The concept of disability is complex, and there are historical, social, legal and philosophical influences on its interpretation. The experience of disability is unique to each person but there are common impacting factors. There are common aspects also in the rights of people to access specific disability services provided directly or indirectly by governments. The need for some agreed definitions, largely to ensure that disability support programs are fair about who is to receive benefits and why, has prompted much discussion and debate, both in Australia and internationally.


Disability and definitions

Disability is usually conceptualised as being multi-dimensional for the person involved.

There may be effects on organs or body parts, for instance impairments in the mobility of joints or bones. There may be effects on certain activities, for instance lifting or gripping objects with the hand. There may be effects on a person's participation in a full community life; for instance, environmental modification or equipment may be needed so that the person is enabled to work in their usual employment.

To present data on disability and disability services it is necessary to classify or summarise people's needs and relate them to service...
data items and definitions. Classification necessitates balancing two important but sometimes countervailing requirements. On the one hand, it is important to try to use appropriate and acceptable terminology which acknowledges the full extent of people's experience. On the other hand, clear service and data definitions are needed so that it can be seen who is eligible for and receiving services. Inevitably, data definitions and quantitative data represent an uneasy compromise between the drive towards and the resistance to such simplification, classification or labeling.

Three dimensions of disability are recognised in the International Classification of Impairments, Disabilities and Handicaps (ICIDH), the 1980 definitions being set out in Box 9.1.

A new version of the ICIDH is now being drafted, to embrace developments in the field since 1980, and criticism of the first ICIDH. A range of countries, including Australia, is involved in the work with the World Health Organization, as well as organisations representing people with a disability. One of the major developments is the more specific recognition of the social construction of the third dimension of disability. It is being proposed that this third dimension be renamed ‘participation,’ and that its definition recognise the critical role played by environmental or contextual factors in restricting full participation (Box 9.2).

Physical health and autonomy (including opportunities for worthwhile social participation) have been argued to be the two primary, universal prerequisites for human wellbeing (Doyal & Gough 1991). The evolving ICIDH concepts—impairment, activity (limitation) and participation—can thus be situated in a broader framework for universal needs and wellbeing.

These definitions and terminology are therefore in a state of flux. In this chapter, the words of the new draft ICIDH will generally be used, except when referring specifically to some existing data sources which define and contain data items such as ‘handicap’.

### Box 9.1

**Definitions of the ICIDH 1980**

The International Classification of Impairments, Disabilities and Handicaps (ICIDH), provides a conceptual framework for disability which is described in three dimensions—impairment, disability and handicap:

**Impairment:** In the context of health experience an impairment is any loss or abnormality of psychological, physiological or anatomical structure or function.

**Disability:** In the context of health experience a disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.

**Handicap:** In the context of health experience a handicap is a disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfillment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual.

Impairment is considered to occur at the level of organ or system function. Disability is concerned with functional performance or activity, affecting the whole person.

The third dimension—handicap—focuses on the person as a social being and reflects the interaction with and adaptation to the person’s surroundings. The classification system for handicap is not hierarchical, but is constructed of a group of dimensions, with each dimension having an associated scaling factor to indicate impact on the individual’s life.

The Australian Institute of Health and Welfare has published also a valuable discussion.


More detailed discussion of physical and intellectual disability is provided in two other publications from the AIHW:


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### Box 9.2

**Definitions of the new draft ICIDH**

In the context of health condition:

*Impairment* is a loss or abnormality in body structure or of a physiological or psychological function.

*Activity* is the nature and extent of functioning at the level of the person. Activities may be limited in nature, duration and quality.

*Participation* is the nature and extent of a person's involvement in life situations in relationship to impairments, activities, health conditions and contextual factors. Participation may be restricted in nature, duration and quality. Participation is considered within seven broad domains: personal maintenance; mobility; exchange of information; social relationships; education, work, leisure and spirituality; economic life; and civic and community life.

*Context* includes the features, aspects, attributes of, or objects, structures, human-made organisations, service provision, and agencies in, the physical, social and attitudinal environment in which people live and conduct their lives.

The draft ICIDH2 has been issued as a public document for field trial purposes. The final version is planned to be published in 1999.


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### Box 9.3

**Areas of limitation, restriction or impairment identified by the ABS**

Affirmative responses to any of the following categories ‘screen’ the person into the ABS survey, where the limitation, restriction or impairment has lasted or was likely to last for 6 months or more:

- loss of sight, not corrected by glasses or contact lenses
- loss of hearing
- speech difficulties in native languages
- blackouts, fits, or loss of consciousness
- slowness at learning or understanding
- incomplete use of arms or fingers
- difficulty gripping or holding small objects
- incomplete use of feet or legs
- treatment for nerves or an emotional condition
- restriction in physical activities or in doing physical work
- disfigurement or deformity
- long-term effects of head injury, stroke or any other brain damage
- a mental illness requiring help or supervision
- treatment or medication for a long-term condition or ailment, person still restricted
- any other long-term condition resulting in a restriction

This list thus creates the implicit definition of disability for the survey. In ICIDH 1980 terms, the ABS notion of disability ranges over impairment, disability and even handicap and health condition.
The Australian Indigenous HealthInfoNet is an innovative Internet resource that contributes to ‘closing the gap’ in health between Indigenous and other Australians by informing practice and policy in Indigenous health.

Two concepts underpin the HealthInfoNet’s work. The first is evidence-informed decision-making, whereby practitioners and policy-makers have access to the best available research and other information. This concept is linked with that of translational research (TR), which involves making research and other information available in a form that has immediate, practical utility. Implementation of these two concepts involves synthesis, exchange and ethical application of knowledge through ongoing interaction with key stakeholders.

The HealthInfoNet’s work in TR at a population-health level, in which it is at the forefront internationally, addresses the knowledge needs of a wide range of potential users, including policy-makers, health service providers, program managers, clinicians, Indigenous health workers, and other health professionals. The HealthInfoNet also provides easy-to-read and summarised material for students and the general community.

The HealthInfoNet encourages and supports information-sharing among practitioners, policy-makers and others working to improve Indigenous health – its free on line yarning places enable people across the country to share information, knowledge and experience. The HealthInfoNet is funded mainly by the Australian Department of Health and Ageing. Its award-winning web resource (www.healthinfonet.ecu.edu.au) is free and available to everyone.