Health Inequalities and Disabled People

1 Introduction:

1.1 Inclusion Scotland (IS) is a Scottish-wide consortium of self-organised groups of disabled people and disabled individuals. Currently over 60 organisations of disabled people and over fifty individual disabled people are members. Inclusion Scotland’s main aim is to draw attention to the physical, social, economic, cultural and attitudinal barriers that affect disabled people’s everyday lives in Scotland and to encourage a wider understanding of those issues throughout Scotland.

1.2 Inclusion Scotland notes that the Health Committee’s Inquiry is concentrating on health inequalities between men and women and those experienced by minority ethnic communities, remote & rural communities and those living in deprivation.

1.3 Inclusion Scotland urges the Health Committee to accept our evidence on the health inequalities experienced by disabled people as disabled people are more likely to experience health inequalities both because they are more likely to live in poverty and because disabled people experience discrimination in accessing and securing the same level and quality of health services as non-disabled patients.

1.4 Health inequalities also contribute to a higher risk of disability. People experiencing social deprivation, are more likely to become disabled for example through accidents, intentional injury and coronary vascular disease. For example, Stroke is the major cause of disability in Scotland and people living in deprived communities are significantly more likely to have a stroke before 65.

2 Background

2.1 Disabled people, i.e. people with physical, sensory, learning or psychiatric impairments or other long-term health conditions, make up about 20% of Scotland’s population and over a third of NHS users. While many disabled people receive an excellent service from the NHS, many others have experienced discriminatory assumptions about their quality of life or strict adherence to a 'medical model’[1] of disability which has adversely influenced the sort of service they receive[2]

2.2 When discrimination occurs within the health services it can affect disabled people from the moment they are born, when disclosure of disability can be treated insensitively; through to restrictions or refusal of treatment or even the posting of Do Not Resuscitate (DNR) notices[3]

2.3 The Disability Rights Commission (DRC) conducted a Formal Investigation in England and Wales into the physical health inequalities experienced by people with mental health problems or learning disabilities. The investigation found that people with learning disabilities, especially more severe learning disabilities, have much lower rates of cervical screening, mammography and other routine tests than other citizens.
2.4 Over half of those taking part in the DRC consultation said that as people with a mental health problem or learning disability they faced difficulties when trying to use the service provided by their health centre or doctor’s surgery. A small number reported not being registered or being struck off a GP’s list, for instance for being ‘too demanding’. It is extremely unlikely that similar discrimination is not faced by those with mental health problems or learning disabilities north of the border but additional Scottish research is urgently required.

2.5 **Fair For All-Disability** undertook a baseline survey of all Scottish Health Boards in 2004, to ascertain what extent of knowledge existed within the NHS in Scotland of Part 3 of the DDA 1995, which prohibits discrimination against disabled people with respect to the provision of goods and services. The results indicated that knowledge of the DDA 1995 was poor. The report’s authors concluded that this lack of knowledge makes it likely that disabled people will have experienced difficulties when attempting to access health services.

2.6 There is a great deal of evidence of inequalities in health outcomes between disabled and non-disabled people and of significant problems in access, staff attitudes and quality of service. There have been several reports published on the continuing institutional discrimination faced by disabled people as service users, including from the British Medical Association (*Disability equality within healthcare*: BMA, June 2007), and the Guide Dogs for the Blind Association (*The experiences of visually impaired users of the NHS*: The Guide Dogs for the Blind Association, 2004).

2.7 DRC research shows that some groups of disabled people (such as those with learning difficulties/impairments or long term mental health problems) die younger than non-disabled people, often from preventable conditions such as respiratory illness. Learning disabled people are four times more likely to die from a treatable illness (the term "learning disabled" covers the 1.5m people in the UK with an IQ of 70 or under. It includes conditions like Downs Syndrome, severe autism and brain damage through head injury, or oxygen deprivation). Learning-disabled people were 58 times more likely to die before the age of 50 than other non-disabled members of society. They do not die younger purely because of their impairments. Other reasons include deprivation, lifestyle and barriers to accessing health promotion, assessment, screening and treatment.

2.8 The same research also showed that learning-disabled people were 58 times more likely to die before the age of 50 than other non-disabled members of society. They do not die younger purely because of their impairments. Other reasons include deprivation, lifestyle and barriers to accessing health promotion, assessment, screening and treatment.

2.9 There is also a problem with the health service co-ordinating physical and psychological care. Where people have an impairment which is medically defined as physical, their mental health care needs are then often neglected. For example, it is estimated that up to a third of stroke survivors will have significant mental health problems, but most available support is for their physical impairment and there is insufficient support for their mental health difficulties following stroke.

2.10 Inclusion Scotland notes that despite evidence of discrimination and poorer outcomes for disabled patients Scottish Government policy on health inequalities continues to focus on health differences linked to geographical area, gender, deprivation level and ethnicity.
3 Inclusion Scotland – members’ views:

3.1 In 2006/7 inclusion Scotland surveyed our members on their experience of treatment within the NHS. The results showed that as disabled people they experienced a lack of sensitivity and understanding of their health care needs from all areas of the health service from primary through to acute care.

3.2 On the basis of this we believe that disabled people are receiving unequal levels of care and treatment throughout the Scottish NHS. We further believe that this unequal treatment stems from health professionals applying a medical model of disability onto their disabled patients.

3.3 Inclusion Scotland has been informed by members of DNR directives being placed on the notes of disabled patients without consultation with that person or with family members. The directives sometimes remain in place long after recovery from the initial life-threatening episode that had initiated hospitalisation - thus influencing all future medical treatment. This is strong evidence of an underlying attitude, held by many health professionals, that disabled people have a lower quality of life because of their disability, and that therefore lesser efforts should be made to prolong it.

3.4 Increased awareness, and funding, of disabled patient’s independent advocacy services is crucial in this field. Decisions are made by hospital staff about the medical management of a disabled person without a proper understanding of the quality of life of that person.

3.5 It is not possible for the Scottish Government or NHS Scotland to deliver on the priority areas of improving the health of the general population, supporting people with long term conditions, improving access to services or the patient/user experience without meeting the requirements of disabled people.

3.6 Inclusion Scotland would argue that making services accessible for disabled people is good news for all patients (e.g. straightforward information provided for people with learning disabilities is also useful for people whose first language is not English; and making premises accessible to wheelchair users also helps parents pushing buggies and prams). The Health Service also has a crucial role in enabling disabled people to live independently – participating in work, education, leisure, and family and community life.

3.7 Inclusion Scotland agrees with the DRC that disabled people should:

- have the same rights, choice and opportunity in accessing health services - and achieving positive health outcomes - as non-disabled people;
- not encounter discrimination in the provision of health services or health improvement;
- have access to health services, which support their independence, social participation, autonomy and control, and respect their dignity;
- encounter health services that are based on an understanding that all life is of equal value; value disabled people and their quality of life equally to non-disabled people;
- have the right to be consulted.
4 Recommendations

4.1 Inclusion Scotland calls for:

Further research to be conducted, within Scotland, on the health inequalities experienced by Scottish disabled people.

All frontline staff in the National Health Service to receive Disability Equality Training delivered by disabled trainers with personal experience of using NHS services.

Disability Equality Training to be given to all NHS Managers.

Disability equality training and understanding of the Social Model should be a core module in the training of all medical staff.

Annual health checks for groups known to be at higher risk of premature death (e.g. people with learning disabilities or with long term mental health problems).

Health promotion services to be offered equally to disabled and non-disabled people.

Health improvement programmes to explicitly aim for a reduction in inequalities in health linked to impairment (e.g. targets could be set to reduce disproportional rates of early death among people with learning difficulties or mental health problems, from cancer and heart disease).

A programme of awareness raising, and improved funding, of disabled patient's independent advocacy services.

Footnotes:

[1] The 'medical model' of disability focuses on the impairment of the individual as the core of the problem believing medical treatment or cures must be used to 'normalise' the individual. The 'social model' of disability aims to address the problems with social and environmental barriers in terms of discriminatory policies, practices and attitudes which cause social exclusion.


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