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The discourse of disability in higher education: Insights from a health and social care perspective

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ABSTRACT

This article considers perspectives on student disability in the context of health and social care disciplines in higher education. The first phase of the research, which adopted an appreciative inquiry approach, involved interviews with students and educators from fifteen health and social care professions across the United Kingdom (UK). Findings were used by the Health Care Professions Council (HCPC) to redraft guidance for potential applicants.

The second phase of the research involved analysis of the discourse underpinning the new guidance, which was compared with responses to its publicly open review. Analysis revealed that despite an affirmative stance adopted by the HCPC, the principle of inclusivity for people with a disability remains far from universally and unconditionally accepted.

1. Introduction

More than a billion people (about 15% of the world's population) are estimated to live with some form of disability (based on 2010 global population estimates) (World Health Organization (WHO) 2011, 7). There are over 11 million people with a limiting long term illness, impairment or disability in the United Kingdom (UK) alone. People with a disability remain significantly less likely to be in employment than those without a disability, and in terms of tertiary education, people with a disability are around three times as likely not to hold any qualifications compared to those without a disability, and around half as likely to hold a degree-level qualification (GOV-UK, 2014).

We open our discussion with these stark statistics because it is our contention that higher education has a part to play in altering the social, political and economic climate for people with disabilities. That there are fewer people with disabilities in the workforce or gaining qualifications does not necessarily mean that they lack the required capabilities. It suggests that strategies to increase inclusivity for people with disabilities, may not be working as well as they might. The WHO suggests that academic institutions can:

remove barriers to the recruitment and participation of students and staff with disabilities; ensure that professional training courses include adequate information about disability, based on human rights principles; and conduct research

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on the lives of persons with disabilities and on disabling barriers, in consultation with disabled people's organizations (WHO, 2011, 22).

Our aim is to invigorate academic debate and change how the needs of students with disabilities are met in higher education. Specifically, we focus on the issues in opening up educational opportunities in the health and social care professions in the UK. However, the issues are equally as relevant across other disciplines, and internationally, as evident in the literature. Nevertheless we acknowledge that:

the ideology of inclusive education is implemented in different ways across different contexts and varies with national policies and priorities, which are in turn influenced by a whole range of social, cultural, historical and political issues (UNESCO, 2011, 15).

Despite the neo-liberal discourse in higher education that is reflected in the drive to prepare students for the world of work, which is a dominant international discourse in higher education (Middlehurst, 2014,1481), there is a moral imperative to understand the support and guidance needs for people with disabilities wishing to work. This article has two main aims: to address a gap in the limited literature (with the exception of nursing) concerning the experiences of students with disabilities in the health and social care professions, and to remedy the lack of analysis of the wider vocational context's readiness to accept a more inclusive stance.

2. Disability: the concept and context

Disability is a blanket term with multiple interpretations. The International Classification of Functioning, Disability and Health (ICF) framework views disability and function as the outcome of the interaction between health and contextual factors (WHO, 2002). The UK Equality Act (HMSO, 2010, 4) adopts a medical definition of disability as 'a physical or mental impairment that has a substantial and long term adverse effect on a person's ability to carry out normal day to day activities'. The social model attributes disability to the physical and social barriers within society (Marks, 1999). It has been critiqued as homogenising disabilities, that can vary between cases and in intensity over time (Shakespeare, 2006). However, we adopted the social model standpoint in the belief that people with disabilities are a heterogeneous group with many different impairment diagnoses, but who all face overlapping experiences of disablement or exclusion (Goodley & Lawthom, 2006, 2); disability is socially constructed (Shakespeare, Lezzoni, & Groce, 2009). Terminology is contentious with all terms being potentially offensive to some. We opt to use 'student with a disability' rather than 'disabled student'.

A decade ago, the UK Government identified the achievement of equality for people with disabilities by 2025 as a key objective (Prime Minister's Strategy Unit, 2005). Strengthening anti-discrimination legislation and increasing the employment of people with disabilities were recognised as crucial to promoting change. Legislative changes were arguably piecemeal until the passing of the all encompassing Equality Act in 2010, its purpose being to 'review, simplify and modernise discrimination law' (Government Equalities Office, 2013). All employers are required to comply with the act ostensibly opening up employment in all fields, including the health and social care professions.

3. Professional regulation

Higher education institutions host qualifying programmes in the health and care professions. However, these programmes also involve substantial periods of work-based learning in National Health Service locations, Social Services, third sector organizations and schools. All of these organizations are required to adhere to the code of practice for academic standards and students with disabilities (Quality Assurance Agency, 2010). Whilst, professional bodies such as the Chartered Society of Physiotherapy, the College of Occupational Therapy and the Society of Radiographers have input into quality, the regulators such as the HCPC, the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) quality assure courses through their approval processes. The professional and regulatory bodies are powerful players in influencing standards of education and ultimate entry to the professions.

The HCPC, which is the regulator at the centre of the research presented here, is responsible for the regulation of sixteen professions including, art therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational therapists, operating department practitioners, paramedics, physiotherapists, practitioner psychologists, prosthetists/orthotists, radiographers, social workers and speech and language therapists. Graduates are required to meet general and profession-specific Standards of Proficiency (HCPC, n.d.). The HCPC does not ask registrants to inform them of any disability, rather to declare that their health does not affect their ability to practise safely and effectively (HCPC, 2013). Importantly, completion of training does not give automatic entry to the professions. Inclusion and exclusion are part of the HCPC's remit.

Contributing to the debate about increased representation of people with disabilities in health and social care professions, Sin and Fong (2007) argued that this would only be achieved if qualifying courses widened the gateway for participation of students with disabilities. They highlighted the need to review regulations and guidance across the professions in line with legislation. The Disability Rights Commission's (DRC) (2007) investigation into professional regulations, especially fitness to practice requirements for nursing, teaching and social work, noted an often implied link between disabilities, competence and safety, which arguably created negative attitudes towards practitioners with disabilities (Chih, 2009). Over seventy