

Redefining Medicine: Inclusive Practices for Disability - Friendly Healthcare Delivery

Arjunveer Khera

Vasant Valley School, Delhi, India

Email: arjun71veer[at]gmail.com

Abstract: *Healthcare and medicine are critical in fostering equality and providing accessible services to individuals with impairments. However, there is still an urgent need to reshape medicine and embrace inclusive practices that prioritise disability - friendly healthcare delivery. This study investigates the significance of building an environment that accommodates a wide range of demands, encourages patient autonomy, and promotes equal healthcare opportunities for people with disabilities. In this research, we examine the current state of disability - friendly healthcare and highlight the barriers to quality care that patients with disabilities face. We highlight the existing gaps in healthcare infrastructure, communication, and provider training that hinders effective healthcare delivery for this marginalized population. To address these issues, we propose a framework that encompasses physical accessibility enhancements, such as barrier - free facilities and assistive technologies, to ensure equitable access for patients with disabilities. Furthermore, we emphasize the importance of cultivating a patient - centred approach that respects individual autonomy, cultural sensitivity, and effective communication strategies, including accessible information and communication technologies.*

Keywords: Accessibility World Health Organization, Care, Policy

1. Introduction

According to the 2010 United Nations World Population Prospects, it is estimated that about 15% or 1 billion people live with some form of disability. According to the World Health Organization's Global Health Survey, approximately 785 million people aged 15 and over live with a disability. Of these, approximately 110 million (2.2%) are severely disabled, i. e., disabled due to conditions such as quadriplegia, major depression, and blindness. The number of people with disabilities is increasing. This is due to an aging population (older people are at higher risk of disability) and a global increase in chronic health conditions related to disorders such as diabetes, cardiovascular disease, and mental illness. Chronic diseases account for an estimated 66.5% of all years spent with disability in low - and middle - income countries (WHO, 2008). Disability patterns in specific countries are influenced by trends in health, environment, and other factors such as traffic accidents, natural disasters, conflict, diet, and substance abuse. (UNICEF, 2008).

Reports from the Commission on the Rights of Persons with Disabilities (CRPD) and the International Classification of Functioning, Disabled and Disabled (ICF) highlight the role of the environment in facilitating or restricting the participation of persons with disabilities. Some of them are listed below:

- Inadequate policies and standards – Policies do not always address the needs of people with disabilities. For example, a survey of 28 countries participating in the "Education for All" Fast Track Initiative Partnership found that 18 countries received suggestions for integrating children with disabilities into schools. It turned out that they provided little detail about their strategy or did not address disability or inclusion issues at all. (Bynes, 2009)
- Inadequate service provision – People with disabilities are particularly vulnerable to a lack of services such as

health care, rehabilitation, assistance, and support. A study in the Indian states of Uttar Pradesh and Tamil Nadu found that lack of services in the community was the second most common reason people with disabilities did not use health facilities, after cost. (World Bank, 2009)

- Insufficient funding – Resources allocated to implement policies and plans are often inadequate. For example, in high - income countries, typically 20% to 40% of persons with disabilities have an unmet need for assistance with daily living. In many low - and middle - income countries, governments are unable to provide adequate services, and commercial service providers are either unavailable or unpaid for most households. His 2002–Her 2004 World Health Survey analysis of 51 countries found that people with disabilities have greater difficulty obtaining exemptions or reductions in medical costs than people without disabilities. I understand.

There is ample evidence that people with disabilities are more likely to have poor health than the general population due to different mechanisms that may differ among people with different disabilities. First, by definition, they have a primary disorder, which can be an increasingly serious medical condition, such as multiple sclerosis or muscular dystrophy. Second, many people with disabilities are at increased risk of secondary health conditions causally related to their primary diagnosis or disability. Third, people with disabilities are also at increased risk of comorbidities that do not have direct causes. In many cases, comorbidities may result from the increased risk of poverty and social exclusion that people with disabilities may face. Breaking down barriers and isolation can have different effects on people with disabilities. (Shakespeare et al., 2018).

2. Background

Research by Shakespeare et al. says there is limited evidence that people with disabilities have less access to universal

Volume 12 Issue 11, November 2023

www.ijsr.net

Licensed Under Creative Commons Attribution CC BY

health services than people without disabilities. There are several possible reasons for this conclusion, but further research is needed. There is a lack of quality data collection to capture the full extent, not just usage. Using such crude metrics can obscure differences in access to healthcare between people with and without disabilities. Another possibility is that people with disabilities may have more difficulty accessing services, but those who actually need treatment do.

People with disabilities are likely to be more involved in the health care system because of their disability and various health conditions, and this can help overcome some of the barriers they face in obtaining health care. There is evidence that for people with disabilities, the cost of receiving treatment may be higher and the quality of services and healthcare experience may be lower. There is also evidence that people with disabilities have little access to rehabilitation, leaving them without the care they need and are entitled to.

People with disabilities face many hurdles when seeking medical care. Achieving universal health coverage and realization of rights requires strategies to overcome these diverse barriers. People with disabilities are a diverse group, and people with different types of disabilities may be particularly vulnerable to certain types of barriers to accessing services. Disabilities also vary due to differences in geographic, cultural, and political environments. Perhaps the conceptually simple hurdle stems from limited physical access to medical facilities. Obstructions can make access to the facility difficult, but they can also make it difficult to access treatment rooms through elevators and doors and to use restrooms. The availability of accessible and adaptable furniture and equipment is also an important consideration. If these are not available, people with disabilities may not be tested or tested to the same standards as others. Other types of barriers may be less recognized and understood. (Shakespeare, 2018)

Negative attitudes can also be a significant barrier to access to health care for people with disabilities. Stigma against people with disabilities is widespread and can prevent people from accessing health services. This experience can be further complicated when a person with a disability hails from a particular racial or ethnic minority group, presenting a cross-section of disadvantages. (Grech, 2016) Stigma can also lead to the complete exclusion of many people with disabilities from certain health efforts. For example, people with disabilities are often misunderstood as sexually inactive and may be denied access to sexual and reproductive health education and care. (Tepper, 2000) This can also result in certain services being underutilized by people with disabilities, misinterpreted as a lack of need rather than as a result of exclusion or barriers to access. In Argentina, Human Rights Watch documented in 2010 long-delayed, unnecessary barriers to access to reproductive health services for women with disabilities, including contraception, voluntary sterilization, and post-rape abortion. reported poor referrals, outright refusal, and the need for the husband's consent.

3. Discussion

In the COVID - 19 pandemic, India reported more than 44 million cases, the second - highest in the world, and the third - highest number of deaths, surpassing 500, 000. Aside from the enormous loss of life, the impact of the pandemic on health systems and on people with disabilities has also been overlooked. Of the 146 people who responded to a question about the availability of medical services, 33.5% said they felt these services were unavailable during the pandemic, according to a report by Vidhi Legal Policy. He said 69.5% of the 239 respondents were able to register on the CoWIN platform. However, of the 69.5% of respondents who were able to self - register, only 33.1% did not require external support, and the remaining respondents required external support for vaccination registration. Of the total available population, 52.8% were prioritized for vaccination. 87.7% of the respondents said they had no chance to participate in the house - to - house vaccination.

Mariadi et al. Addressing the issue of diversity and intersectionality, Al outlined practical tips for inclusive medical practice and service delivery in his paper. They are listed like this:

- Beware of Assumptions and Stereotypes – Healthcare professionals must avoid assumptions that can interfere with an accurate and complete picture of an individual's medical and personal background. Uncontrolled beliefs are barriers to accessing health services and establishing comprehensive, patient - centred care. undermining care.
- Replace labels with appropriate terminology – Healthcare providers should keep up to date with best practice terminology for patient - centered care. Patients may prefer neutral, nonjudgmental language that is factual and biology - based and/or emphasizes health and health behavior. Labels such as "schizophrenia" and "obesity" may equate the person with the condition, and terms such as "disobedience" and "disobedience" may imply blame or criticism. there is. Preferred terms include factual phrases such as "high blood sugar". Words that reflect a common purpose, such as 'conformity' rather than 'nonconformity'. and neutral descriptors such as 'living together' instead of 'suffering'.
- Ensuring inclusiveness in physical space – A physical healthcare environment that is inclusive and addresses a patient's diverse physical, sensory, and cognitive needs has been shown to enhance the patient experience (Myerson, 2015). The World Health Organization has developed seven modules and fact sheets to help healthcare organizations implement more accessible practices. Some accessibility requirements (such as ramps and elevators) may be regulated, but not all, and HCWs must address additional requirements that are not yet regulated. For example, doors should be wide enough to pass through for people using power wheelchairs or power scooters. Furniture, gowns and equipment (such as blood pressure cuffs and scales) should be suitable for a range of body sizes.
- Ensure Appropriate Communication Methods – In addition to using appropriate and inclusive language, healthcare professionals should assess client/patient preferred communication methods. Culturally appropriate communication is the cornerstone of individual - centered care and considers linguistic,

cultural, racial, ethnic, religious, and sexual diversity. Understanding the patient's background is essential to avoid frustrating and ineffective consultations for both healthcare professionals and patients. Health worker training on intercultural communication includes language/culture - specific written information, audio channels for those with low native language literacy, culture/language - specific training for staff, publicly funded

- Advocating for a more inclusive health system – To meet the needs of diverse populations when operating complex health systems, we need to advocate for the alignment of health and social services. Institutional barriers such as eligibility requirements, lack of integration of benefits, discrimination, referral procedures, waiting times, welfare, disability, or child support negotiations are exacerbated by social and structural factors.

Accessibility, restrooms, and facilities within the building should also be considered. Provisions are also needed to ensure that information can be provided in a variety of formats to meet the needs of people with various disabilities. Considering these accessibility aspects when designing your service will be most beneficial and efficient. Providing services at or near their place of residence also helps improve access, especially for people with physical or multiple disabilities. Improved coverage can also be achieved by promoting the inclusion of people with disabilities in decision - making and health care delivery, whether at the central or local level. Examples include training health professionals in disability awareness and the rights of people with disabilities through regular online and other courses, or ideally as part of the health care curriculum.

4. Conclusion

The lack of information on the prevention and treatment of secondary diseases and general health problems in people with disabilities indicates that there is a great need for training of national primary care providers. Training should also be offered to general health organizations, especially in government agencies. The results of this study can be used to raise awareness of the barriers faced by disabled people. Primary care providers who work in a community health center and community health workers who come into contact with many people in the community will benefit from the training. Social initiatives such as income generation and health education activities should be inclusive of people with disabilities and their families to reduce stigma and increase help - seeking behavior. Continued initiatives to improve social attitudes should be encouraged to increase social participation. (Hees, 2015)

Social initiatives such as income generation and health education activities should be inclusive of people with disabilities and their families to reduce stigma and increase help - seeking behavior. Disability organizations, healthcare providers, and non - governmental organizations could do this by including people with disabilities in their mainstream programmes. Continued initiatives to improve social attitudes should be encouraged to increase social participation. To address barriers and achieve UHC, three

key dimensions must be considered: population covered, financial coverage, and services covered. Many countries already have laws and practices. Therefore, more effort is needed to make changes at the service and program level rather than at the policy level.

By making health services inclusive, respectful, and barrier - free, access to other vulnerable groups is improved and healthcare delivery generally improves. Strengthening rehabilitation services has similar population benefits because people with short - term disabilities also need them. Improving healthcare services is likely to save costs, reduce future healthcare costs, promote inclusion and increase economic productivity. Overall, these changes will help achieve the goals of UHC and sustainable development by ensuring that health services reach the entire population so they can experience better health, higher productivity and less poverty.

References

- [1] Grech, S., & Soldatic, K., (2016) Disability in the Global South: The Critical Handbook. *International Perspectives on Social Policy, Administration and Practice* <http://dx.doi.org/10.1007/978-3-319-42488-0>
- [2] Human Rights Watch. (2010) *Illusions of Care: Lack of Accountability for Reproductive Rights in Argentina*. <https://www.hrw.org/report/2010/08/10/illusions-care/lack-accountability-reproductive-rights-argentina>
- [3] International Disability Rights Monitor. (2004) *Regional report of the Americas* <http://www.idrmnet.org/content.cfm?id=5E5A75andm=3>
- [4] Marjadi, B., Flavel, J., Baker, K., Glenister, K., Morns, M., Triantafyllou, M., Strauss, P., Wolff, B., Procter, AM., Mengesha, Z. (2023) Twelve Tips for Inclusive Practice in Healthcare Settings. *International Journal of Environmental Research and Public Health*.20 (5): 4657. <https://doi.org/10.3390/ijerph20054657>
- [5] Myerson, J., West, J. (2015) Make It Better: How universal design principles can have an impact on healthcare services to improve the patient experience. *In Proceedings of the Universal Design in Education Conference*. <https://arrow.tudublin.ie/cgi/viewcontent.cgi?article=1005&context=exdesthel>
- [6] Shakespeare, T., Bright, T., & Kuper, H. (2018). Access to health for persons with disabilities. *International Centre for Evidence in Disability*. https://www.ohchr.org/Documents/Issues/Disability/StandardHealth/BackgroundDoc_EGM_Righttohealth.docx
- [7] Stanford, F. C. (2020). The Importance of Diversity and Inclusion in the Healthcare Workforce. *Journal of the National Medical Association*. doi: 10.1016/j.jnma.2020.03.014
- [8] Tepper, M. S., (2000) The Missing Discourse of Pleasure. *Sexuality and Disability* **18**, 283–290. <https://doi.org/10.1023/A:1005698311392>
- [9] Thiagesan, R., Gopichandran, V., & Soundari, H. (2023) Ethical Framework to Address Barriers to

Healthcare for People with Disabilities in India. <https://doi.org/10.1007/s41649-023-00239-4>

- [10] United Nations Children's Fund. (2008) *Monitoring child disability in developing countries* https://www.unicef.org/protection/Monitoring_Child_Disability_in_Developing_Countries.pdf
- [11] UN World Health Organization. (2011) *World Report on Disability: Summary*. <https://www.refworld.org/docid/50854a322.html>
- [12] van Hees, S., Cornielje, H., Wagle, P., & Veldman, E. (2014). Disability Inclusion in Primary Health Care in Nepal: An Explorative Study of Perceived Barriers to Access Governmental Health Services. *Disability, CBR and Inclusive Development*, 25 (4), p.99 - 118. DOI: <https://doi.org/10.5463/dcid.v25i4.373>
- [13] Vidhi Centre for Legal Policy. (2022, November 10). COVID - 19, Persons with Disabilities and an (Un) Inclusive Healthcare System. <https://vidhilegalpolicy.in/research/covid-19-persons-with-disabilities-and-an-uninclusive-healthcare/>
- [14] World Health Organization. (2004). *World Health Survey* <http://www.who.int/healthinfo/survey/en/>
- [15] World Health Organization. (2004) *The Global Burden of Disease* <https://apps.who.int/iris/handle/10665/43942>