Theoretizing the Models of Disability Philosophical Social and Medical Concepts- An Empirical Research based on existing Literature

Shanimon.S M.Com. BE.d, CCC [*], **Rateesh .K. Nair M.Com, BE.d** [**]

[*] Assistant Professor, PG Department Of Commerce, GPM Government College, Manjeshwer, Kasaragode (Dist) ,Kerala (State),South India,India.
Research Scholar, University of Kerala,Thiruvananthapuram.Kerala (State),India.
[**] Assistant Professor, PG Department Of Commerce, Government College, Madappally, Kozhikod(Dist) ,Kerala (State),South India,India.
Research Scholar, University of Kerala,Thiruvananthapuram.Kerala (State),India.

Abstract- Over the years, perceptions towards disability have varied significantly from one community to another in time to time. Limited literature is available in disability history, concepts and varied models. This situation continues to pose a great challenge to governments, policy makers, other agencies and students of disability studies. In their endeavour to trace the development and formation of policies and perceptions towards persons with disabilities. It is towards this end, this article seeks to present a coherent literature review of disability studies based on existing literature. That influence perceptions and policy matters towards children, women and adults with disabilities. This article provides a few diagrammatical representation that illustrate different models of disability. These models are being taken by the academicians, international community, several bodies and countries to improve disability perception and betterment of policy decisions. Construction of disability from different perspectives and its implications have been a major challenge in the modern and developing world order. The generally adopted and accepted concepts of disability narrowing the definitions of disability and confines and limited it to "blindness; low vision; leprosy-cured. In each of these models there is a practical issue, How does the model and its way of thinking, relate to the outcomes for people with disabilities and their families? Such a question assumes that individuals who deal with policy in any aspect based on these varied models in mind will deliberately or not, reach some conclusions about people with disabilities and their families. And also the policies that should apply to them. There is a danger in discussing issues related with disability, that is it will end up with more models and concepts than a clear one . The implementation of policies for the empowerment of disabled population based of different concepts and varied models ultimately leads to worsen their conditions in real life.

Index Terms- Disability, Medical Model, Social Model, Administrative Model, Economic Model, Culture-linguistic Model, Provisional Model, Charity Model.

I. INTRODUCTION

According to United Nations (UN) estimates, there are more than 600 million persons with disabilities throughout the world, 70% of them in developing countries. Disability is caused by disease, malnutrition, incorrect treatment or non-treatment, physical or mental violence and war, accidents due to inadequate protection at the workplace and in traffic situations, and, increasingly, age-related diseases. Persons with disabilities suffer from discrimination throughout the world and are frequently excluded from social, economic and political processes in their societies. Disability was long considered an individual problem that was treated from a medical and charitable viewpoint, but neglected in terms of equal rights for disabled persons. The Decade of Disabled Persons (1983-1992) proclaimed by the UN, and the World Programme of Action2, triggered a change from the care approach to a human rights approach, by including the equal rights of disabled persons to participate in social processes. The core element of this viewpoint is that it considers disabled people, their families and organizations as active partners in implementing these rights. It also allows disabled persons to make better use of their own potential.

According to the World Health Organisation (WHO), disability can be defined as "an umbrella term, covering impairments, activity limitation, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is difficulty encountered by an individual in executing a task of action; while a participation restriction is problem experienced by an individual in involvement in life situations. Thus disability is complex phenomenon, reflecting an interaction between features of a person's body and features of the society in which he or she lives.

There are various definitions of disability, depending on (national) social legislation and cultural standards. What is considered a disability in one country may not be perceived and labelled as such elsewhere (examples are mental disability or female infertility). This makes it more difficult to establish reliable data on the number of persons affected. The figure most frequently cited is that of 600 million disabled persons in the world, published by WHO, which corresponds to approximately 10% of the global population. The prevalence in developing and industrialized countries diverges widely due to different reference systems and the lack of registration systems. Whereas industrialized countries have a percentage of persons with recognized disabilities of between 8 and 20%, often the developing countries only acknowledge much lower percentages officially.

II.   Review of Literature

The data was collected from existing studies, published articles, and reports of various national and international bodies and non-governmental agencies and various other sources. Information gathered was summarized for theoretical context and analyzed conceptually. Information was depicted under categories of model shapes of disability and its   historical, philosophical characteristics, The study is purely an empirical study based on past data address the problem in policy formation based of differential models and concepts of disability.

Relevance and Importance of the Study

There are various ways of thinking about disability; various models that reflect how any one of us conceptualizes disability as a condition, how any one of us responds to that condition in others, and how any one of us and, ultimately, how all of us, through the policy-making processes-respond to people with disabilities and the claims they assert. We have based these models in part on the perspectives that our respondents shared as they engaged in focus groups or individual interviews related to the core concepts of disability policy. We also have based these models on the statutes and cases that we set out in the Matrix. By no means have we been comprehensive in describing the policies (statutes and cases) that attach to these models or in exemplifying the models. We have, however, suggested that the perspectives of policy leaders and of their constituents do ultimately reflect how they—and how "we the people"--think about disability and thus how we structure our public policy responses to it and to people who have disabilities.

One cannot understand the under structures of the core concepts of disability policy without also acknowledging and beginning to understand the ways in which we and others think about disability. Finally, we have argued that for each of the models, there is a practical issue: How does the model and its way of thinking relate to the outcomes for people with disabilities and their families? Such a question assumes that individuals who deal with policy in any aspect with these various models in mind will, deliberately or not, reach some conclusions about people with disabilities, their families, and the policies that should apply to them. In reaching these points, that is, in coming to the "so what" challenge, they can advance the interests of people with disabilities of and their families by connecting to the core concepts. Is it appropriate for their thoughts about disability to relate to a core concept? We think so, because thinking implies action, and action in policy should be related to what is core.

Philosophical and historical Concept of Disability.

The Plato's *Republic* as one of the first, foundational philosophical texts to specifically argue that an ideal city governed by reasonableness should actively kill individuals with intellectual and physical disabilities because such individuals embody injustice as the lack of order. Although the programs of *euthanasia* found within the **Republic** have been largely analyzed simply as historical facts about ancient Greek culture, Plato should be understood as one of the first philosophers to introduce a conception of normative human embodiment based on rationally-identifiable criteria in direct contradistinction to a defective form of embodiment (see Moravcsik 1976; Galton

1998; Carrick 2001; MacFarlane and Ronald 2004). That is, Plato's argumentation in effect creates a philosophical conception of disability as a type of deficiency when compared to that which is considered fully rational, healthy, or ideally human. Despite the relative dearth of scholarship on this particular issue, there are some notable exceptions that focus on Plato's considerations of disability without adequately addressing the philosophical and rational sources of such argumentation (Jowett 1986; Goodey 1992; Stainton 2001; Becker 2005).

Souls, Bodies, and Cities

Before turning to the specific argumentation concerning the treatment of individuals with disabilities in the **Republic**, a brief analysis of Plato's teleological conception of human embodiment must be understood. More specifically, the reasoning put forth behind the proposal of using rationality to manipulate individual human bodies and collectives is fundamentally important for understanding the relationship between philosophy and disability insofar as the rationalization of individuals with disabilities follows from others commitments concerning the nature of the world, health, and the human soul.The conception of human embodiment put forward in the *Republic* by Plato*,* and by correlate the rejection of defective human embodiment in the form of *euthanasia*, marks an important development in Platonic thought. In the early, so-called "Socratic" dialogues, Plato has Socrates argue in large part for a type of dualistic intellectualism whereby the reasoning faculty (*nous*) of the human soul (*psychē*) is prioritized over and above the physical body (Reynolds 2004). That is, the physical body is primarily equated with the transient nature of matter within the realm of becoming (*genesis*) as distinct from and ultimately contrary to philosophical wisdom because the body through itself has no rational access to the intelligible realm of ideas (Reynolds 2004; cf. *Phaedo* 73b-74b; *Meno* 81b-82b). However, and despite this apparently crude prioritization of the soul over the body in the early and early-middle dialogues, Plato presents a much more nuanced understanding of human embodiment in the *Republic* by introducing a tripartite conception of the soul divided into three interrelated though distinct aspects, the rational (*nous*), spirited (*thumos*), and appetitive (*epithumia*) parts (*Republic* 437b5-441b in Hamilton & Cairns 1961; Brickhouse and Smith 2002).

Based upon a theological and naturalistic conception of human embodiment and influenced by Pythagorean and Empedoclean conceptions of nature (*physis*), medicine, and health (*hygeia*), Plato understood bodily and psychical health not merely as medical states of the body but indications of the proper functionality of human nature itself (Carrick 2001, 37). Specifically, maintaining health and the equilibrium of humors is most explicitly tied to the teleological end of human nature in book IV of the *Republic* wherein Socrates argues that "to produce health is to establish the elements in a body in the natural relation of dominating and being dominated by one another, while to cause disease is to bring it about that one rules or is ruled by the other contrary to nature" (444d3-6). Health is thus characterized not as the contingent condition of a particular individual's body considered in isolation, but as an objective good associated with order, beauty, and proper functionality as a type of harmony (*harmonia*). Contrastingly, disease and dysfunction are associated directly with disorder, ugliness, the

bad condition of the soul, and most importantly for the *Republic, in*justice as a type of *dis*harmony.

Philosophical discourse is predicated upon rationality and the application of rational principles, the exclusion of individuals with disabilities due to considerations of normative conceptions of embodiment will always remain an inherent possibility within human reasoning. The application of rational principles entails that incongruous, wasteful, and otherwise defective elements must be removed, and if such principles are instrumentally applied to human embodiment, then the result is that certain human beings themselves embody that which is inimical to reason and must be purged. However, as normative considerations of rationality and human embodiment will remain an inherent possibility, such attempts will also necessarily fail to adequately address human embodiment insofar as such rationalized schemas exclude some individuals and deny inevitable borderline cases to *appear* rationally coherent. The attempt to use rational principles to derive an intelligible basis for human embodiment exists only by denying those individuals that lie outside of and beyond reason, strictly construed. Thus rationalized conceptions of normative human embodiment cannot be fully deduced from philosophical principles alone without incompleteness, and only empirical rather than *a priori* rational considerations can adequately address the individuality and contingency of concrete human embodiment.

While the exclusion of individuals with disabilities based upon philosophical or rational grounds in particular is beginning to currently decrease, understanding the motivation behind the philosophical attempt categorize a normative conception of embodiment is important as such exclusion will remain a possibility in the future. Additionally, numerous contemporary philosophers still appeal to a normative conception of embodiment when considering whether or not a being is a "person" who ought to enjoy certain medical and ethical considerations owing to cognitive criteria or considerations of physical ability. This contemporary trend is most explicit in the work of some bioethicists and utilitarian thinkers who attempt to categorize rationally-identifiable criteria for accepting or rejecting individuals based upon considerations of normative embodiment and the failure to achieve this embodiment as represented by disability; I refer mainly to thinkers such as Michael Tooley (1983), Peter Singer (1993), Helga Kuhse (1987), James Rachels (1986), and most recently, Alberto Giubilini and Fracesca Minerva (2012).

III.   MODELS OF DISABILITY

THE SOCIAL MODEL OF DISABILITY

The Social Model of Disability locates disability as being socially constructed through the creation of artificial attitudinal, organisational and environmental barriers. Impairment is regarded as being a normal part of the human condition, with everyone experiencing impairment differently and having different access needs. Life is accepted as including negative experiences, and impairment may be - but is not necessarily - one of them. Disabled people are defined as being people who experience the unnecessary barriers created by society within their daily life. Social model of disability has gained ground in

the international debate. This views disability as a social construct and emphasizes society's shortcomings, stigmatization and discrimination in its reaction to persons with disability. It distinguishes between functional impairments (disability) both of a physical and psychological nature, and the loss of equal participation in social processes that only arises through interaction with the social setting (handicap). These developments have contributed to a new (WHO) model, which bears in mind social as well as functional and individual factors in its classification of health and health-related areas.

INDIVIDUAL AND SOCIAL MODELS

There are two fundamental points that need to be made about the individual model of disability. Firstly, it locates the 'problem' of disability within the individual and secondly it sees the causes of this problem as stemming from the functional limitations or psychological losses which are assumed to arise from disability. These two points are underpinned by what might be called 'the personal tragedy theory of disability' which suggests that disability is some terrible chance event which occurs at random to unfortunate individuals. Of course, nothing could be further from the truth. The genesis, development and articulation of the social model of disability by disabled people themselves is a rejection of all of these fundamentals (Oliver 1990). It does not deny the problem of disability but locates it squarely within society. It is not individual limitations, of whatever kind, which are the cause of the problem but society's failure to provide appropriate services and adequately ensure the needs of disabled people are fully taken into account in its social organisation. Further, the consequences of this failure does not simply and randomly fall on individuals but systematically upon disabled people as a group who experience this failure as discrimination institutionalised throughout society. It would be possible to devote the rest of this paper, and much more, to discussing different models.

THE MEDICAL MODEL OF DISABILITY

The Medical Model of Disability locates disability as being a medical condition experienced by the individual affected, and disabled people are often referred to and defined by their impairments e.g. 'the blind', 'the deaf', 'epileptics', 'schizophrenics' etc. People with the same condition are expected to share the same experiences of their impairment and to have the same access needs, rather than each individual having different experiences and needs (as is actually the case). The medical model represents the notion of deafness as an impairment or problem that needs to be corrected. Many people who experience deafness later in life either suddenly or slowly over timeare likely to identify with this model. It is also the first model that parents are likely to apply or see applied by doctors to their deaf children upon diagnosis.Why then is the medicalisation of disability inappropriate? The simple answer to this is that disability is a social state and not a medical condition. Hence medical intervention in, and more importantly, control over disability is inappropriate. Doctors are trained to diagnose, treat and cure illnesses, not to alleviate social conditions or circumstances. Justification for this criticism rests upon the distinction between illness and disability and the fact that they are not the same thing;

some illnesses may have disabling consequences and many disabled people have illnesses at various points in their lives. Further, it may be entirely appropriate for doctors to treat illnesses of all kinds, though even here, the record of the medical profession is increasingly coming under critical scrutiny. Leaving this aside however, doctors can have a role to play in the lives of disabled people: stabilising their initial condition, treating any illnesses which may arise and which may or may not be disability related. The problem arises when doctors try to use their knowledge and skills totreat disability rather than illness.

Scientific Model of Disability

A Scientific Model of Disability include the belief that science is all-powerful and will soon eliminate abnormality forever. This is despite the fact that experienced scientists do not believe this at all, since their work proves daily that it is not true. However, scientists are largely unable to admit this in public because their ability to attract funds for their research depends on their fulfilling society's stereotypes. In reality, as the old saying goes, the more they learn, the more they realise they have yet to learn. Despite this, most people believe that scientists are experts in the most absolute sense, and this belief must form part of a Scientific Model of Disability.As we have seen, disabled people are of interest to scientists primarily because we help to advance the understanding of the 'normal' human body. Within a Scientific Model of Disability, then, normal people are the important ones. This is often voiced overtly by society, for example when urging drug testing to be carried out on disabled people rather than healthy volunteers.

In fact, scientists rarely meet a disabled person in the course of their working week, either as colleagues - I was the first wheelchair user to have worked at the National Institute of Medical Research that anyone could remember, despite lab work being so easily adaptable to disabled people's access needs - or as research subjects, since research is now carried out largely at the cellular level. Similarly, within a Scientific Model of Disability, disabled people ourselves are invisible.

Charity model of disability

The charity model of disability views the person with disabilities as the problem and dependent on the sympathy of others to provide assistance in a charity or welfare mode.

Right Base Model of Disability.

Right Base Model of Disability builds on the insights of the social model to promote creation of communities, which accept diversities and differences, and have a non discriminating environment in terms of inclusion in all aspects of the life of society. It took time to build consensus on a conceptual framework that reflected dimensions of disability beyond the medical. The International Classification of Impairment, Disability and Handicapped (ICIDH) from WHO in 1980 was a breakthrough in this evolution, It recognised that personal, social and environmental   factors are all that play in " creating" disability . This acknowledged that not only physical or mental impairments but the attitudes and institutions of society had significant impact on the opportunities of PWD.

Model of Human Capacity

The Model of Human Capacity Studies deals generally with the sciences of human development: how individuals acquire various capacities. There are at least three submodels: medical/public health, psychological, and educational. Each has played and continues to play a large part in disability policy and ser vices and thus in the impact that core concepts and partnerships have on family quality of life. The medical/public health submodel generally regards the person with a disability as having a disease or condition that renders him or her "sick" and that is properly addressed through the usual means whereby physicians treat their patients. There are two aspects to the medical/public health model: physical medicine and psychiatry. That physical medicine and psychiatry have played significant roles in disability policy and in the lives of families cannot be doubted. The psychological submodel regards behaviour as a learned consequence to external stimuli. It holds that in order to modify behaviour, it will be necessary to control the environments and the conditions within these environments that produce behaviour. These conditions include relationships between the individual with a disability and others. The psychological submodel gave rise to the intervention known as applied behaviour analysis and, more recently, to the intervention known as positive behavioural supports.

Educational submodel

The educational submodel holds that everyone can learn; there is no such person as one who is ineducable; and that, accordingly, all people who are of school age have a right to attend school if even one such person has the right to attend school. This submodel arose from research on language acquisition, was the foundation for the assertion in the early right-to-education. This submodel is associated with the core concept of anti-discrimination. The education submodel is also reflected in IDEA's principle of non-discriminatory evaluation and especially in the requirement for an evaluation of a student's cognitive capacities. It is also inherent in IDEA'S provisions that the student with a disability should have access to the general curriculum where, it is assumed, the student will learn certain skills (with accommodations) that will lead to an independent, economically self- sufficient, productive, and fully participatory life. This submodel thus is associated with the core concepts of integration, productivity and contribution, and autonomy (independence). It is responsible for a variety of teaching techniques tailored to the needs and capacities of the student, which collectively are expressed as individualized and appropriate education and related services.

Model of Public Studies

The Model of Public Studies subsumes various disciplines that are linked to each other because each is basically concerned with the relationship between government and individuals. Along with the Model of Human Capacity, this was the most dominant way of thinking about disability in the United States during the 20th century, especially during the last 30 years of it. This is ot difficult to understand: The civil rights revolution that began when advocates for African -American students insisted that racially segregated education is inherently unequal set the precedent for the disability-rights movement, which began in earnest in the early 1970s when advocates for people with

disabilities successfully established the rights to education and rehabilitation in the least restrictive (most normal) settings. The core concepts associated with this model are antidiscrimination, autonomy, liberty, privacy and confidentially, integration, cultural responsiveness, service coordination and collaboration, empowerment/participatory decision making , professional and system capacity-building, and classification.

The Model of Public Studies contains six submodels: law, political science and philosophy, political economy, demographics, public administration, and social welfare. None is entirely separate from the others; in fact, they tend to overlap significantly. The law submodel is concerned with the rules of a community-particularly the rules that derive from governments and their enforcement. It regards disability as an unalterable trait that thus should not be the basis for invidious treatment by governments; this is the core concept of antidiscrimination.

The law submodel also regards disability as a condition that should evoke a positive response by government. As such, its concerns are with the substantive rights and entitlements of people with disabilities and their families, and with the procedures whereby those rights and entitlements are made available and their denial is remedied.Political science is the study of how governments work (the practice of government)and of the institutions of government; political philosophy is concerned with how to deploy or limit public (governmental) power so as to maintain the sanctity and quality of life of the governed.

The political science and philosophy submodel conceptualizes disability as a human condition that should be addressed through political processes and that justifies, or does not justify, various governmental responses. Accordingly, some practitioners of this submodel are concerned with whether the majoritarian democratic processes are available to people with disabilities and their advocates, and, if so, how and with what results. Other practitioners are concerned with the nature and extent of the claims that people with disabilities legitimately may make on others and on the body politic; their issues are ones of the philosophy of government as applied to people with disabilities. Whatever the precise concern of the political scientist, the core concepts involved in this area are antidiscrimination, autonomy, privacy and confidentially, liberty, empowerment/ participatory decisionmaking, and classification.

Political economy is the study of the ways in which economics and government politics interact. The political economy submodel addresses disability from the bases of (a) the allocation of resources in the public and private sectors of a national or subnational economy and (b) the maximization of effectiveness, efficiency, and choice (responding to the needs and preferences of individual consumers). It comes into play in such diverse arena.

Demographics is the study of human populations, including their size, growth, density, and distribution, and it relies on statistics concerning birth, marriage, age, income, disease and disability, and human life. This discipline is concerned with population trends and the distribution of people throughout the nation or parts of the nation. In this submodel, the core concepts are antidiscrimination and, to a lesser degree, individualized and appropriate services and service coordination and collaboration. Public administration is the study of government organizations

and their relationships to other government organizations; it is concerned with how these organizations work and how they can be made more effective and efficient in carrying out the responsibilities assigned to them by appropriate branches of government. This submodel addresses how policies are administered, that is, how authorized services are imple mented and why those who are charged with implementation act in various ways when providing or denying services to people with disabilities and their families. public administration are the core concepts of capacity-building (at the system level), service coordination and collaboration, individualized and appropriate services, and accountability.

Social welfare is the field of human service that is generally aimed at enriching and enhancing individual and group development or at alleviating adverse social and economic conditions. This submodel proceeds from a purposefully "caring" or "empowering" perspective about people with disabilities and their families. In this arena, the concern is with the core concepts of autonomy, privacy and confidentially, liberty, integration, cultural responsiveness, empowerment/participatory decision-making, and classification.

Model of Cultural Studies

This model approaches disability and the role of the individual and family affected by disability from the perspective of how they are viewed within their particular society. Unlike the Model of Human Capacity Studies, it is only very tangentially, if at all, concerned with understanding the causes of disability that may lie within the person and thus with the interventions that maybe addressed specifically and sometimes solely to the individual. Instead, it is more concerned with how people with and without disabilities regard the fact of disability, with how disability is conceptualized by various cultures, and with how disability is expressed or portrayed through the various modes of expression available to a culture or group of people. The core concepts associated with this model are cultural responsiveness, classification, family integrity and unity, family centeredness, autonomy, liberty, and protection from harm. There are five sub models: cultural anthropology, sociology, literature, the performing arts, and history.

Model of Ethical and Philosophical Studies

This model is concerned with the ethics and philosophies that shape the Cultural Studies and Public Studies models. Ethics is the study of moral standards and how they affect individual and group conduct. Its concerns are with the "right and wrong" of decisions about people with disabilities and their families, that is, about the morality of decisions affecting them. The core concepts associated with this model are protection from harm, prevention and amelioration, autonomy, and cultural responsiveness. Theology is the study of religion, and religion refers to people's beliefs and opinions concerning the existence, nature, and worship of one or more deities and those deities' intervention in the universe and in people's lives. Religion is concerned with how people think about deities and how that thinking affects their behaviour toward people with disabilities, their families, and the societies in which disability exists. Under this area fall debates about "wrongful life" and "wrongful birth" cases, about the quality and sanctity of life, about the essential attributes of being

human, and about the rightfulness/ wrongfulness of aborting a fetus diagnosed as having a disability or at risk of being born with a disability. These debates are cast in terms of what is "morally/ethically right" or what "God" commands our personal, societal, and policy responses to be. Like the Cultural Studies Model, this model shapes one's understanding about the existential or metaphysical meaning of disability.

Model of Technology Studies

This model is concerned with the "built" or "constructed" environment, with the physical world that people with disabilities and their families inhabit. The core concepts associated with this model are antidiscrimination, productivity, integration, appropriate and individualized services, and capacity-building.This model is similar to the Human Capacity Studies Model and the Public Studies Model in that it has been applied directly in disability policy-making and service provision. Three sub models of this model are architecture, industrial engineering, and ergonomic cs. Technology Studies Model, The concern is with the core concepts of productivity, integration, individualized and appropriate services, capacity-building (that is, building the capacity of the individual, through individualized services, to be productive and integrated), and prevention.

The Administrative Model of Disability.

The administrative model comes into effect when the deaf person is assessed post-diagnosis for benefits or an education. It may mark the point at which he starts to "come out.".The model point out the effect within which the disabled person is examined as the normal person or as the abled people to inculcate some benefit. This approach is emerging and developing intime.

The Provisional Model of disability.

This is adhered to by those who believe that deaf people's access requirements have been met once they start using their designated equipment or the services of a lip speaker, note taker or sign language interpreter (SLI).

The Culturo-linguistic Model of Disability.

Born deaf or prelingually deaf people, Deaf families and Deaf communities are likely to relate to this model because they regard deafness not as a disability, but as a cultural identity. This model is the most diametrically opposed to the medical model because it emphasises what the person has gained (as opposed to lost) through being deaf, i.e. a strong community, a language with its own syntax and grammar, enhanced visual perception, and a culture that he can truly empathise with. Some prelingually deaf people who learn BSL later in life also identify with this model due to long held beliefs commonly supported by evidence of discriminatory barriers that continue in adult hood that mainstream society or education has failed them.

The Economic Model of Disability.

Evolution from the medical to social model of disability saw a major shift in attitude from one that concentrated on teaching an individual how to cope with a disability in an otherwise hostile environment to changing social attitudes to manipulate the environment to be more accessible to a person with a disability. It was a rights issue and based on the premise that

society had an obligation to assist those with a disability. The final evolution is to stop concentrating on the "disability" but rather the needs and abilities in a customer focused environment. An economic model of disability changes the basic driver from a rights and compliance issue to a market demand driver. The economic model will change that focus by changing how access is looked upon. Once any industry appreciates that the disabled and their friends are a large market they will start to research their interests. The economic model is suggesting that the market already exists and is growing rapidly with the retiring baby boomers. The real issue is attracting them by providing the facilities and services that they need.This group will not identify with the disability sector but will simply want to keep doing those things that they have always done and even relive their youth in their retirement. Their abilities will not be what they were in their 20's but they will still expect be able to fulfil their aspirations. This impetus of new demand for more accessible facilities and service will change the paradigm for the disability sector. The business case is about making the industry aware of the market size and redefining disability away from the concept that it is an homogenous group to regarding it as significant group of people with differing levels of ability desires and needs.

Economic model and realize that any disability is simply a different level of ability. We are not all equal in a number if ways. Physical ability is just one set in the total capability set of the human being. If we do take physical ability as the cornerstone of the push for greater accessibility then we need to put it into context. Evolution from the medical to social model of disability saw a major shift in attitude from one that concentrated on teaching an individual how to cope with a disability in an otherwise hostile environment to changing social attitudes to manipulate the environment to be more accessible to a person with a disability. It was a rights issue and based on the premise that society had an obligation to assist those with a disability. The final evolution is to stop concentrating on the "disability" but rather the needs and abilities in a customer focused environment.

The Human Rights Approach

The international development community is increasingly guided by a rights-based approach. This is an inclusive approach which calls for the participation of all groups of the population, but particularly disadvantaged persons in the development process, and for all people to have equal access to public services such as health and education. Inclusive development builds on the idea of a Society for All in which all people are equally free to develop their potential, contribute their skills and abilities for the common good and to take up their entitlements to social services. The human rights approach focuses not only on prevention and rehabilitation but also on equal rights to participation. It emphasizes strengthening the rights of people with disabilities, and fosters their participation in all aspects of society.

IV. CONCLUSION

Here there is a danger that in discussing issue related to disability, that we will end up with more models than one. This is dangerous in that, if we are not careful we will spend all of our

time considering what we mean by the medical model or the social model, or perhaps the psychological or more recently, the administrative or charity models of disability. These semantic discussions will obscure the real issues in disability which are about oppression, discrimination, inequality and poverty. Construction of disability from different perspectives and its implications have been a major challenge in the modern and developing world order. The generally adopted and accepted concepts of disability narrowing the definitions of disability and confines and limited it to "blindness; low vision; leprosy-cured; hearing impairment; locomotor disability; mental retardation; and mental illness". As opposed to this, the Disability Convention of UN recognises that "disability is an evolving concept" and avoids listing specific conditions and severities and broadly casts "persons with disabilities" to "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." The barriers of disability Laws are mainly from the concept level , that makes complexities and hindrens to the fruits of that statutes, That the differences in the Conceptual Models of Disability taken from different perceptions leads to a pathetic situation that may lead to worsen the present conditions of Disabled people . The different concepts and models of disabilities adopted by different agencies ultimately make hindrances to the fruits and flowers of all endover that would have been beneficial to disabled communities.

Case:1

The number of disabled population in developing countries are vary according to differences in approaches. In the case of developing India, the estimates vary, there is growing evidence that people with disabilities comprise between 5 and 8 percentage of the Indian population (around 55-90 million) individuals. The main sources of the estimates are of the National Sample Survey (NSS), 2001 census, The official estimates of disability are low (around 2 percent), alternative estimates using better method and more inclusive definitions suggest a higher incidence of disability (of at least 5-8 percent). 11th Five year plan acknowledges that at least 5-6 percent of the population have disabilities. WHO estimates of the disabled population of India are considerably higher again. The 2001 census found 21.91 million persons with disabilities (2.13 percentage of the population), while the NSS round's disability estimates is 1.8 percentage of the population. Alternetive estimates from variety of sources suggests that the actual prevalence of disability in India could be easly around 55 million people, and as high as 90 million if more inclusive.From the case study it is found that the differences in approaches and methods in defining and considering disability leads to false estimates of disabled population and thereby incorrect policy formation for their betterment.

REFERENCES

[1] 'THE DRAFT RIGHTS OF PERSONS WITH DISABILITIES BILL'', 2012.Government ofIndia, Ministry of Social Justice & Empowerment,Department of Disability Affairs,September- 2012.

[2] "THE INDIVIDUAL AND SOCIAL MODELS OF DISABILITY", MIKE OLIVER- BA PhD READER IN DISABILITY STUDIES THAMES POLYTECHNIC.

[3] Oliver, M. (1983). Social work with disabled people. London: Macmillan.

[4] "Model of Intellectual Disability and the Relationship of Attitudes Towards the Sexuality of Persons   with an Intellectual Disability", Monika Parchomiuk.open access at Springerlink.com (2013) 31,P:125- 139.

[5] "An Essay on Modelling:The Social Model of Disability",Anita Silver. Department of Philosophy, San Francisco State University, California ,USA.

[6] " A Pragmatic Evalution of Three Models of Disability in Special Education ",Scot Danforth,Journal of developmental and Physical Disabilities.13(4)2001.

[7] " Model of Diagonsis And Rehabilitation in Musculoskeleltal Pain-Related occupational Disability", Izabela Z.Schultz, Joan Crook, Kerri Fraser, and Peter W.Joy, Journal of Occupational Rehabilitation, 10(4)2000.

[8] " PEOPLE WITH DISABILITIES IN INDIA: FROM COMMITMENTS TO OUTCOMES ", Human Development Unit, South Asia Region,Document of the World Bank,The World Bank-May 2007.

[9] " Disability at a Glance 2012,STRENGTHENING THE EVIDENCE BASE IN ASIA AND THE PACIFIC ", United Nations -ESCAP,(Economic and Social Commission for Asia and Pacefic), ST/ESCAP/2642.

[10] "Disability in Conflict and Emergency Situations: Focus on Tsunami-affected Areas", Maria Kett Sue Stubbs and Rebecca Yeo,India contributions by Shivaram Deshpande and Victor Cordeiro, June-2005, IDDC Research Report: Submitted to KaR Disability Programme, Overseas Development Group, University of East Anglia.

[11] "Convention on the Rights of Persons with Disabilities and Optional Protocol" ,UNITED NATIONS.

[12] "The World Health Report – 2013, Research for Universal Health Coverage"World Health Organisation. 2013.

[13] "SUMMARY WORLD REPORT   ON DISABILITY",World Health Organisation and THE WORLD BANK : WHO/NMH/VIP/11.01.

[14] "Empowerment Assessment tools in People with Disabilities in Developing Countries. A systematic literature review", LUTIEN BAKKER & WIM H. VAN BRAKEL ,Athena Institute, VU University Amsterdam, De Boelelaan 1085, 1081,HV Amsterdam-The Netherlands,Lepr Rev (2012) 83, 129– 153.

[15] The Government of Jordan. Law No.31 for the Year 2007: Law on the Right of Persons With Disabilities.

[16]   "People With Disabilities In India: From Commitments To Outcomes" WHO Report

AUTHORS

First Author – SHANIMON.S M.Com. BE.d, CCC., Assistant Professor, PG Department Of Commerce, GPM Government College, Manjeshwer, Kasaragode (Dist) ,Kerala (State),South India,India., Research Scholar, University of Kerala,Thiruvananthapuram.Kerala (State),India. shanimonimon@gmail.com.

Second Author – RATEESH .K. NAIR M.Com, BE.d Assistant Professor, PG Department Of Commerce, Government College, Madappally, Kozhikod(Dist) ,Kerala (State),South India,India. Research Scholar, University of Kerala,Thiruvananthapuram.Kerala (State),India. rateeshknairkollam@yahoo.com