How do we improve access to healthcare for people with disabilities?

The question and the problem

Gaining access to healthcare is often a challenge for people with disabilities in low- and middle-income countries. Part of this has to do with a general dearth of healthcare services in low-resource settings. But part of this difficulty has to do with structural, attitudinal, economic and social barriers to participation and healthcare which affect people with disabilities more than people without disabilities. This lack of access to healthcare is a problem because, in general, people with disabilities may need to access healthcare more frequently than people without disabilities. Full and equitable access to quality healthcare is a human right, and an important imperative of the global agenda. This evidence brief summarises what we know about how to improve access to healthcare for people with disabilities in low-resource settings.

Recommendations

- Recommendation #1: Train generalist healthcare workers to provide healthcare to people with disabilities.
- Recommendation #2: Train nurses or community health workers to provide specialist knowledge concerning disability within general healthcare settings.
- Recommendation #3: Deliver preventative health checks for people with disabilities.
- Recommendation #4: Deliver anti-stigma interventions for mainstream healthcare.
- Recommendation #5: Reasonable accommodations need to be made to make healthcare accessible to people with disabilities.
- Recommendation #6: Coordinated care and multi-sectoral coordination of care for people with disabilities seems to have positive effects, but models which work in LMIC need to be explored

"States Parties will provide persons with disabilities with the same range, quality and standard of free affordable health care and programmes as provided to other persons."

[Article 25, UNCRPD, Jan 2007]

Challenges

Challenge #1: Healthcare workers do not know how to work with people with disabilities or have negative attitudes towards disability.

- There is a need for increased training for generalist healthcare workers in providing healthcare to people with disabilities. Supervised placements, resource packs, workshops, e-learning resources and service user-led trainings could improve healthcare workers' capacity.
- Train nurses or community health workers to provide specialist knowledge concerning disability within general healthcare settings.

Challenge #2: Because people with disabilities may face additional health risks, there is a need for preventative care, but this does not often happen.

- Health checks for people with disabilities are important. These routine check-ups can be conducted by a community health worker or nurse. What is important is that healthcare workers should implement health assessment tools for people with disabilities to during routine visit.

Challenge #3: People with disabilities are excluded from decision-making and management of healthcare.

- Although many reviews note that the views and preferences of people with disabilities need to be integrated in assessment, goal-setting and intervention, there does not appear to be evidence concerning which way of engaging service users in this process is most effective.

Challenge #4: Healthcare facilities make be inaccessible to people with disabilities, due to attitudinal and physical barriers.

- Although many reviews note that healthcare facilities need to comply with standards for accessibility, there is little information applicable to low-resource contexts, about how to improve physical accessibility.
- Anti-stigma interventions for mainstream healthcare workers could include both education and contact as key components. Educational interventions may improve the self-efficacy of healthcare workers to provide healthcare to people with disabilities, but attitude change is also necessary.

Challenge #5: People with disabilities are not reasonably accommodated during the care-seeking process.

- Reasonable accommodations need to be made to make healthcare accessible to people with disabilities. These include specific protocols for people with disabilities during admission, outpatient services, discharge planning and follow-up.
- 'Positive discrimination' can be used to reduce waiting times to ensure that people with disabilities do not have to spend too long at the clinic, and videos, accessible information, and books can help to better prepare people with disabilities for healthcare appointments and procedures.

Challenge #6: Care for people with disabilities may be fragmented and there is a lack of clear leadership to drive provision.

- Positive discrimination and multi-sectoral coordination of care for people with disabilities seems to have positive effects, but models which work in LMIC are not available.
- Many reviews note the relevance of collaboration between Departments/Ministries and between different care provision stakeholders to facilitate coordinated care for people with disabilities, but no models from LMIC could be identified.

How did we find answers

We conducted a review of reviews, examining systematic, narrative, and other types of review evidence on the topic of access to healthcare for people with disabilities. All recommendations are based on reviews of literatures from low- and middle-income countries, as well as some reviews of literature from high-income countries where the recommendations made were transferable to low-resource settings. This evidence note is based on the findings of 4 reviews of low- and middle-income country evidence, 1 review which covered literature from a range of settings, and 8 reviews concerning evidence from high-income countries.

Evidence-informed Recommendations and Actions

Key Recommendations	Actions
Train generalist healthcare workers to provide healthcare to people with disabilities.	*Supervised placements, resource packs, workshops, e-learning resources and service user-led trainings could improve healthcare workers' capacity.*
Train nurses or community health workers to provide specialist knowledge concerning disability within general healthcare settings.	*Champions with specific training could be placed at the community or facility level, to advise on disability.*
Deliver preventative health checks for people with disabilities	*A community health worker or nurse can conduct these routine check-ups. What is important is that healthcare workers should implement health assessment tools for people with disabilities during routine touch points.*
Deliver anti-stigma interventions for mainstream healthcare workers.	*Healthcare provider attitude change interventions could include both education and contact as key components.*
Reasonable accommodations need to be made to make healthcare accessible to people with disabilities.	*These include specific protocols for people with disabilities during admission, outpatient services, discharge planning and follow-up. Positive discrimination can be used to reduce waiting times to ensure that people with disabilities are the first to be seen.*
Coordinated care and multi-sectoral coordination of care for people with disabilities seems to have positive effects, but models which work in LMIC need to be explored	*Many reviews note the relevance of collaboration between Departments/Ministries and between different care provision stakeholders to facilitate coordinated care for people with disabilities, but no models from LMIC could be identified.*

Policy priorities

Disability and services for people with disabilities should be integrated within well-known, pre-existing Ministerial models of healthcare, leveraging existing provision to support the sustainability of services. Multi-sectoral coordination between governmental Departments/Ministries, allied agencies, non-governmental organisations, and community-based partners, will be important for people with disabilities to received holistic support. Yet, clear leadership – possibly from a single Department/Ministry – is required at the national and sub-national levels to coordinate activities. Governance, political will and a common understanding of what it means to reasonably accommodate people with disabilities are crucial for implementation of programming.

Conclusion

In general, there is a lack of review evidence from low- and middle-income countries specifically dealing with improving access to healthcare for people with disabilities. This seems to be indicative of a lack of evidence from these settings, as many systematic reviews simply did not find any studies from low- and middle-income countries to include. Many of the reviews used quality ratings for their evidence, and much of the evidence was considered low quality. Still, some recommendations recur throughout the literature, and may be possible to implement in low- and middle-income countries.

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GAPS & RESEARCH NEEDS

There is an urgent need for more research conducted within LMIC as recommendations made in HIC may not be feasible in LMIC in terms of resource needs for implementation of interventions. There is little concrete evidence regarding how to improve physical accessibility of healthcare facilities in low-resource settings.

Further, although many reviews note that the views and preferences of people with disabilities need to be integrated in assessment, goal-setting and intervention, there does not appear to be evidence concerning which way of engaging service users in this process is most effective.

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