Att.: The Special Rapporteur on the rights of

persons with disabilities  
 Catalina Devandas-Augilar

Taastrup, *26 Mar 2018*

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Reply to the questionnaire from the Special Rapporteur on the right to health for persons with disabilities

We thank you very much for the opportunity to supply information on health matters in Denmark for persons with disabilities.

**Question no 1.** We have little information on planned legislation specifically targeted at the realization of the right to health of persons with disabilities. However, we shall point to current initiatives of interest.

*First*, health checks targeted at persons with intellectual disabilities and persons with psychosocial disabilities have been introduced in 5 municipalities in Denmark, but on an experimental and time-limited basis only.

The level of premature mortality of persons with intellectual disabilities (more than 14 years) is documented by this report: <http://www.si-folkesundhed.dk/upload/udviklingshæmning.pdf>

The level of premature mortality of persons with severe psychosocial disabilities (15 to 20 years) in Nordic countries, including Denmark, has been documented in this study: <https://www.ncbi.nlm.nih.gov/pubmed/23372832>

It is therefore of utmost importance that health checks to these very vulnerable groups be introduced on a nationwide, regular and permanent basis. We cannot be sure, though, that this in fact will happen.

We therefore strongly urge the Special Representative to focus on this problem. We shall also draw attention to the fact that the level of premature mortality among persons with psychosocial disabilities was considered a violation of the right to health (article 25) in the Concluding Observations on Denmark from the UN Committee of Persons with Disabilities.[[1]](#footnote-1) Very little has happened since then.

The social experiment with health checks is briefly described in this call for applications from the Danish Health Authority: <https://www.sst.dk/da/puljer-og-projekter/2014/lighed-i-sundhed-og-sundhedsvaesnet>

<https://www.sst.dk/da/puljer-og-projekter/2014/~/media/0A701C05EC1344208C8FF6F99E20A13A.ashx>

*Secondly*, the Danish government has recently announced that the dental health care system is to be scrutinized. One of the aims is to improve equal access to dental health care. This is much needed. Dental care is generally not for free, and this creates an economic barrier of equal access to dental health care.

One aspect of this is the fact that certain types of medicine cause damage to the teeth because of dry mouth (or xerostomia). Persons with disabilities are more often dependent on medication for health reasons and are therefore much more affected by this problem.

This is well documented, but despite this there is little attention to this problem. Reasonable accommodation in this field is needed. There is a need to educate health personnel, improve preventive efforts and to amend health legislation to provide affordable access to dental treatment of damages caused by necessary drugs.

Many types of disabilities are affected. But especially drugs targeted at treating mental illnesses are heavily represented on the list. Persons with psychosocial disabilities form a very vulnerable group and cannot address dental problems without services targeted at their needs.

See this article for a research review of medicine causing xerostomia <https://www.tandlaegebladet.dk/sites/default/files/tb10-2017_840.pdf>

See the SIF report for evidence that persons with disabilities have worse dental health than persons in general (p. 38 and p. 109): <https://www.sum.dk/Aktuelt/Nyheder/Lighed-i-sundhed/2014/Maj/~/media/Filer%20-%20dokumenter/Handicappede-2014/Sundhedsprofil%20for%20voksne%20med%20helbredsrelateret%20aktivitetsbegrænsning%20og%20fysisk%20funktionsnedsættelse.ashx>

**Question no 2.** Few, if any, health services in Denmark can be considered completely barrier-free. We have documented, on the basis of public data, that less than 50 % of the services in the primary health sector (GP’s, dentists, physiotherapists, psychologists, etc.) are accessible to persons with disabilities. <https://www.dr.dk/nyheder/regionale/fyn/trapper-og-smaa-doere-handicappede-udelukkes-fra-mange-sundhedstilbud>

A recent report from the social research center VIVE documents that persons with disabilities are worse off in many health related aspects than people without disabilities. This also includes many important social determinants of health such as income, access to education and to the labor market. <https://pure.sfi.dk/ws/files/1045522/personer_med_handicap_pdfa.pdf>

A national health profile of persons with disabilities from the State Institute for Public Health (SIF) evidenced the existence of massive inequality in health and access to conditions promoting a healthy life. Persons with disabilities are worse off in all aspects in comparison with persons with no disabilities.

<http://www.si-folkesundhed.dk/upload/sundhedsprofil.pdf>

A recent report on the health of persons with cerebral paresis (CP) documents that they attend services of preventive care, e.g. cancer screening programmes, to a much lesser extent than people without CP. <http://www.si-folkesundhed.dk/upload/voksne_med_cerebral_parese_i_danmark.pdf>

As in many other countries, mental health problems are on the rise. Persons with disabilities are disproportionately affected by this trend. This is documented in the VIVE and SIF reports referred to above (e.g. on such parameters as sleep deprivation, stress and psychic symptoms). There is a lack of easily accessible and affordable mental health services. E.g. psychotherapy is not for free which disfavors persons with disabilities.

**Question no 3**. The evidence provided both above and below shows that persons with disabilities face considerable barriers to access to health services and conditions furthering a healthy life. Discrimination in fact is therefore widespread.

As regards insurance, the VIVE report documents that 24 % of the respondents with disabilities report to have been denied access to insurance for reasons of disability or health (see chapter 10 in the report).

**Question no 4**. *First,* in 2014 the Danish government and the regional authorities responsible for psychiatric treatment in hospitals agreed that the use of coercion should be reduced by 2020. The use of coercion is regularly being monitored, but progress has been slow or non-existent, and few believe the targets will be met in 2020.

The statistical monitoring database can be found here: <http://esundhed.dk/sundhedsregistre/tip/Sider/tip01.aspx>

The latest monitoring report can be seen here: <https://www.sst.dk/da/nyheder/2017/~/media/C3591B2DDEE84FAEBD5507878BC1591A.ashx>

By 1st January a new law on coercive treatment of persons lacking the ability to consent to somatic treatment entered into force. With a few exceptions, the use of coercion in the somatic health sector has not been legal, but this has changed now. The main target groups of the law are persons with intellectual and psychosocial disabilities.

In our view the law is not the right answer to the poor health situation of the targets groups, Instead as we have pointed out above, the introduction of systematic health checks would be a much more appropriate and effective answer. In addition, this would be in conformity with human rights requirements and WHO recommendations. [[2]](#footnote-2)

Targets for reducing the use of coercion ought to be set up, too, together with an effective monitoring system, including the provision of regular statistics to monitor the development in the use of coercion.

*Secondly,* the idea that coercion is an appropriate measure in social and health care settings is, unfortunately, becoming more widespread. Two brief examples shall be mentioned here.

The Danish Ministry of Social Affairs has recently published a report recommending a more flexible and extended use of coercive measures in social care towards persons with intellectual and psychosocial disabilities.

Link to the report: <http://www.ft.dk/samling/20171/almdel/SUU/bilag/256/1870417.pdf>

The Danish Parliament has passed a bill on special places in psychiatric hospitals targeted at persons with aggressive behavior and drug or alcohol abuse. In the original proposal, the use of coercive measures was authorized, even though the persons were not in a state of mental illness requiring psychiatric treatment. The final legislation does not contain elements of coercion, though, but this was definitely the intention.

Link to the law in question: <https://www.retsinformation.dk/Forms/R0710.aspx?id=191819>

**Question no 5**. To some extent, DPOD is consulted in matters of health, but on an ad hoc basis only. There is a need to institutionalize dialogue with and consultation of DPOD on the central political level in all stages of the political process.

Yours sincerely,

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Thorkild Olesen, chairman

1. <http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhsrxgrMqyLrvLrl%2F6hod6mnZ5w6Or5OgmaXjKC%2BkJbNwXf58Tuqzhdo7nnm2ksXJYLVUELVMje6X74w4dYLO91T2%2FW%2Ft8G8g3rUbOPHhh%2F51P> [↑](#footnote-ref-1)
2. ] WHO Europe, European Declaration on the Health of Children and Young People with Intellectual Disabilities and their Families, 2010. See especially pa 9.6. This recommendation is no less relevant for adults. <http://apps.who.int/iris/handle/10665/108010> [↑](#footnote-ref-2)