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A Study of the Improvement of Health Rights for People with Disabilities

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I Research Overview

1. Background and Objective

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1. Background and Objective

□ Research background

○ Of people with disabilities in South Korea, the percentage of seniors grew from 38.8 percent in 2011 to 43.3 percent in 2014. Moreover, the percentage of single-person households with disabilities doubled in a decade, reaching 22 percent. The numbers and percentages of elderly and single-person households with disabilities, which are especially prone to various health-related risks, have been rising steadily.

○ Until now, the right to health of people with disabilities had existed more or less in name only in Korea. There is, however, growing awareness of the importance of the social and environmental factors that influence health and the need to transition from a medical model of understanding disability to a social model.

○ The Act on Guarantee of Right to Health and Access to Medical Services for People with Disabilities (hereinafter "Health Right Act" or "HRA") was enacted in 2015 and remained in effect as of the end of 2017. As the law is still in its early stages, it is upon us to discuss and find

measures for protecting the right to health of people with disabilities by considering diverse theories and approaches.

□ Research objective

○ The goal of this study is to survey the concept of the right to health of people with disabilities and related laws in effect today, the health status and needs of people with disabilities, and policy examples found abroad, all with a view to finding local community-based measures for protecting and promoting the right to health of people with disabilities under the HRA.

□ Research method

○ First, we survey the literature to identify trends in relation to the concept of the right to health of people with disabilities and in related research in Korea and abroad. We also survey the existing health-related laws and policy programs specifically serving people with disabilities in Korea. We analyze these in comparison to similar policy and statutory measures abroad.

○ Second, we analyze the data of the Disability Survey (2014) and the Medical Panel Survey (2014), secondarily, to identify the disparities in health conditions between people with and without disabilities.

○ Third, we organize focus group interviews (FGIs) with people with disabilities and disability organization representatives to survey their opinions on health-related needs and the challenges they face.

II Findings

1. Theories on the Right to Health of people with Disabilities
2. Health Gap and Needs of people with Disabilities
3. Legal and Policy Support for the Right to Health of people with Disabilities
4. International Examples

Ⅱ Findings

1. Theories on the Right to Health of people with Disabilities

□ Right to health as defined in international law

○ Constitution of the World Health Organization (WHO): "The enjoyment of the highest attainable standard of health is one of the fundamental rights" and is crucial to "full physical, mental, and social happiness."

○ Universal Declaration of Human Rights (UDHR): "The right of everyone to enjoy the highest attainable standard of physical and mental health."

○ United Nations Convention on the Rights of people with Disabilities: "people with disabilities have the right to enjoy the highest attainable standard of health without discrimination on the basis of disability."

- These international conventions explicitly acknowledge the right that people with disabilities have to health, and also expressly state active measures that are to be taken to protect and uphold that right, such as the prohibition of discrimination on the basis of disability in health-related programs, health management and services, provision of food and beverages, and life insurances.

□ Right to health as defined in Korean law

○ Constitution: States that "all citizens are entitled to the protection of health provided by the state," but does not provide a distinct definition of the right to health.

○ Framework Act on Health and Medical Services (FAHMS): Does not specifically define either health or the right thereto, but expressly prohibits discrimination, acknowledges the right to information and self-determination, and guarantees confidentiality in related procedures.

○ HRA: "people with disabilities shall have the right to optimum health care and protection." And "people with disabilities shall have the right to access health care and health care services equivalent to those for non-disabled people."

□ Components of the right to health

○ We can understand the right to health as the "right to be healthy," "right to health care," and "rights in health care" (Moon, 1997, p. 275).

□ Right to health of people with disabilities

○ In a broader sense, we can understand the right to health of people with disabilities as consisting of the right to access health and medical services, various

facilities, settings, and other medical resources that are essential to the protection of health; the right to the equal enjoyment of resources without discrimination within a comprehensive system of health-related services; and the right to enjoy the highest attainable standard of physical, mental, social, and cultural health.

○ Specifically, these rights include:

- Right to be healthy:
- This right entitles people with disabilities to all forms of policy support for health. Examples of necessary policy measures include services that help disabled people participate in athletic and other various activities, provide adequate supplies of clean water and hygiene, and offer protection from environments that can adversely affect health.
- (Procedural) right to health care:
- This right entitles people with disabilities to policy measures on non-discriminatory and appropriate medical care for routine illnesses and injuries, vaccinations, basic pharmaceuticals, services that aim to minimize and prevent secondary disabilities, and support for accessing local health resources.
- Rights in health care:
- These rights entitle people with disabilities to equal

participation in health-related policymaking, control over their own health and physical activities, freedom from interference, information on the content and processes of medical services, and medical services of equal quality.

2. Health Gap[1] and Needs of people with Disabilities

□ Health gap between non-disabled and disabled people

○ Health conditions

Compared to people without disabilities, people with disabilities had lower good health awareness rates and higher chronic morbidity rates. Health awareness rates were higher among men and proportional to education and income. Chronic morbidity rates, on the other hand, were higher among women and inversely proportional to education and income.

1) The analysis of disparities in health conditions between people with and without disabilities as well as among people with different types of disabilities is based upon the raw data of the 2014 Korean Medical Panel Survey and 2014 Disability Survey.

〈Table 1〉 Health Conditions of people With and Without Disabilities

Condition	Without disabilities	With disabilities	F
Good health awareness rate (%)	42.2	30.6	37.59***
Chronic morbidity rate (%)	62.8	71.0	30.73***

Notes: 1) An adjusted mean test that was age controlled.
2) "Good health awareness rates" refers to the sum of the percentages of respondents who rated their health, subjectively, as "very good" or "good."
3) "Chronic morbidity rates" refers to the percentages of respondents who affirmed that they had suffered from a chronic disease for at least three months at the time of the survey.
4) *** p 〈 .001.
Source: Korean Medical Panel Survey (2014) (raw data re-analyzed).

○ Mental health

people with disabilities had higher rates of experience with depression, suicidal thoughts, and drug dependency than people without disabilities. Depression and suicidal thoughts were also more prevalent among women than men and inversely correlated to income.

〈Table 2〉 Mental Health of people With and Without Disabilities

Type	Without disabilities	With disabilities	F
Symptoms of depression (%)	7.6	13.7	32.90***
Suicidal thoughts (%)	5.7	10.1	23.28***
Drug dependency (%)	4.3	8.4	26.39***

Notes: 1) An adjusted mean test that was age controlled.
2) *** p 〈 .001.
Source: Korean Medical Panel Survey (2014) (raw data re-analyzed).

○ Use of medical services

people with disabilities also had higher hospitalization and emergency room usage rates than people without disabilities. Although people without disabilities are required to pay greater out-of-pocket expenses for public health services than people with disabilities, people with disabilities had higher rates of incomplete treatment and limits on dental treatment.

〈Table 3〉 Use of Medical Services by people With and Without Disabilities

Type	Without disabilities	With disabilities	F
Outpatient care usage rate (%)	84.9	84.7	0.05
Hospitalization rate (%)	12.5	18.6	24.83***
Emergency care usage rate (%)	7.8	14.4	42.58***

Notes: 1) An adjusted mean test that was age controlled.
2) *** p 〈 .001.
Source: Korean Medical Panel Survey (2014) (raw data re-analyzed).

○ Experiences with limits on medical services

people with disabilities were more likely to have experienced limits on their usage of medical services (i.e., higher incomplete treatment rates) than people without disabilities. They also faced greater restrictions on their usage of dental treatments.

〈Table 4〉 Experiences with Limits on Usage of Medical Services

Type	Without disabilities (b)	With disabilities (a)	F
Incomplete treatment rate (%)	17.3	20.5	35.67***
Limited dental treatment rate (%)	20.4	25.5	40.01***

Notes: 1) An adjusted mean test that was age controlled.
2) *** p 〈 .001.
Source: Korean Medical Panel Survey (2014) (raw data re-analyzed).

○ Health behavior

people with disabilities walked less than people without disabilities. However, there were no significant differences with respect to other behavioral health risks, such as smoking, drinking, lack of high- and medium-intensity exercise, and obesity.

〈Table 5〉 Health Behavior of people With and Without Disabilities

Type (%)	Without disabilities	With disabilities	F
Current smoking rate	20.7	19.8	0.34
Excessive drinking rate	15.9	14.8	0.42
High-intensity exercise rate	15.3	13.6	1.64
Medium-intensity exercise rate	11.8	11.1	0.33
Walking rate	34.4	30.1	6.09*
Obesity rate	24.5	27.0	2.26

Notes: 1) An adjusted mean test that was age controlled.
2) Current smoking rate: percentage of every day smokers + percentage of occasional smokers
3) Excessive drinking rate: sum of percentages of men who drink seven or more glasses at a time, women who drink five or more glasses at a time, and men and women who drink at least twice a week
4) High-intensity exercise rate: percentage of people who exercise vigorously for at least 20 minutes per session three times a week

5) Medium-intensity exercise rate: percentage of people who exercise at medium intensity for at least 30 minutes per session five times a week
6) Walking rate: percentage of people who walk for at least 30 minutes per session five times a week
7) Obesity rate: percentage of people with a BMI of 25 or higher.
8) ** p < .05.

Source: Korean Medical Panel Survey (2014) (raw data re-analyzed).

□ Health Disparities among people with Disabilities by Disability Type

○ Health conditions

people with organic and mental disabilities had lower good health awareness rates and higher chronic morbidity rates than people with other types of disabilities. In addition, people with severe disabilities had lower good health awareness rates and higher chronic morbidity rates than people with mild disabilities. The same pattern was observed with respect to people who had been disabled for less than 20 years, compared to those who had been disabled for 20 years or longer.

〈Table 6〉 Health Conditions among people with Disabilities by Disability Type

Type		Health awareness rate (%)	Chronic morbidity rate (%)
Disability type	External physical (excluding sensory)	12.0	78.2
	Sensory	19.5	72.0
	Organic	6.6	96.6
	Developmental	14.9	74.3
	Mental	9.6	100.0
	(F)	19.57***	78.29***

Type		Health awareness rate (%)	Chronic morbidity rate (%)
Severity of disability	Severe (Grades 1 to 3)	9.8	83.4
	Mild (Grades 4 to 6)	15.5	76.3
	(F)	40.82***	50.62***
Duration of disability	Less than 20 years	11.5	82.3
	20 years or more	16.6	73.2
	(F)	37.68***	88.64***

Notes: 1) An adjusted mean test that was age controlled.
2) *** p < .001.
Source: Disability Survey (2014) (raw data re-analyzed).

○ Mental health

Symptoms of depression and suicidal thoughts were more common among people with organic and mental disabilities than people with other types of disabilities. The same was true for people with severe, rather than mild, disabilities.

〈Table 7〉 Mental Health of people with Disabilities by Disability Type

Type		Depression	Suicidal thoughts	Suicide attempts
Disability type	External physical (excluding sensory)	22.8	18.9	1.3
	Sensory	19.8	15.5	1.5
	Organic	29.3	27.3	2.8
	Developmental	15.5	0.6	0.0
	Mental	45.5	34.5	4.8
	(F)	25.25**	22.88**	9.35**
Severity of disability	Severe (Grades 1 to 3)	27.9	23.1	1.8
	Mild (Grades 4 to 6)	19.5	15.8	1.2
	(F)	56.92**	50.15**	4.16*

Type		Depression	Suicidal thoughts	Suicide attempts
Duration of disability	Less than 20 years	24.4	19.7	1.7
	20 years or more	21.0	17.2	1.1
	(F)	9.42**	7.09*	3.43

Notes: 1) An adjusted mean test that was age controlled.
2) * p < .05 and ** p < .01
Source: Disability Survey (2014) (raw data re-analyzed).

○ Medical services

The continued treatment, outpatient care, and hospitalization rates were all higher among people with mental and organic disabilities than among people with other types of disabilities. The same was true for people with severe, as opposed to mild, disabilities. On the other hand, people with mental, developmental, or severe disabilities were less likely than others to seek physical and dental checkups. Incomplete treatment rates were higher among people with external physical, sensory, or severe disabilities than among others.

〈Table 8〉 Use of Medical Services by Disability Type

Type		Continued treatment rate	Outpatient care rate	Hospitalization rate
Disability type	External physical (excluding sensory)	79.6	55.0	22.6
	Sensory	72.1	51.3	18.9
	Organic	99.6	70.8	43.1
	Developmental	74.2	49.6	19.0
	Mental	10.7	60.4	39.1
	(F)	80.15***	13.95***	35.80***
Severity of disability	Severe (Grades 1 to 3)	83.5	54.6	27.6
	Mild (Grades 4 to 6)	77.9	55.1	20.1
	(F)	29.98***	0.12	46.16***
Duration of disability	Less than 20 years	84.1	57.9	24.9
	20 years or more	73.2	50.2	21.0
	(F)	122.86***	37.58***	12.49***

Notes: 1) An adjusted mean test that was age controlled.
2) *** p 〈 .001.
Source: Disability Survey (2014) (raw data re-analyzed).

○ Experiences with limited medical services

people with external physical (excluding sensory) disabilities had the highest percentage of experiences with limited medical services, followed by people with sensory disabilities. There were no statistically significant differences associated with disability types in relation to limits on dental treatment. However, people with severe disabilities had higher incomplete treatment rates than those with mild disabilities. The same was true for limits on dental treatment. Although no statistically significant differences emerged in incomplete treatment rates due

to the duration of disability, people who had been disabled for 20 years or longer had higher rates of limited dental treatment than those who had been disabled for less than 20 years.

〈Table 9〉 Limits on Medical Services and Types of Disabilities

Type		Incomplete treatment rate (%)	Limited dental treatment rate (%)
Disability type	External physical (excluding sensory)	19.9	26.3
	Sensory	17.3	26.6
	Organic	12.2	26.0
	Developmental	16.0	27.6
	Mental	16.4	25.4
	(F)	4.58**	0.11
Severity of disability	Severe (Grades 1 to 3)	19.7	28.4
	Mild (Grades 4 to 6)	17.4	24.9
	(F)	4.90*	8.63**
Duration of disability	Less than 20 years	18.1	25.1
	20 years or more	19.1	28.6
	(F)	0.95	9.73**

Notes: 1) An adjusted mean test that was age controlled.
2) * p < .05 and ** p < .01
Source: Disability Survey (2014) (raw data re-analyzed).

○ Health behavior

Smoking was most prevalent among people with mental disabilities. Excessive drinking rates were higher among people with external physical or sensory disabilities than people with other disabilities.

〈Table 10〉 Health Behavior and Types of Disabilities

Type		Current smoking rate (%)	Excessive drinking rate (%)	Exercise rate (%)
Disability type	External physical (excluding sensory)	20.4	4.7	40.8
	Sensory	20.0	4.0	42.9
	Organic	9.2	1.0	46.0
	Developmental	-1.8	-3.2	40.3
	Mental	24.3	-0.8	41.2
	(F)	29.92***	16.68***	1.28
Severity of disability	Severe (Grades 1 to 3)	14.3	1.8	37.6
	Mild (Grades 4 to 6)	21.3	4.9	43.8
	(F)	47.26***	38.00***	21.99***
Duration of disability	Less than 20 years	18.6	3.9	43.6
	20 years or more	19.1	3.5	37.8
	(F)	0.30	0.62	21.49***

Notes: 1) An adjusted mean test that was age controlled.
2) Current smoking rate: percentage of every day smokers + percentage of occasional smokers
3) Excessive drinking rate: sum of percentages of men who drink seven or more glasses at a time, women who drink five or more glasses at a time, and men and women who drink at least twice a week
4) Exercise rate: percentages of people who exercise for at least 30 minutes per session three times a week
5) *** $p < .001$.
Source: Disability Survey (2014) (raw data re-analyzed).

□ FGIs on the Health Needs of people with Disabilities

○ Disruptions in use of medical services due to disability

- Major issues identified by people with disabilities regarding their use of medical care included: (1) limitation on physical access to facilities and equipment

for testing and treatment; (2) problem of psychological access due to medical workers' prejudices against people with disabilities; and (3) general difficulty accessing medical services due to disruptions in communication.

- The interviewees also pointed out the relative alienation of people with organic or developmental disabilities, as much of the policy debate on supporting disabled people' access to medical resources, rehabilitation sports, etc. is focused upon mobility and physical disabilities.

○ Recommendations

- First, the discourse on the right to health of people with disabilities should be expanded to include increases in medical equipment and devices, dental care, and mental health support. Second, the discourse should also focus on protecting disabled people' right to health as part of prevention efforts. Third, there should be more discussion on how to achieve the first two goals, e.g., by increasing budgets. Fourth, and finally, the discourse on guaranteeing medical care for people with disabilities should begin from the perspective of social integration.

3. Legal and Policy Support for the Right to Health of people with Disabilities

□ Laws

○ FAHMS: Provides for the health of and related services for people with disabilities in Articles 34 (Promotion of Health for Disabled people) and 45 (Provision of Health and Medical Services for Disadvantaged Classes).

○ Act on Welfare of people with Disabilities (AWPD): Contains provisions concerning the health of people with disabilities, including Articles 17 (Prevention of Disabilities) and 18 (Medical and Rehabilitation Treatment).

○ Act on the Prohibition of Discrimination against people with Disabilities (APD): Defines the right to health in Article 3 (Definition) and provides for specific measures, under Article 31, prohibiting discrimination in terms of the right to health.

○ HRA: Provides for the formulation of comprehensive plans, implementation of programs, and organization of health care services for people with disabilities.

□ Government Plans for the Health of people with Disabilities

○ Health Plan 2020

- Health Plan 2020 lays down policy tasks in six areas. The health of people with disabilities is part of the 32

core tasks in the area of “demographic-specific health management.”

○ Disability Policy Master Plan

- Among the four key areas of policymaking for people with disabilities under the Fourth Disability Policy Master Plan, the reinforcement of preventive and rehabilitative care for people with disabilities is a core task, and the development of health infrastructure is one of the lower-level tasks.

○ Mid- to Long-Term Plan for Promoting the Rights of people with Disabilities

- This plan lays down seven policy objectives, including the protection of the right to enjoy good health without discrimination.

□ HRA[2)]

○ Consists of a total of six chapters and 28 articles.

- Purpose: “To contribute to improving the health of people with disabilities by providing for matters concerning support for the guarantee of the right to health, establishment of a health care system, and guarantee of access to medical care for people with disabilities” (Article 1).

2) Enacted in December 2015, effective as of December 2017.

- Subjects: people defined under Article 2 of the AWPD, including, for the purposes of rehabilitation medicine and exercise, people who have been ill or injured and are diagnosed as being disabled due to their inability to recover fully from their illness or injury (Articles 3.1, 3.4, and Article 15).
- Formulation of comprehensive plans for health care for people with disabilities (Article 6): The Minister of Health is to formulate a comprehensive plan every five years following deliberation by the Committee on Policy Coordination for people with Disabilities. Said plan is to be included in the development and implementation of the national health promotion plans formulated under the National Health Promotion Act.
- Budget: The national and local governments are to subsidize, fully or partially, expenses pertaining to the tasks of health and medicine centers for people with disabilities and health care programs for people with disabilities (Article 22).

○ Recommendations

- First, the law should be made to state specific measures for monitoring, evaluating, following up on, intervening in, and improving health care programs for people with disabilities so that those programs can be executed with greater effectiveness.

- Second, the law should also specify the objectives and details of a policy support system tailored to different types of disabilities, and introduce similar statutory measures, too.
- Third, policymakers should compare the HRA to other health-related statutes, including those for cancer, cardiovascular disease, and chronic cancer patients and prevention, in order to review and introduce measures for providing a wide range of equivalent services and benefits for people with disabilities currently in effect.

□ Public Health and Medical Programs for people with Disabilities

○ Health programs for the disadvantaged: absence of an effective system, institution, and statutory grounds for connecting public medical and welfare services.

- A public medical and welfare service center should be set up in each region to enable people with disabilities, seniors, and the poor to receive all the medical services they need. A network should also be established to ensure more efficient use of locally available resources.

○ A public health and welfare hub program for the disadvantaged

- The regional or local public medical and welfare centers should serve as efficient channels via which disadvantaged clients in need can receive support with respect to diagnosis, treatment, and post-treatment return to society.
- Since 2015, the Public Medicine Division of the Ministry of Health and Welfare (MOHW) has been supporting six regional hospitals through the Public Health Program Subsidization Fund, enabling them to function as sources of integrated public services related to medicine and welfare.

4. International Examples

□ United Kingdom

○ Background for reform: The Health and Social Care Act was enacted in 2012 to replace the National Health Service Act, instituting a wide range of reforms in health and care services.

- The new law required the National Health Service (NHS) to provide proactive health services for local communities under the NHS Continuing Healthcare brand. The NHS was to directly fund and subsidize the costs incurred by these proactive services.

○ Health inequality facing people with developmental disabilities

- people with developmental disabilities were found to face serious health inequality in the United Kingdom (Emerson and Baines, 2010; Mencap, 2017). The UK government has responded to these findings by monitoring the health of developmentally disabled people using diverse indicators.
- Six main causes of this health inequality have been identified (Emerson and Baines, 2010):
  - Social determinants, such as poverty and poor living conditions, which affect the rest of the public as well; genetic and biological factors related to disability; problems with communication and lack of health education; individual behavior that increases health risks; lack of access to health services and poor quality of the services available; and lack of access to health checkups.

○ Personal Health Budgets to improve the health of people with disabilities

- As part of the 2012 health reforms, the NHS introduced the Personal Health Budgets for people with disabilities.
  - Inspired by the previous Individual Budgets for people with disabilities, the Personal Health Budgets,

provided from the budget of the NHS, were to be spent specifically on health-related matters.

- Individual eligible people (or their representatives) were to devise budget spending plans in consultation with the local clinical commissioning groups. Eligible people were to specify how to measure the improvements in their health and quality of life and how they would spend the budgets according to these plans.

- The goal was to provide greater choice and control for individuals so that they could choose health services according to their needs.
- The Personal Health Budgets were to be spent on any and all services included in the NHS' support plan (excluding primary health services, such as emergency care, visiting family doctors, and dental care).

○ Implications

- The accessibility of health services should be improved before the accessibility of medical services, as part of the efforts to enhance disability prevention.
- Budget-type support is needed to grow beyond the supplier-centered model of health services and enable people with disabilities to exercise greater freedom and control.

- Solving the problem of health inequality facing people with disabilities requires efforts to eliminate their exclusion from all aspects of society, going above and beyond enhancing access to health and medical services for people with disabilities.

□ Germany

○ Basics of the German policy on the right to health of people with disabilities

- Germans do not consider disability as a disease. They regard social conditions as equally important to ensuring individuals' health as personal conditions.
- The objective of the German health policy is to establish and provide a health system for all. The needs of people with disabilities are taken into account within this larger system.
- In an effort to fulfill the requirements of the UN Convention on the Rights of people with Disabilities, the federal government introduced Nationaler Aktionsplan 1.0 in 2011, and followed it up with Nationaler Aktionsplan 2.0 in June 2016, listing 175 strategic tasks to be carried out across 13 areas requiring action.

○ Health policy and programs for people with disabilities

- Policy benefits for people with disabilities include medical rehabilitation benefits,[3] which are provided to prevent, eliminate, ameliorate, compensate for, and prevent the deterioration of chronic diseases and disabilities and minimize restrictions on the ability to earn a living and dependency on care services (Article 26.1, Volume 9, Social Code).
- Medical rehabilitation benefits are provided by public health insurance, public pension, and public accident insurance agencies. Rehabilitation services for the recovery of health are mostly handled by the health insurance, while services that help people restore their ability to earn a living are handled by the public pension.
  - To obtain medical rehabilitation services, one must submit a doctor's note to the authority in charge for authorization.
- Rehabilitation sports and functional training: These are benefits provided to enhance people's capability

3) Medical rehabilitation benefits (Chapter 1, Volume 9, Social Code) include follow-up treatment, treatment for children, parental rehabilitation, family-oriented rehabilitation, after-care for cancer patients, early education and training for children with (or at the risk of developing) disabilities, non-medical pediatric benefits, social medical recuperation for children up to the age of 14, intervention for addiction patients, stage-by-stage reintegration, and elderly rehabilitation services.

to engage in daily activities in the aftermath of their diseases or injuries. As such, they form a supplementary subcategory within medical rehabilitation benefits.

- The objective is to strengthen the physical and social functions of people with disabilities so that they can continue to work and participate in society. Eligible people undergo rehabilitation and functional training aimed at helping them engage in athletic activities on their own.

○ Implications

- The health policy for people with disabilities should be refined to ensure that it satisfies the diverse needs that arise from diverse circumstances.
- More emphasis should be placed on rehabilitation sports and functional training. These are necessary to enable people with disabilities to live more autonomous lives and participate fully in society.
- Sports and related support systems should be established at the level of local communities under the ideal of "barrier-free medicine" (barrierefreie medizing) so that all people can benefit from health support programs irrespective of disability.

□ Japan

○ National Health Promotion Movement and the Health Promotion Act

- National Health Promotion Movement in the 21st Century ("Healthy Japan 21"): The Japanese government launched the Healthy Japan 21 campaign in 2000 as part of its response to the rising demand for medical care and nursing. The goal was to reduce the gap between the average lifespan and the healthspan.
- Health Promotion Act (2002): Capital cities and prefectures, as well as cities, counties, and villages, are to establish health promotion plans and policies on organizing health checkups for local residents (Chapter 2).

○ Promoting the health of people with disabilities

- Disability-preventing checkups for different age groups: There are legally required checkups and general checkups that individuals can choose to undergo. The former are relatively simple tests that employers are required to provide for their employees under the Labor Safety and Hygiene Act. The latter are more expensive and sophisticated tests, ranging from 50 to 100 tested items, and may not be covered by insurance.
- Health examinations for people with disabilities (1992): These tests are similar to those involved in general

checkups, but patients can choose the types of tests and add special requirements in light of their disabilities. Patients pay 100 percent of the costs.

- Family doctors: The family doctor system was introduced to provide routine health-related consultations on and diagnoses of lifestyle diseases (hypertension, diabetes, etc.) for locals and refer them to specialized practitioners or hospitals when more advanced tests or hospitalization is needed. The system is meant to more evenly distribute the workload across the medical system.

○ Medicine and medical rehabilitation for people with disabilities

- Medical programs for people with disabilities (274, as of 2014): The overarching objective of these programs is to enable people with disabilities to receive medical services in their medical communities. The programs include: raising funds to finance the treatment and dental care of people with severe disabilities, detecting and treating diseases early, financing the costs of medical care for people with mental disabilities, supporting children with disabilities, and training disability welfare workers.
- Specialized rehabilitation for people with disabilities (Health and Exercise Science Support Center for people with Disabilities at the National Rehabilitation

Hospital): This institution provides health management care, athletic support, and functional training that enable people with disabilities to function better in their daily life and enjoy longer lifespans.

○ Sports for people with disabilities

- Basic Sports Act (2011): This law provides for policy programs that increase the participation of people with disabilities in local sports, including those for promoting and advertising sports, supporting the athletic activities of disabled students at special-needs schools, subsidizing the activities of sports associations for people with disabilities, and organizing national sporting events.
- Sports centers for people with disabilities: These centers, which are properly equipped to help people with disabilities engage in exercise and sports, are found in most prefectures, cities, counties, and villages.

○ Implications

- Health-related organizations cooperate to strengthen health support for people with disabilities.
- Comprehensive care for disability prevention, exercise and sports therapies, and rehabilitation.
  - A system of continuous support involving family doctors, sports support, and rehabilitation support

in local communities (people with disabilities admitted to rehabilitation hospitals before finally being discharged and allowed to go home).

- Health plans and programs for people with disabilities should be based upon statutes.
- Policy support is needed to develop rehabilitation and sports personnel, including those capable of prescribing and instructing exercises, for people with disabilities.

III

Promoting the Right to Health of people with Disabilities

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□ Main aims

○ Policy programs that promote the health of people with disabilities should reflect the specific disabilities, health conditions, and needs of their beneficiaries. Efforts must be made to establish a nationwide environment in which people with disabilities are not discriminated against or denied any resources necessary to enjoy a healthy life in their own communities.

○ people with disabilities have the right to optimum health and protection, the right not to be discriminated against, on the basis of their disabilities, in health and medical services, and the right to equal access to medical care along with people without disabilities.

- Active policy measures are needed to protect the right to health of people with disabilities by enhancing the accountability of related programs and enabling people with disabilities to overcome discrimination in relation to health in their local communities.

□ Promoting the right to health

○ Serving diverse needs

- Health policy for all age groups

  • As aging is a leading risk factor for health, it is unsurprising that disabled people of advanced age also face greater risks than younger people. It is therefore essential to prioritize the health of elderly people with disabilities. However, given the fact that elderly health conditions are outcomes of diverse personal and socio-environmental factors since childhood, the health policy for people with disabilities should encompass measures for all age groups. Furthermore, such policy should provide for post-disability treatment and management as well as efforts to prevent disabilities from occurring or deteriorating.

- Customizing policy to different needs

  • In devising the health policy for people with disabilities, it is important to prioritize the needs of people with organic, mental, and severe disabilities. Sustained management services for chronic diseases and disabilities should be tailored to different types or severities of disabilities. As people with disabilities are especially vulnerable to depression, suicidal thoughts, and other mental health risk factors, greater support for mental health is needed.

- Measures are also needed to reduce health and welfare inequality concerning disabled women and seniors as well as people with low educational attainment. Special care is needed to reduce the difficulties disabled people face in seeking dental care in local communities.

○ Reinforcing health and medical management

- Systematizing health checkups and follow-up
  - Compared to people without disabilities, disabled people undergo fewer checkups and walk or exercise far less. These behavioral factors contribute to the deterioration of disabilities and seriously threaten their health in old age. Measures are thus needed to increase the percentage of people with disabilities undergoing checkups and ensure the continuous management of their health and disabilities by age and disability type. Post-checkup follow-up is also needed to ensure the original objectives of checkups are met.
- Establishing rehabilitative sports and support for participation
  - As the HRA requires the Korean state to provide the diverse facilities and resources needed to enable people with disabilities to achieve and enjoy good health, it is crucial to foster an environment nationwide in which people with disabilities can easily participate

in rehabilitative sports. The eligible people and schedules of such services should be stated clearly, and the agencies and people to provide such services specified.

- Developing user-centered and active health management programs
  - Considering the fact that societal medical expenditure is on rise due to the increasing prevalence of disabilities, secondary disorders, and related chronic diseases, health management services should lead efforts to provide active support for health. The system for providing health management services should thus be reformed with the crucial aim of reorienting the entire health program system to ensure the convenience of users.
- Ensuring a multidisciplinary approach to and interdepartmental cooperation for health management for people with disabilities
  - A multidisciplinary and team-based approach is needed in order to provide a comprehensive range of professional services, from medical treatment to rehabilitation and beyond, that satisfy the needs of people with disabilities. To this end, disabled people as well as medical and related personnel should be educated on the right to health based on an approach

that encompasses medicine, rehabilitation, welfare, and so forth. Interdepartmental cooperation among related agencies is also crucial.

○ Enhancing access to health and medical services

- Introducing family doctors for people with disabilities
  - As people with disabilities face great difficulties in achieving and maintaining good health, having family doctors is all the more important for them. A family doctor system should be established so as to ensure sustained and centralized health management for people with disabilities. Although the HRA currently provides for family doctors for people with severe disabilities (Article 16), further debate and research are needed to determine whether its scope should be expanded to include all disabled people in need of professional health management. Training is also needed to help make family doctors more sensitive to disabled people' needs.
- Promoting barrier-free medicine (providing mobility support)
  - Given the restrictions they face in terms of mobility and communication, people with disabilities have less access to medical services than non-disabled people. people with external physical disabilities have trouble traveling to the medical institutions

they need to visit, while people with sensory and mental disabilities have difficulty communicating.

- Taxi services should be increased specifically to help people with disabilities visit medical institutions. Public health service agencies, including health checkup agencies and local health centers for people with disabilities, should also provide vehicles, sign language interpretation, and other such resources to assist patients in making their visits. Physical barriers should be removed, and accessible medical equipment and resources increased (including different auxiliary devices for people with different types of disabilities).

- Arrangements should also be made to have medical professionals visit people with severe disabilities and bedridden patients in their homes to provide services.

○ Amending the HRA as the "mother legislation" on all matters of health for people with disabilities

- There are multiple statutes on the health of people with disabilities, including FAHMS, AWPD, and HRA. The divergence between these statutes in terms of scope and content prevents effective cooperation among related organizations, while redundant investments of resources continues to occur. The HRA should thus be expanded and strengthened to serve as the "mother

legislation" on all matters of health for people with disabilities.

○ Achieving a comprehensive health policy geared toward ending discrimination in local communities

- Efforts should be made to enhance disabled people' access to health and medical services and the resources necessary for a healthy life in their local communities. Active intervention and support is needed to end discrimination in matters related to the right to health.

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