Disabled people's access to healthcare services

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The United Kingdom as a signatory of the UNCRPD should recognise 'that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability' and shall provide health services needed persons with disabilities specifically because of their disabilities (Article 25). In particular States Parties shall prevent 'discriminatory denial of health care or health services or food and fluids on the basis of disability.'

With this in mind, this paper summarises some key points from Policy Brief of the UN Secretary-General: A Disability-Inclusive Response to COVID-19. It is well established that COVID-19 has disproportionately impacted disabled people and the effects of the coronavirus pandemic has heightened the anxiety we face. It is important however to unpack the distinct reasons for this disproportionate impact, in order to target solutions that can address the problems.

Disabled people face three distinct but related dimensions of increased risk of COVID-19:

1. Increased risk of contracting the disease;
2. Increased risk of developing a severe case of the disease once contracted;
3. Increased risk of negative secondary consequences from the COVID-19 response.

Disabled people have an increased risk of contracting COVID-19. This higher risk results from environmental barriers that limit protection against infection. One barrier is the lack of timely and accessible public health information, without which disabled people may not receive the necessary information, or receive it too late. Other barriers include lack of necessary accommodations to facilitate the implementation of basic public health behaviours, such as frequent hand-washing and maintaining physical distance. Case patterns have shown that that in places where physical distancing is a challenge, such as institutional settings, disabled people and older people are more likely to contract the disease.

Disabled people have an increased risk of developing a severe case of COVID-19 once contracted. ONS data shows disabled people are disproportionally represented among severe cases and deaths of COVID-19 in the UK. Though more research is needed on the causes of this, we can assume that that disabled people are disproportionally represented among severe cases and deaths, firstly, because many disabled people have underlying health conditions that are exacerbated by COVID-19. Secondly, disability increases with age, and current data show clearly that COVID-19 affects older populations more severely.

Beyond underlying health conditions that increase risk of severe infection, **disabled people may also develop severe cases of COVID-19 due to inaccessible health care.** It is well known that in general, disabled people experience barriers in accessing health services. In the context of the COVID-19 response, these barriers are exacerbated. Barriers to transportation may also prevent disabled people from even reaching a health-care facility in time to receive needed care. Furthermore, once in the facility, physical barriers, or barriers in communication or attitudes may be present. Indeed, evidence is mounting on the inconsistency with World Health Organisation standards of the UK's Government's guidance on combating coronavirus in care. All of these barriers may worsen in the context of an emergency situation such as COVID-19. Additionally, during the outbreak, some health systems have become overburdened in their efforts to provide care to a large number of people, in

part due to limited resources such as in emergency care beds and ventilators. This can lead to resource allocation decisions being made that put disabled people at a high level of disadvantage. Such barriers in the UK context have left disabled people in doubt about their right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability.

Disabled people have an increased risk for negative secondary consequences from the COVID-19 response, even if they don't contract COVID-19 themselves. As described in Professor Jonathan Herring's powerful essay on shielding (see below), measures to keep the outbreak under control can lead to poorer health outcomes for disabled people. Firstly, although country lockdowns and mandates can have positive consequences for controlling the outbreak, there can be negative consequences for disabled people. Lockdowns can lead to restricted access to essential goods and medicines and can also lead to restricted access to the personal care needed for disabled people to perform activities of daily living. Restrictions in access to public spaces can also make it harder for disabled people to undertake healthy behaviours such as physical activity or socialising. Not performing healthy behaviours can have direct physical and mental health consequences, including an increased risk of depression.

Secondly, in order to provide the level of care needed to control the outbreak of COVID-19, governments may reduce other health services to an absolute minimum. The disruption of these necessary services puts disabled people, who often require access to health-care services more frequently, at a disadvantage in maintaining their general health.

Recommendations

1. **Ensure access to accessible public health information for disabled people**. This includes providing information in accessible formats such as captioning, sign language, Easy Read, and formats accessible by electronic screen readers. Accessible public health information should also be distributed directly to community networks of disabled people.
2. **Ensure that disabled people have access to health care services they need over the course of the outbreak**. This includes regular health care services, but also services related to COVID-19 treatment. Disabled people must have access to scare health resources such as ventilators on an equal basis with others.
3. **Ensure that reasonable adjustments disabled people had in place prior to the COVID-19 outbreak remain operational**. This includes any provision of water, sanitation, health care waste management, hygiene and environmental cleaning infrastructure in healthcare facilities, care services and transportation.