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The highest attainable standard of health for persons with disabilities

Report by the Director-General

BACKGROUND

1. The Seventy-fourth World Health Assembly adopted resolution WHA74.8 (2021) on the highest attainable standard of health for persons with disabilities, which aims to advance the agenda of disability inclusion in the health sector, focusing on three key areas: access to effective health services, protection during health emergencies and access to cross-sectoral public health interventions. The resolution requests the Director-General to, inter alia, submit a global report on the highest attainable standard of health for persons with disabilities for consideration by the Seventy-sixth World Health Assembly, through the Executive Board at its 152nd session. The report should include an update of the WHO estimates of the global disability prevalence presented in the *World report on disability (2011)*.

2. The *WHO global report on health equity for persons with disabilities*[1] responds to that request, presenting an analysis of the factors that lead to systemic health inequities for persons with disabilities and outlining key policy and programmatic actions and recommendations to reduce these health inequities.

3. The report calls on Member States to take action to advance health equity for persons with disabilities. It also invites other entities within the United Nations system and non-State actors, including organizations of persons with disabilities, as well as academic institutions, development partners, philanthropic organizations and the private sector, to collaborate on and advocate for the implementation of the recommendations included in the report, so that persons with disabilities can achieve the highest attainable standard of health. The specific objectives of the report are to:

(a) bring health equity for persons with disability to the attention of decision-makers in the health sector;

(b) document evidence of health inequities and country experiences of approaches taken to advance health equity through a disability lens; and

(c) make evidence-based recommendations that stimulate country-level action.

[1] Available at: https://www.who.int/activities/global-report-on-health-equity-for-persons-with-disabilities (accessed 19 December 2022).

REPORT DEVELOPMENT PROCESS

4. The report is based on the best available evidence and was developed over a period of 15 months through a highly consultative process involving Member States, other entities within the United Nations system, non-State actors, WHO teams and persons with disabilities themselves.

Literature reviews

5. Between August 2021 and March 2022, the Secretariat undertook a number of scoping reviews to identify the latest evidence related to health equity for persons with disabilities. Approximately 20 000 documents from scientific journals, grey literature and relevant webpages were identified. After applying inclusion and exclusion criteria, approximately 700 documents were reviewed and their evidence included in the report.

Working groups with technical experts and non-State actors

6. Two working groups were created to advise the Secretariat on the evidence selected and the conceptual development of the report. One working group consisted mainly of senior academic researchers and technical experts on disability, development and health. A second working group consisted of civil society representatives, including representatives of organizations of persons with disabilities, as well as health, disability and development organizations. Both working groups included persons with disabilities and ensured gender and regional diversity.

Consultations

7. Consultations with Member States were conducted in all six WHO regions in collaboration with the WHO regional offices. At these Member State consultations, government officials from health and disability ministries, together with representatives of non-State actors, including organizations of persons with disabilities, were presented with content from the report. They were then requested to provide feedback during and after the consultations.

8. Global web consultations with interested stakeholders and the general public were conducted on three occasions. They were conducted in all six United Nations languages and in international sign language, and at various times of day to accommodate for different time zones.

9. Two Member State information sessions with Geneva-based missions took place, with the objective of obtaining feedback on the strategic direction of the report, its results and its recommendations.

10. Two consultations with other United Nations entities working in health and disability were conducted to gather feedback, share opportunities for collaboration and seek case studies to be included in the report.

11. Two consultations were held with WHO technical staff from over 15 departments at headquarters to obtain contributions to strengthen the report, particularly regarding its alignment with broader WHO health system policies and technical guidance.

12. The draft report was also available online for almost four weeks in July and August 2022, to enable interested stakeholders and members of the public to review it in their own time and provide feedback. The draft report was posted in English, with summaries in all of the other five official

WHO languages, and in an Easy Read version to enable people with intellectual disabilities to review the report and provide feedback.

Key messages of the report

13. The report has four main chapters: the first chapter sets out the reasons why health equity for persons with disabilities matters; the second chapter presents the latest evidence on the factors that contribute to health inequities for persons with disabilities; the third chapter outlines 40 actions, across 10 strategic entry points, for governments to take to address health inequities, with a focus on strengthening health systems; and the fourth chapter presents high-level recommended principles for implementation by all health sector stakeholders.

Why health equity for persons with disabilities matters

14. The report begins by setting out the following reasons why health equity for persons with disabilities matters:

(a) A significant proportion of the differences in health outcomes between persons with and without disabilities are associated with unjust or unfair factors that are avoidable. These are referred to as health inequities and are the focus of the report.

(b) Under international human rights law, which is reflected in many domestic legal frameworks, governments have an obligation, through coordination with other sectors, to address existing health inequities so that persons with disabilities can enjoy their inherent right to the highest attainable standard of health.

(c) Addressing health equity for persons with disabilities will advance the achievement of global health priorities, first, because health equity is inherent in ensuring progress towards universal health coverage; secondly, faster progress in improving the health and well-being of populations can be achieved through cross-sectoral public health interventions that are inclusive and provided in an equitable manner; and lastly, because advancing health equity for persons with disabilities is a central component of all efforts to protect populations in health emergencies.

(d) Addressing health inequities for persons with disabilities benefits everyone. Older persons, people with communicable and noncommunicable diseases, migrants and refugees, and frequently unreached populations can all benefit from disability-inclusive approaches that target persistent barriers to inclusion in the health sector.

(e) Advancing health equity for persons with disabilities is a contributor for their wider inclusion and participation in society, since having good health and well-being is important to enable people to lead a good and meaningful life.

(f) The financial investment necessary to create a disability-inclusive health sector is an investment with dividends. For example, there is a US$ 9 return per US$1 spent on disability-inclusive cancer care. This finding challenges the existing stereotype that investing in disability inclusion is costly and not feasible, and provides a strong argument for advancing health equity for persons with disabilities.

(g) Currently, there are approximately 1.3 billion persons with disabilities – about 16% of the global population. These numbers reinforce the political importance, scale and public health relevance of disability.

Contributing factors to health inequities for persons with disabilities

15. The second chapter of the report outlines the evidence for and analysis of the factors contributing to these health inequities in relation to mortality, morbidity and the functioning experienced by persons with disabilities. Persons with disabilities die earlier, have poorer health and functioning, and are more heavily affected by health emergencies than the general population.

16. These inequities are due to unfair conditions that affect persons with disabilities disproportionately, and in the report they are grouped into four interrelated categories:

(a) Structural factors: these relate to the very broad socioeconomic and political context and the mechanisms that generate social stratification.

(b) Social determinants of health: these are the conditions in which people are born, grow, live, work and age.

(c) Risk factors: these factors may include, for example, tobacco use, diet, alcohol consumption and the amount of exercise, all of which are associated with communicable and noncommunicable diseases, as well as environmental factors such as air pollution. A key reason for the increased exposure to risk factors for persons with disabilities is that public health interventions are often not inclusive.

(d) Health system factors: these are the barriers across all health system building blocks – service delivery, the health and care workforce, health information systems, medical products and technologies, financing and leadership.

17. Chapter 2 also explains how the COVID-19 pandemic has uncovered the entrenched structural, social and health system factors driving health inequities for persons with disabilities.

Advancing health equity for persons with disabilities

18. The third chapter outlines the ways in which the health sector can address these inequities through government leadership and by strengthening existing approaches and investments. The report recommends 40 actions, across 10 strategic health system entry points, that governments can act on, regardless of their resource level or context. The strategic entry points are adapted from the primary health care approach, so that efforts on disability inclusion can be made as part of larger strategic and programmatic actions already being implemented or planned by governments. The primary health care approach is a health systems strengthening approach that goes beyond primary care, and is built on three pillars:

(a) integrated health services with an emphasis on primary care and essential public health functions;

(b) multisectoral policy and action; and

(c) empowering people and communities.

19. In principle, primary health care as a health systems strengthening approach addresses the contributing factors to health inequities in the population. However, health equity for persons with disabilities will only be achieved if, when implementing primary health care, targeted disability-inclusive actions are integrated into mainstream country approaches. The 40 targeted actions recommended in this report will also contribute to progressing global health priorities without leaving persons with disabilities behind.

20. The table below presents the 40 targeted actions for disability inclusion across 10 strategic entry points:

• **Political commitment, leadership and governance**
1. Prioritize health equity for persons with disabilities
2. Establish a human rights-based approach to health
3. Assume a stewardship role for disability inclusion
4. Make international cooperation more effective by increasing funding to address health inequities for persons with disabilities
5. Integrate disability inclusion into national health strategies, including health emergency preparedness and response plans
6. Set health sector-specific actions in national disability strategies or plans
7. Establish a disability inclusion committee or focal point within health ministries
8. Integrate disability inclusion into health sector accountability mechanisms
9. Create disability networks, partnerships and alliances
• **Health financing**
10. Adopt progressive universalism in health financing with persons with disabilities at the centre
11. Include health services for specific impairments and health conditions in packages of care for universal health coverage
12. Include the costs of making facilities and services accessible in health system costs
13. Ensure that existing social protection mechanisms and health insurance laws fully support the diverse health needs of persons with disabilities
• **Engagement of stakeholders and private sector providers**
14. Engage persons with disabilities and their representative organizations in health sector processes
15. Empower persons with disabilities in their communities, including through gender-sensitive actions
16. Engage informal support providers
17. Engage persons with disabilities in research
18. Request private sector providers that support the delivery of health services to be inclusive
• **Models of care**
19. Enable provision of integrated people-centred accessible care close to where persons with disabilities live
20. Ensure universal access to assistive products
21. Invest more in support people, interpreters and assistants
22. Develop the full spectrum of health services along a continuum of care for persons with disabilities
23. Strengthen models of care for children with disabilities
24. Promote deinstitutionalization
• **Health and care workforce**
25. Develop disability inclusion competencies in the education of all health and care workers
26. Provide disability inclusion training to all health service providers

27. Ensure the availability of a skilled health and care workforce
28. Include persons with disabilities in the health workforce
29. Train all non-medical staff working in the health care sector on issues related to accessibility and respectful communication
30. Guarantee free and informed consent for persons with disabilities
• **Physical infrastructure**
31. Incorporate a universal design-based approach in the development or refurbishment of health facilities and services
32. Provide appropriate reasonable accommodation
• **Digital technologies for health**
33. Take a systems-based approach to the digital delivery of health services with health equity as a key principle
34. Adopt international accessibility standards
• **Quality of care**
35. Integrate the specific needs and priorities of persons with disabilities into existing health safety protocols
36. Enable persons with disabilities, their families and carers to provide feedback on the quality of health services as part of general feedback mechanisms
37. Establish a clear system to monitor care pathways, considering the specific needs of persons with disabilities
• **Monitoring and evaluation**
38. Create a monitoring and evaluation plan for disability inclusion
39. Integrate indicators for disability inclusion into health system monitoring and evaluation frameworks
• **Health policy and systems research**
40. Develop a national health policy and systems research agenda on disability

Recommended principles

21. Chapter 4 presents the recommended principles for implementation that should be followed by all health sector partners, irrespective of which of the recommended actions they are implementing to advance health equity for persons with disability. The recommended principles are to: (1) put health equity for persons with disabilities at the centre of any health sector action; (2) ensure the empowerment and meaningful participation of persons with disabilities and their representative organizations when implementing any health sector action; and (3) monitor and evaluate the extent to which health sector actions lead to health equity for persons with disabilities.

NEXT STEPS

22. As a next step – and in response to the request made in resolution WHA74.8 (2021) for the Director-General to provide technical knowledge and capacity-building support for Member States in implementing actions to achieve the highest attainable standard of health for persons with disabilities – the Secretariat is developing a guide for action on disability inclusion in the health sector. The guide for action, which will serve as a toolkit to help countries to move forward with actions to promote disability inclusion in the health sector, will:

(a) facilitate leadership and planning processes for disability inclusion in the health sector;

(b) provide practical guidance on how to implement the 40 actions on mainstreaming disability in the health sector presented in chapter 3 of the report; and

(c) support the strengthening of accountability for disability inclusion in the health sector.

ACTION BY THE EXECUTIVE BOARD

23. The Executive Board is invited to take note of this report. In its discussions, the Board may wish to make suggestions on:

- how to ensure that the Secretariat mainstreams disability across the programmatic areas of the Organization;
- how to strengthen disability inclusion within WHO.

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