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The Right to Work for Persons with Disabilities

International Perspectives

Nomos

edition sigma

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Conceptualizations of Disability in ICF and CPRD: Their Contribution to the Realization of the Right to Work

by Marianne Hirschberg

The two constructs of disability, the International Classification of Functioning, Disability, and Health (ICF) and the Convention on the Rights of Persons with Disabilities (CRPD), have similar but different perspectives on disability. The ICF is a health related classification and used especially in the rehabilitation sector whereas the CRPD is an international juridical contract. The signatory states are obliged to implement it regarding justice for disabled people. Consequently, they follow different goals and they are used in different ways. Their contribution to the realization of the right to work will be explored in this essay.

1. Introduction

Disabilities were considered as a problem of the individual for a long time. The UN Convention on the Rights of Persons with Disabilities (CRPD)[1] establishes a changed view of disabilities: It is not people with impairments who are disabled, but rather they are hampered by barriers in the environment. This new concept of disability provides a socio-political impetus to conceptualize disability differently and to keep this in mind for the further juridical development and for societal practices.

The concept of disability that includes social barriers has become accepted internationally. Not only the CRPD but also the World Health Organisation (WHO) includes barriers in the definition of disability. In its understanding of disabilities and impairments, the CRPD is essentially based on the International Classification of Functioning, Disability and Health (ICF) of the WHO.[2]

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1 In this essay the terms: the CRPD or the Convention will be used. The CRPD was adopted by the general assembly of the United Nations in New York on the 13th of December 2006. It got into force in Germany on the 26th of March 2009.

2 The WHO assembly adopted the ICF in May 2001.

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Referring to both conceptualizations of disabilities it is important to be precise how they differ from each other. Therefore, in this essay it will be explained critically with reference to the constructions of disability and normalcy in the ICF and to the Human Rights Model of Disability. The leading questions being discussed are: How is disability construed in the ICF and in the CRPD? How do these conceptualizations contribute to the realization of the right to work?

As a Human Rights Treaty, the CRPD contains of two instruments being relevant for participation in the labour market: the principle of accessibility and the individual right to reasonable accommodation. On the contrary, the ICF is an internationally recognised classification system various occupational groups in the health care sector work with. Therefore it provides a common language for describing the state of health and disabilities and the associated conditions in order to improve communication between professionals, research, policy, and the public, but it does not offer any instruments regarding inclusion in the labour market explicitly. Whether the ICF can be regarded as having implicit effects will be tackled shortly. As a conclusion both conceptualizations will be estimated regarding their importance for the right to work and in an overall perspective for an inclusive society for all.

2. Classifications as powerful instruments

Classifications have a long tradition in the health sector, in the juridical field decisions are made with reference to medical norms and standards (Hirschberg 2009: 21ff, 69f). Therefore classifications are important instruments being influenced by societal perspectives on disability and construing or setting societal standards of disability. Classifications are not only to be seen as "Properties of mind and standards, as ideal numbers of floating cultural inheritances" but as having "material force in the world" (Bowker/Leigh Star 2000: 48). Concluding it has to be acknowledged that classifications are powerful constructs as Gregory explained for definitions in the context of disability and rehabilitation (1997). Regarding the ICF its conceptualization has to be estimated in the light of its development as well as the influence and different interests of the various players: the collaboration centres of the WHO, task forces, networks, NGOs, and consultants (WHO 2001: 254ff).

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3. Conceptualization of Disability in the ICF

In the light of the CRPD it is crucial to make the participation of disabled persons a priority (Hirschberg 2010). The CRPD understands the term disability as the result of the interaction between persons with impairments and the psychological and physical barriers they face in their environment and society (Art. 1). Its definition of disability is based on the acceptance of the term as outlined by the ICF (Hirschberg 2011). If one applies the standard of participation as outlined in the CRPD to the further development of the ICF, environmental factors become significant because they can be either supportive or obstructive to disabled persons (Wansing 2005). Consequently, environmental factors are a decisive component in disability assessment and social conditions should be precisely categorized according to this component in order to improve the classification in terms of its practical applications, for example in rehabilitation.

3.1 Differentiating Disease and Disability

Since its establishment in 1946, the WHO has been tasked with the classification of diseases (ICD). The ICD provides a means of measuring the seriousness and frequency of diseases worldwide and can be used for various purposes; for example, to collect data for national or international comparison purposes, or to develop measures towards health promotion. After criticism by rehabilitation researchers and the growing international disability rights movement about the amalgamation of disability and disease in the late 1960s and 1970s, the WHO developed the International Classification of Impairments, Disabilities and Handicaps (ICIDH) and adopted it in 1980. The ICIDH was the first to differentiate disability and disease clearly (Hirschberg 2009: 46ff). Its development process to specifically address disability shows that several stakeholders not only proposed, but indeed insisted that the definition of disability should not be limited to its physical dimension (Hirschberg 2006). The impact on the specific population as well as their position within society were also to be taken into account.

Due to a number of points of contention such as the view that disability is a consequence of disease in the ICDIH, the WHO launched a revision process in the early 1990s which resulted in 2001 in the adoption of the ICF. Contrary to the ICIDH, the ICF addresses all populations, even

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though it only classifies disabilities and not the individual's specific abilities (i.e. functioning) (WHO 2001: 7; Hirschberg 2009: 207ff.). However, primarily the ICF remains relevant for disabled people given that their impairments are assessed in conjunction with their social environment. The ICF thus lays the foundations for rehabilitation measures. As such it serves as a benchmark for, for example, the Assistive Technology Guidelines of the Federal Joint Committee in deciding which technologies should be covered by the German national health insurance (GBA 2008).

3.2 Disability: no longer a consequence of disease, but the result of the interaction between individual and society

The ICF is the first document taking into account the social environment of the individual. Disability is no longer regarded as a corollary to disease or impairment (as in the ICIDH), but rather as the result of the interaction between different components. It is defined as the negative result of the interaction between the following health components (Fig. 1):

"Disability is an umbrella term for impairments, activity limitations and participation restrictions. It denotes the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors)" (WHO 2001: 213).

Thereby, not only physical, individual and social components in disability are taken into account, but also the private sphere and personal life experiences as well as specific personal barriers or facilitators.

The conceptual changes to the notion of disability date back to the disability rights movement and its demands to remove barriers and social obstacles (as well as challenge negative attitudes towards disabled people): "In our view it is society which disables physically impaired people. Disability is something imposed on our impairments by the way we are unnecessarily isolated and excluded from full participation in society" (UPIAS in: Oliver 1996: 33).

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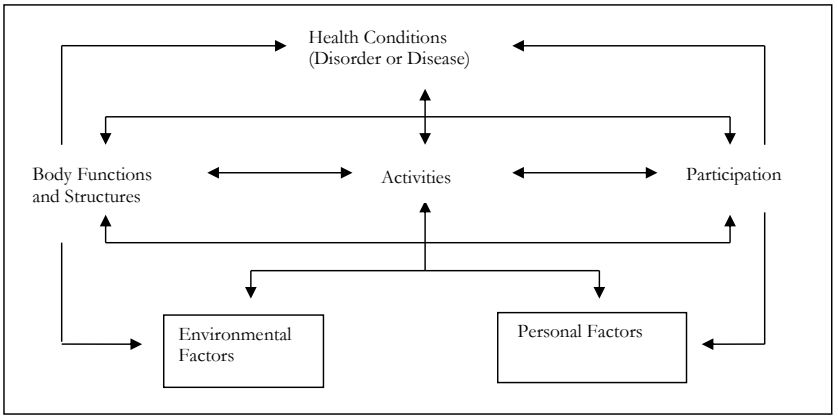
Fig. 1: Interaction between components of disability (WHO 2001: 18)



This perspective being known as the Social Model of disability comprehends disability as a product of society (Oliver 1990) instead of perceiving it as a purely individual problem as in the medical system. The WHO has tried to unify these concepts: the medical and the social model within its biopsychosocial model of the ICF (2001: 20).

In my discourse analysis, I found the ICF-model to be somewhat imprecise and suggest that this model should be enlarged so that all components interact with each other. Therefore, I added the arrows in order to highlight the interdependencies between the health condition and the environmental and personal factors. So, in the revised model all components interact with each other (Fig. 1; WHO 2001: 18 modified according to the results of my analysis of the ICF, Hirschberg 2009). It can be used to understand chronic diseases, as well.

3.3 Analysis of the Conceptualisation of the ICF

Due to the fact that the ICF belongs to the Family of International Classifications it is a powerful, multipurpose instrument designed to be used in an international context, in different disciplines and for various purposes. Therefore it is important to analyse how disability is conceptualised in the ICF; not only by the definition but throughout the classification.

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By integrating the medical and the social model of disability in the ICF the WHO attempts to achieve a synthesis of these opposing models with the "biopsychosocial" approach. Regarding the conceptualization of these models disability is viewed in different ways: one centres on the individual body and the other on the social environment. To analyse the conceptualization of disability in the ICF the analysis of this synthesis shows an uneven integration of both models: the individual perspective on disability is much stronger, more differentiated in detail than the perspective on environmental factors of the physical and social environment (Hirschberg 2009: 234ff, Imrie 2004). Viewing the biopsychosocial approach critically, internal ambiguities can be identified (ibid. 289ff).

Examining how far the different understandings of disability relate to a one-dimensional or to a pluralistic conception of normalcy, to normative (social, medical or juridical) norms or to normalistic (statistically based) norms both are found in the ICF. The former is referred to as protonormalistic, the latter as flexible-normalistic (Link 1999: 77ff). In distinguishing different conceptions of normalcy reference is made to the theory of "normalism" that has been developed by the German literary scholar, Jürgen Link (1999, 2004). As a result of the discourse analysis the ICF represents a pluralistic understanding of disability and normalcy on the grounding of a clear normative dichotomy between disability and functioning (Hirschberg 2009: 299ff). The heterogeneity of the relationship between disability and normalcy is not only perceptible in this dichotomy but in the flexibility characterising the spectrum between disability and functioning in the ICF, as well (ibid. 302ff). For example, there are features of a grey area between severe and light impairments, and furthermore from light impairments to "superhigh" functioning. The transition zone in the ICF between normalcy and abnormalcy is identified by risks through disabilities, construing abnormalcy as a risk area of denormalisations (Link 2004). According to Link's theory of normalism disability and normalcy are conceptualised as a flexible normalist differentiation on a protonormalist basis in the ICF (for the detailed comparison Hirschberg 2009: 304).

As a conclusion, the different constructs of disability in the ICF have to be understood recognising the historical development of conceptualizations of disability. The diversity of voices in the lines of discourses in the ICF reflects the heterogenous conceptualization of disability: especially regarding biomedicalisation, capacity and participation (cf. for a critical analysis of biopolitics Foucault/Sennelart 2010). The ICF as a classification is not only a product of a discourse of influential players but it consti-

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tutes and construes the notion of disability, as well, as a practise. Hereby, disability is constructed as societal reality – in the light of the analysis of the biopsychosocial approach as a synthesis of medical and social model in the ICF it is decisive how the ICF is employed practically: whether for the identification and reduction of barriers or for a medicalised, individualised view and treatment of people with disabilities. The ICF should therefore be applied to facilitate the participation of disabled people in society and thereby promote the goal of the CRPD. This is relevant for the application of the ICF in different disciplines and for various purposes.

4. Conceptualization of Disability in the CRPD

Human Rights are an analytical instrument and normative fundament for politics as I will explain for the CRPD.

4.1 Disability Rights as Human Rights

Disability Rights are Human Rights – why is this so important to emphasize?! Considering the long shadow of history with regard to the participation of disabled people in German society, especially the shadow of the national socialist regime's mass murder of disabled people, the CRPD is an important tool against the discrimination of disabled people. With the CRPD as international and national law crimes as the systematic murder of disabled people by the national socialist, being euphemistically called "euthanasia", should be prevented.

By the ratification Germany as state party is obliged to "ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability" (Art. 4 Para. 1 CRPD). A lot of different measures are linked with the duty to implement the CRPD, including legislation, and "to refrain from inconsistent practices with the … convention and to ensure that public authorities and institutions act in conformity with (it)" (Art. 4 Para. 1d CRPD) as well as to take appropriate measures to eliminate discrimination on the basis of disability by any person, organization or private enterprise (Art. 4 Para. 1e CRPD). Article 4 is the core of the CRPD, explicitly entitling the obligations of the signatory states.

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Considering the importance of these obligations in the light of the long shadow of historical neglect, ignorance and NS mass murder the meaning of the state's duties is definitely clear: "to promote, protect and to ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities" (Art. 1 CRPD). Hereby, it is clearly stated that all disabled persons, without distinction, have the same rights. There is no differentiation between persons with minor or severe impairments, nor any exclusion of persons regarding the intersection with other categories of difference as race, class, gender, religion, age or any other status (Preamble Cl. p CRPD). Thus, regarding the debate about whether all people with all kinds of disabilities can be included in the German regular school system or whether distinctions shall be made according to severity of impairment, there is neither a juridical fundament in the CRPD, nor in any other human rights treaty. Nevertheless, the discussion concerning individual capacity, productivity or effectiveness is not new and it is necessary to be alert and vigilant that no one is judged or excluded because of little capacity (Foucault 1973, Foucault/Sennelart 2010). In practice it is decisive to focus on the depletion of barriers, the increase of accessibility and the provision of individual reasonable accommodation with the aim not only to have but to enjoy human rights.

Similar to the establishment of a memorial of the mass murder of disabled people by the national socialists in Berlin, established as late as 2014, the CRPD was developed very late compared to other human rights treaties, as the treaties to prevent discrimination against women or children, or the Convention on the Elimination of All Forms of Racial Discrimination. Disabled people were and maybe still are a forgotten group, often not being regarded as part of human diversity. Without the international disability rights movement the CRPD would not have been developed, and disabled persons would still not be acknowledged as subjects with *legal* rights but as objects of welfare, health and charity as they were before (Degener 2016, Sabatello 2014). This paradigm shift is backed by human rights principles, especially focusing on non-discrimination, equality of opportunity, and explicitly the "respect for difference and acceptance of persons with disabilities as part of human diversity and humanity" (Art. 3d).

The CRPD contains no new but the same rights as the other Human Rights Treaties, as for instance the Covenant on Civil and Political Rights and the one on Economic, Social, and Cultural Rights. Yet, it adds a new perspective on these Human Rights: assisted self-determination of people

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with disabilities (Hirschberg 2017). This perspective is supported by the instruments of accessibility, reasonable accommodation and universal design (Art. 3f, Art. 9, Art. 2 Sub-Para. 4 and 5).

Now, with the CRPD there is a clear outline of state obligations and societal responsibility, but still the challenges of how to change respectively improve the living conditions of disabled people with the implementation of the CRPD have to be faced. With the CRPD the rights of disabled people can be claimed but it will be a long way before disabled people may enjoy the rights in everyday life without any discrimination.

4.2 Discrimination on the Basis of Disability

In the light of the CRPD and, also, in the light of its disability conceptualisation, social legislation and any legislation that is concerned with disability have to be re-read and re-interpreted. This is a process that started with the ratification of the CRPD and will take a longer period. Discrimination on the basis of disability has to be prevented immediately; the right to non-discrimination has to be observed immediately, if it is self-executing (Art. 2 in conj. with Art. 5 on equality and non-discrimination). Nobody may suffer discrimination on the basis of a disability, as is defined: "For the purposes of the present Convention, 'Discrimination on the basis of disability' means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation" (Art. 2 Sub-Para. 3).

In concrete terms, the issue is not the discrimination on the basis of somebody being a woman or a man or achieving low performance, but on the basis of the particular disability. The denial of reasonable accommodation as a discriminatory element is emphasized here, and thus, its significance has to be strengthened in legislation in those states having ratified the CRPD.

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4.3 Impairments, Disability and Barriers: Definitions according to the CRPD

The CRPD defines, on the one hand, who is meant by the term *persons with disabilities*: "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others" (Art. 1 Sub-Para. 2). Thereby, it also characterizes impairments as relating to individual, long-term and different aspects of the body. Furthermore, it states that a disability is in principle the result of an interaction between two components: an impairment and a barrier. Only the result of the interaction is taken to be a disability: being hindered in one's participation in society (Hirschberg 2011).

This understanding records the daily experiences of disabled persons who are not disabled by virtue of their impairments but by the interaction between the barriers existing in society and their impairment. This leads to the conclusion that people cease to experience disabilities as soon as the barriers in society are removed. Thus, the social conditions are crucial and affect the opportunities of disabled persons to be able to participate in society as far as education, work, accommodation, culture, health, politics, etc. are concerned.

The Preamble of the CRPD states that the concept of disability is "constantly evolving" (Preamble Cl. e). These explanations show the concept of disability is open; it supplements the main emphasis: the interrelationship between impairments and barriers, which can lead to participation being restricted. A distinction is also made with respect to barriers, which can be "attitudinal and environmental" (ibid.). This refers to various barriers of the physical, institutional or technical environment but also to prejudices or stereotypes which exist individually or can be influential in society (also Art. 8). The different forms of barriers are explained in terms of accessibility; they can include restrictions on "access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas" (Art. 9 Para. 1).

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5. Embodiment of Intersectionality in the CRPD and in the ICF

The WHO points out the ICF does not contain an intersectional perspective:

"The classification does not cover circumstances that are not health-related, such as those brought about by socioeconomic factors. For example, because of their race, gender, religion or other socioeconomic characteristics people may be restricted in their execution of a task in their current environment, but these are not health-related restrictions of participation as classified in the ICF" (WHO 2001: 7).

For sure, categories of difference are no reason for a restriction of health but they have implications for one's participation restrictions. Therefore, especially the intersectional disadvantage or disablement should be discussed as it could be relevant regarding the broader assessment of disability and functioning of a person (Campbell 2009, Crenshaw 1991).

In contrast, the CRPD advocates an intersectional perspective and relates disability to further categories of discrimination. A catalogue of preliminary provisions precedes the agreements of the States Parties: the Preamble. This illustrates the purpose of the CRPD. The intersectional discrimination experienced by disabled persons is emphasized, against whose background the legally-binding articles are to be understood and implemented as legislation: "Concerned about the difficult conditions faced by persons with disabilities who are subject to multiple or aggravated forms of discrimination on the basis of race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, birth, age or other status" (Preamble Cl. p). Even though the Preamble is not legally binding, it is to be applied to all articles of the CRPD.

Explicitly, as a human rights principle (Art. 3), the equality of women and men is emphasized. This human rights principle is part of all human rights treaties. Furthermore, the CRPD emphasizes the possible multiple discriminations of disabled girls and women (Art. 6, Preamble Cl. q). The state must take measures to protect against discrimination, in particular "to ensure the full development, advancement and empowerment of women, for the purpose of guaranteeing them the exercise and enjoyment of the human rights and fundamental freedoms set out in the present Convention" (Art. 6 Para 2, also in the Preamble Cl. q). The gender-specific aspects are also pointed out expressly in the provisions regarding health and the freedom from exploitation, violence and abuse (Art. 16 and 25). These

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multiple emphases can be particularly attributed to the involvement of disabled women in the development process of the CRPD (Arnade 2010).

The relevance gets clear by the difference between the passive possession of human rights and the active exercise of rights (the access to the right): If women with disabilities are not protected against experiencing discrimination the right to non-discrimination remains unexercised (Art. 5).

6. The relevance of the ICF and the CRPD for the right to work

Persons with disabilities (in conjunction with further categories of difference, see above) do not have adequate access to the labour market, neither historically nor currently (Pieper/Haji Mohammadi 2014). How can they acquire this? What do they need in order to be able to participate in the labour market without discrimination? Which barriers do they experience in a society that is governed by the underlying focus on performance and efficiency, as well as in conjunction with the interconnected axes of difference of ableism and other dimensions of discrimination (Crenshaw 1991, Campbell 2009)?

According to the CRPD, disabled people are to be considered as subjects with the same human rights as everybody else. This also includes the right to work on an equal basis with others and the participation "in a labour market and work environment that is open, inclusive and accessible to persons with disabilities" (Art. 27 Para. 1).

6.1 ICF and Access to the Labour Market

Regarding the right to work the ICF has to be acknowledged in two ways: On the one hand it can be judged as a rehabilitation-related classification being employed to support disabled people returning to work by classifying their disability (Post et al. 2006, Heerkens et al. 2004). This application is relevant for all medical and rehabilitation experts and users of the ICF, relating it with the state's duty to fulfil the right to work according to the CRPD and the necessity of health professionals promoting this in their daily work. On the other hand the ICF contains of work related items in the common list of the components activity and participation but does not tackle the issue of the right to work concretely (WHO 2001: 165f). Sum-

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ming up the ICF's relevance to access to the labour market the main focus is raising awareness in the use of the ICF for this goal.

6.2 CRPD and Access to the Labour Market

The CRPD provides two instruments to promote participation in the labour market: The significance of the human rights principle of accessibility (Art. 3 and 9) and the legal instrument of "reasonable accommodation" (Art. 2) will be elucidated. These instruments are applied to the right to work focusing the human rights principles of participation and inclusion. Which specific obligations do employers have if they have to provide reasonable accommodation for disabled employees? Which obligation is placed on the state with respect to the rights of disabled persons with regard to their individual right of non-discrimination (Art. 5)? According to the principle of accessibility, the state is obliged to systematically create the conditions for an accessible labour market in society. These two instruments act in different ways, but can be used together effectively.

6.3 Access to the Labour Market for Persons with Disabilities

Disabled people are confronted with various barriers concerning their working life. This is similar in Germany and in other developed countries (WHO/World Bank 2011). Although the German legislation offers different measures to reduce discrimination against persons with disabilities in education and vocational training, their participation in the labour market is still limited (BMAS 2016: 160f.). Therefore, the unemployment rate of people with a severe disability was about 13,4% in 2014 (BMAS 2016: 161). To improve participation of disabled people in the labour market, social and labour market policy instruments, such as wage subsidies, assistance in working life, or support by assisting services could be applied. All of the instruments should help to overcome the barriers to the labour market in individual cases. Nevertheless, for most disabled people their wish remains unfulfilled to be employed regularly. Instead, many are trained in special vocational training centres, sheltered workplaces and vocational rehabilitation centres and, thereby, have a relatively low income (BMAS 2016: 160ff.).

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The reason for the gap between legislation and societal practice are socio-psychological, institutional and structural barriers. Concerning socio-psychological barriers, often, employers still have a broad range of prejudices and are partly focused on assumed deficits. In many cases, neither are employers prepared for inclusion nor is this issue considered as strategically necessary. As a result, disabled people are confronted with discrimination against them in job application procedures and in workplaces. From an institutional perspective, barriers often exist because the workflow is not adapted for disabled staff members, and some colleagues avoid being in contact with them. The reason for these incidences could be found in too little awareness of the range of possible employment, the efficiency and the toughness of disabled people. Often, there also is a lack of information about possible assistance, facilitators and financial or personal support for employers. The structural barriers could be identified in the structure of the regional labour market, the difficult situation of the labour market as a whole and their impact on the employment possibilities of disabled people (Kardorff et al. 2013, BMAS 2016).

6.4 Two Instruments for Participation in the Labour Market of the CRPD

While accessibility is a structural means towards achieving full and effective participation in society on an equal basis the instrument of reasonable accommodation is directed at individuals (Art. 9 and Art. 2). Both are used for the objective of the CRPD, to promote equality of disabled persons with respect to non-disabled persons and to prevent discrimination (in conj. with Art. 5).

6.5 Accessibility as a Structural Principle

Accessibility is already widespread through the efforts of the disability rights movement; it has to be implemented structurally in all areas of life, such as access to the labour market and also in the education system and healthcare, for instance. This requires both a change of awareness in society, as well as a short-term, medium-term and long-term plan of measures by the state.

The human rights principle accessibility (Art. 3) goes along with a wider understanding of accessibility in the sense of universal design

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(Frankenstein 2018). In detail Art. 9 explains which measures States Parties have to take "to enable persons with disabilities to live independently and participate fully in all aspects of life" (Art. 9 Para. 1). This means all state institutions are obliged to take suitable measures "to develop, promulgate and monitor the implementation of minimum standards and guidelines for the accessibility of facilities and services open or provided to the public" (Art. 9 Para. 2a). Furthermore, the state has to ensure private entities that provide public facilities and services "take into account all aspects of accessibility for persons with disabilities" (Art. 9 Para. 2b). Both public and private institutions are therefore called upon to implement accessibility though private entities only indirectly via the state (Welti 2012, Gould et al. 2012).

The measures to create access to the public domain include suitable technical, animal or personal assistance for blind or visually-impaired people, professional sign language interpreters and further forms of simplified communication and information (Art. 9). The obligation of the state to create comprehensive accessibility derived from Art. 9 alludes the structural responsibility for the self-determined, independent participation of disabled people in society by taking the measures required in each case. The implementation of this structural principle of accessibility can be illustrated by means of a social services office whose structural design is accessible to all clients, as well as to people with different impairments being employed there.

6.6 Instrument of Equality: Reasonable Accommodation

Reasonable accommodation is subject to the following conditions: It must be "necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms" (Art. 2 Sub-Para. 4). The characteristics are:

- the necessity of an accommodation for the disabled person in a specific situation,
- a proportionate burden for the institution (state, employer or similar) providing the accommodation

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- and with the objective of being able to exercise all human rights and fundamental freedoms on an equal basis with others.

Examples include the necessary provision of an individually-adapted computer mouse at the workplace having to be provided for a disabled employee but may not consist of disproportionately expensive and unreasonable material. A further example would be the provision of a sign language interpreter for a deaf employee or – as an alternative – the provision of a sign language course for colleagues as a measure to create accessibility.

Reasonable accommodation is approved on a case-by-case basis to ensure equality. It is an integral part of individual rights such as the right to work or to education (Art. 27 and Art. 24). Therefore reasonable accommodation must be made exactly for the needs of an individual in the workplace or in the education system in order to ensure that the right to work or to education can be realized. The instrument of reasonable accommodation is closely linked to the principle of equality and non-discrimination. However, in Germany, for instance, it is sometimes not yet structurally implemented in legislation, especially where employment is concerned. It has to be included in national legislation; the denial of reasonable accommodation has to be expressly stated as an element of discrimination. The state must gradually create the conditions to ensure reasonable accommodation is provided (Art. 5). The implementation is directed towards creating substantial equality and strengthening disabled persons' protection against discrimination.

Every disabled person has the right to reasonable accommodation so that their workplace is appropriately designed to meet their needs. Reasonable accommodation depends on the individual needs; it is used to overcome barriers in an individual case. It would be sensible to enshrine it in national law as an obligation (Art. 2). As part of the non-discrimination principle under human rights, it is immediately effective and legally enforceable (Lord/Brown 2010).

7. Conclusions

With both being oriented towards individuals, the CPRD is based on but looks beyond the ICF's concept. The ICF as a health related classification focuses more on the individual perspective and the different components

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of disability than on the environmental factors, i.e. barriers and facilitators. In contrast, the CRPD emphasizes physical and attitudinal barriers much more. While the ICF contains of a categorization system of barriers and facilitators and thereby acknowledges the relevance of the environment regarding disability the CRPD as a Human Rights treaty is a normative instrument disabled people can use to claim their rights. The emphasis of accessibility as a human rights principle and the interdiction of discrimination of people with disabilities are related to the right to participation in the labour market.

Concluding, as both constructs of disability belong to different disciplines, they follow different interests and have different goals. The ICF as a classification in the health and rehabilitation sector is oriented towards disseminating the biopsychosocial approach regarding disability among health professionals whereas the CRPD as a juridical instrument the signatory states have to implement focuses on justice for disabled people. Both conceptualisations are relevant in their specific field, the Human Rights perspective should be leading and acknowledged in the field of health and rehabilitation, as well. Regarding the right to work the impact of the ICF-conceptualisation has not to be underestimated as a contribution strengthening the full and effective participation of persons with disabilities in society on an equal basis with others.

https://doi.org/10.5771/9783845291673-100

References

Arnade, Sigrid (2010): "Wir waren viele und wir waren überall". Ein persönlicher Rückblick zur Einbeziehung von Frauen in die Behindertenrechtskonvention. In: Jacob, Jutta/Köbsell, Swantje/Wollrad, Eske (Ed.): Gendering Disability. Intersektionale Aspekte von Behinderung und Geschlecht, Bielefeld, Transcript, pp. 223-229.

Bowker, Geoffrey/Leigh Star, Susan (2000): Sorting Things Out. Classification and its consequences, Massachussetts, MIT-Press.

Bundesministerium für Arbeit und Soziales (BMAS) (2016): Zweiter Teilhabebericht der Bundesregierung über die Lebenslagen von Menschen mit Beeinträchtigungen. Teilhabe – Beeinträchtigung – Behinderung, Bonn.

Campbell, Fiona K. (2009): Contours of Ableism. The Production of Disability and Abledness, New York, Palgrave Macmillan.

Crenshaw, Kimberly (1991): Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. Stanf. Law Rev., 43, pp. 1241–1299.

Degener, Theresia (2016): Challenges and Compliance of the UN CRPD, In: Estrada-Track, Dorothy (Academy of European Law) (Ed.): Human Rights of Persons with Disabilities in International and EU Law, EUI Working Papers, AEL 2016/01, ISSN 1831-4066, pp. 7-45.

Foucault, Michel (1973): The Birth of the Clinic: An Archaeology of Medical Perception. New York: Pantheon.

Foucault, Michel/Senellart, Michel (2010): The Birth of Biopolitics. Lectures at the Collège de France, 1978–79, 1st ed., New York: Picador.

Frankenstein, Arne (2018): Universelles Design und Zugänglichkeit der Arbeitsplätze, in diesem Band.

Gemeinsamer Bundesausschuss (GBA) (2008): Richtlinie des Gemeinsamen Bundesausschusses über Leistungen zur medizinischen Rehabilitation (20.3.2008), http://www.g-ba.de/downloads/62-492-249/RL-Reha-2007-12-20.pdf.

Gould, M.; Leblois, A.; Cesa Bianchi, F.; Montenegro, V.; Studer, E. (2012): Convention on the Rights of Persons with Disabilities. 2012 ICT Accessibility Progress Report; Survey Conducted in Collaboration with DPI – Disabled Peoples' International; G3ict.

Gregory, Robert (1997): Definitions as power, In: Disability and Rehabilitation, Vol. 19, Nr. 11, pp. 487-489.

Heerkens, Yvonne/Engels, Josephine/Kuiper, Chris/Gulden, Joost van der/Oostendorp, Rob (2004): The use of the ICF to describe work related factors influencing the health of employees, In: Disability and Rehabilitation, 26, No. 17, pp. 1060-1066.

Hirschberg, Marianne (2006): Classifying of disability. Discourse Analysis of the International Classification of Functioning, Disability and Health (ICF), In: newsletter of the WHO-Family of International Classifications (FIC), Vol. 4, No. 2, p. 7.

Hirschberg, Marianne (2009): Behinderung im internationalen Diskurs, Frankfurt/Main: Campus

https://doi.org/10.5771/9783845291673-100

Hirschberg, Marianne (2010): Partizipation – ein Querschnittsanliegen der UN-Behindertenrechtskonvention. POSITIONEN 3, Berlin: Deutsches Institut für Menschenrechte.

Hirschberg, Marianne (2011): Behinderung: Neues Verständnis nach der Behindertenrechtskonvention. POSITIONEN 4, Berlin: Deutsches Institut für Menschenrechte.

Hirschberg, Marianne (2017): Fragilität des Körpers – ein menschenwürdiges Leben durch Assistenz, In: Welsh, Caroline/Ostgathe, Christoph/Frewer, Andreas/Bielefeldt, Heiner (Ed.): Autonomie und Menschenrechte am Lebensende. Grundlagen, Erfahrungen und Reflexionen aus der Praxis, Bielefeld: transcript, pp. 223-236.

Imrie, Rob (2004): Demystifying disability: A review of the International Classification of Functioning, Disability and Health, In: Sociology of Heath & Illness, 2004, Vol. 26, No. 3, pp. 287-305.

Kardorff, E.v./Ohlbrecht, H./Schmidt, S. (2013): Zugang zum Allgemeinen Arbeitsmarkt für Menschen mit Behinderungen. Expertise im Auftrag der Antidiskriminierungsstelle des Bundes, Berlin.

Link, Jürgen (2004): "From the 'Power of the Norm' to 'Flexible Normalism': Considerations after Foucault." (translated by Mirko M. Hall), Cultural Critique 57 (1), pp. 14–32.

Link, Jürgen (1999): Versuch über den Normalismus. Wie Normalität produziert wird, Opladen, 3rd ed.

Lord, J.; Brown, R. (2010): The Role of Reasonable Accommodation in Securing Substantive Equality for Persons with Disabilities: The UN Convention on the Rights of Persons with Disabilities, http://ssrn.com/abstract=1618903.

Lord, J. E. (2010): U.N. Disability Convention: Creating Opportunities for Participation. Bus. Law Today, 19, http://apps.americanbar.org/buslaw/blt/2010-05-06/lord.shtml.

Oliver, Michael (1990): The Politics of Disablement, London.

Oliver, Michael (1996): Understanding Disability. From Theory to Practice, London.

Pieper, Marianne/Haji Mohammadi, Jamal (2014): Ableism and Racism: Barriers in the Labour Market, In: Can. J. Disabil. Stud. 3, pp. 65–92.

Post, Maaike/Krol, Boudien/Groothoff, Johan (2006): Self-rated health as a predictor of return to work among employees on long-term sickness absence, In: Disability and Rehabilitation, 28, No. 5, pp. 289-297.

Sabatello, Maya (2014): A short history of the International Disability Rights Movement, In: Sabatello, Maya/Schulze, Marianne (Ed.): Human Rights and Disability Advocacy, Philadelphia, University of Pennsylvania Press, pp. 13-24.

Trenk-Hinterberger, Peter (2012): Artikel 27 – Arbeit und Beschäftigung. In UN-Behindertenrechtskonvention mit Rechtlichen Erläuterungen; Welke, A., Ed.; Eigenverl. des Deutschen Vereins für Öffentliche und Private Fürsorge: Berlin, Germany, pp. 190–202.

United Nations (1979): Convention on the Elimination of All Forms of Discrimination against Women, New York.

United Nations (1965): Convention on the Elimination of All Forms of Racial Discrimination, New York.

https://doi.org/10.5771/9783845291673-100

United Nations (2006): Convention on the Rights of Persons with Disabilities, New York.

United Nations (1989): Convention on the Rights of the Child, New York.

United Nations (1966): International Covenant on Civil and Political Rights, New York.

United Nations (1966): International Covenant on Economic, Social and Cultural Rights, New York.

UPIAS (Union of the Physically Impaired Against Segregation) (1975): Fundamental principles of Disability, London, http://disability-studies.leeds.ac.uk/files/library/UPIAS-fundamental-principles.pdf.

Wansing, Gudrun (2005): Teilhabe an der Gesellschaft. Menschen mit Behinderung zwischen Inklusion und Exklusion. Wiesbaden: VS.

Welti, Felix (2012): Artikel – Zugänglichkeit. UN-Behindertenrechtskonvention mit rechtlichen Erläuterungen; In: Welke, Antje (Ed.): Berlin, Deutscher Verein für Öffentliche und Private Fürsorge, pp. 127–135.

World Health Organization (1946): Constitution of the WHO, Reprinted in: Basic Documents, 37th ed. Performance, Genf.

World Health Organization (2001): The International Classification of Functioning, Disability and Health, Genf.

World Health Organization/World Bank (2011): The World Report on Disability, New York.

Zola, Irving Kenneth (1993): Self, Identity and the Naming Question: Reflections on the Language of Disability, In: Social Science and Medicine, 36, pp. 167-173.

https://doi.org/10.5771/9783845291673-100