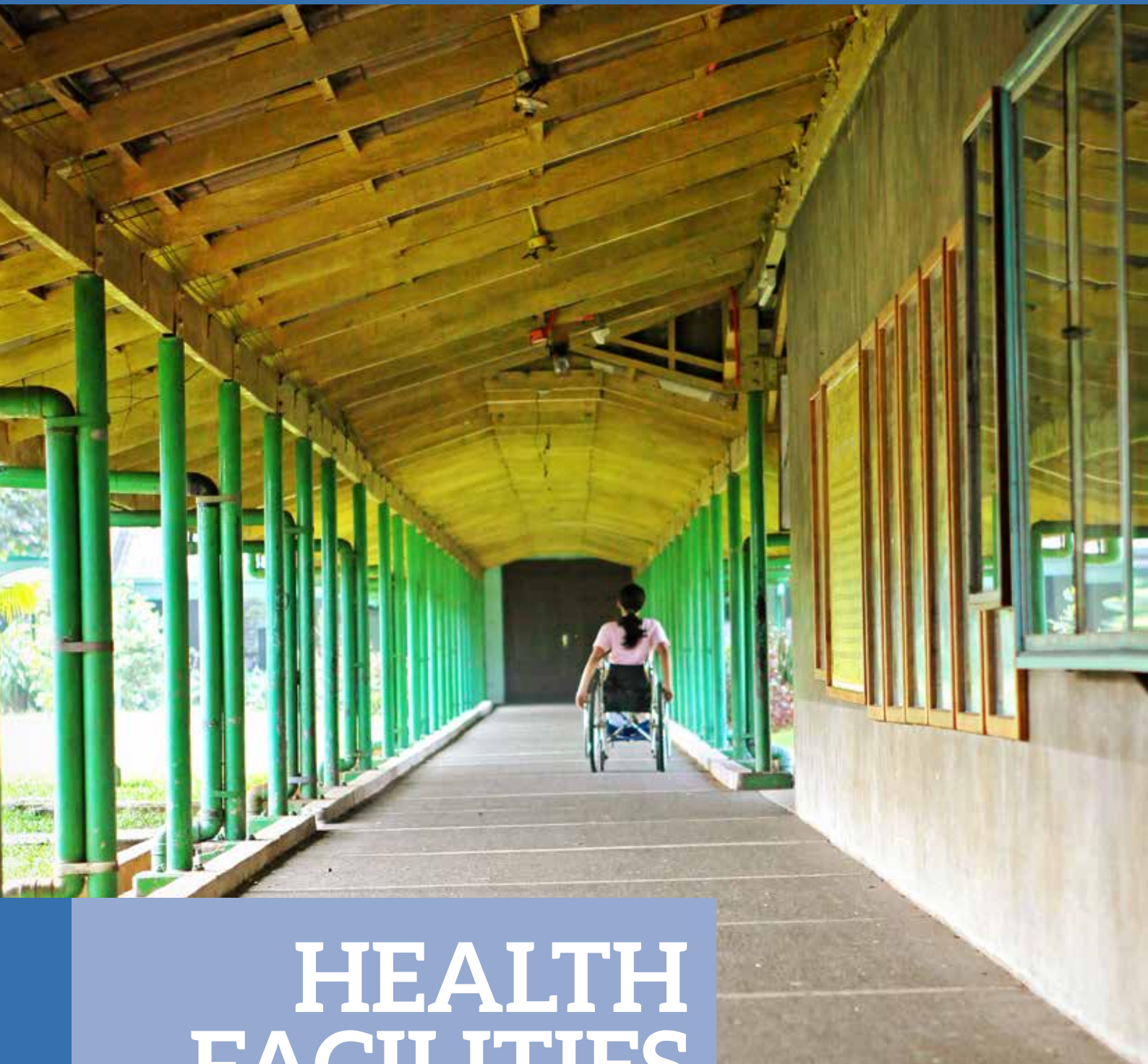


HEALTH FACILITIES FOR ALL



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Making health facilities
disability-inclusive:
actions against barriers

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**Making health facilities
disability-inclusive:
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Health Facilities for All

Making health facilities disability-inclusive: actions against barriers

Objectives:

- (1) To raise awareness of disability-inclusive health.
- (2) To educate the health sector (and allied ministries) on barriers encountered by people with disabilities in accessing health care.
- (3) To suggest actions that can be taken to remove barriers.

Dimensions of change: (1) treatment of people with disabilities with respect and dignity; (2) accessibility of health facilities and services; (3) affordability of health care; (4) people-centred and integrated health care and referral pathways, case management, and self-help groups; and (5) participation of people with disabilities in governance and decision-making.



Situation, challenges, trends and barriers

According to the *WHO Global Disability Action Plan 2014-2021: Better health for all people with disability*, evidence shows that people with disabilities, throughout the life-course, have unequal access to health-care services, have greater unmet health-care needs and experience poorer levels of health compared with the general population.

As a result, people with disabilities have poorer health outcomes than the general population. This means that people with disabilities frequently experience preventable diseases and report high incidences of risk behaviour such as obesity, smoking and physical inactivity. It means not being able to go to school or to earn a living. It means a parent or spouse who could potentially be contributing income to the family is sometimes taken away from this to provide support and care. It means potential catastrophic health expenditures that can drive individuals and their families into poverty. However, many avoidable and unjust health inequities reported among people with disabilities are not necessarily a direct result of having a disability but rather are linked to difficulty accessing community services and programmes.

For further information on avoidable and unjust health inequities see "Key Findings: Persons with Disabilities as an Unrecognized Health Disparity Population" (<http://www.cdc.gov/ncbddd/disabilityandhealth/features/unrecognizedpopulation.html>) or "Persons with Disabilities as an Unrecognized Health Disparity Population" (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4355692/>).

Population differences between people with and without disabilities on health indicators of health-care access, health behaviours and health status, United States of America

Health indicator	People with disabilities (%)	People without disabilities (%)	Data source
Health-care access			
In the past year, needed to see doctor but did not because of cost	27.0	12.1	Behaviour Risk Factor Surveillance System 2010
Health behaviours			
Adults who engage in no leisure-time physical activity	54.2	32.2	National Health Interview Survey 2008
Children and adolescents considered obese (aged 2-17 years)	21.1	15.2	National Health and Nutrition Examination Survey 1999-2010
Adults who are obese	44.6	34.2	National Health and Nutrition Examination Survey 2009-2010
Adults who smoke (100 cigarettes in lifetime and currently smoke)	28.8	18.0	National Health Interview Survey 2010
Health status			
Annual no. of new cases of diagnosed diabetes (per 1000 persons)	19.1	6.8	National Health Interview Survey 2008-2010
Adults with cardiovascular disease			National Health Interview Survey 2009-2011
18-44 years	12.4	3.4	
45-64 years	27.7	9.7	

Source: Krahn GL, Walker DK, Correa-De-Araujo R (2015). Persons with disabilities as an unrecognized health disparity population. *Am J Public Health*. 105(Suppl 2):S198-S206. doi.org/10.2105/AJPH.2014.302182.

Failure to address health-care needs of people with disabilities is to deny people the right to participate in society. It is a deprivation of their dignity and a violation of their rights. Continued exclusion is unacceptable. Health-care facilities can make improvements so people with disabilities can have better health and consequently participate fully and effectively in society.

More than 270 million people (15% of the population) in the Western Pacific Region experience disability. Disability includes impairments, activity limitations and participation restrictions that result from the interaction between an individual with a health condition and that individual's contextual factors. "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with barriers, may hinder their full and effective participation in society on an equal basis with others" (United Nations Convention on the Rights of Persons with Disabilities, <http://www.un.org/disabilities/convention/conventionfull.shtml>).

Ageing populations, rising prevalence of chronic diseases such as diabetes, hypertension and mental illness, and the upward trend in injuries due to road accidents, natural disasters and conflict are strongly influencing disability prevalence. The health status of people with disabilities is affected not only by their primary conditions but also by unhealthy behaviours and lifestyle choices, and other coexisting or resulting diseases or conditions.

All people with disabilities have the same general health-care needs as everyone else, and therefore need access to mainstream health-care services. Some people with disabilities due to their health conditions require extensive or specialist health care, but other people with disabilities do not have such needs. Health systems frequently fail to respond adequately to both the general and specific health-care needs of people with disabilities.

Health care for people with disabilities is often expensive. Assistive products and adaptive equipment are often costly and difficult to obtain and maintain. Wheelchairs, suitable to different conditions, are costly. Hearing aids, magnifiers and spectacles that could transform lives are often unobtainable, especially in rural and remote areas.

Health system response to the situation is constrained by insufficient and misaligned health financing, lack of community empowerment and engagement, suboptimal health workforce (volume, distribution and competencies), and inappropriate service delivery models. Health service delivery is also affected by sociopolitical changes such as rising costs of health care, innovations in technology, increased citizen advocacy and continued globalization.

People with disabilities encounter a range of barriers when they attempt to access health care.

Prohibitive costs	Affordability of health services and transportation are two main reasons people with disabilities do not receive needed health care in low-income countries. Data show that 32–33% of nondisabled people are unable to afford health care compared to 51–53% of people with disabilities.
Limited availability of services	The lack of appropriate services for people with disabilities is a significant barrier to health care.
Physical barriers	Uneven access to buildings (e.g. hospitals, health centres), inaccessible medical equipment, poor signage, narrow doorways, internal steps, inadequate bathroom facilities, and inaccessible parking areas are examples of physical barriers to health-care facilities. For example, women with mobility difficulties are often unable to access breast and cervical cancer screening because examination tables are not height-adjustable and mammography equipment only accommodates women who are able to stand.
Inadequate skills and knowledge of health workers	<p>People with disabilities are more than twice as likely to report finding health-care provider skills inadequate to meet their needs, four times more likely to report being treated badly and nearly three times more likely to report being denied care.</p> <p>Misconceptions among health workers about the health of people with disabilities lead to assumptions that they do not require access to health promotion and disease prevention services and programmes.</p> <p>Some people with disabilities encounter lack of respect or negative attitudes and behaviour towards them. They also experience informational barriers and communication difficulties; and receive inadequate information about their right to access health-care services.</p>

Source: WHO 2016. *Disability and health: factsheet*. Geneva (<http://www.who.int/mediacentre/factsheets/fs352/en>).



Action to remove barriers

Governments can improve health outcomes for people with disabilities by improving access to quality and affordable health-care services that make the best use of available resources. As several factors interact to inhibit access to health care, reforms in all the interacting components of the health-care system are required.

Policy and legislation	Assess existing policies and services, identify priorities to reduce health inequalities and plan improvements for access and inclusion. Make changes to comply with the UN Convention on the Rights of Persons with Disabilities. Establish health-care standards related to care of persons with disabilities with enforcement mechanisms.
Financing	Where private health insurance dominates health-care financing, ensure that people with disabilities are covered and consider measures to make the premiums affordable. Ensure that people with disabilities benefit equally from public health-care programmes. Use financial incentives to encourage health-care providers to make services accessible and provide comprehensive assessments, treatment and follow-up. Consider options for reducing or removing out-of-pocket payments for people with disabilities who do not have other means of financing health-care services.
Service delivery	Provide a broad range of modifications and adjustments (reasonable accommodation) to facilitate access to health-care services. For example, change the physical layout of clinics to provide access for people with mobility difficulties or communicate health information in accessible formats such as Braille. Empower people with disabilities to maximize their health by providing information, training and peer support. Promote community-based rehabilitation (CBR) to facilitate access for people with disabilities to existing services. Identify groups that require alternative service delivery models, for example targeted services or care coordination to improve access to health care.
Human resources	Integrate disability education into undergraduate and continuing education for all health-care professionals. Train community workers so that they can play a role in preventive health-care services. Provide evidence-based guidelines for assessment and treatment.
Data and research	Include people with disabilities in health-care surveillance. Conduct more research on the needs, barriers and health outcomes for people with disabilities.

With the goal of “better health outcomes for people with disabilities” in mind, WHO proposes five steps (dimensions of change) to work towards disability-inclusive health facilities.

Goal	Dimensions of change	Actions for change (some examples)
<p><i>Better health outcomes for people with disabilities</i></p>	<p>People with disabilities are treated with respect and dignity.</p>	<ul style="list-style-type: none"> ✓ Promote disability inclusion through policy reform. ✓ Develop human resource capacity to deliver disability-inclusive care.
	<p>Health facilities and service delivery are accessible (physical and communication) to people with disabilities.</p>	<ul style="list-style-type: none"> ✓ Improve skills of the health workforce. ✓ Adopt reasonable accommodation including additional time to carry out adapted procedures.
	<p>Health care is available and affordable for people with disabilities.</p>	<ul style="list-style-type: none"> ✓ Increase awareness of people with disabilities on health-care services and financing options. ✓ Reach out to people with disabilities who cannot go to health facilities.
	<p>Achieve people-centred and integrated health service delivery</p>	<ul style="list-style-type: none"> ✓ Ensure continuous referral pathways.
	<p>People with disabilities and disabled people’s organizations have an opportunity for participation in decision-making regarding health.</p>	<ul style="list-style-type: none"> ✓ Provide people with disabilities with the education and support they need to make decisions and participate in their own care. ✓ Partner with disabled people’s organizations.



Suggestions for accomplishing the dimensions of change

The following are suggestions for accomplishing the steps/dimensions of change.

People with disabilities are treated with respect and dignity.

Many people with disabilities are discouraged to seek health care because they were treated badly in the health-care system, were denied health care or experienced inadequate health-care provider skills and facilities. Health-care practitioners can:

- ◆ Partner with local disabled people's organizations (DPOs) that can help facilitate disability-awareness sessions for the entire staff of the health facility and recommend ways to make its system more disability-inclusive.
- ◆ Provide health-care staff with continuing education about disability such as communicating in appropriate formats, finding information about how to access disability resources, coordinating care, making reasonable accommodations for people with disabilities, addressing health needs (including sexual and reproductive needs), and assisting people with disabilities in using the health facilities (including completing forms and educating about health).
- ◆ Have an organizational or facility-level disability anti-discrimination policy.

Health facilities and service delivery are accessible (physical and communication) to people with disabilities.

Women and men with disabilities can face physical barriers in accessing health care. Some people with disabilities regularly cite communication difficulties between themselves and service providers as an area of concern. Health-care practitioners can:

- ◆ Make structural modifications to facilities to make them accessible for all people with disabilities.
- ◆ Use equipment with universal design features.
- ◆ Communicate information in appropriate formats.
- ◆ Link with translation services.
- ◆ Use information and communication technologies.

Health care is available and affordable for people with disabilities.

More than half of people with disabilities cannot afford health care. Affordability was the primary reason people with disabilities, across gender and age groups, did not receive needed health care in low-income countries. Health ministries can:

- ◆ Raise sufficient resources for health by increasing the efficiency of revenue collection, reprioritize government spending and development assistance, and promote efficiency and eliminate waste.
- ◆ Remove financial risk and barriers to access like providing affordable health insurance and general payments to improve access.
- ◆ Target people with disabilities who have the greatest health-care needs.

Achieve people-centred and integrated health service delivery.

People with disabilities are frequent users of the health-care system. Many seek more collaborative relationships in managing primary, secondary and co-morbid health conditions. Health practitioners can:

- ◆ Support primary health-care workers to work with specialists who may be located elsewhere.
- ◆ Explore the options for use of information and communication technologies for improving services, health-care capacity and information access to persons with disabilities.
- ◆ Identify groups who require alternative service delivery models, for example targeted services and care coordination to improve access to health care.
- ◆ Coordinate care by identifying a care coordinator and compiling a directory of referral services.

People with disabilities and disabled people's organizations have an opportunity for participation and decision-making regarding health.

Health practitioners can:

- ◆ Educate and support people with disabilities to manage their health.
- ◆ Provide time-limited, self-management courses involving peer support to enable people with disabilities to better manage their health.
- ◆ Involve family members and caregivers in service delivery where appropriate. Family members and caregivers can support the health-seeking behaviours of people with disabilities.

Additional information

World Health Organization

http://www.wpro.who.int/disability_rehabilitation/en/

<http://www.who.int/disabilities/actionplan/en/>

<http://www.who.int/disabilities/publications/care/en/>

CBM

<http://www.cbm.org/Publications-252011.php>

Development for All

<https://www.did4all.com.au/ResourceTheme.aspx?a4f44d2b-7700-452d-80bd-4a833388b1b0>

Nossal Institute for Global Health, University of Melbourne

<http://mbspgh.unimelb.edu.au/research-groups/nossal-institute-for-global-health/inclusive-health-and-development>

Department of Foreign Affairs and Trade, Australia

<http://dfat.gov.au/about-us/publications/Pages/accessibility-design-guide-universal-design-principles-for-australia-s-aid-program.aspx>

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