Ensuring healthy lives and promoting well-being (Goal 3)

This chapter discusses the current situation of persons with disabilities vis-à-vis the realization of Goal 3 and the progress made by countries in the past several years. It provides an overview of the health inequities experienced by persons with disabilities, the factors contributing to these inequities, and the efforts countries have made to address them and to promote the implementation of Goal 3 by, for and with persons with disabilities. The chapter also lists recommended actions to promote progress towards Goal 3.

Goal 3 calls for ensuring healthy lives and promoting well-being for all. This implies achieving the highest attainable standard of health for all persons with disabilities. Persons with disabilities have an equal right to the highest attainable standard of health, on an equal basis with others. This right to health is inherent and universal and is enshrined in international law through human rights treaties. Despite this universal right, persons with disabilities continue to experience a wide range of health inequities, which are largely avoidable and due to unjust and unfair factors at both the societal and health system levels. These contributing factors have not changed in the last decade, and many persons with disabilities continue to die prematurely and have poorer health. The COVID-19 pandemic fully exposed the disadvantaged position of persons with disabilities within the health sector and the need to act in an urgent manner.

Since 2006, the Convention on the Rights of Persons with Disabilities (CRPD) has provided an international framework that promotes and protects the right of persons with disabilities to enjoy their highest attainable standard of health through, inter alia, the provision of healthcare of the same quality to persons with disabilities as to others, including on the basis of free and informed consent (article 25). In addition to article 25, there are other articles in the CRPD relevant to health, such as article 9 on accessibility, which states that health facilities and information must be accessible to people with different types of impairments, and article 26, which includes strengthening comprehensive habilitation and rehabilitation services and programs to maximize the independence, inclusion and participation of persons with disabilities in all aspects of life. Several recent high-level declarations have highlighted the importance of universal health coverage and of promoting healthier populations and addressing health emergencies as global health priorities. For universal health coverage, a central and guiding document is the Declaration from Astana (2018).

During the COVID-19 pandemic, momentum for disability inclusion in the health sector was created as countries recognized and committed to act towards health equity for persons with disabilities. A landmark World Health Assembly resolution (WHA 74.8) on “The highest attainable standard of health for persons with disabilities” was adopted by countries in 2021. This resolution reiterated the need for a commitment to ensure that persons with disabilities exercise their full right to health. The Resolution aims to advance the agenda of disability inclusion in the health sector in countries, focusing on three key areas – access to effective health services within the context of universal health care; access to cross-sectorial public health interventions to improve the health and well-being of persons with disabilities; and protection during health emergencies.

Current situation and progress so far

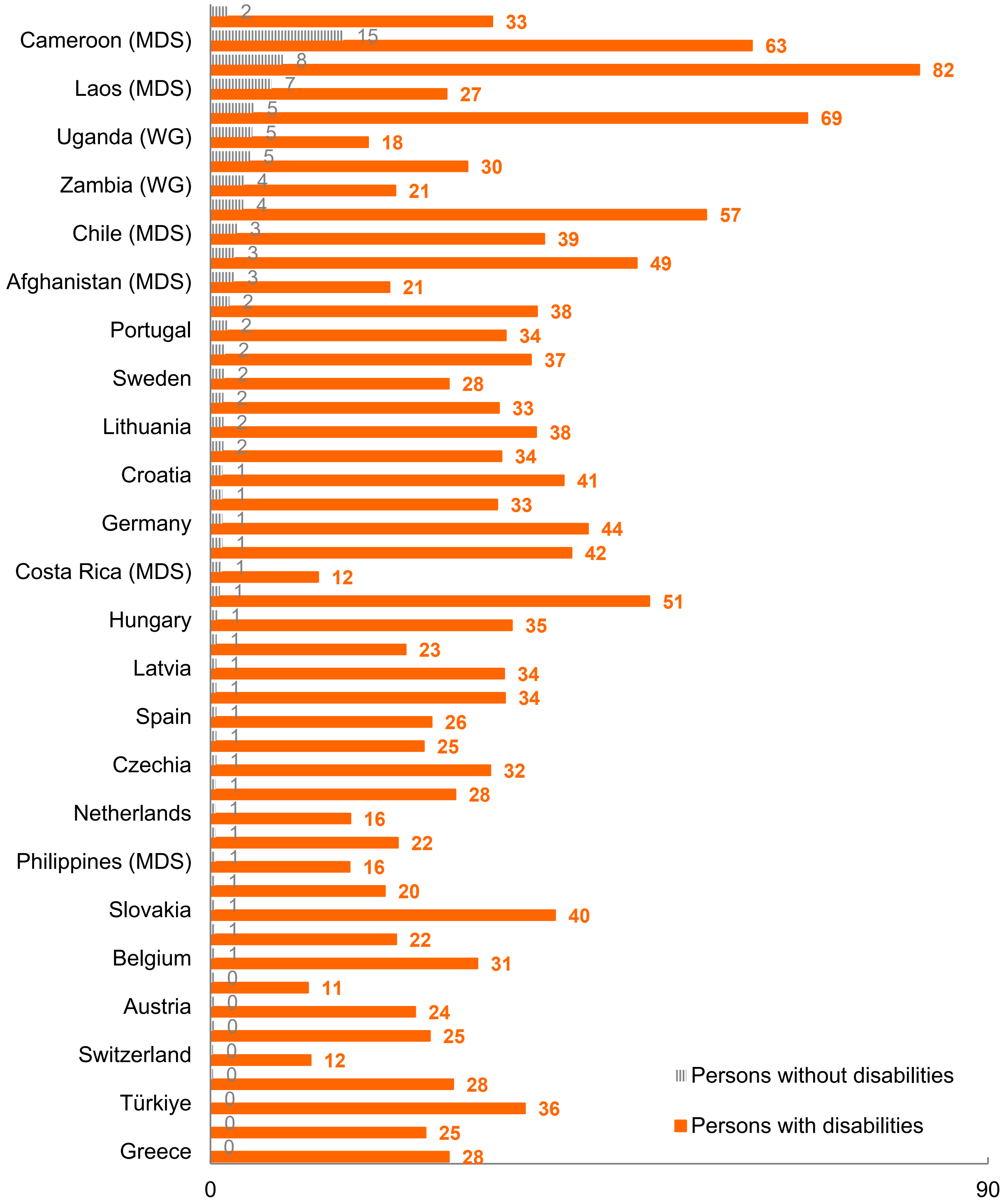
Persons with disabilities still experience health inequities in terms of higher premature mortality and morbidity rates.[51] In 2017, the crude annual death rate for persons with intellectual disabilities was double compared to the general population in the United Kingdom, with children with disabilities being eight times more likely to die before the age of 17,[52] and older adults with disabilities dying significantly more often within 30 days of hospitalization compared to those without disabilities.[53]

There are also health inequities in morbidity faced by persons with disabilities. Persons with disabilities have higher incidences of communicable and non-communicable diseases such as tuberculosis, diabetes, stroke, cardiovascular problems and asthma.[54] The differences in prevalence of comorbid health conditions between those with and without disabilities continue into older age[55] and apply also to women’s health issues (see the chapter on targets 3.1, 3.7 and 5.6). For example, there is evidence that significantly more women with physical (33 per cent), sensory (30 per cent), intellectual (49 per cent) and multiple (42 per cent) impairments have a postpartum emergency visit compared to those without these impairments (24 per cent).[56] Persons with disabilities are also significantly more likely to report having been diagnosed with a sexually transmitted infection or mental health condition, compared to individuals without disabilities.[57,58,59]

Persons with intellectual disabilities have a range of secondary chronic conditions in higher rates than those without disabilities, including thyroid dysfunction,[60] viral or infective diseases, neurological disorders, blood diseases, eye diseases, respiratory system diseases, digestive system diseases, skin diseases and diseases of the genitourinary system.[61,62,63,64] Similarly, adults with intellectual disabilities have higher rates of diabetes, asthma, arthritis, cardiac disease, and hypertension, than those without intellectual disabilities.[65,66] These differences are visible from a very early age. For example, children with developmental disabilities are three times more likely to have diabetes than other children.[67]

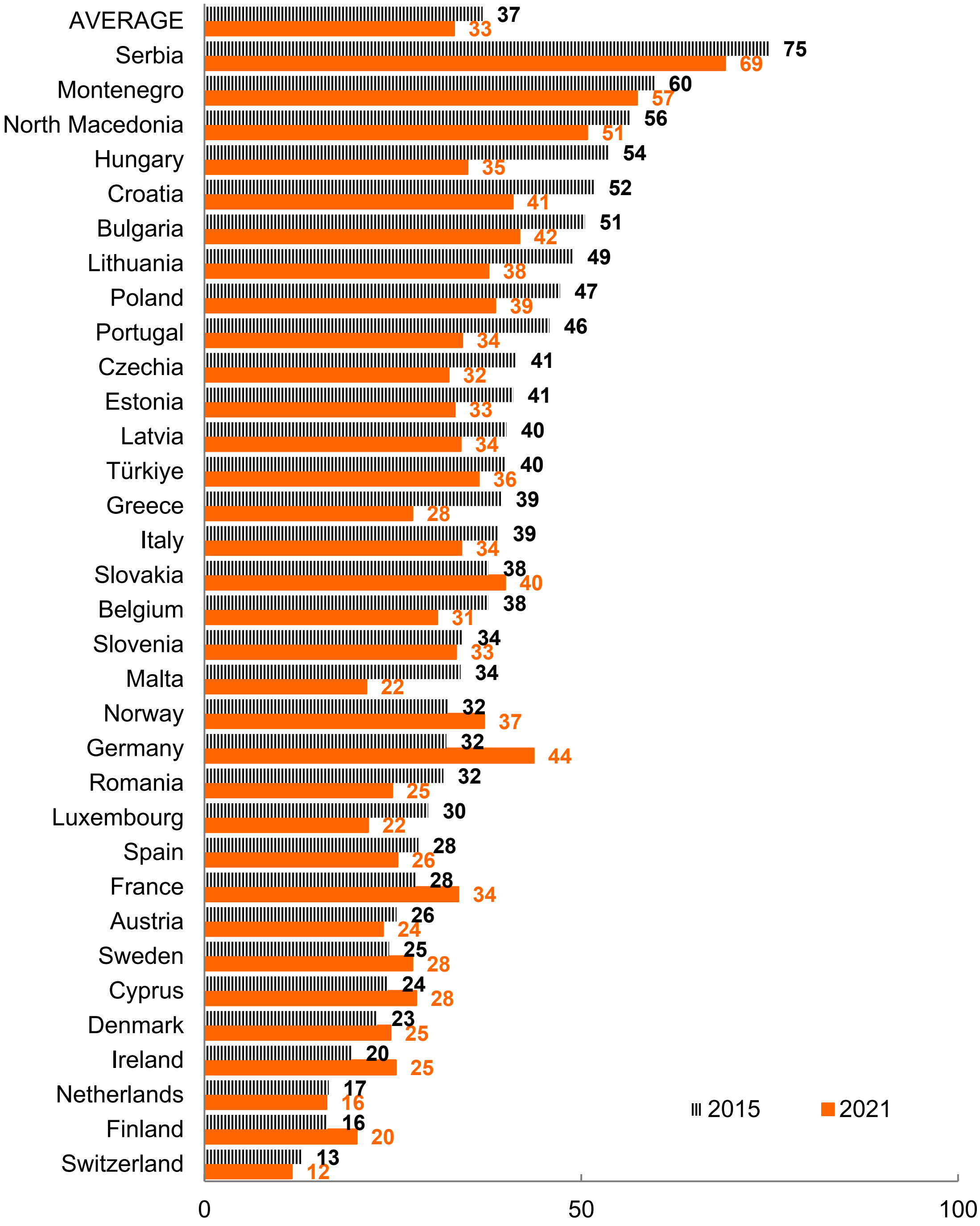
These health inequities are observed in national data on the health of individuals, in which persons with disabilities systematically report poorer health than others. In 47 countries or areas, health is self-perceived as bad or very bad by an average of 33 per cent of persons with disabilities compared to 2 per cent of persons without disabilities (Figure 29). Persons with disabilities are more likely to experience poor health than persons without disabilities in all 47 countries. Data from European countries suggest there has been some progress since 2015. Among 33 countries, on average, 33 per cent of persons with disabilities self-reported bad or very bad health in 2021, down from 37 per cent in 2015 (Figure 30). But the progress has been mixed, with a higher percentage of persons with disabilities reporting bad or very bad health in 2021 than in 2015 in nine countries.

Figure 29. Percentage of persons with self-perceived health as bad or very bad, by disability status, in 47 countries or areas, in 2021 or latest year available.



Note: (MDS) identifies data produced using the Model Disability Survey. (WG) identifies data produced using the Washington Group short set of questions on functioning. Data from Cameroon were collected in selected regions of the country and are not nationally representative.
Source: Eurostat,[7] UNDESA (on the basis of data from SINTEF[9]) and WHO.

Figure 30. Percentage of persons with disabilities with self-perceived health as bad or very bad, in 33 countries, in 2015 and 2021.



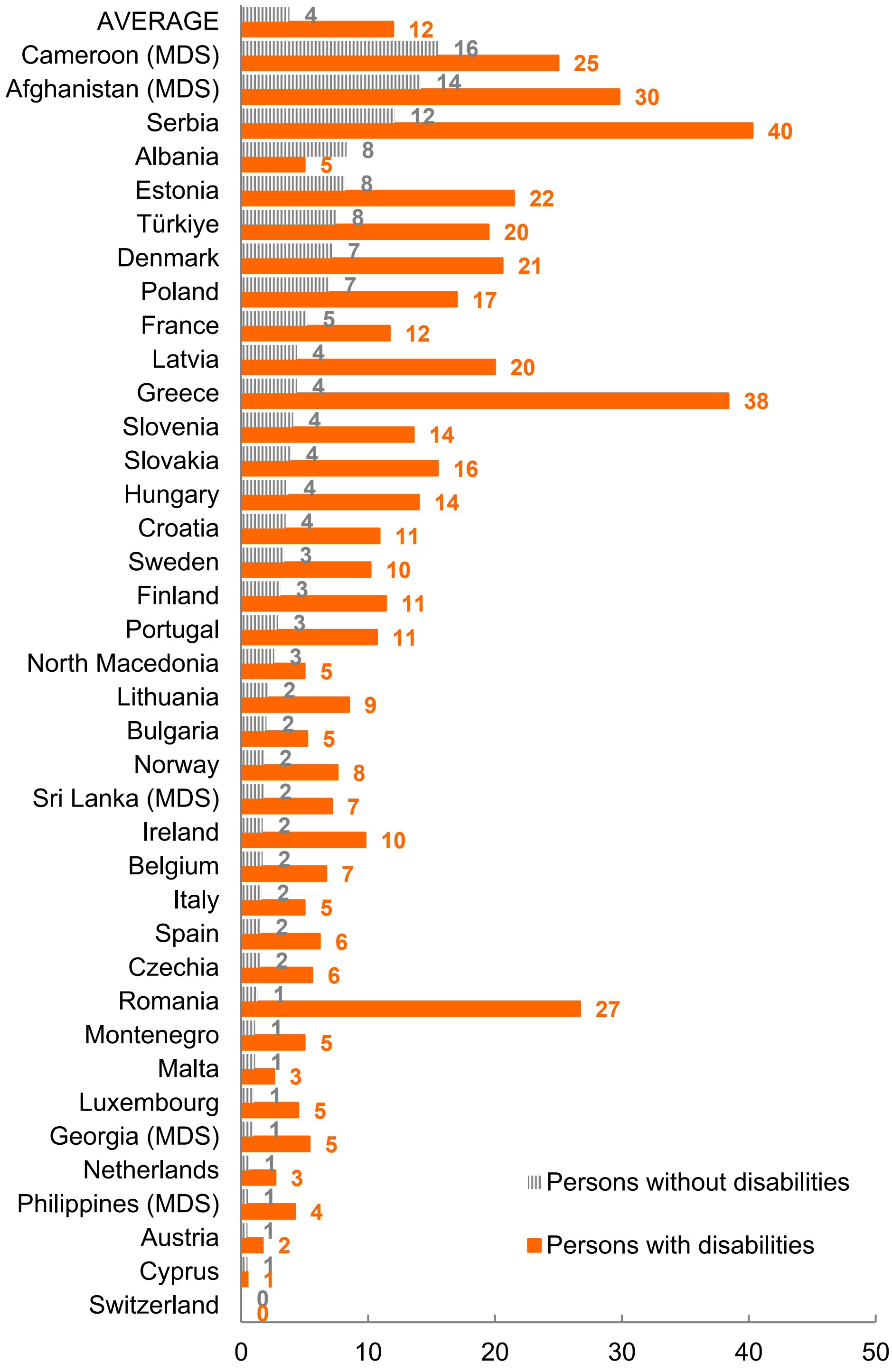
Note: Persons with disabilities include persons with some or severe limitations. Data for Montenegro, North Macedonia, Norway, Serbia, Slovakia, Switzerland and Türkiye are for 2020 instead of 2021.
Source: Eurostat.[7]

Target 3.8 calls for achieving universal health coverage. Universal health coverage means that all people have access to the full range of health services they need, including preventive, promotive, treatment, rehabilitative or palliative care, without financial hardship. Yet, many persons with disabilities face barriers to accessing these services, including: (i) higher health expenses for persons with disabilities who need additional healthcare due to their disability; (ii) higher costs of living for persons with disabilities which make healthcare more unaffordable for them; (iii) lack of accessibility of health facilities; and (ii) lack of accessible transportation to and from healthcare services. In addition, persons with disabilities tend to earn lower wages than persons without disabilities and therefore have fewer financial means to pay for healthcare.

Indeed, evidence shows that persons with disabilities have less access to health services compared to those without disabilities (Figure 31). In 38 countries or areas, persons with disabilities are on average three times more likely than persons without disabilities to be unable to get healthcare when they need it: 12 per cent of persons with disabilities versus 4 per cent of persons without disabilities indicated that they needed but could not get healthcare. In nine of these countries – Afghanistan, Albania, Cameroon, Denmark, Estonia, Greece, Romania, Serbia and Türkiye – more than 20 per cent of persons with disabilities are not able to get healthcare when they need it.

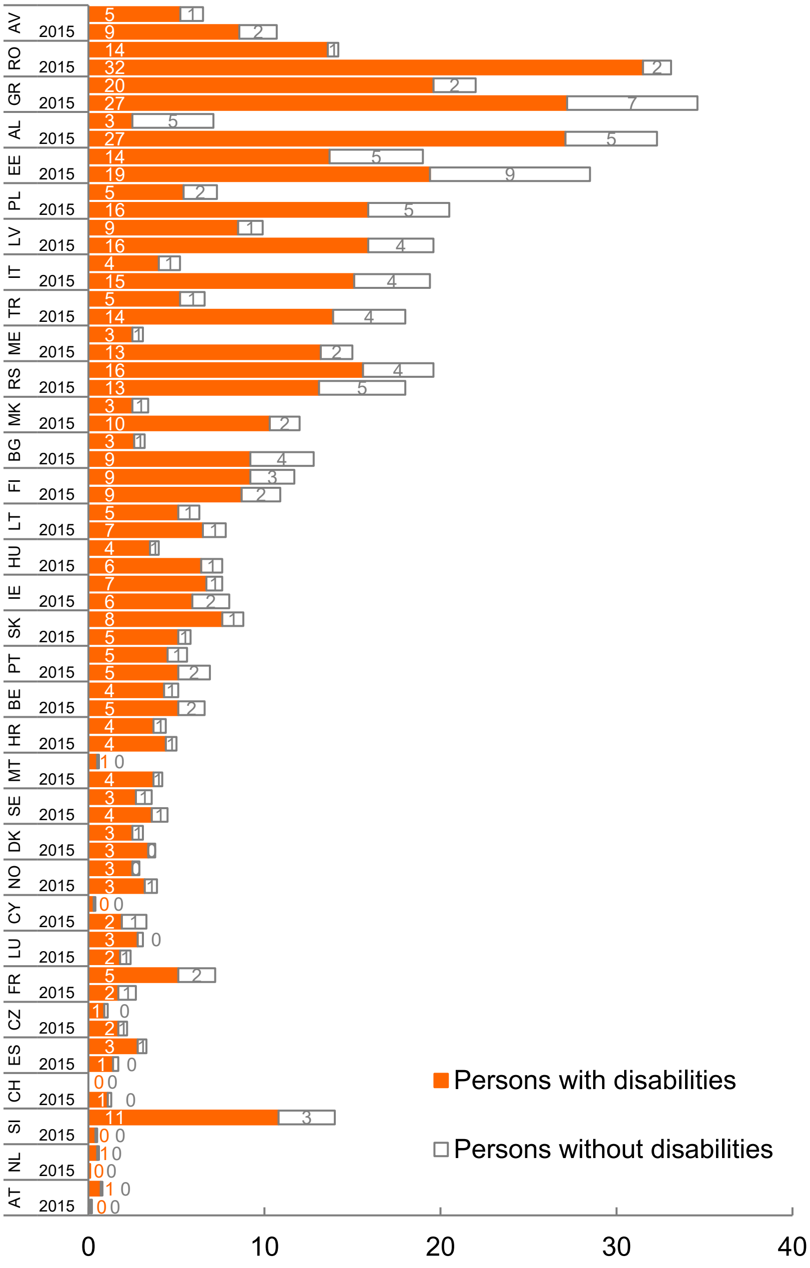
In European countries, the costs of the services, the geographical location (which can be difficult for persons with disabilities to reach) or the long waiting lists (which disproportionately affect persons with disabilities) are major factors contributing to persons with disabilities' reduced access to health services (Figure 32). Among 33 countries, in 2021, 5 per cent of persons with disabilities could not get medical care when they needed it because of these barriers. Even though a positive trend is observed between 2015 and 2021 and progress has been made in many countries in removing barriers for persons with disabilities, the differences in unmet needs for medical examination between persons with disabilities and the rest of the population are still significant. For example, in Poland, the percentage of persons with disabilities who needed but could not get medical examinations because of cost, distance or waiting lists, decreased from 16 per cent to 5 per cent from 2015 to 2021, but this figure is still larger than that for persons without disabilities (2 per cent). Similarly, in Latvia, there was a decrease of 7 percentage points for persons with disabilities in a period of six years, yet the difference with persons without disabilities is nine-fold.

Figure 31. Percentage of persons who needed but could not get healthcare, by disability status, in 38 countries or areas, in 2021 or latest year available.



Note: Data from Cameroon were collected in selected regions and are not nationally representative.
Source: Eurostat[7] *and WHO.*

Figure 32. Percentage of persons who needed but could not get a medical examination because the examination was too expensive, too far to travel to or the person was still on a waiting list, by disability status, in 33 countries, in 2015 and 2021.

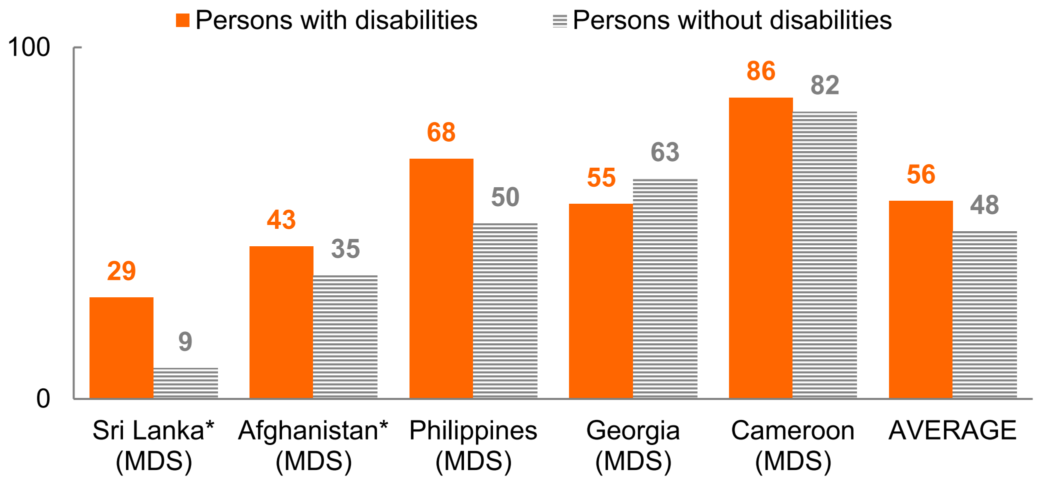


Note: AV, AVERAGE; AL, Albania; AT, Austria; BE, Belgium; BG, Bulgaria; CH, Switzerland; CY, Cyprus; CZ, Czechia; DK, Denmark; EE, Estonia; ES, Spain; FI, Finland; FR, France; GR, Greece; HR, Croatia; HU, Hungary; IE, Ireland; IT, Italy; LT, Lithuania; LU, Luxembourg; LV, Latvia; ME, Montenegro; MK, North Macedonia; MT, Malta; NL, Netherlands; NO, Norway; PL, Poland; PT, Portugal; RO, Romania; RS, Serbia; SE, Sweden; SI, Slovenia; SK, Slovakia; TR, Türkiye. Data for Albania are from 2017 and 2020; data for Montenegro, North Macedonia, Norway and Slovakia are from 2020 instead of 2021.
Source: Eurostat.[7]

Table 1. Coverage gaps between persons with and without disabilities for various health interventions.

Intervention	**Countries**	**Coverage gap**
Cardiovascular health and diabetes control[68,69,70]	Israel, United States	13-45 per cent
Cervical cancer and HPV screening[71,72,73,74,75,76]	Canada, Republic of Korea, United Kingdom, United States	5-33 per cent
Healthy diet[77]	United States	Up to 20 per cent
Physical activity programs[78,79]	United Kingdom	Up to 14 per cent
HIV knowledge, testing or counselling[80,81,82]	South Africa, Uganda	Up to 8 per cent
Family planning[83,84,85]	India, United States	Up to 5 per cent

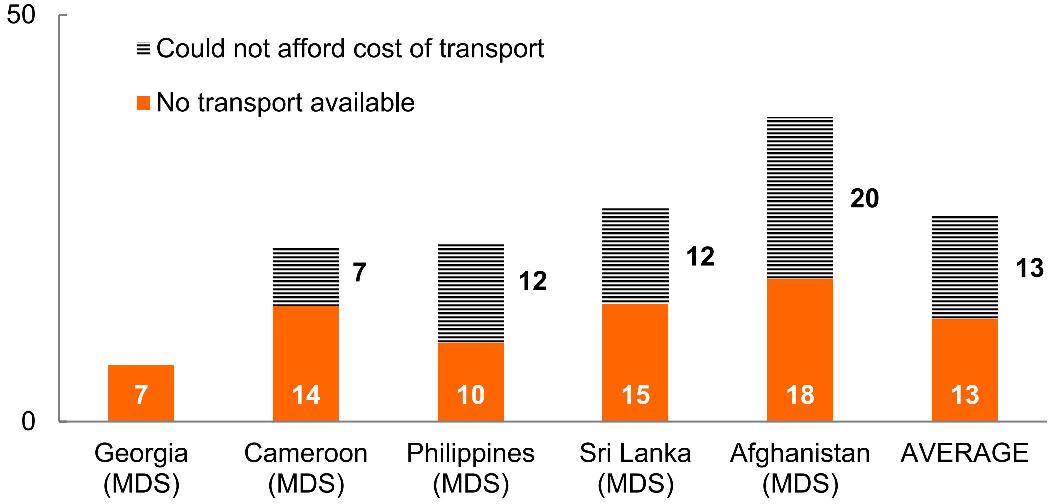
Figure 33. Percentage of persons with disabilities who did not get healthcare when needed because they could not afford its cost, in 5 countries, in 2021 or latest year available.



Note: (MDS) identifies data produced using the Model Disability Survey. Data from Cameroon and Pakistan were collected in selected regions of the country and are not nationally representative.
Source: WHO.

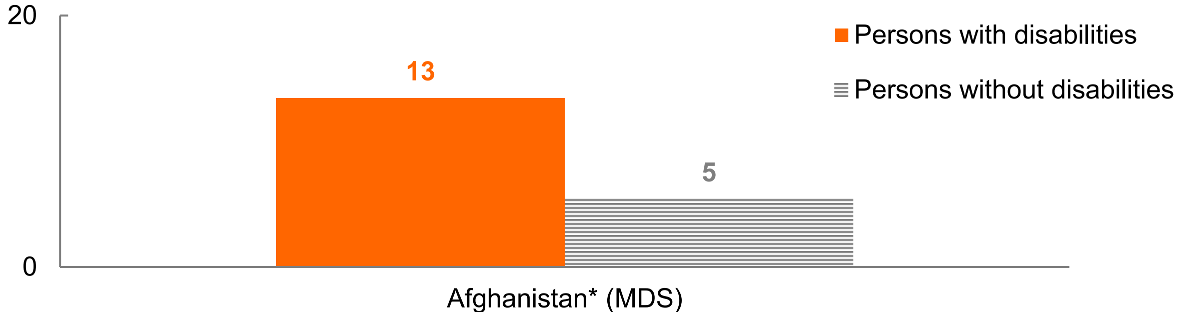
Cost is also a major barrier to healthcare for persons with disabilities in other developed countries. In the United States, persons with cognitive impairments and persons with physical impairments have up to five times more medical expenditures compared to those without disabilities.[86] In the United States, a greater percentage of older adults with disabilities compared to older adults without disabilities delay seeing a doctor due to cost (6 per cent versus 3 per cent).[87] In the United Kingdom, persons with disabilities living in the community are five times more likely to have unmet needs for mental healthcare due to cost, including the cost of prescribed medicines, with women with disabilities seven times more likely than men with disabilities to have unmet needs due to the cost of care or medication.[88]

Figure 34. Percentage of persons with disabilities who did not get healthcare when needed because transport was not available or not affordable, in 5 countries or areas, in 2021 or latest year available.



Note: (MDS) identifies data produced using the Model Disability Survey. Data from Cameroon were collected in selected regions of the country and are not nationally representative.
Source: WHO.

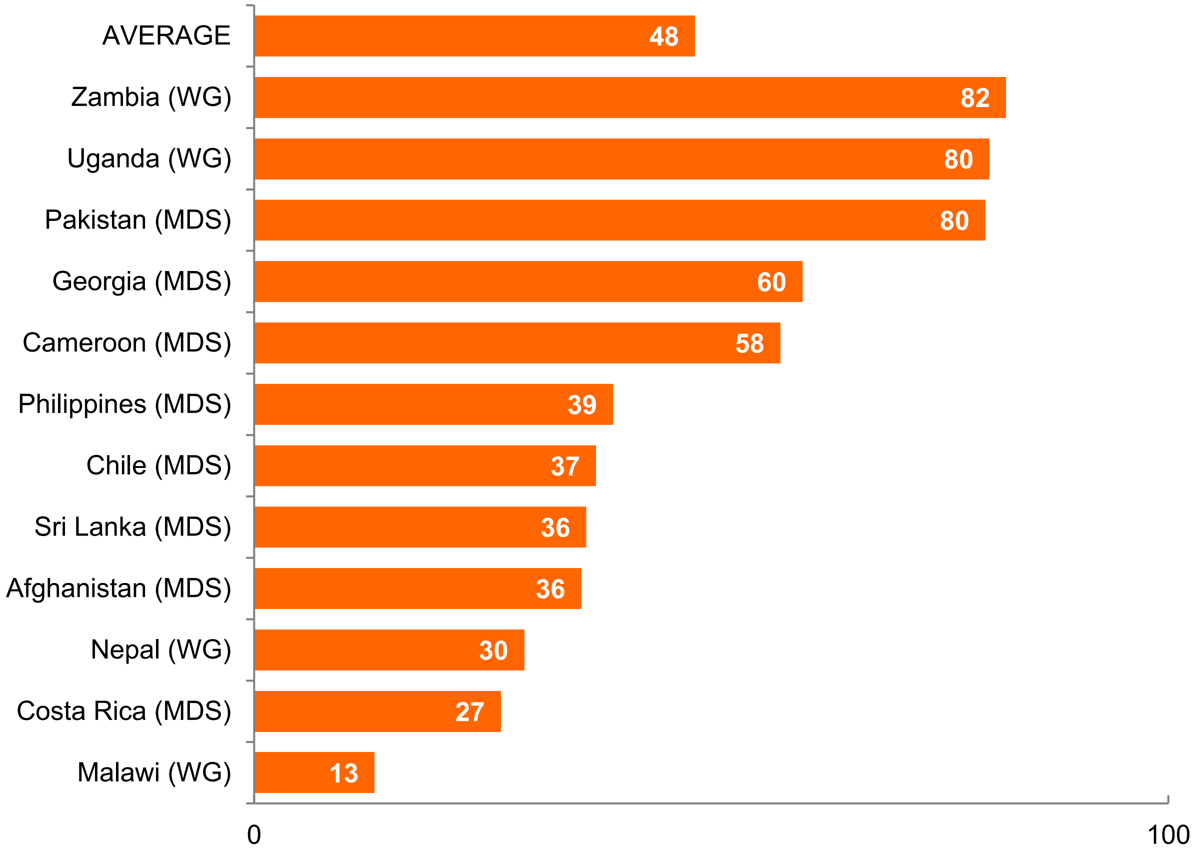
Figure 35. Percentage of persons who were badly treated during inpatient or outpatient healthcare, by disability status, in Afghanistan, in 2019.



Note: (MDS) identifies data produced using the Model Disability Survey. An asterisk (*) indicates that the difference between persons with and without disabilities is statistically significant at the level of 5 per cent.
Source: WHO.

In developing countries, the inability to pay for healthcare or the inability to get transport to the healthcare facility tends to be a major barrier for persons with disabilities. Among five countries, an average of 56 per cent of persons with disabilities could not afford the cost of needed healthcare, compared to 48 per cent of persons without disabilities (Figure 33). In Cameroon, 86 per cent of persons with disabilities who needed but could not get healthcare indicated unaffordability as the barrier. In the Philippines, 68 per cent indicated they could not afford the healthcare service; 55 per cent in Georgia; 43 per cent in Afghanistan; and 29 per cent in Sri Lanka. Lack of transport hinders access to health services to a much larger extent for persons with disabilities than for persons without disabilities. Among five countries or areas, on average, 13 per cent of persons with disabilities could not get healthcare when needed because they had no transport, and another 13 per cent because the transport was not affordable (Figure 34). In Afghanistan, 20 per cent could not afford the cost of transport to the health facilities and 18 per cent had no transport available to get to the facilities.

Figure 36. Percentage of persons with disabilities who reported that healthcare facilities were hindering or not accessible, in 12 countries or areas, in 2021 or latest year available.



Note: (WG) identifies data produced using the Washington Group short set of questions on functioning; (MDS) identifies data produced using the Model Disability Survey. Data from Cameroon and Pakistan were collected in selected regions and are not nationally representative.
Source: UNDESA (on the basis of data from SINTEF[9]) and WHO.

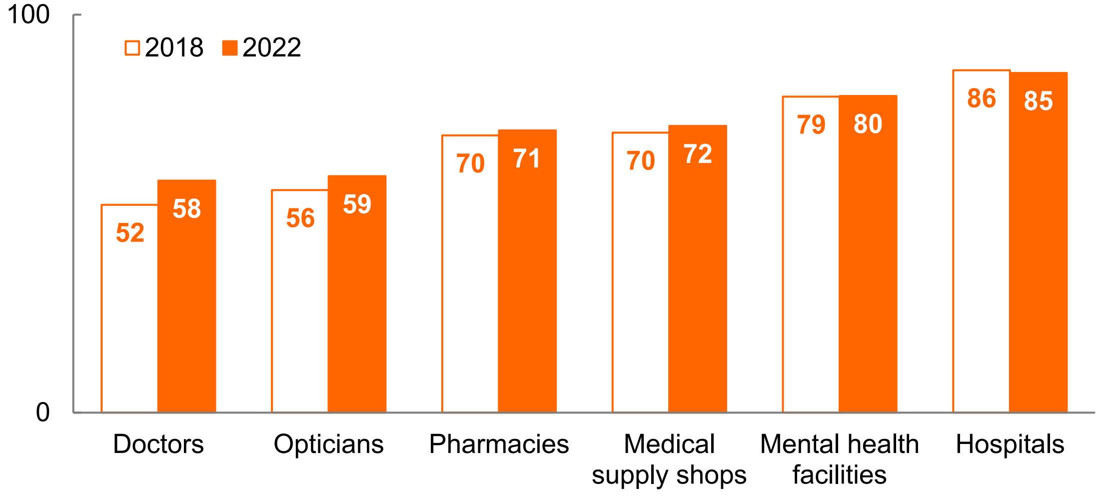
Attitudinal barriers also compromise access to healthcare for persons with disabilities when health professionals have negative or stigmatizing attitudes towards these patients and do not treat them with respect. For example, in Afghanistan, in 2019, 13 per cent of persons with disabilities versus 5 per cent of persons without disabilities indicated that they were badly treated during inpatient or outpatient healthcare (Figure 35).

Persons with disabilities have lower rates of receiving population-wide interventions compared to persons without disabilities, including for various interventions such as cancer screening, HIV testing and treatment, family planning or prevention of noncommunicable diseases (Table 1). In terms of rehabilitation services, data from Uganda show that only 22 per cent of persons with disabilities who needed rehabilitation have received it in the past year. Similar unmet needs for rehabilitation are observed in many other low- and middle-income countries.[89]

Another major factor that hinders access to health services for persons with disabilities is the lack of physical accessibility of health facilities. On average, more than 48 per cent of persons with disabilities experience difficulties accessing health facilities due to physical barriers (Figure 36). This percentage is particularly high in Pakistan, Uganda and Zambia. Crowdsourced data mostly from developed countries indicate that in 2022, 58 per cent of doctors' premises, 59 per cent of opticians, 71 per cent of pharmacies, 72 per cent of medical supply shops, 80 per cent of mental health facilities and 85 per cent of hospitals were accessible for wheelchair users, with little or no improvement in accessibility since 2018 (Figure 37). Accessibility features in health services are also generally lacking. The use of surgical masks by medical professionals creates barriers for persons with hearing impairments who rely on lip-reading. Although transparent masks exist and eliminate these barriers, research into their efficacy in preventing the transmission of disease remains limited and they are still not typically used in healthcare settings.[90,91]

The health of persons with disabilities is often disproportionately affected by different risk factors, including physical inactivity, high body mass index, smoking, or drug and alcohol use. In terms of physical inactivity, adults with disabilities are significantly more likely to be physically inactive compared to persons without disabilities,[92,93] and this is observed from a very early age as children and adolescents with disabilities participate much less in sporting activities, compared to those without disabilities.[94] Obesity affects more adults with disabilities than those without.[95,96] In terms of alcohol and substance use, prevalence rates are higher among persons with disabilities as well.[97,98]

Figure 37. Percentage of doctors' premises, hospitals, medical supply shops, mental health facilities, opticians and pharmacies that are accessible for wheelchair users, worldwide, in 2018 and 2022.

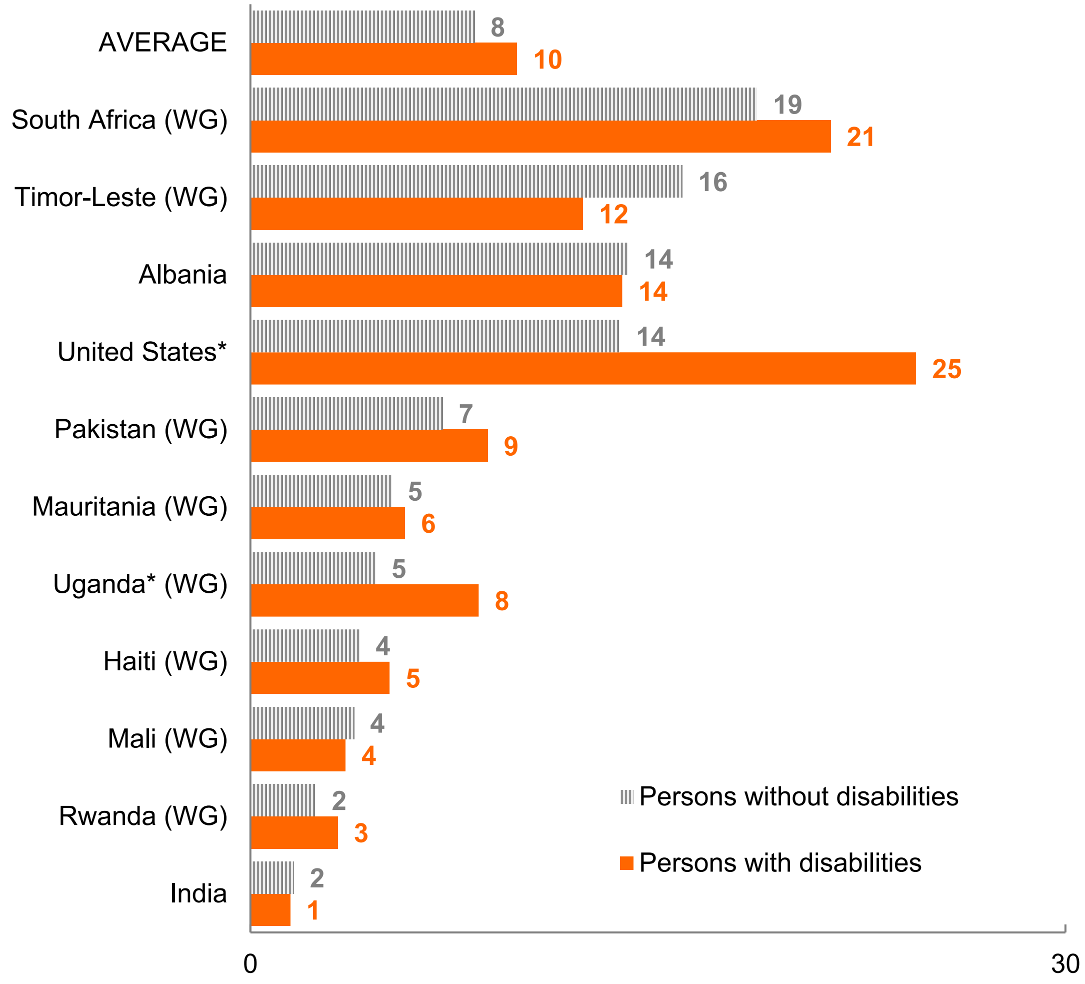


Source: UNDESA (on the basis of data from Sozialhelden[10]).

Depending on the country, smoking may be more or less prevalent among persons with disabilities (Figure 38). In the United States, there is a higher percentage of persons with disabilities who smoke than persons without disabilities, with 25 per cent of adults with disabilities currently smoking compared to 14 per cent of adults without disabilities. A higher prevalence of smokers among persons with disabilities compared to others is also observed in Haiti, Mauritania, Pakistan, Rwanda, South Africa and Uganda.

Multisectoral public health interventions to address these risk factors often miss persons with disabilities (Table 1) and therefore they do not benefit on an equal basis with others. For example, public health information is often not provided in accessible formats,[99] or not tailored to the information needs of persons with disabilities.[100] The physical environment where indoor or outdoor interventions take place is a barrier for many persons with disabilities. A lack of ramps, properly surfaced ground cover, accessible bathrooms, accessible changing spaces and accessible fitness facilities and equipment can all create barriers to inclusion.[101] Healthcare workers can block access to public health interventions by making assumptions about the appropriateness of referrals or recommendations for persons with disabilities.[102] A key reason for these existing barriers is the fact that responsibilities for public health and disability inclusion are often not clear within the government, with some countries struggling to define whose role it is to provide inclusive public health interventions.[103]

Figure 38. Percentage of smokers of cigarettes, by disability status, in 11 countries, in 2021 or latest year available.



Note: Data from the United States refer to current smokers aged 18 years and older; all other data refer to daily and occasional smokers aged 15 to 49. (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference between persons with and without disabilities is statistically significant at the level of 5 per cent.
Source: Okoro et al (2020)[104] and UNDESA (on the basis of data from DHS[6]).

Health emergencies – such as infectious disease outbreaks, natural hazards, conflicts, unsafe air, food and water, antimicrobial resistance and the effects of climate change, among others – exacerbate the challenges persons with disabilities experience in the health sector (see the chapter on targets 1.5 and 11.5 and Goal 13).

Regarding national legislation, there has been some progress in the last decades in terms of implementing the right to health for persons with disabilities in national constitutions. Prior to 1990, only 6 per cent of adopted constitutions guaranteed some form of this right. This percentage increased to 33 per cent of constitutions adopted in the 1990s, 52 per cent adopted in the 2000s and 63 per cent of constitutions adopted in 2010.[105] However, overall guarantees of the right to health for persons with disabilities are still very low. As of 2022, only about one third of countries in the world had disability inclusion incorporated in their national health strategies.[106]

Regarding national policies, in the past decade, there are examples of practices and initiatives adopted by governments, international agencies or civil society organizations in various countries to advance disability inclusion in the health sector. One example is a policy initiative developed by WHO and aligned with the CRPD that aims at promoting the rights of persons with psychosocial disabilities across the globe by changing the attitudes of mental health professionals and other stakeholders. The initiative has been implemented in various countries, including in Armenia, Bosnia and Herzegovina, Czechia, Estonia, Italy, Kenya, Lebanon, Philippines, Poland, Türkiye and Zimbabwe.[107] The first large-scale implementation and systematic evaluation was done in the state of Gujarat in India, and showed improvements in the attitudes of health professionals towards persons with mental health conditions. The evaluation also showed that service users felt more empowered and had higher satisfaction with services.[108]

Some countries have supported access to health services by widening the inclusion of persons with disabilities in their social protection mechanisms (see the chapter on Goal 1). Brazil, for instance, has taken steps to achieve universal social protection for persons with disabilities, by offering benefits equivalent to the minimum wage to more than 2.3 million persons with disabilities and providing a disability pension for partial and full disability as well as sickness benefits for those working in the formal sector.[109]

Another area of progress is digital health, with some countries creating mechanisms to involve persons with disabilities in digital health innovation processes. One such example is Australia. The country adopted the Digital Transformation Strategy 2018-2025, which describes how digital developers must ensure that their services can be used by every person who needs them, including persons with disabilities.[110] Furthermore, some countries have invested in strengthening informal care services. For example, Slovakia and Slovenia have taken steps to support informal carers through care allowance and community-based training programs.[111]

Community-based rehabilitation programmes aimed at enhancing the social inclusion of persons with disabilities and their families[112] have been particularly prevalent in developing countries as a means to implement the CRPD, but have evolved to extend to education, social integration, livelihoods and empowerment.[112] Studies in Afghanistan[113] and Namibia[114] have demonstrated the positive impact of community-based rehabilitation programmes on emotional, social participation, unemployment, and communication challenges for persons with disabilities. In Afghanistan and India, research shows that the effects of community-based rehabilitation programmes have had positive results on improved wellbeing that have been maintained over time.[115]

Impact of the COVID-19 pandemic

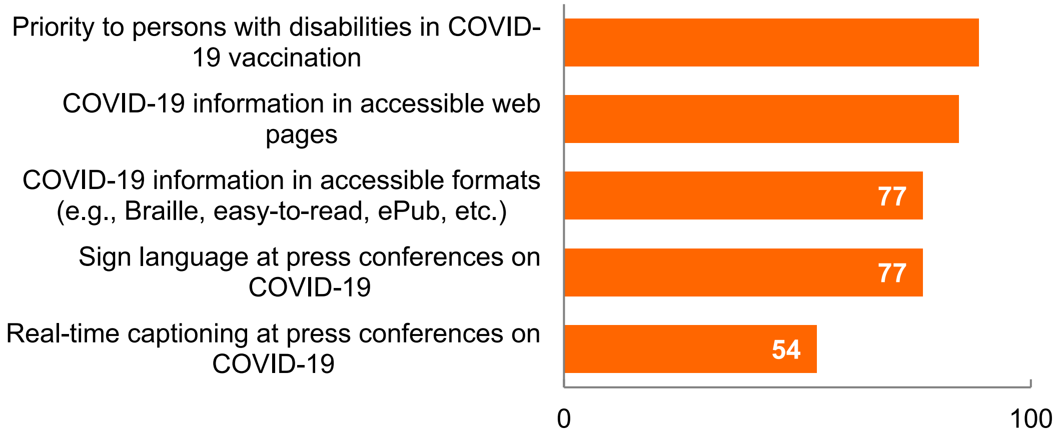
The COVID-19 pandemic disproportionately affected the health of persons with disabilities and persons with disabilities were more likely to die from COVID-19 than others. For example, in the Republic of Korea and the United Kingdom, more than half of the COVID-19–related deaths occurred among persons with disabilities, and it can be assumed that this number was much higher in countries with lower resource settings where evidence is more limited.[116,117] In the Republic of Korea, in the early phase of the pandemic, the chance of dying once infected with COVID-19 was 16 per cent for persons with severe or moderate disabilities, 11 per cent for persons with mild disabilities and 2 per cent for persons without disabilities.[118] In England, persons with disabilities were up to three times more likely to die from the virus,[119] with those with intellectual disabilities being seven to eight times more likely to die than those without an intellectual disability.[120] This higher death rate especially impacted young persons with intellectual disabilities, aged 18 to 34, who were 30 times more likely to die from COVID-19 than others in the same age group.[121]

The higher mortality rates may be linked to various risks and barriers experienced by persons with disabilities during the COVID-19 pandemic.[122] Persons with disabilities with pre-existing conditions such as respiratory challenges, were at higher risk of developing critical conditions or dying once infected with COVID-19. Persons with disabilities also encountered barriers to accessing timely and equal medical attention due to a lack of accessible information about symptoms and primary steps in case of exposure to infection. For instance, in Asia and the Pacific, only 85 per cent of countries or areas provided COVID-19 information in accessible webpages for persons with disabilities; only 77 per cent provided COVID-19 information in other accessible formats (such as Braille, easy-to-read, and ePub, among others) and provided sign-language in COVID-19 press conferences; and only 54 per cent provided real-time captioning in these press conferences (Figure 39). Other barriers to accessing timely heath care once infected with COVID-19 included inaccessible health systems, inaccessible transportation, lack of financial resources, lack of adequate personal assistance or support, lack of access to COVID-19 testing, lack of access to personal protective equipment and discriminatory practices in COVID-19 treatment in health facilities.

Unconscious bias[123,124,125,126,127] and preconceptions of medical staff[123] have been linked to discriminatory triage practices in the COVID-19 response. In a review of triage policies for intensive-care units in 14 European countries, in 2020, in more than half of the countries' triage protocols recommended the consideration of functional status or frailty assessments,[128] terms which can be confused with "disability". In the United Kingdom, persons with intellectual disabilities infected with COVID-19 were 50 per cent less likely to be admitted to intensive care, despite having more severe symptoms on admission and similar rates of complications as their counterparts without disabilities.[129] Moreover, persons with disabilities encountered barriers in accessing personal protective equipment and COVID-19 testing during the pandemic. In 2020, a higher proportion of parents and caregivers with disabilities, compared to those without, reported needing and not having essential items to protect them from the COVID-19 virus such as sanitiser (66 per cent versus 54 per cent) and masks (64 per cent versus 50 per cent).[16] And more parents and caregivers with disabilities than those without reported needing and not having access to COVID-19 testing (41 per cent versus 28 per cent).[16]

One of the barriers to access was cost, as many persons with disabilities could not afford essential items and services needed to stay healthy during the COVID-19 crisis.[16,130] Another obstacle was accessibility: COVID-19 testing as well as many COVID-19 outpatient and inpatient services, including online health services, were not accessible to many persons with disabilities.[128] In particular, the standard at-home COVID-19 tests have barriers for blind users as they rely on visual information that is not accessible to persons with visual impairments. The technology to produce accessible tests, which rely on non-visual information such as temperature, smell or sound, already existed at the start of the pandemic but they were not produced until about two years after the start of the pandemic.[131] Moreover, during the COVID-19 pandemic, wearing face masks became necessary within healthcare settings, but face masks hinder speech comprehension for persons with hearing impairments who rely on lip-reading. Although transparent face masks already existed in 2020, research into their efficacy in blocking the transmission of COVID-19 was not pursued in a timely manner to inform their usage during the pandemic.[132]

Figure 39. Percentage of countries or areas that prioritized persons with disabilities in the COVID-19 vaccine roll-out and provided information on COVID-19 in formats accessible to persons with disabilities, in Asia and the Pacific, as of 2022.



Note: Data on COVID-19 vaccination rates are based on 27 countries or areas; data on real-time captioning are based on 24 countries or areas; all other data are based on 26 countries or areas.
Source: ESCAP.[14]

Measures to control the COVID-19 outbreak – like community lockdowns, physical distancing requirements and prioritization of selected health services – without considering the needs of persons with disabilities may have caused a lack of sufficient physical activity as well as a reduction of essential health services, social care and support services for persons with disabilities, leading ultimately to higher risks of new or worsening health conditions. About 70 per cent of persons with autism in Europe were left without everyday support due to interruptions in health and social care.[128] Regarding critical health services, worldwide, in 2020, more parents and caregivers with disabilities than those without reported needing and not having access to medicine (40 per cent versus 32 per cent) and to in-person healthcare (34 per cent versus 22 per cent).[16] This lack of access to health services and support may have deteriorated the health of persons with disabilities during the pandemic and made them more vulnerable to death when infected by COVID-19. Disrupted access to critical services such as regular health consultations, medication, psychosocial support, rehabilitation including assistive devices provision, as well as personal assistants and home support services also led to increased pressure on the families of persons with disabilities and on informal care mechanisms.[133,134,135,136,137,138,139]

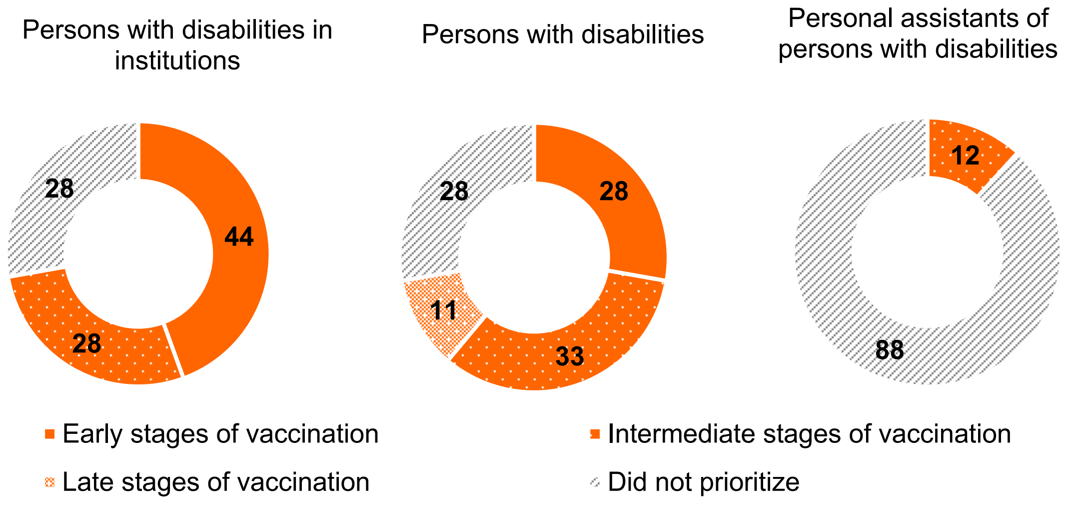
The mental health and psychosocial wellbeing of persons with disabilities has also been impacted by the COVID-19 crisis. In 2020, a total of 82 per cent of parents and caregivers with disabilities reported reduced psychosocial wellbeing since the start of the COVID-19 outbreak.[16] Among persons with disabilities who looked for mental health support during the pandemic, 33 per cent said the support was not accessible to them.[140] The impact of COVID-19 on social interaction and play among children with disabilities as well as other pandemic stressors had an impact on the mental health and psychosocial wellbeing of children with disabilities: 69 per cent of parents and caregivers observed increases in signs of distress among their children with disabilities, compared to 47 per cent of parents and caregivers of children without disabilities.[16] Children with disabilities reported playing less, sleeping less, doing more chores and caring more for siblings or others since the beginning of the COVID-19 pandemic. They were less likely to be able to interact socially with their friends during the pandemic. In 2020, only 29 per cent of parents and caregivers of children with disabilities reported that their child could stay in touch with friends during the COVID-19 pandemic, compared to 45 per cent of parents and caregivers of children without disabilities.[16]

In addition, the health of persons with disabilities may have been disproportionately affected by the wider social and economic impacts of the pandemic. Already more likely to live in poverty and to face exclusion in the world of work, persons with disabilities faced job losses and fewer hours of work, reduced household income, and in some countries, food insecurity during the COVID-19 pandemic (see the chapters on Goal 1, Goal 2 and Goal 8) – all of which are determinants of health and well-being.

Persons with disabilities have expressed the need to be prioritized in national COVID-19 vaccination plans and the need to also prioritize their support networks, including personal assistants, family caregivers and persons working in disability-related services.[141] However, despite higher mortality rates, persons with disabilities and their support networks were not always prioritized in national vaccination campaigns. In Asia and the Pacific, persons with disabilities were prioritized in 89 per cent of countries or areas (Figure 39). In Latin America and the Caribbean, persons with disabilities living in institutions were prioritized at the early stage of COVID-19 vaccination in 44 per cent of countries and at the intermediate stage in 28 per cent of countries (Figure 40). Persons with disabilities not living in institutions were less likely to be prioritized, with only 28 per cent of countries prioritizing them in the early stages, 33 per cent in the intermediate stages and 11 per cent in the late stages of COVID-19 vaccination. Some 28 per cent of countries did not prioritize persons with disabilities in their COVID-19 vaccination plans at any stage. Personal assistants were seldom prioritized, with just 12 per cent of countries in Latin America and the Caribbean prioritizing them and only at the intermediate stage of vaccination. Moreover, many online COVID-19 vaccination registration sites were not designed with accessible features for persons with disabilities (see the chapter on SDG target 9.c).

The COVID-19 pandemic has drawn attention, albeit too slowly, to the importance of including persons with disabilities in responses to health emergencies. Some countries have taken steps to make COVID-19 information available in accessible formats[142,143,144,145] and to address physical barriers that persons with disabilities faced in accessing COVID-19 vaccination.[146,147,148] In addition, there are isolated examples of public health responses[149] and clinical triage protocols[150,151,152] being adapted to avoid the discrimination faced by persons with disabilities during the COVID-19 pandemic. Civil society played a vital role during the pandemic, encouraging governments and health authorities to protect the rights of persons with disabilities and to act in accordance with the CRPD.[153,154]

Figure 40. Percentage of countries that prioritized persons with disabilities and their personal assistants in national COVID-19 vaccination plans, in Latin America and the Caribbean, as of 1 May 2021.



Note: Data on persons with disabilities, in and out of institutions, are based on 18 countries; data on personal assistants are based on 17 countries.
Source: UNESCO (2021).[155]

Summary of findings and the way forward

Persons with disabilities continue experiencing higher rates of mortality and morbidity; and the contributing factors to these inequities have not changed over the past decade. Persons with disabilities are 15 times more likely to perceive their health as bad or very bad than persons without disabilities and evidence since 2015 suggests that progress has been too slow. For example, in European countries, to achieve levels of health similar to persons without disabilities by 2030, the percentage of persons with disabilities self-reporting bad or very bad health would have to decrease five times faster than current trends.

The higher rates of mortality or morbidity among persons with disabilities can be explained to some extent by the underlying health conditions or impairments that some persons with disabilities may have. But a significant proportion of these differences in health outcomes between persons with and without disabilities are associated with unjust or unfair factors that are avoidable, including barriers to healthcare access.

Many persons with disabilities still do not receive health services according to their needs. Persons with disabilities are seven times more likely than others to not have access to healthcare when they need it. In various developing countries, more than half of persons with disabilities do not get healthcare when needed because they cannot afford the cost, and about a quarter because they do not have or cannot afford transport to healthcare facilities. In some developed countries, more than 10 per cent of persons with disabilities do not get healthcare when needed because they cannot afford the cost, the healthcare service is too far to travel to, or the waiting list is too long.

The evidence that exists for European countries suggests significant progress since 2015 in removing barriers for persons with disabilities related to healthcare cost, distance or waiting lists as the rates of unmet healthcare needs due to these barriers were halved since 2015. Keeping these successful rates of progress in Europe will ensure that the health needs of persons with disabilities are met by 2030 and contribute to the realization of universal health coverage and the achievement of Goal 3, specifically target 3.8. In other regions, there is insufficient evidence to evaluate progress towards this target.

Public health interventions to promote health and well-being for the population – like nutrition information campaigns and regular health testing and monitoring – often do not reach persons with disabilities. For various interventions, the gaps in coverage between persons with and without disabilities range from 5 per cent to 45 per cent. Promoting the health and wellbeing of persons with disabilities will require closing these gaps and establishing health policies and public health interventions that deal comprehensively with different determinants of and risk factors for the health of persons with disabilities.

Many health facilities remain inaccessible for persons with disabilities. In various developing countries, more than 30 per cent of persons with disabilities indicate that healthcare facilities are hindering or not accessible to them. In some countries, this percentage reaches 80 per cent. Crowdsourced data indicates that worldwide, in 2022, 42 per cent of doctors' offices, 29 per cent of pharmacies and 15 per cent of hospitals were not accessible for wheelchair users. In the past five years, progress in increasing the accessibility of health-related premises has been slow or stagnant. Doctors' offices would need to become accessible for persons using wheelchairs at a rate three times faster and pharmacies seven times faster than current rates of progress to achieve full accessibility by 2030. Progress for hospitals' accessibility has stagnated and needs to be revived to achieve full accessibility by 2030.

The number of countries whose constitution guarantees the right to health explicitly for persons with disabilities has increased since the 1990s and indicates that the importance of this right has received greater recognition over the past decades and especially after the early 2000s. As of 2010, about two thirds of countries guaranteed this right for persons with disabilities in their constitutions. However, as of 2022, only about one third of countries had incorporated disability inclusion in their national health strategies.

The lack of disability-inclusive health policies and the gaps in healthcare access continued and were exacerbated during the COVID-19 pandemic. The response to the pandemic has largely not been inclusive of persons with disabilities, especially during the early stages of the pandemic. Persons with disabilities faced discriminatory practices in COVID-19 treatment in health facilities and were less likely to be admitted to intensive care despite having more severe symptoms on admission; had less access to personal protective equipment – like masks and sanitizer – and to COVID-19 testing; encountered barriers to accessing timely and equal medical attention due to a lack of accessible information about symptoms and primary steps in case of exposure to infection; and were not always prioritized in national COVID-19 vaccination campaigns. In 18 per cent of countries or areas in Asia, the Caribbean, Latin America and the Pacific, persons with disabilities were not prioritized. These barriers took a heavy toll on persons with disabilities: available evidence points to half of COVID-19 deaths occurring among persons with disabilities although they constitute only about 15 per cent of the world population. The pandemic also had a negative impact on the mental health and psychological wellbeing of persons with disabilities. Yet, many persons with disabilities do not have access to mental health care.

To make progress towards achieving Goal 3 for persons with disabilities, countries need to integrate targeted actions to advance health equity for persons with disabilities in their efforts to strengthen their health systems, using primary healthcare as a foundation. Moreover, addressing health inequities for persons with disabilities should not be a siloed activity conducted by the health sector, but rather a strategy that is integrated into the overall efforts of a country to strengthen its health systems. The implementation of any disability-targeted actions needs to take into consideration the contexts, strengths and weaknesses of the health system, and the national and local priorities of countries. Depending on the national and local circumstances, different entry points may be prioritized in addressing the health inequities that exist for persons with disabilities.

Some of the key areas in which governments, international agencies and civil society can collectively invest in efforts to trigger progress in health equity for persons with disabilities include:

1. Include health equity for persons with disabilities at the centre of every health sector action. This implies prioritizing, in any health sector action, the persons with disabilities who are most left behind, protecting their rights and addressing their needs, including when planning for health financing. It can also mean (i) establishing legal frameworks that prohibit discrimination against persons with disabilities; (ii) providing strategies and solutions to eliminate discriminatory practices, unjust power relations and other unjust conditions for persons with disabilities through different policies, such as developing disability-inclusion competencies among health and care professionals; (iii) addressing the right to legal capacity, as well as having systems for safeguarding to ensure that acts of violence and abuse against persons with disabilities in healthcare settings are appropriately investigated and prosecuted; and (iv) ensuring the accessibility of health services in terms of physical access to facilities and accessible communication and provision of reasonable accommodation. Promote research into accessibility features and services in the health sector, including on the efficacy of transparent face masks in surgical settings and by medical professionals with the aim of making transparent face masks the universal standard. Ensure the availability of accessible tests for COVID-19 and other medical conditions in order to remove barriers for blind users and users with visual impairments. Include health equity in any health sector action, which is strongly associated with adopting a human rights-based approach to health, as it involves a change in the mindset of the health sector and the way it operates. The human rights-based approach ensures that policies, programmes and their implementation are all guided by respect, protection and the realization of human rights.

2. Ensure the provision of integrated health services without financial hardship and close to where persons with disabilities live. This involves the provision of accessible and affordable people-centred healthcare across the life cycle, that is close to where persons with disabilities live and is responsive to their needs. This requires the provision of the full spectrum of services, including preventive, promotive, curative, rehabilitative and palliative care services, as well as services specific to the underlying health conditions or impairments of persons with disabilities. Strengthening linkages with social care is also fundamental, including expanding access to health insurance.

3. Strengthen multisectoral collaboration to address structural, social and health system determinants and factors that contribute to health inequities among persons with disabilities. Through the stewardship role of the health sector, progress in this area can be achieved by making multisectoral public health policies, actions and interventions inclusive of persons with disabilities. The responsibilities for public health and disability inclusion need to be better defined within the government to improve the provision of inclusive public health interventions. Establishing good coordination mechanisms with the private sector is also important.

4. Ensure that the management of health emergencies includes and protects persons with disabilities. If countries invest in having an inclusive and well-functioning health system, they will be better prepared and able to respond to health emergencies like the COVID-19 pandemic. In practice, this can be done through strengthening essential health service coverage and public health interventions, contributing to the prevention of outbreaks, mitigating risks and building community resilience to such hazards. In addition, responses to health emergencies should take into account accessibility and impact on the overall lives of persons with disabilities. More efforts are needed to put in practice existing technology and produce at scale tests for medical conditions that are accessible for blind users and users with visual impairments, including accessible COVID-19 tests. Persons with disabilities, their family members, support services and healthcare providers should play a central role in health-emergency planning, response and implementation, working together to identify the needs of persons with disabilities.

5. Ensure the empowerment and meaningful participation of persons with disabilities, their families and representative organizations in decision-making about their health. This can be achieved through: (i) enabling persons with disabilities to take control of their own health needs and make decisions by improving health education opportunities and health information; (ii) making sure that persons with disabilities and organizations of persons with disabilities are engaged when packages of care, in the context of universal health coverage, are decided and when designing responses and planning for health emergencies is underway; and (iii) providing opportunities to persons with disabilities to participate in health research as well as in the healthcare workforce.

6. Monitor and evaluate the extent to which health sector actions advance health equity for persons with disabilities. A well-planned monitoring and evaluation process is fundamental to track progress and adjust actions as the context evolves. This normally includes collecting data through indicators that measure the extent of progress towards the achievement of objectives. Integrating disability data collection and disaggregation in national health information systems is a key element of such a framework. Monitoring and evaluation also allow for the entire health system to learn what works and what does not work, and to inform constant improvement. In addition, more data is needed to understand the extent to which higher rates of mortality or morbidity among persons with disabilities are due to underlying health conditions or impairments or due to avoidable conditions, in order to guide policies to eliminate these unavoidable conditions.

7. Develop a research agenda on the health system and policies to advance health equity for persons with disabilities. Developing and implementing a research agenda on the health system and policies will help countries address health inequities for persons with disabilities. Research can identify mechanisms and innovative strategies that work to advance health equity for persons with disabilities in different contexts. To do so, countries need to establish well-functioning links between ministries of health and research organizations and institutions for a collaborative approach to ensure that research is aligned with national disability and health priorities.