Access to healthcare for disabled people in the uk

Access to healthcare for disabled people in the UK is not as straight forward as it can be. Disabled people face serious barriers to accessing care including structural, financial and attitudinal barriers among others (Zaide, A., Burchardt, T., 2005). While some argue that disabled people must have full access to healthcare due to their disability (Braitwaiste, J. and Mont, D. 2006), others highlight that accessing health care is much difficult for the disabled because their needs are not fully understood (Papworth Trust, 2016).

This essay will explore in detail the factors that affect the disabled from accessing healthcare fully in the UK. Evidence will be taken from academic books; peer review journals, searches on the internet on published journals and working papers.

Socio-economic status is connected with degrees in health category and needs for health care. Many evidences from source shows that people of all ages with lower socio-economic status are more likely to die, suffer from specific diseases, or to experience illness or disability. The meaning of disabled people has drastically changed over the years in our society. Disabled people were a group of people who appeal pity and were the subjects of charitable movement, but they are now more likely to be the focus of equal rights legislation.(Punch, S., Harden, J., Marsh, I. and Keating, M. 2013).

Disability is very common in the UK population. According to the Equality Act 2010, a person with physical or mental impairment that has substantial and long -term negative effect on their daily lives is classified as a disabled. In

the UK, there is a good evidence, long-standing inequalities both in terms of access to health care, unmet needs, and health outcomes. However, only limited information about access to healthcare for people with disabilities is there. The available information shows that people with disabilities report worse access (such as physical access into buildings) to services and worse satisfaction with provided services. Their needs are not recognised, they generally face several barriers, structural (such as lack of transportation), financial and cultural (e. g., misconceptions about disability). Many studies have shown that disability is an added impediment in accessing health service. Disabled people are restricted in accessing healthcare and report less satisfaction with their medical care. Some of the barriers to healthcare access include lack of transport and inaccessible buildings. Disabled people often report that their needs are not understood, or they are treated as patients of low priority (Papworth T, 2016).

The delivering of equal access to healthcare for all has been built by the British National Health Service (NHS). Wenzl et al (2015) said, the NHS is expected to work towards greater access to healthcare and reduction in health inequalities. However, through the establishment of tangible policies, the extent that has either been realised or operationalised should be debatable. Powell & Exworthy (2003) argue that most of the NHS policies that are aimed to provide an equitable service focus on service availability rather than on any other dimension of access and concluded that there is “… discrepancy between the ‘ paper’ aim of equal access and the operational aim of equal provision” (p 59). The 2010 Equity and Excellent document put service accessibility at its core but failed to either acknowledge people’s

disparities demands to healthcare or the different resources that people have at their disposal.

Popplewell, et al (2014), found out that people with severe disability are the ones most likely to have an unmet healthcare need. Almost 7. 2 times more disabled are more likely to have an unmet mental healthcare need due to the cost, than people with no dis ability in the UK. Popplewell et al, 2014, demonstrated how adults with physical disability in England report wore access to primary care, while Allerton & Emerson (2012) found similar inequalities in the UK national study with people with chronic conditions or impairments. Some research from UK has also shown that people with disabilities report wore experiences of cancer care (bone, A., McGrath-Lone, L. Day, S., et al 2011-2012)

Drainoni, M., et al (2008) emphasizes that, people with disabilities face structural, financial and attitudinal barriers when they seek to access healthcare. Disabled people in the UK faces difficulties in accessing healthcare that is caused by lack of transport, inaccessible buildings and inadequate training of healthcare professionals, among other factors. People with disabilities usually reports that they feel their needs are not understood, they feel they are not heard, and they are patients of low priority due to their pre-existing condition. Such difficulties can be further compounded by the systematic ban that people with disabilities normally face, such as lower rate of employment, lower income levels of poverty than general population. People with disabilities often have greater healthcare needs and therefore may need to access healthcare services more that the general population (Braitwaiste, J. and Mont, D. 2006).

The connections between disability, socio-economic condition, and gender affect access to healthcare. According to (Zaidi, A., Burchardt, T. 2005), shows that access to healthcare is mediated by the type of health service provider, which is in turn interceded by income. People with disabilities are normally excluded from the job market and they also have a higher daily living costs, for instance, increase heating costs if they spend more time at home or out of pocket payment for equipment. They often cannot afford to pay for private coverage or out of pocket payment for medication. In Beatty et al (2003) studies found out that people with the poorest health and with the lowest incomes are the least likely to receive all health services needed. Low income can affect access to healthcare in various ways through, such as, reduced access to suitable transportation and reduced ability to pay for medication or make out-of-pocket payments. This has a gender dimension too, with women consistently reporting worse access to healthcare.

Women with a disability are more likely to have an unmet healthcare need than any of the other groups, for example, they are 7. 2 times more likely to have an unmet mental healthcare need due to the cost if compared to men without disability, and by men with a disability they are almost four times more likely to have an unmet healthcare need due to the cost of prescribed medicines (Gideon, J. 2012). There is a gender differences in barriers to healthcare. One of the reasons for this may be the invisibility of the wider social dimensions of gender within the healthcare system, including the NHS. Healthcare systems usually do not recognise the additional obstacles that women may face when they seek healthcare, such barriers may be due to

lower income or higher caring responsibilities compared with men (Gibson, BE., Mykitiuk, R. 2012).

The fact that these results come from UK, a country with a national, public free at-the-point-of- access healthcare system (apart from prescriptions), is particularly worrying. The NHS aims to provide equal access to the population, but this does not seem to be distributed equitable, especially when we consider the use of service and do not their availability. This shows how the interaction of disability and gender can create a structural disadvantage for disabled women who report the worst access to healthcare from any other group (Smith, DL. 2006). To develop effective policies to move towards a more equitable healthcare access, it is important to explore in detail the reasons behind the worse access to healthcare services for people with disabilities, acknowledge how the significance of gender in any exploration of access to services. It is also important to acknowledge how multiple factors, such as disability, gender and the social and financial realities that are implanted affect access to healthcare (Gibson, J., O'Connor, R. 2010). It is vital to determine the actual accessibility of healthcare rather than expected access based on the availability of services or the provision of health reporting, which do not always acknowledge people's specific needs (eg, transportation needs to reach a healthcare facility). It is also equally important to understand that health inequalities are largely based on disparities in wider determinants and therefore, policies aimed at achieving a more equitable distribution of health, need to address broader socio-economic inequalities (Morris, S., Sutton, M. and Gravelle, H. 2005).

In conclusion, people with disabilities report worse cases every day for access to healthcare, with transportation, cost, buildings and long waiting lists being the main problem. It is very worrying as they illustrate that a section of the population, who may have a higher healthcare needs, faces an increased problem in accessing health care services.

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