

国際セミナー2025

障害者の健康公平性への取り組み



日時 2025 年 11 月 22 日（土） 13:30～17:15
主催 国立障害者リハビリテーションセンター



National Rehabilitation Center for Persons with Disabilities
4-1 Namiki, Tokorozawa City, Saitama Pref., 359-8555 Japan

国立障害者リハビリテーションセンター

国際セミナー2025

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日時：2025 年 11 月 22 日（土）13:30-17:15

会場：第一ホテル両国 5 階会場「北斎」（東京都墨田区横網 1-6-1）

時間		発表	登壇者
13:30-13:35	5 分	開会挨拶	芳賀 信彦 国立障害者リハビリテーションセンター 総長、日本
13:40-14:05	25 分	発表 1 基調講演 「すべての人に健康を」実践：障害者の健康公平性に向けて	ジョディ・アン・ミルズ リハビリテーションおよび長期ケア担当オフィサー 保健政策・サービス設計、保健システム・サービス部 世界保健機関（WHO）西太平洋地域事務局
14:10-14:35	25 分	発表 2 身体障害者の医療アクセスからみる障害者の健康公平性	芳賀 信彦 国立障害者リハビリテーションセンター 総長、日本
14:40-15:05	25 分	発表 3 障害者の健康公平性への取り組み：インドの視点、環境、そして変革の岐路	サントシュ・クマール・クラレティ スシェナ・ヘルス財団創設者兼事務局長 フット・ソルジャーズ・フォー・ヘルス創設者兼 CEO リシフッド大学ヘルスケア学部教授兼准学部長
15:05-15:15	10 分	休憩	
15:15-15:40	25 分	発表 4 車椅子利用者が対面及びオンラインフォローアップ診察に感じる障壁：横断研究	ラモン・アンヘル・サルード・ペリケ 中国総合病院・医療センター リハビリテーション科 コンサルタント マニラ医療センター リハビリテーション科 コンサルタント
15:45-16:10	25 分	発表 5 障害に起因する保健サービス利用の格差：日本の課題と取り組み	齋藤 崇志 国立障害者リハビリテーションセンター研究所 障害福祉研究部 研究員、日本
16:15-16:40	25 分	発表 6 ケアの架け橋：急性期病院における障害者の入退院支援	松村 幸子 国立健康危機管理研究機構 国立国際医療センター 入退院支援センター看護師長 訪問看護認定看護師、日本
16:45-17:10	25 分	ディスカッション 司会：仲村 一郎 国立障害者リハビリテーションセンター病院 病院長、日本	
17:10-17:15	5 分	閉会挨拶	阿久根 徹 国立障害者リハビリテーションセンター 自立支援局長、日本

「すべての人に健康を」実践：障害者の健康公平性に向けて



ジョディ・アン・ミルズ

リハビリテーションおよび長期ケア担当オフィサー
保健政策・サービス設計、保健システム・サービス部
世界保健機関（WHO）西太平洋地域事務局

【略歴】

Dr. ジョディ・アン・ミルズは WHO 西太平洋地域事務局の保健政策・サービス設計ユニットのオフィサーであり、リハビリテーション、支援技術、障害、長期ケアの分野を担当している。2023 年に西太平洋地域事務局に着任する前は、WHO 本部に勤務し、リハビリテーション人材の育成を専門としていた。作業療法の学士号、国際公衆衛生の修士号、そしてオーストラリアのシドニー大学医学保健学部にて博士号を取得。

【発表要旨】

2022 年 12 月に発表された WHO の障害者の健康の公平性に関するグローバルレポートは、障害を抱える 13 億人（世界人口の 16%）に影響を与える深刻な格差を明らかにしました。報告書は、障害者は障害のない人よりも最大 20 年早く死亡するリスクに直面しており、喘息、うつ病、糖尿病、肥満、口腔疾患、脳卒中などの慢性疾患を発症するリスクが最大 2 倍あることを示しています。

こうした顕著な健康格差は、「すべての人に健康を」という目標達成に向けた私たちの進歩を阻むものであり、障害者の早期死亡や疾病リスクを高める構造的・制度的障壁に対処するための緊急の対策が求められています。重要なのは、健康格差は、健康状態や機能障害によって説明できるものではなく、保健システム自体に存在する回避可能な、不公平で不当な要因によって説明できるということです。

このような状況に対応するため、WHO はすべての政府と保健分野のパートナーに対し、3 つの基本原則を推進しています。第一に、障害者の健康公平性をすべての保健分野の行動の中心に据えること。第二に、障害のある人々をエンパワーし、意思決定プロセスに意義ある形で参加させること、そして第三に、障害のある人々の成果をモニタリングすることです。WHO は、世界中の保健省やパートナーと協力し、緊密な協議に基づく状況評価や行動計画の策定などを通じて保健システムの包摂性向上に努め、これらの原則を実践に移しています。この包括的なアプローチは、誤解を解き、障害に関する保健システムの視点を広げ、真の健康公平性を達成するために不可欠な保健計画や意思決定プロセスに、障害のある人々が参加する有意義な機会を確保するものです。



How we conceptualise disability

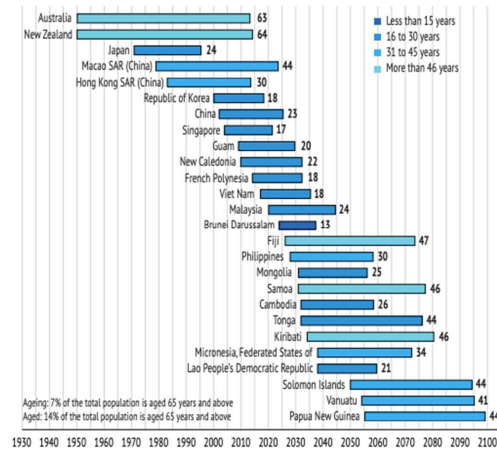
- Disability is not the same as a health condition
 - A health condition can contribute to disability, along with personal, social and environmental factors
- It is the responsibility of the health sector to:
 1. Prevent and manage health conditions that may contribute to disability
 2. Provide care that optimizes functioning
 3. Advance health equity for persons with disabilities



Why health equity for persons with disabilities matters

- Impacts a significant portion of the population
 - 1.3 billion people, or 16% of people experience disability
 - This number is growing due to epidemiological and demographic factors
- There is a clear link with the health sector
- There are striking disparities in health outcomes that need to be addressed

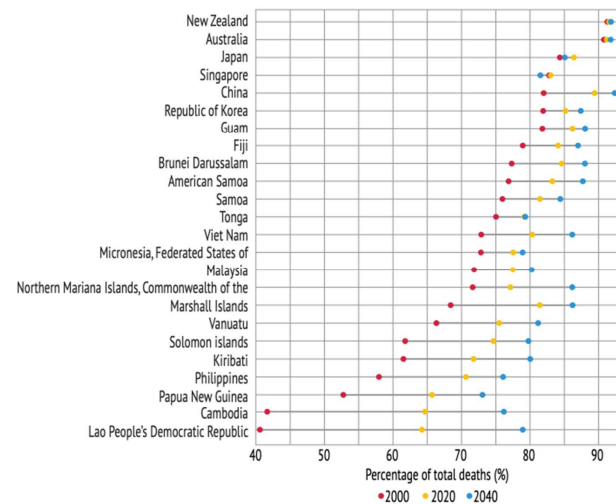
Speed of ageing for select countries and areas in the Western Pacific Region: projected time required to transition from an ageing to aged society



Source: United Nations Department of Economic and Social Affairs, Population Division

There are more than 240 million people over the age of 65 in WHO Western Pacific Region, and that number is expected to double by 2050.

Percentage of NCD burden in select countries and areas in the Western Pacific Region



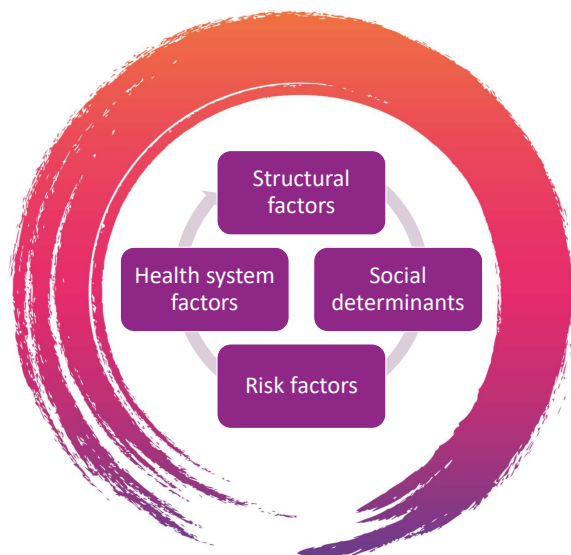
Significantly increasing prevalence of NCDs in the region, mean more people are living with disability

Disparities in health outcomes

- **Premature death**
 - up to 20 years earlier
- **Poorer health**
 - More than double the risk for certain health conditions
- **More limitations in functioning**
 - Health facilities are six times as hindering
 - Transportation is 15 times hindering

Unjust

These health inequities are due to unfair and avoidable conditions which affect persons with disabilities disproportionately



Contributing factors to health inequities...

Structural factors

Stigma & Discrimination

- Cultural and societal values that manifest in ableism, stigma and discrimination
- Intersectionality (e.g., gender)

Policies and processes

- Lack of efficient, equitable and transparent policies and processes
- Examples of non-inclusive social protection mechanisms

Governance

- Systems of accountability in the health sector are weak, with disability legislation and guidelines rarely enforced or implemented
- Persons with disabilities and their organizations are still not engaged in decision-making processes

Social determinants

Poverty and added costs

- A higher % of persons with disabilities live under the poverty line
- Higher healthcare costs

Transportation

- Lack of accessible transport

Intersectionality

- Health inequities are shaped by the interaction of different aspects of social identities and systems

Education and employment

- Disparities in education and employment

Social determinants

Climate impact

- Climate change related hazards exacerbate vulnerabilities

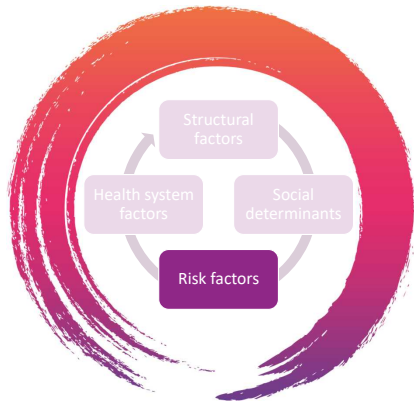
Living conditions

- Poor living conditions, relating to housing and food security
- Institutionalization and social isolation

Violence

- Added risks of violence, particularly women and girls with disabilities

Risk factors



Public health interventions are often not inclusive



Physical inactivity

- Added risk to poor health outcomes due to physical inactivity



Drug and alcohol use

- Added risk to poor health outcomes due to drug and alcohol use



High body mass index

- Added risk to poor health outcomes due to high BMI



Air pollution

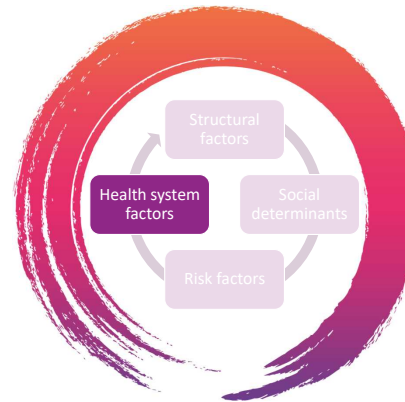
- Added risk to poor health outcomes due to air pollution



Smoking

- Added risk to poor health outcomes due to smoking

Health system factors



Health and care workforce

- The lack of knowledge, skills and competencies by health and care professionals on the needs of persons with disabilities



Leadership

- The lack of leadership on disability inclusion



Health information systems

- National health information systems often do not collect and disaggregate valid and reliable disability data



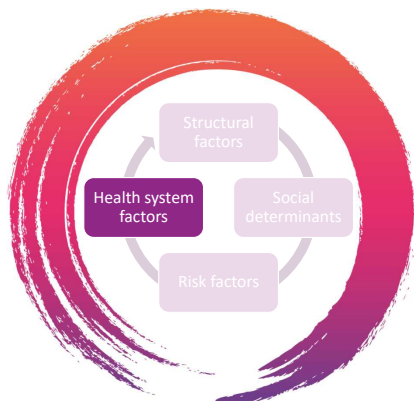
Service delivery

- Multiple gaps in service delivery that disadvantage persons with disabilities (e.g., poor health service coordination, inaccessible environments, etc.)



Health systems financing

- Often disadvantage persons with disabilities



The case for addressing health equity for persons with disabilities

State obligation

- Each country has an obligation, under international human rights law and many domestic legal frameworks, to address these inequities
- Article 25 of the CRPD: States Parties must recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination.

Smart investment in Health for All

A disability-inclusive health sector **brings dividends** for individuals and communities.

For every US\$1 spent on disability inclusive NCD prevention and care, the return on investment could be US\$10.

Multiplier effect

Addressing health inequities for persons with disabilities **benefits everyone**

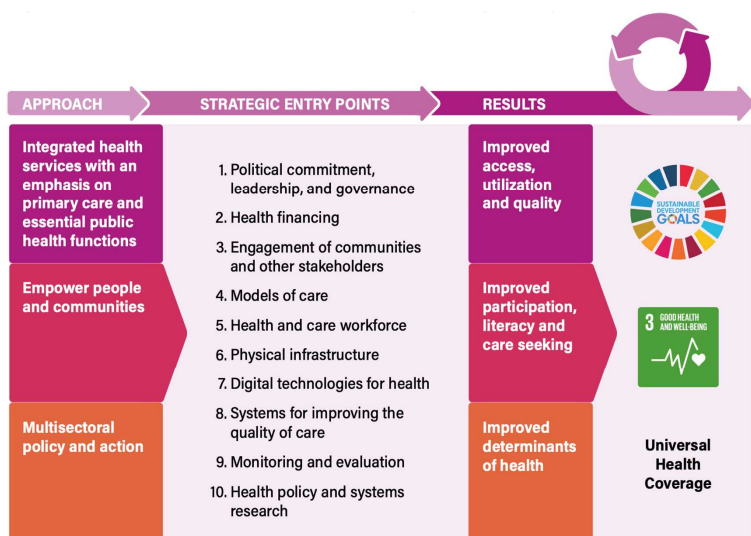
How to advance health equity for persons with disabilities?



1

Include **health equity for persons with disabilities at the centre** of any health sector action.

- **Integrate targeted actions for disability inclusion** within wider health system strengthening efforts of countries.



Framework for health sector strengthening through PHC – 10 strategic entry points for disability inclusion

2

Ensure **empowerment and meaningful participation** of persons with disabilities and their representative organizations **when implementing** any health sector action.



Monitor and evaluate the extent to which health sector **actions lead to health equity** for persons with disabilities.



How is WHO working to advance health equity for persons with disabilities?

WHO Tools and initiatives

- Disability-inclusive health systems: Guide for Action
- Disability-inclusive health services toolkit and toolkit
- Data collection instruments (MDS, and Brief MDS, F11)
- Disability Inclusive Health Network

Find out more about our work and resources



Website

who.int/health-topics/disability

Contact me

millsj@who.int

身体障害者の医療アクセスからみる障害者の健康公平性



芳賀 信彦

国立障害者リハビリテーションセンター 総長、日本

【略歴】

国立障害者リハビリテーションセンターにおいて、2 年間の自立支援局長の経験を経た後、2023 年 4 月に同センター総長に就任、現在に至る。研究所、病院、自立支援局等から構成される同センター全体を統括している。

1987 年東京大学医学部卒業後、整形外科医として 19 年間、特に小児整形外科、小児障害分野に従事。2006 年、東京大学リハビリテーション部教授・部長に就任。2019 年から 2021 年まで東京大学医学部附属病院副院長を務めた。

専門はリハビリテーション医学、先天性四肢欠損症や骨系統疾患など稀な遺伝性運動器疾患の管理であり、リハビリテーション科及び整形外科の専門医である。日本リハビリテーション医学会理事を務め、また、国際リハビリテーション医学会など多数の学会に所属している。リハビリテーション医学、小児整形外科の各分野で 170 以上の英文論文を発表。

【発表要旨】

日本では高齢身体障害者の実数と割合が増えている。これには、国民全体の高齢化と、障害者の寿命延伸が関係している。成人身体障害者では、障害そのものの医学的管理に加えて、障害とは無関係の病態に対して医療を受ける機会も多い。しかし障害者の受け入れ経験が少ない機関では、対応が難しいことが予測される。

WHO Global Report on Health Equity for Persons with Disabilities では、40 の行動目標を挙げている。この中には、医療従事者や医療分野で働く職員への教育が含まれている。

われわれは 2024 年から厚労科研の中で、身体障害者の医療機関受診への対応を研究している。その初めにわれわれは、関連団体ホームページ等の資料を検索した上で、文献検索を行った。その結果、英文論文 2,537 編、和文論文 116 編が検出された。これらの内容を検討し、最終的に 86 編の論文（英文 75 編、日本語 11 編）が残った。これらを分析するにあたり、女性障害者に特化した論文が多く確認されたことから、①全体（複数の障害種別を対象とするものなど）、②聴覚障害、③視覚障害、④肢体不自由、⑤女性障害者、の 카테고リーに分類した。障害により、医療機関受診に際しての障壁には特徴があったが、いずれの障害でも、医療機関へのアクセス、医療側とのコミュニケーション、医療機器の障害者に対する有用性、医療側の知識と態度、が障壁になることが多かった。今後これらの結果を参考に、医療機関向けの対応マニュアルを作成する予定である。

Health Equity and Access to Health Care Service for Persons with Physical Disabilities

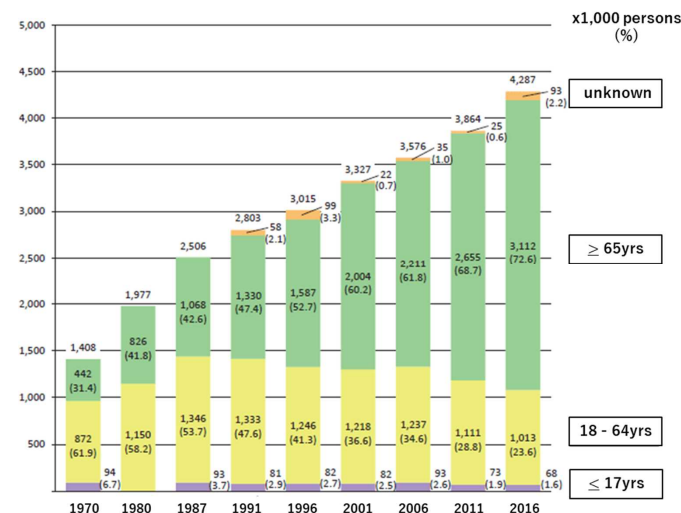


Nobuhiko Haga, M.D., Ph.D.

National Rehabilitation Center for Persons with Disabilities

In connection with this presentation, there is no COI to be disclosed with any companies.

Age Distribution in Persons with Physical Disabilities (PWPD)



National population aging
→ Elderly persons become physically disabled.

Improved medical management
→ PWPD become old.

Adult PWPD need to access health care services



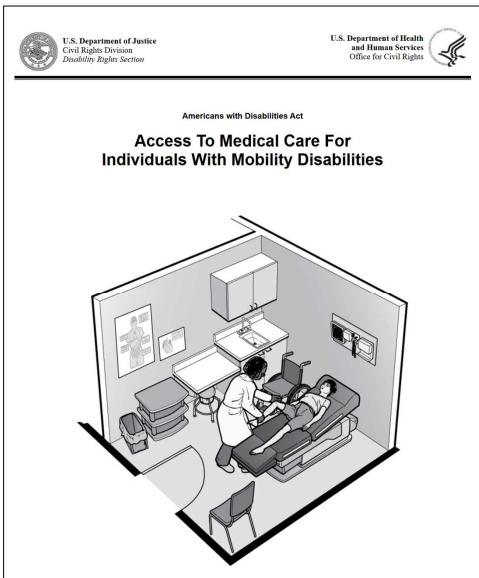
- to receive medical management of their disabilities
- to undergo inspections and treatment for clinical conditions unrelated to their disabilities

Health care services that have few experiences of accepting PWPD may have difficulties in meeting their needs properly.



Disability targeted actions to strengthen PHC and advance health equity for persons with disabilities

- #26. Provide training in disability inclusion to all health service providers
- #29. Train all non-medical staff working in the health sector on issues relating to accessibility and respectful communication



adjustable height examination table



accessible scale

A critical, but often overlooked component to ensuring success is adequate and ongoing training of medical practitioners and staff.

<https://www.ada.gov/resources/medical-care-mobility/>

2024~2026: Development of methods necessary to promote cooperation between disability welfare and medical care

as a Research on Disability Health and Welfare funded by the Ministry of Health, Labor, and Welfare Research Grant



NRCD Group has performed research on access to health care services in PWPd.

Physical disabilities include those in hearing, vision and mobility.

After collecting related materials through website search, we conducted literature search for studies written in English or Japanese.

Literature Search

Data Source:

PubMed for English literature and Ichushi-Web for Japanese literature

Published Year:

Jan. 1980-Jan. 2025

Search Words for PubMed (similar for Ichushi-Web):

("physical disability" OR "physically disabled" OR wheelchair OR amput* OR "visual impairment" OR "hearing impairment")

AND (health*care OR hospital)

AND (barrier OR access*)

Inclusion Criterion:

Those related to barrier in access to health care services

Exclusion Criteria:

Preprints

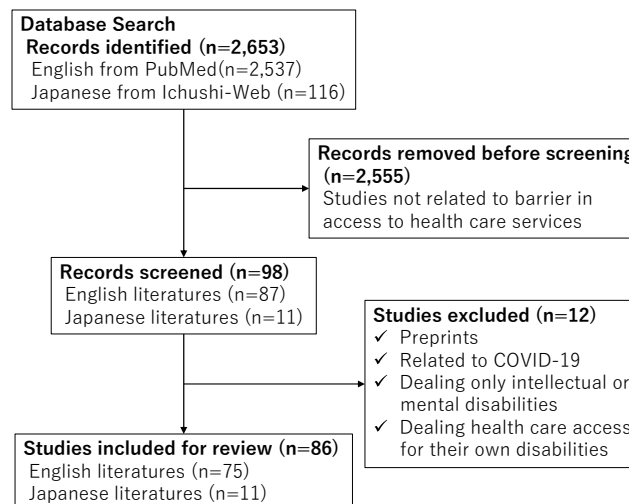
Those related to COVID-19

Those dealing only intellectual or mental disabilities

Those dealing health care access for their own disabilities

Flow Diagram for Identifying Studies

Studies Included for Review



86 studies
(75 English and 11 Japanese)

Categorization

1. General or multiple disabilities
2. Hearing disabilities
3. Visual disabilities
4. Mobility disabilities
5. Disabilities in women

General or Multiple Disabilities

27 English & 2 Japanese literatures

- PWPD experience barriers in accessing various health care, including emergency medical service, primary health care, surgery, and cancer medicine. (Popplewell: *BMJ Open* 2014, Edwards: *Disabil Health J* 2020, Johnston: *Health Aff* 2021, Jolley: *PLOS Glob Public Health* 2024)
- Main barriers in accessing medical services in Africa and India were transportation and its necessary cost. (Vergunst: *Glob Health Action* 2015, Senghor: *BMC Health Serv Res* 2017, Mutwali: *Disabil Health J* 2019, Arunkumar: *Cureus* 2024, Ssemata: *BMC Health Serv Res* 2024)
- Barriers arising from communication problems, attitude of medical staff, and problems in facilities and medical equipment were reported from Europe, North and South America, and Africa. (Graham: *Disabil Health J* 2008, Sakellariou: *BMJ Open* 2019, Carmichael: *West J Emerg Med*, 2023, Tesfaye: *Risk Manag Healthc Policy* 2021, Reichenberger: *Rev Saude Publica* 2024, Ssemata: *BMJ Open* 2024)
- Persons with multiple types of limitations are at high risk of reduced access to health care and unmet health care needs. (Horner-Johnson: *Health Ser Res* 2014)
- PWD who perceive discrimination are less likely to seek healthcare. (Moscoso-Porras: *Disabil Health J* 2018)
- Common concerns of physicians involved high costs, too little time, insufficient space, inadequate training, and lack of adequate mental health services to care for PWD. (Iezzoni: *Disabil Health J* 2024)

Hearing Disabilities

5 English & 3 Japanese literatures

- A systematic review on healthcare use and health literacy in people with hearing impairment revealed lower health literacy, higher medical cost, barriers to obtaining health-related information, and difficulty in communicating with healthcare providers. (Piao: *Arch Public Health* 2023)
- Barriers including scheduling appointments and communicating with providers can lead to avoidance of doctor visits, misdiagnosis, and treatment other than the patients' wishes. (Witte: *Jam Board Fam Pract* 2000, Rannefeld: *BMC Public Health* 2023, Baimbridge: *Cureus* 2024)
- Installing fax machines, setting sign language interpreters, and educating clinicians are necessary but insufficient. (Kitajima: *J Jpn Acad Com Health Nur* 1999, Char: *Am Fam Physician* 2024)

Visual Disabilities

3 English & 5 Japanese literatures

- A review article on healthcare access in people with visual impairment pointed out that they are likely to have limited access to information and healthcare facilities, and to receive sub-optimal treatment because staff are unaware of specific needs related to vision. (Cupples: *BMJ* 2012)
- Barriers exist in primary healthcare, dental healthcare, medical checkup, and cancer screening. (Yamaki: *Jpn J Public Health* 2017, Binder-Olibrowska: *Int J Environ Res Public Health* 2022, Jena: *Cureus* 2024)
- Variations in the webpages of national university hospitals may prevent visually impaired persons' access to the information due to difficulty of understanding the structure of the webpage. (Tanaka: *J Jpn Assoc Med Informatics* 2016)
- "How to Support the Patients with Low Vision: Guides for the Medical Professionals" has been developed. (Yamaki: *Jpn J Quality Safety Healthcare* 2019)

Persons with visual disabilities feel at ease when they are supported like these at healthcare facilities!



"How to Support the Patients with Low Vision: Guides for the Medical Professionals"
(<https://plaza.umin.ac.jp/~CanRes/wp-content/uploads/2023/04/26447488d3eef50ec3a3f73813910a43.pdf>)

Mobility Disabilities

19 English literatures

- Wheelchair users were unsatisfied with parking, waiting area, and toilet facilities. They also pointed out lack of height-adjustable examination table, safe transfer devices, and wheelchair accessible weight scale.
(Sanchez: *Rehabil Nurs* 2000, Monro: *J R Soc Med* 2004, Stillman: *Arch Phys Med Rehabil* 2014, Frost: *J Rehabil Res Dev* 2015, Alkawai: *J Community Hosp Intern Med Perspect* 2017)
- Many wheelchair users remained clothed and were examined seated in their wheelchairs.
(Frost: *J Rehabil Res Dev* 2015, Stillman: *Disabil Health J* 2017, Agaronnik: *Arch Phys Med Rehabil* 2019)
- As for dental clinic accessibility for wheelchair users, the guide for general dental practitioners was published, and a modified dental chair was constructed which would accommodate the wheelchair-bound patients to the dental chair without any transfer.
(Ramirez: *Br Dent J* 2018, Lakshmi: *Disabil Rehabil Assist Technol* 2020)
- Experiences of telemedicine and telerehabilitation for wheelchair users have been reported.
(Leochico: *Spinal Cord Ser Cases* 2020, Salud: *Acta Med Philipp* 2024)



Disabilities in Women

21 English & 1 Japanese literatures

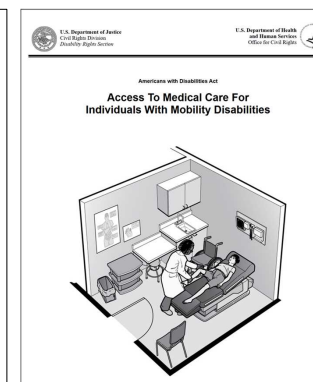
- Many articles on women with disabilities deal with cancer screening and reproductive health.
- Barriers to breast and cervical cancer screening services exist in women with physical disabilities.
(Ramjan: *Women Health* 2016)
- In UK, Attendance rates of wheelchair-dependent spinal cord injury women for cervical screening and mammography were within the national average attendance rates in the general population. While, women with visual impairment in US are less likely to receive screening for breast and cervical cancers, and the screening compliance rate for mammography is low in women with severe cerebral palsy in US.
(Graham: *Spinal Cord* 1998, Xu: *Ophthalmic Epidemiol* 2017, Nandam: *Disabil Health J* 2018)
- Women with major mobility problems who developed early-stage breast cancer confronted numerous physical barriers during their diagnosis and treatment. (Iezzoni: *Oncol Nurs Forum* 2010)
- Review articles on reproductive health in women with physical disabilities reported barriers related to inadequate equipment and facilities, inexperience and lack of knowledge of clinicians, and negative attitudes of medical staff.
(Pavlidou: *Maedica* 2021, Heideveld-Gerritsen: *Midwifery* 2021)

Barriers in Accessing to Health Care Services for People with Various Physical Disabilities

- Physical barriers in accessing and moving in healthcare facilities
- Medical equipment unsuitable for PWP
- Communication problems with healthcare services
- Limited knowledge of disabilities and how to assist PWP in physicians and medical staff, and their attitude

How can we remove these barriers?

Share information with and train health service providers and non-medical staff working in the health sector.



We are developing brief manuals that health care services can refer to in accepting PWD.

Manuals for

- ✓ mobility disabilities
- ✓ hearing disabilities
- ✓ visual disabilities
- ✓ intellectual disabilities
- ✓ neurodevelopmental disorders
- ✓ cognitive dysfunction
- ✓ aphasia

Acknowledgements:

Core Research Members in *“Development of methods necessary to promote cooperation between disability welfare and medical care”*

Takaoka T, MD, Iwasa M, MD, & Fujitani J, MD

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Thank you for your attention!!

障害者の健康公平性への取り組み：インドの視点、環境、そして変革の岐路



サントシュ・クマール・クラレティ

スシェナ・ヘルス財団創設者兼事務局長

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リシフッド大学ヘルスケア学部教授兼准学部長

【略歴】

Dr. サントシュ・クマール・クラレティは公衆衛生の上級専門家、学術リーダー、そして社会起業家であり、母子保健、公共政策、そしてヘルスケアの革新に 20 年以上にわたり貢献している。Foot Soldiers for Health の創設者兼 CEO を務め、現在はリシフッド大学ヘルスケア学部の教授兼副学部長を務める。また、国家医療委員会（NMC）、国家人権委員会（NHRC）の健康とメンタルヘルス小委員会、インド政府保健家族福祉省 NPCB 傘下の医療諮問委員会など、重要な名誉職を歴任。スシェナ・ヘルス財団とグローバル・イルミネ財団の創設者兼事務局長を務め、ダートリ母乳バンク・チェーンの事務局長も務める。

先見の明を持つ彼のリーダーシップは、世界最大の眼科キャンプとして知られる Netra Kumbh や、州全体の失明予防プログラムである Kanti Velugu といった画期的な取り組みにつながった。国際的には、WHO、国連、世界銀行の様々なプラットフォームにおいてインドを代表し、公平な医療アクセスの実現を訴えた。RMNCH+A、母乳育児支援、医療財政、障害者インクルージョン、地域眼科医療に深い関心を持ち、すべての人々のより健康な未来のために、政策と実践を続けている。

【発表要旨】

インドでは、過去 10 年間で障害者の健康の公平性の向上において大きな変化が見られました。一部の州と中央政府は、医療財政において抜本的な転換を遂げました。私のプレゼンテーションでは、次の大きな課題（医療施設と地域社会におけるアクセスと公平性）がどのように解決されているのか、そして現状を改善するために何ができるのかを明らかにしたいと思います。

Advancing Health Equities for persons with Disability



INDIAN PERSPECTIVE, THE MILIEU AND THE CROSSROADS OF METAMORPHOSIS

Dr Santhosh Kumar Kraleti



FOUNDER & GENERAL SECRETARY, SUSHENA HEALTH FOUNDATION

FOUNDER & CEO, FOOT SOLDIERS FOR HEALTH

PROFESSOR & ASSOCIATE DEAN, SCHOOL OF HEALTHCARE, RISHIHOOD UNIVERSITY

Disability and the Current Indian Milieu



Definition

According to the World Health Organization...

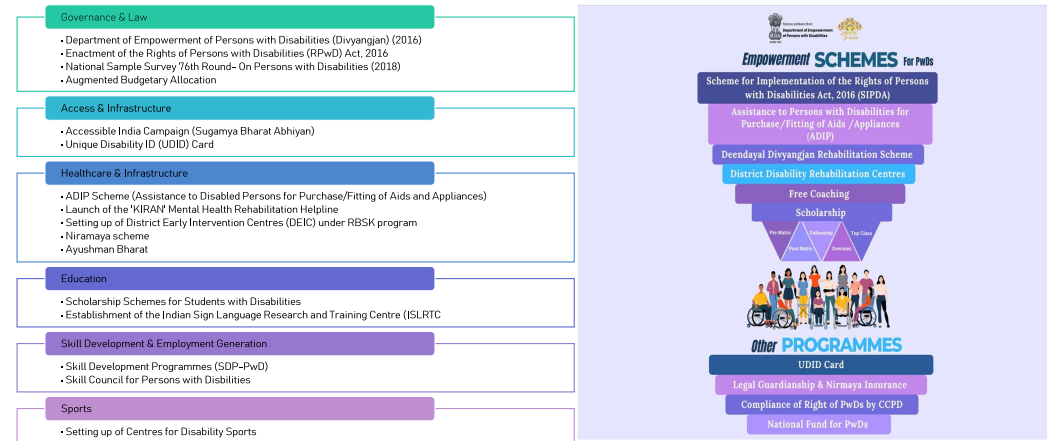
"Disability results from the interaction between individuals with a health condition, such as Cerebral palsy, Down syndrome and Depression, with personal and environmental factors including [negative attitudes](#), [inaccessible transportation](#) and [public buildings](#), and [limited social support](#)."

A person's [environment](#) has a huge [effect on the experience and extent of disability](#)."

Reducing inequities for the disabled in India



Notable achievements in last 10 years



Governance and Law



Department of Empowerment of Persons with Disabilities (Divyangjan) (2016) with Augmented Budgetary allocation

- A separate Department of Empowerment of Persons with Disabilities was carved out of the Ministry of Social Justice and Empowerment on 12.05.2012 as the Department of Disability Affairs to ensure greater focus on policy matters to effectively address disability issues and to act as a nodal Department for greater coordination among different stakeholders, organizations State/UTs Governments and central Ministries and Departments.
- The Department was renamed as the Department of Empowerment of Persons with Disability in December 2014 and as the Department of Empowerment of Persons with Disabilities (Divyangjan) DEPW(D) in May 2016 to explicitly express the focus of the Department on overall empowerment of PwDs
- Augmented Budgetary Allocation:** The budget for the Department has been significantly increased from ₹338 crore in 2014 to over ₹1,313 crore today, reflecting a higher priority for disability welfare.

Rights of Persons with Disabilities Act, 2016

An Act to give effect to the UN Convention on the Rights of Persons with Disabilities on 13th Dec 2006

- Enacted as an Act of Parliament in December 2016, came into force in 2017.
- Overwrote earlier Persons with Disabilities Act, 1995
- Defines 'Person with Disability' as "a person with long term physical, mental, intellectual or sensory impairment which, in interaction with barriers, hinders his full and effective participation in society equally with others"
- "Barrier" means any factor including communicational, cultural, economic, environmental, institutional, political, social, attitudinal or structural factors which hampers the full and effective participation of persons with disabilities in society
- Specifies 21 types of Disabilities (earlier Act had only 7)
- Responsibility of the state governments to ensure disabled persons enjoy right to equality, life with dignity and respect for integrity
- Benefits- Reservation in govt. / aided higher education institutions (increased from 3% to 5%), government jobs (increased from 3% to 4%), in allocation of land
- Healthcare- Provide free healthcare in the vicinity; barrier free access in hospitals; priority in attendance and treatment

Source: <https://cdnbbsr.s3waas.gov.in/s3e58aea67b01fa747687f038dfde066f6/uploads/2023/10/202310161053958942.pdf>



21 type of Disabilities- Classified in RPwD Act, 2016

1. Blindness	2. Low-vision	3. Leprosy Cured persons	4. Hearing Impairment (deaf and hard of hearing)	5. Locomotor Disability	6. Dwarfism
7. Intellectual Disability	8. Mental Illness	9. Autism Spectrum Disorder	10. Cerebral Palsy	11. Muscular Dystrophy	12. Chronic Neurological conditions
13. Specific Learning Disabilities	14. Multiple Sclerosis	15. Speech and Language disability	16. Thalassemia	17. Hemophilia	18. Sickle Cell disease
19. Multiple Disabilities including deaf-blindness	20. Acid Attack victim	21. Parkinson's disease			

Source: <https://www.pib.gov.in/newsite/printrelease.aspx?relid=155592>

National Sample Survey (NSS) 76th Round (July-Dec 2018)

Most recent household survey to identify persons with disabilities (as per the RPwD Act 2016)

- Household level survey, 1,18,152 households (68.55% Rural & 31.45% Urban)
- Prevalence of disability- 2.2% (2.3% in rural and 2.0% in urban)
- More in males (2.4%) than females (1.9%)
- 52.2% of persons with disabilities (Aged >= 7 years) were literate
- 3.7% of persons with disability were living alone, 62.1% had a caregiver and for 37.7% caregiver was not required
- 5.1% persons did not take treatment for their disability since they could not afford
- 21.8% received aid from government, 1.8% received aid from other organizations, 76.4% did not receive aid
- 28.8% had a certificate of disability
- 23.8% was the labour force participation rate (Aged >=15 years)

Source: Persons with Disabilities in India, NSS 76th round report, July -Dec 2018, Government of India, MoSPI, https://www.mospi.gov.in/sites/default/files/publication_reports/Report_583_Final_0.pdf



Access and Infrastructure

BREAKING BARRIERS AT PUBLIC SPACES

1700+

Govt buildings now barrier-free

90+

airports equipped with inclusive features

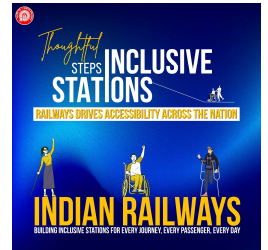
700+

railway stations now Divyangjan-friendly with lifts & escalators



Accessible India Campaign (Sugamya Bharat Abhiyan)

- Launched in 2015 by the Hon'ble PM, this flagship program focuses on creating a barrier-free environment in public infrastructure, transportation systems (airports and railways), and information and communication technology (ICT) ecosystems.
- Covers 3 verticals (sectors) viz.
 - Physical Environment (Infrastructure)- State Govt and Central Govt buildings- Retrofitting and increasing access for the disabled, Budget allocation of 563.85 crores in Phase 1.
 - Transportation- Railways (Provision of ramps, lift, reserved parking, use of braille), Airways (lifts with audio signage & braille, ramps and toilets) and Buses (partially/ fully accessible by PwD)
 - ICT- Govt. websites made accessible, more than 1000 sign language interpreters trained, Accessible TV channel viewing



Unique Disability ID (UDID) Card

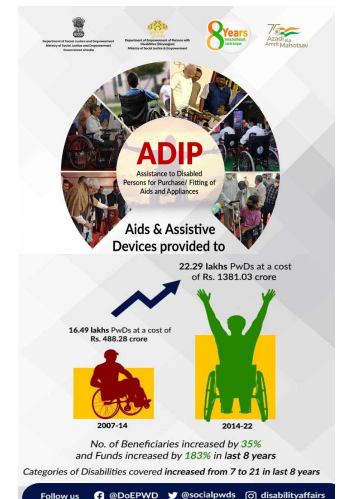
- The government introduced the UDID project in 2016-17 with an objective to create a national data base for Persons with Disabilities (PwDs) and provide a single, universal identity card for persons with disabilities, simplifying access to various government schemes and benefits eliminating the need for multiple documents.
- New version of UDID Portal was rolled out on 6th May, 2024.
- As on date, above 1.10 crore UDID Cards have been generated and issued through the Swavlamban Portal across the country.



Search unique Disability Certificate & card



Healthcare & Rehabilitation



ADIP Scheme (Assistance to Disabled Persons for Purchase/Fitting of Aids and Appliances)

- Funds are released to various implementing agencies for distributing aids & assistive devices to Divyangjan, resulting in their social, economic and educational empowerment
- This scheme was revised and expanded to provide modern, durable, and scientifically manufactured aids and assistive devices at subsidized rates or for free.
- Registration of beneficiaries is also done through ARJUN PORTAL (<https://adip.depwd.gov.in/>) where beneficiaries may register themselves directly by login on the portal for requisite aids and appliance
- Under the Scheme, aids and assistive devices at a cost of Rs. 2055.42 crore have been provided to 28.79Lakh Divyangjan in the last ten years.
- 65786 Motorized tricycles distributed, 6764 cochlear implant surgeries (5960 under ADIP and 804 under CSR) successfully completed

Mental Health Rehabilitation

- National Institute of Mental Health Rehabilitation (NIMHR), Sehore made operational in September 2019, set up with an estimated cost of Rs 179.54 crore
- Launch of the 'KIRAN' Mental Health Rehabilitation Helpline: A 24x7 toll-free mental health helpline (1800-599-0019) has been launched to provide early screening, psychological support, distress management, and mental well-being services in 13 languages.



Rehabilitation Council and Centres

REHABILITATION COUNCIL OF INDIA

- Regulates and monitors the training programmes in the field of rehabilitation of PwDs.
- Maintains Central Rehabilitation Register of persons possessing the recognized qualification.
- Promotes research in rehabilitation and special education
- It has recognized about 57 programmes which includes Master, Bachelor, Diploma and Certificate level programmes.
- Total number of Registered Professional/ Personnel: - 2,34,139 (Incl. special teachers, audiologists, speech therapists, prosthetics, etc.)

REHABILITATION CENTRES

- 25 Composite Rehabilitation Centres (CRC) set up across the country
- Provide rehabilitation services, education and skill development to all categories of PwD, train rehabilitation professionals and workers
- Create awareness among parents and the community regarding the needs and rights of PwDs
- 449.40 crore have been released as Grant-in-Aid to CRCs and 58.65 Lakh beneficiaries served

Niramaya Scheme



- Provides affordable Health Insurance to persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities
- Medical cover upto Rs 1 Lakh including In-patient, OPD treatment, medicines and diagnostics
- Treatment can be availed from any hospital across the country
- Covers transportation costs as well

District Early Intervention Centres (DEIC) under RBSK program



- Setting up of DEIC in each District under the RBSK program of National Health Mission, MoH&FW
- Programme is a systematic approach for early identification of medical conditions and providing the required intervention thereof for children from birth to the age of 18 years
- The initiative covers four Ds (covering around 30 medical conditions)– Defects at Birth (club foot, congenital cataract, etc), Diseases in Children (Convulsive disorders, Rheumatic heart disease, etc), Deficiency Conditions (Anaemia, Goitre, etc) and Developmental Delays including Disabilities (Motor, cognitive, language delays, etc)

Ayushman Bharat- Health & Wellness Centres (HWC) & PM-JAY

- HWC or Ayushman Aarogya Mandir
 - Upgradation of 1.5 Lakh SC to HWC or Ayushman Aarogya Mandir having 10 service packages including RMNCHA and Geriatric care at the primary level.
 - These also includes early detection and response to early childhood development delays and disability.
- PM-JAY
 - Globally the Largest government funded health insurance scheme providing hospital based secondary and tertiary treatment in public and private sector hospitals in the country.
 - Launched in 2018 with 1393 packages and extended to 1949 packages for all ages and gender. Some of these include musculoskeletal, childhood (clubfoot), RoP, childhood cataract, mental illnesses, neurological conditions, hearing disabilities, blood disorders and palliative care packages, etc.



Ali Yavar Jung National Institute of Speech and Hearing Disabilities (Divyangjan) Ministry of Social Justice & Empowerment, Government of India



- Established in 1983 in Mumbai.
- 4 Regional centres and 4 Composite Regional Centres across various States
- Autonomous organization under Department of Empowerment of Persons with Disabilities (Divyangjan)
- Objectives– Manpower Development through UG, PG and PhD programs; Research; Educational programs such as Open school for the drop outs/ illiterates; service facilities like early identification and rehabilitation procedures; Community programs such as tele-rehabilitation services; Material Development for education, Public awareness and parent counselling; Documentation of recent developments in the science and technology of speech and hearing.

Source: <https://ayjnishd.nic.in>

Education



Scholarship Schemes for Students with Disabilities

- An Umbrella Scholarship Scheme with 6 components such as pre-matric, post-matric, top-class education, National fellowship, National Overseas and free coaching for students with disabilities was launched from 2014-15.
- Objective to provide financial assistance from school to post-graduation levels and increased maintenance and disability allowances.
- Direct transfer (DBT) of Scholarships amounting to Rs 834.74 crore released to 2.57 lakh students with disabilities

Indian Sign Language Research and Training Centre (ISLRTC)

- Establishment of the Indian Sign Language Research and Training Centre (ISLRTC) in September 2015
- This center focuses on using teaching and conducting research in Indian Sign Language (ISL).
- Offers diploma courses and free online training modules
- It has developed and launched an ISL dictionary with over 10,000 terms and converted NCERT textbooks into sign language in digital format.
- 183 hearing students and 79 deaf students have been trained as ISL interpreters and teachers
- Provide free skill training and coaching to deaf students



Sports & Recreation



EMPOWERING DIVYANGJAN EMPOWERING INDIA

ATAL BIHARI VAJPAYEE TRAINING CENTRE FOR DISABILITY SPORTS



- ▶ A Centre for Disability Sports at Gwalior is being set up with a total cost of Rs.170.99 crore
- ▶ The Centre will have modern state-of-the art facilities for both indoor and outdoor games with a capacity for training 300 sports persons and residential facilities for 200 sports persons, per batch

Atal Bihari Vajpayee Centres for Disability Sports

- The government has established a state-of-the-art international level Centre of Excellence for Divyang sports persons (PwDs) in Gwalior (named after Atal Bihari Vajpayee) with full accessibility as per norms.
- Its working on another in Shillong to provide world-class training facilities and promote participation in sports for Divyangjan athletes.
- Aim is to create specialized sports infrastructure so that the para-sports persons can undergo rigorous and specialized training in the Centre and to facilitate their integration into Society.
- It offers sports training for persons with disabilities, enabling them to compete in Paralympics, Deaflympics, Special Olympics, and other international events. Facilities include outdoor and indoor activities, a hostel, and a range of sports facilities

Skill development & employment creation

National Action Plan For Skill Development Of Persons With Disabilities



Skill Development for PwD

- National Action Plan for Skill Development of PwDs (NAP-SDP) launched in March, 2015
- Key objectives of the Scheme are to enhance skills of PwDs to enable them to become self-reliant and productive member of the society
- Training are imparted through Empanelled Training Partners (ETPs) comprising Govt. Organizations (GOs) and Non-Govt.
- Organizations (NGOs) (like Infosys) through MoUs have been established to offer specialized skill training and enhance the employability and self-reliance of persons with disabilities in various fields.
- Amount of Rs. 204.68 Cr. has been released for skill training of 1.94 Lakhs PwDs upto 2023-24.



Skill council for Persons with Disability

- Skill Council for Persons with Disability (SCPwD) was incepted as a National Body in October 2015 to fulfil the mission of mainstreaming 'Persons with Disability' (PwD) through skill training to enable them to earn a livelihood and lead a life of dignity in the mainstream society and in turn contribute to growing economy of the country.
- Skill training is imparted at accredited training centres through trained and certified trainers
- Enables successful skilling of Persons with Disability (PwD) on the National Occupational Standards (NOS) such that the disability does not become a restraint factor in his/ her learning



Factors contributing to Health inequities for PwD

Structural factors– Socioeconomic & political context

(Budgetary allocations and utilization are low)

Social determinants of Health– Conditions in which person is born, live, grow, work and age

(Implementation at ground level unequal such as lack of rehabilitation centres)

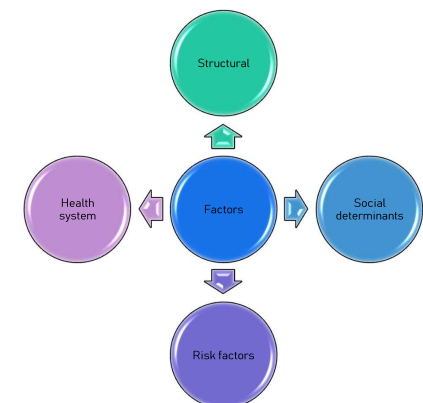
Risk factors– NCDs, Environmental factors (air pollution) due to lack of non-inclusive public health interventions

(Non availability of Safe & Disabled friendly infrastructure in many hospitals pose challenge to access quality care)

Health system factors– Barriers in service delivery, healthcare workforce, IT, technology, financing and leadership

(Accessibility and equity are still a major challenge in some regions esp for vulnerable and poor)

Source: Global report on health equity for persons with disability, WHO, <https://iris.who.int/>



Advancing health equities for PwD

10 Strategic entry points



Source: Global report on health equity for persons with disability, WHO, <https://iris.who.int/>

The Indian Metamorphosis

Sr. No.	Strategic Entry Points	India's crossroad to metamorphosis
1	Political commitment, leadership & governance	<p>RPwD Act 2016- 21 specified disabilities increased from earlier 7. Blood disorders- Hemophilia, Thalassemia and Sickle cell disease and Acid attack victims are some newly identified disabilities.</p> <p>National Health Policy 2017 – Equity & universality are at its core; establishing DALY index as a measure of burden of disease</p>
2	Health financing	<p>Ayushman Bharat- Health & Wellness Centres (HWC) & PM-JAY in 2018, Niramaya Health Insurance scheme.</p> <p>HWC- Upgradation of 1.5 Lakh SC to HWC or Ayushman Aarogya Mandir having 10 service packages including RMNCHA and Geriatric care at the primary level, includes early detection and response to early childhood development delays and disability.</p> <p>PM-JAY- Globally the Largest government funded health insurance scheme providing hospital based secondary and tertiary treatment in public and private sector hospitals in the country. Launched in 2018 with 1393 packages and extended to 1949 packages for all ages and gender. Some of these include musculoskeletal, childhood (clubfoot), RoP, childhood cataract, mental illnesses, neurological conditions, hearing disabilities, blood disorders and palliative care packages, etc.</p> <p>Niramaya- Provides affordable Health Insurance to persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities, cover upto Rs 1 Lakh including In-patient, OPD treatment, medicines and diagnostics</p>

The Indian Metamorphosis

Sr. No.	Strategic Entry Points	India's crossroad to metamorphosis
3	Engagement of stakeholders & private sector providers	<p>The NHP 2017 lays a strong foundation to collaborations with NGOs and engagement with Private sector and leveraging CSR for awareness generation and filling health infrastructure gaps. Government's commitment to Public Private Partnerships in all healthcare programs including the National Health Mission and Ayushman Bharat (HWC, PM-JAY, ABDM) and empaneling private sector hospitals for healthcare delivery.</p> <p>Engagement of multisectoral stakeholders for policy designing and implementation</p>
4	Physical infrastructure	NABH and NQAS guidelines for Disability friendly physical infrastructure in hospitals; Establishing primary and secondary facilities as per norms
5	Health and care workforce	Reservation for PwD in Medical colleges (5%) by the National Medical Commission for UG and PG courses and in healthcare workforce employment (4%) in public sector as mandated by the RPwD Act 2016; Informed consent mandatory by law before carrying out minor and major procedures/ treatment in health facilities.
6	Models of care	Besides PHCs, Health and Wellness centres have been set up to provide a bouquet of services at the community level. Forward and Backward referral mechanisms are a work in progress.

The Indian Metamorphosis

Sr. No.	Strategic Entry Points	India's crossroad to metamorphosis
7	Digital technologies for health	Telemedicine and ABDM including ABHA have been actively taken up by the Government of India.
8	Quality of Care	NABH, NQAS and PM-JAY standards have been laid down for healthcare providers to ensure that they are adopted by the accredited hospitals for patient's safety and quality of care
9	Monitoring & Evaluation	The NSS (by MoSPI) and NFHS (by MoH&FW) are large national level surveys conducted by the GoI to evaluate the parameters and disability indicators. Besides each health program has its own MIS for regular monitoring at National and State level
10	Health policy & systems research	The NHP 2017 has recognized key role of health research and to increase investment in health research in areas such as social determinants of health and neglected health issues such as disability.

Sushena Health Foundation- Enabling Equity for Disabilities

Thank you

車椅子利用者が対面及びオンラインフォローアップ診察に感じる障壁：横断研究



ラモン・アンヘル・サルード・ペリケ

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【略歴】

Dr. ラモン・アンヘル・サルード・ペリケは、フィリピンのマニラを拠点とする物理療法およびリハビリテーションの専門医である。2022 年にフィリピン総合病院で研修医として研修を修了し、同病院の車椅子寄付・フィッティングプログラムの責任者として、移動に困難を抱える患者の自立と尊厳の回復を支援。

現在はマニラメッドにある中国総合病院・医療センターで診療を行っており、フィリピン総合病院との提携も継続している。主な業務は、一般的なりハビリテーション、筋骨格超音波検査、画像ガイド下の手技、そして疼痛や運動障害の管理に対する保存的アプローチである。

多血小板血漿注入、神経ハイドロリリース、関節穿刺といった超音波ガイド下インターベンションも行っている。筋骨格超音波検査の国際認定資格を取得しており、ドイツと日本で実践ワークショップに参加するなど、海外での研修を続けている。

また、ローテーション研修医を指導し、現地での経験と海外研修の両方から得た実践的なリハビリテーションのアプローチを共有している。医療以外では、旅行、料理、新しいスキルの習得を楽しみ、常に他者へのケアの質の向上を目指している。

【発表要旨】

国立三次医療機関であるフィリピン総合病院 (PGH) は、末日聖徒慈善事業団 (LDSC) と長年提携し、車椅子を必要とする患者に提供してきました。このプログラムには、スクリーニング、フィッティング、移動訓練などの対面サービスが含まれています。しかし、多くの受給者はフォローアップのための診察を受けることに障壁を感じており、代替手段として遠隔リハビリテーションへの関心が高まっています。本研究は、車椅子受給者が対面及びオンラインフォローアップケアの両方において認識している障壁を明らかにすることを目的としています。

フィリピン総合病院 (PGH) と末日聖徒慈善事業団 (LDSC) の提携プログラムを通じて車椅子を受け取った 113 名 (平均年齢 42.9 歳) を対象に、横断調査を実施しました。大半はマニラ首都圏外に居住し (53.1%)、月収は 9,520 フィリピンペソ未満でした (86.7%)。大多数は標準型車椅子を受け取っています (85.8%)。対面フォローアップにおける主な障壁としては、アクセスの問題 (82.3%)、交通費 (79.6%)、長距離移動 (71.7%) などが挙げられました。遠隔医療に関する事前の認知度 (50.9%) や経験 (74.1%) は限られていましたが、回答者の 72% が将来的に遠隔リハビリテーションの利用に関心を示しました。ほぼ全員が携帯電話を所有しており (98.2%)、67% が安定したインターネット接続を利用できました。

これらの調査結果は、構造的な障壁が対面ケアを妨げている一方で、遠隔による代替手段の可能性を浮き彫りにしています。しかしながら、認知度の低さとインターネットアクセスの不均一性は依然として課題です。特に障害のある方については、デジタルリテラシーの向上、接続性の拡大、対面ケアと比較した遠隔医療の費用対効果の評価への取り組みが推奨されます。

FACTORS AFFECTING IN-PERSON AND TELEREHABILITATION FOLLOW-UP CONSULTATIONS AMONG WHEELCHAIR RECIPIENTS: A CROSS-SECTIONAL STUDY

Ramon Angel P. Salud MD

Completed as a Resident-Trainee (Oct 2022)

Department of Rehabilitation Medicine

University of the Philippines – Philippine General Hospital

BACKGROUND

- **Philippine General Hospital – Latter-Day Saint Charities**
 - Serves patients in need of **mobility devices**, such as wheelchairs, through in-person services from screening to assessment, measurement, assembly, fitting, and mobility training
 - Healthcare provision may be difficult
 - Telerehabilitation in developing countries has been rising as a practical and innovative solution

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 - **Serves patients in need of mobility devices**, such as wheelchairs, through in-person services from screening to assessment, measurement, assembly, fitting, and mobility training
 - Healthcare provision may be difficult
 - Telerehabilitation in developing countries has been rising as a practical and innovative solution



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OBJECTIVES

- 1) to determine the **demographic characteristics and clinical profile** of the wheelchair recipients since the start of the program of LDSC until September 2020;
- 2) to determine the barriers to in-person follow-up consultations with their local wheelchair assessors; and
- 3) to determine the factors that can potentially facilitate or hinder telerehabilitation as an alternative to in-person follow-up consultations.

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METHODOLOGY

- **Cross-sectional study**
 - total enumeration of patients that received a wheelchair from the PGH-LDSC program
- An **original checklist**
 - Potential factors that affect patients' compliance to actual in-person and potential virtual follow-up consultations

Rehabilitation Partner Survey (to be filled by local wheelchair assessors) * Survey is optional, and data will be kept confidential.

Demographic Data	
Code:	
Age (years):	<input type="checkbox"/> 18-24 <input type="checkbox"/> 25-34 <input type="checkbox"/> 35-44 <input type="checkbox"/> 45-54 <input type="checkbox"/> 55-64 <input type="checkbox"/> 65-74 <input type="checkbox"/> 75+
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Education level:	<input type="checkbox"/> No formal education <input type="checkbox"/> Elementary <input type="checkbox"/> High school <input type="checkbox"/> College <input type="checkbox"/> University
Occupation:	<input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Homemaker <input type="checkbox"/> Other (specify): _____
Referral source:	<input type="checkbox"/> Self-referred <input type="checkbox"/> Referral from family/friend <input type="checkbox"/> Referral from community health worker <input type="checkbox"/> Referral from other (specify): _____
Referral date:	<input type="checkbox"/> 2018 <input type="checkbox"/> 2019 <input type="checkbox"/> 2020
Healthcare Provider/Assessor:	

Barriers to in-person follow-up consultations	
1. Lack of knowledge about the program	<input type="checkbox"/>
2. Lack of transportation	<input type="checkbox"/>
3. Lack of time	<input type="checkbox"/>
4. Lack of interest	<input type="checkbox"/>
5. Lack of financial resources	<input type="checkbox"/>
6. Lack of social support	<input type="checkbox"/>
7. Lack of information about the program	<input type="checkbox"/>
8. Lack of motivation	<input type="checkbox"/>
9. Lack of awareness of the program	<input type="checkbox"/>
10. Lack of understanding of the program	<input type="checkbox"/>
11. Lack of knowledge of the program	<input type="checkbox"/>
12. Lack of information about the program	<input type="checkbox"/>
13. Lack of motivation	<input type="checkbox"/>
14. Lack of awareness of the program	<input type="checkbox"/>
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16. Lack of knowledge of the program	<input type="checkbox"/>
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Referral source:	<input type="checkbox"/> Self-referred <input type="checkbox"/> Referral from family/friend <input type="checkbox"/> Referral from community health worker <input type="checkbox"/> Referral from other (specify): _____
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17. Lack of information about the program	<input type="checkbox"/>
18. Lack of motivation	<input type="checkbox"/>
19. Lack of awareness of the program	<input type="checkbox"/>
20. Lack of understanding of the program	<input type="checkbox"/>

METHODOLOGY

- This checklist was administered to wheelchair recipients either electronically or through individual phone interview
- **Descriptive statistics** was used to analyze and present the data

RESULTS

Characteristics	n (%)
Sex	
Male	59 (52.2%)
Female	54 (47.8%)
City of Residence	
Antique	20 (17.7%)
Batangas	1 (0.9%)
Binan	1 (0.9%)
Cagayan	1 (0.9%)
Caloocan	1 (0.9%)
Cavite	8 (7.1%)
Laguna	33 (29.2%)
Las Pinas	10 (8.8%)
Malabon	3 (2.7%)
Mandaluyong	2 (1.8%)
Manila	11 (9.7%)
Marikina	1 (0.9%)
Navotas	1 (0.9%)
Pampanga	2 (1.8%)
Quezon	1 (0.9%)
Rizal	10 (8.8%)
San Juan	1 (0.9%)
Taguig	2 (1.8%)
Valenzuela	3 (2.7%)
Zambales	1 (0.9%)

RESULTS

Type of Wheelchair Received	
Standard	97 (91.5%)
Active	4 (3.8%)
All-terrain	0 (0%)
Supportive	5 (4.7%)
Unknown	7
Year of Receipt of Wheelchair	
2018	51 (45.1%)
2019	22 (19.5%)
2020	40 (35.3%)
Household Income Bracket	
Less than 9,520	98 (86.7%)
Between 9,520 – 19,040	12 (18.8%)
Between 19,040 – 38,080	3 (4.7%)
Between 38,080 – 66,640	0 (0%)
Greater than 66,640	0 (0%)

RESULTS

Table 2. Factors that Hinder In-person Follow-up Consultations with their Wheelchair Assessor (N=113).

Barriers	Yes n (%)	No n (%)
Distance to the hospital/wheelchair assessor	81 (71.7%)	32 (28.3%)
Transportation concerns	77 (68.1%)	36 (31.9%)
Cost of travel	90 (79.6%)	23 (20.4%)
Cost of meals	73 (64.6%)	40 (35.4%)
Patient will have to miss the day's work or wage	21 (18.6%)	92 (81.4%)
Patient's companion will have to miss the day's work or wage	65 (57.5%)	48 (42.5%)
Health issues (i.e., cannot tolerate travel due to medical problems; pressure injuries)	61 (54.0%)	52 (46.0%)
Difficulty in transfers, standing, or walking	93 (82.3%)	20 (17.7%)
Busy schedule	54 (47.8%)	59 (52.2%)
Appointment scheduling difficulty	68 (60.2%)	45 (39.8%)
Nobody will take care of the house	25 (22.1%)	88 (77.9%)

RESULTS

Factors	Yes n (%)	No n (%)	Not Sure n (%)
Have you heard of telehealth before? (Prior telehealth awareness)	51 (45.1%)	57 (50.4%)	5 (4.4%)
Have you had telehealth experience in the past? (Prior telehealth experience)	24 (21.2%)	84 (74.3%)	5 (4.4%)
If not, are you willing to try telehealth in the future? (missing: n = 5) (Willingness to adapt)	78 (72.2%)	16 (14.8%)	14 (13.0%)
Do you or does your companion know how to engage in videocall? (Technical skill)	100 (88.5%)	6 (5.3%)	7 (6.2%)
Do you have a companion at home who is trained in healthcare (e.g., nurse, caregiver, midwife,	16 (14.2%)	97 (85.8%)	0 (0%)

RESULTS

Factors	Yes n (%)	No n (%)	Not Sure n (%)
Technology access either personally owned or borrowed at home:			
Landline phone	9 (8.0%)	103 (91.2%)	1 (0.9%)
Mobile phone	111 (98.2%)	2 (1.8%)	0 (0%)
Tablet	23 (20.4%)	90 (79.6%)	0 (0%)
Computer (desktop/ laptop)	18 (15.9%)	94 (83.2%)	1 (0.9%)
Stable access to internet	76 (67.3%)	22 (19.5%)	15 (13.3%)
Stable telecommunication network signals	77 (68.1%)	15 (13.3%)	21 (18.6%)
Stable electricity	99 (87.6%)	10 (8.8%)	4 (3.5%)
Private space for telehealth	71 (62.8%)	38 (33.6%)	4 (3.5%)

DISCUSSION



TOP 3 REASONS HINDERING COMPLIANCE



82%: Accessibility Issues

79%: Costs of Travel

72%: Distance to Hospital/Wheelchair Assessor

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82%: Accessibility Issues

79%: Costs of Travel

72%: Distance to Hospital/Wheelchair Assessor



FACTORS AFFECTING VIRTUAL FOLLOW-UPS

72% Willing to experience telerehabilitation despite lack of awareness (50%) nor prior experience (74%)

98% Access to Mobile Phones

67% Internet Stability

68% Stable Telecommunication Access

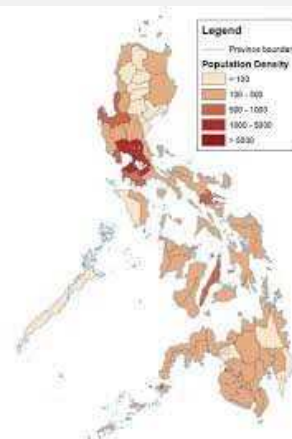
FACTORS AFFECTING VIRTUAL FOLLOW-UPS

No access to landline phone (91%), tablet (80%), or computer (83%)

Stable electricity only present in 87%

Private space for telehealth only present for 62.8%

ACCESSIBILITY

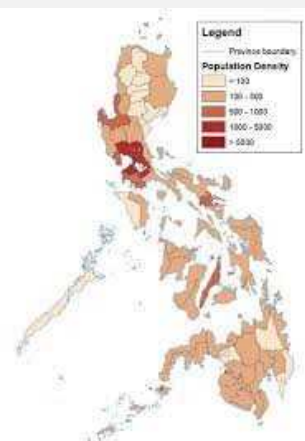


- Philippines – 7,641 island-archipelago

+

- Poor transportation system & infrastructure

ACCESSIBILITY



- Philippines – 7,641 island-archipelago + Poor transportation system & infrastructure
- PLUS wheelchair patient



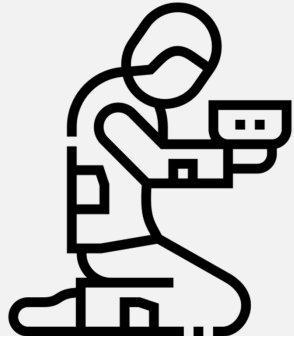
DISCUSSION

- Majority of respondents had household incomes below the poverty line (threshold estimated at Php 12,082 per month)

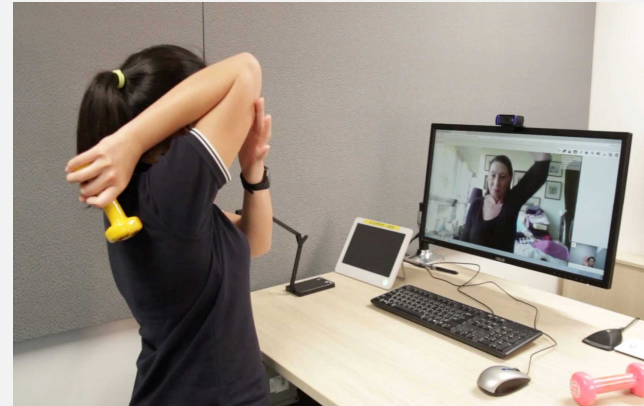


DISCUSSION

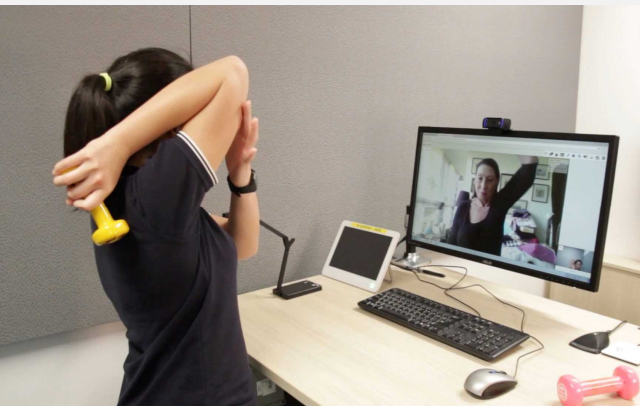
- Majority of respondents had household incomes below the poverty line (threshold estimated at Php 12,082 per month)
- Php 12,082 = ~JPY 31,541



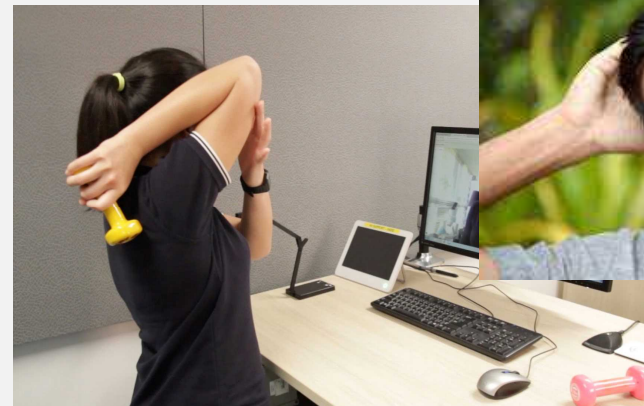
TELEREHABILITATION AS AN ALTERNATIVE?



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- Despite the previous research done on the benefits of telehealth **(+) identified potential barriers** to experiencing the benefits
- **Other countries** – connectivity issues, resistance to technology, difficulty expressing self and symptoms

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- Despite the previous research done on the benefits of telehealth **(+) identified potential barriers** to experiencing the benefits
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LOCAL RESEARCH

Barriers:

Internet speed
Skepticism and legal concerns (privacy issues)

CURRENT STUDY

- Beyond connectivity and technological issues, legal concerns, and skepticism, majority of the participants expressed that there was a **gap in knowledge** regarding said services

CURRENT STUDY

- Approximately half had **never heard** of telehealth
- ~80% of the participants had **never tried** engaging in telehealth services

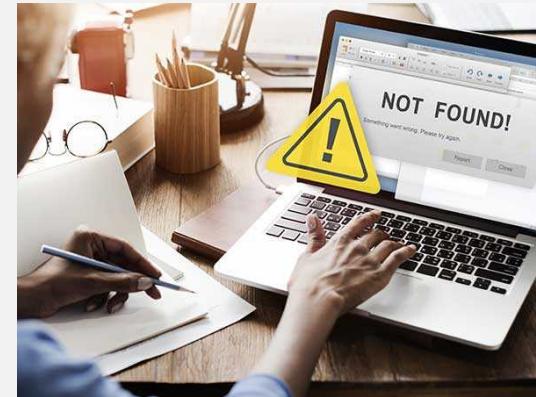
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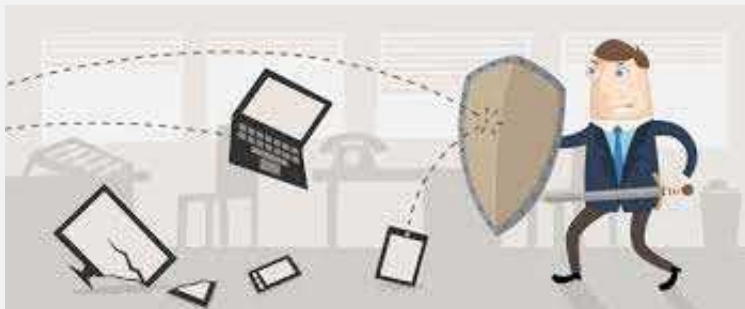
Important to note

72% of the participants expressed **an interest** in trying to avail of this service

CONNECTIVITY ISSUES REMAINED TO BE A MAJOR HINDRANCE



CONNECTIVITY ISSUES REMAINED TO BE A MAJOR HINDRANCE



CURRENT STUDY

- the presence of a companion skilled in technology could serve as a potential facilitator to engaging in said services



? ACCESS TO TECHNOLOGY

- Despite this, (+) poor access that patients have to technological equipment
- Majority reported not having landlines, computers, or tablets at home
- Instead, the most available communication devices were **mobile phones**

? ACCESS TO TECHNOLOGY

- Many of this study's participants **lacked proper resources** to avail of telerehabilitation services to its fullest extent



STRENGTHS OF THE STUDY



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ACCESS TO INTERNET



Year 2010 – 27%



Current study 67%

STUDY LIMITATIONS

- Difficulties in recruiting participants
 - 1) patient demise
 - 2) invalid contact number
 - 3) no answer to call attempts
- This resulted to a small sample size which **can limit the scope of our data analysis and generalizability of the results obtained**

CONCLUSION

- **Main Barriers**

- Related to accessibility, costs and travel

- **Telerehabilitation**

- Despite its emergency globally still has yet to be fully adopted in our country

- **Needs Improvement**

- Connectivity and technological issues
- Stakeholder awareness



RECOMMENDATIONS



- Given the **lack of awareness** regarding telehealth service delivery, future efforts can focus on **improving awareness in this specific population**

**FROM BARRIERS TO BRIDGES: REVISITING
2020 DATA IN 2025'S TELEHEALTH LANDSCAPE**

Where does telerehabilitation stand now?

THEN (2020-2022)

- **In-person barriers:** cost, distance, transport issues
- **Telerehabilitation** seen as a promising solution
- 72% of wheelchair users were **open to telehealth**

Study captured early patient perspectives before mass adoption

NOW (2025)

- Face-to-face consultations have largely returned to pre-pandemic patterns
- Telerehabilitation use **sharply declined** after 2022
- Many hospitals shifted focus back to physical assessments
- Funding and training programs for telehealth plateaued

WHY HAS TELEREHABILITATION DECLINED?

- **Clinical limits:** Difficult to examine tone, balance, spasticity, transfers virtually
- **Equipment issues:** Challenging to inspect or adjust a wheelchair accurately via video
- **User preference:** Patients feel “safer” and more reassured in person
- **System inertia:** No sustained reimbursement or policy support

THE REALISTIC ROLE OF TELEREHABILITATION TODAY

- **Adjunct**, not replacement
- Useful for:
 - Education and counseling
 - Basic exercise follow-up
 - Screening or triage for distant patients

THE REALISTIC ROLE OF TELEREHABILITATION TODAY

- **Adjunct**, not replacement
- Not ideal for:
 - Complex physical exams
 - Equipment fitting or troubleshooting
 - Training new wheelchair users

WHAT 2022 STILL TEACHES US

- Identified real barriers (cost, travel, access) that remain unsolved
- Showed patient **willingness to adapt** — still crucial for future hybrid models
- Serves as a **baseline** for comparing digital access pre- and post-pandemic
- Reminds us that **equity and inclusion** matter more than technology itself

REGIONAL REFLECTION (JAPAN-PHILIPPINES)

Japan	Philippines
Advanced infrastructure but aging, tech-averse users	Connectivity improved but financial barriers persist
Policy-backed telerehab for chronic care	Limited institutional support post-pandemic
Both countries rediscovering value of in-person assessment	Shared opportunity: hybrid follow-ups for select cases

KEY TAKEAWAY

Telerehabilitation was never meant to replace hands-on care—it was meant to fill gaps when face-to-face care isn't possible.

- The challenge now is how to **integrate telehealth sustainably**, not abandon it.
- **Future focus:** hybrid models, cost-effectiveness, and patient-centered selection.

FACTORS AFFECTING IN-PERSON AND TELEREHABILITATION FOLLOW-UP CONSULTATIONS AMONG WHEELCHAIR RECIPIENTS: A CROSS-SECTIONAL STUDY

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Completed as a Resident-Trainee (Oct 2022)

Department of Rehabilitation Medicine

University of the Philippines – Philippine General Hospital

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Pangkalahatang Panuto: Punan ang lahat ng kinakailangang sagutan, at iayon ng pananda ang mga kahon batay sa iyong tugon.

Demographic Data
Code: _____
Edad (taon): <input type="checkbox"/> <input type="checkbox"/>
Kasarian: <input type="checkbox"/> Lalaki
<input type="checkbox"/> Babae
Kasalukuyan adas: _____
Buwatang Kita ng <i>Pamula</i> (Php/Month):
<input type="checkbox"/> < 9,520 <input type="checkbox"/> 9,520 to 19,040 <input type="checkbox"/> 19,040 to 38,080 <input type="checkbox"/> 38,080 to 66,640 <input type="checkbox"/> > 66,640
Uri ng Wheelchair <input type="checkbox"/> Standard <input type="checkbox"/> Active <input type="checkbox"/> All-terrain <input type="checkbox"/> Supportive
Taon nang <i>natanggap</i> ang wheelchair <input type="checkbox"/> 2018 <input type="checkbox"/> 2019 <input type="checkbox"/> 2020
Healthcare Provider/Wheelchair Assessor _____

Dahilan sa pagsasapawa ng in-person na konsultasyon
Para sa Babae A hanggang K, iayon ng tsek ang kahon sa ilalim ng "Oo" o "Hindi", alimman anakop
Mayroon bang dahilan upang magin mahirap na maisagawa ang konsultasyon sa iyong healthcare provider or wheelchair assessor?

	Oo	Hindi
A. Layo sa ospital/ wheelchair assessor		
B. Uapin ng transportasyon		
C. Gastosin sa pamamahala		
D. Gastosin sa pagkain		
E. Kinakailangang lumiban sa trabaho o mawalan ng kita		
F. Ang kasama ng pasyente ay kinakailangang lumiban sa trabaho o mawalan ng kita		
G. Uapin ng pangkalusugan(i.e., hindi kayang magbiyahe dahil sa problema ng medikal, pressure injuries)		
H. Hirap na magpalipat-lipat ng sasakyan, tumayo, o maglakad		
I. Busy ang iskednyul		
J. Kahirapan sa iskednyul ng appointment		
K. Walang maghahantay ng babay		
Ila		
Pakisabi/sulat		

Dahilan na nagpapasinaya o nagiging balakid para sa Telerehabilitation	Oo	Hindi	Hindi tiyak
Para sa mga aytem A hanggang M, pakilagyan ng tsek ang kahon sa ilalim ng "Oo" o "Hindi" ayon sa kung alin ang naaangkop.			
Salik bunsod ng tao			
A. Batid mo na ba ang telehealth dati pa?			
B. Nakaranas ka na ba ng telehealth noon pa?			
C. Kung hindi, nais mo bang subukin ang telehealth sa hinaharap?			
Bakit/Bakit hindi? Pakisabi/sulat			
D. Ikaw ba, o ang iyong kasama, ay maalam kung paano gamitin ang videocall?			
E. Mayroon ka bang kasama sa babay na may kasanayan sa healthcare (gaya halimbawa ng nars, caregiver, midwife, physical therapist, doktor, atbp.)			
Kung oo, pakisabi/sulat: _____			
Salik bunsod ng teknolohiya			
Mayroon ka ba ng sumusunod na maaaring magamit para sa telehealth:			
A. Telepono?			
B. Cellphone?			
C. Tablet?			
D. Kompyuter (desktop/laptop)?			
E. Maayos na akses sa internet?			
Via data: _____			
Via WiFi: _____			
F. Maayos na signal ng cellphone? (Globe, Smart, etc.)?			
G. Maayos na kurvente?			
H. Pribadong espasyo para sa telehealth via videocall?			

障害に起因する保健サービス利用の格差：日本の課題と取り組み



齋藤 崇志

国立障害者リハビリテーションセンター研究所 障害福祉研究部 研究員、
日本

【略歴】

学歴

- ・山形県立保健医療大学，保健医療学部 理学療法学科（2004 年）
- ・桜美林大学，大学院老年学研究科 博士前期課程（2011 年）
- ・桜美林大学，大学院老年学研究科 博士後期課程（2016 年）

主な職歴

- ・麻生リハビリ総合病院（2004-2006）
- ・訪問看護リハビリステーションネットワーク（2006-2015）
- ・日本理学療法士協会（2017-2018）
- ・JICA 海外協力隊（パプアニューギニア，2018-2020）
- ・国立障害者リハビリテーションセンター研究所（2021-現在）

【発表要旨】

障害に起因する保健サービス利用の格差は、世界的な公衆衛生上の課題の 1 つである。約 1100 万人の障害者が暮らす日本では、この健康課題の解消に向けた取り組みが行われてきた。本発表では、まず、日本の障害者の現状について紹介する。そして、障害者の保健サービス利用における課題と、その課題の解決に向けた取り組みを紹介する。

Disability-based inequality in health service access:
Challenges and initiatives in Japan

Takashi SAITO

(Researcher, Ph.D., physiotherapist)

National Rehabilitation Center for Persons with Disabilities, Japan

This talk will cover

- 1. Disability-based inequality in health service access
- 2. Overview of persons with disabilities in Japan
- 3. Challenges of the service access
- 4. Initiatives for equal access



Disability-based inequality in health service access

1. Disability-based inequality in health service access

- People with disabilities are, on average, more likely to experience a broad range of health problems than those without disabilities
 - “Narrow margin of health”
 - People with disabilities represent significant health needs and investment in health care resources
- Smith, R. D. (2000). Health Promotion International, 15(1), 79–86.



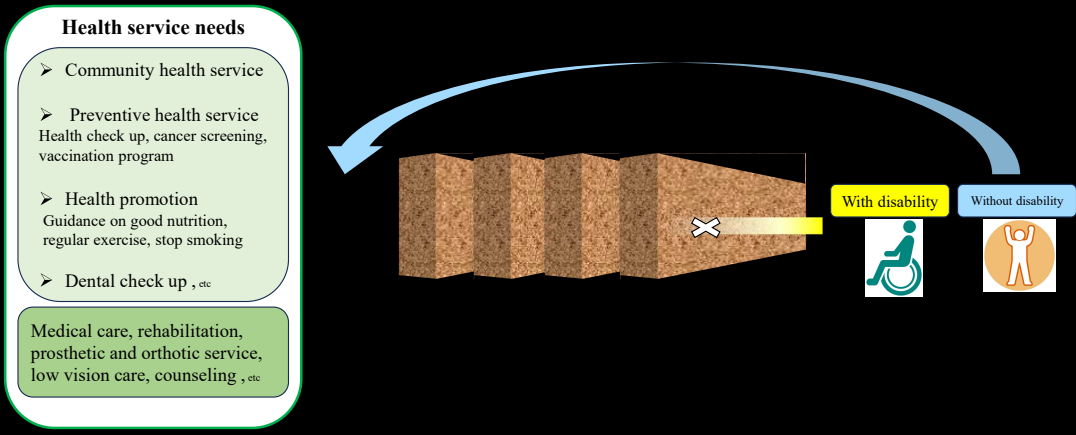
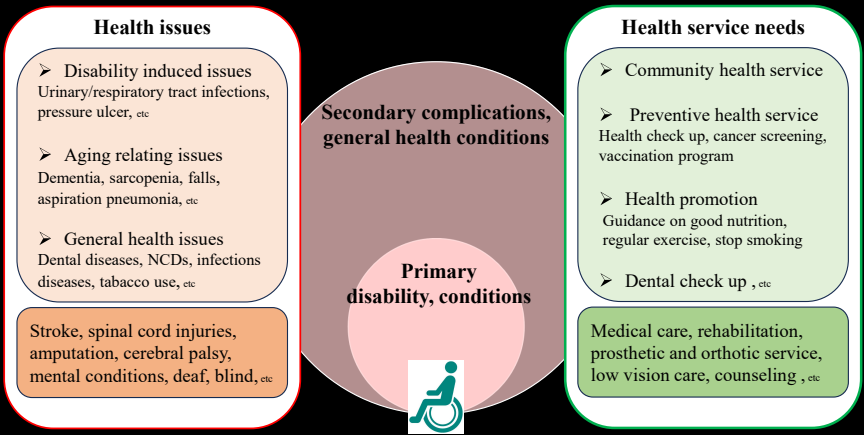
However,

People with disabilities are, disproportionately, hindered from accessing health services, that directly affects their lives

Disability-based inequality in health service access is a global public health issue

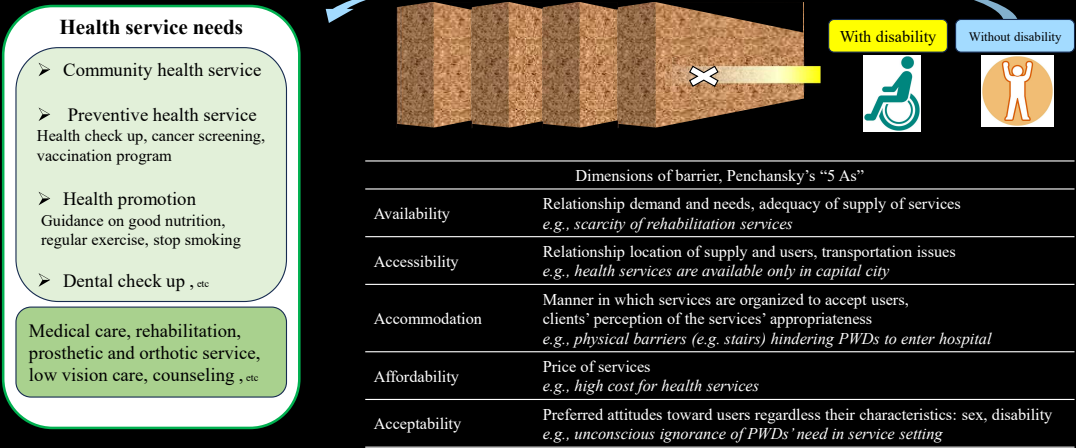
Health issues and health services needs of PWDs

Barriers for health services access in PWDs



WHO. (2015). WHO global disability action plan 2014-2021. Better health for all people with disability.
Smith, R. D. (2000). Health Promotion International, 15(1), 79- 86.

Barriers for health services access in PWDs



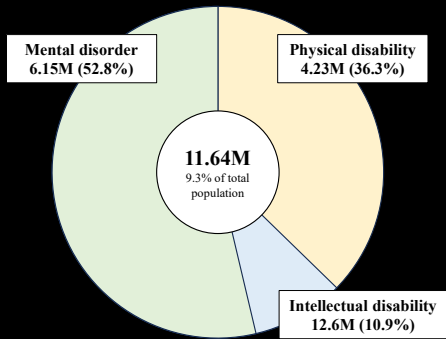
Penchansky R. et al. (1981). Med Care. 1981 Feb;19(2):127-40

2. Overview of persons with disabilities in Japan

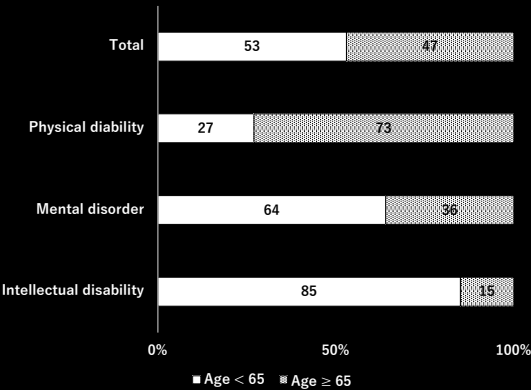


Overview of persons with disabilities in Japan

<Number>



<Age distribution>



The Ministry of Health, Labor and Welfare of Japan
https://www.mhlw.go.jp/toukei/list/dl/seikatsu_chousa_b_r04_02.pdf

Health services for PWDs in Japan

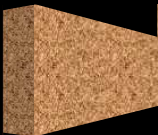
Comprehensive Support for Persons with Disabilities Act (since 2013)

	Service items	Examples
Welfare services	Care services	Home-help, medical care, assistance on travel
	Training services	Rehabilitation, support for employment
	Community consultation assistance service	Assistance to shift to community life
	Community life support services	Sign language volunteer program, voluntary activity support program
Medical service	Outpatient psychological treatment	
	Medical rehabilitation service	
	Public health care to the disabled children	
	Prosthetic appliances and daily-use equipment	

The Ministry of Health, Labor and Welfare of Japan (2025)
<https://www.mhlw.go.jp/content/12200000/001327493.pdf>

3. Challenges of the service access

Challenges of the service access in Japan



Health services need

For secondary complications, general health conditions

- Community health service
- Preventive health service
- Health check up, cancer screening, vaccination program
- Health promotion
- Guidance on good nutrition, regular exercise, stop smoking
- Dental check up , etc

For primary conditions


Medical care, rehabilitation, prosthetic and orthotic service, low vision care, counseling , etc



- Generally speaking, access to services for primary conditions has been improved in past decades thanks to relevant legislations.
- Contrary, access to services for secondary complication, which is not necessarily organized to accept PWDs, is still needed to become more accessible

Compromised access to the health services for the secondary complications or general health condition is one of challenges in Japan

Use of health check up and cancer screening in PWDs



International Journal of
Environmental Research
and Public Health

Article

Use of General Health Examination and Cancer Screening among People with Disability Who Need Support from Others: Analysis of the 2016 Comprehensive Survey of Living Conditions in Japan

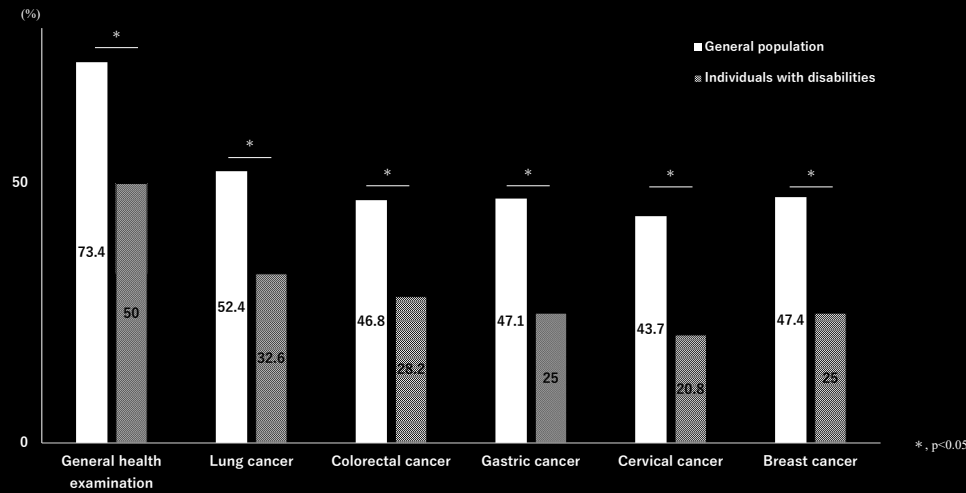
Takashi Saito ^{1,*}, Kumiko Imahashi ^{1,†} and Chikako Yamaki ^{2,†}

- Health check up and cancer screening are crucial for early detection of diseases and health conditions
- Analyzing secondary data of a national representative survey in Japan (n=15,294)
- Describing gap of use of general health examination and cancer screening between people with and without disabilities.
- Disability definition: individuals who need support or super vision from other others in daily life.



Saito T., et al. (2024). Int J Environ Res Public Health. 2024 Feb 13;21(2):219

Participation rate of health check up and cancer screening in Japan



Saito T., et al.(2024). Int J Environ Res Public Health. 2024 Feb 13;21(2):219

Regular dental check up among PWDs



Archives of Physical Medicine and Rehabilitation

Journal homepage: www.archives-pmr.org

Archives of Physical Medicine and Rehabilitation 2017;98(24):2442-8

ORIGINAL RESEARCH

Access to Preventive Services for Working-Age Adults With Physical Limitations

Gimm G., PhD,^a Elizabeth Wood, MHPA,^b Preeti Zanwar, PhD^c



- Unfortunately, no direct evidence of disability-based inequality in dental check up was found in Japan
- Instead, a representative data in U.S. adults (n=75,145; age range, 18-64y)
- Describing gap of dental health check up (in the past 12months) between people with and without disabilities.
- Disability definition:
Physical limitations,
Nonphysical limitations, and
No limitation



Gimm G., et al. (2017). Arch Phys Med Rehabil. 2017 Dec;98(12):2442-2448.

Regular dental check up among PWDs

Table 1 Descriptive characteristics of working-age adults by type of limitation				
Characteristic	Physical Limitation	Nonphysical Limitation	No Limitation	χ ² P
Weighted population size, n	13,143,426	22,519,330	133,842,933	
Unweighted sample size, n	6042	9680	59,423	
Dental visit (in last year), %	44.7	51.5	59.4	<.001

Adults with physical limitation were less likely to have a dental checkup (44.7% vs 59.4%, respectively; P<.001) than those with no limitation

Gimm G., et al. (2017). Arch Phys Med Rehabil. 2017 Dec;98(12):2442-2448.

Table 4 Logistic regression of dental care visit in last year (n = 67,919)

Variables	OR	P	95% CI
No limitation	NA	(Reference)	NA
Physical limitation	0.76	<.001	0.69–0.83
Nonphysical limitation	0.87	<.001	0.81–0.93

After adjusting confounding factors, the likelihood of receiving a dental checkup was lower for adults with physical limitations and nonphysical limitations compared with adults with no limitations

Gimm G., et al. (2017). Arch Phys Med Rehabil. 2017 Dec;98(12):2442-2448.

歯科口腔保健の推進に関する基本的事項
最終評価報告書（案）
（令和 4 年 6 月 24 日暫定版）

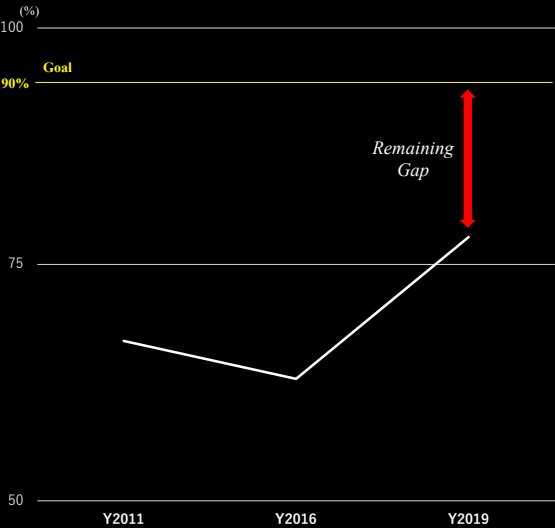
Final report on promotion of dental oral health(2022)

The Ministry of Health, Labor and Welfare of Japan
<https://www.mhlw.go.jp/content/000999685.pdf>

- Although, there is no direct evidence of disability-based inequality in Japan, some reports suggest difficulties accessing regular dental check among PWDs.
- In 2012, a target rate* (90%) was set to promote regular dental check up in nursing facilities for PWDs, based on Act on Promotion of Dental and Oral Health

*Percentage of nursing facilities in which regular dental check ups are implemented

Percentage of nursing facilities in which regular dental check ups are implemented



- An upward trend was observed, but the percentage has not yet reached the goal
- The report highlights necessity for more efforts to encourage dental health check up in nursing facilities for PWDs in Japan

The Ministry of Health, Labor and Welfare of Japan
<https://www.mhlw.go.jp/content/000999685.pdf>

4. Initiatives for equal access



Initiatives for equal access

Examples of initiative for equal access in Japan

Health services need

For secondary complications, general health conditions

- Community health service
- Preventive health service

Health check up, cancer screening, vaccination program

- Health promotion

Guidance on good nutrition, regular exercise, stop smoking

- Dental check up , etc

Availability

Accessibility

Accommodation

Affordability

Acceptability

Solutions

With disability

To overcome the barriers, multifaceted initiatives consisting of unique solutions that are specific for each barriers are needed

- Example1:
Teaching Leaflets for health professionals
- Example2:
Teaching Leaflets for PWDs
- Example3:
Dental oral health care center



Example1. Teaching Leaflets for health professionals

Example1. Teaching Leaflets for health professionals

Availability

Accessibility

Accommodation

Affordability

Acceptability

Solutions

Example1:
Teaching Leaflets for health professionals

Example2:
Teaching Leaflets for PWDs

Example3:
Dental oral health care center

Teaching Leaflets for health professionals

➢ Teaching leaflets for health providers in hospital settings.

➢ Raising awareness about disability to overcome the barriers relating “acceptability”

Tips for accommodating visually impaired

『視覚に障害のある方が
病院に来院されたら』

うまく伝えられるか不安だな...

I'm anxious about communication

何かお困りですか？

May I help you?

障害の程度や症状は、ひとりひとり異なります。

あ

あ

や

まぶしさ（眩明）

全盲

視覚的な情報が制限されるため、情報を収集することが困難です。空間を把握すること、目的地までの距離や経路を確認することが困難です。コミュニケーションを大切に、柔軟な対応を心がけましょう。

• Brief teaching leaflet (4 pages) providing basic knowledge and skills for accommodating patients with visual impairments

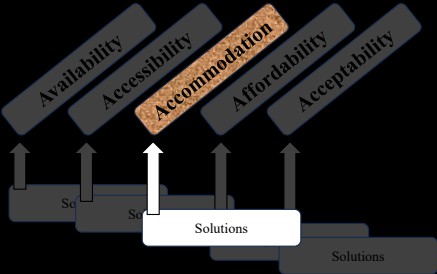
• Available online, free of charges

• Similar leaflets focusing on patients with hearing impairment (deaf), intellectual and developmental disabilities are also available.

• These leaflets are expected to raise awareness about disabilities among health providers, that would contribute to make hospital setting more acceptable for PWDs

Cancer Control Research
[https://plaza.umin.ac.jp/~CanRes/match/match-achievement/Health_Labour_and_Welfare_Sciences_Research_Grants\(20EA1014\)](https://plaza.umin.ac.jp/~CanRes/match/match-achievement/Health_Labour_and_Welfare_Sciences_Research_Grants(20EA1014))

Examples of Initiatives for equal access in Japan

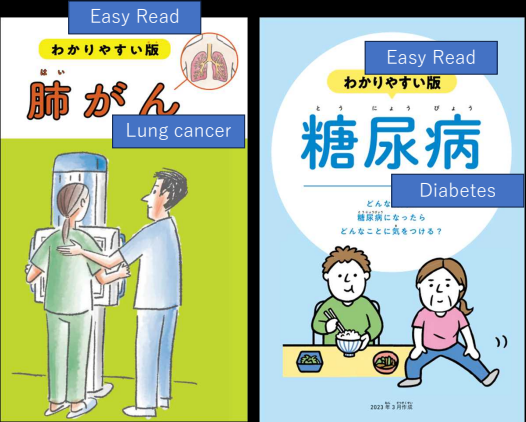


- Example1:
Teaching Leaflets for health professionals
- Example2:
Teaching Leaflets for PWDs
- Example3:
Dental oral health care center

Teaching
Leaflets
for
PWDs

- Teaching leaflets for persons with disabilities.
- Providing knowledge on diseases, symptoms, examinations, and treatments to overcome the barriers relating “accommodation”

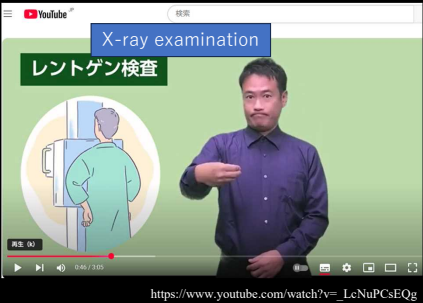
Example2. Teaching Leaflets for PWDs



- Brief teaching leaflet (10-20 pages), written in “Easy Read,” provides basic knowledge on disease and relevant info.(examinations and treatments) for PWDs.
- Available online, free of charges
- Similar leaflets focusing on colorectal and cervical cancer are also available.

Cancer Control Research
[https://plaza.umin.ac.jp/~CanRes/match/match-achievement/Health,LabourandWelfareSciencesResearchGrants\(20EA1014\)](https://plaza.umin.ac.jp/~CanRes/match/match-achievement/Health,LabourandWelfareSciencesResearchGrants(20EA1014))

Example2. Teaching Leaflets for PWDs

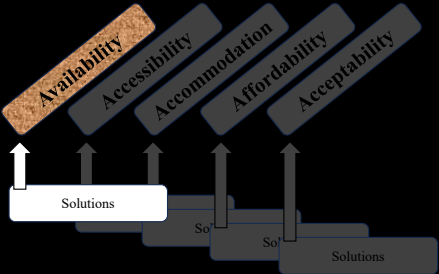


DAISY version

- Sign language version is available for Leaflet of lung cancer
- DAISY version is available for:
Leaflet of lung cancer
Leaflet of colorectal cancer
- These leaflets are expected to help PWDs understand diseases and relevant medical procedures, that would contribute to make hospital setting more accommodative for PWDs

Cancer Control Research
[https://plaza.umin.ac.jp/~CanRes/match/match-achievement/Health,LabourandWelfareSciencesResearchGrants\(23EA1030\)](https://plaza.umin.ac.jp/~CanRes/match/match-achievement/Health,LabourandWelfareSciencesResearchGrants(23EA1030))

Examples of Initiatives for equal access in Japan



- Example1:
Teaching Leaflets for health professionals
- Example2:
Teaching Leaflets for PWDs
- Example3:
Dental oral health care center

- Dental oral health care centers.
- Providing dental care for PWDs to overcome the barriers relating “availability”



Dental oral health care centers

- The dental oral health care center aims to provide oral health care for PWDs who cannot receive treatment at ordinary dental clinics due to disability relating issues (e.g., individuals with intellectual disabilities who cannot receive treatment calmly)
- The centers are established based on Act on Promotion of Dental and Oral Health
- 354 centers are available across Japan (as of 2017)

https://www.city.saitama.lg.jp/006/007/002/015/012/p065463_d/fil/01_20190626_1.pdf
<https://www.mhlw.go.jp/content/10804000/000840095.pdf>

Conclusions

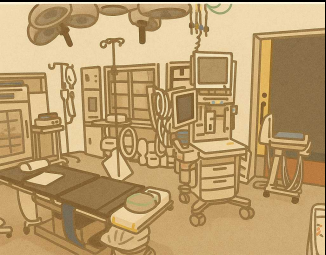
- The solutions presented are promising, but barriers for services access are still existing in Japan
- Further efforts are needed to overcome the barriers and to make health service access equitable for all



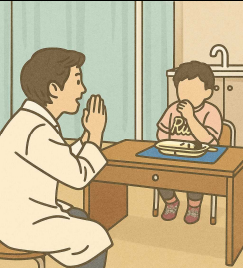
Dental oral health care centers



Special unit for W/C users



General anesthesia



Eating and swallowing training

ケアの架け橋：急性期病院における障害者の入退院支援



松村 幸子

国立健康危機管理研究機構 国立国際医療センター 入退院支援センター
看護師長 訪問看護認定看護師、日本

【略歴】

1988年に国立病院看護学校を卒業。千葉県がんセンターで4年間勤務した後、1992年に国立国際医療研究センターに異動。これまでの臨床経験には、手術室、集中治療室（ICU）、外来部門での勤務が含まれる。2011年からは地域医療連携センターの看護師として退院支援に携わり、2017年から看護師長を務めている。日本看護協会認定の訪問看護認定看護師。

【発表要旨】

この発表では、私が現在看護師長を務めている東京都内にある716床の急性期病院の入退院支援センターの取り組みをご紹介します。2017年に設立されたこのセンターは、入院前および退院時における患者支援において重要な役割を果たしており、入院に際しての不安や障壁に対応しています。

当センターのチームは、看護師、薬剤師、栄養士などで構成されており、入院前に患者さんへの面談を行い、健康状態、服薬状況、日常生活上の課題などを確認しています。このプロセスにより、入院時からの不安を軽減し、より質の高いケアの提供が可能になります。

この国際セミナーのテーマに沿って、特に障害のある方への支援に焦点を当ててご紹介します。障害のある患者さんが入院予定の場合、私たちは介護者から日常生活の様子、コミュニケーションの方法、必要なケアの内容などを詳しく聞き取ります。また、訪問看護師やケアマネジャーと連携し、ケアプランや指示書を事前に入手します。これにより、個別の看護計画を事前に立て、安全で快適な入院生活を支援することができます。

私たちの役割は入院時だけにとどまりません。退院時にも同様の支援を行い、ケアの継続性と地域への円滑な移行を確保します。このような連携体制により、特に複雑なニーズを持つ患者さんにとって、病院と自宅の間のギャップを埋めることが可能になります。

A bridge of care

Bridging Acute and Community Care for Persons with Disabilities in Japan.

“Hospital Admission and Discharge Support
for Persons with Disabilities”



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self-introduction



Sachiko Matsumura

National Center for Global Health and Medicine
Hospital Admission Support Center
Head nurse
Certified nurse in visiting nurse

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National Center for Global Health and Medicine (NCGM)

- Beds: 706
- Departments: 43
- Outpatients: 1,400 per day
- Ambulance acceptance:
Approximately 10,000 units/year
- Roles: Infectious disease center,
acute care,



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Outline of Today's Talk

1. What is Health Equity?
2. Challenges for persons with disabilities in acute care
3. Our hospital-based support model
4. A case example
5. Lessons and future directions



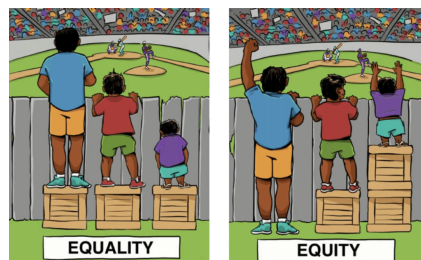
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1. What is Health Equity?

Health Equity Concept

Health equity means everyone should have a fair opportunity to attain full health potential.”

— WHO
(World Health Organization)



<https://unifywestfield.org/news/equity-versus-equality/>

Creating a level starting line toward a shared goal

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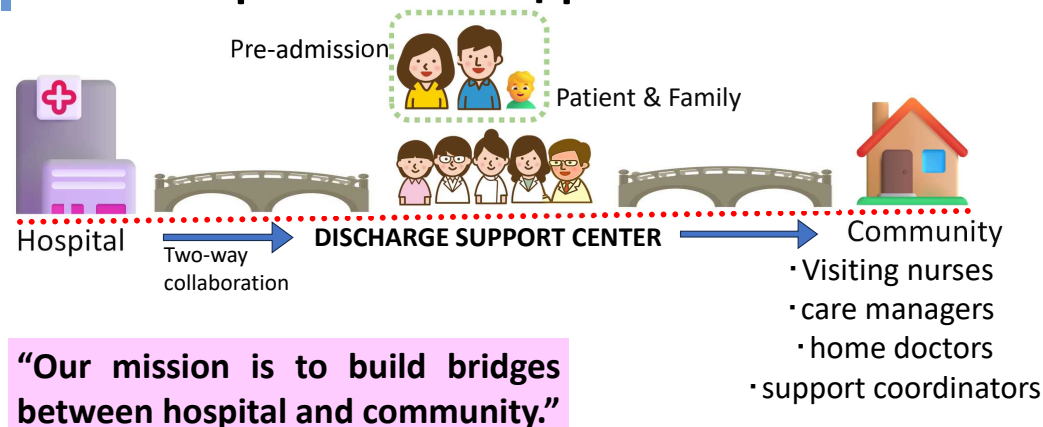
2. Challenges for persons with disabilities in acute care

Supporting children and adults with disabilities from admission to discharge.



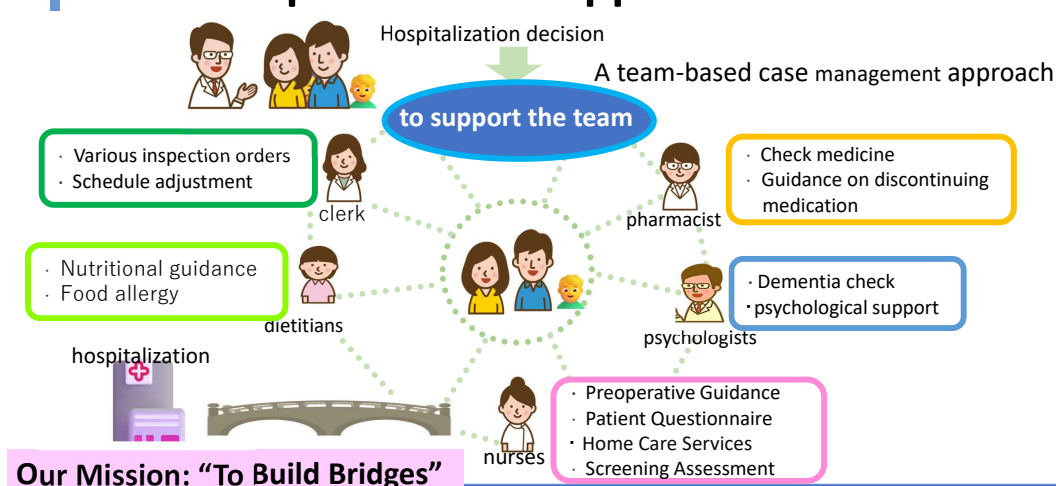
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3. Our hospital-based support model



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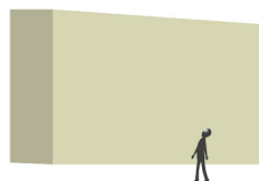
3. Our hospital-based support model



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Challenges faced by persons with disabilities during hospitalization

1. Barriers to information and communication
2. Barriers in the medical environment
3. Difficulties in continuing care



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Main Activities ① Pre-admission Support

Early information sharing from families/facilities

- Environmental check for medical care needs (suction, PEG, ventilator)
- Psychological support for families
- communication methods

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Main Activities ② In-hospital Support



- Communication aids (visual tools, interpreters) and psychological support
- Multidisciplinary case conferences
- **Advance Care Planning (ACP)** -based decision-making support

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Main Activities ③ Discharge Support

- Collaboration with home-visiting nursing services, welfare, and education sectors
- Pre-discharge conference to ensure smooth transition
- Focus on continuity of care and empowerment of families



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Case example

Female in her 20s – Spinocerebellar Degeneration

- Information collected at the Admission and Discharge Support Center
- Patient questionnaire and family interview
- Summary memo from family and home care service providers
- Use of communication aids



Bridging Care Settings:

home → inpatient care → Conduct pre-discharge conference → Discharge
→ Home-visiting nursing service continues post-discharge

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Home-visiting nursing services Summary

Communication aids and psychological support throughout hospitalization



コミュニケーションの取り方について

1. イエス・ノーの質問なら、手を握ってイエスの時握ってもらう
もしくは、筋緊張が四肢にある時など、イエスの場合、くちびるをすぼめてムッとするというと出来るときもあります。
2. または 50 音で質問、手を握り、あかさ たなは まやらわ とゆっくり読むと手でにぎってくれます。
3. エアスイッチを左手に握らせてください。
調子のよいときは iPad の電源がついていれば自分で操作できます。
コミュニケーションアプリ指伝話が iPad に入っています。

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Daily care schedule

一日スケジュール

病内服薬の内容、吸入薬の内容、カフアシスト指示、経管栄養の量・投与は指示コメントを確認してください！！

6:30	ネブライザー吸入、経管栄養(A)
7:00	経管栄養(PEG C)
7:30	朝食後薬投与
10:00	ネブライザー吸入、カフアシスト
12:00	経管栄養(A・B)
14:00	ネブライザー吸入、カフアシスト 経管栄養(A)
14:30	経管栄養(D 50%)
16:30	ネブライザー吸入
17:00	カフアシスト
19:00	ネブライザー吸入、カフアシスト、夕食後薬投与
	経管栄養(C)

Requires care every 1 to 2 hours.
The family posts a handwritten schedule in the room to share care information.

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Multidisciplinary Discharge Conference

The multidisciplinary team reviews the patient's progress and finalizes the discharge plan before discharge.



⇒ Discharge

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5. Challenges and Learnings

- System limitations and regional disparities
- Shortage of human resources in coordination roles
- Importance of flexible and patient-centered responses



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5. Future Directions

1. Education and training for inclusive care
2. Strengthening regional care networks
3. Policy recommendations and advocacy for inclusive healthcare



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Thank you for your attention !

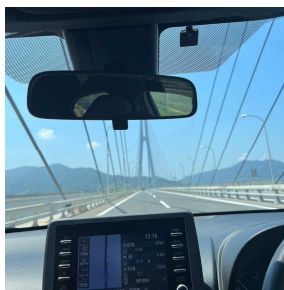


Photo: Shimanami Kaido, symbolizing the bridge of care

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