Impact of the COVID-19 pandemic on people with disabilities and implications for health services research

Journal of Health Services Research & Policy
2023, Vol. 28(2) 77–79

DOI: 10.1177/13558196231160047
journals.sagepub.com/home/hsr
SAGE

The COVID-19 pandemic significantly constrained health systems worldwide, exposing and exacerbating multi-layered health inequities. People with disabilities, about 16% of the global population, often experience worse health outcomes than people without disabilities due to multiple barriers to accessing health care.[1] These inequalities have been particularly exposed during the pandemic, indicating a pressing need to strengthen health systems so that they are inclusive and responsive to the needs of people with disabilities including during crises.

Even in non-crisis contexts, people with disabilities face inaccessible services, lack of appropriate transport to and from health care facilities, high out-of-pocket expenditure, and stigma and discrimination from health care workers.[2] COVID-19 exacerbated many of these existing challenges, widening health inequalities.[3,4] For example, a study in Vietnam found that people with disabilities were three times more likely to report their access to health care was ‘a lot worse’ during the pandemic compared to their peers without disabilities and a third reported additional barriers to accessing disability-related health care.[5]

People with disabilities were particularly affected by changes in routine services because of diversion of health care staff and facilities to respond to the pandemic, given that many have higher needs for health services, such as rehabilitation, medications or other specialist services. Where disability-related health and social care services for children are delivered through schools, school closures adversely impacted not only learning outcomes of children with disabilities but also their health and functioning. Even when services were available, fear of infection could influence health-seeking behaviour, especially where required services are provided in large hospitals that were at the forefront of COVID-19 responses. Caring arrangements for people with disabilities such as support from personal assistants, family members and friends were frequently disrupted due to lockdowns and social distancing regulations, which made it harder to connect with others and travel to health facilities.[6]

The pandemic also affected the ability of people with disabilities to pay for services. For example, disruptions to accessing routine services in the public sector meant that many people with disabilities either had to pay large amounts for privately provided health services or simply go without needed health care.[6] Inflation also affected the cost of goods and services, particularly medicines and assistive devices, further straining household budgets.[7] This, combined with rising cost of living, increased the risk of acute economic impoverishment resulting from loss of jobs and earnings. Not only were people with disabilities at higher risk of poverty before the pandemic, there is some evidence that they were more likely to lose their jobs during the pandemic than people without disabilities.[8] The combination of these factors has substantially constrained access to required routine health services for people with disabilities, with significant negative impacts on functioning and wellbeing.

COVID-19 specific preventative and response measures were seldom designed with disability inclusion in mind. Yet, people with disabilities are at particularly elevated risk of morbidity and mortality from COVID-19.[9] This exclusion of people with disabilities is reflective of their larger political, economic, and social marginalisation, which precluded consideration of their different needs and vulnerabilities from response measures globally.[4,5] Importantly, the access and communication needs of people with disabilities were largely neglected from the outset of the COVID-19 response.[3–5] For instance, the dissemination of information about COVID-19 and strategies for preventing infection were not often available in accessible formats (e.g. Braille, sign language or Easy Read). Further, measures such as social distancing, mask-wearing and hygiene protocols did not always include adaptations for people with disabilities (e.g. exemptions to social distancing for people requiring personal assistance). People with disabilities also faced increased barriers to accessing COVID-19 vaccines, including difficulties in booking vaccination appointments, travelling to vaccination centres, lack of support to attend appointments and physical inaccessibility of centres.[10]

It does not have to be this way as a range of encouraging examples of more inclusive health system responses illustrate. For instance, evidence from Southwest China indicates that uptake of telerehabilitation services was improved by developing easy to use platforms, educating health care providers on their use, promoting awareness in communities, and ensuring continuous communication between patients and providers.[11] Telemedicine has substantial potential to enhance access to health services for people with disabilities, including during emergencies: it can reduce cost and travel barriers to access key services, particularly for those living in remote areas or where specialist services are heavily centralised. Still, its uptake is restricted in many settings by factors such as limited availability in the public sector, prohibitive costs, lack of access to electronic devices and the internet, inaccessibility of telemedicine platforms, and lower levels of digital literacy.[6] It is also imperative to recognise that technology-based interventions may be inappropriate for people with certain impairments and underlying health conditions; hybrid alternatives need to be designed accounting for individual needs and contexts.

The voluntary sectors, particularly Organisations of People with Disabilities (OPDs) and non-governmental organisations (NGOs), have stepped in to fill the void left by tenuous system responses.[4] In many settings, OPDs and NGOs were instrumental in advocating for inclusive adaptations to response measures, translating information into accessible formats and distributing food and medicines. Yet, OPDs and NGOs should not be used as a substitute for effective and inclusive health system responses. OPDs and people with disabilities must be actively engaged by state actors in designing and implementing policies, including emergency responses such as COVID-19. Australia's COVID-19 response was informed by people with disabilities, their families and carers, and service providers.[12] This was reflected in key measures such as a website with accessible information, publicly funded telemedicine, COVID-19 hotlines with options for video calls with alternative communication for people with hearing and speech impairments, individualised emergency preparedness plans and community-based routine care including disability-related services.

As we seek to learn lessons for living with COVID-19, there are opportunities to move to stronger, more responsive and inclusive health systems, with a particular focus on building institutional capacities to include people with disabilities. Health services research can help address the challenge of maintaining continuity of care during current and future crises as well as addressing systematic inequalities in the health sector that marginalise people with disabilities during crisis and non-crisis times. Further research is needed to explore the effectiveness of interventions to improve access to health care for people with disabilities and the resilience of these interventions in the face of disruptions (e.g. future epidemics and humanitarian crises). Importantly, there is a need to decentralise and provide timely, affordable and consistent access to good quality disability-related services, including rehabilitation, such as through community-based interventions. Evidence on the effectiveness of interventions to address pervasive biases in health systems and ensure all services are inclusive of and responsive to the needs of people with different types of disabilities is also critical for informing planning. Further, information systems used to track health and other outcomes during crises should include data on disability to enable real-time disaggregation to understand the impact on people with disabilities and monitor whether people with disabilities are being adequately reached and included in response activities. Finally, research is needed to understand the extent to which people with disabilities, and their representative organisations, are engaged in health service design and delivery and to identify strategies to maximise their active participation.

Declaration of conflicting interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was supported by the Foreign, Commonwealth and Development Office (COVID Collective and PENDA project (PO8073)).

ORCID iD

Lena Morgon Banks https://orcid.org/0000-0002-4585-1103

References

1. World Health Organisation W. *Global report on health equity for people with disabilities*. Geneva, Switzerland: World Health Organization, 2022.
2. Missing Billion Initiative and Clinton Health Access Initiative. Reimagining Health Systems that Expect, Accept and Connect 1 Billion People with Disabilities. *Missing billion initiative and clinton health access initiative*, 2022.
3. Kuper H, Banks LM, Bright T, et al. Disability-inclusive COVID-19 response: What it is, why it is important and what we can learn from the United Kingdom's response. *Wellcome Open Res* 2020; 5:79.
4. Shakespeare T, Watson N, Brunner R, et al. Disabled people in Britain and the impact of the COVID-19 pandemic. *Soc Policy Adm* 2022; 56: 103–117.
5. Mai VQ, Ngoc LA, Goyal D, et al. *People with disabilities during the COVID-19 pandemic in Vietnam: summary brief.*

London, UK: International Centre for Evidence in Disability & Hanoi University of Public Health, 2023.

6. Hunt X ST, Smythe T, et al. Impacts of the COVID-19 Pandemic on Access to Health Care for People with Disabilities: Evidence from 6 Low- and Middle-Income Countries. In press.
7. Mont D, Layton N, Puli L, et al. Assistive technology during the COVID-19 global pandemic: The roles of government and civil society in fulfilling the social contract. *Int J Environ Res Public Health* 2021; 18: 12031.
8. Hasan MT, Das AS, Ahmed AI, et al. COVID-19 in Bangladesh: an especially difficult time for an invisible population. *Disability & Society* 2021; 36: 1362–1367.
9. United Kingdom Office for National Statistics. *Updated estimates of coronavirus (COVID-19) related deaths by disability status*, England: 24 January 2020 to 9 March 2022, https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronaviruscovid19relateddeathsbydisabilitystatusenglandandwales/24january2020to9march2022 (2022, accessed Jan 2023).
10. Rotenberg S and Nagesh S. Opinion: Many people with disabilities lack access to COVID-19 vaccines. *Devex*, https://www.devex.com/news/opinion-many-people-with-disabilities-lack-access-to-covid-19-vaccines-100081 (2021, accessed Jan 2023).
11. Zhu S, Zhang L, Xie S, et al. Reconfigure rehabilitation services during the Covid-19 pandemic: best practices from Southwest China. *Disabil Rehabil* 2021; 43: 126–132.
12. Kavanagh A, Dickinson H, Carey G, et al. Improving health care for disabled people in COVID-19 and beyond: lessons from Australia and England. *Disabil Health J* 2021; 14: 101050.

Divya Goyal
Independent Consultant, Guwahati, India

Xanthe Hunt
Department of Global Health, Institute for Life Course Health Research, Stellenbosch University, Cape Town, South Africa

Hannah Kuper
International Centre for Evidence on Disability, Department of Population Health, London School of Hygiene and Tropical Medicine, London, UK

Tom Shakespeare
International Centre for Evidence on Disability, Department of Population Health, London School of Hygiene and Tropical Medicine, London, UK

Lena Morgon Banks
International Centre for Evidence on Disability, Department of Population Health, London School of Hygiene and Tropical Medicine, London, UK