>
<td>UPIAS:</td>
<td>Union of the Physically Impaired Against Segregation</td>
</tr>
<tr>
<td>VRRI:</td>
<td>Vocational and Rehabilitation Research Institute</td>
</tr>
<tr>
<td>WHO:</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
LIST OF TABLES

Table 1: Comparative Criteria—Disability Models…………………………… 53
1. INTRODUCTION

Throughout modern history, people with disabilities have been socially and economically excluded and subject to intrusive, segregated services. The systemic exclusion of people with disabilities from mainstream society is a product of entrenched discrimination and the devaluing of their lives. The majority of people with disabilities are left with limited options, forcing them to rely on charity and/or state programs to meet their financial and daily living needs.

Over the past three decades, disability activists have fundamentally challenged the mainstream belief that disability is an individual problem. This hegemonic conception of disability is termed the ‘individual pathology’ model of disability. In a 1976 grassroots manifesto, the Union of the Physically Impaired Against Segregation (UPIAS) proposed a critical model to help people radically rethink disability (Barnes & Mercer, 2003). In what has come to be known as the ‘social model’ of disability, it is our modern culture and economy that are ‘disabling’ and create and marginalize a category of persons who do not fit its ideal of bodily or cognitive norms. Disability in the ‘social model’ is defined as “…the outcome of social barriers and power relations, rather than an inescapable biological destiny” (p. 12). The ‘social model’ views disability as entirely subjective and societal—a problem with the competitive capitalist economic system and cultural beliefs about bodily difference—rather than a problem within individuals. Disability theorists have begun to challenge ableism, redefine disability as a “positive source of identity,” and demand policy changes that respect their lived experience (Barnes, Oliver & Barton, 2002a; Hahn, 2002, p. 182; Lee, 2002).

Utilizing choice analysis, critical discourse analysis and comparative criteria, this thesis analyzes the history, language and features of the Assured Income for
the Severely Handicapped (AISH) in Alberta. The question posed for examination is:

*Analyzing the choices made, which ideology of disability, the social model or the individual pathology model, has informed the Assured Income for the Severely Handicapped program? Concomitant with that analysis, has the AISH program reflected the evolution in thinking that defines disability as a socially and economically constructed category.*

This study examines how the underlying perception that disabled people are tragic and flawed, deserving of charity but not equality, may be a factor in how Canadian disability policy is still constructed in modern times, despite evidence of some progress towards a social model understanding of disability in policy language. The analysis is then used to reflect on the emerging Saskatchewan Assured Income for Disability (SAID) program. The literature review examines the current literature on disability theories, disability, society and the state, and the use of language in disability studies.

This study is important because the poverty, social exclusion, abuse and segregation of disabled people has been de-politicized and largely ignored in mainstream social work theory and policy discourse (Oliver, 1996; Titchkosky, 2006). The individual pathology model of disability has remained a dominant factor in social policy development (Oliver, 1996; Titchkosky, 2006). Prince’s (2009) review of research on public perceptions of disability reveals that the devaluing of disabled lives is socially acceptable and remains largely unchallenged, creating a barrier to real accommodations or entitlements. The purpose of this study is to uncover the policy choices made which prioritize individual pathology beliefs about disability. These underlying beliefs are inherent in our society and discourse, and shape the conventional policy responses (Prince, 2009; Rioux, 2002).
The conception of disability creates a challenge for social workers who wish to adopt an anti-oppressive framework for their practice. Morgan (2012) describes the social model of disability as a “threshold concept,” an idea that is it difficult to integrate as it requires a personal paradigm shift in thinking (p. 215). The motivation for this thesis topic was my experience of being personally challenged by my own analysis of social policy and front-line practice in the area of disability. While working in the disability community, I was confronted by the social model of disability as an alternative way of understanding the experience of disability, and the incredible lack of individualized support for people with disabilities. If the economic system and social policies are shaped by the individual pathology model of disability, and that reality is experienced by disabled people as injustice, social workers have a responsibility to challenge the status quo. Social workers can become part of the solution, both in their individual practice with disabled people and in influencing policy change. Oliver and Sapey (2006) argue that social work is the occupational group which is in the best position to challenge the injustices and barriers that people with disabilities face and change their practice to support and reflect the social model of disability.

Ultimately, there are no easy solutions, government or otherwise, to facilitating the full inclusion of people with disabilities as there are deeper exclusionary problems within the fabric of our society. If people with disabilities are to be included into mainstream society, economically and socially, social model theorists argue that we must first reframe disability and challenge the individual pathology model which views disability as a tragedy and an individual problem. The social model deconstructs labels and analyzes how culture and the economy produce disability, which may provide the theoretical framework necessary to create better policy outcomes. By framing the
problem of disability as cultural and economic, the social model re-politicizes the situation of people with disabilities, acknowledging their collective experience and allowing them to define their own needs (Oliver, 1996; Oliver, 1990a).
2. REVIEW OF LITERATURE AND CONCEPTUAL FRAMEWORK

This chapter will review the following: mainstream and critical theories of disability; the historical relationship between disabled persons and society/state; disability income policy; poverty and unemployment; medical and genetic practices that compromise disability rights; social contract theory as it relates to disability; and language use in disability theory. These overarching concepts frame the serious need for mindful and anti-oppressive policy solutions to improve the economic situation of people with disabilities, but also to ensure they are respected and fully included as citizens.

2.1 Disability Theories

This section will cover the disability theories that construct the comparative criteria used to analyze disability policy in this thesis. It will include the individual pathology model of disability as well as various versions of critical social model theory including the materialist, social constructionist, oppressed minority theory. The word ‘model’ can be confusing, but is the descriptor used by disability theorists to describe an orientation, ideology, conception or worldview with which one views and defines disability.

In order to understand how disability theory has developed, it is important to understand the how the collective experience of people with disabilities, historically, economically and culturally, has been ignored or misinterpreted. Generic social science theories, including psychology, history, social work, political science and sociology, have failed to challenge the individualistic explanations of the disadvantages that people with disabilities face (Albrecht, 2002; Borsay, 2002; Oliver, 1990a; Oliver & Sapey, 2006). Oliver (1990a) writes:
[The] social sciences do not have a very good track-record in critically examining dominant definitions of disability nor the policies and practices to which they give rise. This is somewhat surprising, for there is a tradition within the social sciences which has examined some of the definitions, policies and practices based upon methodological individualism and underpinning a whole range of other social problems. What is urgently needed therefore is a social theory of disability. (p. 10)

He goes on to explain that a social theory must be based upon the daily experience of people with disabilities, and should ultimately radically redefine disability and service provision through political efforts.

In studying the social work literature, the lack of commentary on disability rights is obvious (Morgan & Roulstone, 2012). While some newer textbooks on anti-oppressive practice and social policy cover disability, many academic collections dealing with minority groups facing oppression do not include a discussion of disability issues. Many people, including social workers, are surprised by the concept of disability rights, and especially disability pride, and the challenge it presents to social policy and professional practice (Lee, 2002). The experiences of poverty, segregation and lack of power that disabled people live with are not yet widely recognized as collective oppression in need of a systemic solution. Rather, the experience of disability is still seen as an individual problem and the result of a ‘personal tragedy,’ requiring professional intervention and rehabilitation, not justice.

2.1.1 The individual pathology model of disability.

The manner of thinking which views the experience of disability as problematic, individual and pathological has many descriptors: the personal tragedy model; the individual model; the medical model; and the individual pathology model (Oliver, 1996;
Rioux & Valentine, 2006). In the literature, these terms are generally used synonymously as they focus on the same core ideology, one that reveres the ablebodied experience as the norm, and sees disability as a problem within the individual related to their unfortunate impairment. In the ‘ableist’ worldview, the appropriate response is medical or professional intervention and charity. I will follow Rioux and Valentine (2006) and use *individual pathology model* as a collective descriptor of this belief system. They explain that the assumptions of *individual pathology* include both the medical approach to disability, as well as the functional approach that focuses on rehabilitation. It is important to note that those who adhere to the individual pathology model would likely not define their point of view as such. This determination is applied by theorists who critique this ideology about disability.

In the *Politics of Disablement*, Oliver (1990a) explains how disability and impairment were created as inherently exclusionary categories, pointing to social, economic, historical, cultural and ethical factors. He utilizes Gramsci’s concept of hegemony to explain how the economy, the state and civil society reinforce the dominant ideology of personal tragedy. The individual pathology model is truly hegemonic, in that it is embedded in culture, science and economics, and creates the story of disability in modern society:

The hegemony that defines disability in capitalist society is constituted by the organic ideology of individualism, the arbitrary ideologies of medicalization underpinning medical intervention and personal tragedy theory underpinning much social policy. Incorporated also are ideologies related to concepts of normality, ablebodiedness and able-mindedness. (Oliver, 1990a, p. 44)
Oliver describes how the view that disability is “…an individual, medical problem and a personal tragedy” came to be dominant in modern capitalist culture (Oliver, 1990a, p. 25). As a precursor to this dominant belief, Barnes and Mercer (2003) explain that the industrial revolution was the beginning of the segregation of disabled citizens into the categories of sick, non-productive and unemployable. The creation of this dichotomy was critically important to exploit the labour of the able-bodied. This division of the poor would ensure that state relief was only provided to the ‘non-able-bodied’ and would create the necessary desperation amongst the able-bodied poor to work in the factories. Those who did not fit the prescribed expectations for productivity were forced into institutions, hospitals and asylums as their form of state relief and treated as patients.

Secondly, Oliver (1990a) uses Comte’s ideas on the development of human knowledge to describe how disability was medicalized. The eighteenth century produced a shift away from religious interpretation of disability to a more naturalistic or scientific interpretation. This did not improve the lives of people with disabilities, but rather became a new, insidious type of social control.

This evolutionary model has proved useful in developing an understanding of changing historical perceptions of deviance (Kittrie, 1971) including drug addiction, homosexuality, alcoholism, and mental illness; each being regarded first as moral, then legal and now medical problems. As a result of these perceptions particular deviants were subjected to moral, then legal, and now medical mechanisms of social control. (Oliver, 1990a, p. 30)

Oliver (1990a) explains how the medical profession came to achieve a dominant position in the definition and control of social problems. He argues that the enlightenment belief
that medicalization was entirely progressive is almost never challenged and that there is a denial of the profound, negative and oppressive effect it has had on disabled people.

Barnes and Mercer (2003) describe how the medical profession legitimized the individual pathology approach. The belief that a tragedy prevents the disabled person from integrating and contributing to society lead to the idea that professional intervention was the solution. Disability theorists, while recognizing the importance of pain-reducing interventions, critique the underlying ideology that results and the ‘professional’ attempts to normalize, rehabilitate or cure disabled people, and failing that to segregate and marginalize them (Linton, 1998; Oliver, 1996). Professional control in the lives of people with disabilities is considered imperialistic, disabling, self-serving and oppressive by many disability theorists (Barnes & Mercer, 2003). Many professions are built on ‘helping’ individuals adjust to their individual problem of disability and enforcing the need for individual rehabilitation.

While people with disabilities have faced stigma and marginalization throughout recorded history, the dawn of industrial capitalism, individualism and the scientific revolution stand out as the points at which the ‘individual,’ ‘pathological’ category of disabled was created. Since then, disability has been equated with negative medical, economic and values-based definitions that all indicate tragedy, a deviation from what is normal, an individual loss/lack of sufficient functioning and loss of quality of life (Linton, 1998; Oliver, 1996; Titchkosky, 2007). Oliver and Sapey (2006) argue that the individual model of disability is “politically convenient” as it places the responsibility on the person to rehabilitate and adjust, rather than on society to change (p. 26).
2.1.2  Critical social model theories: challenging conceptions of disability.

People with disabilities have begun to challenge the underlying assumptions, attitudes and values that create and sustain the systematic, often unrecognized oppression they face (Linton, 1998). This political re-thinking of disability did not begin as an academic exercise, but as an organic recognition of oppression and reclamation of identity in order to achieve the goal of emancipation (Barnes, Oliver & Barton, 2002b; Vernon & Swain, 2002).

In contrast to the individual pathology model, social model theorists maintain that impairments are a naturally occurring difference in humanity, not a tragedy or something to be eradicated. Disability is a phenomenon that is an essential part of human genetic variation, is experienced socially, and can be explained in many different ways (Oliver & Sapey, 2006; Wilson, 2006). Disability is defined not as something inherent or located in the person, but as a set of disabling barriers imposed on a group of individuals by the structure of society, in particular post-industrial capitalist society (Oliver, 1996). Social model theorists point out that the real ‘tragedy’ of disability is the economic and social exclusion that people with disabilities face. The alternative viewpoint that people with disabilities might actually have good lives, and they may not want to be cured or fixed even if the option is there, is a radical, shocking and even offensive idea in our current culture (Hahn, 2002). As with feminism, the personal daily experience of disabled people being devalued is so depoliticized and ingrained in culture, that it will take a great deal of work to reframe this experience as a collective, social phenomenon (Thomas, 2004; Tregaskis, 2004).

According to social model theorists, the personal experience of a physical, mental, intellectual or health impairment will not inevitably be disabling, but our modern culture
and society ‘disables’ people who do not fit the norm. The concept of ‘normal’ is
critiqued as oppressive, stemming from industrial capitalist standardization and social
judgments about biological variation (Pfeiffer, 2001). In other times and other cultures, a
person’s disability may not even register as a pertinent difference.

Barnes (1991) explains that “to pinpoint precisely the origins of society’s attitude
toward disability and disabled people would be almost impossible” (p. 11). Aversion to or
fear of disability can be found throughout religious and historical literature and art, in
Greek philosophy and society, ancient religious texts such as the Old Testament,
Shakespearean Drama, and in Buddhist, Confucian and African religious practices
(Barnes, 1991; Linton, 1998). The point that many social model theorists make however,
is that specific ideas on what constitutes a disability, and what is socially ostracized as a
burden/tragedy, is variable, dependent on the cultural and economic context. Prejudicial
attitudes, combined with industrial capitalism, created a world hostile to people with
impairments, excluding them from economic inclusion.

2.1.2 (a) History of the social model.

The disability movement began simultaneously in many countries, as people with
disabilities joined the plethora of rising social movements questioning the status quo in
the 1960s. Disability organizations already existed, but were generally made up of
nondisabled people lobbying for changes to specific policies. The consumer-led activism
that began to replace these efforts, such as in the United Kingdom with leaders Paul Hunt,
Vic Finkelstein, Alan Sutherland and Michael Oliver, was more radical and militant in its
approach (Barnes et. al., 2002b).

British activist Paul Hunt was the first to publicly challenge the prevailing ableist
ideology and the preoccupation with the ‘suffering’ of disabled people with his book

A sharp dividing line is drawn between the social lives and interests of ‘able-bodied’ and disabled people. The latter are ‘set apart from the ordinary’ because they pose a direct ‘challenge’ to commonly held societal values: ‘as unfortunate, useless, different, oppressed and sick’. (p. 9)

Still living in an institution in 1971, Hunt wrote a letter to The Guardian newspaper calling for the creation of a consumer group of people with disabilities who were also living in institutions (Shakespeare, 2006). UPIAS was formed from the people who answered his letter and became the first radical consumer groups to challenge ideas and the lack of services for people with disabilities. They rejected the “…liberal and reformist campaigns of more mainstream disability organizations,” and utilized Marxist analysis (Shakespeare, 2006, p. 197). In their 1974 policy statement, UPIAS members argued for the closure of all segregated environments (including schools, sheltered workshops and institutions), the right to integration and full control over their lives, an end to prejudice and medical labels, and “…the right kind of help” (UPIAS, 1974, pp. 1-9). UPIAS was the first group to distinguish between impairment and the experience of disability as social oppression in their manifesto: The Fundamental Principles of Disability (Hughes, 2002).

Michael Oliver, who coined the term ‘social model of disability,’ argues in the face of criticism that the model was never a complete ‘theory’ of disability on its own, but a model for thinking about the collective experience of disablement (Oliver, 1983; Oliver 1996; Oliver, 2004). Oliver prefers to think of the social model as an umbrella term for all critical theories of disability that present an alternative to the traditional, medicalized,
individual models. Rioux and Valentine (2006) also provide the umbrella term ‘social pathology’ model of disability, which incorporates environmental factors and citizenship rights. Throughout this thesis, the *social model* will be used as an umbrella term for all critical theories of disability. Pfieffer (2001) lists nine main critical theories of disability which fall under the umbrella of the social model and challenge the individual pathology model. From these, the materialist, social constructionist and oppressed minority theories will be described. Concerning criticisms of the social model, Oliver notes the importance of theory leading to action:

…I have argued that the social model of disability is a practical tool, not a theory, an idea or a concept. Furthermore, I have suggested that too much time has been spent discussing it rather than attempting to use it to produce social and political change. If we imagine that throughout human history the carpenters and builders of the world had spent their time talking about whether the hammer was an adequate tool for the purpose of building houses, we would still be living in caves... (Oliver, 2004, pp. 19-20)

Theory has lead to action in many areas, as disability activists and theorists have worked together to create change, challenging poverty and incarceration in institutions and demanding accommodation, individualized services and access to employment (Barnes et.al., 2002b). In developed countries, activists have changed numerous policies that limited individual autonomy, lobbied for physical accessibility to public buildings and demanded laws that protect the rights of disabled citizens. The front-line battles have often centred on legislative recognition of disability rights, including accommodation and access to and control over services. However, even as policies changed and the rights of
people with disabilities were recognized, rarely has the underlying individual pathology conception fundamentally been altered or questioned.

2.1.2 (b) Historical materialist theory.

The initial theorizing around the social model, and indeed the framework which is most associated with it, was a historical materialist or Marxist analysis. Historical materialism was first applied to disability theory in 1980 by Vic Finkelstein. A member of UPIAS, a psychologist and a political refugee from South Africa, Finkelstein had been exiled for his involvement with the anti-apartheid movement (Shakespeare, 2006). Oliver greatly modified, expanded and used Finkelstein’s ideas in his concept of the social model of disability. Sometimes their ideas are subsumed together as the ‘Marxist perspective,’ but Finkelstein was a building block in Oliver’s more complex analysis.

Finkelstein (1972) posited that ‘disability’ was socially produced and experienced as oppression by those who were placed in that category. If people with disabilities were to experience emancipation, this created social category had to be exposed for what it was and people labeled as having a disability needed to unite. With this foundational belief in the social production of disability, Finkelstein looked at history using Marxist analysis to explain how people with impairments came to be regarded as ‘disabled.’ Finkelstein used the three stages of historical materialism (feudal to capitalist to socialist) to explain his model. In Phase 1, feudal society, people with disabilities were not segregated or precluded from involvement in the economic life of the community (Oliver, 1990a). Finkelstein sees Phase 2, industrial capitalism, as the point at which the exclusion of disabled people from the workforce and from communities became standard. In Phase 3, Finkelstein saw the liberation of disabled people through technology, and that disability would be recognized as a social instead of an individual restriction.
Oliver (1990a) saw the characterization of the relationship between feudal society and disabled people, although somewhat relevant, as overly simplistic and romanticized. For Oliver, the relationship was more complex and nuanced than what Finkelstein’s model allows. He also saw Phase 3 as overly optimistic, as it is incumbent upon the disability movement to ensure that technology is used to liberate disabled people, rather than to further oppress them.

What Oliver did take from Finkelstein’s work was how competitive capitalism is fundamental in influencing society’s beliefs about disability. Looking at early industrial capitalism, Oliver (1990a) explains that the new workplace demands for speed, standardization and increased efficiency, along with the capitalist push for higher profits and outputs, changed citizens into individual waged labourers. The individualization of labour meant that those who did not fit the new norms were excluded. Individuals with disabilities whose labour was now seen as inadequate no longer had a valid social role to play, as they may have had in a family-based, subsistence society.

Oliver’s social model of disability, with its materialist posture, represents the first attempt to critically examine both cultural and economic reasons why disabled people are oppressed and is thus considered the “big idea” in disability studies (Oliver, 2004, p. 10). It has received prominence in the disability community, but has also been criticized for subsuming cultural realities and unique aspects of oppression into a historical materialist analysis. However, Oliver maintains that the criticisms are a misunderstanding of intent, which was to describe the collective experience of disablement, not the personal experience of impairment. It is evident that all critical disability theory incorporates some of the initial economic awareness proposed by Finkelstein and Oliver, even if theorists reject the Marxist underpinning. Oliver (1990a) explains that one does not need to agree
with historical materialist analysis in order to recognize that capitalism has produced a
view of disability as an individual problem and resulted in exclusion.

Other theorists have also contributed to critical disability theory using a
materialist perspective. Gleeson has written extensively on the “historical emergence of
disability” with the transition from feudalism to capitalism (Thomas, 2002, p. 47; Thomas, 2004b). Thomas (2002) writes that this perspective has been important in
showing disability as a phenomenon that is located in social relationships as well as
“…spatially, temporally and economically” (p. 47).

2.1.2 (c) Social constructionist theory.

The social constructionist view is another critical social model theory, with a less
overt political criticism and more prominent cultural or linguistic criticism, as well as a
focus on the experience of disability identity. For social constructionists like Goffman,
Shakespeare and Zola, disability as an identity and ‘disabled’ as a social category are
created by social and environmental norms:

The medical model situates disability exclusively in individual bodies and strives
to cure them by particular treatment, isolating the patient as diseased or defective.
Social constructionism makes it possible to see disability as the effect of an
environment hostile to some bodies and not to others, requiring advances in social
justice rather than medicine. (Siebers, 2006, p. 173)

Many authors who wrote about social constructionism, beginning in the 1940s,
touched on disability as a category, but the concept was not clearly stated until Goffman
in 1963 and Birenbaum in 1975 (Pfieffer, 2001). Goffman explained that disabled people
are stigmatized and have their identities constructed by “normal” people, based on
perceived differences (Pfieffer, 2001, p. 32). The social constructionist view became
popular in the 1980s with Zola and other theorists who identified environmental factors in
the construction of the disability identity (Pfieffer, 2001). While mainstream sociology
has not widely embraced the social construction of disability, Albrecht (2002) argues that
he and Oliver made significant contributions to disability theory with social
collectionist analysis in the early 1990s.

According to Siebers (2006), there are two types of social constructionism in
relation to disability theory, weak and strong. This differentiation helps explain how
modernists such as Oliver, are placed in the social constructionist camp, alongside
postmodernists such as Shakespeare. Neither are essentialist in their view of disability,
but they have very different views on how disability is constructed. Materialists, such as
Oliver, espouse the social construction of disability as a category constructed by
competitive capitalism and the medicalization of the body, not an inherent individual trait
or identity. To Oliver, embracing the collective identity, however subjective and created,
is essential to pursuing social change.

Weak constructionism explains that “…the dominant ideas, attitude and customs
of a society” influence the perception of differences, and “…tries to advance a
commonsense approach to thinking about how people victimize individuals unlike
themselves” (Siebers, 2006, p. 174). This represents the modernist/materialist version of
social constructionism.

In strong constructionism, linguistic representation is an ideological force that
stabilizes the oppressive political culture, a more post-modern view. Siebers (2006) notes:

In fact, political ideologies and cultural mores exert the greatest power, social
constructionists claim, when they anchor their authority in natural objects such as
the body. Michel Foucault defined *biopower* as the force that constitutes the
materiality of any human subject; it forms, secures and normalizes human subjects through a process of “subjection” (History of Sexuality, 140-141, 143-144). The techniques of biopower—statistics, demographics, eugenics, medicalization, sterilization—are all familiar to scholars of disability studies. They create the political alliance between knowledge and power in the modern state, but biopower is not merely a political force, controlled by one or two institutions. Biopower determines for Foucault the way that human subjects experience the materiality of their bodies. (p. 174)

Thomas (2004a) explains how the anti-essentialist insight of social constructionism is used in disability theory:

From these anti-essentialist perspectives, disability theory centres on the interrogation of cultural categories, discourses, language, and practices in which ‘disability’, ‘impairment’ and ‘being normal’ come into being through their social performance, and on the power that these categories have in constructing subjectivities and identities of self and other. (p. 5)

What postmodernist social constructionists have offered in deconstructing categories such as “normal” is a way for disabled people to understand the psycho-emotional dimensions of their oppression, such as how seeing others as “disabled” constructs oneself as “normal” (Thomas, 2004a, p. 11). However, postmodernist ideas are criticized for doing little to address the issues of injustice face by disabled people (Thomas, 2004a; Watson, 2004).

Both materialist and post-modern social constructionist views offer an important critique of the culture that creates disability, an essential piece to social model analysis. Ultimately, disability theorists, such as Tregaskis (2004), explain the need to utilize both
economic and cultural social model principles, and that one should not be sacrificed or ignored at the expense of the other. In the analysis of social welfare policy, social constructionism will play an important role as the language used to describe people with disabilities, the cultural values that policies stem from, and their identity as ‘unemployable’ and ‘deserving’ is analyzed.

2.1.2 (d) **The oppressed minority theory of disability.**

The oppressed minority theory represents another political challenge to the individual pathology model of disability. Under the umbrella of the social model, oppressed minority theory looks at the structural, collective experience of oppression and segregation that disabled people face in relation to other groups, as opposed to the class-based analysis of historical materialism (Barnes & Mercer, 2003; Pfieffer, 2001).

Pfieffer (2001) uses the five attributes in Vander Zanden’s 1972 classic definition of a minority group to show how disabled people fit this category. These are:

1) As a group and individually the members face prejudice, discrimination, segregation or persecution, or a combination of them;
2) It has a trait which is viewed negatively by the dominant group;
3) It has a collective awareness of itself and its problems;
4) It has an involuntary membership, usually through birth;
5) It experiences endogamy, that is, intergroup marriage.
(p. 35)

While Pfieffer (2001) notes that some people with disabilities live in the mainstream of society without experiencing oppression and even may participate in the oppression of others, this is the same case for every minority group. There are always exceptions but the reality for most of the group is oppression.

Barnes and Mercer (2003) describe how people with disabilities experience the five aspects of oppression: exploitation, marginalization, powerlessness, cultural imperialism and violence. While marginalization and powerlessness are self-apparent,
they struggle with how to identify how people with disabilities are exploited in the classic Marxist sense. However, in Saskatchewan today, the labour of people with disabilities is most definitely exploited through non-standard, poorly paid jobs, and especially in sheltered workshops where they are not paid for their labour or protected by basic labour laws. In a secondary sense, disabled people are exploited by the fact that their caregivers’ labour is exploited; their care is simply not seen as important enough to warrant living wages for those who provide support to them.

Cultural imperialism happens for disabled people through ableist practices:

“‘Able-bodied normalcy’ is embedded in everyday thinking and behaviour as a privileged or desirable state of being. The notion of able-bodied assumes normative or universal standards by which all other ‘bodies’ are judged” (Barnes & Mercer, 2003, pp. 21-22). Nondisabled people fail to see how they participate in oppression through the conviction that their own bodily and cognitive experience is what qualifies as normal.

Disabled people face violence in all forms at a higher rate than the average population (Council of Canadians with Disabilities, 2010). They are often vulnerable to sexual and physical abuse in caregiving situations, as their support options are limited (Sobsey & Varnhagen, 1988). In a book describing horrific hate crimes, Quarmby (2011) argues that this unrecognized hostility and disturbing levels of violence towards people with disabilities stems from a sense that they do not deserve the equality they are requesting. She argues that crimes against disabled people are invisible or ignored and are a result of centuries of malicious stereotyping.

The 2006 documentary, *The Freedom Tour*, describes the physical and sexual abuse that people with disabilities faced living in institutions in the prairies. Class action lawsuits are already certified in Ontario and won in British Columbia to compensate
victims of abuse in state institutions. In British Columbia, the former Ombudsman Dulcie McCallum wrote that the abuse at Woodlands institution was systemic in her report *The Need to Know: Administrative Review of Woodlands School*. Barnes and Mercer (2003) note how eugenic policies, including sterilization, have marked the lives of disabled people with violence.

Hahn (2002), an American disability theorist, shows the similarities that people with disabilities have with other oppressed minorities. They are working to gain equality or parity, improve their status and are using a range of non-violent and community organizing tactics. Hahn notes the following difference: “Perhaps the primary differences between the experience of disabled people and other minorities are reflected in the residual effects of medical concepts…” (p. 173). Barnes and Mercer (2003) make this point more directly, suggesting:

> Historically, the oppression of other social categories, notably women and black people, has been justified in terms of their biological shortcomings and weaknesses. However, in the last quarter century these claims have been in general retreat. In stark contrast, there has been no such reversal in popular thinking or public policy with regard to people with impairments. There is a continuing and exclusive emphasis on the deficiencies of the disabled mind/body.
> (p. 20)

So, while people with disabilities, as Hahn noted, view themselves as an oppressed minority, society has yet to recognize their oppression, even if their unemployment and need for services is recognized. The argument could be made that the more that disabled people use their identity as an oppressed minority, the greater the chance will be of obtaining policy changes, as other groups have. There are however
barriers, such as the psychological internalization of the individual pathology identity which alienates and divides disabled people (Charlton, 2006). As well, the underlying medical categorizing of disability, and the culturally esteemed attempts to cure or prevent disability, stand in the way of disabled people being viewed as a minority group. If attempts were made to ‘prevent’ any other minority group from existing, or to change them to fit the norms of the majority, it would be unacceptable.

Of course, with the recognition of minority group oppression comes the work of empowerment. Oliver (1996) explains that as the powerless resist and struggle, they also articulate their world view. Barnes and Mercer (2003) agree.

Initially, the politicization of disabled people was viewed as a response to their common experience of oppression. This provided a unifying group identity and interest, while identifying the source of their grievances in the structures and processes of a disabling society. For many disabled people, engaging in collective action was liberating and empowering. In this way, they openly challenged the public stereotype of their passivity and dependence. Moreover, by mobilizing against the injustices of social oppression, disabled people built on a positive definition of group differences, instead of being regarded as signs of abnormality. (p. 129)

While Hahn (2002) does not hold out hope for changing the root causes of oppression, which he links to our capitalist economic system, he sees opportunities for empowerment in ensuring that people with disabilities work their way into political positions of power, both locally and nationally, in order to influence decision-making.
2.2 Disability, Society and the State

In this section, literature that outlines themes and issues of oppression in the relationship between disabled people, society and the state will be reviewed.

2.2.1 The historical relationship with society and state.

At various times since the industrial revolution, people with disabilities have been viewed as unproductive, unemployable, needy, deviant, dangerous, tragic, and automatically and unavoidably dependent (Linton, 1998). More benevolent terms used would be the worthy or deserving poor. These are images that leave little room for quality of life, contribution, self-determination, independence and citizenship; they reflect devalued lives and experiences. Interestingly, the services and supports they are “deserving” of are largely residual, piecemeal, micro-managed and prescribed by professionals, and very much based on an antiquated charity model.

The institution and workhouse became the means of social control in the 18th and 19th century, removing the non-compliant and unproductive from the community, while creating a “visible monument” with which to create fear in the general population (Oliver, 2002, p. 32). Both people with disabilities and able-bodied people were contained in the workhouses, receiving harsh treatment for not conforming to the new social order. For governments at the time, the workhouse was not specific enough to separate those who were seen as unemployable from those who were seen as able-bodied but unwilling to work. Oliver (1990a) notes that the Poor Law Amendment Act of 1834 in the United Kingdom played a crucial role in separating the poor into distinct groups and these distinctions carry on today.

Over time, asylums became more specialized, separating the deserving from the undeserving poor, while ensuring that both groups faced harsh sanctions (Oliver, 1990a).
The fear, shame and disregard for people with disabilities resulted in them being housed in state-funded institutions. Still today, people with disabilities are segregated in schools, sheltered workplaces, housing and in too many cases, institutions, even in Canada.

Borsay (2002) explains the relationship that developed with the state was complex. While oppressive institutions and workhouses were developed by the state, many segregated services were also developed by charitable organizations with the goals of moral and medical surveillance and education. The charitable organizations worked on behalf of the state, controlling the lives of disabled adults and children.

Today government agencies, charities and the medical establishment have authority in the provision of services to people with disabilities. Social workers, case managers, employment counselors, health care professionals and front-line service providers continue to be the gatekeepers who assess individuals and control access to income, daily living and rehabilitative supports (Oliver, 1996; Oliver & Sapey, 2006). While many professionals in these roles respect their clients and are committed to providing high quality service, they retain a great deal of control over people’s lives. Over the past thirty years, disability rights activists have begun to critique and challenge these service models, and more importantly, the underlying social beliefs that define and construct disability and determine how services will be administered (Oliver & Sapey, 2006).

2.2.2 Disability income policy.

Encountering the field of disability, it is evident that there is an endless need for reforms to disability policies. The publicly funded services that exist to support people with daily living, transportation and personal care are often experienced by disabled people as personally limiting, inadequate and inaccessible (McCull & Jongbloed, 2006).
The perspective and unique demands of people with various disabilities and their associated advocacy groups vary a great deal. Still, there are common demands to address the issues of social isolation, employment discrimination, segregation, and above all poverty. Citizens with disabilities have also begun to demand direct involvement in policy development and direct payments to manage their own services and supports. Most of the policy suggestions from disability activists have yet to be taken seriously in any kind of meaningful way in Canada, as disability groups continue to ask for change year after year. As the focus of this thesis is income policy specifically, it is important to look at the current thinking around income policy and disability in Canada.

Jongbloed (2003) quotes Rioux and others who point out that the distinctions amongst people with disabilities matter a great deal when it comes to income policies. She explains that in Canada and other developed countries, the circumstance in which a person becomes disabled has bearing on their economic fate. Those who are born with a disability are generally deserving of less government assistance than those who acquire a disability in military service and cannot access a ‘payout’ that one would get in car or industrial accident. Those who acquire a disability later in life will do better than those who have only worked a few years and receive the base of disability coverage through the Canadian Pension Plan Disability Program (CPP-DP). These distinctions, which determine the economic status of people with disabilities, are based on the perceived economic ‘contribution’ that the individual has made.

Prince (2009) has written extensively on disability and income policy, lecturing on the need for a national disability income program and reforms to Employment Insurance and the CPP-DP. In the book *Absent Citizens: Disability Politics and Policy in Canada*, he uses the CPP-DP as a case study of how the Canadian state engages in stratification.
He notes that stratification through selective measures enforces “…status boundaries, to include some people and exclude others, and to rank and categorize individuals and groups for purposes of eligibility…” (p. 75). The eligibility process creates dualisms, those who are disabled enough versus those who aren’t, those who have contributed enough and remained attached to the labour force versus those who were intermittently attached. Prince argues for an expanded federal role and the creation of a national Basic Income to replace the existing welfare provisions for disabled people. This has long been the policy ask of many national disability organizations. Recently, Prince teamed up with Yvonne Peters, the Council of Canadians with Disabilities (CCD) and other national disability organizations to create a research alliance to examine “…the disproportionate poverty of Canadians with disabilities” and to propose policy solutions (Council of Canadians with Disabilities, 2011). The result of the Disabling Poverty/Enabling Citizenship (CURA) project will be a clearer picture of poverty and disability and an analysis of existing disability income programs.

In the recent past there were discussions about privatizing or reforming the CPP-DP, a move which concerned activists at the time as they watched the federal government relinquish responsibility in other areas of social policy in the mid 1990s. In 1996, Sherri Torjman prepared a report for the Task Force on Disability Issues when the future of the CPP-DP was threatened. She argued that any reform should be guided by the following principles: mainstreaming; supporting and enhancing individual potential; entitlement; comprehensiveness; accessibility; adequacy, equity; responsiveness; promotion of independence and integration; accountability; and efficiency (Torjman, 1996, pp. 2-4). Her suggestions for long-term reform included creating a variation of private or public insurance plans separate from CPP-DP, a means-tested income support, or a Guaranteed
Annual Income for people with severe and prolonged disabilities. She cautioned that benefits would need to be increased to make any difference to income security and that any income guarantee could discourage workforce attachment.

Many disability organizations and activists in Canada have lobbied for a national disability income to replace the welfare-based provincial income programs including the CCD, the Canadian Association for Community Living (CACL) (2010), the Multiple Sclerosis Society of Canada (2007), the Canadian Mental Health Association (Alexander, 2009), and the Task Force on Modernizing Income Security for Working-Age Adults (2006). The federal government does not presently seem interested in creating a federally funded and administered universal disability income program.

In 2010, the Caledon Institute for Social Policy partnered with the CCD and CACL to promote the idea of a Basic Income to replace provincial measures for people with severe disabilities. The new program would be similar to the Old Age Security and Guaranteed Income Supplement provisions for seniors. They surmise that there is little public appetite for generous income security programs and that people with disabilities would need to prove that their disability was severe and that they were unemployable.

In our design, we accept the need for rigorous eligibility standards to provide public support for a decent benefit system. In other words, there will have to be a high fence around the Basic Income program in respect of determining eligibility. Once a person is over the fence, there will be relatively generous treatment and many fewer rules. Inevitably some people will find themselves on the wrong side of the fence, but these should be no one worse off than today, while most Canadians with severe disabilities would be much better off under our proposal. (Mendelson, Battle, Torjman & Lightman, 2010, p. 18)
Critical analysis of disability income programs has been done in various Canadian provinces. In 2001, Hyland applied a citizenship model of disability to her analysis of interviews with recipients of the newly formed Ontario Disability Support Program (ODSP). Hyland’s findings are informative as we consider the ideological base the shapes disability income programs. From the interviews, Hyland (2001) says it is evident from the interviews that the low benefit levels and program rules prevent people from participating as citizens:

As I stated at the beginning of this paper, money lies at the root of our society, therefore to have little or no money means that the opportunities for involvement in one’s community or in society at large are greatly restricted. Therefore, I have argued that we must extend our understanding of social citizenship beyond our current acceptance of employment as the primary form of legitimate social participation. (p. 79)

In Saskatchewan, disability policy has become an area of interest in recent years, as reform to social assistance has significantly downsized the welfare caseload and left behind a long-term caseload comprised largely of citizens with disabilities. At least 70% of those left on the welfare caseload were people with disabilities (Saskatchewan Community Resources, 2007). Saskatchewan and Alberta have the highest percentages of people with disabilities making up the welfare caseloads at 74.5% and 84.7% respectively, compared to 50.2% nationally (Mendelson et al, 2010). This is likely due to draconian welfare reform measures that moved thousands of people off the welfare rolls in these provinces.

Saskatchewan has been an example of the ‘Third Way’ approach to welfare reform, one that values attachment to employment, and denigrates ‘dependency’ upon
public resources (Hunter & Miazdyck, 2003). Third Way proponents tie citizenship to employment in a way that further devalues and stigmatizes people with disabilities. Roulstone (2000) explains that “…despite the rhetoric of inclusion and eradication of social dependency,” the ‘Third Way’ does not help the situation of disabled people, and actually might promote further competition between marginalized groups (p. 427):

A wider, more theoretical point is that both theoreticians (Giddens, 1998) and politicians of the ‘Third Way’ (Blair, 1998) have presented non sequitor ideas that because *individuals* experience dependency, the solution is to provide the conditions in which *individuals* respond to structures of dependency. Here, with ‘Third Way policy’, the role of the government has shifted from the now discredited blanket interventionism of the post-1945 welfare consensus, to one of enabling dependent groups to identify routes out of their predicament. (p. 427, emphasis original)

The former Executive Director of Strategic Policy for the Ministry of Social Services, Rick August, who was responsible for many of the draconian changes to policy in Saskatchewan applied this view of citizenship to disability income policy in his writing. August (2009) suggested that “passive” income support holds people with disabilities back from “economic inclusion,” which is attachment to the labour force (p. 1). He recommended income benefits that are conditional and targeted to focus on supporting people with disabilities to find employment. He also recommended a new benefit that is individualized and administered outside of the welfare system, suggestions that disability organizations may have agreed are appropriate. August’s critique included his interpretation that income policy should not acknowledge or respond to the social pathology of the labour market.
Current Canadian disability policy is based, explicitly or implicitly, on a compensation strategy to provide financial and other resources to adults who are presumed to suffer competitive disadvantages that prevent them from using the market economy to their advantage [emphasis added]. (p. 3)

The suggestion that the residual welfare benefit available during August’s tenure was in any way ‘compensation’ for ‘competitive disadvantages,’ and how that was misguided, showed, at best, an incredible lack of insight. At the time, Saskatchewan’s welfare rates had remained stagnant for years and kept recipients far below the poverty line. August’s opinion was not well received by disability advocates, particularly as he focused so heavily on individual labour-force attachment.

In 2005, economist Ronald Kneebone wrote specifically about the AISH program in Alberta and how benefits had been in sharp decline since the early 1990s, coinciding with the tenure of the conservative government of Premier Ralph Klein. No matter if one uses an absolute or a relative measure for determining increases to the AISH benefit, recipients were far worse off during the Klein years. Based on the Consumer Price Index, Kneebone (2005) explains that the AISH benefit had increased by $40 in the 22 years between 1993 and 2005, but after adjusting for inflation, it had decreased by $188 per month in purchasing power.

The only way of justifying such a small increase over such a long period of time is to suggest that the size of the AISH financial benefit in 1993—an amount equal to 54% of the average income and 71% of the low income cut-off—was overly generous. If one held that view—a view that would seem difficult to justify given that the LICO is best thought of as an income level that defines someone who is substantially worse off than the average person in society—allowing inflation to
whittle-away at the purchasing power of the AISH financial benefit would be
deemed to have been an appropriate policy. (p. 8)

He argues that reducing the AISH benefit by inflation is a poor way to tackle public
policy decisions and that the Alberta government “...needs to clearly state where it stands
on the issue...” of an appropriate level of financial support (p. 8).

Perhaps the most relevant writing for this thesis is Malacrida and Duguay (2009)
as they tackle the issue of the lack of public consultation and neoliberal politics in the
reform of the AISH program. Malacrida and Duguay conclude that the AISH policy
review process reflected neoliberal restructuring, prioritizing disability organizations, and
excluding people with disabilities from legitimate participation or influence. They
discovered that women on AISH did not view the program as ideal or meeting their
needs. Residual, poverty-level income, lack of options and accessibility, lack of
information, fear of surveillance and adversarial administration marked their AISH
experience.

AISH recipients were not informed with sufficient time to participate in the public
consultation and the questionnaire that was mailed to all AISH recipients was framed by
neoliberal values and focused on cost-cutting (Malacrida & Duguay, 2009). The
environment was exclusionary and intimidating (p. 30). Some of the language could be
viewed as inaccessible, biased, misleading and even threatening the future of AISH if
costs were not contained. They explain that although the government claimed to be
seeking input, their actions spoke louder than words:

As Robert Drake (2002) noted, it is often a strategy of governments to create the
illusion of public consultation while actually limiting choices and outcomes from
the outset. Clearly, citizen feedback itself is not enough – although the
government indicates that it received 18,000 completed discussion guides and almost 500 individuals attended the public consultations, the review process, embedded in an agenda of limiting state financial responsibilities and ‘getting people back to work’, shaped the direction of AISH policy changes from the outset. (p. 30)

Interestingly for this study, Malacrida and Duguay (2009) refer to AISH as a “last resort” income program and describe a reality for AISH recipients that does not resemble social model thinking about disability (p. 19). Their review of AISH is important, as some of the same textual data related to the AISH program are reviewed for this study.

2.2.3 Disability, poverty and unemployment.

The result of economic exclusion is that a large percentage of people with disabilities live their whole lives in poverty, twice that of the general population (Fawcett, 1999). Using census data from Statistics Canada, Fawcett found that 34.2% of men with disabilities and 36.2% of women with disabilities were in poverty overall, including many who work full and part-time. She compared this to poverty rates of those who do not have a disability—15.6% for men and 18.5% for women. The situation is worse for those who do not work, as 47% of men with disabilities and 45.4% of women with disabilities are in poverty when they have no employment, compared to 39.8% of men and 34.7% of women without disabilities.

In a longitudinal study from 1993 to 1998, the Canadian Council on Social Development (CCSD) found that of the people who reported having a disability for all six years, only 44.7% rose above the Low Income Cut-Off line at some point during that period (Canadian Council on Social Development, 2002, p. 4). It is important to recognize, as this study shows, that people with long-term disabilities face greater
economic insecurity and a higher rate of poverty than those with temporary disabilities. The CCSD research indicates a poverty rate of 55.3% for people with long-term disabilities over those six years, a number which more closely matches the unemployment rate for people with disabilities. Caution should be used in interpreting these numbers, as people with disabilities who reside in institutions and residential facilities are not included in the Statistics Canada surveys. With thousands of individuals living in these facilities in each province and territory, it is safe to assume that the poverty rate of persons with disabilities is underestimated.

People with disabilities who do work in the paid labour market face greater work instability and have a greater incidence of low wages than people who are not disabled (Fawcett, 1999). Fawcett found that the risk of work instability, such as losing or having to leave a job, was 27% higher for a woman with a disability and 22.5% higher for men with a disability than for those without a disability.

An issue that arises for policy makers is that as a category, ‘disability’ is not easily or consistently defined. It can involve people who have developed an impairment or sickness with age. Often it is considered equivalent with the category ‘unemployable’ in welfare policy. As well, those who remain unlabeled, despite having a disability, are sometimes at a disadvantage in the welfare system, as their entitlement may be questioned. Although there is a higher percentage of Aboriginal people who are disabled in the general population, there is a relatively low percentage of long-term welfare clients who are Aboriginal and identify themselves as disabled (Saskatchewan Community Resources, 2007). It is unlikely that Aboriginal people with disabilities are less likely to need income support than the general population, and far more reasonable to believe that their disabilities have not been acknowledged in the system.
2.2.4 Medical and genetic policies.

Some might argue that medical and genetic practices have nothing to do with social policy and the welfare state. However, almost all disability theorists refer to this issue, as the economic and social oppression of disabled people cannot be properly understood without reference to the social agenda which underlies genetics—the eradication of all disability as human defect (Wilson, 2006). This essentialist view of human value is intricately tied to economic value, what society is prepared to pay for in terms of services, support and accommodation (Russell, 1998; Saxton, 2006). Russell (1998) explains:

Perhaps the greatest social danger in the developing gene culture is the ideology that accompanies genetic determinism. Genetic essentialists could argue today, as did the Spencerian survival-of-the-fittest capitalists, that there is no reason to spend social dollars on correcting the social environment because it is nature, via genes, that has brought people to the bottom of the socioeconomic hierarchy, not the existence of class-based social policy that rejects egalitarianism and denies quality, disability-sensitive health care to all…Disabled people are just awakening to our oppression and to resist the physicalism that put us there. (p. 54-55)

Individual pathology model thinking is evident in the politically acceptable “laissez-fair eugenics” movement (Saxton, 2006, p. 107; Wilson, 2006, p. 71). Genetic research, or the new eugenics, as it is called by disability theorists, still focuses on the eradication of all disability and the search for the perfect human, while repudiating the negative eugenics of the past and casting itself as politically and ethically neutral (Davis, 2006). The eradication of disability through prevention (selective genetic abortion), infanticide, do not resuscitate orders, selective non-treatment, euthanasia, and physician
assisted suicide, are justified as these measures end ‘suffering’ and eliminate expense and burden (Linton, 1998; Russell, 1998; Saxton, 2006). One would be hard-pressed to argue that this does not frame disabled people as second-class citizens.

Disability theorists emphasize that they are not interested in opposing the alleviation of pain or removing a woman’s right to abortion. However, they see the presumption that disability incontrovertibly equates with suffering and a lack of quality of life as the problem (Linton, 1998; Oliver, 1996; Saxton, 2006). Linton (1998) and Russell (1998) explain how the desperate lack of financial and social support for people with disabilities and their families influences these seemingly personal decisions, while supporting the social agenda of eradication. Feminist disability writers argue that women’s reproductive choices are limited by selective abortion, as it is a patriarchal tool of “quality control” of the population (Hubbard, 2006; Saxton, 2006, pp. 111-112).

A woman must have the right to abort a fetus, whatever her reasons, precisely because it is a decision about her body and how she will live her life. But decisions about what kind of baby to bear inevitably are bedeviled by overt and unspoken judgments about which lives are ‘worth living.’ Nazi eugenic practices were fairly coercive. The state decided who should not inhabit the world, and lawyers, physicians and scientists provided the justifications and means to implement these decisions. In today’s liberal democracies the situation is different. Eugenic principles are part of our largely unexamined and unspoken preconceptions about who should and who should not inhabit the world, and scientists and physicians provide the ways to put them into practice. Women are expected to implement the society’s eugenic prejudices…(Hubbard, 2006, p. 102)
After the *Canadian Medical Association Journal* recently denounced the selective abortion of female fetuses, Roxanne Mykitiuk, an associate professor of law, asked how this thinking applies to disability in *The Globe and Mail*:

If Dr. Kale had cited evidence that a significant number of Canadians were deliberately using ultrasonography to identify fetuses with cleft palates or lips, missing limbs, spina bifida or Down syndrome, followed by their abortion, would he regard this as discrimination against some people with disabilities in its most extreme form? I suspect not….But if sex selection can be characterized as a social or cultural practice informed and perpetuated by demeaning attitudes toward women that many of us can agree is discriminatory, what about the selection of fetuses on the basis of disability? For those of us living with, or living with someone with, Down syndrome, a cleft lip or a missing limb, the selection against fetuses with these characteristics is as troubling as the selection against female fetuses. (Mykitiuk, 2012, online)

The comment section for this article overwhelmingly revealed that people do make a clear distinction that disability is a burden and deserving of eradication, where being female is not.

In March 2012 in Canada, there was a discussion on ‘after-birth abortion’ or infanticide of disabled children on Global news. The “*Taking Mercy*” *Live Blog* featured three pro-euthanasia speakers, but no one from the disability community (Global News, 2012). This may have been in response to an international discussion that was started in February 2012 on infanticide in the *Journal of Medical Ethics* in a piece called “After-birth abortion: why should the baby live?” (Giubilini & Minerva, 2012).
The individual pathology conception upon which genetic practices are based crosses political lines. Russell (1998) criticizes and offers examples of how both right-wing and left-wing political movements have historically supported and continue to support euthanasia and eugenic initiatives.

There are similarities in Holland, and in the U.S. where ‘cost-containment,’ ‘efficiency,’ Slow Codes, CTDs, DNRs, and managed care have infiltrated our health care systems…. Yet the political dynamics are complex. While those on the right profess a right-to-life philosophy by coming out against physician-assisted suicide and euthanasia, they are nonetheless busily slashing public health care programs and they have staunchly opposed universal health care which could entitle everyone to equal services. Those on the left often view the right to die as ‘progressive,’ not comprehending that physician-assisted suicide opens the door to dumping the socially expendable by forcing them to ‘choose’ to die. (p. 45)

Saxton (2006) agrees, suggesting that although right-wing anti-abortion groups have attempted to court disability activists, “…they have shown no interest in disabled people after they are born” (p. 111). At the same time, some on the left have suggested that “…disabled people should not be allowed a voice in the selective abortion debate because ‘they make women feel guilty’” (p. 113). People with disabilities may gravitate towards universal welfare and health care policies that support all citizens, but their identity issues have not been readily welcomed or affirmed by left-leaning organizations. An understanding of how both the left and the right have ignored or been hostile towards disability issues underscores the importance of identity politics in disability theory.

Linton (1998) explains how disabled people throughout history have been categorized as “economic and social liabilities,” and that the new eugenics is a way to
manage the perceived economic burden and social threat to society (p. 45). It is a slippery slope to place value on human life, as other social or economic “threats,” such as hereditary disease, homosexuality, addiction or criminality, could also be targeted in the future of genomics (Wilson, 2006, p. 72).

2.2.5 Disability and the social contract.

The existence of disability poses a huge challenge to classic social contract theory, as the majority of theories are based on mutual advantage in very narrow terms. Disability theorists are beginning to tackle the ideas of mutual advantage and utilitarianism, and put forward new ideas about ability and entitlement.

One of the most thorough critiques of social contract theory that considers disability is Nussbaum’s *Frontiers of Justice: Disability, Nationality and Species Membership*. Nussbaum (2006) examines the theories of Hobbes, Locke, Kant and primarily Rawls, in order to detail how disabled people, citizens in the developing world, and animals represent the “unsolved problems of justice” (p. 3). In Rawl’s social contract theory, there is no allowance for benevolence, which means that those outside of the contract will be dealt with through charity at the legislative stage. Rawls includes the “Difference Principle,” which ensures the well-being of the least well-off, but those at the bottom are still included in the Original Position and “their productive capacities all lie within the normal range” (p. 122). This creates the issue where those outside the ‘normal’ range of abilities cannot expect justice. In the real world as well, the needs of the normative, ‘productive’ group are dealt with first, and the needs of the ‘outliers’ are dealt with through charity. This affects one’s status as a citizen, as the concept of citizenship is based on economic contribution. Concerning Rawl’s understanding of citizenship, Nussbaum (2006) notes:
Rawls makes it clear that he understands the concept of the “fully cooperating” in a way that excludes people with physical and mental impairments. All the unusual needs of people with disabilities, then, will be considered only after society’s basic structure has already been designed. (pp. 109-110)

Nussbaum’s (2006) solution to the issue of justice and people with disabilities is the Capabilities Approach. This alternative social contract entails a list of ‘capabilities’ that all citizens are entitled to as rights, and that society has a responsibility to ensure that each individual has the opportunity to make use of capabilities. The social goal would be to get each citizen above the capability threshold through the provision of supports.

In Kittay’s alternative to classic social contract theory, an ethic of care and human dependency are concerns for justice (Hartley, 2011). We are all dependent in infancy, childhood and senior years, while some citizens due to disability are dependent throughout their lives. Hartley (2011) summarizes Kittay’s argument that justice “…based simply on the idea of society as an association of free and independent equals...” is not adequate and “…cannot deliver justice for dependents or their caregivers.” (p. 126). As “some mother’s child,” we have the right to have our needs met (p. 126):

As some mother’s child, a dependent has a claim on his caregivers to meet his needs; hence, among the principles of justice must be a principle of care that requires the needs of dependents be met in a caring relationship. However, also as some mother’s child, caregivers have a claim on others to meet their needs. The recognition of this requires revising liberalism’s conception of social cooperation based on reciprocity. (Hartley, 2011, p. 126)

Silvers and Francis (2005) explain the issue of ‘outliers’ in social contract theory, and how Kittay and Nussbaum have tried to replace it with an ethic of care or the
procedural justice of the Capabilities Approach. They argue that Nussbaum’s approach can be critiqued as still holding on to the ableist idea of normality, and that “…setting thresholds for capabilities encourages oppressive, judgmental practices,” stigmatization and assimilation (p. 54).

In practice, a capabilities approach that values threshold standards cannot also remain positive or even neutral about whoever cannot be brought up to these standards…. [She] so eloquently portrays cores capabilities as crucial to human dignity that either real or imagined deficiencies may give permission for less than respectfully dignified treatment…. So on her capabilities approach, just treatment of the disabled seems to mean permitting, encouraging, or obligating the nondisabled to relate to the disabled primarily by improving them, whether or not they can be improved and whether or not they prefer to be improved. This approach is hazardous for disabled people because it privileges the normal.

(Silvers & Francis, 2005, pp. 54-55)

However, Silvers and Francis (2005) shared Nussbaum’s grave concerns about Rawlsian contract theory. They claim Rawls idealizes the citizens involved, leaving out those who are judged incapable of the standard forms of contribution. These ‘outliers’ are alienated and permitting them to participate amounts to insincere pretense, or “consensual subordination” (p. 49). The go on to argue that social contract theory is tied to competition and bargaining, as since disabled people cannot succeed in this scenario, they and their families become a political underclass and their interests are not considered.

As a replacement for the culture of mutual advantage, Silvers and Francis (2005) offer the idea of a culture bargaining based on trust, where no one would be an ‘outlier.’
Essentially, the theory of trust reframes that idea of contribution from economic to relational, with the common goals of “reliability” and “social stability” (p. 44).

While social contract theory is indeed theoretical, certainly the principles of mutual advantage and utilitarian ethics are real and influential in the development of economic and social policy, particularly when there are numerous competing interests for limited resources. It is important to re-evaluate the foundational philosophy of the ‘contract’ in a welfare state such as Canada. When the outcome is residual entitlements to inadequate state programs, and citizenship is a reward for narrow ideas of productivity, justice is not accomplished for people with disabilities and other ‘outliers.’

2.3 The Use of Language in Disability Studies

As language is reflective of bodily experience in critical disability theory, an overview of language is important in this thesis. The definitions of disability reflect the oppression that people with disabilities face (Devlin & Pothier, 2006). In the dictionary, the term disability is fraught with negative associations. Some of the definitions of disability include: “…a lack of inadequate power or physical or mental ability;” disqualification; incompetence; incapacity; impotence; “…impairment that interferes with or prevents normal achievement in a particular area” [emphasis added]; want of ability; unfitness; and weakness (Dictionary.com, 2008, online).

Given these definitions, some labeled as having a disability have resisted self-identification as a group. Yet there is sometimes a need to refer to people collectively, particularly when describing a minority group that experiences oppression based on their deviation from the ‘norm’ of acceptable human existence. Lee (2002) describes how a collective identity is also used to exclude those without impairments from being involved
in disability activism. This of course gets complicated when a decision must be made about who is in and who is out:

Any politics based purely on ‘identity’ is likely to face major problems, not least due to the fact that such socially constructed identities are contestable and subject to change; sub and splinter groups emerge, as different aspects of the identities are prioritized. What of non-visible impairments—learning or mental health ones? Or deaf people ‘who are classified as disabled…but who repudiate the disabled identity on the grounds that they constitute a distinct linguistic and cultural minority’ (Humphrey, 2000; 65). (Lee, 2002, p. 151)

The distinction between *impairment* and *disability* is also an important one for activists in the disability community. The UPIAS and the Disability Alliance (1975) defined the terms from a critical perspective at a 1975 conference and this definition is still used today by disability theorists:

- **Impairment**: Lacking part or all of a limb, or having a defective limb, organ or mechanism of the body.

- **Disability**: The disadvantage or restriction of activity caused by a contemporary social organization which takes no or little account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities. Physical disability is therefore a particular form of social oppression. (p. 14)

The separation between impairment and disability signifies that being ‘disabled’ is not inevitable, but is an experience created by our present social order, not one’s physical or cognitive differences.
There is considerable debate concerning how to refer collectively to people who are labeled as having a disability. Person-first language, such as the term “persons with disabilities” is popular amongst disability theorists, as it signifies that the disability is only part of the person and does not define the person (Devlin & Pothier, 2006, p. 3). Although it has limitations, Devlin and Pothier (2006) argue that this is the least, worst option, removing some of the “pejorative and exclusionary origins” (p. 4). Other disability theorists, such as Titchkosky, do not agree, arguing that person-first language separates the person from their self, and is therefore apolitical and individualized (Devlin & Pothier, 2006). For this reason, many disability theorists have begun to reclaim their language and used the term “disabled persons” to refer to their constituency group (Devlin & Pothier, 2006, p. 4; Linton, 2006, p. 163). Russell (1998) agrees that it is politically necessary to reclaim language.

FREAK…all booger ed up, gimp, goon, spastic, spaz, cripple, creep, cretin, handicapper, handi-capable, handicapped, monster, mongoloid, invalid, idiot, retard, defective, deaf, dumb, mute, devil, blind, blind as a bat, people with differing abilities, physically challenged, differently abled, disabled. Obviously these labels are not value-free, rather they mark physical or sensory differences that are charged with meaning….In our hierarchical society it is the social meaning of words that have power. Why do we choose ‘disabled?’ It has negative connotations; the dictionary definition is ‘unfit’ or ‘useless.’ But being disabled/impaired is not a negative, not something to be ashamed of, rather it is a shared identity amongst those who have the common experience of being disabled in a world dominated by non-disabled people. (p. 14)
Theorists such as Linton and Russell argue that even “nicer” terms such as ‘special’ or ‘challenged’ in reference to people with disabilities still signify deviance, while depoliticizing their experience (Linton, 2006, p. 163). Due to the societal view of people with disabilities as inferior, these less obviously offensive terms obtain negative connotations in the public sphere and are depoliticized (Russell, 1998).

‘Physically challenged’ sounds so politically correct, but it is loaded with the faulty notion that it is the individual who is challenged to “overcome” his or her disability, rather than society’s responsibility to overcome its prejudice against disabled individuals….Discrimination is absent in the ‘challenged’ scenario. No wonder it has caught on like wildfire! Disabled people—at least those I listen to—have determined that we prefer ‘disabled,’ plain and simple, because it underlines the oppression. (Russell, 1998, p. 14)

Disability theorists use language to express the oppression, stigmatization and degradation leveled at people with disabilities by able-bodied people. The term ‘ableism’ is used by disability theorists to explain the root of oppression, a term that has the same implications as racism or sexism.

2.4 Summary: The Relevance of the Literature in the Review of AISH

In the literature review, descriptions of the individual and social models of disability provide a contrast and an anti-oppressive lens with which to analyze the AISH policy. This knowledge is important because a thorough analysis of social policy must take into account the underlying theories and values on which it is founded. If the ‘individual model’ or conception of disability predominates, then policies are likely to be built on individualized, charitable solutions. Conversely, if a critical social model is used
in the development of policy, then the outcome should be a more level playing field, and amelioration for the effects of injustice.

The literature review provides an overview of the historical and current relationship with the state, which is important as many traditional views of disabled people, particularly that of the ‘deserving poor’ and ‘unemployable’ carry on today. The incidence of poverty outlined frames the need for adequate and respectful state intervention. AISH will be reviewed for its effectiveness in addressing poverty.

The devaluing of people with disabilities through unquestioned genetic interventions presents a challenge to activists who are working towards reframing disability as human variation, not pathology (Scotch & Schriner, 1997; Wolbring, 2003). While this doesn’t directly relate to the review of AISH, it affects how all policy is shaped, since it reveals the fundamental value society places on disabled people (Armer, 2000). Similarly, the review of social contract theory and people with disabilities provides a philosophical background for understanding the decisions that states make concerning citizens who are deemed non-contributing in the economic sense.

The concepts outlined in the literature review frame the serious need for mindful and anti-oppressive policy solutions that respect the self-defined needs of disabled people and address their ongoing economic and social exclusion. Reviewing social policy by honestly and critically evaluating the way people with disabilities are seen and treated in our society is essential to creating better policy outcomes. This thesis attempts to tie theory to practice, by critically analyzing a specific disability policy intervention.
3. METHODOLOGY

3.1 Analyzing Social Policy with a Critical Lens

Social welfare policies that target vulnerable citizens are a good reflection of the influence of power, ideology and prevailing values in government and society
(Pulkingham & Ternowetsky, 1996). Social policy is always political and therefore should be analyzed from a critical perspective, one that is conscious of the cultural, political and ideological meaning and context in which it was developed and evolved.

George and Wilding (1985) suggest that critical analysis of the welfare state is complex, going beyond basic ideological explanations such as the pluralist theory of consensus or the Marxist conception of class struggle. Social work as a field of study has a responsibility to critically analyze policy and use this knowledge to challenge injustices, especially for those who are marginalized (Westhues, 2006).

This thesis attempts to bring a critical disability perspective to social policy. As my methodology, I have completed a choice analysis of a welfare program upon which people with disabilities depend for their financial security, the Assured Income for the Severely Handicapped (AISH) program in Alberta. This thesis attempts to answer the following question:

*Analyzing the choices made, which ideology of disability, the social model or the individual pathology model, informed the Assured Income for the Severely Handicapped? Concomitant with that analysis, has the AISH program reflected the evolution in thinking that defines disability as a socially and economically constructed category.*

The purpose of the thesis is to examine if this program was built on the individual pathology model of disability as its theoretical underpinning. If so, has the AISH program
evolved to reflect social model thinking as disabled people demand the reinterpretation of
disability. To make this study relevant to Saskatchewan, I have used the analysis to
critically reflect on the emergence of the Saskatchewan Assured Income for Disability
(SAID) program.

This thesis approaches the research methodology utilizing a specific method of
policy analysis. In their book *The Policy Based Profession*, Popple and Leighninger
(2011) list several different methodological approaches to social policy analysis such as
content analysis, comparative analysis, historical analysis, process analysis, logical
evaluation, quantitative evaluation, ethical evaluation and the method adopted for this
thesis; choice analysis. In describing choice analysis, Popple and Leighninger (2011)
write:

Largely developed by social workers Neil Gilbert, Paul Terrell, and the late Harry
Specht, choice analysis is a systematic process of looking at the options available
to planners for dealing with a social welfare problem. Gilbert and Terrell describe
this type of analysis as dealing with choices that "may be framed in program
proposals, laws and statutes, or standing plans which eventually are transformed
into programs. The analytic focus of such studies is upon issues of choice: What is
the form and substance of the choices that compose the policy design? What
options did these choices foreclose?" (p. 37)

Based on the work Gilbert and Terrell (2002) and earlier contributor, Specht,
Popple and Leighninger (2011) list four potential dimensions of policy decisions to
analyze in choice analysis: bases of allocation; types of benefits; delivery structure; and
financing benefits. The first two are relevant in this policy study and will be used as a
framework to understand the underlying ideology of the AISH program. The latter two,
the choice between a public or private delivery structure and how benefits are financed are less significant factors in analyzing social policy in Canada, as most income support programs are publicly financed through taxes and publicly delivered, with little variation.

The primary concern of this thesis is how and why the AISH program was constructed the way it was and the form it takes now. The bases of allocation refers to the choice of how social benefits are allocated and why that decision is made (Popple and Leighninger, 2011). Generally, policy makers can choose universal allocation or selective, targeted, categorical allocation, depending on who they deem to be eligible for the benefit.

Popple and Leighninger (2011) describe four alternative bases for targeted allocation in Gilbert and Terrell’s choice analysis: attributed need; diagnostic differentiation; means-tested need; or compensation. In the case of compensation, the benefit is allocated for "...membership in a group, such as war veterans, that has made a specific contribution to society (p. 38). Attributed need allocation is targeted to a group that has a specific, common need. In the case of diagnostic differentiation, targeting is based upon: “…professional judgments of individual cases to determine need for social welfare benefits, as in the situation of the physically or mentally impaired” (Gilbert, 2000, p. 217). Means-tested need is “…conditioned upon evidence regarding an individual’s financial circumstances, which can be limited to income (sometimes referred to as an “income-test”) or include both income and assets” (p. 218). Gilbert explains that these four approaches to targeted policies are not mutually exclusive, but are often blended.

The choice of what type of benefits are allocated is also an important factor in choice analysis (Popple and Leighninger, 2011). The distinction between cash and in-kind benefits represents one choice that is made in the development of social benefits. The
distinction is also made between voluntary and mandated services. Often recipients of
government benefits are mandated to be involved in efforts of rehabilitation in order to
remain eligible. Another consideration is whether the benefit is viewed publicly as a
charitable benefit or an accommodation. As well, the choice around the adequacy of the
benefit, whether it is residual or generous, is essential to understanding the ideology and
choices made.

Choice analysis includes raising awareness of the axes that underlie the
dimensions of choice: values; alternatives; and theories (Ginsberg & Miller-Cribbs,
2005). In order to answer the proposed thesis question and understand the policy choices
made in the development of AISH, the theory of disability must be identified. The axis
for understanding and critiquing the choices made by AISH policy-makers will be
primarily the identification of which disability theory is predominant. The two
alternatives, the social model or the individual pathology model are marked and defined
by particular values and perceived policy alternatives. Ginsberg and Miller-Cribbs (2005)
explain the strength of delving into the belief system that influences policy development:

Gilbert, Specht and Terrell make a valuable contribution to social policy analysis
by defining their axes, because they show that, almost always, there are many
alternative ways of achieving a social policy objective, because they explain that
social policy is not simply a technical concern, but one that is affected by values
and beliefs; and because they show that theoretical considerations and theories are
also part of the process of social policy analysis. (p. 268)

It is important to use critical disability theory because disabled people are
demanding a reinterpretation of disability and are beginning to successfully change policy
directions (Barnes & Mercer, 2003; Oliver. 1996). Priestly (2012) describes how the
thinking around disability has progressed in recent years, reframing disability as an issue of discrimination, limitations imposed by society and exclusion, with corresponding policy solutions that focus on the removal of barriers, human rights and full citizenship. This 'social' model of disability is laid in contrast to the prevailing, mainstream theory of disability as an individual deficiency, with corresponding policies that offer caregiving, rehabilitation and charity.

Disabled people have begun to demand recognition as an oppressed minority and inclusion as central players in the development of the policies that affect them. Priestly (2012) argues that in part they have been successful. The social model of disability has started to influence policy development, even international agreements. Recently in policy responses there is an acknowledgement that discrimination exists and must be remediated, but policies generally still fall short of addressing the systemic exclusion of disabled people. The question remains, how far have disability policies come in reflecting disability as categorical exclusion, rather than an individual deficit or problem?

There are weaknesses and strengths in any type of research. The weakness of using choice analysis lies in what it cannot identify. It cannot precisely identify the personal beliefs concerning disability of any of the policy-makers. It can only extrapolate what the ideology or theory of disability was/is based on the available documents and resulting program. However, all of the available documents concerning the development of/changes to AISH and all references to AISH in the Hansard were reviewed to ensure accuracy. Another weakness is the inability to determine all of the factors which influence policy choice, such as perceived budgetary constraints or public opinion.

The strength of this methodology includes a deeper, critical understanding of the process, and the product—the AISH program itself. O’Conner and Netting (2009) suggest
that when power and politics are central to the choices made, then a politically responsive framework provides greater clarity. The use of a choice analysis in this thesis goes beyond a surface understanding of a disability policy in order to analyze the ideology which supports it. This concentrated approach to studying the history and choices around the formation of the income, rules, expectations and language provides a greater insight into how the challenge of “disability” is viewed and addressed. This deeper understanding of the choices involved sheds light on the issue of how policy is influenced by predominant social values. Further, exposing the choices made can challenge commonly held assumptions about the intent and effectiveness of a particular policy.

Analyzing policy from a critical perspective requires the analyst to take a side and emphasize an unconventional perspective. As the author of this study, my position is that I value the social model of disability, as I believe it exposes and challenges one of our last unrecognized human prejudices. Until I came face-to-face with the social model, challenged personally by people with disabilities to see their impairment as diversity, not tragedy, I was influenced by the individual pathology model. From my experience, I believe all people defined as able-bodied or able-minded to some extent fear disability and that the predominance of individual pathology ideas comes from this fear.

I strive to be an ally with disabled people in their struggle, and this influences my analysis. I carry with me the stories I have heard about the impact of institutionalization, abuse, segregation, unemployment, poverty and exclusion. I have also seen the hopefulness of real acceptance that comes when people are valued as contributing citizens, both in society and in relationships. It is humbling to tackle analysis from a critical disability perspective, as I don’t have the first person experience to draw from. I
know that my analysis is a shadow of the forty years of scholarship by disabled academics and community activists. I draw heavily on their work.

In managing my bias towards the social model, I was careful and judicious in the analysis, strictly using the comparative criteria to determine the meaning of the text. From 1978 until the present, each of the statements made by elected representatives in the Hansard record were evaluated by identifying the descriptors which best characterized their statement. In some cases, there were both individual pathology and social model descriptors which fit the text. Using CDA, absences and silences were also identified. The same process was used in evaluating the policy documents.

Lastly, in an effort to frame choices made in the development and evolution of the AISH program, historical analysis will also be employed. Popple and Leighninger (2011) argue that a review of the preceding events creates a fuller understanding of the policy: “If a policy is a continuation of a long trend, as in the case of the recent welfare reform legislation, historical analysis seeks to explicate that trend and to understand why it has continued” (p. 45).

3.2 Analysis of Underlying Ideology Using Comparative Criteria

I have adapted the descriptors of disability models developed by Rioux and Valentine (2006) as comparative criteria to analyze the ideology of the AISH policy. The descriptors in Table 1 are used to identify the individual pathology or social model of disability in the AISH program literature:
TABLE 1: Comparative Criteria—Disability Models

<table>
<thead>
<tr>
<th>Individual Pathology Model Descriptors</th>
<th>Social (Pathology) Model Descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>The problem or pathology of disability lies within the individual. The <strong>individual’s impairment disables them</strong> and causes their economic and labour market exclusion;</td>
<td>The problem or pathology of disability is societal. Society’s response to impairments and the structure of compensation in the capitalist labour market are why disabled people are economically excluded. It is <strong>society that disables them</strong> and causes their exclusion;</td>
</tr>
<tr>
<td>Disability is <strong>determined by professionals</strong>;</td>
<td>Disability is <strong>not inherent to the individual</strong>, independent of social structure;</td>
</tr>
<tr>
<td>Disability is addressed with <strong>individual interventions</strong>;</td>
<td>Disability is addressed with <strong>changes to the political, economic, social and built environment</strong>;</td>
</tr>
<tr>
<td>Disability is <strong>incapacity in relation to non-disabled persons</strong>;</td>
<td>Disability is <strong>diversity and a normal part of the human experience</strong>;</td>
</tr>
<tr>
<td>Disability and its attached costs are a <strong>tragedy, anomaly and social burden</strong>;</td>
<td>Disability is <strong>difference rather than anomaly</strong>;</td>
</tr>
<tr>
<td>The inclusion of people with disabilities is a <strong>private burden</strong>;</td>
<td>The inclusion of people with disabilities is a <strong>public responsibility and an entitlement</strong>;</td>
</tr>
<tr>
<td>Social programs/services are offered as a <strong>charitable or protective response</strong> to those who are <strong>dependent due to their disability (deserving poor)</strong>;</td>
<td>Social programs are offered as a <strong>reasonable accommodation in a disabling society</strong>;</td>
</tr>
<tr>
<td>People with disabilities are <strong>offered protective and charitable services</strong> as an entitlement;</td>
<td>People with disabilities are full citizens and are <strong>entitled to support based on equality of outcome</strong>;</td>
</tr>
<tr>
<td><strong>Equality of treatment and opportunity</strong> are markers of success</td>
<td><strong>Equality of opportunity and outcome</strong> are markers of success.</td>
</tr>
</tbody>
</table>

(Adapted from Rioux & Valentine, 2006, pp. 50-52 and pp. 56-58).

In the criteria, Rioux and Valentine (2006) note that equality has a different meaning in the individual pathology model than it would in the social model. In the individual pathology model, equality of **treatment** and **opportunity** are the benchmarks of success. These are marked by an entitlement to protection and charity, with the outcome being paternalistic services. Programs such as social assistance are provided “…not as a matter of right, but as a matter of charity and compassion…when this standard is used, people with disabilities trade rights for charity” (p. 58). In the social model, equality of
opportunity and outcome would indicate true equality. Entitlement to support would be based on citizenship status, ensuring that people with disabilities, as citizens, have the same opportunities and outcomes as other citizens:

[In the social model] society’s responsibility is to provide for the disabled political and social entitlements that are equal in outcome to those of other citizens. It is built on the acknowledgement that disability is a consequence of social, economic and political factors, not simply of individual pathology or incapacity. Further it acknowledges both the historical disadvantages that people with disabilities have faced as well as the role and function of the current structure of society in contributing to their ongoing marginalization. (Rioux & Valentine, 2006, p. 58)

Analysis using these comparative criteria is a subjective exercise and open to interpretation. Overall, if the AISH rules, language and outcomes supported a social model of disability, disabled Albertans would experience greater financial equity, and a greater sense of citizenship and social inclusion. Not all readers may come to the same conclusion about the textual data, especially if they are working from an individual pathology mentality. I will attempt to use the actual language and rules to determine which ideological beliefs about disability were used in the creation of AISH.

Interesting for this analysis, entitlement to accommodation is a principle in the 2006 United Nations Convention of the Rights of Persons with Disabilities, to which Canada is a signatory. Entitlement to economic accommodation as an equal citizen stands in sharp contrast to the charity model, which emphasizes dependency and depoliticizes the social construction of disability. Devlin and Pothier (2006) explain, “…a charitable approach tends to focus on bare survival rather than on genuine participation in society, and is highly susceptible to claims on budgetary restraint” (p. 11).
3.3 Critical Discourse Analysis

As the data are textual, principles of critical discourse analysis (CDA) are used to help formulate questions about the text. CDA can reveal how a micro level dialogue or text influences macro level oppression, such as a racist speech influencing the production of racist legislation (Van Dijk, 2001, p. 354). Phillips (2007) explains how the use of CDA compliments social research:

But whether CDA is a method of discourse analysis or a means to study the use and implications of language as a social practice is controversial. The emerging consensus is that CDA is not a method of discourse analysis per se, but rather a means to relate textual analysis to the social and political context under study. CDA is an interpretive study of how language-in-use, in whatever form, reflects sociopolitical relations. (Phillips, 2007, p. 44)

Malacrida and Duguay (2009) use CDA in their review of textual data to analyze the AISH policy review process. They refer to Fairclough’s theory, explaining, “CDA does not simply describe the texts but also attempts to identify the power relations and systems of knowledge present within them” (Malacrida & Duguay, 2009, p. 21). Wodak (2002) describes how the study of text can reveal the underlying social and political relationship between words and the production of oppression:

CDA sees discourse – language use in speech and writing – as a form of ‘social practice’….That is, discourse is socially constitutive as well as socially conditioned – it constitutes situations, objects of knowledge, and the social identities of and relationships between people and groups of people. It is constitutive both in the sense that it helps to sustain and reproduce the social status
quo, and in the sense that it contributes to transforming it. Since discourse is so socially consequential, it gives rise to important issues of power. (pp. 7-8)

Wodack (2002) goes on to explain that discursive practices have an ideological effect, producing and reproducing unequal power relations.

In this study, as the government documents, legislation and policies are analyzed in relation to the social model of disability it will reveal an underlying belief system and how that has shaped the policy choices. One relevant step to take is to formulate a question to the text in order to identify the discursive strategies that are employed by the writer(s) (Phillips, 2007). In the case of the social model of disability, a relevant question to direct to the government data is: “How are the discourses of ‘disability,’ ‘normal’ and ‘citizen’ used throughout the text?” Phillips also suggests looking for themes, “inter-relationship among discourses,” “absences and silences” within the text and resistance to the discourse (pp. 47-48). In this study: “Are the principles of the social model of disability evident in the text or are they absent?” or “Do stakeholders resist or challenge the discourse?”

A further consideration for CDA in this context is what the effect of the discourse is on people with disabilities (Phillips, 2007). Smythe (2006) notes:

What makes discourse analysis “critical” is the illumination of the ways in which unequal power relations are produced and naturalized in discourse (Lemke, 1995). A critical approach to discourse analysis explores texts not as truths but as discourses that act in the world in ways that both define and distribute power. Such approaches are concerned not just with what texts say but also with what texts do. (pp. 22-23)
Ultimately, the question about what the text does for people with disabilities is “Are the principles of the social model, if present within the dialogue, acted on in the development of policy and legislation?” These considerations from the discipline of CDA may help to establish a better understanding of how language contributes to and reflects ideology.

3.4 Data Collection

In this study, the primary data were Hansard records from 1978 until present, reports, policy documents (current and past) and legislation, created by government or opposition parties, relevant to AISH. The secondary data sources were the available grey literature from disability organizations that represent the recipients of the AISH program, as well as available statistics on the cost of living in Alberta. I have used comparative criteria and critical discourse analysis as tools to analyze the data. The goal of the thesis is to find evidence demonstrating the underlying ideology of the AISH program and identify the underlying intention of the policy choices.

The data were collected through a variety of means. The Hansard records were found online on the Government of Alberta website (1994-present) and the Our History, Our Past website which preserves and makes available the Hansard records from 1972-1993. All of the AISH policies were found online. The majority of the historical documents about AISH were sourced from the Legislative Library of the Legislature of Alberta.

Disability organizations: the Alberta Committee of Citizens with Disabilities (ACCD); the Alberta Disability Forum (ADF); and the Alberta Association for Community Living (AACL), were contacted asking for copies of historical, public briefs sent to government recommending changes to AISH. Some documents were sourced from their library collections. The grey literature was also collected from disability
organizational websites. The media articles that relate to the welfare reform period of AISH were found in the archives at the ACCD library. All other media articles were found through media websites. The current data concerning the raise in AISH rates were collected online through media sites and on Premier Redford’s public Facebook page.

In this thesis, Alberta’s AISH program was chosen because it represents a targeted, pension-style program which disability groups prefer over generic welfare programs. On its own, this study of AISH is useful in reflecting on disability income policy as AISH is often seen to be a superior program compared to others. As well, this study has implications for Saskatchewan. Until recently, Saskatchewan only offered a generic last-resort welfare program to people with disabilities. After a lobby effort from the disability community, the Government of Saskatchewan has begun developing a parallel income program which may resemble AISH (DISC, 2010). The new Saskatchewan Assured Income for Disability (SAID) is still emerging, so only time will tell if it embraces a social model understanding of disability. This thesis discusses how our learnings from AISH offer important insight, as Alberta’s disability income model may be replicated in Saskatchewan.

Language is important in studies about disability. As the cornerstone of this thesis is the social model of disability, which emphasizes the created nature of the category ‘disability’ as a label for those who are not accommodated by the current structures in society, I am most comfortable using the term ‘people with disabilities.’ Also to respect disability activists who feel strongly that their impairment is not something to be ashamed of, and therefore relegated to a secondary aspect of their personhood, I have also used ‘disabled people.’ A discussion of the use of language in disability studies can be found in the literature review.
4. ANALYSIS OF THE ASSURED INCOME FOR THE SEVERELY HANDICAPPED

This thesis examines the history, rules, language and stated goals of Alberta’s Assured Income for the Severely Handicapped (AISH) program, and whether the policy design reflects the individual pathology model or social model of disability. The analysis will attempt to determine which of these theories is predominant in the AISH program. The question will be asked: has the AISH program evolved as thinking around disability began to shift towards the social model in the early 1990s? Throughout the analysis, the choices made by policy-makers will be analyzed utilizing critical discourse analysis (CDA) and the comparative criteria in Table 1.

There is not necessarily a clear black and white answer to these questions, as various aspects of this program may reflect both theories on disability. This analysis will cover three stages in the development of AISH: the historical development of AISH; the welfare reform era; and AISH today. In addition, section 4.3 will look at a missed opportunity to implement social model principles in disability policy in Alberta.

4.1 The Historical Development of AISH

The Assured Income for the Severely Handicapped program, widely known and referred to by the acronym AISH, was created by the Government of Alberta in 1979 under the Progressive Conservative (PC) party and former Premier Peter Lougheed. AISH was developed as an income program for Albertans with disabilities who would otherwise be reliant on welfare benefits if they were unable to earn an income from employment or rely on family and personal resources. With the mandate of providing an assured income to people with severe disabilities, AISH was the first social assistance program of its kind in Canada (Bogle, 1979a, p. 759; Faid, 2009).
Through this policy response, the government had the goal of ensuring an adequate income for people with disabilities, similar to the pension offered to seniors. Robert Bogle, Minister of Social Services and Community Health at the time noted:

The purpose of this very significant Bill is to implement the announcement made by our Premier and my predecessor to provide to severely handicapped Albertans who are age 18 through 65, and not resident in institutions, an income which will be equivalent to that guaranteed [emphasis added] to Alberta senior citizens.

(Bogle, 1979b, p. 373)

And further: “[The] Bill will have a significant impact on severely handicapped Albertans in assuring them a guaranteed income equivalent to that provided to Alberta senior citizens [emphasis added]” (Bogle, 1979c, p. 521).

The idea for the development of AISH came from the grassroots, both through pressure from disability organizations and from PC party members. The Camrose PC association received credit for bringing the idea of AISH to the provincial convention in 1977 (Stromberg, 1979). Another reason for the creation of AISH was to address the financial needs of people with disabilities who were leaving institutions in the 1970s (VRRI, 2004). Advocates note that deinstitutionalization was an important precursor for the creation of AISH as an “entitlement pension program” to provide guaranteed, adequate income to those who had limited employment potential (VRRI, 2004, p. 1). While the investment of funding into an assured income program represents forethought and a first step in addressing the needs of those leaving institutions, it certainly was not sufficient in combating poverty and homelessness. Thirty years after the creation of AISH in spring 2009, the Government of Alberta announced a $3.3 billion investment into combating homelessness, in particular for individuals with mental disabilities.
The PCs had little debate on the *Assured Income for the Severely Handicapped* Act, which was no surprise given that they held 74 of the 79 seats in the legislature after the October 1979 election. The opposition Social Credit leader, Robert C. Clark, agreed with the Bill and only raised a parallel concern about the income of seniors (Clark, 1979). Comments made in the Alberta legislature about the proposed AISH program were almost entirely positive, with a few ruling PC members arguing for more generous and far reaching benefits, to ensure a good quality of life. The Hansard record reveals a great deal about the thinking and ideology involved in the construction of AISH.

PC member Catherine Chichak expressed her happiness and a few concerns about the new program, citing the financial hardships faced by people with disabilities (Chichak, 1979a). During the second reading of Bill 28, Chichak voiced concerns about whether the program would cover the extraordinary costs such as transportation and drugs, and whether the criteria for eligibility would be flexible enough to allow those with invisible disabilities to access it. She also was worried about clawing back employment income for those who were able to hold some employment, suggesting partial income exemptions.

Gordon Stromberg (1979), another PC member, expressed concerns from his constituents over what department the AISH cheque would come from, suggesting it should not come from the department of social development lest it be viewed as a welfare cheque. The answer Stromberg suggested was that even if the Department of Social Development administered the funding, the cheque itself should be generic from the Government of Alberta with no link back to social assistance.
A third PC member, Ed Oman, in his statement expressed a broader, more adequate vision for what the AISH program should be, although he was not critical of the proposed monthly amount.

It’s been my political philosophy all along, Mr. Speaker, that those who can help themselves should, but certainly society should give a hand to those who cannot. It seems to me that this brings these people to a level where they can live with some integrity and without having to come through the welfare system and feel they are begging. It gives them some sense of equality with the rest of us. I think they have enough to bear in the sort of physical and mental or emotional setbacks the acquired or perhaps were born with. (Oman, 1979, p. 522)

Interestingly AISH was not designed entirely as a stand-alone income program, as the adequacy of the benefit was an issue in this and previous debates. The AISH benefit was originally $370 a month, which was less than the amount that some people with disabilities were already accessing on social assistance in Alberta. For this reason, AISH recipients were also eligible for a top-up from social assistance, depending on their individual needs and if they met the more onerous criteria for social assistance. Bogle (1979a) explains that this decision and offers an example:

As I may use as an example an individual who under the social assistance program has needs of $500 a month, the first $370 would be met by the assured income for the severely handicapped, program, if he qualifies for it, and the remaining $130 would be provided through the normal social assistance programs. (p. 758)

The Assured Income for the Severely Handicapped Act (Bill 28) was passed in conjunction with the Social Development Amendment Act (Bills 29 and 37) which was intended to add this flexibility. During the debate Bogle explained his rationale for both
Bills being tabled at the same time. On the topic of the amendments to social assistance, Bogle said the following about Bill 29:

As I outlined, the main purpose of this Bill is to provide additional assistance to individuals who require assistance above and beyond the maximum which may be provided under assured income for the severely handicapped. This Bill will ensure that there is a consistency of form between the eligibility criteria for a handicapped benefit paid under this act and the criteria applied under the Assured Income for the Severely Handicapped Act. (Bogle, 1979c, p. 523)

On Bill 37, Bogle (1979d) explained the need to top up the AISH benefit:

Mr. Speaker I request leave to introduce a Bill. The Social Development Amendment Act 1979 (No. 2). The purpose of this Bill is to complete the package of legislation relating to the handicap benefit, and specifically to provide a top-up amount for a handicap benefit to handicapped persons who are eligible for and in receipt of a social allowance and to permit the department to recover overpayments of social allowance of amounts not exceeding $500, by deducting monthly amounts…(p. 755)

In October 1979, the adequacy of AISH came up again in the legislature. Bogle was questioned by the Social Credit MLA Raymond Speaker whether the AISH benefit was meeting the needs of people with disabilities, and if the government would commit to reviewing the issue of adequacy over time (Speaker, 1979). Bogle defended the benefit, stating that AISH was “the most generous in Canada,” despite the fact that he had just explained that some individuals, likely those with dependents, were going to need a top-up from social assistance (Bogle, 1979a, p. 759). He did commit to reviewing benefit limits over time, noting that there had been a “great deal of deliberation” in caucus about
the AISH benefit levels (p. 759). Over the years, little action was ever taken to address the inadequacy of AISH. Until 2004, AISH recipients with dependent children often opted to be on social assistance, as the benefit was more generous for families. The addition of discretionary benefits in 2005 was the first step in tackling this issue.

In order to analyze the choices made in the historical development of the AISH program from a critical disability perspective, it is essential to identify the underlying theory of disability, either the social model or the individual pathology model (Rioux & Valentine, 2006). The comparative criteria in Table 1 and CDA are used to identify which theory of disability was predominant in the development stage. The choices made for the original AISH program were shaped by the theory of disability and the economic theory that the policy-makers embraced. The bases of allocation and type of benefit were results of their belief system.

Indications of the social model in Hansard include a concern for adequacy and dignity, showing a commitment to entitlement, and the belief that these financial supports to people with disabilities are a public responsibility. Unfortunately their valuation of adequacy was effectively empty, as the AISH benefit kept people with disabilities in poverty. Certainly their language and sentiment was that AISH would make life better for people with disabilities, using the terms ‘guaranteed income,’ ‘equality,’ and ‘pension’ to describe the benefits, all descriptors that could fall under the social model. However, at the same time they were arguing to make sure the new AISH program would be at least as adequate as welfare. The rhetoric of equality was not matched by the reality of the program, reflecting a charitable mindset, rather than one of economic accommodation.

Analyzing the historical text in Hansard, the following indications of the individual pathology model appear in the descriptions of AISH:
- Disability is incapacity in relation to non-disabled persons;
- Individual disability is the reason for labour market exclusion;
- The entitlement is to an insufficient benefit, denoting charity and viewing people with disabilities as the deserving poor;
- An individual impairment is what disables the individual and is an unfortunate tragedy and social burden;
- Social programs are offered as a charitable and protective response, to those who are dependent due to their disability;
- Equality of treatment with “the rest of us” (Oman, 1979, p. 522);
- The inclusion of people with disabilities is a private burden;
- The individual is the point of intervention, not the social and economic structures.

Individualism and the economic theory of competitive capitalism are valued in the Hansard text. One MLA, Ed Oman, used individualistic language, such as people with disabilities cannot “help themselves,” alluding to their personal incapacity in relation to the labour market, and that they bear the burden of their setbacks (Oman, 1979, p. 522). Disability is portrayed as a burden and an inability to live within the normal rules of economic engagement, in relation to the non-disabled. The discourse of “disability” and “normal” are used as opposite ends of the spectrum of labour market capacity and participation in this text. Equality is something to be given to those who are marginalized, not something that is inherent or expected for all citizens. People with disabilities become the deserving poor in the new AISH program.

In the original text, there are references to the plight of the disabled, but the question of why their income was inadequate was not asked or answered in the majority of the text. The issue of where the pathology of disability lies, whether it is individual or social, is only explicitly addressed by one MLA. In arguing for higher benefits, Chichak (1979b), an MLA for the governing PC party, gave an explanation for why people with disabilities were outside the labour force, that reason being their individual handicap:
Another point that has been raised to me on many occasions by recipients who are receiving social assistance—not because they are not able to get a job or because of lack of availability of work for them—but are not able to hold a job because of some handicap [emphasis added], a minor one perhaps. But industries, with the costs they face, are just not prepared to cope with allowing a lower standard of productivity within the workplace. [emphasis added] So they’re not able to have this work. They are finding that the allowance that we have calculated allows them no time or availability for social recreation, from time to time. Not that they should be able to go on a regular basis—every week, every other night, or whatever—for some social recreation, but to be able to do that at least on occasion. (pp. 832-833)

Chichak’s words quite graphically describe the individual pathology approach to disability in her understanding of economic exclusion. While she explains the fact that the labour market, reliant on a narrow definition of productivity, will not accommodate disabled workers, she does not recognize a problem or pathology within this reality. The pathology is placed entirely on the individual and the impairment which limits them from keeping up with the demands of productivity. She characterizes disability as incapacity, in relation to non-disabled workers. In talking about the costs of financing adequate social assistance and accommodating people with disabilities in the labour market, she understands these actions as an anomaly and a social burden. Not only are people with disabilities viewed as unemployable, a problem blamed on their personal characteristics, but there is no expectation that the labour market could or should include them. It would be too great a burden.
Chichak goes on to argue for a very limited entitlement to social inclusion, suggesting that people with disabilities should be permitted to enjoy a small portion of what other citizens enjoy in terms of social engagement (Chichak, 1979b). Anything more would be too expensive. She clearly describes the social inclusion of people with disabilities as a private burden, but is willing to offer a minimalistic, charitable response from the state to stem the effects of social isolation. Certainly, Chichak’s comments reveal how a concern for the well-being of people with disabilities can be genuine, yet still be based in an individual pathology ideology that marginalizes them further.

No elected representatives argued with Chichak’s estimation that the problem of economic and social exclusion lay within the individual and his/her disability. While this alone does not prove that the individual pathology model was the predominant underlying theory upon which the AISH program is based, it is strong evidence that this type of thinking was accepted as fact. Certainly, the AISH program was developed in a time when the social model and disability rights were only in their infancy. Disability was, and still is today, widely seen as an individual problem. As with other marginalized groups, the structural conditions which cause poverty and exclusion for people with disabilities were not examined.

The title of the program itself, Assured Income for the Severely Handicapped, reveals an individual pathology mindset. While the United Nations has updated their definitions today, in the late 1970s when AISH was developed, a “handicap” was officially defined as a lack of individual success in expected social roles, such as employment, although environmental barriers were also acknowledged (Kaplan, 1999). One of the individual pathology determinants is to view disability as an incapacity in relation to non-disabled people, something which is inherent in the word “handicap” and
particularly “severe handicap” as it was defined at this time. Interestingly, the AISH program retains the same title today, where many disability-related programs reflect updated language.

The original Assured Income for the Severely Handicapped Act and the eligibility process had criteria that emphasized the individual pathology perspective that disability is a tragedy. A person was only eligible for AISH if “…he suffers [emphasis added] from a severe handicap” (The Ministry of Social Services and Community Health, 1979, Section 4 (2) (b)). The language of suffering indicates a medical understanding of disability, viewing disabled people as inevitably sick, miserable or in pain. This language, as mentioned, was also present in the legislative debates.

Using the comparative criteria, and based on analysis of the available text, the choices made in the development of the AISH program largely reflected the theory that disability is an individual pathology. It is also evident from statements in the text that the choices made were the result of valuing the theories of individualism and free-market capitalism. Since it is apparent that the predominant theory about disability was the individual pathology model, how did that affect the program design?

In choice analysis, the bases of allocation in policies are selected as a result of the policy-makers’ theories about life, values and perceived alternatives. The basis of allocation in the original AISH program was a targeted approach, and more specifically it blended a means-test and diagnostic differentiation for determining eligibility. The original process for determining AISH eligibility included an income-test, which is a form of means-testing, reminiscent of targeted, last-resort welfare programs. The income test was followed by a medical examination to establish the presence and severity of disability. While this was and still is a standard practice in determining access to
disability income programs, it reflects a belief that it is professionals, in particular physicians, who establish the parameters of disability. Gilbert (2000) suggests that this type of assessment of individuals is reflective of diagnostic differentiation as the basis of allocation in targeted programs. Social model theorists question the role of professionals in the lives of disabled people, and argue that disability is not illness, but the result of an unaccommodating society.

The *type of benefits* offered is another dimension that is analyzed in choice analysis. The policy-makers make decisions about the type of benefit will be offered, based on their analysis of the need, the theories they adhere to, their values and alternatives. One consideration is whether a benefit will be cash or in-kind. The AISH benefit was created as a cash benefit, which is typical of most income support programs, whether they are pensions or last resort, welfare programs.

Another consideration about the type of benefit is whether it is understood as charity or an accommodation. A charitable benefit, such as the original AISH benefit, requires absolute poverty and is framed as a charity to those in need. Alternately, policy-makers could create a benefit that reflects economic accommodation, an alternative that was not considered based on the available data analyzed for this thesis. In the data, there are no references to disability as diversity or social programs as an economic accommodation, and no critique of the structural reasons for poverty. Essentially, throughout the Hansard record, it is apparent that elected representatives did not view AISH as an economic accommodation for a disabling world, but viewed it as a charitable approach to those who experience the personal ‘tragedy’ of disability.

A third choice in what type of benefit will be offered is the adequacy level, whether it will be residual or generous. AISH was constructed by elected representatives
as an entitlement to a residual amount, far below minimum wage, or even social assistance, which are examples of minimally acceptable social standards. The minimum wage in Alberta in 1979 was $3.00 an hour or $520 a month based on a 40 hour work week (Ministry of Labour, 2012, online). The AISH benefit at $370 a month was 71% of minimum wage.

To develop a benefit that was so low that it would need to be topped up by social assistance does not reflect the intention of providing an adequate accommodation for the systemic labour-market exclusion that disabled people face in competitive capitalist economies. It certainly does not reflect the goal of equality of outcome for people with disabilities, as would be the goal in a program built on social model theory.

What the policy choices of the original AISH program reveal is a charitable and protective response to those seen as the deserving poor, reflective of the individual pathology model. It also reflects the principle of “less eligibility,” an artifact and expectation of modern capitalist economies, that social programs should always provide less than one can earn in the lowest paid employment (Rice and Prince, 2000, p. 36). Any benefit which is more generous is seen to cause dependency and to undermine the work ethic and low-cost labour. In essence, the unspoken message of the original creators of the AISH program is that people with disabilities were entitled to support by virtue of their unfortunate individual circumstance, but that entitlement would be insufficient, far below the lowest acceptable standard of living in society.

The Alberta government created the AISH benefit as a pension-style benefit for those who met the income test and had medical proof of a ‘severe handicap.’ AISH was not a pension in the true sense of a permanent entitlement, as it displayed many characteristics of last-resort welfare programs. The residual and charitable nature of the
original AISH benefit, combined with the portrayal of disability in the debates and legislation, point to the presence of the individual pathology model underlying the development of this program. Alternately, the social model indicators were not readily identifiable or predominant in the Hansard discussions, debates or available documents.

4.2 **AISH in an Era of Welfare Reform**

From the origins of AISH, we turn to the effects of welfare reform on the program. This section describes the historical accounts of reforms to AISH from 1999 to 2004 and how the Alberta Government was clearly not interested in supporting a social model approach to economic accommodation during this time.

In the 1980s and 90s, there was an attempt by most industrial welfare states to curb spending on welfare programs, based on what was seen as the ‘crisis’ of the welfare state. Welfare reform in many jurisdictions included actions such as limiting eligibility to reduce caseloads, reducing benefits, forced workfare or training compliance and promoting labour force attachment. In addition, the Government of Canada abandoned their responsibility as an equal funding partner for income replacement programs, thereby eliminating the program standards that came with the funding.

In the case of the AISH program, the attempt to reform the program came later than most, in 1999, and largely failed due to public outcry. This drastic attempt to abolish the AISH program and move the majority of the caseload on to welfare in 1999 reveals the individual pathology mindset that has informed disability policy in Alberta.

Alberta is generally seen as a province in which conservative ideas are explicitly embraced. Dependency on social programs is discouraged and all citizens are expected to contribute through the paid labour market. This ideology values equality of opportunity, not equality of outcome, in line with individual pathology model thinking. It is with these
views that the Alberta government tackled welfare reform with vigour throughout the 1990s. Commenting on the pace of welfare reform in Alberta, starting in 1993, Reichwein (2002) writes:

The minister desired a fundamental change of “welfare” from a passive system of support into an active employment program. Benefit levels were reduced and some benefits were eliminated entirely….From anecdotal information it was learned that government reform initially focused on training and employment and “not” on reduction in benefits. When caseload reduction, however, did not move fast enough, drastic budget reductions were introduced. Subsequent implementation of reforms happened hastily and effected a great deal of human suffering. Needs, interest and dignity of citizens were secondary. Alberta led the nation in reducing public welfare caseloads, a dubious reputation for a “have” province. (pp. 27-28)

He explains that by 1999, in six years, Alberta’s public welfare caseload was reduced by 63%, more than any other province (p. 32).

In 1998 the Alberta government began planning further reform, this time to include disability income assistance programs. Both AISH and what was then known as Assured Support (now known as Supports for Independence, SFI) were targeted. Assured Support was an extension program under provincial welfare for people who had less severe disabilities which prevented them from working full-time, but who were still considered to be employable—the less deserving of the ‘deserving poor.’

In November 1998, Minister Lyle Oberg announced changes would be coming for these programs and committed to consulting Albertans (Alberta Family and Social Services, 1999). The announcement came ostensibly as action taken to follow the
recommendations in the October 1998 *In Unison* agreement. *In Unison: A Canadian Approach to Disability Issues* was developed as ministers responsible for social services in Canada came together to devise a blueprint for disability supports, as a part of the larger Social Union Framework Agreement (Federal, Provincial, and Territorial Ministers Responsible for Social Services, 1998). *In Unison* was seen by some as progressive, as it embraced a vision of inclusion and full citizenship for disabled people.

However, many disability groups had railed against the lack of consultation in the development of *In Unison*, and 13 national groups responded. In their critique, the groups explained that while *In Unison* contains strong principles, the political will to act on the recommendations in a comprehensive manner was absent (Council of Canadians with Disabilities, 1999). They critiqued the reduction in social investments in the 1990s and the negative impact it was having on people with disabilities. They explained that *In Unison* did not address the poverty faced by people with disabilities as a result of residual benefits. They called for a comprehensive study to find a better way to offer income support nationally. The disapproving response of the disability community to *In Unison* across Canada helps provide context to the hotly debated reforms to AISH and Assured Support in 1998.

Canadian disability theorist Titchkosky (2007) explains how *In Unison*, written by bureaucrats, narrowly defines citizenship as inclusion and participation in the economic world, revealing an individual pathology, neoliberal understanding of human life and disability. This economic understanding of contribution and citizenship expects disabled people to conform and become the “able-disabled” (p. 148). Titchkosky argues that disability policy such as *In Unison* has become the “…prime site for constitution of the neo-liberal version of the individual” (p. 148). She argues the programs developed to
include those who are defined as ‘excluded,’ by virtue of their deviance from normal roles, only further reinforces their exclusion.

Oberg began the government consultation with a questionnaire and public consultations with the disability community. *New Directions for AISH and Assured Support: A Discussion Guide* outlined a plan to bring AISH and Assured Support “…in line with the ‘In Unison’ vision” (Alberta Family and Social Services, 1999, p. 1). The guide described how AISH has been considered the best disability income program in the country, but that it does not “…live up to the vision articulated in the ‘In Unison’ document” (p. 2). It goes further to explain how *In Unison* focuses on ability, not disability, and that the Alberta government was considering this shift in thinking. Given Titchkosky’s analysis, it seems the Alberta government accepted the individual pathology overtones in the *In Unison* document and the associated judgment of what is ‘normal’ and valued—participation in paid employment.

Just as the consultations got underway in January 1999, the release of a leaked memorandum to the media revealed the real agenda behind the AISH reforms. Dated September 8, 1998, the memorandum from Oberg to four cabinet ministers summarized that cabinet had approved specific, regressive changes to AISH earlier that year, immediately calling into question the authenticity of the consultation process. It included a complete business plan for the redesign of disability income programs, a communications and consultation plan, a time line and an implementation plan (ACCD, 1999a). The plan was to freeze the AISH program from accepting new applicants and funnel people with disabilities to a new welfare program called Open Doors. Although the disability-specific admission criteria for the new program would be relaxed, recipients would receive substantially lower benefits than on AISH, with intentionally inflexible
regulations to restrict the discretionary power for both program administrators and appeal panels (Oberg, 1998). As well, asset limits would be introduced as a way to immediately reduce the AISH caseload and make qualifying for Open Doors difficult.

Portions of *In Unison* were used by Oberg to justify the extreme reforms proposed. The argument used in the memorandum was that AISH “…no longer fits the needs and aspirations of disabled people” (Oberg, 1998, p. 6). Getting rid of AISH and putting disabled Albertans in need of income support on a less generous welfare benefit was the individual pathology solution offered to ‘honour’ their desire for inclusion into the mainstream. Oberg (1998) goes on to state:

> Benefit levels should respond to need. The presence of disability does not in and of itself justify *high income support benefit levels* [emphasis added]. It is important to recognize that the AISH program cannot be “fixed” to address these issues, since it is the very existence of a separate program for the disabled, *with a higher benefit rate, which is the cause of the problem* [emphasis added]. (pp. 6-7)

In understanding how the Alberta government viewed the AISH program, it is interesting to note that Oberg argued that the “high” AISH benefits for disabled people were a large part of the problem. The problem identified earlier was that AISH provides an entitlement to support with no expectation of paid employment. As well, Oberg expressed concern about the cost of AISH with its expanding caseload. In the discussion guide AISH and Assured Support, as entitlement programs, are blamed for social exclusion, as they were not designed to help people gain skills and therefore participate in their communities (Alberta Family and Social Services, 1999, p. 2).

Oberg’s views of the AISH program and his estimation of the origin of social exclusion and unemployment for disabled people represents classic individual pathology
thinking, with a draconian bent. The disabled individual and his/her lack of motivation
due to a ‘generous’ entitlement is the source of pathology, not the discriminatory
economic system. Therefore, the calculated policy response is not entitlement to
economic accommodation, but a forcible push towards individual skill attainment and
labour market attachment. The removal of economic security is spun as the benevolent
and fair thing to do, again representing a paternalistic, ‘protective’ stance that is
illustrative of the individual pathology mindset.

Judging from the protests, and numerous letters and briefs provided to the
government from individuals and organizations concerned about the reforms, disability
advocates did not share the view that AISH was too generous. They were concerned that
lower benefits and asset testing would drive disabled people further into poverty
(Edmonton Social Planning Council, 1999). Disability organizations had regularly been
asking for an increase in AISH benefits prior to the reforms and were now faced with the
possibility of reduced support. In response, a coalition of disability advocacy groups
started a campaign called “Stop and Start Over” (Official Opposition, 1999, p. 11). Their
demands included that the AISH benefit take into account the cost of living, that there be
a transparent, comprehensive review of disability programs and that the real issue of
discrimination and employer attitudes be the focus of change to deal with unemployment
(p. 11). They presented a social model alternative to the government’s individual
pathology justification of program changes.

AISH certainly was far from generous, as in 1999 it was $823 a month. This left
recipients 45% under the Low Income Cut-Off (LICO) line for a large centre like
Edmonton or Calgary and 20% under for the smallest rural community (Canadian Council
for Social Development, 1999). The proposed Open Doors program would have left
disabled people with an income 58% under the LICO line. It is unlikely that any disabled person envisioned the extremely residual poverty of welfare programs as the solution to social exclusion, income insecurity and unemployment. Poverty is often pointed to by disability advocates as one of the major causes of social exclusion. By aiming to reduce benefits and further impoverish disabled people through the reforms, it remains unclear how Oberg planned to fight social exclusion, particularly for those who would not easily enter employment.

In defense of eradicating AISH, Oberg also noted the *In Unison* recommendation to separate disability supports from income support. In actuality, AISH as a flat rate income replacement was not tied to disability supports in any way, as there were no discretionary benefits. All exceptional disability-related supports were covered through other programs (AAACL, 1999; ACCD, 1999b). In fact, the Alberta Association for Community Living (AAACL) made the point that Oberg’s plan went against *In Unison* by tying employment-related disability supports to the new income program. They argued that the proposed, mandated training programs were a way to limit eligibility and would not address unemployment: “The government fails to understand that people with disabilities are not unemployed due to their abilities but due to their disabilities combined with systemic and societal barriers” (1999, p. 8).

According to disability advocates, the real agenda of the Alberta government in the planned reforms was to limit access to income support through asset testing, and to funnel more people into work-first employment programs (ACCD, 1999a). Supporting people with disabilities to enter employment was most definitely a desired outcome in the *In Unison* document. However, the Alberta reform plan did not address the underlying issues causing unemployment, such as a lack of adequate disability supports.
transportation and accommodations in the workplace and, of course, entrenched
discrimination. While Oberg used the employment focus of *In Unison* to support and
defend his reform agenda, no new investment was planned for employment supports, as
the reforms were intended to be cost-neutral. There was no social model focus on the
systemic discrimination from employers who exclude people with disabilities deemed
non-competitive. The focus of the reforms laid entirely with fixing the individual, or
making them desperate enough to accept any employment.

The backlash from the leaked memorandum was widespread and forceful, as
evidenced in the media coverage of the issue for the months that followed (Davies, 1999;
Jeffs, 1999a; Jeffs, 1999b; Pannu, 1999; Sadava, 1999; Thorne, 1999). People with
disabilities participated in protests and public forums, demanded real consultation and
developed action notices to rally letters of opposition. The opposition Liberals and New
Democratic Parties also criticized the process and the proposed changes (Official
Opposition, 1999; Pannu, 1999).

The government consultations and the survey carried out by the Equus Consulting
Group proceeded despite the calls by disability groups to “Stop and Start Over” (Official
Opposition, 1999, p. 11). In the report, Bill McMillan of Equus repeatedly described that
there was a marked distrust of the process by those participating in the consultation. In the
acknowledgements, he thanked the Equus staff for fielding hundreds of calls from
“distraught AISH consumers” who were concerned about the implications of the leaked
memorandum (McMillan, 1999, p. 12). The first major finding reported was that “…trust
levels are low. Advocates, consumers and caregivers believe the financial concerns of the
government will overwhelm public commitment to social support” (p. 3). Participants
also raised the issues of the hardship of increased reporting, complex regulations making
it difficult to understand one’s rights, and the inadequacy of benefits. Consumers and advocates voiced their concerns despite the inadequate nature of the consultation.

By focusing public attention on the issues, disability advocates successfully convinced the Alberta government to rescind their plans to cap admittance to the AISH program and replace it with Open Doors (Official Opposition, 1999). Oberg issued a notice in March, 1999, indicating that they were implementing asset testing, rapid reinstatement, more job training and the inclusion of family income, raising both AISH and Assured Support benefits and offering extended medical benefits into employment. In an internal document from the ACCD, advocates pondered whether the government had intended all along to create the scare of a worst case scenario and then follow-up with less extreme changes such as asset testing (ACCD, 1999b, p. 1).

Previous to the 1999 reforms, assets were not a factor for AISH applicants. The new rules on assets were implemented despite ongoing opposition from disability groups. Instead of the $20,000 asset limit that the government had planned for, they conceded to a $100,000 combined asset limit for the AISH recipient and their spouse. The ACCD felt that asset testing and the inclusion of “family” (spouse) in the determination of assets signaled a policy shift to make AISH a “last resort” income program instead of an entitlement or pension (ACCD, 1999a, p. 6).

The updated legislation, Bill 32, contained an increased focus on work and was a concern to advocates (ACCD, 1999b, p. 2). Ability to work had always been factored in by medical professionals assessing AISH candidates. The employability focus had also been ever present in annual reviews and policy with an expectation to seek, accept and retain employment as specified in the AISH Program Purpose and Authority: Introduction, dated October 1996 (ACCD, 1999a, p. 4). Yet the new language and focus
in Bill 32 was to emphasize what potential recipients “can do” (ACCD, 1999b, p. 2). One fear raised was that tying ‘citizenship’ or ‘inclusion’ to employment diminished the personal worth of those receiving AISH and their value as citizens (ACCD, 1999a).

The 1999 AISH reforms clearly demonstrated the Alberta government’s individual pathology mindset. Both the documents and the government actions as recorded by the disability community show the following individual pathology indicators:

- The individual’s impairment disables them and causes their economic and labour market exclusion;
- Disability is addressed with individual interventions;
- Disability and its attached costs are a tragedy, anomaly and social burden;
- Social programs are offered as a charitable or protective response to those who are dependent due to their disability (deserving poor);
- Equality of treatment (through residual benefits to properly motivate recipients);
- Equality of opportunity (through labour force attachment initiatives).

The government documents, especially the leaked memorandum, clearly described disability and the associated costs as a burden. The only social role that was valued and seen as normal throughout the documents and in the resulting legislation was attachment to the labour force. Participation in the labour force is linked to citizenship, devaluing those who are excluded. There was no social model analysis of labour market exclusion and the underlying causes of unemployment were not addressed in the reform plan. The individual’s disability and their dependence on social supports were seen as the pathology, rather than the cause being the discrimination of the economic system. The consultation process was entirely focused on cost-savings and actively excluded the voice of consumers. Ultimately, the Alberta government’s original goal of offering a more residual benefit and implementing tougher rules through the reforms denotes an even less favourable view of disabled people than the charitable approach of the individual pathology model.
In the end, as the government backed down from the planned changes, it could be assumed that they disavowed their commitment to individual pathology principles and adopted the position of the disability community. However, at no point did the language or actual changes to AISH indicate even a slight commitment to social model thinking.

After the 1999 reforms, the Alberta government committed to review the AISH legislation in five years. The 2004 AISH review brought very much the same response from disability groups as in the past. In anticipation of the upcoming review, the Alberta Disabilities Forum (ADF), a coalition of 33 disability groups, sent out a preemptive position paper to express their concerns and strengthen the program (Alberta Disabilities Forum, 2004a).

Perhaps having learned from the past, the government emphasized their commitment to keeping AISH a separate program, even in the title of the discussion guide, *Renewing AISH: Ensuring AISH is available into the future for Albertans who need it* (Lukaszuk & DeLong, 2004, p. 1). The title produced a mixed message that AISH was at risk, but the government was committed to providing it *to those who need it*. The emphasis on accountability to the tax payer, the rising costs of AISH and the current ‘generousity’ of the program in the guide made certain that message of AISH at risk was heard. Speaking notes from the AISH Review Launch reveal a focus on the rising cost of AISH and a question about whether it was affordable (Alberta Human Resources and Employment, 2004). Both the ACCD (2004) and Malacrida and Duguay (2009) believed that reducing spending was an obvious concern which could presuppose the outcome of the review. The twenty-two page discussion guide had a seven page introduction outlining a preoccupation with cost reduction and a veiled threat that: “…if individuals do
not behave responsibly they will deplete the AISH programme for future, deserving citizens. (Malacrida & Duguay, 2009, p. 27)

Collectively, ADF members voiced concern that the proposed idea of a medical eligibility review would only add to AISH program costs, as the criteria of a permanent and severe disability have already been met (Alberta Disabilities Forum, 2004b). Focusing on the negatives about their disability to stay on the program would be counterproductive for AISH recipients. ADF members together and independently also voiced concerns about the hurried process, limited opportunity for input and the issue of low benefits (AAACL, 2004; Makhoul, 2005).

In their research about the 2004 AISH consultations, Malacrida and Duguay (2009) report alleged disparaging remarks made by MLAs about AISH recipients who had spoken at a public hearing. One MLA asked how much a participant with multiple disabilities was “costing us” while another MLA suggested that the militancy of the participants was not really anger and their reactions were “for show” (p. 28). This language from the MLAs reveals individual pathology model thinking. In the consultation, participants were treated as a social burden, not deserving of equity and accommodation.

Following the AISH review, the independent consultants’ report written for the Alberta government noted the “overwhelming consensus” that higher benefits, discretionary benefits and higher earning exemptions were necessary (Nichols Applied Management, 2005, p. ii). Another significant issue was the undignified treatment of AISH recipients:

To summarize this complex issue in a few words, many feel that AISH clients are currently not always treated with dignity. Many feel that AISH clients are being
treated as if they don’t want to contribute to society and that they were unjustly accessing public funds. (Nichols Applied Management, 2005, p. 42)

These feelings of marginalization came from the annual review process, inconsistency in the interpretation of rules, scrutinizing income sources, inadequate income to meaningfully participate, limited access to employment/training, limited access to AISH workers, reduction in services, application process, wait-times, complex appeal process and bureaucracy (p. 43). As well, the public consultation process was disrespectful:

“…the limited notice, location and lack of provision for free or reasonable priced means at the all-day public consultation” (p. 43). The consultants noted that “…only the most mobile and capable of AISH clients” were able to participate due to the short timelines, lack of transportation and the intimidation of the large group setting (p. 4). They concluded that the presentations were not representative of the “…spectrum of AISH clients” (p. 4).

A number of individual pathology indicators were apparent in the government documents and grey literature about the 2004 reforms:

- Disability is determined by professionals (individuals must emphasize their incapacity to retain their benefits);
- Disability and its attached costs are a tragedy, anomaly and social burden;
- Social programs/services are offered as a charitable or protective response to those who are dependent due to their disability (deserving poor);

Just as in the 1999 reforms, the message of AISH at risk, the emphasis of the rising costs to taxpayers and the belief that AISH was too expensive all point to the individual pathology indicator that disability is a social burden. The comments from MLAs involved in the review further emphasize this belief that disability and the attached costs are a burden, not that programs are an accommodation due to systemic exclusion. The appalling lack of adequate consultation does not show respect for social model principles,
but defaults to a protective, charitable response. As in the 1999 reforms, the ongoing reality for AISH recipients in 2004 was that they felt scrutinized and marginalized and continued to live in poverty.

To address the consultants’ report, the MLA AISH Review Committee (2005) laid out eleven recommendations for changes to AISH which encompassed some of the suggestions of the disability community. The language in the report is mixed, with some language focusing on the social model and some revealing an individual pathology stance. For example, financial security and responsiveness to clients were emphasized showing a commitment to social programs as a public responsibility. However, the government’s concern that AISH was unsustainable continued to be an issue, revealing a belief that disability and the attached costs are a social burden. There was a focus on “helping individuals succeed,” and reach their potential, indicating that the individual is the point of intervention and that the acquisition of paid employment continued to be the bar of what was considered successful citizenship (p. 3). The greatest changes were an increase to the AISH benefit, although it still failed to address poverty in any meaningful way, and the addition of discretionary benefits.

Overall, during the reforms in 1999 and 2004, it was clear that social model principles were not guiding the changes proposed or made to AISH during those years. The disability community fought to keep AISH from being eroded, as flawed as it was at the start. Inclusion and citizenship were defined by government as attachment to the labour force. This focus on labour-force attachment, without increased supports or an effort to reduce discrimination, reveals a belief that the pathology lay within the individual. Identifying what is missing from the dialogue, there was no evidence that the goal of AISH was to ensure equality of outcome and economic accommodation for
recipients. There was no evidence of a belief that it is society that is disabling to individuals and no commitment to make changes to the political, economic, social and built environment.

For AISH recipients, the welfare reform era resulted in a few positive changes, due to the mobilization of grassroots activists and public shaming of the government. However, that was not the Alberta government’s plan. Based on their overt, draconian cost-saving agenda in 1999 and limited commitment to adequacy in 2004, the AISH program still largely reflected the individual pathology model of disability.

The choices made by policy-makers and the reality for AISH recipients remained largely the same. AISH remained a means-tested benefit based on diagnostic differentiation. As a charitable response, the AISH benefit was still financially inadequate, leaving people with disabilities in poverty. As well, based on future statements from disability organizations, the rules and treatment by of recipients by AISH workers were still demeaning post-reform. Even though the government bowed to public pressure and did not implement the planned reforms, the changes they made did not embrace the social model.

4.3 A Missed Opportunity: Ignoring the Social Model Roadmap

Ironically, while the 1999-2005 reforms were happening, another branch of the Alberta government was constructing a strategy that included social model principles. The Alberta Disability Strategy (ADS) was developed in 2002 by the Premier’s Council on the Status of Persons with Disabilities, based on wide-reaching meetings with stakeholders. The strategy embraces social model language and is, to a large extent, a social model roadmap for disability policy. In the introduction the writers conclude:
Equality for all citizens, regardless of their race, creed, background or abilities, is a fundamental right in Albertan and Canadian society. But equality doesn’t exist for the half a million people in Alberta who have a disability. Persons with disabilities are not free from intolerance and discrimination. They do not have adequate personal or financial supports to live a life of dignity. They cannot go everywhere in the province and have ready access to buildings, offices or public facilities. They are not treated equally when vying for employment and educational opportunities. (The Premier’s Council on the Status of Persons with Disabilities, 2002, p. 3)

The recommendations of the ADS focused on reducing barriers that create disability, using the social, environmental and in a limited way the economic structures as the points of intervention, rather than the individual. Social model indicators are evident, in that government intervention is framed as an entitlement and a reasonable accommodation. Recommendations included making public spaces physically accessible, providing individualized funding for disability supports and correcting judicial, educational and bureaucratic problems. They also called upon private employers and governments to provide “…long-term support and commitment” to people with disabilities (The Premier’s Council on the Status of Persons with Disabilities, 2002, p. 3). A decent standard of living, choice and full citizenship were part of the vision created. Full citizenship was defined through a social model lens:

Full citizenship means being treated fairly and without discrimination by individuals, companies, organizations and governments. It means having adequate supports to live a life of safety, security and dignity. It means having the chance to pursue educational and employment opportunities. And it means having the
opportunity, choice and ability to participate in all aspects of Alberta society. (The Premier’s Council on the Status of Persons with Disabilities, 2002, p. 5)

The ADS authors do not directly critique the economic system which favours the non-disabled. They do acknowledge that people with disabilities are “not treated equally” in the realms of employment and education (The Premier’s Council on the Status of Persons with Disabilities, 2002, p. 2). As well, their vision for economic security reflects a social model outcome, going beyond basic needs: “…a standard of living and quality of life that ensures health, safety, comfort and dignity” (p. 7). In most of the document, equality of opportunity language is used. Terminology like evening “the playing field” and creating “equal opportunities,” indicate individual pathology thinking (pp. 4, 12). Individuals must still play the same economic game, without reference to the fact that the game was created with no regard for differences in ability. In the vision statement, a more robust goal of people with disabilities achieving similar rates of education and employment to the general population represents a social model approach, valuing equality of outcome. As well, the “inherent financial disadvantage” faced by disabled people, the “welfare” and charity lenses through which they are viewed and the “discrimination and inequities” in the labour market are critiqued (pp. 12, 17 & 24) However, the strategy’s actual recommendations lacked the strength of equality of outcome and were considerably less ardent than the vision, both for economic security and employment.

Despite softer expectations in the recommendations, they did reflect social model thinking in that they did not put the impetus for change on the individual, but suggested that the government and private business enact measures to accommodate people with disabilities. They note: “…full reclamation of citizenship rights for all Albertans will

The authors of the strategy, which included MLA Rob Lougheed as chair, called on the Government of Alberta to “…accept the Alberta Disability Strategy, develop an implementation plan, and establish the Strategy as the foundation for future legislation, government policy and direction concerning persons with disabilities” (The Premier’s Council on the Status of Persons with Disabilities, 2002, p. 4). An implementation plan or even a clear and firm acceptance of the ADS never happened.

In a review of the subsequent 10 years of Hansard, MLAs made reference to the ADS when debating various changes to disability policy, but in no instance was the strategy as a whole considered for implementation. In 2003, the Department of Community Development was internally reviewing the ADS. During this time, Lougheed attempted to initiate the only conversation on record in Hansard concerning full implementation, but was interrupted as a point of order (Lougheed, 2003). By March 2004, the Minister of Community Development Gene Zwozdesky noted the development of the Office of Disability Issues (ODI) to “…assist government in responding to the recommendations contained in the Alberta Disability Strategy” (Zwozdesky, 2004, p. 783). In a review of the annual reports of the Premier’s Council, the 2004-05 report noted this collaboration with government to implement the strategy (Premier’s Council on the Status of Persons with Disabilities, 2005, pp. 7-8). In subsequent annual reports there was no indication that progress has been made.

One example of how the ADS had been used was with Bill 510 which intended to “…introduce legislation requiring every gasoline service station in Alberta to have at least one full-service bay” (Masyk, 2003, p. 1427). MLA Gary Masyk insisted that this Bill
was a necessity and would address the issues of equality rights, freedom of mobility as a daily living activity and universal accessibility laid on in the ADS. It is probably fair to say that Masyk missed the point, as full-service gas stations were not a pressing need identified by the disability community. Throughout 2004, Lougheed aggressively continued to speak to the ADS during the discussions of more relevant bills, Bill 4 for the certification of guide dogs, and Bill 201 to amend the safety codes to include barrier-free design and access. MLA Hector Goudreau made a telling comment in the discussion of Bill 201, that “…by supporting Bill 201 we are making part of the commitment [emphasis added] recommended by the Alberta Disability Strategy” (Goudreau, 2004, p. 363). The lack of real commitment to the ADS, a substantively social model roadmap to better policy, revealed that the Alberta government did not share this vision.

In 2012, ten years after the release of the strategy, the Premier’s Council suggests on their website that a plan for implementation should happen as soon as possible.

[The] Premier’s Council recommends government develop as soon as possible an action plan to implement this Strategy and its recommendations. In addition, government should actively encourage various stakeholders to support the Strategy by incorporating applicable initiatives within their own organizations and communities. (The Premier’s Council on the Status of Persons with Disabilities, online)

4.4 AISH Today

The study of the historical development and welfare reform era of AISH reveal that social model thinking was not influential, even when a solid effort was made in 2002 with the Alberta Disability Strategy to propose a social model roadmap to better policy outcomes. Most often in the past, the AISH program was plagued by narrow, individual
pathology thinking, and rarely was there any consideration given to how the capitalist economic model and ongoing discrimination perpetuate poverty for disabled people.

Today even though most aspects of the AISH program have not changed, there was a large benefit increase, so that recipients nearly meet the LICO line and are almost at par with minimum wage. This is a divergence from the past and may indicate a shift in thinking towards social model principles. Until 2012, the AISH program regularly faced criticism from recipients and stakeholders, particularly around the adequacy of the benefit. It is too early and difficult to estimate how the 34% increase in benefits in March 2012 will change the way AISH is viewed and experienced by recipients.

The remainder of this choice analysis will look at AISH today, and whether or not recent policy changes move AISH away from defining disability as an individual pathology, towards a social model definition. Specifically, I will look at the following aspects of the program:

- application procedure and eligibility;
- description of clientele;
- stated goals of the program;
- benefit structure compared to cost of living (financial outcomes); and
- rights and responsibilities of, and restrictions on clientele.

4.4.1 Application procedure and eligibility.

The choice made around the *bases of allocation* when AISH was developed was that it would be a targeted, means-tested program that would also assess applicants based on diagnostic differentiation. This aspect of the program is the same today, with the addition of a new means-test (assets) post-welfare reform and a less-stringent income-test.

As with many other disability income programs, the AISH application process is complex. The fifteen page paper application begins with a comprehensive financial
review, asking personal and financial information about the applicant and his/her cohabiting partner. The extensive financial questionnaire deals in detail with any type of income, savings or assets. This initial means-test disentitles potential applicants who have assets beyond a particular poverty-based limit or those who have the financial support of a partner. Essentially, applicants must fall below a certain poverty benchmark to be eligible for support. This aspect of the AISH program distinguishes it from pension-style programs such as the CPP Disability Benefits, which is only concerned with one’s disability status. “…CPP Disability pays benefits to all who are eligible, regardless of other income or benefits received from other programs, and no reference to offsets exists in the statute governing CPP [emphasis added]” (Government of Canada, 2003, p. 5).

Conversely, entitlement for the AISH program is based on demonstrated poverty, not based on social model indicators such as economic accommodation within a disabling society. This focus on residual financial means as a criterion places AISH within the last-resort, welfare style of income programs.

The application also includes sections on residence, education, training, rehabilitation and work history. The documentation necessary to apply to AISH includes identification for the individual, partner and children, tax returns, proof of residence, consent to communicate with CPP disability benefits, immigration papers, pay stubs, Employment Insurance stubs, and confirmation of all income sources and declared assets. Concerning eligibility for the program, the policy manual is clear about the importance of diagnostic differentiation:

Having a disability alone does not mean a person is eligible for AISH. Applicants and clients must have a permanent disability that severely impairs them physically or mentally to the extent they are substantially limited in their ability to earn a
livelihood to support themselves financially. Applicants and clients are responsible for proving that a severe handicap exists and obtaining the appropriate documentation from a specialist physician. (Government of Alberta, 2012b, online)

The medical portion of the application is intended to determine the extent of impact that the disability has on an individual’s life and employment status. This portion of the application utilizes individual pathology descriptors, that disability is a medical condition which necessitates individual treatment. While some disabilities are certainly associated with medical conditions, social model proponents view disability not as an illness to be cured or treated, but as a natural part of human diversity that is not accommodated by our societal structures. Once an applicant is past the financial eligibility test, he/she must have his/her physician fill in “...one or more standard medical eligibility assessments” (Government of Alberta, 2012c, online). Requiring the stamp of approval from a physician falls squarely into the individual pathology model of disability, as disability is determined by a medical professional. In the AISH Policy, the stark reality of the individual pathology criteria is established:

When making a decision on medical eligibility, consideration is given to the: need for ongoing medical intervention; need for a major organ transplant; individual effort made to correct, control or lessen the severity of the disability [emphasis added]; existence of multiple conditions that are not responsive to treatment; existence of generalized medical conditions that require extensive and extreme treatment, and are not likely to yield a favorable prognosis; and availability of remedial therapy, including medical and non-medical treatments or rehabilitation that may improve the condition. (Government of Alberta, 2012b, online)
At the core of this list of considerations is the individual medical problem or pathology of disability, and the expectation of individual effort to rehabilitate and join the “normal” and valued social role in the paid workforce.

On the topic of doctors and the medicalization of disability related social policy, social model theorist Michael Oliver (1996) has this to say:

Disability as a long-term social state is not treatable medically and is certainly not curable. Hence many disabled people experience much medical intervention as, at best, inappropriate, and, at worst, oppressive…As society’s experts, [doctors] have a great deal of power and this gives them control over fundamental aspects of people’s lives and they have not been noticeably reticent about using this power to make decisions about disabled people’s lives; where they should live, whether they should work or not, what kind of school they should go to, what kinds of benefits and services they should receive and in the case of unborn disabled children, whether they should live or not. (p. 36)

Barnes and Mercer (2003) agree:

…‘impairment’ is identified as the cause of both ‘disability’ and ‘handicap’. This privileges medical and allied rehabilitative and educational interventions in the treatment of social and economic disadvantages [emphasis added]. It justifies the domination of disabled people’s lives by health professionals. In contrast, disabled people increasingly argue that disability (as defined by the social perspective) is not a health issue, and therefore that health professionals are not the appropriate judges of their support needs. (p. 14)
Barnes and Mercer (2003) go on to argue that the medical profession’s involvement in social policy has legitimized the personal tragedy approach, and that this has been a form of social control.

Access to income support based on diagnostic differentiation as determined by medical professionals seems to be unique to disability. No other group who experiences social and economic marginalization is evaluated by medical professionals when it comes to accessing income support. Oliver (1990) suggests that this reliance on doctors to assess eligibility for income support overreaches their training and is inappropriate. Left with no choice in a competitive, ableist economy, a disabled person is forced to experience and frame their disability as a medical problem and tragedy in order to access financial support. The policy choice of targeted diagnostic differentiation for allocating benefits reflects the underlying theory that disability is an individual pathology. The concept of economic accommodation due to the ‘disabling’ aspects of our society is absent from this policy instrument. In fact, no social model indicators are present in the application and eligibility documents. The individual pathology model indicators mentioned already which are present in these documents are:

- The individual’s impairment disables them and causes their economic and labour market exclusion;
- Disability is determined by professionals;
- Disability is addressed with individual interventions;
- Disability and its attached costs are a tragedy, anomaly and social burden;
- Disability is incapacity in relation to non-disabled persons.

If an individual is denied AISH, there is an appeal process available with the possibility of support from Alberta Legal Aid or legal centres that specialize in appealing income replacement denials. In 2006, AISH officials interviewed estimated that 70% of applicants are approved (Miazdyck-Shield, 2006).
4.4.2 Description of clientele.

The name of the AISH program, Assured Income for the Severely Handicapped, uses ‘handicapped’ which is an antiquated term and is rarely used by governments to refer to disability programs today. The issue of language is thoroughly covered in the literature review, but the use of the word handicap is particularly interesting in this context. In the AISH Act, “severely handicapped” is defined as:

…“severe handicap” means an impairment of mental or physical functioning or both that, in a director’s opinion after considering any relevant medical or psychological reports, causes substantial limitation in the person’s ability to earn a livelihood and is likely to continue to affect that person permanently because no remedial therapy is available that would materially improve the person’s ability to earn a livelihood. (Assured Income for the Severely Handicapped Act, 2006, Section 1 (i))

This definition clearly portrays disability as an individual problem and maintains that it is the individual’s impairment that causes their labour market exclusion, revealing the individual pathology theory of disability. It does not describe disability in social model terms, as difference, diversity and a normal part of human experience.

Similarly, Barnes and Mercer (2003) point to the World Health Organization’s definition of handicap as “A disadvantage for a given individual resulting from an impairment or disability that limits or prevents the fulfillment of a role...” (p. 13). While this definition for some observers would vindicate the term handicap used in AISH as accurate, a social model interpretation would challenge the underlying assumptions. Barnes and Mercer criticize this definition for ignoring the relative nature of social roles and expectations and how society plays a role in creating disability. Their critique
highlights the ideological underpinning of the term ‘handicap,’ which is illustrative of the individual pathology model of disability.

4.4.3. Stated goals of the AISH program.

While there are no specific goals in the form of a visioning document for AISH in recent years, in the AISH policy manual, the stated purpose of the program is as follows:

AISH provides assistance to adult Albertans with a permanent disability that substantially impairs their ability to earn a living. AISH provides a monthly living allowance, a child benefit, health benefits, and personal benefits. Benefits are provided to assist clients with their living needs and with *living as independently as possible* [emphasis added]. In addition to the monthly living allowance, personal benefits help AISH clients with extra monthly or one-time expenses. In determining an individual’s eligibility to receive AISH benefits, consideration is given to the applicant, client and their cohabiting partner’s income and assets.

(Government of Alberta, 2012d, online)

The laudable goal that AISH would help recipients to live as independently as possible is hopeful, but not resolute. Independent living, with the necessary financial and daily living supports, is what people with disabilities continue to fight for. As AISH does not provide independent living supports to accommodate disability, the reality of whether or not the AISH program assists people to live as independently as possible is best reflected in their financial outcomes. In the stated purpose, the pathology of disability lies within the individual, as it is the impairment that disables him/her and results in their inability to earn a living. No thought is given to the economic structures which produce disability and exclude individuals who do not fit the definition of normal.
4.4.4 Type of benefit and analysis of adequacy.

This analysis of adequacy, as one aspect of the type of benefit chosen by policymakers, examines the AISH benefit after the most recent increase. In March 2012, the Government of Alberta increased AISH benefits by $400, a 34% increase, after disability advocates expressed grave concerns about the cost of living in Alberta compared to the benefit levels of AISH (Government of Alberta, 2012e). Currently the AISH benefit for those living independently is a maximum of $1588 per month or $19,056 per year, making the benefit comparable to pay rates for full-time work at minimum wage in Alberta. As well, the earning exemption for AISH recipients was also increased from $400 to $800 a month in March 2012. AISH recipients who live in a residential facility or institution receive a modified living allowance of $315 a month plus an accommodation rate (Government of Alberta, 2012f).

The increases were met with relief and praise from the disability community. The President of the Alberta Coalition of Citizens with Disabilities (ACCD), Weslyn Mather, said the following in a media release: “We welcome this increase to the living allowance of those on the AISH program. Clearly, Premier Redford has recognized the financial restrictions faced by AISH recipients and has made a step in significantly improving their quality of life.” (ACCD, 2012, p. 1). Executive Director of ACCD, Bev Matthiessen, agreed, but called for government to continue on the path to alleviating disparity. The Alberta Association for Community Living (AACL) responded to the announcement with praise for the increase and scolding for the gaps that exist in other programs for people with disabilities (AACL, 2012).

The responses on Premier Alison Redford’s Facebook page retrieved online after the announcement, while not reliably representative of people on AISH, offered some
Many AISH recipients and family members thanked Redford online. One person accurately thanked the Premier that she could leave the poverty class and join the poor class. Richard Sailer, an AISH recipient and frequent poster, rallied support for the Premier, saying that the increase gave people with disabilities dignity and should garner their vote. He noted, “As Kathleen said it sure feels nice to wake up feeling like you're apart [sic] of society and a Albertan not a burden,” and “I can truthfully say that this is the first time 39 years and since being on Aish that I finally feel like I'm party [sic] of Alberta and its future” (Sailer, February 9 and 15, 2012). Another poster responded to the increase saying “Thank you so very much, for giving all of us AISH clients, not only hope of a more stable life, but also our dignity back. I have been waiting for a Premier like you to come along. You have not only my full support, but also my vote. :)” (Huntley, February 9, 2012). Others said that it was not soon enough, asking that the increase be immediate, rather than effective in the upcoming budget cycle which was six weeks after the announcement.

In the legislature, MLAs from each party recognized and lauded the increase. Even members of the ruling Progressive Conservative party had questioned the low rates over the years. Premier Redford (2012) felt the support from the other parties.

One of the things that was very important, that we’ve had tremendous feedback on, was the decision to actually increase AISH payments for vulnerable Albertans. That was a great example of an integrated approach to policy that’s allowing us to make decisions that reflect the way that Albertans feel about their community.

(PP. 244-245)
These statements reveal a commitment on the part of the Alberta government to recognize the public responsibility of supporting the economic inclusion of people with disabilities, a social model indicator.

Still, missing from the announcement in February 2012 was any plan to index AISH to inflation. Indexing AISH has been a goal for the disability community, as increases in the past were infrequent and inadequate. In 2007, the Alberta Disabilities Forum (ADF) charged that poverty leads to isolation and depression. The solution requested was to ensure that the AISH benefit be increased every year to keep up with inflation. Currently, the AISH benefit is reviewed bi-annually and is not indexed. In the legislature, Alberta Liberal MLA Bridget Pastoor has frequently raised the issue of indexing the AISH benefit over the years, continuing to make a monthly donation to the food bank from her own indexed pay raise (Pastoor, 2009). In 2011, MLAs were challenged to live on the AISH benefit, which was $1188 a month (Swann, 2011, p. 124). When asked about indexing, Minister Mary Anne Jablonski (2009), defended the need for flexibility:

I think the way that we conduct our AISH program, which is a review every two years and this year an increase of a hundred dollars per month, an increase probably never seen before, are the reasons why I want to be able to maintain the flexibility of having that review every two years and giving more than a cost-of living increase when necessary. (p. 2070)

Rental rates in Alberta underlined the need for the substantial improvement to the benefit level of AISH. A news article written in 2008 noted that the AISH benefit at the time of $1088 was only $100 more than the average rent in one of Alberta’s largest urban centres, Edmonton (Loome, 2008, online). In 2011, the average rental rate in Alberta was $941 (Canada Mortgage and Housing Corporation, 2011). Today, while the AISH
increase is substantial, people paying market rent would still be paying 59% of their income on housing, with $647 left over for all other needs, including food, clothing, utilities and transportation.

While Canada does not have an official poverty line against which to measure the AISH benefit, the Low Income Cut-Off (LICO) will serve as a barometer of how well those on AISH fair compared to the general population. In 1961 the LICO was developed by Jenny Podolak at the Dominion Bureau of Statistics in order to analyze the incidence of low income in Canada (Hunter & Miazdyck, 2003). Data were used from the comprehensive 1959 survey of consumer expenditures, indicating that on average Canadians spent 50% of their income on the basic essentials, food, clothing and shelter. Citizens who had to spend 70% of their income on these essentials were considered to be living in “straitened” circumstances (Ross, Shillington & Lochhead, 1994, online).

“…Families that spent more than 70 per cent of their income on essentials would have little or no income left to spend on transportation, health, personal care, education, household operation, recreation or insurance” (Ross et.al., 1994, online). Today those who spend 63% of their income on essentials, 20% more than the 43% average, are considered low income (Statistics Canada, 2012a, online). Considering the average rent in Alberta uses up 59% of their budget, AISH clients would most definitely be paying more than 63% of their income on essentials and would still be struggling financially even after the increase in 2012.

With the exception of Podoluk who developed the LICO, the Government of Canada refuses to refer to the LICO as an official “poverty line.” The LICO remains controversial as some contend that it is not an accurate measure of poverty or that poverty is too subjective to measure. Despite the criticisms, the incomes that it reflects as low
would be hard to defend as above any measure of poverty, absolute or relative to the general population. The reality of struggling to survive, pay rent and buy food under the LICO holds true today, as those whose income is less are certainly in straitened circumstances.

While the LICO originally used before-tax income in their calculation, they now use after-tax income which takes into consideration government transfers, but dramatically reduces the number of people in the “low income” category. For this comparison of the AISH benefit to the LICO, it is appropriate to use before-tax income, as the AISH amount is before-tax and does not include transfers.

Currently, the AISH rate of $19,056 per year falls under the before-tax LICO for large communities, but not for rural areas or cities/towns under 99,999 people. The current before-tax LICO varies depending on the size of the community, from $15,302 to $22,229 (Statistics Canada, 2012b, online). Those in larger centres, Edmonton and Calgary, would have 14.3% less income than what is considered low income for those cities, which would undoubtedly mean they were still struggling after the increase. Roughly half of the Alberta population lives in the two major centres, so it would be fair to assume that at least half of AISH recipients also live in Edmonton and Calgary. However, AISH clients living outside of the major centres would be brought slightly above the low income line with the latest increase for the first time in the history of the program. Those in the smallest, rural communities would be 20% above the LICO line.

This calculation does not take into consideration the 2005 changes to AISH which saw the much applauded addition of discretionary benefits or rental assistance. The discretionary benefits are administered by individual AISH workers when the person applying for the additional benefit qualifies. These benefits fall into two categories:
Continuous Benefits include a child benefit supplement, special diet supplement, extraordinary transportation, childcare, remote community allowance and service animal benefit. Non-continuous Benefits include: funeral expenses; children’s school expenses; infant allowance; community start-up allowance (furniture, damage deposit); addictions treatment allowance; employment and training supports; specialized clothing supplement; exceptional travel benefit; escaping abuse benefit; moving allowance; emergency allowance; and medical supplies allowance. (Miazdyck-Shield, 2006, p. 30)

As with welfare-style programs, clients must demonstrate a need in order to receive the discretionary benefits. This may prevent absolute poverty, especially in cases of extraordinary expenses. However, the provision of discretionary benefits is not a guarantee, nor does it address general budget deficits. Important to note is that only those who have less than $3000 in assets may be eligible for discretionary benefits. Prior to the 2005 change, there was no provision for exceptional needs and many eligible AISH clients were forced to utilize the provincial welfare program, Alberta Works, as it was more generous.

Rental subsidies are another support available to AISH clients and other residents from the province of Alberta. In 2010 the Government of Alberta introduced cuts to the rental supplement budget, despite the fact that nearly 80,000 Albertans were receiving a monthly rental supplement (Turner, 2010, online). Research on the impact of these cuts, including the availability of supplements to AISH clients, is not available.

It is important to recognize that AISH has generous earning exemptions, relative to other disability income or welfare programs. While it is still a means-tested benefit, the means-test is considerably less poverty-based than it was in the past. For a single person,
the exemption for earned income is $1150 of the first $1500 earned. For a family, $2225 of the first $2500 earned is exempt. Passive business income is clawed back at a much steeper rate and pension income is clawed back dollar for dollar. Unfortunately most people cannot make use of the exemptions due to barriers in the workforce. AISH officials estimate that 17% of recipients have any employment earnings (Government of Alberta, 2012e). Temporary exemptions can be made for those who do have earnings if they are facing income hardship.

It is also notable to point out that the AISH benefit at $19,056 a year is comparable to the minimum wage. At $9.40 an hour, 40 hours a week full year, one would make $19,552 a year, which is $448 a year more than AISH. However, by many accounts the Alberta minimum wage is still a poverty wage, and far from what would be defined as a living wage (Public Interest Alberta, 2012, online).

While the AISH benefit is substantially better than many other disability income programs, it is still inadequate to address poverty for at least half of all AISH clients, as defined by the LICO line. For some on AISH, particularly those working part-time or living in the smallest communities, the benefit may be enough to pay their bills and live comfortably, although rental rates are variable and have a large impact on affordability. Comparing the benefit to minimum wage demonstrates that people with disabilities are considered worthy of Alberta’s minimum standard for acceptable social outcomes. However, that minimum standard is regarded as inadequate by some and constitutes poverty for most people. Those on AISH who have no other form of income fair the same as the working poor at the LICO line who are considered to be in “straitened circumstances” when they must spend 63% of their income on basic needs.
The 2012 move to substantially raise the AISH benefit to close to, or above, the LICO line showed a commitment to fairer outcomes for people with disabilities. One social model indicator, recognizing the public responsibility to facilitate economic inclusion is found in the remarks of the Premier. However, the AISH benefit is still inadequate at producing equality of outcome, or median income, which would be the social model policy response to address the disadvantages produced by our economic system. Even with the increase, the AISH benefit will likely keep most recipients in poverty and therefore remains a residual, individual pathology model response to the income needs of disabled people.

The type of benefit chosen by policy-makers has not changed substantially since 1979. AISH remains a cash benefit given to recipients monthly. Despite improvements such as increasing the adequacy and making the income-test less stringent, the choice has been made to keep the AISH benefit charitable and residual. The policy manual notes: “Applicants, clients and their cohabiting partners are required to access all income and assets they are eligible to receive” (Government of Alberta, 2012a, online). The underlying theory of the individual pathology model and the veneration of labour-force attachment continue define the program parameters. The belief is that disability is an individual problem and the expectation is still that AISH must be used only as a last resort.

4.4.5 Rights, responsibilities and restrictions on clientele.

The rules surrounding what constitutes a right, responsibility or restriction for anyone accessing a government program is found in Act and Regulations. Individuals receiving AISH have a laundry list of responsibilities and financial restrictions in order to access the program, but aside from entitlement to the AISH benefit, they have few rights.
The most important right in the AISH program is the right to an appeal for a decision that is made by the director. Clients have the right to obtain legal counsel (at their own expense, through Legal Aid or through a legal advocacy group) or to invite the media to an appeal. Most decisions made about a client’s benefit can be appealed, with the exception of a few situations. Notably, if a client is denied a personal benefit to purchase “…medical supplies or equipment, including maintenance of that equipment, essential to manage his or her condition” or “…a special diet or supplement,” the appeal is denied (Applications and Appeals Ministerial Regulation, 2007, Part 1, 6 (a)-(e); Assured Income for the Severely Handicapped Regulation, 2007, Schedule 3, 8:1 (a)-(b)). The appeal process in any government program is a due process to review what could potentially be an unfair decision. For a disability income program to deny the right to appeal for the denial of disability-related supports seems extreme.

Another reason for the denial of an AISH appeal is if the client’s benefit has been clawed back due to his/her refusal to pursue Canada Pension Plan or Old Age Security payments. Also, if AISH recipients agree to receive a discretionary benefit, they must also agree to repay any amount that the director deems to be an overpayment (Assured Income for the Severely Handicapped General Regulation, Section 4(4)). In this case they cannot appeal the decision to require repayment. Appeals based on overpayments and the resulting clawbacks are a frequent occurrence in many welfare programs. Mistakes can be made in administering discretionary benefits due to human error or poor judgement, which makes it difficult to understand how the Alberta Government could justify limiting the right to appeal on such a critical issue for some of the poorest citizens. Lastly, AISH recipients cannot appeal the decision to collect a debt or that the debt is being deducted from their monthly cheque.
Most AISH recipients have the right to basic health benefits. For Status Indians on AISH, the right to health benefits is nullified by the jurisdictional issue that so often drives their ongoing marginalization (Government of Alberta, 2012a, online). For First Nations AISH recipients, this caveat would create even further barriers to accessing the much needed supports which happen to fall under ‘health benefits.’

In the case of individuals who require supported decision making assistance with finances, AISH allows them the right to appoint a personal representative (Assured Income for the Severely Handicapped Act, 2006, Section 6 (2)). Conversely, this right comes along with a potentially invasive restriction. If an AISH director surmises that an AISH recipient is not managing their money properly, a financial administrator or trustee can be appointed with or without the client’s permission. The AISH policy manual notes that that a financial administrator can be appointed in instances when a client:

…lacks the mental capacity to use their benefits in a way that meets their basic needs; or, the client has established a pattern of using their benefits in a way that they are putting their health at risk. This may include the continual loss of housing due to non-payment of rent, or failure to purchase food or other necessities.

(Government of Alberta, 2012g, online)

Of course, given that people on AISH still live close to or under the poverty line, it would be expected that many would face housing and food insecurity, regardless of their choices or mental capacity. One would hope that such a paternalistic move on the part of AISH administrators to take away the right to self-manage one’s finances would only happen on rare occasions.

The responsibilities that come with receiving AISH are numerous. To access AISH, the applicant must provide any information requested at any time about his/her
personal financial situation or health, or that of his/her cohabiting partner. They must agree to provide information on their “condition” and agree to undergo medical examinations (Assured Income for the Severely Handicapped Act, 2006, Section 5 (3)). Once on AISH, recipients must notify their worker if there are any changes to their “handicap,” income, assets, relationship status, number of children, admission to a hospital or other facility or change in address or contact information (Assured Income for the Severely Handicapped General Regulation, Section 11). Failure to comply may result in their benefits being discontinued. These invasive rules are reflective of a welfare mentality, in that they police the individual’s income to the penny. If policy-makers had chosen a genuine pension program, they would not require this sort of information. This aspect of the program reflects the charity approach of the individual pathology model of disability.

Possibly the most invasive rule of the AISH program is that benefits can be discontinued if, in the opinion of the AISH director, a recipient has failed to seek or accept training, rehabilitation or reasonable employment, or has terminated employment (Assured Income for the Severely Handicapped General Regulation, Section 5 (1) (b)). If a client does not follow through with a referral made by an AISH worker, their benefits may be at risk. This expectation could be construed as a form of workfare at worst. It is at least reflective of individual pathology model thinking and a neoliberal labour force attachment mentality. The AISH policy manual is even more emphatic elevating paid employment as the ultimate goal and demonstration of citizenship.

Applicants and clients must seek or accept reasonable employment for reasonable wages, within their ability….Reasonable wages mean minimum wage or a wage agreed to under a permit for employment for persons with disabilities [emphasis
...Applicants and clients must take any action to lessen the severity of the disability. If there is remedial therapy available that would materially improve the applicant or client’s ability to earn a living, they must participate in it [emphasis added]. Remedial therapy includes medical and non-medical treatment, rehabilitation, and employment training. (Government of Alberta, 2012b, online)

It is noteworthy that the standard for reasonable employment for people with disabilities may include a wage other than minimum wage. Although the intent of this stipulation is not clear, it may indicate the ‘training allowance’ or grossly substandard payment for work that people receive in a sheltered workshop. This clearly denotes an individual pathology estimation of the value that people with disabilities offer in relation to the workforce.

Also of note is the non-negotiable requirement to pursue rehabilitation, viewing disability as an individual, medical problem. Rehabilitation, which is representative of the individual pathology model, has been an issue for social model advocates who view disability as a difference, not as a sickness seeking a cure. Many view rehabilitation efforts as a form of social control or a profit-making business (Barnes & Mercer, 2003; Oliver, 1996; Russell, 1998). With the force of this policy statement, rehabilitation certainly seems to wield some control in the lives of AISH recipients. While social model advocates can acknowledge the benefits of some therapies, the abuse of rehabilitation to control disabled people is a concern. Oliver (1996) explains that the link between rehabilitation and social control is invisible, reinforcing its influence.

One restriction that demonstrates a patriarchal and policing approach to AISH recipients is the stipulation that a recipient could lose their benefits if the benefit was used for something other than it was intended [emphasis added] (Assured Income for the
Severely Handicapped General Regulation, Section 5 (1) (b) (v)). Exactly what circumstance would constitute having spent a benefit on something other than it was intended is not clear. The fact that it is written into the legislation, giving administrators the power to determine if a benefit is spent erroneously, clearly leaves an impression of paternalistic, protective response and social control of the individual. It does not show a social model commitment to equality of outcome and entitlement.

The other restrictions that AISH applicants and recipients face are financial, including a limited income and assets under $100,000. Those who receive AISH must continue to meet the financial eligibility restrictions or risk losing benefits. An applicant’s cohabitating partner’s income is also calculated, creating a situation where the disability is a private burden to be dealt with first by the family (Government of Alberta, 2012a, online). This could limit an AISH recipient’s chances of entering a committed relationship if the result would be the cessation of their financial contribution to the family unit. There are many exceptions in the calculation of income, but these are not remarkable, as most welfare programs in Canada have a similar list of income exemptions.

The assets owned by an individual and their partner that are not exempt must be liquidated and are expected to be spent before an individual can access AISH. Generally, AISH recipients can have assets that together have a market value of $100,000 plus the exempted assets before their eligibility is at risk. Exempt assets include one residence, one vehicle, a locked in retirement account, a Registered Disability Savings Plan, clothing and reasonable household items, a prepaid funeral, proceeds from an insurance settlement, an asset held due to a bankruptcy or other assets specifically exempted by the minister. The liquidation of these exempt assets is not required to receive benefits. During
the welfare reform years when AISH was at risk, disability advocates worked hard to maintain these asset exemptions in the face of extreme cuts. As noted earlier, a further qualification is that an AISH recipient must have $3000 or less in total assets to qualify for discretionary benefits on the program.

After the recent changes, it would appear that AISH has the most generous earning exemptions of any disability income program in Canada. Still, the bottom line of the detailed financial eligibility restrictions is that AISH is meant to be a program of last resort. While AISH does allow the retention of assets, there is a message to those with assets that they are not eligible for additional discretionary support, creating a two-tiered system of benefits. In the AISH legislation and policy manual, disability is seen from an individual pathology standpoint, deemed a private burden with those who are worst off receiving an entitlement to extra charity. There are no social model indicators present, no sense that this program is intended as an economic accommodation for a disabling society. There is no recognition of the social pathology involved in creating and maintaining ‘disability.’
5. DISCUSSION

In this study, textual data were analyzed from the creation of AISH in 1979, through the era of welfare reform, until the present to identify the predominant theory of disability that influenced and continues to guide the AISH program. Choices made in the development and reforms to AISH policy were analyzed, using two dimensions of choice analysis: the bases of allocation and the type of benefit. As in the development of any policy, the theories and values of the policy-makers and their perceived alternatives for policy design, shape the resulting policy. The question posed was:

*Analyzing the choices made, which ideology of disability, the social model or the individual pathology model, informed the Assured Income for the Severely Handicapped? Concomitant with that analysis, has the AISH program reflected the evolution in thinking that defines disability as a socially and economically constructed category.*

The AISH program was created in a time when the social model of disability was a very new concept and not widely known. Analyzing the historical records in Hansard, AISH was not built on social model principles, but largely reflected the individual pathology model of disability both in the language and the actual benefit. There was a commitment to supporting people with disabilities as a public responsibility, but the commitment was very limited both financially and socially, demonstrating an individual pathology framework. In the Hansard records, people with disabilities were not portrayed as equal, contributing citizens who must be accommodated for an unjust, discriminatory economic system. They were viewed as the ‘deserving poor,’ not able to contribute or participate in normal social roles because of their individual impairment. The pathology of disability was seen as individual, not societal.
The reasons given for creating the AISH benefit were individual pathology model reasons. People with disabilities were ‘poor’ because of their personal incapacity in relation to non-disabled people and the labour market. They were ‘deserving’ because their disability was seen as a tragedy and personal burden that would inevitably leave them socially and economically excluded without the charitable, protective response of the province. It was assumed that the labour market could not accommodate disabled workers because they would have lower productivity.

In the historical text, there was no evidence of social model thinking, that disability was seen as diversity and a normal part of human experience. There was also no evidence that changes to the political, economic, social and built environment were contemplated or considered as an appropriate response. Economic accommodation and equality of outcome with non-disabled citizens were not expectations or goals of the AISH program.

As a result, the basis of allocation chosen for the AISH program was a blended, targeted program—a means-tested benefit that required diagnostic differentiation for determining eligibility. The type of benefit was a residual cash benefit, and was considered a benevolent, charitable response. The AISH benefit was inadequate, far below the poverty line or any other minimum, acceptable standard. From the beginning, AISH had to be topped up to reach the social assistance rate for some recipients. As it was originally developed, AISH was reflective of the individual pathology model of disability that informed social thought in 1979.

The welfare reform era in Alberta revealed a less benevolent or charitable posture towards people with disabilities. Not only was their disability seen as the reason for their economic and social exclusion, but also a social burden that was too burdensome and
unsustainable for the province to finance. Elected representatives sought a way to
disentitle AISH recipients through proposed reforms. The reform agenda was based on
the erroneous ideas that people with disabilities were not properly motivated to join the
labour force and that their benefits were far too generous.

During the 1999 reforms, there were no indicators of social model thinking around
disability, while the textual data indicated an individual pathology model mindset.
Disability was seen as a tragedy, anomaly and social burden that needed to be addressed
by motivating individuals to overcome their impairment and attach to the labour market.
Labour-force attachment was seen as the primary pathway to citizenship and inclusion.
There was no mention of the pathology of the economic system or the problem of a
disabling society. As a result, the policy options did not include economic
accommodation or changes to the environment.

The reforms in 2004 were less severe, though the elected representatives appeared
to hold the same underlying premise that AISH was too expensive and that disability was
a social burden. There was a limited commitment to AISH as an entitlement for certain
people, but the embarrassing consultation process and the inadequate improvements to
benefits revealed that AISH would remain a charitable response to disability as an
individual problem. The focus on eligibility reviews reinforced the individual pathology
mentality that professionals determined disability and that individuals must emphasize
their incapacity and dependence to retain their AISH benefits. The veiled threat that AISH
was at risk, or unsustainable, worried recipients and the disability community. Malacrida
and Duguay (2009) suggest that this fear created an acquiescence to neoliberal beliefs
about the supremacy of labour-force attachment. The individualism and self-reliance of
neoliberalism fits within the individual pathology model of disability, which upholds
attachment to the labour market as the norm and incapacity as deviance. The MLA AISH Review Committee made some positive changes to AISH and used some social model language in their 2005 report. Despite a verbal commitment to financial security and responsive and respectful processes, the report did not result in social model changes to the administration of AISH. Just as in 1999, the 2004 changes left people with disabilities in poverty.

The social model of disability was not guiding the reforms to AISH in 1999 and 2004. With blatant efforts to disentitle recipients in 1999 and a limited commitment to financial security for the most needy in 2004, the Alberta government demonstrated that the individual pathology model of disability guided their policy development. Disability activists and organizations worked hard to improve AISH during the years of welfare reform, shaming the Government of Alberta when draconian cuts were pending. People came out and told their stories of poverty and marginalization, and their collective voice and actions ensured that AISH would continue and the adequacy of the benefit would improve.

The current AISH program policies were analyzed to determine if the program has evolved in response to a growing acceptance of the social model of disability in policy development internationally. Analysis was done to identify if, based on the available text, a change in the theories and values of the policy-makers had occurred and, if so, if that had affected the basis of allocation and type of benefit offered. Using comparative criteria to identify the predominant theory of disability and critical discourse analysis, the final section of this study looked at the application procedure and eligibility; description of clientele; goals; benefit structure; and rights, responsibilities and restrictions on clientele.
Currently, the application procedure and eligibility criteria of AISH are based on demonstrated need (poverty), the assessment of a medical professional and the presentation of an applicant as unemployable. These criteria demonstrate the individual pathology belief that the individual’s impairment in the cause of their labour market exclusion and that disability is incapacity, as determined by a medical professional. The individual pathology model indicator that disability is properly addressed by individual interventions is also present. Written into the policy is the expectation that an applicant must make the individual effort to correct their disability and accept rehabilitation. As labour force attachment is the ultimate goal of rehabilitation, the message of this policy is that the normal, valued social role is involvement in the paid workforce. Social model indicators are absent from the application and eligibility documents.

The language describing disability was fairly limited in the policy documents. The title of the Assured Income for the Severely Handicapped carries two messages. One message is a social model message of public responsibility to assure income to those who are economically excluded by disability. The other message is that the AISH program is for the ‘severely handicapped,’ portraying disability as an individual problem or pathology.

Similarly, the goals of the program showed a mix of social model and individual pathology model language. The ideal is to help AISH recipients to live as independently as possible, but the program does not provide adequate options to accommodate disability-related needs. In the description of the purpose of AISH, disability is portrayed as an individual problem that results in labour market exclusion. There is no reflection on discrimination or the economic structures which produce disability.
In 2012 as the Alberta government raised the AISH benefit by $400, a 34% increase, showing a limited commitment to equality of outcome in a way that was unprecedented. This increase represented a notable exception to the long history of individual pathology thinking, as it acknowledged and tried to account for the economic disadvantage and extreme poverty faced by citizens with disabilities. The benefit itself is now comparable to full-time work at minimum wage and brings recipients in rural settings above the LICO line. As well, with the recent changes, AISH has generous earning exemptions relative to other income programs, making the original income-test much less stringent.

Despite the increases, which are generous in comparison to other programs, the changes did not go far enough to demonstrate a commitment to the social model understanding of disability. There was no essential change in how disability is understood and it is unlikely that people with disabilities will experience equality of outcome with Albertans in general. Alberta is a wealthy province, with a median income of $32,179 for a one person household in 2006, likely more in 2012 (Statistics Canada, 2006). With a yearly income of $19,056, people on AISH receive only 59% of the median income in Alberta. The changes demonstrate that disabled people are considered worthy of Alberta’s minimum standard for acceptable social outcomes, minimum wage. However, the minimum standard for the working poor in Alberta is considered by many as inadequate in ensuring any sort of security or quality of life, given the high cost of living.

The rights, responsibilities and restrictions in the AISH program largely reflect the ‘deserving poor’ mentality of the individual pathology model of disability. Appeals are not a right if one is denied a discretionary benefit for certain disability-related needs. Access to discretionary benefits is not a right and requires the client to be in acute
poverty. Recipients with over $3000 in assets are not eligible for discretionary support, creating a two-tiered system of benefits. The responsibility to provide any information requested at any time and to immediately report changes that may limit eligibility reflect a welfare mentality. In the policy there is the threat that if a recipient fails to seek or accept training, rehabilitation or reasonable employment, or has terminated employment, they could lose their benefits. This non-negotiable requirement to pursue rehabilitation defines disability as an individual, medical problem. Even with the most generous earning, income and asset exemptions of any disability income program in Canada, AISH is meant to be a program of last resort.

Looking at AISH from the beginning until the present, the individual pathology model of disability is the predominant theory guiding the policy response. Ultimately, at the heart of the AISH program, the individual’s disability is still the pathology—the reason and cause of their economic exclusion.

The choices that policy-makers have made with regards to AISH have not reflected a significant change to the program. The basis for allocation is still a targeted, means-tested benefit based on diagnostic differentiation. The benefit is still charitable and residual, instead of being an adequate, economic accommodation. The welfare mentality which is built into the rules of engagement ensures that the program is a last resort and denotes a charitable, patriarchal policy response. The fact that income and assets are the first eligibility test upon application, not disability, reveals the welfare approach to entitlement—one is entitled only if their poverty is already acute. The use of the medical establishment as gatekeepers and the expectation to ‘rehabilitate’ and progress towards paid work as the only meaningful goal deems economic exclusion an expected result of disability, an anomaly and a social burden. The benefit rates, although substantially better
than most disability income programs or welfare programs, still keep most people with
disabilities in poverty.

The Alberta Disability Strategy (ADS), developed in 2002 by the Premier’s
Council on the Status of Persons with Disabilities, provided a social model roadmap for
disability policy. A review of 10 years of Hansard revealed that the strategy was not
considered for implementation. If the Alberta government supported a social model
understanding of disability, they may have chosen to adopt and implement the ADS. Ten
years after it was written, the Premier’s Council still suggests that a plan for
implementation should happen as soon as possible.

The individual pathology model of disability persists as the dominant model for
framing impairment in today’s culture and economy. This ideology is hegemonic and
largely unchallenged, and therefore informs and shapes public policy, as demonstrated in
the AISH program. The result is policy that treats disability as an individual problem and
responds with charity-based, inadequate supports. While social model language is
sometimes used and abused in promoting disability policies, a genuine commitment to
understanding disability as a socially and economically constructed category is lacking.

A true commitment to a social model of disability would result in the pursuit of
equality of outcome and economic accommodation for those who are systematically
excluded from the paid labour market. Efforts would be made to correct the economic
structure that values only particular abilities and narrowly defines social contribution, so
that people with disabilities would have the equitable opportunities and outcomes in
employment. People born with or acquiring disabilities would experience inclusion
economically and socially in all aspects of life. Facilitating inclusion would be a public
responsibility and attention would be paid to correcting the disabling aspects of society.
Moreover, people with disabilities would not experience segregation, institutionalization or eradication, as disability would be seen as diversity and a normal part of the human experience. Clearly, creating social model policies is a high bar to achieve compared to where we are now. A paradigm shift in cultural beliefs about disability would be necessary, as social policy is limited in its ability to correct injustices in society without accompanying social mores.

As the goal would be equality of outcome and accommodation, creating a disability income policy that is based on the social model would be more expensive. Admittedly this would be extremely difficult to achieve given what is currently perceived as feasible and acceptable in the realm of public policy. However, what the social model of disability critique demonstrates is how comfortable we as a society are with the individual pathology understanding of disability. Taking the time to challenge those assumptions and messages one by one, and to really understand the damage that occurs through a charitable, protective response, is the first step to building better policy.

5.1 Learning from AISH—Reflections for Saskatchewan

Disability activists in Saskatchewan spent decades lobbying for the development of a disability pension program here, similar to AISH. Up until recently, people with disabilities relied on the generic Saskatchewan Assistance Program (SAP), the provincial welfare program, receiving residual benefits and being subject to the harsh rules that accompany all last-resort income replacement programs.

In the disability community, many advocates would say, “We want something like AISH here in Saskatchewan.” Although advocates knew that a pension program was not perfect, it could provide a level of security that was missing from the SAP program. Briefs were frequently written to government pointing out the extreme poverty that
people experienced on SAP. In 2006, twenty-five disability organizations came together in a formal way to work towards policy change, creating the Disability Income Support Coalition (DISC). Through a process of facilitation, the organizations agreed to lobby together for a distinct income security programs for people with disabilities, based on the following principles: adequacy; hope and security; person-centred and user friendly; higher income exemptions and consistent implementation (DISC, 2010). They describe their vision:

These principles describe a respectful system that truly accommodates disability. It moves away from a welfare-based system that is insufficient, disrespectful and degrading and was never meant to meet the needs of people who may rely on it long-term. Living with a disability should not guarantee a life of financial, emotional or spiritual poverty. (DISC, 2010, p. 2)

A review of SAP in 2007 revealed that over 70% of the long-term welfare caseload were people with disabilities, creating a problem for bureaucrats (Saskatchewan Community Resources, 2007). The draconian labour-force attachment welfare reforms of the late 1990s did not effectively reduce the long-term caseload. In their report about the findings, this is noted:

The evidence demonstrates that disability is emerging as the most common characteristic of those who remain on social assistance. Even with our strong economy, it remains difficult for some people with disabilities to escape the welfare system without additional assistance. (Saskatchewan Community Resources, 2007, p. 7)

As a result of persistently lobbying the government, the DISC group was successful in getting a commitment to a separate income program. In May 2009, the
Government of Saskatchewan announced the creation on a new income support program for people with disabilities. The Saskatchewan Assured Income for Disability (SAID) would replace social assistance for people with disabilities who qualify. Initially there was a graduated caseload transfer for 3000 people with disabilities living in residential care settings. Currently in March 2012, the application packages to apply to the new program are being sent to thousands of SAP recipients who may qualify. The program is slated to be fully operational within the year.

Although this thesis seeks to apply a critical lens to disability income policy, it would be unfair and presumptuous to critique the SAID program before it is fully implemented. There are positive signs that the Ministry of Social Services is serious in their attempt to closely involve the disability community in the development of the program. They have begun to increase benefits, agreed to include community representatives at the planning table and on all committees, and are implementing a community-based assessment process as an alternative to a government-based assessment. Time will tell whether it makes a substantial difference to people with disabilities in Saskatchewan. In these early stages of development, the SAID program appears to be similar to AISH and other disability pension-style programs in terms of its rules, language and benefits. Given the similarities, what can be learned from AISH?

The first point to make is that in the development of social policy there are generally compromises, and rarely is a new program the ideal. Cost factors and competing interests come into play. In the case of disability policies, the challenge remains that the individual pathology model of disability is deeply ingrained in our culture and economy and is therefore difficult to recognize or challenge. Compared to the existing SAP program, the new SAID program, regardless of whether or not it meets
social model criteria, will be a vast improvement for those who qualify. For those who meet the criteria, the benefits will be improved and the rules will be more respectful. However, the forecast is that many people with less of an impact of disability, even though they are on the long-term caseload and considered ‘unemployable’ will not make it on to the new program.

Learning from the analysis of AISH, the aspects of the AISH program that are most marked by the individual pathology model are those which denote a charitable response, rather than a public responsibility to accommodate those who face disabling barriers in society. The AISH program still carries over a welfare-based, last-resort mentality in its administration. It also sends a clear message that the only valued role that all AISH recipients should work towards is attachment to the labour force. Many of the rules of the AISH program are invasive, such as the scrutiny of spousal assets and income and the requirement to pursue rehabilitation. Ultimately, the biggest barrier to AISH becoming a social model response is that it treats the ongoing poverty of disabled people as inevitable and acceptable. Based on the analysis of the choices of policy-makers, the AISH benefit, while substantially better than in the past, does not produce equality of outcome. It has come much closer than other disability income replacement programs, bringing recipients to the level of the working poor.

The Ministry of Social Services is currently developing the SAID policy with a spirit of accommodation, and therefore the strict welfare-based rules that have plagued AISH may not evident in the new SAID program. How can Saskatchewan avoid adopting the individual pathology policy features that are still a large part of AISH? In order to truly move away from an individual pathology mindset, the government must first acknowledge that disability is socially and economically constructed and that our
economic system excludes those whose abilities are outside the defined norm. The language, rules, application, goals and benefits must reflect accommodation and entitlement, and an acknowledgement that disability is not tragedy, but a normal part of the human experience.

With AISH, the acceptance of poverty as a suitable expectation for people with disabilities influences the benefit rates. While AISH has begun to address the inadequate benefit rates with the latest increase, there is a long history of allowing inflation to eat away at purchasing power. Historically, AISH recipients have been far below the LICO line, with the exception presently of a small percentage who live in unpopulated areas. Additionally, the LICO measure likely misses the growing cost of rent and utilities as a result of economic growth and deregulation in Alberta. The benefit has simply not been enough to ensure quality of life, security and inclusion—let alone equality of outcome.

Saskatchewan should avoid setting this poverty mentality limitation and work towards economic accommodation with the goal of equality of outcome. Looking at the goals presented by the DISC coalition, the first criterion of a respectful program would be financial adequacy. They note:

People with disabilities should have an adequate income that truly meets their needs without the indignity of having to justify their needs. Lifelong disability and subsequent economic insecurity needs to be a consideration. What does DISC consider adequate? A disability income should be enough financial support to meet individual needs, not just basic needs. Our primary aim is to see an income system that offers both an adequate baseline income for people with disabilities and a user-friendly mechanism to address individual financial needs based on the impact of disability. (DISC, 2010, p. 1)
Further, they describe the need for hope, security, dignity, respect and financial accommodation in how the benefits are administered and how those who use the program are treated.

With the SAID program, Saskatchewan has the opportunity to be the first jurisdiction in Canada to create policy that is not marked by a belief system that sees disability as an individual problem and personal tragedy. Saskatchewan could create the SAID program as a way to ensure economic security and freedom from the inevitable focus on day-to-day survival which is intimately linked to poverty. Efforts could be made to begin to address the social, environmental and economic factors that create disability. Beyond income security, people with disabilities would be able to expect access to adequate disability services and supports that are individually defined and managed. Hopefully in thirty years when people look back on the SAID program, they will see a different mentality than the individual pathology model of disability that has largely defined the AISH program.

5.2 The Social Model of Disability in Practice—Reflections for Social Work

*Is this simply neglect, or is there something inherent in the way diversity is considered that makes it impossible to recognize disability as a valid human identity?*


Social workers aim to integrate anti-oppressive strategies into their front-line practice. Students are taught to be critical of how systems and institutions control the lives of marginalized people and how to be aware of their own biases and power. Having a critical or structural understanding of social problems is essential if social workers wish to have a positive effect on people’s lives and make lasting social change. Mullaly (1997) describes what oppression looks like and how social workers are to respond.
Everyone suffers frustrations, restrictions, and hurt. What determines oppression is when these happen to a person not because of individual talent, merit or failure, but because of his or her membership in a particular group or category of people… Oppression protects a kind of citizenship that is superior to that of the oppressed. It protects the oppressor’s access to a range of better paying and higher status work. It protects the oppressors’ preferential access to and preferential treatment from our social institutions. (Mullaly, 1997, pp. 138-139)

Mullay (1997) explains that “structural” social workers must critically examine their own actions and determine if they are contributing to oppression (pp. 202). Carniol (2000) directs social workers to challenge the current treatment of people who are oppressed by supporting individual empowerment and social change.

The social model of disability is an essential theory in anti-oppressive practice. It was developed by Oliver as a way to help his social work students understand the hegemonic oppression of disabled people within society. As a professor of social work and a disabled person, Oliver (1990b) understood that social workers have power in their relationships to clients and that they needed to rethink disability in a critical way. I originally conceptualised models of disability as the binary distinction between what I chose to call the individual and social models of disability (Oliver. 1983). This was no amazing new insight on my part dreamed up in some ivory tower but was really an attempt to enable me to make sense of the world for my social work students and other professionals whom I taught [emphasis added]….I wanted to put this distinction into a framework that could be understood by professionals with a limited though expanding knowledge of disability issues. (p. 2)
Unfortunately, Oliver expressed that in twenty years social work had failed to embrace the social model, failed to meet disabled people’s needs and was dead in the lives of disabled people (Morgan & Roulstone, 2012; Oliver, 2004). He explains: “There is little doubt that the hegemony of the individual model still endures within social work, as in other professions” (Oliver, 2004, p. 11).

Still, Oliver continued to work towards the goal of using the social model to inform anti-oppressive social work practice. In Social Work with Disabled People, Oliver and Sapey (2006) critique the “disability industry” and that social workers have been complicit in ignoring disability issues (p. ix). Social workers have relied on individual pathology assumptions in their practice, and ignored the social context that people face when they acquire a disability. They quote Paul Wilding (1982) in his comment that the emphasis on “…a medical, psychotherapeutic and individualized model of work” was for social workers a way to gain professional status (Oliver & Sapey, 2006, p. 22). They argue, however, that social work is the occupational group which is in the best position to challenge the injustices and barriers that people with disabilities face and change their practice to support and reflect the social model of disability.

Morgan (2012), Oliver and Sapey (2006) and Reeve (2012) describe how the social model should inform social work practice, both in the critical analysis of social policies (macro level) and the one-on-one, front-line relationship with disabled people (micro level). Morgan (2012) frames the social model of disability as a paradigm shift or “threshold concept,” and explains that this is why it is so difficult for social work students to integrate (p. 215).

Most students enter social work programmes with the professed aim of ‘helping’ and so to be confronted by an approach (the social model of disability) and a body
of research and theorising (disability studies) that challenges their taken-for-
granted assumption that social work practice is ‘helpful’ is unsettling and can lead to resistance. (p. 215)

The result is that students mimic what they believe the social model to mean, a problem that Morgan calls “ritualized performance” (p. 220).

A threshold concept has five main characteristics, it is transformative; irreversible; integrative; bounded; and troublesome (Morgan, 2012). Morgan explains that the social model is often personally transformative, challenging personal beliefs and once explained often denotes irreversible knowledge. It is integrative and bounded in that it exposes underlying ideas and it creates conflict between disciplines, in this case between disability studies and social work. Lastly, it can be troubling for the learner:

[A threshold concept can be] “alien”, counterintuitive or even intellectually absurd at face value’ (2003, p. 2). Clearly a social model perspective can be all three to some learners. Many students are distant from the lived experience of disability and take their cues from wider social and cultural depictions of and scripts for understanding disability. The idea of disability as an individual’s personal tragedy is so hegemonic that it is extremely difficult for some students to grasp an alternative despite the modelling of similar approaches to issues like gender and ethnicity and the pervasiveness of claims to non-judgementality and antidiscriminatory practice within social work. Threshold concepts like the social model can be ‘subversive’ and undermine deeply-held beliefs and attitudes and, in the context of social work, they trigger fundamental questions about the nature, practice and future existence of social work itself. (Morgan, 2012, p. 221)
As a social work student doing a practicum at a disability organization, I was tasked with representing the philosophy and values of the organization in writing a handbook on education. The enormity of the task meant that I had to understand the radical, anti-oppressive side of the movement. When confronted with disability pride, or parents who were angry at selective abortion or segregated services, I was shocked. At first I had trouble getting past the ingrained tragedy perspective and found the alternative viewpoint upsetting and completely absurd. I experienced this new knowledge as a radical, threshold concept in my own social work practice and began rethinking how I viewed people with disabilities and how they were treated by society. I started from an individual pathology framework, but I rapidly understood that this belief system was oppressive. I had also assumed that people with disabilities had access to the supports they needed, which was challenged by the reality of residual, micro-managed services that limit personal choice.

The most difficult problem to be confronted with was how interpersonal exclusion and the devaluing of their lives affected the quality of life of many disabled people. They live a life that most people do not inherently see as valuable and are systematically excluded from typical work, recreation, education, living and social situations. This is the real tragedy, not their impairment. Forming relationships and being valued in any social role is difficult unless they fit into a stereotype or learn to manage and thrive within ‘normal,’ ableist society. For me, incorporating the social model affected both my micro-level practice, but also my macro-level analysis of the problem.

In front-line practice, there are practical ways that social workers can implement the social model at the micro-level. Reeve (2012) uses Honneth’s work on social justice, suggesting that for justice to be realized, people need to experience recognition in three
areas: love; rights; and solidarity. A lack of recognition leads to exclusion, shame and degradation (Reeve, 2012). She points out how holding individual pathology model beliefs about disabled people has a cumulative emotional, personal effect in their lives.

[It] is particularly important that professionals such as social workers understand how their behaviour and attitudes might (inadvertently or not) disable the person they are working with. Significantly, psycho-emotional disablism is cumulative like any form of emotional abuse (see Reeve, 2006). Consequently past experiences of being ridiculed or patronised may play out in current relationships with professionals. (Reeve, 2012, pp. 229-230)

This presents a challenge to social workers, showing how a progressive, social model perspective changes their practice with disabled people:

Put simply, a student on placement may not be able to do anything concrete about a voluntary sector service which is housed in an inaccessible building (structural disablism); however, the student does have control over the manner in which they interact and support a disabled person, the attitudes and assumptions that they make (psycho-emotional disablism), which in turn influence the services provided…..[In] contrast the elimination of psycho-emotional disablism relies on the social work student to be reflexive and self-aware of their own prejudices about disabled people so that these are not acted out and so is commensurate with the politics of recognition advocated by Honneth. (Reeve, 2012, pp. 230-231)

Oliver and Sapey (2006) suggest that social workers evaluate the usefulness of their interventions in removing disabling barriers, and implement a position of “determined advocacy,” allowing disabled people the right to define their own needs (p. 186).
At a macro level, social workers need to embrace the social model in order to be relevant in the lives of people with disabilities, as social work from and individual pathology perspective is no longer viable (Oliver & Sapey, 2006; Morgan, 2012).

There are fundamental questions about the future role of social work in the lives of disabled people in the personalisation era and about whether statutory social work can meet the wider needs and entitlements of disabled people….social work and social work education need to provide an articulate and convincing argument about what social work can offer disabled people in the twenty-first century. (Morgan, 2012, p. 224)

In 1983, the original challenge that Oliver and Sapey gave social workers was to “...review the individualising and pathologising knowledge and methods that had dominated their practice, and to join disabled people in challenging the political, cultural and professional barriers they faced in their everyday lives” (Oliver & Sapey, 2006, p. ix).

In relation to using the social model as a lens to analyze specific welfare policies, Oliver and Sapey (2006) suggest becoming a profession that is allied with the disability community, understanding their needs and goals:

What is also required is that social workers have a knowledge of the social model of disability that will inform their actions as practitioners and managers within a welfare system that has itself been seen to be oppressive….If social work is to be an effective ally to the struggle and to use its influence within the welfare state to alter and modify disability policies, it must do so from a position that is informed by its work with collective organisations of disabled people. It may, in Finkelstein’s terms, need to become a profession allied to the community. ( pp. 184-188)
6. CONCLUSION

While this thesis analyzes policy from a theoretical or ideological standpoint, the implications are real for people with disabilities. Many people with disabilities experience life-long poverty with no opportunity to escape. The charity mindset that pervades income replacement programs, the low benefits and the policing of personal details does not create a feeling of equity and accommodation, but further segregates and disables people. People with disabilities should not be celebrating a benefit increase on AISH that keeps them well below the poverty line, but that is the reality. They are the “deserving poor,” but not deserving of equity and accommodation as a result of that label. Most people with disabilities are still poor, and that combined with frequent social exclusion is the real tragedy of disability. Oliver (1996) describes the limits of income replacement programs.

‘Benefits’ which are not carefully related to the struggle for integrated employment and active social participation will constantly be used to justify our dependence and exclusion from the mainstream of life—the very opposite of what is intended. This is why the…appeal to the state for legislation to implement a comprehensive, national disability incomes scheme is in reality nothing so much as a programme to obtain and maintain in perpetuity the historical dependence of physically impaired people on charity….The appeal to the public on our behalf is still the same old appeal to pity, the begging bowl in modern form. (pp. 24-25)

The purpose of this study was not necessarily to generalize about all disability income programs, but to demonstrate how readily and subtly the individual pathology model of disability can influence and define the choices made in the development of social policy. What we can learn is how to carefully apply a social model lens when
analyzing policies. Disabled people have pointed out their oppression, socially and economically, through the social model. The profession of social work has a responsibility to incorporate the social model of disability into our understanding of anti-oppressive practice and analysis.

Once one realizes that the disadvantage that people with disabilities experience are socially and economically constructed, it has a lasting impact on how social policies are analyzed. For too long, the individual model has defined the programs, services and supports that people with disabilities receive, ignoring their lived experience and what they need to experience true equity. Perhaps, as Oliver (2004) suggests, it is time to use the ‘hammer,’ that is the social model of disability.

If we imagine that throughout human history the carpenters and builders of the world had spent their time talking about whether the hammer was an adequate tool for the purpose of building houses, we would still be living in caves….Finally, I have tried to demonstrate that we do have a hammer in the Disability Movement and that, if properly used, the social model of disability could become the means of achieving justice and freedom for disabled people ‘all over this land’. (p. 20)
REFERENCES


*your input is needed.* Edmonton, AB: Alberta Association for Community Living.

AAACL (2004). *Renewing AISH: Ensuring AISH is available into the future for Albertans who need it.* Edmonton, AB: Alberta Association for Community Living.

AAACL (2012). *Families of individuals with developmental disabilities applaud Redford budget.* Edmonton, AB: Alberta Association for Community Living.


Applications and Appeals (Ministerial) Regulation, Alberta Regulation 89/2007(2007), Part 1, 6 (a)-(e), Edmonton, AB: Alberta Queen’s Printer.


Assured Income for the Severely Handicapped Act, Statutes of Alberta (2006) C. A-45.1, S. 1 (i); S. 5 (3); S. 6 (2). Edmonton, AB: Alberta Queen’s Printer.

Assured Income for the Severely Handicapped General Regulation 91/2007 (2007) Schedule 3; S. 4(4); S. 5 (1)(b); S. 8:1 (a)-(b); S. 11; Edmonton, AB: Alberta Queen’s Printer.


Canadian Association for Community Living (2010). *Position statement on income security June 2010.* Toronto, ON: Canadian Association for Community Living.


Canadian Council on Social Development (2002). *CCSD’s disability information sheet no. 5.* Ottawa, ON: Canadian Council on Social Development.


Multiple Sclerosis Society of Canada (2008). *Multiple sclerosis & income security, the need is now.* Toronto, ON: Multiple Sclerosis Society of Canada.


Edmonton, AB: Legislative Assembly of Alberta. 27th Legislature, Second Session.


146


